Child sexual exploitation and mental health

Children's Social Care Innovation Programme

Thematic Report 3

Dr Nikki Luke
With Professor Judy Sebba, Dr Alun Rees and Di McNeish
July 2017

REES CENTRE
Research in Fostering and Education
University of Oxford Department of Education

UNIVERSITY OF OXFORD

Contents

Executive summary

This report presents an overview of eight projects in the Innovation Programme that focused specifically on groups of young people who were experiencing or at risk of experiencing child sexual exploitation (CSE) or mental health issues. The projects took differing approaches to support young people with complex needs, including testing residential facilities as an alternative to secure accommodation or mental health inpatient settings, working with family members and specialist foster carers to increase their understanding of CSE and their ability to manage risks, developing a new service model based on building supportive relationships, a bespoke outreach service, and out-of-hours support for families that included access to psychiatric and psychological services.

Despite the short period available for evaluation, all of the evaluations presented some evidence of positive change. The use of health and social care services was reduced or managed with less intensive or high-cost services in six of the projects, and there was evidence of a reduction in key CSE risk factors and an increase in protective factors in all four CSE projects. Interviewees (particularly parents/carers and other professionals) reported improvements in young people's emotional and behavioural well-being and mental health across the projects, but the findings from standardised quantitative measures of well-being were more equivocal. Some of the projects showed that young people's engagement with education had improved, and half the projects revealed improvements in family functioning and relationships. Common elements of successful projects included strong leadership and inter-agency working, provision of support to family members, empowering young people and families, and a focus on building positive relationships. The four mental health projects reported encouraging cost-benefit findings, albeit with a number of caveats around their calculations. There was less financial information available on the four CSE projects, but one project reported potential annual benefits of over £1.6m.

Recommendations

The analysis suggests a number of avenues that should be considered by services looking to improve mental health and reduce the risk of CSE. Services are encouraged to self-audit against these recommendations, using the tool provided in Appendix 2:

- Projects that can support young people and families to manage their needs before they reach a crisis situation can provide benefits in terms of individual well-being, placement stability, and reduced service use. Services should consider whether they might target some resources 'downstream' to prevent the escalation of difficulties.

- Multi-Disciplinary Teamwork enables the sharing of resources, experience and expertise, as well as allowing staff to work to their individual strengths. At minimum,

services working with young people at risk of or experiencing CSE or mental health difficulties should bring together staff from social care and mental health teams.

- Approaches that work with the whole family rather than focusing solely on the young person can enable the development of family relationships, provide strategies for managing difficulties without the need to involve services, and can increase the likelihood that young people remain in a stable placement. Services should offer training and support to families/carers that increases their understanding of issues relevant to CSE and mental health (as appropriate), and provide ongoing support in the way of home visits and/or telephone contacts.

- Projects that seek to empower young people and their families to manage their own needs and life choices increase their confidence and self-esteem in the short-term. They may also help individuals manage their lives without the input of social care or mental health services in the longer-term. Services should adopt approaches to training and relational work that have an emphasis on empowerment.

- Relationships were viewed as the key mechanism of change across projects. Efforts to develop relationships included the provision of personalised care, consistency and stability, and respectful communication. Services should explore methods that enable the development of trusting, reliable and consistent relationships between young people, families, and staff.

- Clear approaches to referrals and discharge should be developed from the outset. Projects encountered difficulties where the young people being referred were not those originally being targeted, and where there were insufficient placement options at the planned point of discharge. Services should ensure that all partners are aware of referral criteria, and decide at an early stage whether these should be flexible. They should also identify potential placements and specialist training needs for staff and/or families/carers at the point the young person enters the service.

Introduction

Evaluation of the Children's Social Care Innovation Programme

The first Wave 2014-2016 of the Children's Social Care Innovation Programme received a major investment of £100m in 57[1] projects and their evaluations. The evaluations were undertaken by 22 evaluation teams and the reports of these evaluations can be found on the DfE Publications website. Two-page summaries of these reports designed to engage the interest of a wider community can be found on the Spring website.

Most projects were funded in late 2014 so implementation started in early 2015 - evaluations in Wave 1 therefore ran for 10-18 months typically, providing some early outcomes but rather more on process. Some projects have commissioned evaluations that extend beyond this window, but they sit outside the scope of this report.

The Rees Centre as Evaluation Coordinators had responsibility for the standards of evaluation in the first Wave of the Innovation Programme. The Evaluation Coordinator was also responsible for the over-arching evaluation. Five issues were identified that merited cross-cutting thematic reports drawing on findings from across the projects:

1. What have we learned about good social work systems and practice in children's social care?
2. Adolescent service change and the edge of care
3. Child sexual exploitation and mental health
4. Systemic conditions for innovation in children's social care
5. Informing better decisions in children's social care

The purpose of the thematic reports is to provide a summary of evidence that emerged from across projects about innovation in children's social care, thus demonstrating the added value of a Programme of projects rather than 57 unconnected innovations. The evaluation teams evaluating projects in specific areas – e.g. adolescence, children's social work – shared their findings and identified issues across projects. Furthermore, the Evaluation Coordinator synthesised messages from across evaluation reports in each of these areas. The thematic reports of these messages are designed to support future innovation in children's social care in local authorities and other providers, by promoting learning across the sector.

---

[1] Elsewhere, Wave 1 of the Innovation Programme is referred to as 53 projects because the 5 National Implementation Service projects are treated as one. As they are separate interventions individually evaluated, we treat them as 5 projects.

Child sexual exploitation and mental health: the context

This report presents an overview of eight projects in the Innovation Programme that focused specifically on groups of young people who were experiencing or at risk of experiencing child sexual exploitation (CSE) or mental health issues. We decided to cover both CSE and mental health in one report owing to a number of common features and areas of overlap across these two issues, as discussed below. These commonalities are reflected in the projects discussed in this report, including overlapping age groups: with both CSE and mental health issues being more common in adolescence than in younger childhood, the young people involved in these projects were typically aged 13-17 years old. Moreover, our joint report also reflects the fact that there were similarities in the approaches the projects used, including the use of residential care, specialist fostering, and family outreach work. Where appropriate, we acknowledge where differences lie and how this reflects the unshared aspects of CSE and mental health issues.

