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A MULTI-METHOD STUDY IDENTIFYING THE BARRIERS AND SOLUTIONS TO MEETING THE PHYSICAL AND PSYCHOLOGICAL HEALTH NEEDS OF YOUNG PEOPLE INVOLVED IN OR VULNERABLE TO SEXUAL EXPLOITATION

Meeting the health needs of young people

involved in or vulnerable to sexual exploitation

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ABSTRACT

Title

A multi-method study identifying barriers and solutions to meeting the physical and psychological health needs of young people involved in or vulnerable to sexual exploitation.

Research question

What are the health risks, health needs and health seeking behaviours of young people involved in or vulnerable to sexual exploitation?

Keywords

Youth, Physical, Psychological, Sexual, Health, Exploitation, Risks, Support.

Background

Awareness of sexual exploitation has increased over the past decade. However, physical and psychological health needs, risks, health seeking behaviour and use of health services by sexually exploited young people have been inadequately explored.

Methodology/method

Phase 1: descriptive, phenomenological, approach to encourage young people involved in or vulnerable to sexual exploitation to describe their personal accounts of health, risks, health seeking and support.

Phase 2: quantitative methodology consisting of a questionnaire survey with professionals supporting young people involved in or vulnerable to sexual exploitation.

Data analysis

Phase 1: phenomenological approach to data analysis (Giorgi, 1985).

Phase 2: questionnaire data were analysed using software S.P.S.S. and thematic content analysis (Burnard, 2006).

Results/findings

Intentional self harm and substance misuse were concordant themes from phase 1 and 2. Novel themes that emerged from this study included a taxonomy of risk behaviours related to health, and the use of youth offending teams for health support

Conclusion

A significant range of physical and psychological health problems were reported alongside risks to health and barriers to health support for sexually exploited young people. Psycho-social vulnerability factors undermine health and impact on health seeking behaviour.

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GLOSSARY OF TERMS

AIDS: Acquired Immuno-deficiency Virus
BSA: British Sociological Society
CEOP: Child Exploitation On Line Protection
COREC: Central Office for Research Ethics Committees
CRD: Centre for Reviews and Dissemination (York)
CROP: Coalition for the Removal of Pimps
CYPP: Children's and Young People Plan
DCSF: Department for Children Schools and Families
DH: Department of Health
EATA: European Association for the Treatment of Addiction
ECM: Every Child Matters
EPCAT: End Child Prostitution and Trafficking
HAS: Health Advisory Service
HIV: Human Immuno-deficiency Virus
HO: Home Office
HMG: Her Majesty's Government
HPA: Health Protection Agency
LREC: Local Research Ethics Committee
LSCB: Local Safeguarding Children Board
MoCAM: Models of Care for Alcohol Misusers
MRC: Medical Research Council
MSM: Men Who Have Sex with Men
NCB: National Children's Bureau
NCSSG: National Chlamydia Screening Steering Group
NCSP: National Chlamydia Screening Programme
NICE: National Institute for Clinical Excellence
NRES: National Research Ethics Service
NSF: National Service Framework
NSPCC: National Society for the Prevention of Cruelty to Children
NTA: National Treatment Agency
PMSU: Prime Minister's Strategy Unit
PSHE: Personal, Social and Health Education
RCN: Royal College of Nursing
RCPCH: Royal College of Paediatrics and Child Health
SCIP: Safeguarding Children Involved in Prostitution
SCODA: Standing Conference on Drug Abuse
STI: Sexually Transmitted Infection
SOA: Sexual Offences Act
SRA: Social Research Association
SVAAP: Sexual Violence and Abuse Action Plan
UK: United Kingdom
UKACMD: UK Advisory Council on the Misuse of Drugs
UKHTC: UK Human Trafficking Centre
UNICEF: United Nations International Children's Emergency Fund

Table 1.1 Operational definitions

Term/concept	Operational definition	Reference source
Health	'A state of complete physical, mental and social well being and not merely the absence of disease or infirmity'.	World Health Organization (1948)
Missing/runaway	'Children and young people up to the age of 18 who have run away from their home or care placement, have been forced to leave or whose whereabouts is unknown'	Department for Children, Schools and Families (2009)
Substance misuse	'Intoxication by- or regular excessive consumption of and/or dependence on psychoactive substances, leading to social, psychological, physical or legal problems. This includes problematic use of both legal and illegal drugs'.	The National Institute for Clinical Excellence (2007)
Sexual exploitation	'The sexual exploitation of young people under 18 involve exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs alcohol, cigarettes, affection, gifts money) as a result of performing, and/or others performing on them sexual activities'.	The National Working Group for Sexually Exploited Children and Young People.
Young person	'A child or a young person is someone up to the age of 18 years'.	The Children Act (1989). United Nations Convention on the Rights of the Child .

CHAPTER 1: INTRODUCTION

There are no UK based empirical studies relating to the health status, health risks and health seeking behaviour of sexually exploited young people. This study has addressed this gap through the presentation of original evidence and has made a contribution to knowledge. The results of this study contribute towards a greater understanding regarding a taxonomy of risk taking and factors that influence health and health seeking in the context of youth sexual exploitation. This thesis presents a mixed method study to address the following research question,

'What are the health risks, health needs and health seeking behaviours of young people involved in or vulnerable to sexual exploitation?'

The study was undertaken in 2 phases. Phase 1 was qualitative in design, drawing from aspects of a phenomenological approach. This approach enabled an exploration of participant accounts of their experience of health, illness, risk taking, health seeking behaviour and health service utilisation.

Phase 2 was quantitative in design, using a questionnaire survey. This approach enabled professionals supporting young people involved in or vulnerable to sexual exploitation, to describe their experience and understanding of the health issues, risks and patterns of health seeking behaviour and health service utilisation by this group. Literature was reviewed as a mechanism to gain further insight into the phenomena investigated.

Background to the study

There are several dimensions to the commercial sexual exploitation of young people. Barnardos (2011) identified 3 types of sexual exploitation: inappropriate relationships (for example, a young person involved with an older person who exerts power and control over them), the second type relates to the 'boyfriend scenario', where the young person is groomed by an exploitative adult and the third type relates to organised sexual exploitation (for example, trafficking). The most commonly recognised forms tend to be sexual exploitation, pornography (referred to as the production of abusive images of children and young people), and trafficking, to and through the UK.

The Department for Children, Schools and Families (2008, 2009) pointed out that sexual exploitation is characterised by a power differential between the young person and the adult and may involve sexual acts in exchange for rewards such as alcohol, or organised crime and trafficking. This study has focused on youth sexual exploitation rather than pornography or trafficking.

There are several discourses and social constructions surrounding youth sexual exploitation. For example, at one end of the spectrum a young person may consider themself to be formally involved in prostitution, whilst at the other end, the young person may be regarded as an abused child requiring safeguarding. These interpretations pose challenges in terms of responding to a young person involved in sexual exploitation.

Gough (1996) raised the issue that whilst the concept of child abuse is generally a familiar one, the different types of abuse tends to be less understood. This issue remains contemporary and is particularly relevant in the context of youth sexual exploitation. Edinburgh *et al.* (2006) stated that the majority of the literature around sexual abuse focuses on incest and pre-adolescence. Additionally, extra-familial abuse has a lower profile in the literature.

In 1996 a declaration was made at the World Congress against youth commercial sexual exploitation, in Stockholm. The declaration stated that:

'*Urgent concerted action is needed at the local, national, regional and international level to express our outrage at the sexual exploitation of children and young people and bring an end to the practice*'.

According to the Department for Children Schools and Families (2009) sexually exploited young people are a vulnerable group, with special needs in relation to health and social care. In particular sexually exploited young people are more likely to experience difficulties relating to their health (for example, assault and sexually transmitted infections), and emotional and behavioural development (for example, anti-social behaviour and low self esteem). Family and social relationships may pose challenges to a sexually exploited young person (for example, hostility) and difficulties related to educational engagement and performance are more likely.

An additional factor that may heighten a sexually exploited young person's vulnerability is that they may be regarded as a prostitute by other people and therefore less deserving. This may influence the response towards them and increase their vulnerability. The young person may view themself as a prostitute and reject unwanted health and social welfare interventions. The Department for Children Schools and Families (2009) stated that responses from professionals ought to take these special needs into account when engaging with a sexually exploited young person.

Although there is national and international commitment to end youth sexual exploitation, it remains a significant contemporary issue. Youth sexual exploitation has been a recognised and established problem in British society since the Victorian period (Walkowitz, 1995).

At a national level there is evidence of governmental commitment to eradicate youth sexual exploitation through criminal justice interventions, the establishment of the UK Human Trafficking Centre, United Nations International Children's Emergency Fund, End Child Prostitution and Trafficking, and Child Exploitation On-Line Protection. The key aims of the current UK legislation, relating to the sex industry are the prevention of the sexual exploitation of young people, protection of those affected and prosecution of those who facilitate sexual exploitation (Home Office, 2006).

According to Calder (2001), no formal structure to address youth sexual exploitation existed in England before 1999. Prior to this, youth sexual

exploitation received a relatively low profile with inadequate policy guidance or relevant legislation to address the issue. Services dedicated to supporting sexually exploited young people have been in existence for a considerable length of time, mainly funded through children's charities (for example, Barnardos). A relatively recent development is the location of sexual exploitation in generic literature relating to the health and well being of young people (Department of Health, 2003, Department for Education and Schools, 2004, 2006).

Young people have equal rights to access health services, irrespective of their personal circumstances (Swann and Balding, 2002). To promote health and improve life chances for sexually exploited young people it is important that health services are organised in a manner that is both appropriate and acceptable to them. Limited data exists that specifically outlines the consequences of sexual exploitation, unmet health needs and health seeking behaviour.

Earle *et al.* (2007) suggested that young people's voices are becoming more audible in terms of health care planning and delivery, through consultation. Historically young people have been marginalised and ignored. Earle *et al.* (2007) stated that whilst young people are considered to be amongst the healthiest in our society, there is an unequal distribution of health with obvious health inequalities prevalent. Sexually exploited young people are a socially excluded group, and frequently disenfranchised from mainstream health care services.

There is intrinsic value in examining an aspect of adolescent health, particularly when the target group is considered to be extremely vulnerable. Since youth sexual exploitation has received relatively sparse attention prior to the publication of '*Safeguarding Children Involved in Prostitution*' The Department of Health, Home Office, Department for Education and Skills (2000) limited information exists, particularly in relation to health. The majority of literature available tends to refer to protection, prevention and criminal justice interventions. However, the political landscape is changing and there appears to be a more obvious level of interest in youth sexual exploitation from a multitude of perspectives, including health.

Terminology

There are several terms used to describe sexually exploited young people and those who exploit them. Prostitute, sex worker, pimp and punter are considered to be inappropriate in relation to a young person. Sexual abuse, sex offender and perpetrator tend to be the more acceptable and contemporaneous terms as these relate to the current national legal framework. Young people's support services tend to use the term 'sexually exploited young person' to encompass a broad spectrum of exploitation. The term adopted in this study is sexual exploitation. The use of the terms prostitute and sex work have been used in this study to reflect an authentic account of the range of terminology used both by academics and by professionals from health, social care and the criminal justice system.

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Outline of the thesis

Chapter 2 provides an overview of the prevalence and definitions of youth sexual exploitation with an examination of the circumstances that heighten the risk of a young person's involvement. The literature review outlines vulnerability factors and the impact of sexual exploitation on a young person's physical, mental and sexual health. Unmet health needs and health seeking behaviour of sexually exploited young people are discussed.

Chapter 3 outlines general methodological considerations and the justification for a mixed methods design. Ethical considerations and competing paradigms are discussed.

Chapter 4 orientates phase 1 of the study in the philosophical tradition of constructivism and justifies the use of a phenomenological approach.

Chapter 5 describes the methods adopted in phase 1 with an overview of reliability and validity in the qualitative phase.

Chapter 6 offers an overview of the findings from phase 1.

Chapter 7 outlines the methodological approach taken in phase 2.

Chapter 8 describes the sampling strategy, data collection and analysis and reliability and validity considerations in phase 2.

Chapter 9 provides an overview of the findings from phase 2.

Chapter 10 offers a discussion of the findings from respondents in the context of reviewed literature. Study strengths and limitations are outlined.

Chapter 11 describes the implications for the provision and management of health services to sexually exploited young people. These are discussed alongside implications for health education and training. Recommendations for future research are offered.

CHAPTER 2: LITERATURE REVIEW

Search strategy

Introduction

To enable the research study aims and question to be fully addressed a comprehensive search, retrieval and review of available literature was undertaken. According to Parahoo (2006) the literature review offers a rationale and context for the study and enables theoretical/conceptual formulation in relation to existing relevant research.

Research question

What are the health risks, health needs and health seeking behaviors of young people involved in or vulnerable to sexual exploitation?

Study aims:

- To identify unmet physical and psychological health needs of young people involved in or vulnerable to sexual exploitation

- To explore the young person's perspective of risks to health.

- To identify health seeking behaviour and barriers to meeting the physical and psychological health needs of young people involved in or vulnerable to sexual exploitation

- To make recommendations to improve health service utilisation for young people involved in or vulnerable to sexual exploitation

Study objectives

- Recruit and interview young people to generate personal accounts of their experiences of health, risks and health seeking behaviours

▪ Administer a questionnaire to professionals supporting young people involved in or vulnerable to sexual exploitation.

A search strategy was designed in accordance with the 2001 and 2009 guidelines from the York Centre for Reviews and Dissemination and literature was reviewed systematically. A preliminary search was undertaken at the beginning of the study and a further search was undertaken towards the end to ensure that the review was comprehensive and contemporary.

Information was obtained through both hand and electronic searching a variety of sources including internet data bases, journals, books, abstracts, reference lists, indexes, the Cochrane library, Centre for Reviews and Dissemination data base, grey literature, governmental reports and young person specific websites. A concept map was used to formulate search terms which were identified from the study objectives:

Table 1.2 Definition of terms used in the search for relevant literature

Term	MESH heading
Young people	Youth, adolescent, child, children
Health	Physical health, psychological health, sexual health, well being, risk
Exploitation	Abuse, prostitution
Support	Access, services, care
Barriers	Inaccessible

Table 1.3 Review protocol used to inform inclusion and exclusion of studies

Population	Young people below 18 involved in or vulnerable to sexual exploitation. **Rationale**: relevance to the research. UK studies **Rationale**: International and UK health care systems will be different as the economic and regulatory environment in which health services are provided varies between countries. Therefore there will be a lack of generalisability in international studies to the UK.
Interventions	Physical and psychological health interventions. **Rationale**: relevance to the research question.
Outcomes	Any outcomes considered. **Rationale**: research aims to describe a range of outcomes.
Study design	All research designs are considered. Research 15 years or less. **Rationale**: new developments in field are of interest to this study as solutions to the current problems are sought.

Table 1.4 Literature search and retrieval strategy

Electronic databases	Number of releva documents Retrieved
ASSIA (Applied Social Sciences Index & Abstracts)	22
CRD (Centre for Reviews & Dissemination York)	0
DARE (Database of abstracts & reviews of effects, York)	0
CINAHL (Nursing & allied health)	25
Cochrane (Human health care & policy)	0
EMBASE (Biomedicine)	3
MEDLINE (Medicine)	17
PsycINFO (Psychology & psychiatry)	10
Social Care Online (Social care)	21

Literature review

Introduction

This study addressed the research question:

'*What are the health risks, health needs and health seeking behaviours of young people involved in or vulnerable to sexual exploitation?'*

Gaps in the literature reviewed were identified and linked to the study aims. This literature review is a systematic overview of key literature offering an insight into the experiences of young people involved in, or vulnerable to, sexual exploitation, in the context of health, risks to health and meeting health needs through access to relevant support services. To promote clarity and to address each element of the research aims the literature review has been structured into the following sections:

- Prevalence of youth sexual exploitation in the UK
- Defining youth sexual exploitation
- Vulnerability factors and sexual exploitation
- The consequences of sexual exploitation on physical and sexual health
- Unmet health needs and health seeking behaviour of sexually exploited young people

The prevalence of sexual exploitation of young people in the UK

Accurate statistics relating to the prevalence of youth sexual exploitation in the UK are unavailable, Chase and Stratham (2005), Department for Children,

Schools and Families (2009), Barnardos (2011). This is partly due to the clandestine nature of sexual exploitation and that many sexually exploited young people do not come to the attention of officials. Melrose (2004) suggested that the way sexual exploitation is defined varies, resulting in different estimates of scale with unreliable data. Barnardos (2011) highlighted the need for improved data on the prevalence of sexual exploitation.

Prevalence data that are available are primarily from localised research projects and voluntary agencies that support sexually exploited young people. Within the past decade data are also being collated through criminal justice, health and social welfare organisations as sexually exploited young people are likely to come into contact with these services due to 'going missing', truancy, substance misuse, anti-social behaviour, and being abducted or assaulted.

Criminal justice data may be recorded from convictions relating to sexual offences against under 18s, young people cautioned or convicted of soliciting, the Human Trafficking Centre (UKTC), Child Exploitation on Line Protection (CEOP) and Missing Persons data. However, there is a lack of consistency in recorded data nationally and this distorts prevalence data.

CEOP (2010) reported a 16% increase in numbers of on-line youth grooming incidents rising from 5,411 cases in 2008/09 to 6,291 cases in 2009/10. These cases related to inciting the young person to perform a sexual act and the perpetrator arranging to meet the young person off line.

In 2006, the Home Office estimated that there were approximately 5000 young people under 18 in the UK known to be affected by sexual exploitation, although this is considered to be a conservative estimate. These figures were derived from an analysis of Home Office data for England and Wales: between 1989 and 1996, 2615 cautions were issued and 1880 convictions issued against children and young people for prostitution related offences (Lee and O'Brien, 1995).

Several attempts have been made to estimate the extent of youth sexual exploitation, both locally and across the UK. In response to an increased awareness of sexual exploitation amongst major children's charities, statutory and non-statutory organisations and professional groups, the government published guidance in 2000 entitled *Safeguarding Children Involved in Prostitution* (SCIP) (Department of Health and Home Office). This guidance was a significant milestone in acknowledging the issue of youth sexual exploitation as a significant social policy issue. A criticism of the SCIP guidance lies in its wholesale construction of youth sexual exploitation within a child abuse paradigm, excluding alternative interpretations or scope to understand pre-cursors to it. The SCIP guidance also assumed that all sexually exploited young people have an agenda to withdraw from sexual exploitation, although in reality this may not be the case.

