Why do you think this issue will be important to include in the 2016 Health and Wellbeing Strategy?

Child sexual exploitation (CSE) is a form of child abuse and sits within the continuum of sexual violence, the NHS spends more time dealing with the impact of sexual violence than almost any other agency. It has direct health consequences and represents a risk factor to a wide range of long-term health problems.

As a Marmot Pilot City, Coventry health professionals, and those concerned with improving the health and welfare of their local population have a responsibility to tackle child abuse. CSE disproportionately affects women and girls and is both a cause and a symptom of gender inequality and reducing its impact is vital to reducing health inequalities.

CSE is related to other public health concerns which make up causal factors such as drug and alcohol abuse, teenage pregnancy, mental health issues. There is a clear need for a long-term Public Health strategy, linked to other local and regional priorities which represent causal factors in sexual victimization across the continuum.

The Government Tackling Child Sexual Exploitation Action Plan 2011 states that the ‘Department of Health, as part of its work programme on violence against women and children, will work with its partners to see whether more can be done to highlight the particular needs of children who have been sexually exploited.’

Child sexual exploitation is a safeguarding matter. There is a strong need to improve health professionals’ understanding of child sexual exploitation so that they can better protect victims and support them to recover well. The problem is costly.

The costs – to women, men and children of ineffective responses represent a waste of potential in both individual lives and for the community as a whole.

1. The Home Office estimates the cost of each rape at £96,000 (Home Office, 2005).

2. Without accurate prevalence figures it is impossible to assess the number of rapes due to CSE in Coventry. However in 2014, West Midlands Police recorded 406 child rapes, an increase of 13% since 2009 and the cost of these in physical and mental health impacts, cost to the criminal justice system and lost output is £96,000 each.

The under-reporting of CSE is well reported, therefore the actual numbers of children affected by CSE is likely to be substantially higher. The scale of the problem is significant. Not only is the prevalence of violence and abuse serious but the demand for support and services has significantly increased over the last 5 years and this shows no sign of decreasing.

An estimated 13,878 children and young people under the age of 18 have been victims of sexual abuse in the West Midlands and Coventry is one of the Local Authority areas with the highest overall numbers of sexual abuse cases. (NHS England, 2014: p14). It is likely that some of these children will be victims of CSE or will go on to become victims in the future.
The West Midlands has the third highest rate of sexual offending recorded by the Police in England & Wales;

Coventry has the highest rate of sexual offending in the West Midlands and in 2013 recorded 8.5% more offences than the second most affected regional area of Birmingham. (Coventry City Council, 2014.)


Can you tell us any data or information which you feel makes this an issue worthy of inclusion in the strategy?

1. Victimisation over lengthy timeframes means damage caused by CSE is often deep and is often not expressed to others in many instances for a significant period of time. Wider national estimates suggest that 75% of abused children keep the abuse a secret all their life.

2. 40 to 70 per cent of children diagnosed with a borderline personality disorder reported having been sexually abused when younger (Zanarini M.C., 2000).

3. Women and girls widely documented greater fear of sexual crime than men’s, particularly in relation to violent offences, is directly connected to a perceived need to factor personal safety into routine decisions and activities. A 2013 survey by Coventry Women's Voices showed that 61% of women had experienced public sexual harassment in the previous 12 months, with women and girls routinely employing a range of avoidance strategies. 46% of the women surveyed said they did not feel safe in public spaces in Coventry (Osmond, J. & Coventry Women's Voices, 2013: p5).

4. The Office of the Children’s Commissioner report ‘Child Sexual Exploitation in Gangs and Groups’ (Berelowitz et al, 2013) identified ‘a high prevalence of victims of sexual exploitation had previously been abused within the family environment’ that ‘the abuse was often perpetrated by a family member or known individual in the family home’ and that: ‘this had not been identified and addressed’.

5. National findings accept that although the majority of victims of child sexual exploitation live at home with their families, victims of sexual exploitation are disproportionately represented in residential care. However, public policy tends to ricochet between an emphasis on the family or on strangers when the majority of sexual offenders are neither – they are neighbours, friends, work colleagues, recent acquaintances and a range of professionals (teachers, doctors, therapists, sports coaches). Too many policy initiatives are built around the high profile minority.
6. There are 66 GP surgeries across Coventry and according to a survey distributed by the Coventry Sexual Violence and Exploitation Health Group, in the last 12 months;
   a. only 3 out of 66 GP practices have taken disclosures of some form of sexual violence;
   b. only 7 out of 66 GP practices feel confident dealing with patient disclosure, which may account for the extremely low number of GP disclosures;
   c. only 8 out of GP 66 practices were aware of local services to signpost or refer patients to.

7. In addition, almost half of emergency department patients across Coventry who are a victim of sexual violence are released without any further follow up, one in 20 leave without treatment (Source: West Midlands Police and Public Health West Midlands Collaborative, 2014). Little is known about those survivors who attend A&E and leave without being treated and there is no effective referral pathway from A&E to sexual violence services.