The four CSE projects included in this report are:

- Aycliffe Secure Centre (Aycliffe)
- South Yorkshire Empower and Protect (SYEP)
- St. Christopher's Fellowship (Safe Steps)
- Wigan and Rochdale Achieving Change Together (ACT)

The four mental health projects included in this report are:

- The Compass Service (Compass)
- Priory Group and Suffolk County Council (Belhaven)
- Surrey County Council (Extended HOPE)
- Wigan Specialist Health and Resilient Environment (SHARE)

Prevalence

The most recent English survey[2] showed that 8.5% of children aged 5-17 years showed symptoms that were consistent with a diagnosable mental health condition. In socially disadvantaged children, the figure rose to 14.6%, and in looked after children it was yet higher at 46.4%. Looked after children are also at risk of developing severe mental ill health, and despite making up only 0.5% of the general population, children and adolescents in care represent 12% of those using Tier 4 inpatient services (for young people with the most serious difficulties) in England and Wales[3]. There is no research on

---

[2] Ford, Vostanis, Meltzer & Goodman, 2007 – Note that an updated version of this survey is due to be reported in 2018.
[3] Mental Health Foundation, 2002

prevalence rates for CSE. In addition, the signs of CSE can be hard to spot, and young people who are sexually exploited may not recognise that their experiences constitute a form of abuse. An inquiry by the Office of the Children's Commissioner in 2012-13[4] reported that over 2400 young people were known to have experienced CSE at the hands of gangs and groups, with a further 16,500 young people at risk of CSE (based on children who displayed three or more signs of behaviour indicating they were at risk of child sexual exploitation). In an update to the inquiry[5], 70 of the 148 Local Safeguarding Children Boards in England responded to a survey, and between them identified 2092 known victims of CSE from gangs or groups in 2013. The 48% survey response rate suggests that the national figure is much higher, and this is backed up by figures from regional police forces across England and Wales, who recorded 7373 CSE crimes between November 2014 and October 2015[6].

Issues with existing approaches

There is more research on the effectiveness of interventions for mental health issues than for CSE. Reviews of the evidence on approaches to interventions for young people with mild to moderate mental health issues have covered children in the general population[7] as well as those in care[8]. For those with more severe or complex needs, inpatient services may be the only option, and a review by Shepperd and colleagues[9] suggests that existing alternatives to inpatient care that do not use a residential setting are unlikely to improve outcomes. In the case of CSE, Research in Practice have revieewd the limited evidence available on interventions to draw out effective principles such as early intervention and the use of therapeutic trauma-informed practice[10]. secure accommodation may be used when other options have been exhausted, though research suggests that secure settings may not be effective, and outcomes are likely to depend on young people receiving support to meet their needs after being discharged from the setting[11].

Placement away from home

The Department for Education[12] has issued guidance for local authorities that stresses the importance of keeping children in their local community, where it is safe to do so. Yet the most recent figures show that 18% of looked after children were living more than 20

---

[4] Berelowitz, Clifton, Firmin, Gulyurtlu & Edwards, 2013
[5] Berelowitz, Ritchie, Edwards, Gulyurtlu & Clifton, 2014
[6] http://www.npcc.police.uk/documents/CSEProblemProfile.pdf
[7] Tennant, Goens, Barlow, Day & Stewart-Brown, 2007
[8] Luke, Sinclair, Woolgar & Sebba, 2014
[9] Shepperd et al., 2009
[10] Research in Practice, 2015
[11] Creegan, Scott & Smith, 2005
[12] DCSF, 2010

miles away from their home address[13]. Distant placements may be more likely where specialist provision such as mental health inpatient settings or secure units are not locally available, or where local authorities are seeking to reduce the risk of CSE by removing a young person from a risky environment. Yet increasing appropriate local provision is important: an inquiry into children who go missing from care[14] identified distant placements as a factor predicting both incidents of young people going missing, and lower levels of social work support for young people. Out-of-authority placements (like those in secure settings) represent a high-cost approach that disrupt existing relationships and may not be effective in reducing risk beyond the end of the placement[15].

Stability and relationships

The opportunity to develop and maintain a supportive relationship with an adult has also been shown to promote recovery from trauma[16], particularly in the case of CSE[17] and mental health issues[18]. These relationships might be with parents or foster carers, mentors, residential workers, or other professionals[19]. There is evidence that more stable placements can reduce the risk of CSE[20], as well as promoting positive mental health[21]. Placement stability and relationship development have been identified as key mechanisms of change in settings offering 24-hour care for young people with complex needs[22].

Education

Related to placement stability is the young person's engagement with education. Although placement stability can support stable schooling, research also suggests that foster placement disruption is also more likely when children were permanently excluded from school[23]. Conversely, school attendance and the opportunity to develop positive relationships with friends can act to buffer the effects of childhood trauma on mental health[24], and to reduce the risk of CSE[25].

---

[13] DfE, 2017
[14] APPG, 2012
[15] Harper & Scott, 2005
[16] Newman, 2004
[17] Berelowitz et al., 2013
[18] Bellamy, Gopalan & Traube, 2010
[19] Winter, 2015
[20] Shuker, 2013
[21] Newton, Litrownik & Landsverk, 2000
[22] Snodgrass & Preston, 2015
[23] Jackson & Thomas, 2000
[24] Haskett, Nears, Ward & McPherson, 2006
[25] Scott & Skidmore, 2006

Meeting mental health needs

Child and Adolescent Mental Health Services (CAMHS) in England have their resources stretched, with young people experiencing difficulties and delays in accessing treatment[26], and services cannot always meet the needs of the young people targeted by the Innovation Programme, particularly those with chaotic lives; yet responsive care is needed to prevent mental health issues from escalating into crisis situations[27]. A Health Select Committee report points out that out-of-hours and crisis services are especially limited, and argues for the use of intensive community-based services as an alternative to inpatient care[28]. Whereas some young people's mental health is a cause for concern in itself, mental health issues have also been identified amongst the range of factors requiring attention and support for young people experiencing CSE, whose issues with trauma and attachment may not be fit into the diagnosable disorders that are the focus of many services[29,30]. For this reason, Ofsted's thematic report on sexual exploitation[31] recommends that local authorities should make therapeutic support available for young people who have experienced CSE.

Approaches taken by the projects

The eight projects in the Innovation Programme that focused specifically on CSE or mental health took differing approaches, which reflected the local context and the needs of each cohort. Their aims are given in Appendix 1 and on the website of the Spring Consortium[32].