Following publication of the SCIP guidance, in 2001, a large scale review of estimate of the prevalence of sexual exploitation in England was made by Swann and Balding. Two of the aims of the review were to assess the

implementation and impact of the SCIP guidance nationally in preventing and exiting sexual exploitation. The study methodology comprised of a brief telephone survey targeting chairs of Area Child Protection Committees (ACPCs) with all 146 ACPCs in England at that time. A further method was a targeted follow up interview with 50 selected ACPCs. A seminar was also undertaken with 40 participants to allow dissemination of the initial review results and to explore the findings of the review. The findings from this review indicated that from a total sample of 146 ACPC's in England, 76% reported supporting young people involved in sexual exploitation, 27% reported no sexual exploitation in their area and 5.5% reported no knowledge of sexual exploitation in their area. Limitations in the methodology are apparent. There was no detailed description of the sampling strategy or what steps were taken to promote reliability, validity and trustworthiness of the findings. As a consequence the likelihood of bias is relatively high and this reduces confidence in the findings.

Hudson and Rivers (2002) undertook a research study in Bradford, in order to find out, from a local perspective, how many young men (below 40 years), were involved in sex work, and to collate information about existing services. The methodology included an interview based survey with 31 service providers from 21 local agencies. The results of these interviews indicated that 52% of agency representatives had direct evidence of young men selling sex in Bradford and evidence that some were exchanging sexual favours for accommodation. Questionnaires were administered to 10 young men (aged 14-18 years) through social and youth services and 27 men (aged 18 to 36

years) engaged with outreach services. The questionnaire results also showed that men in Bradford were buying sex from boys below 16 years. A limitation of this study was the timeframe of 4 months, thus reducing opportunities for further engagement with more young men and the broad age range used. A further limitation of this study was the low generalisability to other areas due to specific demographics relating to Bradford that may not be similar in other geographical areas.

Crawley *et al.* (2004) attempted to quantify the extent of sexual exploitation in a geographical area, through action research, in order to influence future service development for sexually exploited young people. Action research has been described by McNiff and Whitehead (2008 p7) as "*a form of enquiry that enables practitioners everywhere to investigate and evaluate their work.*" Crawley *et al.* devised the 'Taking Stock Life experiences' questionnaire which was a tool designed to be used by professionals to identify young people at risk of sexual exploitation. The methodology used in this study was a questionnaire survey and interviews to collect data from 19 young people and 10 adults currently or previously involved in sexual exploitation. From 35 agencies participating in the study 24 services stated that they supported sexually exploited young people. The findings of the study indicated that 378 young people of 19 years or below were at risk of, or involved in, sexual exploitation. Recommendations from this study specific to sexually exploited young people included prevention measures, a specialised referral system, a co-ordinated, integrated approach to care, early intervention and outreach

services. A limitation of this study was the lack of validity and reliability of the research instrument, reducing confidence in the results.

Further attempts have been made to estimate the prevalence of sexual exploitation across 3 Welsh authorities, within social services, and youth offending teams. Clutton and Coles (2008) undertook a scoping study in 2005, using the Barnardos Sexual Exploitation Risk Assessment Framework to collate and analyse 1478 cases of young people aged 10-22 to assess levels of risk of sexual exploitation. Results indicated that 129 young people were at significant risk and 329 young people were at mild or moderate risk. Limitations of this study included a biased sample as the case files of the young people were taken from social services and youth offending teams. These young people are more pre-disposed to the vulnerabilities associated with sexual exploitation than are their peers. The prevalence rates reported represented a particular group and are therefore not generalisable to a wider, generic population of young people.

In 2008 a survey of referrals to specialist sexual exploitation services for young people in the UK was undertaken by the National Working Group for Sexually Exploited Children and Young People. Between April 2007 and March 2008, sexual exploitation agency staff recorded 2509 referrals of young people below 18 years. This data represented 23 local authority or trust areas across the UK. This represented approximately 10-15% of trust/local authority areas within the UK with a duty to safeguard children and young people (National Working Group Sexually Exploited Children and Young People,

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2009). Whilst the data offer a useful indicator of prevalence of youth sexual exploitation, the limitations of the small sample render the generalisability of the survey results low. A general lack of description of the appropriateness of the referrals made is also a weak indicator of prevalence as some of the referrals may have been unsuitable. Referral is an unreliable indicator of prevalence as it relies on the definition of sexual exploitation which will vary nationally.

Defining sexual exploitation

The Department for Children, Schools and Families (2009 p9) stated that:

'Sexual exploitation of young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (for example, alcohol, affection), as a result of them performing, and/or another performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition (for example, being persuaded to post sexual images on the internet/mobile phones without immediate payment or gain). In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability'.

This definition of sexual exploitation encompasses the definitions drawn up by the United Nations International Children's Emergency Fund (UNICEF) (2004), the World Congress against the Commercial Sexual Exploitation of Children (Stockholm 27-31 August 1996), End Child Prostitution and Trafficking (EPCAT, 2003) and Barnardos (2001).

Pearce (2009) noted that this definition intentionally encompassed a full spectrum of risks that young people might encounter. This was a strategy to draw attention to the risks in an attempt to encourage others to contemplate the impact on the young person rather than to view them as engaging in behaviours that may be morally offensive.

Further attempts to define sexual exploitation have been made by Melrose and Barrett (2001): *'The exchange of sexual services for some form of payment such as money, drink, drugs and other consumer goods or even a roof over one's head for the night'.*

Defining sexual exploitation is complex and the practice of who perceives certain behaviours as exploitation is contentious. Social constructions relate to socio-cultural, political, professional, personal, legal and moral influences. They are often changeable and underpinned by assumptions.

Sexual exploitation has multiple definitions both in a historic and a contemporary context and these may be locally or nationally interpreted. The definition adopted tends to reflect a personal or an organisational attitude

towards sexually exploited young people and has an impact on how they are valued and responded to in society.

Gough (1996) and Melrose and Barrett (2001) stated that applying a definition to any form of child abuse is extremely important. The process of defining the abuse influences the response from society, an agency or an individual's work or responsibility and the criteria applied to provide interventions including legal proceedings. Gough (1996) also stated that whilst definitions are important, they will be biased by culture.

Jago and Pearce (2008) argued that defining sexual exploitation is extremely significant and influences the approach taken by local partnerships in establishing intervention thresholds.

Phoenix (2002) argued that viewing youth sexual exploitation within a sexual abuse and child protection framework obscures both material and social realities underpinning youth sexual exploitation and may have a detrimental impact on young people seeking support.

Sexually exploited young people as criminals or victims

Sexual exploitation of young people is not a new phenomenon. Voluntary organisations such as Barnardos have been supporting sexually exploited young people since the 19th century. The Victorians became concerned about 'child prostitution' and in response began to establish child welfare legislation.

In the 21st century there is still a lack of consistency regarding the interpretation of and approach towards youth sexual exploitation. Gorham (1978) noted that the Victorians tried to rescue and penalise young women involved in prostitution simultaneously, viewing them as both morally innocent victims and as promiscuous offenders. Victorians valued family life and childhood was an integral part of that; therefore, middle class reformers tried to rescue young people from sexual exploitation under the rubric of reform. This conceptualization of a young person and sex limited scope for individualism or choice. Pearce (2009) argued that these tensions still remain in contemporary discourses relating to youth sexual exploitation and prostitution. According to Gorham (1978) Stead (a 19th century journalist) was a key figure in drawing attention to sexual exploitation in the 19th Century and was instrumental in spearheading changes in The Criminal Law amendment Act of 1885, referred to as Stead's Act resulting in the age of consent for sexual intercourse being raised to 16.

Walkowitz (1992) and Gorham (1978) suggested that economic necessity and limited choices were the predominant reason for young girls to be engaged in sexual exploitation in late Victorian England, rather than due to being sexually innocent and passive victims as suggested by Stead.

According to Bindel *et al.* (2004) there are 3 broad socio-political positions relating to sexual exploitation/prostitution: the abolitionist, the regulatory and the legislative. It is recognised that the opposing agendas of these positions create problems in the formulation of a legal and political framework. If young

people are referred to as prostitutes, these opposing agendas will apply to them as they will be seen as criminals rather than victims. This observation is reflected in the current legislative framework pertaining to prostitution which permits the criminalisation of young people who sell sex and are considered to be persistent offenders and are therefore treated as offenders. The genesis of this practice was the Wolfendon Committee's Report on Homosexual Offences and Prostitution (HO, 1957) which considered prostitution to be a private and moral issue and therefore exempt from regulation under criminal law. The implication of this was that whilst prostitution in Britain is legal, soliciting or loitering are not. The Wolfenden Report failed to distinguish between children, young people or adults involved in prostitution and there are currently no age criteria other than being criminally responsible. Therefore in the 21st century, children below the age of sexual consent may be convicted as prostitutes.

Goddard *et al.* (2005) advocated the construct of children as victims of abuse rather than offenders, as this was more likely to promote responsiveness to their needs. However, the Home Office (2004a) publication 'Paying the Price' endorsed the criminalisation of the young person by the assumption that 'persistent and voluntary return' to the sale of sex assigned responsibility to the young person rather than the abusive adult.

In relation to youth sexual exploitation the emphasis has been on the disruption and prosecution of perpetrators and protection of the young person through the involvement of Local Safeguarding Children Boards (LSCB) (Jago

and Pearce, 2008) (Chase and Stratham, 2005). Phoenix (2002) argued that reformation anchored in the social construction of the young person as a victim may have detrimental consequences as this promotes interpretation of their lives through 'victimhood' and marginalizes the detail of the victimisation.

Further limitations in regarding all sexually exploited young people as victims and as children requiring salvation, arise with young people 16 and above who do not see themself as either a child or as a victim of abuse. However, whilst a sexually exploited young person may argue that they are exercising autonomy and choice, in reality their choices may be limited (Scott and Harper, 2006) (Phoenix, 2002).

It is debateable whether the needs of sexually exploited young people may be addressed effectively or wholly through a child protection framework. Pearce (2006) argued that support for sexually exploited young people tends to be organised through the Local Authority Safeguarding Children's Boards and this may create tensions. Pearce (2006) suggested that some of the issues encountered by sexually exploited young people may be more suitably addressed through youth work and domestic violence policies.

It has been suggested that self determination and choice may be contributory factors in sexual exploitation (Melrose *et al,* 1999, Melrose and Barrett, 2004, Pearce *et al,* 2002), with the young person viewing the exploitation as sex work and feeling empowered as opposed to victimised. According to Melrose and Ayre (2002), social care and social control agencies have previously held

the view that there is an element of freedom of choice for a young person entering into or remaining in prostitution. Whilst Ayre and Barrett (2000) suggested that the young person may have no autonomy (for example, they may be experiencing violence or imprisonment).

Jago and Pearce (2008) stated that sexually exploited young people may be challenging to services and fail to recognise that they are being coerced and sexually exploited. Whilst it is important that politicians, the legal system and health and social care providers respond to young people who are being sexually exploited as abused, it is important to recognise that the young person may consider themself to be autonomously involved in formal prostitution. Scott and Skidmore (2006) suggested that young people frequently fail to recognise that they are being exploited, often depend on abusive adults to supply attention and frequently reject professional support. This mismatch in how a young person and a professional may interpret the situation may present challenges in terms of intervening and meeting their needs.

Melrose and Barrett further suggested that there had been a significant shift from justice to welfare (i.e. sexually exploited not criminals); amongst agencies supporting sexually exploited young people. Melrose and Barrett (2001) stated that the response to youth sexual exploitation will vary depending on local definition and argued that for some young people selling sex may be viewed as a viable option to generate an income.

Cusick (2003) suggested that the way in which sexually exploited young people identify themselves is likely to influence their willingness and ability to seek support, particularly if they are portrayed as a criminal. Cusick (2003) also suggested that whilst the term 'sex work' may be considered to be less stigmatising than prostitute, this should never apply to young people below 18 as those who pay to have sex with them are sexually abusing them. Barrett and Melrose (2003) argued that the terms prostitute or sex worker, when used to describe a child or young person, reinforce, rather than highlight the abuse.

Walters (2005) explained that child protection legislation exists in a range of guidance and is regularly updated. Walters explained that child protection legislation may be separated into civil law, private law and criminal law.

With regards to sexually exploited young people, tensions exist between the Criminal law and the principles outlined in the Children Act (1989). According to Criminal law a person aged 10 years and over is considered to be fully responsible for their actions and therefore may cautioned or charged with soliciting or any other offence. From a local authority perspective, there is a duty to safeguard and promote the welfare of children who are in need, and to investigate cases where a child is suffering or is likely to suffer significant harm (Children Act, 1989, 2004). Physical and emotional harm occurs to sexually exploited young people and therefore they are considered to be at risk of, or to be suffering significant harm.

The Department of Health, Home Office, Department for Education and Skills (2000) published *Safeguarding Children Involved in Prostitution,* with a subsequent update in 2009, as supplementary guidance to *Working Together to Safeguard Children* (Department of Health, 1999). This guidance stated that health professionals may be the first to recognise that a child or young person is at risk of sexual exploitation and therefore they have a duty to respond proactively and to work in agreed local area child protection committee procedures (Local Safeguarding Children Boards).

The Department of Health (2000), in the *Safeguarding Children Involved in Prostitution* report, outlined the responsibilities of agencies working with young people and these included recognition of sexual exploitation, consider the young person to be a victim of abuse, safeguarding and promoting their welfare, joint preventative working and the investigation and prosecution of perpetrators. This guidance recommended that the police should refer the young person to Social Services Child Protection Unit and regarded them as a 'Child in Need' (Children Act 1989). In 2001, the *National Plan for Safeguarding Children from Commercial Sexual Exploitation* (Department of Health, 2001) was published to ensure effective implementation of *Safeguarding Children Involved in Prostitution*, and updated in 2002.

The law in relation to prostitution in the UK changed in 2003. The Sexual Offences Act (2003) was gender neutralised, and altered to introduce new offences with severe penalties against those who sexually exploit young people and those who traffic people for the purposes of committing any sexual

offence against them. These include beneficiaries such as pimps, brothel owners, people traffickers and buyers of sex. In particular it is illegal to be involved in any of the following activities with a person under 18 years: to pay for their sexual services, to cause, incite, control or to arrange or facilitate prostitution or pornography. The penalties for these offences range from a fine to life imprisonment (Gillespie, 2005). The Sex Offenders Register is re-enacted in Part 2 of the Sexual Offences Act 2003. The Register and its associated powers allow the police to monitor convicted sex offenders and those who pose a risk of sexual harm such as rape, sexual assault, incest and child sex offences including causing or encouraging the prostitution of children (Release, 2004).

According to the Department for Children, Schools and Families (2008, 2009) sexual exploitation tends to be linked to other forms of criminal activity including domestic violence and/or servitude, child trafficking, immigration and/or drug related offences, online/offline grooming and the manufacture and distribution of abusive images of children. As a consequence, the response required from individuals and organisations assessing a sexually exploited young person, in order to safeguard and promote their welfare, under section 11 of the *Children Act* 2004, needs to be holistic and thorough. Health services identified in this report included mental health, sexual health, problematic substance use services, accident and emergency and health professionals supporting looked after children.

Principles identified in the 2009, Department for Children, Schools and Families *Safeguarding Young people from Sexual Exploitation* document, included adopting a proactive, integrated, young person centred approach, taking into account the rights of young people and acknowledging that the response towards parents, families and carers will vary depending on the circumstances. Another principle underpinned in this guidance was that sexually exploited young people are victims of abuse not criminals and that perpetrators of sexual exploitation should be punished according to the current legislation. The Department for Children, Schools and Families (2009) recommended that all agencies involved in supporting sexually exploited young people should have regular safeguarding training, policies in place that are compatible with Local Safeguarding Children Board policies relating to sexual exploitation, and protocols to enable the sharing of information between agencies.

Autonomous young person or abused child

According to Gough and Stanley (2005), procedures and systems developed to safeguard the health, welfare and rights of children and young people are based on interpretations of what does and does not constitute abuse. There has been a major paradigmatic shift over the past decade to conceptualise a person under 18 years as an abused person in the context of sexual exploitation. This is problematic as 16 is the age of consent for a sexual relation. Also a person below 16 may not view themself as a victim. There is a notable lack of empirical data relating to young people's views of victimhood and defining sexual exploitation as abuse.

The green paper *Every Child Matters* (Department for Education and Schools, 2003) made reference to the sexual exploitation of young people under the rubric of 'ensuring children are safe'. The practice of treating sexually exploited young people as victims of abuse was highlighted in this document.

Brown (2004) noted the importance of recognising that sexually exploited young people have been sexually abused and suggested that there are damaging consequences in portraying abused children as blame-worthy seducers or as the coerced innocent. In doing so the real problems experienced by these children are not recognised. Brown suggested that there has been relatively little published relating to sexually exploited young people in the past and that it was during the 1980s and 1990s that the Government, the public and voluntary organisations began to focus on the subject. Another important observation made by Brown was that whilst it has been accepted that sexually exploited young people tend to become involved due to their vulnerability and as a result of limited choices, they are less likely to be viewed as victims than children who have been abused without the commercial element.

Phoenix (2002) argued that the construction of a young person as a victim of abuse detracts from the personal, social and material elements and reduces the scope to consider alternative perspectives (for example, the young person's).

Consent/coercion

Barrett (1998) pointed out that defining a young person is less straight forward than defining a child, although there are clearly differences between 18 year olds and children. According to Knight (2002) in order to discuss the intricate topic of youth sexual exploitation, it is necessary to define 'childhood'. The Children Act 1989, states that a young person remains a child until they are 18 years old. However, the legal age of consent for a range of behaviours obscures this statement (for example, the age of consent to sexual intercourse in England is 16: therefore the young person is unlikely to consider themselves to be a child requiring safeguarding). In common law, the point at which adulthood begins is unclear, although it is generally agreed that the upper limit for childhood is 16 years, depending on the capacity of the young person (Knight, 2002). Young people below 16 years cannot consent to sex: therefore they cannot be actively associated with behaviours related to prostitution and therefore should not be described as prostitutes (Patel and Pearce, 2004).