8. The Home Office estimate the cost of each rape is £96,000 in physical and mental health impacts, cost to the criminal justice system and lost output;

9. In 2014 the Police recorded 128 rapes in Coventry (100\% more than in the previous year), a cost to the public purse of £12.3 million;

10. But with only 15\% of rape being reported (ONS, Ministry of Justice, Home Office, 2013), a conservative estimate of the realistic figure is more likely to be around 850 rapes in Coventry last year. The corresponding cost of this to Coventry is £81.9 million pounds in physical and mental health impacts, cost to the criminal justice system and lost output.

11. CRASAC counselling service also saw an increase of 50\% in the numbers of young people (aged 5-18 years) receiving specialist counselling in 2013-14.

12. 89.1\% of the victims of sexual offences over the last 5 years have been female, with the proportion rising to 90.2\% where the offence has been classified as rape. 10.6\% of victims of other sexual offences have been male along with 9.1\% of rape victims. (Source: West Midlands Police and Public Health West Midlands Collaborative, 2014).

13. Coventry has the highest rate of recorded sexual offences in the West Midlands and in 2013 recorded 8.5\% more offences than the second most affected regional area (Birmingham).

14. Assessment of future demand - drawing on demographic projections, current trends in reporting and expected developments following current high-profile cases of sexual violence – suggests a likely increase in the need for specialist sexual violence services.

15. The percentage of children aged 18 and under accessing the CRASAC service is significant (between 20-25\%) and approximately 42\% of clients were under 25 years. This shows that Coventry has significant numbers of children and young people who are accessing specialist sexual violence support services. In 2012/13 6.5\% of all face to face counselling clients were children under 11years.
16. One child every day in Coventry on average is admitted to hospital because of self-harming and attempted suicide. The number of children admitted to A&E for drug abuse so far this year stands at 295 (January-July 2015), suggesting a significant increase on the numbers for 2014. In health terms sexual violence can worsen gender inequalities and abused young people are at a greater risk of homelessness, in exhibiting risk-taking behaviours, smoking, alcohol and drug abuse and teenage pregnancy.

17. CRASAC clients indicate that mental health is affected to some degree as a result of sexual abuse; 43% of those individuals formally reported their condition.

18. For £1 invested into CRASAC through the SLA funding, CRASAC has brought in £6 from charitable/private/government funding sources external to Coventry.


Can you tell us anything about your experience of working with the public which makes you feel that this is an important issue to include in the strategy?

CRASAC is a Rape Crisis Centre, established in Coventry 35 years ago, that provides a range of services that together form an integrated and holistic care pathway for women, men and children from 5 years old who have experienced sexual violation, from crisis through to sustainable recovery. The whole pathway incorporates a helpline, advocacy support, individual and group counselling and community based outreach services specifically to BAME women and girls. All of these services address the complex needs of victims for support, information and justice and are free to service users. CRASAC supported more than 6,000 victims and survivors through its services last year and demand for our services increases year on year. The refresh of the Health and Well Being Strategy provides a timely opportunity to develop a long-term approach for these victims and survivors. Sexual violence is a significant public health problem in its own right, but it is also a costly one in terms of the impact on individuals, the support services and also in terms of earnings and the economy. Moreover, the scale of sexual violence is significant and a particular problem for Coventry. As such there would be substantial benefits in developing a strategy that better connects and supports the different activities that support individuals and that deal with causal factors related to sexual violence so that they have the greatest collective impact. Within a health context, CSE is associated with physical violence, sexual health problems, pregnancy, terminations and drug and alcohol misuse. Furthermore, there is reliable evidence that being a victim of sexual violence or abuse may lead to the development of mental health problems/disorders with about half the children affected experiencing
depression, post traumatic stress disorder (PTSD) or disturbed behaviour or a combination of these, 40 to 70 per cent of children diagnosed with a borderline personality disorder reported having been sexually abused when younger (Zanarini M.C., 2000). CSE may also have a significant impact on the child’s school attendance and educational attainment. In addition to the sexual abuse, exploited children can experience violence, addiction to drugs or alcohol, isolation, disrupted relationships and routines, living with threats, humiliation and coercive control. However, certain groups of children may be additionally targeted for sexual exploitation, have more limited resources to resist or find support and/or find themselves in contexts where there is a high incidence of assaults. Combinations of these factors increase people’s vulnerability: for example, those with disabilities or mental health issues are more likely to spend time in residential settings; migrants or asylum seekers may have limited English and knowledge of their rights, not to mention legacies of abuse, or may distrustful of authorities reducing the likelihood of them seeking help. It is widely accepted going missing is the most immediate indicator of vulnerability and that looked after children in residential care are disproportionately represented in CSE figures despite the majority of children experiencing CSE living at home with their families. In health terms CSE can worsen gender inequalities and abused young people are at a greater risk of homelessness, in exhibiting risk-taking behaviours, smoking, alcohol and drug abuse and teenage pregnancy. CSE prevention is a critical element in tackling other public health issues. CSE impacts on mental wellbeing and quality of life, prevents young people maximizing their capabilities and having control over their lives; a Marmot objective. Preventing violence must be seen as a priority for public health, and CSE as part of the sexual violence continuum, is a major cause of ill health and poor wellbeing in Coventry as well as a drain on health services and the wider economy. References Zanarini MC, Childhood experiences associated with the development of borderline personality disorder. Psychiatric Clinics of North America, 2000; 23(1): 89-101