CSE projects

Two projects established dedicated residential care for sexually exploited young people. One of these involved opening a specialist unit at Aycliffe Secure Centre with the aim of accommodating, and providing a therapeutic environment for, young people referred on welfare grounds as a result of their sexual exploitation. The other (St. Christopher's Fellowship Safe Steps) opened two specially adapted children's homes in London and was designed to provide an alternative to secure or out-of-area placements for young women being sexually exploited, or at high risk of sexual exploitation.

Two further projects also aimed to reduce the use of out of area placements and secure units, but did so in different ways. South Yorkshire Empower and Protect (SYEP) worked

---

[26] Department of Health/NHS England, 2015
[27] Mind, 2011
[28] House of Commons, 2014
[29] Harper & Scott, 2005
[30] Research in Practice, 2015
[31] Ofsted, 2014
[32] http://springconsortium.com

to enable young people to remain safely at home, or in stable foster care, through working with family members to increase their understanding of CSE and their ability to manage risks, and the recruitment and training of specialist foster carers, who received intensive support and therapeutic input. The Wigan and Rochdale Achieving Change Together (ACT) project used co-design and co-production involving staff, young people and parents/carers to develop a new service model. The model and pathway is based on building supportive relationships which are responsive to the needs and aspirations of the individual and their family and can enable young people to stay safely in their communities.

Mental health projects

Like Aycliffe and Safe Steps, one of the projects focusing on mental health was also testing a new residential facility. The Priory Group/Suffolk County Council project has piloted a 5-bed residential home known as Belhaven (4 of the 5 beds were funded as part of the DFE Social Innovation programme). Belhaven was designed to provide mental health treatment in a local care home setting to reduce the risk of referral to mental health inpatient services and breakdown of educational and care arrangements for young people. It aimed to integrate health, care and education delivery for the most vulnerable children and due to the local nature of the service, young people are able to continue working with the same professionals as before admission, helping to ensure continuity of care.

Three other mental health projects have built on existing services. The Compass Service built on an existing therapeutic education service in Norfolk (the Compass School) and offered a bespoke multidisciplinary package of care for looked after children and those at risk of being taken into care (Compass Outreach Service; COS), which aimed to support children to remain with the family wherever possible or be reunified at the earliest opportunity. A Virtual Residential School (VRS) also offered training, consultation and supervision to foster carers in placements formally attached to the school's education, and therapy provision for children across Norfolk. Extended HOPE in Surrey built on an existing daytime service for 11-18 year-olds in the early stages of emotional and mental health difficulties, through the addition of an out-of-hours Assessment and Support Service that included both telephone contact and home visits, and through the integration of a residential service. Similarly, in Wigan, SHARE (Specialist Health and Resilient Environment) was an extension or renewal of existing support services provided in routine hours, and aimed to implement a model of supporting young people at risk of becoming engaged with statutory social care services as a result of complex emotional and behavioural problems. SHARE works with young people aged from 11 to 17 over a period of at least 12 weeks, including support for their family and access to psychiatric and psychological services.

Evaluation in the CSE and mental health projects

The quality of evaluation plans

Most evaluations in both the CSE and mental health areas adopted a mixed-methods approach that combined quantitative analysis of case records, and agreed measures of impact, with qualitative evidence from interviews with service clients (including young people and their families/carers), professionals delivering or managing the project intervention, and other stakeholders as appropriate.

Limitations of the evaluation

A number of features common to the eight CSE and mental health projects meant that there were limitations to the evaluations, which should be borne in mind when considering the key messages from the evaluations. First, none of the projects worked with large cohorts of children and young people. Intensive therapeutic interventions or the limited capacity of residential facilities made for inherently small-scale studies. Added to difficulties accessing young people, families and social workers for interviews and getting them to complete quantitative measures, this led to small sample sizes for analysis across the studies: the number of young people with completed measures at two time points is below 15 in each of the projects, making it difficult to assess the statistical significance of any changes over time. Related to this issue is the difficulty that project and evaluation teams had in establishing data sources for comparison groups, making it difficult to attribute any changes in quantitative outcomes reported in these evaluations to the interventions.

Further difficulties in terms of evaluation arise because of the complexity of the services on offer. Most projects offered a bespoke response to individual needs, for example by offering access to psychologists, counsellors, or Child and Adolescent Mental Health Services (CAMHS), dependent on level of need. Although an appropriate approach for the projects, this makes it difficult to identify which aspects of any one project might be most effective in improving outcomes. Similarly, where projects had more than one component (for example the different aspects of Extended HOPE), evaluation teams noted that some interviewees had difficulty in evaluating each component separately in their responses.

Key messages

Were the projects successful in improving outcomes?

Service use

Despite the short period available for evaluation, all of the evaluations presented some evidence of positive change. The use of social care services was reduced or managed with less intensive or high-cost services in two mental health and two CSE projects. Of the discharged cases in the Compass Service, 9 children who were admitted with a legal status were discharged without one, and only 3 children could not be prevented from becoming looked after from admission to discharge. Similarly, although all 37 young people who entered SHARE were identified by clinicians as at risk of requiring respite or planned short-term breaks (the project's definition of a Child in Need – CIN), only 7 (19%) became CIN in this way; and out of the 19 young people who were identified as at risk of becoming looked after if there were no services involved, only 2 (11%) became looked after children whilst in SHARE. In SYEP, 2 of the young people receiving the service were no longer classed as a Child in Need and their cases were closed by social care; a further 2 young people ceased to be under Child Protection Plans. Young people in the SYEP project would previously have been placed out-of-area or in secure accommodation, but were able to remain safely in their own communities in specialist foster placements or with birth families where appropriate. Escalation of need was also avoided in the ACT project, and no secure placements were used.

There were also positive outcomes in terms of health service use in two mental health projects. According to staff on the Extended HOPE project, there were reductions in hospitalisation rates for mental health issues: they classified 23% (126) of the Assessment and Support Service's telephone support contacts and 27% (34) of the face-to-face contacts as having prevented Tier 4 admissions; and 17% (92) of telephone contacts and 26% (33) of face-to-face contacts as having prevented Accidents & Emergency presentations. Similarly, stakeholder interviews in the Belhaven project revealed a number of instances where admissions to hospitals and Tier 4 services had been avoided.