Phoenix (2002) pointed out that the SCIP guidance (2000) was developed on the premise that it is illegal to buy sex from a person below 16 years because they are unable to consent to sex as they are considered to lack capacity to consent. The SCIP guidance also recommended that young people between 16 and 18 who seem to engage in selling sex on a voluntary basis ought not to be regarded, prima facie, as consenting. Phoenix (2002) argued that in constructing all sexually exploited young people as abused, SCIP guidance failed to take into account the prospect of a young person acting voluntarily, as a free agent, rather than being forced or coerced by an adult. As Phoenix

pointed out, 16-17 year olds are able to consent to sex therefore the construct of selling sex as child abuse is an inadequate framework for this age group, although SCIP guidance refers to young people up to 18 years. Consent and voluntariness may offer a rationale for poor uptake of support by sexually exploited young people who do not consider themself to be exploited and are therefore likely to reject unwanted health, social welfare and criminal interventions.

Palmer (2001) suggested that a power imbalance between the young person and adult perpetrator are likely to be reinforced by age, emotional maturity, gender, physical strength and intellect. Palmer (2002) provided a working definition of youth sexual exploitation which has been widely accepted in the community of those supporting them. An observation of Palmer's definition is that it does not address the issue of voluntariness. The definition referred to:

'Any involvement of a child or young person below 18 in sexual activity for which remuneration of cash or in kind is given to the young person or a third party or a third person'.

The importance of language in defining youth sexual exploitation

In 1998 Swann was commissioned by the Home Office to undertake a scoping of the prevalence of sexual exploitation in England. An outcome from this scoping was the development of the Barnardos triangles. The Barnardos triangles were a conceptual framework designed by Swann to influence perceptions about sexually exploited young people and those who sexually

exploited them. The Barnardos triangles altered traditional language used to describe sexual exploitation and encouraged youth prostitution to be referred to as abuse. This was promoted diagrammatically through a triangle illustrating the young person (formerly referred to as a prostitute) as an abused young person; the buyer of sex should be referred to as a sex offender and the pimp (facilitator) as an abusing adult. Swann developed another abuse triangle, entitled the Prosecution-Protection triangle and, significantly, diagrammatically positioned the abused young person at the bottom of the triangle to illustrate the point that they are the victim in the triangle. Swann's Barnardos triangles are present in literature and have been widely used in the social welfare and criminal justice arenas in the context of defining and conceptualising the sexual exploitation of young people.

Phoenix (2002) pointed out that altering terminology relating to youth sexual exploitation (as in the Barnardos triangles) is highly significant as it proposes that relationships are coercive and dependent, and promotes theories of causation. Phoenix (2002) further reinforced the importance of the use of language, particularly in policy documents, as words convey intentional and unintentional meanings.

Goddard and Saunders (2001a) believed that language was extremely important as it could be used as a form of social control, domination, exploitation and objectification. They stated that people who sexually exploit young people may rationalise their behaviour with the use of language by implying that a consensual relationship exists between themselves and the

young person (for example 'having an affair') rather than viewing themself as exploitative. They also argued that the word child prostitution minimized the criminal element and failed to acknowledge the young person's rights.

Goddard *et al.* (2005) and Gough and Stanley (2005) believed that a responsibility lies with those who advocate for young people to use language sensitively to avoid the transformation of sexual assault into a commercial transaction or to a form of employment. Goddard *et al.* coined a phrase known as 'textual abuse'. Textual abuse described a concept that related to the use of language commonly used to describe youth sexual exploitation. Examples of textual abuse included using the words a 'relationship', or an 'affair' to describe sexual exploitation. Other examples of textual abuse were the substitution of the identity of a young person with the word 'it'. This practice reduced the identity of the child to an object rather than a person. A further example was the use of the word pornography to describe the production and distribution of abusive images of children and young people.

Phoenix (2003) described the lack of a 'common universe of meanings' in relation to the use of terminology which ranges from child at risk to sexual exploitation or prostitution; consequently services may be configured on the understanding of these words rather than based on the nature, extent and problems experienced by sexually exploited young people.

Summary

Accurate statistics regarding youth sexual exploitation are unavailable and prevalence data varies as a range of definitions of sexual exploitation exist. Defining youth sexual exploitation is complex and is socially constructed by legal, socio-cultural, political, personal, professional and moral influences. Whilst there are clearly differences between a child and a person aged 16 and above, the current UK legal framework reduces clarity in responding to sexually exploited young people and draws on both protective and paternalistic drivers. It is important to differentiate between youth sexual exploitation and adults who autonomously exercise their right to be involved in sex work. Although the notion of 'choice' is contentious in sex work involvement as economy of alternative choices may be a factor. The use of language in defining sexual exploitation is important as it influences responses, albeit inconsistent, both in the literature and in practice across professional groups and organisations.

Vulnerability factors and sexual exploitation

Introduction

The study aims addressed gaps identified in the literature by examining vulnerability factors relating to the physical and psychological health needs of young people involved in, or vulnerable to, sexual exploitation. Sexually exploited young persons perspectives of risks to health were also explored.

It has been recognised that any young person may be vulnerable to sexual exploitation, although, there are a range of personal vulnerabilities and circumstances and/or external factors that may heighten the risk (for example,

psycho-social vulnerabilities, substance misuse or being 'trafficked'). However, there is less known about the sequence of events or 'what came first' in relation to sexual exploitation. An improved understanding of vulnerabilities to, and facilitators of, sexual exploitation may in itself be a preventative measure. Scott (2001) suggested that developing an understanding of mechanisms involved in the sexual exploitation of young people is beneficial in terms of offering timely support.

In 2002, Pearce *et al.* designed risk indicators for health and social support services to use with vulnerable young people. This framework has been further developed by the National Working Group for Sexually Exploited Young People as a sexual exploitation risk assessment framework to enable the identification of vulnerabilities and was recommended in the Department for Children Schools and Families guidance (2009) *Safeguarding Children and Young People from Sexual Exploitation.*

The risk indicators contain 3 categories of risk designed to enable practitioners to identify the young person's needs, formulate assessment criteria and to promote an objective approach to planning care. A further function of the sexual exploitation risk assessment is to assist professionals in gauging the level and types of interventions required. The assessment focuses on current and past vulnerability factors, or known risk indicators. The 3 categories relate to severity of risk of sexual exploitation and include emotional health, sexual health and substance misuse.

Trafficking young people into sexual exploitation

The United Nations protocol to prevent, suppress and punish trafficking in persons defined trafficking as:

'The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion or abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery, servitude or the removal of organs', Home Office (2007).

According to the Home Office (2007) whilst the evidence to suggest that young people have been trafficked into the UK to be sexually exploited has increased over the past decade, accurate numbers are currently unavailable.

In 2006 the UK government undertook Operation Pentameter 1 and recovered 88 victims of trafficking. In a further initiative, Operation Pentameter 2, 167 victims were recovered: 13 of these were below 18 years.

The majority of trafficked young people tend to be aged 16 to 17 with children as young as 14 having been discovered through the 'Pentameter' operation.

Human trafficking for the purpose of sexual exploitation, particularly young people, has been described by Lee (2007) as having received the most

attention in terms of prevention, law enforcement and research. Lee also pointed out that human trafficking, which is regarded as a contemporary form of slavery, is not a recent development and can be traced back throughout the centuries.

In 2006, the government established the Human Trafficking Centre. There are 3 areas of preventative work identified in the *UK Action Plan on Tackling Human Trafficking*. These are to enhance intelligence and understanding of the issues, to identify and address the consequences of the supply and demand elements of human trafficking, and to increase the preventative aspects.

The internet and sexual exploitation

The advancement in technology and in particular access to the world wide web through the internet has facilitated the on-line sexual exploitation of young people. O'Connell (2003) coined the term 'cyber sexploitation' to describe the grooming of young people through social networking sites. In response to the development of on-line grooming the Home Office designed a Child Exploitation Online Protection service in 2006 (CEOP). Online grooming and exploitation is a recent development and consequently numbers affected, and the nature and extent of the consequences, is not yet known.

Living situation as a vulnerability factor to sexual exploitation

May *et al.* (1999) described the home environment as a further vulnerability factor to possible routes into sexual exploitation and suggested that the

children of sex workers are at an increased risk of being sexually exploited due to the 'prostitution environment'. According to May *et al.* the perceived risks of sex work may be offset by the young person having knowledge of their parent's involvement in it, which may increase their vulnerability to it.

Local authority care

Living in the looked after system has been linked to sexual exploitation in several studies, Pearce (2002), Scott and Skidmore (2006) and Harris and Robinson (2007). Coy (2008) undertook an exploratory study in the UK using interviews and an arts project with 14 women aged between 17-33 years. The aim of this study was to explore women's life story narratives relating to routes into sexual exploitation from local authority care. Findings suggested that there are links between being in care and sexual exploitation. Coy (2008) suggested that the precursors to sexual exploitation involvement are complex and designed a conceptual framework to enable a fuller understanding of these processes. Coy described how the young person may assume the identity of a sex object, and then acquire a sense of survival through the power and control aspects of involvement in sexual exploitation, with a further identity of professional sex worker as a means to acquire a sense of belonging. Coy suggested that peer introduction and association may also promote a young persons route into sexual exploitation. A limitation of this study is the low generalisability potential due to the small sample size. Additionally, limited detail regarding the trustworthiness of the findings reduced the overall credibility of the findings.

Homelessness

Other rationales have been offered to explain the reasons why young people may be vulnerable to sexual exploitation. Ayre and Barrett (2000) suggested that young people who feel alienated may view sex work as a survival strategy, particularly if they are homeless and using drugs. Other reasons offered included sex work as a means to meet material, emotional or social needs (for example, shelter or affection) and the appeal of improved social circumstances. Barrett and Melrose (2003) further reinforced this point and suggested that involvement in sexual exploitation (sex to acquire material rewards) is seen by some young people as a viable economic choice, when other alternatives are limited.

Melrose and Ayre (2002) suggested that economic deprivation may be associated with initiation into sexual exploitation and described less affluent young people in today's society in Britain as being 'significantly structurally disadvantaged' (for example, due to poverty and reduced employment and housing opportunities). They believed that this was in response to changes in welfare policies such as housing, social security and education. Melrose and Ayre suggested that for a minority of young people their rights to independent income and housing benefits have been lost and are linked to unemployment, homelessness and poverty.

Links between mental health and sexual exploitation

There is a notable absence of empirical studies that specifically examine the links between mental health and sexual exploitation. Mental health in youth

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sexual exploitation literature is reported although not as the primary focus and tends not to be examined in detail.

Corby (2006) looked at the psychological consequences of sexual abuse on a child. Corby differentiated between the impact of intra-familial and extra-familial abuse and suggested that intra-familial abuse promotes the most harm due to the violation of trust. Alternatively, Brown and Finkelhor (1986) suggested that the negative impact of intra-familial and extra-familial abuse is similar. Corby (2006) pointed out that the literature relating to the mental health impact of sexual abuse is inconclusive. However, Corby suggested that short term consequences of sexual abuse may be low self-esteem, depression, withdrawal, fear, guilt, hostility and aggression. The possible long term effects may be low self-esteem, fear, anxiety, depression, suicide, eating disorders and problematic substance use. Itzin (2006) pointed out that possible long term effects of sexual abuse include depression, anxiety, posttraumatic stress disorder, psychosis, substance misuse, eating disorders, self harm and suicide.

The conceptual framework of Brown and Finkelhor (1986) outlined the potential impact of sexual abuse on children and young people and has been considered to be useful in understanding the possible psychological impact of sexual exploitation. Brown and Finkelhor (1986) identified 4 psychological consequences of sexual abuse: traumatic sexualisation (due to early initiation into sexual behaviour), stigmatisation (predominantly shame and guilt), betrayal (by someone the young person considered to be a boyfriend) and

powerlessness (due to the absence of choice, control or safety). According to Brown and Finkelhor (1986) the manifestations of these psychological consequences may be low self esteem, fear, anxiety, eating and sleeping disorders

Willis and Levy (2002) suggested that the impact of sexual exploitation on a young person's mental health may be anxiety, depression and behavioural disorders, suicide and post traumatic stress disorder. Willis and Levy (2002) raised the issue that the provision of effective treatment and rehabilitation of sexually exploited young people into society may prove challenging to service providers due to the complexity of their needs.

Shepherd *et al.* (1999) examined young people's entry into, and experience of, sexual exploitation in Middlesbrough through interviews and questionnaires. Service availability and ways of working with sexually exploited young people were investigated. The sample comprised of 70 young people engaged in street based sexual exploitation. Sixty seven of the participants were female and 3 were male with an age range between 12-21 years. Eighty six percent of the sample had experienced childhood sexual abuse, with 97% having gone missing from home or local authority care. Additional findings were that 87% were involved in substance misuse and 53% engaged in self harming behaviour. Shepherd *et al* (1999) reported that mental health difficulties were a common feature amongst this sample. In the under 18 age range 77% of the sample had reported attempting suicide and 47% had reported cutting themselves intentionally. The research findings also

suggested limited coping mechanisms and a high vulnerability to mental health difficulties including anxiety and paranoia, which appeared to impact negatively on the young person's ability to address physical health needs. Recommendations from this study included proactive prevention of sexual exploitation, partially through the introduction of preventative educational initiatives in schools and youth services. Further recommendations included inter-agency training relating to sexual exploitation, improved communication between health and social welfare services supporting sexually exploited young people and joint planning of services targeting this group. A methodological flaw in this study was the lack of generalisability due to the study being undertaken in one town. The respondents were asked to recall their childhood experiences of sexual exploitation and therefore relied on memory and this may have reduced the reliability of the findings from this study.

Scott and Skidmore (2006), evaluated treatment outcomes for 42 sexually exploited young people in the UK, through case history analysis. Additional methodology involved external stakeholder interviews and collecting data over 2 years from a sample of 557 young people accessing Barnardos services. Data were analysed using a study specific outcome monitoring form designed to collate information relating to assessment, review, risk changes and protective factors. The findings indicated that the majority of the young people in their study experienced depleted mental and physical health and this was linked to their current lifestyle and family histories. A further finding was the presence of parental mental health problems which may serve as an

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underlying vulnerability factor for the young person. The outcome monitoring form was not validated which may limit confidence in this study.

Pearce (2007) recognised that whilst structural and environmental risk factors may precipitate a young person's vulnerability to sexual exploitation, individual risk factors need to be considered also. Pearce referred in particular to the grooming process adopted in sexual exploitation. One of the strategies employed by the abusive adult is to concentrate on the young person's vulnerability, which according to Pearce may be the result of low self-esteem. It has also been recognised that lowered self esteem may be a consequence of sexual exploitation.

Suicide, hopelessness, intentional self harm and sexual exploitation

Sexually exploited young people often present with lowered mood, which may be linked to feelings of hopelessness. Beck purported that 'hopelessness is a core characteristic of depression and serves as the link between depression and suicide' (Beck *et al*, 1985). Becks theory of depression was characterised by a cognitive style of pessimistic and unrealistic personal perceptions and expectations regarding one's past and future (1976, 1972, Kashani, Dandoy and Reid 1992). Beck referred to a personal negative outlook towards the future as hopelessness, which Beck *et al* later defined as '*a system of negative expectancies concerning oneself and one's future*' (Beck *et al*, 1974).

Abramson *et al* (1978) initially formulated theory linking helplessness with depression and later highlighted the significance of hopelessness and

depression as indicators of suicidal risk, coining the phrase 'hopelessness depression'. Subsequent studies have linked hopelessness and depression' (Abramson *et al,* 1989; Alford *et al*, 1995; Houston, 1995; Metalsky *et al* 1993).

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) (2010), reported that there has been a reduction in the number of suicides amongst young people below 25 years involved in mental health services, since 1997. Between 1997 and 2007, 1,128 patient suicides amongst people below 25 were recorded, representing a 57% overall reduction in suicides. Although this trend is encouraging, sexually exploited young people tend to experience difficulties in accessing mental health support (Cusick, 2003, Harris and Robinson, 2007) and are therefore unlikely to be represented in this encouraging trend.

The *National Suicide Prevention Strategy for England* (Department of Health, 2002a) identified a range of vulnerability factors that may predispose a person towards suicide. These included biological or mental health issues, their social situation, life events and access to methods of attempting suicide. Sexually exploited young people frequently experience these vulnerability factors and this may heighten their risk of suicidal thoughts, feelings or behaviours. Mind (2007) suggested that suicide is more common amongst young people who have experienced sexual or physical abuse.

According to Meltzer *et al.* (2002) self harm is more common in adolescence and young adulthood than in any other age group. For example a survey of 12,529 young people aged between 5 and 15 indicated that 1.3% had tried to harm themself. Hawton *et al.* (2002) reported findings from a school survey that indicated 13% of 15 to 16 year olds reported harming themselves ever, with 7% having done so in the past 12 months.

It has been recognised that intentional self harm is more common amongst young people who have experienced sexual or physical abuse and may be used as a self defeating coping strategy (Mind, 2007). Self harm is defined as 'self poisoning or self injury, irrespective of the purpose of the act' and may involve poisoning, cutting, burning, swallowing non-consumable objects or other actions that result in personal harm (National Institute of Clinical Excellence, 2004)

The National Institute of Clinical Excellence (2004), also stated that there are links between self harm and socio-economic deprivation, substance misuse, mental illness, and domestic violence. All of these factors are associated with sexually exploited young people. In 2004, The National Institute of Clinical Excellence published good practice guidelines relating to the treatment response of young people who self harm and do access medical treatment, including discussing confidentiality and consent and addressing safeguarding issues.

In 2004, the Department of Health and the Department for Education and Skills published a *National service framework for Children, Young People and Maternity services* in order to promote durable improvements in the health of the nation's young people. A specific feature of this framework was that everyone who works with young people has a responsibility to promote their health and wellbeing. This report highlighted that the co-morbidity that young people tend to present with is often significantly understated. This is particularly pertinent to sexually exploited young people who may have a multitude of health and social care needs. Recommendations included mental health promotion, provision of information, safeguarding and promotion of the welfare of young people.