**In what way do you feel tackling this issue will help the City achieve its objectives to reduce health inequalities as a Marmot Pilot City?**

1. The provision of integrated services, which enable victims and survivors to have their needs met quickly and sympathetically by properly trained staff, will be crucial to promoting recovery and minimising the risk of subsequent physical and mental health difficulties.

2. In health terms sexual violence can worsen gender inequalities and survivors of CSE are at a greater risk of homelessness, in exhibiting risk-taking behaviours, smoking, alcohol and drug abuse and teenage pregnancy.

3. Certain groups of children may be additionally targeted for violence and abuse, have more limited resources to resist or find support and/or find themselves in contexts where there is a high incidence of assaults. Combinations of these factors increase people’s vulnerability: for example, those with disabilities or mental health issues are more likely to spend time in residential settings; migrants or asylum seekers may have limited English and knowledge of their rights, not to mention legacies of abuse, or may distrustful of authorities reducing the likelihood of them seeking help. It is widely accepted going missing is the most immediate indicator of vulnerability and that looked after children in residential care are disproportionately represented in CSE figures despite the majority of children experiencing
CSE living at home with their families. Addressing these issues through tackling sexual violence in marginalized groups will help Coventry reduce health inequalities.

4. Tackling the barriers that currently stop survivors from seeking help can support Coventry’s Marmot objective. We must ensure that help is available when it is needed and that the response of professionals, including doctors, teachers, social workers and the police, is supportive, sensitive and effective.

5. CSE can have a devastating impact on victims, their families and friends and wider society. These crimes violate the basic right of all women, men and children to be treated with dignity and respect, and to live without fear.

6. CSE should not be considered in isolation from other forms of abuse and it is important for tackling health inequalities to note that it is primarily experienced by women and girls and is therefore gendered violence. Proportionately tackling the harm suffered by women and girls and men and boys is an essential element in reducing health inequalities in Coventry.

**How do you think the unique role of the Health and Wellbeing Board can be best used to tackle this issue?**

1. Agree and promote a definition of consent across the Coventry Partnership to make it clear that submission, coercion or threat are not elements in consent and that capacity to consent must be established in the case of those with learning disabilities, mental illness, drug or alcohol abuse etc.

2. To lead on the creation of a separate multi-agency strategy to tackle sexual violence across all its forms; ensuring public sector, private sector and community assets all contribute.

3. To lead on a city-wide sexual violence action plan to sit underneath local strategies with measures to monitor progress. This will make connections between forms of sexual violence and abuse, including CSE, across local, regional and national strategies and highlight where there is no strategy or no reference to sexual violence within an existing strategy but there is a known causal link e.g. drug and alcohol abuse, domestic violence, obesity, child sexual exploitation, teenage pregnancy etc.

4. Ensure there is an effective and monitored referral pathway from all health settings e.g. A&E, mental health services and GP practices to local specialist sexual violence services.

5. Training and monitoring to determine; the rates of routine enquiry on sexual exploitation.

6. To address harmful and prejudicial social attitudes and cultural norms that are tolerant of sexual exploitation.

7. To increase local knowledge through concerted efforts and dedication of resources to data collection within health settings. There is a critical need to understand better the needs of vulnerable groups, including the correlation between CSE and those from diverse ethnic and cultural backgrounds therefore data collected must be disaggregated by gender and by all protected characteristics groups. Data collected should be published and shared.
8. A commitment to providing effective personalised support for all victims of CSE; victims being at the centre of any Health Service response and either directly or through community awareness and education to increase in the numbers of victims coming forward.

9. Encourage Healthwatch (or equivalent body) to include sexual violence across the continuum, as a priority theme within local monitoring and consultations.

10. Develop an effective targeted health promotion approach to raise awareness of the health and social care issues of CSE and help to prevent children becoming victims of CSE thorough education and awareness raising and assuring local communities that agencies take the issue seriously.

11. Ensure timely access to holistic and specialist services to meet the presenting and longer-term, psychological, emotional, and where necessary, practical needs of victims/survivors and their families. The estimated financial costs of sexual violence and abuse in terms of emotional and physical impact, costs to health and social care services and the criminal justice system and lost economic output, have been highlighted earlier in this response. However, the pain, suffering and misery caused to victims/survivors of sexual violence and abuse and to their families, is incalculable. Improving health and social outcomes for victims/survivors should be a central goal of the Joint Health and Wellbeing Strategy and JSNA.