CSE risk factors and mental health

There was evidence of a reduction in key CSE risk factors (e.g. missing episodes) and an increase in protective factors (e.g. a positive relationship with at least one supportive adult) in all four CSE projects. In SYEP, 9 of the 14 young people with completed assessments at baseline and follow up showed a reduction in risk and in 3 of these cases this was a significant reduction. In ACT, all of the 9 young people with data from baseline and 6-month follow-up assessments showed a reduction in risks in some key areas; in 3

cases there was improvement in relation to all 10 risk factors. Improvements were most common in relation to young people's awareness of rights and risks; sexual health; going missing; relationships with parents or carers; school attendance and internet or mobile phone safety. The risks least susceptible to improvement were mental health, alcohol or drug use and association with risky peers or adults. Similarly, the risk assessments completed for 8 of the young women in the Aycliffe project recorded very high levels of risk for CSE at entry to the service. For those with follow up data (3 months later for 6 young women and an additional measure for 3 of these at 6 months), the level of risk reduced for the majority of outcomes assessed. Data from one of the homes in the Safe Steps project showed that for 5 of the 6 young women in the home, there was a decline in incidents involving actual or potential harm to self or others over the course of the intervention.

A common finding was that interviewees (particularly parents/carers and other professionals) reported improvements in young people's emotional and behavioural well-being and mental health across the projects, but that the findings from standardised quantitative measures of well-being were more equivocal. For example, in the Compass project, most of the parents reported improvements in young people's behavioural and emotional functioning, including reductions in violent behaviour. Yet there was a mixed picture from the quantitative measures completed by young people, parents and teachers, which showed no change in young people's internalising and externalising problems and self-esteem, but positive changes in hyperactivity and peer problems and 'total difficulties' on the Strengths and Difficulties Questionnaire. Despite improvements in standardised quantitative measures of mental health and emotional well-being (including attachment styles) for some young people in the Aycliffe and SYEP projects, others in these projects showed no change, and the same was true for the samples in Safe Steps and Extended HOPE. Young people's self-reports in Belhaven and SHARE, however, showed improvements in factors including emotional health and well-being, understanding of emotions, increased confidence, feeling able to ask for help, more positive future thinking, and ability to work though difficulties. In general, the quantitative findings across the projects are likely to have been influenced by the small sample sizes and the lack of longer-term follow-ups. Further monitoring of well-being in young people using these services is needed to determine whether quantitative measures evidence improvements in mental health that are more reflective of the rather more positive qualitative accounts.

Education

Two of the mental health projects and all four of the CSE projects provided some evidence that young people's engagement with education had improved by the end of the evaluation period. Qualitative data from the Belhaven project showed positive outcomes, with no breakdowns in educational placements and improved educational attainment

following admission to the service. For example, one young person was supported in continuing to attend the same school because the service arranged for transport to and from school. In the Compass project, almost half of the young people said their school work and academic abilities had improved. The CSE project evaluations collected quantitative data on education. In ACT and SYEP this was part of the risk assessment, where protective factors including attending school/college had increased after involvement with the service. In the Aycliffe project, young women completing a Pupil Attitudes to Self and School (PASS) assessment on arrival and exit from the facility showed improvements in their attitudes towards learning and their own capacity to do so. Engagement with education from young women in the Safe Steps project was variable, partly due to behaviour and partly to the challenges of setting up educational options to meet needs. However, the homes had some success in getting young women to attend school/college, and in one case a member of staff had committed to accompanying a young woman throughout her days at college.

Relationships

Interviews in two of the mental health projects and two of the CSE projects also revealed improvements in family functioning and relationships (Belhaven, Compass, ACT, SYEP). This was evident in different forms: for example, Belhaven was seen to give families a better insight into their child's needs by allowing frequent contact, compared to more traditional Tier 4 CAMHS services. Similarly, support to develop more positive parenting practices in Compass was linked to improved family functioning and reduced need for service involvement. In ACT, young people said that ACT workers had enabled them to communicate more openly with their families, and many parents expressed their gratitude that the ACT worker had enabled their son or daughter to 'open up'. Parent/carer satisfaction with the programmes and/or their workers was therefore high.

High levels of staff satisfaction were also observed, and staff in the two CSE projects that used residential facilities spoke positively about their relationships with the young people. Staff members felt that the development of positive relationships was enabled by adopting a social pedagogy approach (Safe Steps) or providing emotional support (Aycliffe). Across the CSE projects, relationships are viewed as central to managing risk, and staff in Safe Steps said that their first response to situations of risk is to engage the young women in conversation rather than trying to control risk on their behalf.

Costs

In terms of weighing up the costs of the innovation projects against their potential benefits, the four mental health projects produced positive results, albeit with a number of caveats around their calculations. Results from the cost-benefit analysis (CBA) for the Extended HOPE project showed a positive Fiscal Return on Investment (FROI) of 3.0.

This means a saving of approximately £3 for every £1 invested. The CBA also showed that even under the most pessimistic scenario of 50% outcome sustainability, the FROI remains positive at 1.5. Cost-benefit analysis for the SHARE project calculated an optimistic FROI of 3.3 (i.e., all outcomes sustained for 12 months), which translates into savings of approximately £3.3 for every £1 invested in SHARE. The most pessimistic scenario (50% of all outcomes sustained for 12 months) gave an FROI of 1.7. And for Compass, the cost-benefit analysis calculated an FROI of 3.39, which translates into savings of approximately £3.39 for every £1 invested. However, the CBA was based on Compass Outreach Service (COS) closed cases, meaning it excluded open cases that might have been in COS for a long time. The team now collects data on all cases. For Belhaven, available data suggests that based on intended lengths of stay, the service may offer value for money in comparison with CAMHS Tier 4 services in some cases. Assuming full occupancy, the service would cost £676 per day; but based on the occupancy during the evaluation period, the cost was £849 per day. Placements ranged from 2 to 50 weeks, with a mean of 33 weeks, translating to placement costs ranging from £11,886 to £297,150, with a mean of £196,119. Compared to an average length of stay in a CAMHS Tier 4 service of 112 days and costing £72,016, this shows that Belhaven costs more than the alternative CAMHS service if the facility is not fully occupied and if young people are not moved on to appropriate placements at an earlier time than was possible during the evaluation period. There was less financial information available on the four CSE projects, but a cost-benefit analysis of the ACT project indicated potential annual benefits of over £1.6m through reduced and avoided accommodation costs.

What worked well?