Substance misuse as a vulnerability factor in sexual exploitation

The links between substance misuse and sexual exploitation and related health issues have been reported frequently in the literature, Ayre and Barrett (2000), Cusick (2002), Cusick *et al* (2003), Campbell and O'Neill (2006), Pearce (2002, 2003 and 2007), May and Hunter (2006). Alcohol misuse tends to have a lower profile than drugs in the literature, despite the significant links between alcohol and sexual exploitation. However, this is reflected in the wider arena of alcohol use, where illicit drugs appear to have received a higher profile generally due to public concern (Prime Minister's Strategy Unit, 2004).

Substance misuse and sexual exploitation undermine stability and increase other vulnerabilities such as truancy, unemployment, family breakdown, criminal behaviour and homelessness (The Government's Anti-drugs Co-

ordinating Unit, 1998). Rethink and Turning Point (2004) suggested that substance misuse tends to be co-terminous with youth sexual exploitation and frequently in conjunction with mental health issues which may complicate existing problems.

Rassool (2006) suggested that vulnerable young people who misuse substances may have a heightened risk of suicide, depression or conduct disorder. Rassool (2006) recognised that vulnerable young people, such as sexually exploited young people who misuse drugs tend to exhibit more self harm and suicidal behaviour with poor clinical outcomes. Rassool (2006) stated that problematic substance use has the potential to impair learning, affect social competence and negatively impact on employment, increasing alienation and social exclusion. Furthermore, Rasool suggested that drug and alcohol misuse may precipitate school drop out with poor educational attainment, anti-social behaviour, unplanned pregnancy and relationship difficulties.

Chase and Stratham (2005) highlighted 2 key ways in which substance misuse and youth sexual exploitation are related. Firstly, drug dependency may render a young person more vulnerable due to intoxication. Secondly, the young person may be persuaded or coerced into taking addictive drugs such as crack cocaine, and supplied with them, with a motive of sexual exploitation.

The Home Office (2004) noted that sexually exploited young people are considered to be very vulnerable and substance misuse is a recognised risk factor. It has been suggested that alcohol and other drugs are used by some

perpetrators to facilitate sexual assault and subsequently by victims of sexual assault to enable them to cope (Home Office, 2007a).

Scott and Skidmore (2006), evaluated treatment outcomes for sexually exploited young people in the UK. The findings indicated that out of 42 case studies of young people examined, 30 were involved in problematic drug and/or alcohol use. Alcohol and cannabis were the most commonly used drugs. The findings also suggested that parental dependent drug and/or alcohol use was present in 14 of the cases and this had influenced the young person's vulnerability to personal drug use and sexual exploitation. Findings from this study suggested that substances had been used by young people to combat emotional difficulties and had been associated with grooming the young person for sexual exploitation. Scott and Skidmore (2006) highlighted the importance of understanding vulnerability factors and viewing sexual exploitation as a spectrum of abusive relationships, from 'sexual abuse' at one end to 'formal prostitution' at the other.

Existing drug use as a pre-cursor to sexual exploitation

The Health Advisory Service (2001) stated that the reasons why young people initially use drugs are boredom, curiosity and peer pressure. As tolerance develops the physical and psychological needs associated with the drug use promote continued use.

The National Addiction Centre (Department of Health, 2003c) suggested that there are personal factors associated with the individual taking a drug that, combined with the addictiveness of the drug, influences whether they

graduate from experimental to dependent use. Other factors which may have a long term impact on the personal drug addiction journey include parental drug use, poverty, low intelligence and anti-social personality. Regarding drug use in young people influences include availability, opportunity, peer influence and expectation of the drug effect.

Melrose *et al.* (1999) found that many young people have an existing drug habit prior to sexual exploitation and selling sex is a means to fund the drug use. Melrose *et al.* (1999) suggested that drug use prior to sexual exploitation is more frequent amongst younger people. In their study under 15s were found to engage in sexual exploitation to fund drug use more frequently that over 25s, with heroin, crack and amphetamine use prevalent amongst sexually exploited young people below 26 years. Melrose *et al.* also reported that a significant number of young people had sold sex in exchange for crack cocaine and amphetamines, which may be used to enable the young person to cope physically and psychologically. According to Melrose and Barrett (2001) crack and sex work are linked as crack is a drug that is difficult to detect in screening, lowers inhibitions and is often funded through sex work.

The Home Office published *Tackling Crack: a National Plan* (Home Office, 2002), in response to the escalation in crack use in the UK. One of the themes in the national crack plan was to divert young people at risk of using crack, in particular vulnerable young people.

May *et al.* (1999) examined the links between sex and drug and alcohol markets through case studies in 3 geographical areas in the UK. Sixty seven

sex workers were interviewed, alongside drug workers and police. They found that on average alcohol use became regular by 14 years and cannabis by 15. Also, by 18, respondents had established the use of their main drug of choice. This study found that a close relationship between sex markets and semi-open crack markets was prevalent. This study also involved interviewing a significant number of young people who were found to be selling sex in exchange for crack cocaine. The results indicated that 50% of the young people had become involved in sex work under the age of 16. Recommendations from this study included the deterrence of at risk groups from becoming involved in sex work through harm reduction and a multi agency approach involving drug services, health, social services, housing and the police. Limitations of this study relate to the low generalisability due to the small sample size, specific to 3 geographical areas.

Pearce *et al.* (2002) identified from their qualitative exploratory study that out of 21 young people who had been sexually exploited, 9 said they had started selling sex to buy drugs for personal use and 6 had been funding their boyfriend's drug use. Pearce *et al.* (2002) suggested that the relationship between sexual exploitation and drug use is complex and whilst drug awareness, prevention and harm minimisation are extremely important, young substance misusers also need access to comprehensive treatment programmes. Limitations of this study lie in the lack of generalisability to a different group due to the small sample size and no comparison group.

Cusick *et al.* (2003) investigated vulnerability amongst sexually exploited young people and relationships between sex work and drug use. One hundred and twenty five participants, (mean age 27) with experience of drug use and sex work, participated in the study. The results indicated that drug use and sex work were closely interrelated and reinforced one another. Cusick *et al.* described typical reasons young people remained involved in sexual exploitation as 'trapping factors' including involvement in sexual exploitation and/or 'hard drug' use before 18 and experience of at least one other vulnerability indicator such as homelessness. This study indicated that the most vulnerable participants had experience of these trapping factors. Furthermore, Cusick *et al.* (2003) suggested that although substance misuse was a common feature amongst sexually exploited young people, their uptake of drug treatment services was not routine. Recommendations from this study included the early identification of young people at risk of sexual exploitation, and pursuing and prosecuting those who pay to have sex with a young person. Limitations of this study include the use of a convenience sample, lowering the generalisability of the findings to other populations. A further limitation was that there is no data presented on the gender or ethnicity of the sample and there was no detail provided regarding the reliability or validity of the methods used.

In recognition that the vulnerability of sexually exploited young people is likely to be increased with drug and /or alcohol use, Epling and McGregor (2006) recommended that safeguarding assessments should take the following into account: age and maturity, the seriousness of the drug use, the duration and

level of harm and the context in which drug taking is set. Epling and McGregor (2006) suggested that homeless young people were more prone to sexual exploitation and therefore required a different approach as their engagement and concordance with support services was poor. Suggestions included contact in a range of settings, contact by mobile phones, weekend and night contact, mobile health care units and emergency shelter with an emphasis placed on relationship building with the young person over time and attention to immediate care needs. Epling and McGregor (2006) also stated that a range of agencies need to be involved in supporting young people who use substances and have mental health problems and that all professionals supporting young people ought to be able to address substance use effectively.

Parental substance misuse as a vulnerability to youth sexual exploitation

It has been suggested that parental substance misuse may promote vulnerability factors in their children. Young people with existing vulnerabilities are at heightened risk of sexual exploitation. The UK Advisory Council on the Misuse of Drugs (2003) published a report from an enquiry into the impact of parental drug misuse on their children. According to the UK Advisory Council on the Misuse of Drugs (2003) serious parental drug use is likely to influence their teenagers to use drugs. Alcohol and/or drug misuse may be used by the young person to combat lowered self esteem and feelings of isolation which may increase the young person's vulnerability. A further consequence of lowered self esteem in a vulnerable young person may be to neglect their

health and to engage in risky behaviours (for example, drug and alcohol use), which may lead to unsafe sex (Social Exclusion Unit, 2005).

The UK Advisory Council on the Misuse of Drugs (2003) highlighted that public services engaging with problem drug users have a duty to assess the needs of their family, as effective treatment of the parent is likely to benefit both the parent and their children. A further recommendation was regular educational input, employment and a positive relationship with a trustworthy adult to offset the negative impact of parental drug use on the young person.

National policy relating to drug misuse and sexual exploitation

Sexually exploited young people are a group frequently identified in policy relating to drugs, due to the links between drug misuse and sexual exploitation.

In 1998 the Government's Anti-drugs Co-ordinating Unit published a 10 Year Drug Strategy entitled *Tackling Drugs to Build a Better Britain*. This strategy identified the need for a range of comprehensive and co-ordinated drug treatment services. The 4 main themes identified as priority areas in this strategy were young people, communities, treatment and the availability of illicit drugs. Young drug users were identified in this strategy as a group requiring particular attention. The strategy aimed to make drug use culturally unacceptable with a strong emphasis on healthy lifestyles whilst targeting young people most vulnerable to using drugs (for example, sexually exploited young people) and ensuring access to appropriate interventions.

Sexually exploited young people who misuse drugs, have been identified as a vulnerable group who tend to be affected by social, educational and psychological issues (The Health Advisory Service, 2001). In addition to these vulnerabilities, the Health Advisory Service (2001) identified young people who have contact with the juvenile justice system, are homeless, seeking asylum, pregnant or are parents themselves and have physical and/or mental health problems or a disability, as vulnerable. Sexually exploited young people frequently have a combination of many of these vulnerabilities.

In 2001 the Health Advisory Service published *The Substance of Young Needs* in recognition of developments in the evidence base, policy, commissioning, design and delivery of services regarding young drug misusers. This report highlighted that drug misuse takes place in a developmental and environmental context, and a significant number of young people who take drugs have a multitude of inter relating issues. In recognition of this the Health Advisory Service stated that statutory and non-statutory services in contact with young people using drugs required the capabilities to assess and intervene appropriately.

Further recommendations on working with vulnerable young drug users was provided in the *Young People's Problematic substance use Plan Guidance* (2001). Recommendations included: the need for services to: adopt a young person centred approach, be socially inclusive, accountable, deliver evidence based interventions and work in a seamless way. This guidance stated that

comprehensive drug treatment services should provide health promotion, prevention, early identification and accessible, effective care.

Further attempts to improve circumstances for young drug misusers were made in 2008 when the Government updated the national drug strategy. A key aim of this strategy was the prevention of drug related harm to young people and families. The mechanisms to achieve this aim were: improved drug treatment systems for young people, fast access to support and treatment for drug using parents, interventions for whole families, and support for carers.

The Department of Health (2007c) stated that the main aims of drug treatment for young people are to limit immediate harms relating to problematic substance use, to stabilise the young person and to facilitate their movement away from illegal drug use. In particular brief interventions, intense treatment regimes with the involvement of mainstream child and family services and social and education services for those with complex needs were recommended (Department of Health, 2007c). Services providing treatment to under 18s also need to consider consent issues, confidentiality, safeguarding, the legal, statutory and policy framework for young people, developmental needs, clinician competence, a holistic approach and prescribing. All of these factors relate to sexually exploited young people.

In 2003, a communications campaign aimed specifically at young people (particularly sexually exploited young people) was launched through a range

of media including television, radio and the national press, known as *Talk to FRANK*. The aim of *Talk to FRANK* was to discourage young people from experimenting with drugs through information about the associated risks. *Talk to FRANK* provided information, a confidential help line and a website.

National policy relating to alcohol misuse and sexual exploitation

Sexually exploited young people are a group frequently identified in policy relating to alcohol, due to the links between alcohol and sexual exploitation.

In 2004, the Prime Minister's Strategy Unit published the *Alcohol Harm Reduction Strategy for England*. Young people were identified in this document as the most likely people to binge drink. The implications of binge drinking may be accidents, health problems, being a perpetrator or victim of violence, including sexual assaults, unsafe sex and school exclusion (Matthews, 2006).

Specific interventions outlined in this strategy aimed at young people and likely to benefit sexually exploited young people included: law enforcement, better communication about the harms associated with alcohol, addressing the way alcohol is promoted through the media and improving health treatment. Alcohol education in schools was a statutory requirement of the *National Curriculum Science Order* and is delivered through personal, social, and health education and the Citizenship initiative and is a theme in the *National Healthy School Standard* (Prime Minister's Strategy Unit, 2004).

The Alcohol Harm Reduction Strategy for England (2004) and the *Choosing Health* White Paper (Department of Health, 2005b) documented the need for an improvement in the identification and treatment of alcohol problems. The National Treatment Agency commissioned a review of the effectiveness of treatment for alcohol problems, and this review informed the *Models of Care for Alcohol Misusers* (MoCAM) (2006b). Young people were identified in this review in relation to the services required to meet their needs. Whilst it is believed that young people and adults may benefit from similar treatment, young people have different social needs to adults, requiring a different approach (Raistrick *et al*, 2006), particularly socially excluded young people, such as sexually exploited young people.

In 2007 The Department of Health (2007b) published an updated alcohol strategy. The updated guidance emphasised and proposed the protection of young people through compliance of alcohol suppliers with the laws in relation to licensing (for example, reducing the sales of alcohol to under 18s). It is estimated that young people now are drinking more than young people were a decade ago (Department of Health, 2007a), although the reasons for this are unclear. Excessive alcohol consumption in the young is associated with offending, truancy, unsafe sex, unplanned pregnancy, substance misuse and injuries. All of these behaviours are associated with youth sexual exploitation.

In 2008, the Department for Children, Schools and Families, Home Office and Department of Health published the *Youth Alcohol Action Plan*. Whilst the key areas in this document were targeting generic young people, they are likely to

be valuable in the context of sexual exploitation. The key areas were: enhanced enforcement regarding drinking in public places, tackling the alcohol industry, agreeing a national consensus on the most effective way to address youth alcohol use, promoting partnerships with parents and supporting young people to make sensible decisions.

Summary

Vulnerability factors pre-disposing a young person to sexual exploitation were examined in the available literature. These factors related to the personal characteristics and circumstances of the young person (for example, emotional problems or homelessness). External factors influencing vulnerability to sexual exploitation related to structures and systems designed to support the organised sexual exploitation of young people (for example, human trafficking).

The relationship between sexual exploitation and mental health was examined in the available literature, although there is a scarcity of empirical studies. Mental health and sexual exploitation are linked in several ways. It appears that existing mental health issues may increase a young person's vulnerability to sexual exploitation, particularly when mental health issues are not recognised or the treatment response is inadequate. Additionally, the experience of sexual exploitation has been associated with a negative impact on mental health.

The relationship between substance misuse and sexual exploitation were examined in the available literature. Alcohol, cannabis and stimulants appear to be more commonly used by sexually exploited young people. Drugs and alcohol appear to be co-terminus with sexual exploitation both as a facilitator to sexual exploitation and as a trapping factor. Firstly, it appears that drugs and alcohol may be used to coerce a young person into sexual exploitation. Secondly, an existing drug and/or alcohol problem may increase a young person's vulnerability to sexual exploitation.

The consequences of sexual exploitation on physical and sexual health

Introduction

Gaps were identified in the literature relating to the impact of sexual exploitation on the physical health of sexually exploited young people. The study aimed to addressed this by exploring personal narrative accounts of physical health from the perspective of sexually exploited young people and professionals supporting this group. Available literature predominantly focused on the health needs of women over the age of 18 and involved in sex work. The literature reviewed tended to describe physical health issues as secondary to a primary cause (for example, physical health consequences, alcohol use and sexual behaviours). The main health issues identified were injuries as a consequence of physical and sexual assaults.

Sexually exploited young people are at heightened risk of violence (Bindel, 2004, Hunter and May, 2004) and therefore likely to experience elevated levels of morbidity, with possible long term consequences. Specific areas of

concern from a health perspective relate to sexual, physical and psychological health; all of which are frequently compounded by problematic substance use (Department of Health and Home Office, 2003b).

Similarly, Carter and Dalla (2006) raised the issue that although street level sex workers report a range of physical and mental health issues, the tendency has been to focus on sexual health rather than general health. This may be due to the fact that substance misuse and sexual health matters are viewed globally as public health concerns and therefore there has been a concerted effort from the Government to address them. Substance misuse and sexual health problems are cited prolifically in the literature relating to prostitution and sexual exploitation. This may suggest that sexual health and drug and alcohol use related problems tend to be addressed more frequently, whereas physical health problems may receive a lower profile unless there is evidence of an obvious complaint such as an injury.

Regarding physical health the Home Office (2007a) suggested that there tends to be a higher incidence of smoking, substance misuse, risky sexual behaviour, sexually transmitted infections, gynaecological problems, unplanned pregnancies, eating disorders and irritable bowel syndrome amongst people who have experienced sexual assault and abuse. These may manifest themselves both in the short and the long term.

Sexual health and youth sexual exploitation

The World Health Organization (2002) defined sexual health as '*a state of physical, emotional, mental and social well-being*'.

Sexual health appeared to be the most frequently reported aspect of health in the literature relating to sexual exploitation. This is probably due to concerns associated with the transmission of sexually transmitted infections and public health. Comparative sexual health data between sexually exploited and non-sexually exploited young people is not available.

In 2007, the Health Protection Agency published a report entitled *Testing Times*. This report provided an overview of the prevalence of HIV and other sexually transmitted infections in the UK. This report suggested that rates of HIV and other sexually transmitted infections had risen, with an approximate estimation of 73,000 cases of HIV, some undetected. The rates of syphilis, genital warts and genital herpes were identified as a public health concern. According to the Health Protection Agency (2007) the majority of newly diagnosed sexually transmitted infections diagnosed at genitourinary clinics in 2006 were amongst young adults. The Health Protection Agency (2007), acknowledged that positive steps had been taken to improve sexual health services (for example, a reduction in waiting times), although the prevalence of HIV and sexually transmitted infections remained high in the UK.

In 2007, The World Health Organization identified the reduction in sexually transmitted infections as a global priority and in 2006, the World Health Assembly promoted the development of a global strategy to address

prevention and control. One of the recommendations in this strategy was the provision of services designed to meet the needs of high-risk populations such as sex workers, adolescents and drug users.

Hoggart (2007) highlighted that a conflict exists between those committed to reducing sexual risk without limiting sexual behaviour and those who adopt a prohibitive stance towards young people and sex. Hoggart suggested that these competing positions have negatively influenced policy and practice development in relation to young people and sexual health. Notably, those involved in sex work have been socially excluded historically, partly due to state and public concern regarding the possible transmission of viral infections. Significantly, the attitude towards sexually exploited young people has altered over the past decade, from personal blame to care and protection with an emphasis placed on sexual health promotion and interventions.

Current policy context relating to sexual health and sexual exploitation

The *National Strategy for Sexual Health and HIV* (Department of Health, 2001a) drew attention to a hidden population of drug users such as female sex workers and therefore this aspect of health has had the best and most frequent attention. According to the Department of Health (2001a) sexually transmitted infections and HIV have escalated in England. Young people were a group identified as significant in relation to sexually transmitted infection distribution in England.

The aim of the *National Strategy for Sexual Health and HIV* (Department of Health, 2001a) was to reduce the transmission of sexually transmitted diseases, HIV and unplanned pregnancy rates. Further aims were to reduce waiting times and to accelerate diagnosis and treatment of sexually transmitted infections. Sexually exploited young people were identified as a group requiring a specific response in the *National Strategy for Sexual Health and HIV* (Department of Health, 2001a) and vulnerability and access to services were raised as specific issues. A further problem is that 50% of adolescents do not use contraception at first intercourse. The mechanisms for achieving the above aims were the provision of accurate information regarding prevention of sexually transmitted infections, the formulation of an evidence base to underpin practice, primary care youth services, piloting one-stop clinics and specialist sexual health primary care teams. Other recommendations from this strategy were: for commissioners and service providers to work collaboratively to reduce barriers, for targeted Chlamydia screening, open access genitourinary clinics with urgent appointments, appropriate contraception and abortion services and HIV testing and Hepatitis B vaccines.

Telephone help lines (for example, *Sex Wise*) and other information sources such as the internet, digital television and more traditional methods, such as leaflets and posters, were itemised in the *National Strategy for Sexual Health and HIV* (Department of Health, 2001a) as a valuable mechanism to assist people seeking sexual health support and advise. In particular the anonymity and availability of this form of communication is likely to be appealing to young

people and others who may be disenfranchised from, and lack trust in, mainstream services, such as sexually exploited young people.

In response to the escalation in the incidence of Chlamydia, particularly amongst young people in England, the Department of Health established the *National Chlamydia screening programme* (Department of Health, 2003a). The aims of this programme were to enhance awareness of sexual health and to reduce the rates of infections of Chlamydia through opportunistic screening to sexually active men and women under 25. The lack of consistency regarding access to community contraceptive clinics and sexual health clinics specifically for young people, were cited as problematic. This was particularly important as these venues were ideal for the provision of Chlamydia screening to young people. The *National Chlamydia screening programme* was committed to targeting those identified as having increased vulnerability to contracting Chlamydia (for example, sexually exploited young people).

A further development in the sexual health agenda in England was that the Department of Health (Department of Health, 2005a) commissioned the *Medical Foundation for AIDS and Sexual Health* to recommend and publish good practice standards for sexual health services. There were 10 standards, all of which were pertinent to the health of sexually exploited young people. Recommendations included: integrated care pathways, coordinated services with equitable access, targeting hard to reach groups, targeted sexually transmitted infection screening in a variety of settings, improved pregnancy testing and confidentiality procedures in order to promote service utilisation.

<u>Sexual health implications of sexual exploitation</u>

The Royal College of Paediatrics and Child Health (2003) pointed out that the rates of sexually transmitted infections amongst adolescents are relatively high. Sexually exploited young people who are more sexually active are at an increased risk of acquiring a sexually transmitted infection.

Sexual health issues related to sexual exploitation include increased rates of Chlamydia, gonorrhoea, abnormal cervical cytology, pelvic inflammatory disease, HIV, Hepatitis C, infertility and unplanned pregnancy. The Home Office (2004a) suggested that inconsistent use of genitourinary medicine and contraceptive services were identified features of sexual exploitation. Inconsistent use and poor uptake of sexual health treatment services has been implicated with poor sexual health outcomes.

Shepherd *et al.* (1999) reported that substance misuse was a factor influencing sexual behaviour negatively, as drugs tended to lower capacity to negotiate safe sexual practices and were frequently funded through selling sex. Access to sexual health clinics was raised as problematic in this study. The main issues were the young person wanting to be anonymous during the day and preferring to access services at night; which was not always possible. The other main factors influencing sexual health clinic utilisation were the location and young people feeling negatively judged by staff. In relation to sexual health: Hepatitis, HIV, gonorrhoea, syphilis, Chlamydia, genital herpes, cervical cancer and unplanned pregnancy were some of the risks cited in this

study. The findings from this study suggested that 80% of the young people interviewed claimed to use condoms when having sex with a client or other person. In contrast, barrier methods such as condom usage has been identified as an area of contention in sexual exploitation, with a higher premium often paid for non-usage of condoms by buyers of sex (O'Neill and Barbaret, 2000).

Links between sexual health, substance misuse and sexual exploitation

It has been recognised that sexual exploitation and substance misuse are co-terminus with substances frequently used to coerce and prolong sexual exploitation (Cusick, 2003, Scott and Skidmore, 2006, Pearce, 2007). Substance misuse has also been identified as a factor in risky sexual behaviour amongst young people due to the disinhibitory effects of intoxication (Department of Education and Skills, 2006).

The Home Office (2004) raised the importance of sexual health and problematic substance use interventions being offered simultaneously. In particular it has been highlighted that the use of crack cocaine impairs judgement and therefore increases the potential for unsafe sex.

Pregnancy and sexual exploitation

According to the Department of Health (2001a) England has the highest quota of teenage birth rates in Western Europe. In 1999, the Social Exclusion Unit published a report entitled *Teenage Pregnancy.* In response to this report the Teenage Pregnancy Unit was established along with a 10 year strategy. The

main aims of the strategy were to reduce the under 18 conception rate by 50% (from 46.6 per 1,000 in 1998) and to reduce the under 16 conception rate by 2010. According to the Family Planning Association (2007) the teenage conception rate declined between 1998 and 2005; in the under 18s by 11.8%; in the under 16s by 12.1%. Sexually exploited young people are at an increased risk of unplanned pregnancy due to more frequent sexual encounters.

In 2007, the Department for Children, Schools and Families published *Teenage Parents, Next Steps*. The aim of this report was to further reduce the prevalence of teenage pregnancy in England and to promote adequate levels of support to teenagers who choose to continue with the pregnancy. These aims formed part of the wider strategy which endeavoured to tackle child poverty and reduce inequalities, particularly since deprivation and poverty are linked to teenage parenthood. This report stated that although there had been a reduction in teenage pregnancy rates since 1998, there was still more work required to achieve the 2010 target to reduce the teenage conception rates by 50% in under 18s. The mechanism for achieving these aims was for primary care trusts to have services specifically for teenage mothers, rather than services targeting all ages of women. Children's centres were recommended to review ways to reach the most vulnerable and disenfranchised teenagers; sexually exploited young women are likely to fit into this category.

In 2007, the Department for Children, Schools and Families published further guidance relevant to teenage pregnancy. Standard 11 identified pregnant

women living in a disadvantaged environment as being less likely to access services early or to maintain contact with them. The consequences of this may be post natal depression, smoking during pregnancy, increased rates of infant mortality and low birth weight. This report also suggested that disadvantaged women were less likely to breastfeed, with less favourable maternal and neonatal outcomes. The Department for Children, Schools and Families (2007) stated that services ought to be configured in order to meet the needs of disadvantaged women (for example, sexually exploited young women).

Sexual health support for sexually exploited young people

Phoenix (2003) pointed out that agencies established to support sexually exploited young people in Britain tend to stem from sexual health or drug services or from children's charities.

In 2004, The Home Office reported that access to health care for young people was a significant issue, with sexual health services frequently serving as the point of contact for many young people. The Home Office emphasised the important role health services have, including contraception and sexual health clinics, in the identification of young people at risk of sexual exploitation and those already being exploited sexually. The Home Office recommended that professionals are able to react appropriately, and for services to be well coordinated, in order to facilitate an effective response towards sexually exploited young people.

In relation to roles and responsibilities towards sexually exploited young people, in 2006, the Government stated that all health professionals and staff responsible for the promotion of the health and development of children and young people were expected to be cognisant of the Local Safeguarding Children Board procedures, including how to access named professionals. This guidance highlighted that all professionals supporting children and young people ought to receive appropriate training and supervision to enable them to recognise and respond to welfare concerns. Staff working in genitourinary medicine, obstetric and gynaecological services are amongst those identified in this report as staff likely to be in contact with sexually exploited young people.

The Scottish Executive (2004) raised sexual health issues as one of the health consequences of prostitution. Although prostitution is notably regarded as exploitation in the less than 18 age group, the health issues are similar across all age ranges and they stated that dedicated services to meet the needs of sexually exploited young people should be available; including gynaecological and genitourinary services. The Scottish Executive (2004) raised the importance of ease of access to gynaecological and genitourinary services as a human rights issue and that timely intervention is likely to minimize the need for more costly intervention later. Monitoring, screening, detection and treatment were considered to be the means of lowering the risks in relation to sexual health.

In 2006, the Home Office published the *Prostitution Strategy for England and Wales.* Sexual health had a high profile in this report and was captured under the auspices of 'developing routes out' of prostitution. One strategy for achieving this was to improve access to health services, particularly sexual health services. Strategies suggested to promote sexual health included: the provision of condoms, safety advice and sexual health screening through outreach services. This report recommended that sexual health services needed to be accessible and located where they are required.

Summary

Physical health and youth sexual exploitation were identified as a gap in the literature. The majority of the literature available described physical health issues reported by women above 18 years, namely injuries relating to physical and sexual assaults.

The relationship between sexual exploitation and sexual health was examined in the available literature. Sexual health issues tend to be the most frequently reported health issue in the literature relating to sexual exploitation. The majority of the literature tends to relate to women over 18 years and involved in prostitution. Although there is a marked distinction between those over, or under, 18 legally, professionally, and ethically, the sexual health issues identified are similar. The defining differences relate to the additional vulnerabilities associated with youth and the required responses from support services. Notably professionals responding to a young person are required to regard the young person as vulnerable and to take into account safeguarding

issues relating to protection, consent and welfare. As stated previously, this may be problematic when the young person views themselves as autonomously involved in sex work and not vulnerable, as they are likely to reject unwanted interventions.

Unmet health needs and health seeking behaviour of sexually exploited young people

Introduction

Gaps were identified in the literature relating to the health needs and health seeking behaviour of sexually exploited young people. The study aimed to address these identified gaps by exploring barriers to meeting the physical and psychological health needs of young people involved in or vulnerable to sexual exploitation.

Generally there is a paucity of research relating to marginalised and vulnerable young people. This may explain why there appears to be a mismatch between interventions and the needs of sexually exploited young people (Cusick *et al.* 2003).

Gough and Bell (2005) raised the point that the current awareness of the extent of youth sexual exploitation is limited, and consequently service awareness and responsiveness have been minimal. Gough and Bell (2005) stated that commercially sexually exploited young people are extremely vulnerable members of society and paradoxically many are not known to health, education or social services, which reinforce their vulnerability.

There are a range of negative factors that may affect a sexually exploited young person's ability to access health support including personal and systemic barriers. Personal barriers may refer to characteristics of the individual; whereas systemic barriers refer to the structural and procedural characteristics of the organisation and delivery of health services.

Pearce *et al.* (2002) undertook action research with 55 young women aged between 13-18 years in a city in the UK and a London borough. The aim of the research was to provide young person centred perspectives of the problems and dangers associated with sexual exploitation, including health needs. Case studies using art, poetry, photography, and story writing were undertaken to explore the past and the future, in the context of choices and opportunities. The young women were identified in one of 3 categories: at risk of sexual exploitation, swapping sex for favours in kind or selling sex. It was recognised that all the young women had a range of complex needs including low self esteem, use of alcohol and drugs, physical and mental health problems, and past experience of violence and abuse. Pearce *et al.* reported that service providers supporting sexually exploited young women often felt powerless to effect positive and sustainable change; they recommended support and supervision for staff. The research recommended balancing protection with care as an over riding principle. Other recommendations included the identification of early warning signs of young people at risk of sexual exploitation, and the use of preventative interventions. A limitation of this study was that although 2 geographical locations were used in order to

enable comparison between a southern and a northern city, the demographic composition of each city was so different that it was difficult to compare data.

<u>Policy context</u>

The United Nations Committee on the Rights of the Child (1995, 2003) outlined 54 articles relevant to the rights of children. Whilst every article was relevant to sexually exploited young people, article 24 stated that 'Every child has the right to the best possible health'. The reality is that sexually exploited young people often encounter difficulties in meeting their health needs. The United Nations Committee on the Rights of the Child (1995, 2003) clearly stated that young people have the right to protection from sexual exploitation and access to good quality health care; but this is not always the case.

Current policy aims to eradicate the sexual exploitation of young people by focusing on prevention, protection and prosecution. The Department for Children, Schools and Families (2009) reinforced this message by stating that sexually exploited young people are victims of abuse requiring a safeguarding approach. Whilst these developments indicate a commitment at governmental level to tackle youth sexual exploitation, the approach may be considered too narrow and fails to acknowledge that there are young people who refute victimhood and engage in sex work autonomously. A further observation is the emphasis placed on prevention and protection rather than offering support to those currently affected, particularly health support.

The Home Office (2004) raised concern that current systems of health care are often unsuitable for vulnerable young people, with subsequent poor uptake. A number of sex work projects having raised the issue of inaccessibility of health services, particularly mental health services.

Barnardos (2005) produced a Parliamentary briefing paper entitled *Appropriate support for sexually exploited young people*. This paper acknowledged that, whilst the government were taking measures to protect sexually exploited young people through practice guidance, (Department of Health 2000, Department of Health, 2009), there was scope for further positive action in relation to meeting global needs, including health.

In 1998, the Department of Health published the *Independent Inquiry into Inequalities in Health* (Acheson (1998). Acheson stated in this report that health inequalities were a consequence of social inequalities rather than solely an inability to access health care. A key message from this report was that health inequalities needed to be addressed in the wider context of social, cultural, political and economic influences. This resonated with meeting the health needs of sexually exploited young people who tend to be disadvantaged in these domains. This report recommended that a key principle of all policies in the National Health Service should be to provide equitable access to effective health care based on need. An update to this review was published in 2009, entitled: *Tackling Health Inequalities: 10 years on* (Department of Health, 2009). This review builds on the Acheson report (1998) and set targets designed to improve health inequalities by addressing

the socio-political context, vulnerabilities and consequences (for example, health related behaviours), social stratification and health outcomes.

In 2006, the Department for Education and Skills published a green paper entitled *Youth Matters: Next Steps.* This document outlined radical proposals to change the way in which public services were designed and delivered to young people in order to influence positive life chances and to raise the profile of young people's physical and psychological health. Particular emphasis was placed on the proactive involvement of young people and on targeting support towards the most disadvantaged and vulnerable through: the Healthy Schools programme, extended schools, the Child Health Promotion programme, primary care initiatives, the development of adolescent health as a specialism and young people's health and support services.

In relation to access to health support, a suggestion stemming from the *Home Office Prostitution Strategy* (2005) was for youth services to extend their support to those young people who meet the age threshold for adult services, but would benefit from a longer period of support in a youth service. Plans to combat some of the issues contained in the *Home Office Prostitution Strategy* (2005) included Primary Care Trusts and housing agencies being fully involved in children's trusts and the joint planning and delivery of Young People Plans. Outreach services and advocacy services were considered to be effective strategies to supporting young people who are reluctant to engage in traditional and mainstream services.

Personal barriers

Earlier traumatic sexual experiences may serve as a personal barrier to accessing support for a health problem. Nelson (1999) recognised that traumatic sexual experiences may evoke an unpleasant reaction for that person whilst discussing their sexual history or undergoing genital examination. Nelson stated that sexual abuse and sexual assault result in trauma and the extent and duration of the traumatic after-effects will be influenced by a combination of several factors. These factors included the age at which the sexual abuse/assault occurred, the duration of the abuse, the relationship between the abuser and the abused and the number of assaults.

A further personal barrier to having health needs addressed, according to Hickerton (2001), is that a young person who discloses that they have been sexually abused is likely to feel less abnormal and more able to talk about the abuse to a person displaying a non-threatening, accepting and understanding attitude. Hickerton recognised that often practitioners are unsure how to react to the information and may ignore the significance of what is being said or refer the young person to another professional or organization. Both of these responses may leave the young person feeling abandoned. According to Griffiths (2001), professionals notoriously encounter difficulties when attempting to engage young people in therapeutic work. Griffiths believed that 1 solution is to design services to meet the specific needs of young people in an attempt to reduce the trend of poor uptake.

Victims of sexual abuse and violence often experience difficulties in accessing appropriate support. A factor which influences this is that 40% of adults who

are raped do not disclose this information to anyone and 31% of children who are sexually abused fail to disclose it until they are adults (Walby and Allen, 2004). The Home Office (2007a) also recognised that when victims of sexual abuse and violence have attempted to receive support, frequently it has been unavailable.

The Scottish Executive (2004) identified a range of personal barriers to meeting health needs for those involved in prostitution. The barriers included reluctance to access statutory services due to a fear of repercussions because of being a parent, or rejection (for example, due to illicit drug use). Homelessness and lack of finances to fund travel or medication were other identified barriers.