Some of the reported mechanisms of change were specific to the four mental health projects, where a number of interviewees described the new services as being better than existing alternatives. In some cases, this was about reductions in waiting time (Compass, Extended HOPE); this could ensure that help was received before reaching a crisis situation (Extended HOPE). Out-of-hours mental health services were also popular: parents felt this made services easier to access and was another way of avoiding escalation of risk (Extended HOPE, SHARE), and one young person said that Belhaven "helps my recovery all day every day, not just through meds and treatment sessions" (Belhaven).

The majority of factors that were reported to work well, however, applied across both the mental health and the CSE projects, illustrating the value in assessing these two areas together.

Staff ways of working

First, a number of ways of working for staff were identified that helped the projects to deliver their benefits. Strong leadership was seen as important in projects dealing with potentially anxiety-provoking issues such as CSE (Safe Steps). In addition, Multi-Disciplinary Teamwork (MDT) and inter-agency working were repeatedly highlighted as crucial to the projects' success (Belhaven, Compass, Safe Steps, SHARE), as it provided the opportunity to share knowledge and experience from different teams. Collaborations included care staff working with mental health nurses (Belhaven) and with CSE police officers and missing persons officers (Safe Steps). Bringing together social care and mental health was also evident in the use of training and supervision to promote trauma informed practice in the CSE projects (ACT, Aycliffe, Safe Steps). Clinical supervision of staff was trialled in several projects (Aycliffe, Compass, Safe Steps, SYEP). Staff said they valued the opportunity to share and reflect on their experiences, particularly given the complex levels of need they were dealing with.

Approaches that brought together different teams or disciplines also meant that the right colleagues with the right areas of expertise were able to efficiently come together to address the children's, young people's and families' needs, letting staff members work to their natural strengths (SHARE). Having a range of staff available also allowed staff members to be matched to individual children, which in turn supported the development of relationships (Compass). Interviewees also appreciated services that worked flexibly to meet individual needs, and staff who were attuned to their needs and appeared to understand their problems (ACT, Compass, SHARE, SYEP).

The presence of male residential staff in the residential homes for young women affected by CSE was seen as another benefit, showing positive roles and enabling kind and non-abusive male behaviour to be normalised (Aycliffe, Safe Steps). However, this was also a source of anxiety and complexity, with male staff needing additional support to work effectively with young women in these contexts.

Provision of support to family members

A second area of commonality across the CSE and mental health projects was the provision of support to the family members beyond the young person referred into the service. Young people identified the importance of support that extended to the whole family, rather than focusing solely on them (SHARE). This more 'holistic' approach helped to strengthen family relationships, enabled adults to develop the skills they needed to support their young person, provided opportunities for the families to cope with stress, and ultimately increased the likelihood that placements would be maintained.

Parents and carers reported that where they had received training sessions or support and input from workers, this had increased their understanding of the underlying causes

of young people's behaviours, and that this in turn enabled them to respond with greater empathy (ACT, SYEP). Services that helped parents to reflect on and develop their parenting skills also promoted increased confidence in managing emotional and behavioural needs, and provided parents with a different perspective during a crisis situation (Compass). Relaxation techniques taught by staff helped them to feel less stressed (Compass). Parents were also more satisfied when services offered emotional or practical support for any problems experienced by parents or other family members (Compass). Home visits and telephone support for parents and carers were seen as valuable aspects of the service (Compass, Extended HOPE, SYEP).

A number of projects appeared to have made a substantial effort to engage young people and families in the work, and as a result some projects were said to have accessed those who would not usually engage with services. The ability to contact clinicians directly in crisis situations was valued in some projects (e.g. SHARE, SYEP), and clinicians who conducted home visits and made an effort to build relationships with families were seen as enabling greater engagement (Extended HOPE, SYEP, SHARE). Efforts to engage families have included the provision of specialist training, therapeutic, or outreach services (ACT, Aycliffe, SYEP), regular contact from the service's registered manager to families (Belhaven), co-design of the programme, and for foster carers training and a regular support group (SYEP). CSE projects have worked with families to explain the impact of exploitation and the need to reinforce boundaries (ACT, SYEP).

Empowering young people and families

The third key area of commonality across the projects involved a focus on empowering young people and their families to develop more positive relationships and choices, promoting positive self-esteem and confidence. In some of the CSE projects, staff adopted a new approach to managing risk, developing relationships and communication with the young people and giving them responsibility for many of their own decisions (see Case study 1, below). In the mental health projects, the training and support on offer empowered families to respond to emotional and behavioural difficulties without recourse to clinical services. The provision of techniques and coping strategies for young people and their family members enabled them to rethink their reactions during episodes of need, reducing the escalation to the point of crisis (Compass, Extended HOPE, SHARE). Professionals and families across the projects felt more informed about their options and better prepared to try new approaches (Aycliffe, Compass, Extended HOPE, SHARE, SYEP). However, one report (SYEP) noted that increased confidence in individual practitioners had not translated into the hoped for impact on the overall workforce, due partly to limited engagement by social work staff in reflective practice sessions, lack of shared understanding between social care and clinical staff, and unrealistic expectations about levels of voluntary participation from social workers outside of their allocated time.

Case study 1 – Empowering young people in Safe Steps

Staff were recruited for two new children's homes in London. They were trained in the St Christopher's Fellowship social pedagogy model and provided with specialist training to enable them to work in a trauma-informed and gender-sensitive way with young women experiencing or at risk of sexual exploitation. The project necessitated a different approach to 'managing risk', which focused on empowering the young women to make positive decisions for themselves.

Over the pilot period, 12 young women aged from 14 to 17 were placed with Safe Steps. 8 of them were moved to other placements because of anxieties about their safety. However, they had felt safe enough to begin talking with staff about their abuse and exploitation.

The social pedagogy model helps staff to empower young people as their own agents of change, and to support them to learn from their experiences. Staff invested considerable time and energy in building relationships with the young women in Safe Steps in the hope that these relationships would provide an important route to managing risk, and to supporting the young person to assume greater responsibility.

As a result, the young women differentiated Safe Steps from other services they have experienced where staff tell them what to do and try to keep them safe by controlling risk on their behalf. The positive relationships with staff in Safe Steps supported young women to reflect upon and take responsibility for managing the risks in their lives. As relationships with staff developed, some of the young women became more secure and less confrontational, reflected in a decline in the frequency of 'incidents' (involving actual or potential harm to self or others).