Swann and Balding (2002) acknowledged that sexually exploited young people are often difficult to engage in health services due to a combination of fear of repercussions from pimps, and avoidance of unwanted statutory service interventions (for example, social welfare).

Systemic barriers

Barrett and Melrose (2003) suggested that youth sexual exploitation may occur in a range of locations (for example, on the street or in less visible settings such as saunas, massage parlours or flats). The lack of visibility of sexually exploited young people may serve as a barrier to offering interventions.

Phoenix (2003) undertook a questionnaire survey and interviews which aimed to describe, analyse and catalogue provision and services for sexually exploited young people in England, Scotland, Wales and Northern Ireland. The research also aimed to disseminate this information in the form of a database to aid practice and policy development. Approximately 90 professionals working in generic health and social care were consulted about services and provision in their locality. Phoenix found that practitioners and professionals had an inadequate knowledge base regarding the types of specialist services available to sexually exploited young people. Additionally, Phoenix (2003) noted, that there tended to be 2 types of service provision for sexually exploited young people; services that work partially or exclusively with sexually exploited young people and staff who have experience or expertise in supporting sexually exploited young people and work in generic services. Phoenix (2003) remarked that the geographical location of projects with a remit to support sexually exploited young people was inequitable, urban rather than rural and they tended to be funded by either children's charities or from sexual health or drug services. Limitations of this study include a lack of detail relating to measures taken to uphold reliability and validity in the methodology used: questionnaires, telephone and email interviews. Limited detail regarding sample selection is given therefore the sample may have been biased.

Scott and Harper (2005) undertook a research study over a 2 year period which aimed to establish the level and nature of current need for services amongst young people at risk of sexual exploitation in London. Interviews

were conducted with over 100 respondents including young people, child protection co-ordinators, police health service representatives and other voluntary sector services. The findings from this study suggested that some London boroughs may be under-identifying young people at risk by up to 80%. In relation to health care, Scott and Harper found that young people were known to accident and emergency services, looked-after children's health services, sexual health clinics and teenage pregnancy services. Importantly, it was recognised through this study that young people had experienced problems in trying to access health care, particularly for psychological support. Scott and Harper found that there was variation in the level of awareness and proactive support towards sexually exploited young people from health and social care practitioners. Scott and Harper's recommendations were that primary care trusts should support the guidance and training of health professionals. Additionally health services should be provided in a flexible way to promote accessibility for sexually exploited young people. Scott and Harper (2005) raised the point that health services are amongst many services that encounter young people at risk of sexual exploitation. Therefore knowledge of local protocols is essential in offering appropriate support. The study was undertaken in 1 city therefore there are limits on the generalisability of the findings to other cities due to demographic variations in the sample. Detailed information relating to the steps taken to promote reliability and validity were absent in the published study report reducing confidence in the results.

Harris and Robinson (2007) mapped the needs of young people vulnerable to sexual exploitation in Sussex. The aims of the study were to estimate the level and nature of service requirement amongst sexually exploited young people. The findings of this study indicated that sexual exploitation of young people tended to be inadequately identified due to its discreet nature with limited awareness of sexual exploitation risk indicators amongst practitioners. In particular, Harris and Robinson cited sexual health services as being difficult for young people to access. Examples were given in this study of facilitating access to health services for young people (for example, open access clinics). Inadequate funding was cited as a contributory factor in reducing the level of preventative work that could be undertaken by health professionals (for example, lack of access to school nurses). A further barrier to meeting the needs of this group was the high threshold criteria set by support agencies potentially rendering those aged above 16 years to be a low priority. Harris and Robinson found that a range of health services support sexually exploited young people and appeared to display a good level of insight into sexual exploitation. However, access to services for mental health support was found to be problematic with waiting lists and young people not meeting the child and adolescent mental health service criteria for counselling due to level of need being cited as 2 main barriers. Young people in this study reported experiencing depression, flashbacks and feelings of shame, fear, low self esteem and identity problems. In addition to this child and adolescent mental health service staff reported that they felt unsupported in caring for sexually exploited young people. Limitations in this study relate to study data being formulated on an inconsistent operational definition of sexual exploitation.

The Home Office *Coordinated Prostitution Strategy* (2006) raised the issue that accessing a child and adolescent mental health service is often not immediate, despite the fact that mental health support is a central feature of support for young people who have been abused. This may be due to the young person failing to come to the attention of the service, or failing to meet the threshold criteria for entry to the service. This issue was highlighted in 2009 by Her Majesty's Government through the publication of 'The Protection of Children in England: A progress Report' (The Lord Laming, 2009). One of the recommendations in this report was that 'Children in Need' (Section 17 of the Children Act 1989,) should be able to access the services and support they require to address identified needs. It has been recognised that sexually exploited young people may fail to meet thresholds set by services such as mental health, and are therefore unable to access them. Interagency working was identified in this report as key to positive outcomes for young people, alongside an assessment of their needs and risks, with direct contact with the young person and their family.

Scott and Skidmore (2006) undertook a 2 year quantitative study of 10 Barnardos services for sexually exploited young people in the UK. The aims of the study were to assess whether the core outcomes that Barnardos work towards, were being achieved. (The outcomes were designed to reduce risk factors and increase protective factors in the young people's lives). A second aim was to describe the model of practice used to achieve the outcomes. The results of the study indicated that there had been a reduction in the number of

'going missing' episodes, improvement in appropriate relationships with the ability to recognise risky, exploitative relationships, access to safe, stable accommodation and enhanced awareness of personal rights. This research summarised that a combination of these outcomes suggested a reduction in the risks associated with ongoing sexual exploitation. Scott and Skidmore addressed the third aim of the study, which was to describe the model of practice used by referring to the four A's. The four A's refers to elements that have been found to be instrumental in the promotion of positive outcomes for sexually exploited young people. These are: access, attention, assertive outreach and advocacy. With regards to access to health care, the researchers found that inadequate inter agency working compromises effective primary prevention and early intervention strategies. A lack of detailed description of mechanisms employed to eliminate bias and to enhance reliability and validity of the results may limit confidence in this study.

Adolescent health and health seeking behaviour in general

Defining youth health is complex as there are several critical frameworks to understand young people's health and wellbeing. Robb (2007) argued that the way in which young people's health is portrayed is partly constructed through public and policy discourse. For example, Robb suggested that young people are often portrayed by the media as physically unfit, risk takers and anxious. Robb (2007) argued that contemporary policies and guidance attempting to promote the health and well being of young people have over emphasised the personal responsibility aspect of health and wellbeing. An example of this may be found in the green paper *Every Child Matters (*Department for Education

and Skills, 2003), which set out 5 outcomes, 3 of which emphasised the young persons active involvement in their personal wellbeing and adopted a narrow construct of a child or a young person, reducing scope for individuality in terms of characteristics of the young person and their experiences. Robb (2007) suggested viewing young people's health through a cultural, cross cultural and biographical perspective. This approach encompasses a broader understanding of youth health rather than offering generalised and over simplified explanations. The main assumptions that underpin this critical framework to understanding young people's health are that young people's health is anchored in a historical, social and cultural context and health issues need to be considered as an integral part of changing discourses of youth.

The National Youth Agency (2003, p.1) criticised the green paper, *Every Child Matters (*Department for Education and Skills, 2003) stating that it portrayed children and young people as 'passive recipients of adult care, rather than as partners and active citizens with a full range of human rights'.

The Department for Education and Skills (2005) stated that in the areas of obesity, mental and sexual health, volatile substance abuse and alcohol misuse in adolescents, the situation is either static or declining, in contrast to the marked improvements in the health of younger children and older adults over the past 3 decades. For example, young people are the group most likely to binge drink which is associated with accidents and anti-social behaviour.

According to the Department for Children, Schools and Families and the Department of Heath (2009), *the strategy for children and young people's health*, children and young people are healthier in the 21st Century than previously. This is due to technological, medical, social and economic advances, which have significantly reduced infant mortality rates through health promotion, additional support and access to resources. One aim of this strategy was to address inequalities in adolescent health and to focus on the most vulnerable by offering young people access to free sports, access to young people friendly health services and a campaign to raise awareness of contraception.

In response to general concerns about youth health seeking behaviour and access to health care the Department of Health (2007) published the You're Welcome quality criteria. This document set out guiding principles to promote health services supporting young people to be more accessible and effective in order to encourage uptake by young people. It has been suggested that young people's concerns in particular tend to relate to confidentiality, ease of access, the environment and the staff. These characteristics are important as they may be a deterrent to seeking health support (Department of Health, 2007).

Farrand *et al* (2007) undertook a UK based study to examine adolescent help seeking for emotional and behavioural issues and the professionals likely to be approached for help. A purposive sample comprising of 5 mixed gender secondary schools was used to administer questionnaires to 1007 young

people aged between 13 and 16, with a completion rate of 968 (96%). Findings indicated that the majority of young people stated that they would seek help for emotional and behavioural issues, more so younger females than males. Other findings suggested that the school form tutor had an important role and was cited as the professional most likely to be approached for help, with school based support likely to be sought for a substance misuse problem rather than from a health professional. Young people stated that they would approach a doctor or nurse for emotional issues particularly relating to feeling low and insomnia. Whilst the authors noted the encouraging results regarding intention to seek help, they stated that intention does not always manifest as behavioural action (Ajzen and Fishbein, 1980). Recommendations included additional training for form tutors due to their important role in offering psycho-social support and the availability of information to assist targeted help seeking. Limitations from this study included low generalisability of the findings due to the low numbers of participants from ethnic minorities and the socio demographic profile of the participants.

Gray et al (2004) examined the experiences and perceptions of adolescents' use of the internet for health information in the UK and in the US. The methodology involved 26 same gender focus groups (15 UK and 11 US) involving 157 secondary school students aged 11 to 19 years. Findings indicated that online health information had been sought by a significant number of adolescents'. Although some adolescents reported caution in the credibility of the information, the benefits appeared to out weigh these concerns. For example, it has been suggested that adolescents experience

difficulty in accessing health care and in establishing therapeutic relationships with health care professionals (Jacobson *et al* 2001). The use of the internet enables adolescents to address health needs through access to information without a personal appointment. Other benefits cited were the ability for an adolescent to be viewed as a person rather than categorised as an adolescent. The currency of the online information, in contrast to books, was also cited as an asset by some respondents. Limitations of this study are the lack of scope to generalise the findings to other populations.

Biddle *et al* (2004) undertook a cross-sectional survey in Bristol, in 2000/2001 which aimed to examine and compare help seeking behaviour amongst young men and women experiencing mental distress. An adapted version of the General Health Questionnaire (GHQ 12) and the GHQ-28 suicide subscale was issued to 3004 young people sourced from Avon Health Authority population register aged between 16-24 years to examine mental distress, suicidal thoughts and help seeking behaviours. The questionnaire yielded a 48% response rate and the results indicated that young women were more likely to seek help than young men; the majority of young people considered to be mentally distressed had not sought help, with fewer than 20% respondents experiencing suicidal thought having contacted a general practitioner. The study concluded that there appears to be reluctance amongst mentally distressed young people to seek help professional and there appear to be gender differences in help seeking behaviours. Limitations from this study included a relatively small sample size which placed limitations on the power to elicit clinically significant associations. A further limitation was the

use of the GHQ to examine psychiatric morbidity, as it detects potential and transient disorders. The implications being that potentially some of the cases identified as mentally disordered may be vulnerable rather than disturbed.

In relation to sexual health seeking, French *et al* (2007) undertook a study between 2000 an 2004 in order to examine the knowledge and use of contraceptive services and to examine factors linked to service utilisation. A random location sampling strategy was employed and resulted in 8879 interviews with young people aged 13 to 21 years. The results indicated that 65% of the young men and 77% of the young women interviewed had an awareness of services they could access for sexual health information and help lines and the internet were cited as useful sources of information. Young women stated their usual means of obtaining contraception as being from their general practice, whereas young men tended to acquire contraception from commercial venues. The use of family planning clinics was linked with deprivation and sexual intercourse before 16 years. This study concluded that since the publication for England's teenage pregnancy strategy, whilst there has been a change in patterns of use of contraceptive services by young people, there has not been an increase in use of contraceptive services. Limitations of this study are a non representative sample as young people living independently or away from home (for example in the looked after system) were excluded from this study.

A further study examining sexual health seeking amongst adolescents was undertaken by Wilson and Williams. They undertook a questionnaire based

survey and focus group interviews in Leicester, order to examine teenagers'
views on existing and future sexual health service provision for teenagers. A
postal questionnaire was administered to a sample of 399 school attendees,
aged between 13-16 years, with a response rate of 394 (98.7%). The
questionnaire was also posted to 1255 young people aged 16-19, with a
response rate of 711. Results indicated that respondents appeared to lack
knowledge of local sexual health services and tended to consult with general
practitioners and pharmacies for contraception. The results also suggested
that barriers to the use of sexual health services related to anxiety regarding
confidentiality, embarrassment and physical examination. Limitation in this
study relate to a low response rate and bias as is likely that the teenagers who
did respond are most likely to be users of sexual health services.

Reeves *et al* (2006) examined adolescents' perceptions and requirements of
sexual health education and sexual health services through a questionnaire
based survey. The sample comprised of 360 year 11 school pupils aged 15-
16 years, from 3 schools in Wales, with a response rate of 86%. The results of
this study indicated that adolescents are more likely to seek information and
advice from family and friends than from health professionals. In relation to
accessing sexual health services, important factors included confidentiality,
accessibility, opening times and friendliness. Other findings related to sex
education in schools. Respondents stated that sex education should be taught
by sexual health experts, earlier in the curriculum and in smaller groups.
Limitations form this study related to the questionnaire and included the

inability of respondents to select Saturday evenings or Sundays as a preferable time to access a service, levying a bias towards the other days.

Theoretical framework related to adolescent health behaviour

Earle *et al.* (2007) noted that there is no single theory that can be used in relation to promoting public health as health influences are multi factorial and behaviour that may undermine health is influenced by a range of factors (for example, hedonism or to cope). There are a variety of health promotion models available and it is important to assess the applicability of the model to the target group (for example, adolescents). Earle (2007) suggested that theories may be valuable in designing a health intervention for an individual, based on the assertion that it is necessary to have an understanding of an individual's beliefs about a health issue and to examine elements of these beliefs. For example, in the context of adolescent health, the identification of barriers to health seeking behaviour and making positive health changes is important.

The following models will be critically discussed in relation to their application to adolescents: Transtheoretical Stages of Change Model (Prochaska & DiClemente, 1984), the Health Belief Model (Becker, 1974), and Social Learning Theory (Bandura, 1977).

Transtheoretical Stages of Change Model (Prochaska and DiClemente1984)
The Transtheoretical Stages of Change model (Prochaska and DiClemente, 1984) is commonly used in supporting behavioural changes relating to alcohol

and drug use in treatment settings, including those targeting adolescents. There are 5 stages relating to this model:

- Pre-contemplation: insight may be present, no intention to change behaviour.
- Contemplation: insight is present and considering changing behaviour.
- Preparation for action: intention to change behaviour, at some point.
- Action: behavioural change has occurred
- Maintenance: new behaviour is maintained for an identified time.

The Transtheoretical Stages of Change model tends to be used in conjunction with motivational interviewing (MI). MI has been described as '*a directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence*' (Rollnick & Miller (1995).

There has been increasing interest in the utility of MI and the use of the Transtheoretical Stages of Change model, with adolescents over the past decade. Despite the recognition that there is limited empirical evidence available to support or refute the use of this approach with adolescents, Baer and Peterson (2002) suggest a raft of reasons why this approach may be useful with adolescents. Firstly, ambivalence amongst young people is common and MI encourages exploration of ambivalence and resistance. Secondly, MI lends itself to personal change goals and promotes autonomy. These are both important characteristics in supporting adolescents. Thirdly, principles underpinning MI include the use of a non-judgemental and non-confrontational style (Miller and Rollnick, 2002). Adolescents are more likely to respond to a non-judgemental and non-confrontational approach (Baer and

Peterson, 2002), particularly when they perceive their behaviours to be less risky than they are perceived to be by an adult (for example, the use of the word 'problem' may evoke resistance).

Adolescents differ from adults psycho-socially (for example, adolescence is a period of development in terms of higher order cognitive abilities, autonomy and identity). These differences, according to Baer and Peterson (2002),indicate that there are considerations that need to be taken into account with regards to the use of MI and the use of the Transtheoretical Stages of Change model with adolescents, (for example, whether the young person has sought support or otherwise as this is likely to effect their motivation to engage with treatment.) Additionally, the verbal skills of the young person, and their ability to understand the approach used, need to be taken into account (for example, younger adolescents may benefit from more straight forward and structured feedback).

The increasing interest in the utility of MI and the use of the Transtheoretical Stages of Change model with adolescents warrants further enquiry in order to examine the specific elements of this approach that may be helpful in supporting adolescents change behaviours that may be harmful to themselves or others.

Earle *et al.* (2007) noted that the Transtheoretical Stages of Change model is based upon the premise that individuals tend to move around stages of change in a predictable way, at different paces and not necessarily in the

same order. The Transtheoretical Stages of Change model is used both to assess the individuals readiness to change and as a guide to enable the therapist to match the intervention to the client more effectively (Nutbeam and Harris, 1998). According to this model it is important to be able to establish a young person's readiness to engage in activities which promote health. Therefore, arguably, those who have responsibility for providing or facilitating health care for sexually exploited young people would ideally be able to gauge the young person's motivation to seek and/or accept help and be able to match the intervention to the stage of change. The relevance is that a young person's readiness to change is likely to influence their health outcomes in terms of engagement and concordance with treatment.

Health Belief Model (Becker, 1974)

Becker's Health Belief model (1974) is a psychological model, designed to explain health behaviour and to highlight the reasons why people do or do not participate in disease prevention and disease identification programmes. This model has been used to look at preventative health behaviours, health-risk and sick role behaviours.