The importance of building positive relationships

Finally, several projects shared the provision of personalised care, consistency and stability, and respectful communication, in order to help build the relationships that were the key mechanisms of change. Three of the projects that involved small numbers illustrated the importance of personalised care. The Virtual Residential School in Compass had small class sizes, which were seen as helpful by the young people attending them. Young people in Extended HOPE said that an important aspect of their experience with the service was that they knew the staff and the staff knew them. Similarly, those in SHARE described how the ability to speak to someone they knew when they phoned the support service helped them to feel safe and comfortable, and enabled a therapeutic relationship to be built. Familiarity with the young person's history was valued, but this may be lost if projects receive a wider roll-out (Extended HOPE).

The presence of consistent support workers was valued across several projects (ACT, Aycliffe, SYEP, Compass, Safe Steps). One of the young people in Compass noted that appointments were never cancelled, and if the clinician arranged to meet them they would always be there. Team working within SYEP supported relational stability and security and helped staff to manage risk more confidently. This sense of stability was facilitated where the projects built in a longer period of time for relationships to develop between staff and young people (ACT, Compass). One young person in Belhaven reported that being supported in continuing to attend the same school had helped them to maintain friendships. There was also evidence of consistency in the approaches and expectations of different members of staff (Aycliffe) and those of parents and carers (Compass). Similarly, 2 of the young people accessing COS reported how staff would communicate with their mainstream education provision, to provide the school with advice on how to handle different situations with the young person (Compass), enabling a consistent approach across settings.

Young people, parents and foster carers in the projects reported feeling listened to and treated with respect (ACT, Aycliffe, Compass, SHARE, SYEP). This resulted in a building of trust that enabled young people and their families to talk to staff about emotional or difficult subjects (Compass, Safe Steps). Young people and families described staff as being genuine, non-judgemental, supportive, down-to-earth, and approachable (Compass, Extended HOPE, SHARE). Ultimately this supported the building of relationships between key stakeholders in the projects (see Case study 2, below).

Case study 2 – Building relationships in the Compass Service

There was a focus on building and sustaining relationships that ran through all aspects of the Compass Service. The bespoke care package offered an approach that enabled relationships to be built both within and across the key stakeholder groups: staff, young people, and their families.

- Staff focus groups highlighted the value of multidisciplinary team working that allowed professionals to learn from and support colleagues, and come together to share knowledge and experience about a case.

- Staff worked with families through home visits, and parents said this made it easier to talk about difficult situations. Parents also valued the opportunity to access telephone support, noting that this led to them feeling as though someone was there for them if they needed them.

- Parents described feeling listened to by staff, and also being able to talk to staff about emotional or difficult subjects because they trusted members of staff.

- The young people also felt more able to discuss their problems with staff and other people over the course of their involvement with the service. Staff were described as genuine, non-judgemental, supportive, down-to-earth, approachable.

- The young people described feeling as though the Compass service had supported the whole family, and how this had strengthened the young person's relationships with their parents or carers. Three of the young people reported that, since using the Compass service, their family was arguing less, and had improved their ability to talk nicely to one another.

Quantitative evidence from the evaluation supports the effectiveness of this approach:

- There was a reduction in the use of statutory social care services, with 9 young people being discharged from the service without their former legal status, and 5 young people successfully returning to their homes from foster care.

- Although quantitative measures completed by young people, parents and teachers showed no change in young people's internalising and externalising problems and self-esteem, there were positive changes in hyperactivity and peer problems and total difficulties. Staff reported that young people had a better level of functioning 4 to 6 months after entering Compass.

- Cost-benefit analysis based on closed cases calculated a Fiscal Return on Investment (FROI) of 3.39, which translates into savings of approximately £3.39 for every £1 invested.

Facilitators and barriers

The evaluations identified a number of factors that acted as facilitators or barriers to the project's success.

Facilitators

Evaluations highlighted the importance of a strong, competent, and committed staff team; in the case of mental health projects, the representation of multiple disciplines was also viewed as important. Good partnership working between services was seen as crucial. Some projects (e.g. Extended HOPE) gained support by building on existing services and relationships; others (e.g. SHARE) welcomed the flexibility offered through the innovative approach, but acknowledged that this also meant many things had to be designed from scratch.

Barriers

A number of barriers were encountered in setting up the projects. Some projects started later than they had hoped due to the complexities of obtaining Ofsted approval (Belhaven, Extended HOPE, Safe Steps) and delays with building works (Extended HOPE, Safe Steps). Others struggled with setting up new ways of working that crossed geographical areas (ACT, SYEP) or health and social care services (Compass). Difficulties establishing an infrastructure were linked to a lack of information sharing and communication (Compass). Competition and commercial interests provided further barriers to establishing services (SYEP).

A number of projects experienced challenges in recruiting key staff: foster carers (Compass, SYEP), therapeutic staff (Belhaven), and out of hours nurses (Extended HOPE). Belhaven also experienced high social worker turnover. Under-staffing and reliance on cover staff was seen to limit the ability to offer a consistent approach and to commit to the model being tested (Aycliffe). Added to this, some staff (social workers and service managers/team leaders) were reluctant to 'buy in' to the model. Elsewhere, there were unrealistic expectations from commissioners and local authorities about what the project could achieve (Safe Steps).

Several evaluation reports highlighted the need for greater clarity over the role of the service and the model being used (ACT, Compass, Safe Steps, SHARE). In the case of the ACT project early communication about the ACT model was limited by the co-design phase not being completed until four months after the pilot service started. In Aycliffe, the different component activities intended to deliver improved outcomes were not joined up: the training, supervision, CSE work and therapeutic input to the house were all provided by Barnardo's – but the different individuals delivering each component never met

together as a team and there were differences of emphasis and approach which caused confusion amongst staff.

The referral process was commonly where barriers arose. Referral processes that were slow (Compass) or indirect (Extended HOPE) prevented projects reaching the expected numbers of young people. Further difficulties occurred when referrals were not as originally envisaged: for one project this meant they received more young people than expected from Tier 4 inpatient settings, rather than from family settings (Belhaven); for another, they came from across the country rather than the local area (Aycliffe). Both projects received young people with higher than anticipated levels of need. These increased levels of need, in turn, had emotional impacts on staff, and reports stressed the need for clinical supervision to support staff in dealing with this (ACT).

At the other end of the service, a lack of early, joined-up approaches to discharge planning and a lack of appropriate placements for discharge from the service were also cited as barriers to projects' success (Aycliffe, Belhaven). Belhaven, for example, was designed to provide services for young people for a stay of between 10 and 26 weeks; but levels of need and a lack of discharge options meant that only 5 young people had been admitted to the service in 11 months, with stays being much longer than anticipated.