Becker's Health Belief model is anchored in 4 constructs: threat appraisal and behavioural evaluation, perceived susceptibility, severity and benefits and barriers. The model purports that an individual is likely to protect or promote their health if they are susceptible to a health problem, if the consequences of the problem are severe, if the individual perceives suggested actions to be valuable and/or if the benefits outweigh the costs or barriers (Earle *et al*,

2007). Becker's Health Belief model is underpinned by the concept that an individual's decision to change their behaviour occurs once they have considered available information and contemplated the 'rationality' of protecting their health. Threat appraisal and behavioural evaluation are constructs that may be applied by sexually exploited young people in the process of making choices relating to their health. For example, the experience of a physical health problem may render physical health a higher priority for a young person and be a catalyst to seek health support. Conversely, as Wills and Earle (2007) have suggested, behaviour is influenced by several factors (for example, pleasure). Pleasure may be a stronger driver than a long term health benefit, particularly for a vulnerable or chaotic young person.

Wills and Earle (2007) identified limitations of the Health Belief model, stating that it may: over-simplify information by aligning it to the individual, fail to take environmental and economic factors into account and does not consider the influence of family,and other role models. A further criticism of this model is that it assumes that people are capable of making rational decisions and fails to offer guidance relating to modification of health beliefs. Taking the limitations into account, the Health Belief model may be a useful adjuvant in identifying and understanding barriers and facilitators of adolescent health behaviour change.

Social Learning Theory (Bandura, 1977)

According to Peterson and McBride (2008) Bandura's Social Learning theory (1977) offers a rationale for behaviour. He suggests behaviour is influenced by an individual's expectations of the outcome of an action. This theory spans across both cognitive and behavioural dimensions and highlights the importance of observing and modelling emotional reactions, attitudes and behaviours of other people. An example may be 'a young person avoids a sexual health service' as the behaviour and 'no guarantee of confidentiality' as the expected outcome. These perceptions are likely to have an impact on a young person's decision making in relation to health choices and health support. Bandura described learning from the consequences of other people's behaviours; this is known as 'modelling'. This may encourage or discourage behaviour (for example, parental drug misuse as a catalyst for drug use cessation).

According to Jeffrey (1990) limitations of the Social Learning Theory lie in its inability to acknowledge an individuals' biological state (genetics and brain function) in terms of their individual learning potential. The implications of this according to Jeffrey, relate to possible cognitive deterioration due to use of substances or mental health difficulties, which may suggest alternative processes influencing health seeking behaviour and health choices. An alternative view to Jeffrey's might be that biological states which are necessary characteristics for learning are intrinsic to Social Learning Theory. Whilst these limitations reduce the scope to rely on Bandura's Social Learning theory as a means of fully understanding the behaviour of adolescents in the context of health, it may assist in offering additional insight.

Use of health services by sexually exploited young people

Due to the complex needs of sexually exploited young people support strategies require a multi dimensional approach. To enable this to happen a range of agencies have been developed specifically to tackle the sexual exploitation of young people. These include the Child Exploitation Online Protection Centre (CEOP), Coalition for the Removal of Pimping (CROP) and the UK Human Trafficking Centre (UKHTC). All these agencies have been developed to work alongside existing young person oriented services such as Barnardos.

Other agencies that have a role in safeguarding and promoting the welfare of sexually exploited young people include Local Safeguarding Children Boards, the National Working Group for Sexually Exploited Young people, local authorities, children's centres, children's health and social care, Connexions, youth services, leisure services, housing services, criminal justice services, schools and further education institutions.

Policy Context

In 2007, the Home Office published an action plan and an implementation guide to address sexual violence and abuse (Home Office, 2007a). Sexually exploited young people were incorporated in this guidance. These documents stemmed from the Criminal Justice Review entitled: *Rebalancing the Criminal Justice System* (2006), which aimed to further reduce the most serious crimes including sexual violence and abuse. The objectives of the *Sexual Violence and Abuse Action Plan* (Home Office, 2007) were to increase access to

support and health services for victims of sexual violence and abuse, to improve the criminal justice response and to maximise prevention of sexual violence and abuse.

Another key publication in relation to meeting the health needs of young people is *You're Welcome- quality criteria-making health services young people friendly* (Department of Health, 2007a). The criteria were designed to complement Standard 4 of the *National Service Framework for Children, Young People and Maternity Services* (2004). This document outlined steps required to make health services 'young people friendly'. The criteria identified 10 areas for improvement. These were confidentiality and consent, publicity, accessibility, environmental factors, staff, working in partnership, involvement of young people, adolescent specific health issues, sexual and reproductive health and child and adolescent mental health services. The criteria were designed for use in several settings including general, acute, chronic, long term conditions and health promotion units.

In 2009, the Department of Health and Department for Children, Schools and Families published a national strategy for young people's health. The document entitled *Healthy Lives, Brighter Futures* set out an agenda to achieve world-class health outcomes, high quality services and a reduction in health inequalities. The strategy focused on 3 areas including early years and pregnancy, children of school age and young people. The key areas targeting young people were the proposal for young people to access young people friendly health services, access to sports for 16-19 year olds and a campaign

to enhance contraception uptake. At a systemic level the Department of Health and Department for Children, Schools and Families intend to implement the strategy through effective leadership, strengthening statutory accountability and responsibility and effective commissioning of children's health services.

Stevenson and Petrak (2007) performed what they believed to be the first UK based clinical psychology service evaluation with 29 women aged 17-45. The aim of the study was to report on the development of a clinical psychology service for commercial sex workers. This involved a retrospective analysis of data from referral patterns, demographics, issues, interventions and outcomes. The interventions included consultations, therapy and signposting to other services. The findings from this evaluation suggested that a range of psychological presentations were evident amongst the women including: fear, anxiety, low self confidence, low mood, substance misuse and post traumatic symptoms. A named female clinical psychologist may facilitate trust and familiarity with improved uptake of the clinical psychology service. Limitations of this study include the small sample and no comparison group, rendering the results low in generalisability to a wider population.

Taylor-Brown *et al.* (2002) undertook a study which aimed to take forward recommendations from sexually exploited young people who had previously been involved in work by End Child Prostitution and Trafficking (UK). In 2000, the first international conference was held, bringing together young people to discuss youth sexual exploitation. The conference was entitled 'Hope and

Action'. Forty seven sexually exploited young people were interviewed to obtain information relating to the young person's background, experience of sexual exploitation, exiting and use of services. The research concluded that sexually exploited young people are a significantly vulnerable group due to a higher propensity towards poverty, social exclusion, unemployment and impaired mental health. Recommendations included: appropriate referrals to problematic substance use services, early intervention, appropriate and safe supported accommodation and educational programmes targeting young people who may be vulnerable to sexual exploitation. Limitations from this study included technical difficulties reported by the researcher meant that only 41 out of 47 interviews were transcribed. The research report does not outline details of steps taken to reduce bias and to enhance trustworthiness of the findings therefore credibility may be reduced.

Skidmore (2004) undertook a 12 month joint project between Barnardos, UK and State Advies, Netherlands. The main aims of the research were to analyse and share 'what works' in the prevention of child sexual exploitation. Another aim was to begin to measure the impacts of interventions with sexually exploited young people in the UK and the Netherlands. A monitoring tool was designed and implemented to: measure the impact of service provision on young people, to identify the reduction in risks over the period of service contact with the young person and the short term reduction in risk in relation to associated service intervention and support. The results of this project indicated experience of childhood trauma, poor relationships, a history of violent, sexually abusive relationships, coercion and manipulation by an

older man, accommodation problems and problematic substance use. Regarding involvement with a sexual exploitation service, most of the young people had been referred by either the police or social services and had sustained contact with a service. Other findings included the use of a 'prevention, harm- reduction, support and advocacy to reduce risk and risk-exit strategy' model. The last finding suggested that there were structural constraints to service provision including legislation and criminal justice, local policy and resources.

Limitations from this study relate to the lack of validity regarding the monitoring tool designed to collect data.

Summary

Health needs, health seeking behaviours and use of health services by young people involved in, or vulnerable to, sexual exploitation were examined in the available literature. Whilst this remains an under researched area with apparent gaps 2 key factors were identified in terms of health seeking. These were personal and systemic factors relating to the individual, and the health service delivery and organisation. In terms of services used for health issues, it appears that sexually exploited young people access a wide range of services both health and non health oriented.

There tends to be more literature relating to health issues experienced by sexually exploited young people than literature relating to effective evidence based interventions; particularly those linked to health needs.

Conclusion of the literature review

The majority of the available literature tends to focus on the historical context of sexual exploitation and circumstances promoting vulnerability to involvement. Empirical research relating to youth sexual exploitation in the UK is very limited, particularly relating to health. The research that is available tends to be linked to children's charities and focuses on prevention and safeguarding issues. The legislative framework relating to youth sexual exploitation appears to have expanded over the past decade and tends to be located in child policy literature and in documents relating to sexual abuse.

Defining sexual exploitation and estimating its prevalence has received a significant level of interest and continues to be debated in the literature. In particular, the practice of regarding sexually exploited young people as criminals or victims, and as either, autonomous young people, or abused children, has been widely debated, but remains inconclusive. Gaps in the literature relate to how to effectively respond to and support young people aged 16 or above who are involved in sexual exploitation.

Vulnerability factors and pre-cursors to youth sexual exploitation were located in the literature. A range of psycho-social factors associated with youth sexual exploitation were identified including human trafficking, on-line grooming via the internet, experience of local authority care and homelessness. Personal vulnerabilities included mental health and substance misuse. There is also a body of literature and research specifically reporting on the links between sexual exploitation, sexual health and substance misuse. Gaps in knowledge

were identified in relation to risk behaviours, the sequence of events and the consequences of sexual exploitation on physical health. Other gaps in knowledge identified were related to health seeking behaviour and barriers to health care for sexually exploited young people. The knowledge base relating to effective therapeutic interventions for sexually exploited young people is also limited.

The consequences of these identified gaps and the lack of evidence underpinning interventions, suggests an ineffective and inconsistent approach to responding to the health needs of sexually exploited young people. Therefore further research is indicated in the areas identified.

CHAPTER 3: METHODOLOGICAL CONSIDERATIONS

Sequential mixed methods- justification

A mixed method design was employed linking qualitative and quantitative data, to elicit the views and personal accounts of young people involved in or vulnerable to sexual exploitation, and professionals supporting them. The study was designed in 2 phases. Phase 1 involved undertaking interviews with young people involved in or vulnerable to sexual exploitation, using aspects of a descriptive phenomenological approach. Phase 2 involved a self-completion questionnaire survey with professionals supporting young people involved in or vulnerable to sexual exploitation.

A sequential exploratory design was used in this study to address the research questions. According to Cresswell (2003) the mixed method sequential exploratory design has 2 elements: qualitative followed by quantitative. In line with this design the researcher collected and analysed the qualitative data first.

The quantitative data were collected second in the sequence to enable elaboration of the qualitative results generated from phase 1. The second phase data was used to build on the first phase data and the 2 phases were connected in the intermediate stage of the study.

The rationale underpinning the approach taken was that the qualitative data, following analysis, provided a basic understanding of the research question from the perspective of young people involved in or vulnerable to sexual

exploitation. The quantitative data, following analysis enabled further exploration from the perspective of professionals supporting this group.

Ethical considerations for phase 1 and 2 of this study

Introduction

Medical ethical guidelines were applied in this study, underpinned by the four principles outlined by Beauchamp and Childress (2000): beneficence, non-maleficence, respect for autonomy and justice.

Ethical guidelines governing research with young people were reviewed and used to inform this study. These were the National Research Ethics Service (2004, 2005), National Children's Bureau (NCB, 2003), Medical Research Council (MRC, 2004), Social Research Association (SRA, 2003), Royal College of Nursing (RCN, 2004), Royal College of Paediatrics and Child Health (RCPCH, 2000), Department of Health (DH, 2001b, 2005) and the University of Bradford Code of Practice for Research Students (2005).

This research study was reviewed and approved by the Local Research Ethics Committee (LREC). LREC requested additional information relating to recruitment to the study, information sheets, the age of participants, confidentiality and data analysis. These issues were addressed and approved by LREC.

The research was undertaken in 11 geographical locations in the north of England and ethical approval was obtained from 4 separate National Health

Service Research and Development units: Bradford Research Ethics Committee, West Yorkshire Primary Care Research and Development Unit, North Yorkshire NHS Alliance Research and Development Unit, Doncaster Primary Care Trust Research and Development Unit and Middlesbrough Primary Care Trust Research Management and Governance Unit.

Safety of participants

Physical safety

Interviews were undertaken with participants who were currently in contact with a support agency. The terms of engagement and contact were negotiated with the participants and the agency supporting them to reinforce safety. An enhanced Criminal Records Bureau security screen was undertaken by the researcher and shown to a member of staff from each agency to enhance safety of participants.

Psychological safety

The Royal College of Nursing (2004 p 6) stated that '*Every recipient of health care is in some way vulnerable, but those with more limited ability to act autonomously can also be more vulnerable to the impact of research activity'*.

The researcher took measures to minimise the risks to the young person. For example, a selection criteria protocol was designed to assist the agency staff in identifying young people for the study and included 'too vulnerable', as a trigger for exclusion to the study (Appendix1). The Department of Health (2005 p8) stated that '*If there are any risks to participants the risks must be in*

proportion to the potential benefits'. This research anticipated that sensitive material would be discussed during the interviews with the young person therefore emotional support was available during and after the interview.

The MRC (2004) stated that researchers need to consider the cumulative consequences of research on a child. Each young person participated in 1 interview for less than an hour. Psychological support and a de-briefing period from a member of staff were available for each participant before, during and following the interview.

The MRC (2004 p6), stated that '*if a child becomes upset by a procedure then researcher must accept this as a valid refusal'*. This principle was applied in this research. On one occasion the researcher terminated the interview and enlisted key worker support due to the young person appearing to require psychological support.

During information sharing and seeking consent the researcher used the Fraser guidelines to check for levels of understanding of the information being shared. This interaction was used as an opportunity to gauge the psychological well being of each potential participant and to identify any issues that may have impacted on the participant's ability to be involved in the research. No young persons were excluded by the researcher at this point due to psychological vulnerability.

Information sharing with the young person

The RCN (2005) suggested that it is extremely important that potential participants are able to understand the information that researchers give to them as this influences their ability to give consent to be involved in the research or not. This is particularly pertinent if the participant has a special need such as a sensory impairment. The researcher shared information with each individual in a format that was suitable to their needs to maximise adequate understanding of the research.

The Central Office for Research Ethical Guidelines (2004), the Royal College of Nursing (2004) and the National Children's Bureau (2003) suggested that a young person should receive information according to his/her capacity to understand, setting out the risks and benefits of participating in the research and what is expected of them. An information sheet was made available to all participants in clear, jargon free, appropriate language (Appendix 2, 3).

COREC (2004 p6), stated that the researcher should *'carefully consider the explicit wishes of a child who is capable of forming an opinion and assessing the information, to refuse to participate or withdraw from the research'.*

According to the National Children's Bureau (NCB) (2003) a young person may find it difficult to withdraw from a research study due to power differentials in the relationship between an older researcher and a younger participant. The NCB (2003) recommended the use of a signal to facilitate the young person's withdrawal with ease from the research. In this study, the researcher provided a paper sign which was given to the participant who was

asked to hold this up if they wished to withdraw from the research interview. This was available to young people, although it was not used in this study.

Anonymity was upheld and no information could be linked to any individual. Absolute anonymity was not guaranteed, as the disclosure of information to a third party may have been necessary. Pseudonyms were used in reports to uphold anonymity. Demographical data, rather than biographical data were obtained.

Confidentiality

The Data protection Act (1998) requires personal information to remain confidential. The NCB (2003) recommended that young people are made aware of the extent of a guarantee of confidentiality before being asked to consent to participate in the research. The researcher limited guarantees of absolute confidentiality as disclosure of information may have been necessary.

Alderson and Morrow (2004) stated that young people have the same rights to confidentiality as adults. The NCB (2003) also raised the importance of agreeing the arrangements for confidentiality and anonymity in advance. Therefore in line with the Research Ethics Committee feedback the researcher designed a single confidentiality policy to use throughout the study (Appendix 5).

Privacy

Alderson and Morrow (2004 p43) described privacy as '*the avoidance of undue intrusion into the personal affairs of participants'*. To avoid eroding the privacy of information the researcher obtained information about the participant from the participant during the interview, not from a third party.

Consent for young people below 16 years

The MRC (2004) stated that researchers can only involve competent young people if they have obtained their informed consent in advance. According to the MRC (2004), ideally parents should be involved with the young person in the decision to participate. This is particularly important when the young person is not yet legally competent.

The arrangements for obtaining consent for this research study were partly informed by the Department of Health Consent guide for young people (Department of Health, 2001b), which clearly inform the young person that if they are asked to take part in research they are entitled to know the purpose of the research, possible risks or benefits, and how to complain.

Valid consent according to the Department of Health (2001b) consists of 3 elements: competence, to act voluntarily, and to be provided with sufficient information to be able to make an informed decision. The issue is that children under 16 are not regarded legally to be competent and the guidance available to judge competence relates to consent to treatment and surgical procedures (Piercy and Hargate, 2004).

Wiles *et al (*2005) stated that the law is complex in relation to research with young people and relates to the notion of 'competence'. In England, Wales and Northern Ireland, children are not presumed to be legally competent to give consent. However, if a young person is believed to be 'Gillick competent', using the Fraser guidelines, then parental consent is not deemed to be necessary.

According to the RCN (2005), 'Gillick competent' refers to the notion that the young person has the ability to understand the consequences and nature of their involvement in a research study. The rationale for this, lies in the assumption that a young person may provide consent if they have sufficient understanding.

Richards and Mughal (2009) stated that in accordance with the Mental Capacity Act (2005), in order to undertake research with a person lacking capacity to consent 3 criteria need to be met. These are: approval of the research by an appropriate organization, consultation with carers or significant others and safeguards are in place. These criteria were applied in this study.

Consent was obtained in writing from each participant below 16, in this study and from their parent or guardian. The researcher used the consent form template available on the COREC website (2004) (Appendix 7).