Conclusions and recommendations

This report has reviewed the evidence from eight evaluations in the Innovation Programme to identify common approaches, findings, and mechanisms of change across the projects. The analysis suggests a number of avenues that should be considered by services looking to improve mental health and reduce the risk of CSE:

- Projects that can support young people and families to manage their needs before they reach a crisis situation can provide benefits in terms of individual well-being, placement stability, and reduced service use. Services should consider whether they might target some resources 'downstream' to prevent the escalation of difficulties.

- Multi-Disciplinary Teamwork enables the sharing of resources, experience and expertise, as well as allowing staff to work to their individual strengths. At minimum, services working with young people at risk of or experiencing CSE or mental health difficulties should bring together staff from social care and mental health teams.

- Approaches that work with the whole family rather than focusing solely on the young person can enable the development of family relationships, provide strategies for managing difficulties without the need to involve services, and can increase the likelihood that young people remain in a stable placement. Services should offer training and support to families/carers that increases their understanding of issues relevant to CSE and mental health (as appropriate), and provide ongoing support in the way of home visits and/or telephone contacts.

- Projects that seek to empower young people and their families to manage their own needs and life choices increase their confidence and self-esteem in the short-term. They may also help individuals manage their lives without the input of social care or mental health services in the longer-term. Services should adopt approaches to training and relational work that have an emphasis on empowerment.

- Relationships were viewed as the key mechanism of change across projects. Efforts to develop relationships included the provision of personalised care, consistency and stability, and respectful communication. Services should explore methods that enable the development of trusting, reliable and consistent relationships between young people, families, and staff.

- Clear approaches to referrals and discharge should be developed from the outset. Projects encountered difficulties where the young people being referred were not those originally being targeted, and where there were insufficient placement options at the planned point off discharge. Services should ensure that all partners are aware of referral criteria, and decide at an early stage whether these should be flexible. They should also identify potential placements and specialist training needs for staff and/or families/carers at the point the young person enters the service.

Finally, it is worth noting in the context of the Innovation Programme that some of the reports specifically noted the value that project teams had placed on the evaluation process. For example, a partner agency in lead in ACT noted that having an embedded evaluator had helped keep the project on track and contributed insight and ideas into the project. Elsewhere, the decision to collect cost-savings data for the Compass Service had arisen as a result of the cost-benefit analysis, and the facilitators and barriers encountered in setting up Extended HOPE were being fed back to the project team to inform their ongoing service. Evidencing the success of any similar projects depends on embedding evaluation methods from the outset, to measure whether the desired outcomes have been achieved and to identify the key mechanisms of change.

Bibliography

APPG, 2012. *Report from the joint inquiry into children who go missing from care.* [pdf] London: The APPG for Runaway and Missing Children and Adults and the APPG for Looked After Children and Care Leavers. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/175563/Report_-_children_who_go_missing_from_care.pdf [Accessed 29 June 2017].

Bellamy, J.L., Gopalan, G. and Traube, D.E., 2010. A national study of the impact of outpatient mental health services for children in long-term foster care. *Clinical Child Psychology and Psychiatry*, *15*(4), pp.467-479.

Berelowitz, S., Clifton, J., Firmin, C., Gulyurtlu, S. and Edwards, G., 2013. *"If only someone had listened" The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups Final Report.* [pdf] London: Office of the Children's Commissioner. Available at: http://dera.ioe.ac.uk/18861/1/If_only_someone_had_listened_Office_of_the_Childrens_Commissioners_Inquiry_into_Child_Sexual_Exploitation_in_Gangs_and_Groups.pdf [Accessed 29 June 2017].

Berelowitz, S., Ritchie, G., Edwards, G., Gulyurtlu, S. and Clifton, J., 2014. *"If it's not better, it's not the end": Inquiry into Child Sexual Exploitation in Gangs and Groups: one year on.* [pdf] London: Office of the Children's Commissioner. Available at: http://dera.ioe.ac.uk/23810/1/CYP%20version%20CSEGG%201%20year%20on%20website.pdf [Accessed 29 June 2017].

Creegan, C., Scott, S. and Smith, R., 2005. *The use of secure accommodation and alternative provisions for sexually exploited young people in Scotland*. London: Barnardo's.

Department for Children, Schools and Families, 2010. *Sufficiency: statutory guidance on securing sufficient accommodation for looked after children.* [pdf] London: DCSF. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/273812/sufficiency_-_statutory_guidance_on_securing_sufficient_accommodation_for_looked_after_children.pdf [Accessed 29 June 2017].

Department for Education, 2017. *Child sexual exploitation: definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation.* [pdf] London: DfE. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/591903/CSE_Guidance_Core_Document_13.02.2017.pdf [Accessed 29 June 2017].

Department of Health/NHS England, 2015. *Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing.* [pdf] London: DoH/NHS England. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf [Accessed 29 June 2017].

Ford, T., Vostanis, P., Meltzer, H. and Goodman, R., 2007. Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households. *The British Journal of Psychiatry*, *190*(4), pp.319-325.

Harper, Z. and Scott, S., 2005. *Meeting the needs of sexually exploited young people in London.* London: Barnardo's.

Haskett, M.E., Nears, K., Ward, C.S. and McPherson, A.V., 2006. Diversity in adjustment of maltreated children: Factors associated with resilient functioning. *Clinical Psychology Review*, *26*(6), pp.796-812.

Health Committee, 2014. *Children's and adolescents' mental health and CAMHS: third report of session 2014–15.* [pdf] London: The Stationery Office Limited. Available at: https://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/342.pdf [Accessed 29 June 2017].

House of Commons, 2014.

Jackson, S. and Thomas, N., 2000. *What Works in Creating Stability for Looked After Children?* Barkingside: Barnardo's.

Luke, N., Sinclair, I., Woolgar, M. and Sebba, J., 2014. *What works in preventing and treating poor mental health in looked after children.* [pdf] London: NSPCC. Available at: https://www.nspcc.org.uk/globalassets/documents/evaluation-of-services/preventing-treating-mental-health-looked-after-children-report [Accessed 29 June 2017].

Mental Health Foundation, 2002. *The mental health of looked-after children: Bright Futures: Working with vulnerable young people.* [pdf] London: Mental Health Foundation. Available at: https://www.mentalhealth.org.uk/sites/default/files/mental_health_looked_after_children.pdf [Accessed 29 June 2017].

Mind, 2011. *Listening to experience: an independent inquiry into acute and crisis mental healthcare.* [pdf] London: Mind. available at: https://www.mind.org.uk/media/211306/listening_to_experience_web.pdf [Accessed 29 June 2017].

Newman, T., 2004. *What works in building resilience?* London: Barnardo's.

Newton, R.R., Litrownik, A.J. and Landsverk, J.A., 2000. Children and youth in foster care: Disentangling the relationship between problem behaviors and number of placements. *Child Abuse & Neglect*, *24*(10), pp.1363-1374.

Ofsted, 2014. *The sexual exploitation of children: it couldn't happen here, could it?* [pdf] London: Ofsted. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/386598/The_20sexual_20exploitation_20of_20children_20it_20couldn_E2_80_99t_20happen_20here_2C_20could_20it.pdf [Accessed 29 June 2017].

Research in Practice, 2015. *Working effectively to address child sexual exploitation: an evidence scope.* [pdf] Dartington: Research in Practice. Available at: https://www.rip.org.uk/resources/publications/evidence-scopes/working-effectively-to-address-child-sexual-exploitation-evidence-scope-2015 [Accessed 29 June 2017].

Scott, S. and Skidmore, P., 2006. *Reducing the risk: Barnardo's support for sexually exploited young people: a two-year evaluation. Summary report.* London: Barnardo's.

Shepperd, S., Doll, H., Angus, R.M., Clarke, M.J., Iliffe, S., Kalra, L., Ricauda, N.A., Tibaldi, V. and Wilson, A.D., 2009. Avoiding hospital admission through provision of hospital care at home: a systematic review and meta-analysis of individual patient data. *Canadian Medical Association Journal*, *180*(2), pp.175-182.

Shuker, L., 2013. *Evaluation of Barnardo's safe accommodation project for sexually exploited and trafficked young people.* [pdf] University of Bedfordshire. Available at: http://uobrep.openrepository.com/uobrep/bitstream/10547/315081/1/Barnardo27s-SA-Project-Evaluation-Full-Report.pdf [Accessed 29 June 2017].

Snodgrass, C. and Preston, J., 2015. Psychological practice in secure settings. *Young People in Forensic Mental Health Settings: Psychological Thinking and Practice*, pp.64-95.

Tennant, R., Goens, C., Barlow, J., Day, C. and Stewart-Brown, S., 2007. A systematic review of reviews of interventions to promote mental health and prevent mental health problems in children and young people. *Journal of Public Mental Health*, *6*(1), pp.25-32.

Winter, K. (2015). *Supporting positive relationships for children and young people who have experience of care. (Insights: Evidence Summaries to Support Social Services in Scotland; No. 28).* [pdf] Glasgow: Institute for Research and Innovation in Social Services. Available at: http://pure.qub.ac.uk/portal/files/14604133/iriss_insight28_020315.pdf [Accessed 29 June 2017].

Appendix 1 – Aims of individual projects

Project	In summary, the project intended to …
'Aycliffe' (Aycliffe Secure Centre) [CSE]	… accommodate, and provide therapeutic support to, young people referred on welfare grounds as a result of their sexual exploitation; the relationships between young people and staff were seen as the primary facilitators of change; and there was a focus on well supported transitions
'SYEP' (South Yorkshire Empower and Protect) [CSE]	… enable young people experiencing or at high risk of sexual exploitation to remain safely at home, or in stable foster care in South Yorkshire, rather than being placed in out-of-area or secure accommodation
'Safe Steps' (St. Christopher's Fellowship) [CSE]	… test whether providing intensive support and supervision, while working within existing regulations on restrictions to liberty, can keep young women safe outside a secure setting; enabling young women to continue to live locally in order to limit disruption to their education and family ties, and to minimise the possibility that they will feel blamed or 'punished' for having been exploited
'ACT' (Wigan and Rochdale Achieving Change Together) [CSE]	… improve outcomes for young people and their families and provide effective alternatives to high cost and secure accommodation for those vulnerable to CSE; and to test the value of adopting an action research and co-production approach to service design
'Compass' (The Compass Service) [MH]	… build on the success of a therapeutic education service in Norfolk (the Compass School) through a bespoke multidisciplinary package of care that supports young people who are looked after or are at risk of being taken into care, to ensure that they can remain with the family wherever possible and be reunified at the earliest opportunity; the Compass Outreach Service (COS) and the Virtual Residential School (VRS) allow families to receive individualised care designed around their needs
'Belhaven' (Priory Group and Suffolk County Council) [MH]	… provide mental health treatment in a local care home setting to reduce the risk of referral to mental health inpatient services and breakdown of educational and care arrangements for young people

'Extended HOPE' (Surrey County Council) [MH]	… provide an out-of-hours Assessment and Support Service for young people aged 11-18 facing mental health crisis out of hours, so that out-of-hours mental health needs could be met by appropriate services; also to establish HOPE House with the aim of providing respite beds for young people who are experiencing a mental health crisis and need intensive support, but whose mental health does not require them to be admitted to a psychiatric ward, or to become a looked after child
'SHARE' (Wigan Specialist Health and Resilient Environment) [MH]	… reduce the number of young people becoming engaged in statutory care services due to parents or carers being unable to manage the presenting risk in relation to complex mental health issues, through the development of a new specialist multi-professional team, the implementation of a new integrated duty system with a single assessment of need and single care pathway, the provision of a residential setting that could work in a flexible way to provide a crisis response, bridging placements that would support transitions back to family based care, and the training of a cohort of specialist foster carers

Key: CSE = Child Sexual Exploitation; MH = Mental Health

Appendix 2 – Audit of services

Service descriptor	What happens now in your service?	What needs to happen?	How will you progress this?
Target resources 'downstream' to prevent the escalation of difficulties.			
Bring together social care and mental health staff when working with young people at risk of or experiencing CSE or mental health difficulties.			
Offer training and support to families to increase understanding of issues relevant to CSE and mental health, and provide ongoing support.			
Adopt approaches that have an emphasis on empowerment.			
Use methods to develop trusting relationships between young people, families, and staff.			
Ensure that all partners are aware of referral criteria, and decide at an early stage whether these should be flexible.			
Identify potential placements and specialist training needs at the point the young person enters the service.			