To add clarity to the process of consenting people below 16 years the researcher and her supervisor devised a consent guide for use in this study

Table 3.1 Consent for people below 16 years

Young person is below 16 years	Risk factor	Action to be taken by researcher
Parent/Carer/Guardian consents. Young person consents	Low	Include in research if 'Gillick' Competent.
Parent/Carer/Guardian not available to consent due to non involvement with young person. Young person not in looked after system. Young person consents.	Low	Include in study if 'Gillick' Competent. (No one available to obtain consent from).
Parent/Carer not available to consent due to non involveme with young person. Local Authority guardian gives consent. Young person consents.	Low	Include in research if young person is 'Gillick' Competent.
Parent/Carer not available to consent due to non involveme with young person. Local Authority guardian does not give consent. Young person consents.	Medium	Include in research if child is 'Gillick' Competent and guardian gives consent when issues are explored at consenting meeting. Do not include in research if guardian refuses to give consen
Parent/Carer/Guardian involve with young person and unwillir to consent. Young person consents.	High	Do not include in research.
Parent/Carer/Guardian unwilling to consent. Young person unwilling to consent	High	Do not include in research

<u>Consent for people over 16 years</u>

Persons over 16 are usually regarded as able to give informed consent, as they are deemed to be competent (Wiley *et al*, 2005) (RCN, 2005). When a young person over 16 lacks the capacity to give consent (for example, where there are mental health problems and the young person does not have the ability to understand the information) then parental or guardian consent is necessary. The exclusion criteria in the selection protocol for this study stated that the young person must have been able to give consent to participate in the study. Therefore vulnerable young people lacking capacity to understand were not invited to participate.

It is good practice to obtain parental consent for young people aged between 16-18 years (MRC, 2004). The researcher intended to do this where the parent was positively involved with the young person and aware that he/she was receiving support from a sexual exploitation agency. However, parental consent was not possible to obtain as there was either no contact between the parent and the young person, or the parent was unaware that the young person was involved in sexual exploitation and the young person did not want them to know. The researcher worked alongside the support agencies and respected the young person's choice regarding seeking parental consent. To add clarity to the process of consenting people between 16 and 18 years the researcher and her supervisor devised a consent guide for use in this study

Table 3.2 Consent for people over 16 years

Situation: Young person is above 16 years	Risk factor	Action to be taken by researcher
Parent/Carer/Guardian consents. Young Person consents.	Low	Do include in research
Parent/Carer/Guardian not available to consent due to non involvement with Young Person. Young person consents.	Low	Do include in research
Parent/Carer/Guardian involve with young person and unwillin to consent. Young person consents.	Medium	Do include in research
Parent/Carer/Guardian unwillin to consent.Young Person unwilling to consent.	High	Do not include in research

Conclusion

The researcher identified potential ethical implications for this study and considered suitable strategies to uphold the ethical standards required to undertake safe and effective research in a sensitive manner, with vulnerable young people.

Competing paradigms in nursing research

Parahoo (2006) suggested that the commonality between approaches taken to qualitative research (for example, grounded theory, phenomenology, ethnography and discourse analysis) is that they are generally interpretivist,

rather than anchored in empiricism. The tradition within these approaches tends to be researcher engagement with people through the analysis of dialogue and text. According to Baker *et al.* (1992) the similarities between these qualitative approaches may lead to 'method slurring'. This refers to the lack of distinction between the method chosen and other methods. Baker *et al.* (1992) suggested that clarity is promoted when the philosophical and theoretical underpinning of each approach is understood by the researcher.

Phenomenology was selected for this study as it is located in the constructivist-interpretive field of the qualitative paradigm (Denzin and Lincoln, 2005). This constructivist-interpretive paradigm enabled exploration of multiple realities of an identified group of young people in the context of sexual exploitation.

Ethnography was not a suitable methodology to use in this study as culture was not the focus of the study. Ethnography is anchored in naturalism, and is orientated in anti-positivism. Ethnography is an approach that advocates social researchers studying in the 'natural environment'. According to Parahoo (2006) ethnography is concerned with the description and interpretation of culture.

According to Parahoo (2006) grounded theory aims to develop theory through an inductive process (moving from observations to the development of theories). Grounded theory was not a suitable methodology to use in this study as according to Robson (2004) a grounded theory approach requires

some pre-existing theoretical assumptions and ideas. This study attempted to set aside existing assumptions and ideas in order to focus on the subjective experience of each individual.

According to Parahoo (2006) discourse analysis is concerned with language. Robson (2004) stated that discourse relates to knowledge systems and associated practices and focuses on the use and consequences of language. Discourse analysis was not a suitable methodology to use in this study as the cognitive and behavioural dimensions of the respondents were examined as opposed to the use and consequences of language.

CHAPTER 4: METHODOLOGY: PHASE 1

Phenomenology

The aim of this chapter is to describe and analyse phenomenology as phase 1 of this research study is anchored in a phenomenological approach. The following areas will be focused on: a definition of phenomenology and the rational for choosing a phenomenological approach, the historical perspective of phenomenology, ontology and epistemology, the relationship between the researcher and the approach taken and the strengths and limitations of the use of a phenomenological approach.

Defining phenomenology

According to Robson (2004, p550) phenomenology is 'A theoretical perspective advocating the study of direct experience taken at face value'. Robson believes that it is the phenomena of a person's experiences that influence their behaviour as opposed to 'external, objective and physically described reality'. This research aimed to examine the experiences and views of sexually exploited young people in relation to health and health care.

Crotty (2006) suggested that phenomenology enables us to acquire new meaning and authentication of phenomenon by experiencing them again, whilst attempting to simultaneously set aside our existent understanding of them.

Cresswell (1998) described phenomenology as a means to understand empirical material from the point of view of the participants. Cresswell

reminded us that whilst there are a range of phenomenological methods the aim is to understand the experience of the subject.

Rationale for adopting a phenomenological approach

Denzin and Lincoln (2005, p26) suggested that 'qualitative researchers can create a space where those who are being studied can speak'. In this study, the use of phenomenological research was intended to encourage the respondent's voice to emerge. The research questions were based on client perceptions relating to their everyday experience of a number of phenomena: risk taking, help seeking and help avoidance in the context of health and illness. Phenomenology was intended to enable exploration of these dimensions from the perspective of an identified group: sexually exploited young people. The phenomenological analysis of transcribed client interviews was an appropriate methodology for this study. Phenomenology emphasises the active role that young people play in their socially constructed world.

Thorne (2000) suggested that through phenomenology, the essential nature of a phenomenon may be described and portrayed in a way to facilitate understanding for others who are unrelated to the phenomenon.

In particular, this study aimed to develop insight into the use and meaning of every day language which is usually familiar to most of us. The importance of this according to Bowling (2005, p128), was that 'Human action is not seen as a response to the system, but as a response to interactions with others and the meanings to the individual'.

A further rationale for adopting a descriptive phenomenological approach was that the outcomes of the study will contribute to the existing knowledge base. Whilst evidence from this study lacks generalisability and may have limited impact in relation to health promotion and risk reduction for this group, it may be a catalyst for further research examining cause and effect.

The historical perspective of phenomenology

According to Moran (2005), Edmund Husserl (1857-1938) is believed to be the founder of phenomenology. However, Streubert Speziale and Carpenter (2007p78) stated that the foundations of phenomenology were laid down during the early 20th Century and consisted of 3 phases. The preparatory phase is associated with Franz Bretano (1838-1917) and Carl Stumpf (1848-1936). They attempted to demonstrate the scientific rigor of phenomenology, whilst further conceptualising intentionality (i.e. *consciousness is always conscious of something.*)

According to Streubert Speziale and Carpenter (2007, p78), the second phase, known as the German phase, was dominated by Edmund Husserl (1857-1938) and Martin Heidegger (1889-1976). During this phase the concepts of *essences* (elements related to the true meaning of something), *intuiting* (an accurate interpretation of what is meant in the description of something) and *phenomenological reduction* (the original awareness of the phenomena) were formulated. Husserl's concepts have been adopted for this study with the intention of facilitating the description and interpretation of the experiences of sexually exploited young people's access to health care.

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The third phase, according to Streubert Speziale and Carpenter (2007, p80), was known as the French phase and was dominated by Gabriel Marcel (1889-1973), Jean- Paul Sartre (1905-1980) and Maurice Merleau-Ponty (1905-1980). The concepts developed during this phase were '*being in the world* and *embodiment*'. Streubert Speziale and Carpenter (2007) explained that a person has awareness of being in the world through consciousness, this is known as embodiment and access to this world is through one's body.

Ontology and epistemology

Descriptive phenomenology, according to Husserl, is concerned with 'What do we know as persons and what does it mean (*what are the essences*?)' and emphasises descriptions of the meaning of human experience (Moran, 2005). The underpinning assumption is that the lived experience gives meaning to each person's perception of particular phenomena. The ontological basis of phenomenological research was that it aimed to portray a range of perspectives, which was 1 purpose of this research study. According to Denzin and Lincoln (2005) phenomenology is located in the constructivist-interpretive field of the qualitative paradigm.

Crotty (2006p79) described constructivism as 'the individual human subject engaging with objects in the world and making sense of them'. The constructivist-interpretive paradigm endorses multiple constructed realities, known as relativist ontology. Interpretive epistemological assumptions relate to a phenomenological approach, which implies that 'the knower and the

known interact and shape one another'. The researcher endorsed these ontological and epistemological positions as a mechanism to explore the different experiences and interpretations of a group of young people in terms of health and accessing health care.

The relationship between the researcher and the approach taken

Cresswell (1998) suggested that it is conventional for the researcher undertaking a phenomenological study to declare her attitude, values and beliefs relating to the phenomenon being studied. Additionally, the researcher is required to bracket these assumptions in order to avoid projecting her own hypothesis. However, Newell and Burnard (2006) questioned the extent to which a researcher is able to bracket out their thoughts, feelings and beliefs.

Ahern's (1999) 10 tips for bracketing were used before and throughout phase 1 of the study in an attempt to identify and reduce bias (Appendix 8). This practice was conventional with the approach taken as according to Polit and Beck (2006) descriptive phenomenological studies include bracketing and writing a reflexive journal. A reflexive journal was maintained throughout the study.

As suggested by Robson (2004) following each interview, the researcher recorded field notes (memos). The memos captured ideas, thoughts and feelings about the content and process of the interview.

Other requirements of the phenomenological researcher are to remain open, and listen to the meanings attributed to a phenomenon by those who have experienced them (i.e. sexually exploited young people). This is referred to as *intuiting.*

Strengths of phenomenology

Speziale and Carpenter (2007 p98) highlighted the strengths of a phenomenological approach by describing phenomenology as 'a rigorous, scientific process whose purpose is to bring to language human experiences'. The strengths of a phenomenological approach lie in the ability of the phenomenological researcher to explore, analyze and describe the lived experience.

Limitations of phenomenology

Crotty (2006) pointed out that the researcher is expected to attempt to 'put one's self in the place of the other (respondent)' as a means to try to understand and describe their experience. However, in doing so the researcher will draw from her own experience and understanding, both of which are entrenched in her own culture. Moreover, the researcher's attempts to 'bracket' or set aside her own experiences, can only ever be partially achieved as one can only set aside what one knows. The implication of this is that the researcher's interpretation of the other's experience will be inevitably influenced by the researcher's culturally determined experience.

Newell and Burnard (2006) alerted us to the limitations of phenomenology. They question the possibility of a participant truly exposing their inner life to another person, such as a researcher. Taking this notion into account the researcher constantly questioned the depth and authenticity of the data.

Study design

A descriptive, phenomenological, approach was taken to encourage young people involved in or vulnerable to sexual exploitation to describe their personal experiences and views relating to health and health care. This qualitative, inductive approach enabled the researcher to obtain rich data through the use of semi structured interviews.

Setting

Specialist agencies supporting sexually exploited young people in the North of England were identified through the National Working Group for Sexually Exploited Young people. This organization provides support to professionals working with young people involved in or vulnerable to sexual exploitation and has members from education, health and social services from statutory and non-statutory services.

Data collection took place on site in 11 agencies in the North of England. This was designed to enhance the safety of each young person and the researcher. Interviews were also conducted on 2 occasions in the young person's place of residence as this was more convenient to them. Cresswell

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(1998) recommended that qualitative research takes place in a natural setting as this promotes contextualized, authentic findings.

Recruitment to the study

A preliminary meeting was arranged in each agency to present the research protocol and to elicit any concerns relating to the research. An information leaflet describing the research study, designed by the researcher, was distributed by agency staff to all young people who attended the agency. To assist the agency staff in recruiting young people to the study, and to reduce potential recruitment bias, the researcher designed a selection criteria protocol (Appendix 1). Appointments were made by the agency staff for the researcher and the young person to meet to undertake the interview. The terms of engagement between the researcher and the young person were negotiated with each agency.

Sampling

Sampling approach

A convenience sampling approach was used to recruit young people to the study. This involved approaching young people through staff in agencies supporting them. The rationale for using convenience sampling was that participants were selected on the basis of availability in a particular setting (agencies supporting sexually exploited young people).

Agencies were identified through the National Working Group for Sexually Exploited Young People. Twelve agencies were invited to take part in this

research study and 11 agencies participated. One agency declined due to other research being undertaken in that agency at that time.

Selection criteria

- Involved in or vulnerable to sexual exploitation

- Below19 years

- Receiving support from a sexual exploitation agency

- Able to give consent

- Willing to participate

Exclusion criteria

- Not involved in or vulnerable to sexual exploitation

- Above 18 years

- Not receiving support from a sexual exploitation agency

- Unable to give consent

- Unwilling to participate

- Too vulnerable to participate

CHAPTER 5: METHODS: Phase 1

Measures

According to Crotty (1998) a narrative approach is an ideal method for describing personal experiences. The approach taken to collecting data was designed to reflect the age, cognitive and developmental stages of each participant. Audio-taped, semi-structured interviews were used to collect data as this is a conventional approach in a phenomenological study.

All information pertaining to each young person, other than their name and age was elicited during the interview. All respondents were English speakers consequently translation was not required.

Semi-structured interview schedule

Kirby (2004) suggested that young people are likely to become bored easily and therefore the interviews were scheduled to last less than an hour.

The interview schedule was designed to explore the young person's experience of health, illness, risk taking, health seeking behaviour and health support avoidance.

Robson (2002) raised the importance of asking appropriate questions and alerted us to a list compiled by Hoinville *et al.* (1985). Hoinville *et al.* discouraged the use of jargon and encouraged the use of short, unbiased questions. Open ended prompts were used to encourage a more detailed response (Appendix 8).

Piloting the interview schedule

The interview schedule was piloted with a child and adolescent mental health nurse. Suggestions included offering the young person a comfort break during the interview, considering the duration of the interview, replacing the word perspective with 'point of view', being more explicit about exploring both physical and psychological health, and using the words 'feelings' and 'mood' rather than psychological health. The schedule was amended in light of this feedback.

Justification for use of semi structured interviews.

Limited empirical data exists that specifically involves face to face contact with young persons' offering a narrative account of their experience. Murphy *et al.* (1998, p112) stated 'If you want to understand what people do, believe and think, ask them'. Semi structured interviews enabled dialogue between the young person and the researcher.

The use of an interview schedule enabled exploration of pertinent information. Exploration enhanced the validity of the responses by enabling the researcher to seek clarification from the respondent.

Sapsford and Jupp (2006) suggested that respondents are more likely to engage with the less structured as opposed to more structured interview process as they feel more involved. Using this method means that the researcher has an element of autonomy over process and content of the interview. The respondent also had some control over the interview process and content which partially addressed power differentials between researcher

and respondent. May (2001) suggested that the less structured interview is conducive with a naturalistic approach, which implies that the researcher asserts less control and the respondent is able to respond more spontaneously.

Adapted interview schedule to use with respondents under 13 years

Child sexual exploitation is an area with relatively modest amounts of research undertaken previously relating to health care access from a young person's perspective. Standardized data collection tools were unavailable, to elicit this information from this group. This necessitated the researcher to design data collection instruments to be able to answer the research questions. The instruments were specific to this study and not useful to other studies as they were not validated.

The interview schedule was adapted into a less formal and more interactive format to use with people below the age of 13 (Appendix 10). This was achieved by designing communication tools similar to those that had been developed in some agencies that support sexually exploited young people. They have been widely used with vulnerable young people to facilitate communication around sensitive issues. The inspiration for this initiative also stemmed from the Mosaic approach. According to Clark and Moss (2005) the Mosaic approach offers children an opportunity to articulate their points of view in a multiple ways. The Mosaic approach views children as experts in their own lives and endorses a range of tools to facilitate communication. This

approach tends to be used mainly in the early stages of sexual exploitation (grooming), to explore relationships.

Consideration was given to whom to use the adapted interview schedule with. Essentially the young person would have been offered the choice between the standard and the adapted version by the researcher. The adapted interview schedule was not used as the youngest person in this study was 13.

The researcher took into account the ages of the young person and their levels of maturity and cognitive developmental age. This information was based on a guide for the assessment of child development (Jenner, 2004) which was originally based on Sheridan's aspects of developmental progress (Sheridan, 1997). In relation to 6 to 11 year old children Jenner (2004) suggested that communication and language skills become refined displaying linguistic competence (for example, the use of longer words, with a larger vocabulary and more complex sentences). In terms of cognitive ability, the child in this age group is beginning to understand conversation, with the ability to think in a more concrete way. In order to understand rules and logical mathematical operations, this age group require written and pictorial explanations.

According to Jenner (2004) young people aged between 11 to 18 years are likely to have a sophisticated use of language skills and to be able to think in an abstract way. At a social, emotional level, this age group are typically keen to fit in with their peers, to experiment and to be preoccupied with body image.

Discussions with a child and adolescent psychiatrist, a child and adolescent mental health nurse and sexual exploitation service support staff also informed the data collection instrument design.

In designing data collection instruments, attention was given to the symbols used. The visual aids (traffic light and doors) were selected on the basis of neither of them being likely to cause offence or to be conceived as patronizing by the young person. The traffic light was symbolic of poor, average or good health (red, amber, green), or health care. The door symbolised the young person's ability to access care. Visual aids are useful as they are on display throughout the session and assist memory and concentration. There was no requirement for the young person to be artistic, numerate or literate as the intention had been for the researcher to offer to write on the poster for the young person.

Piloting the adapted interview schedule

The adapted interview schedule was piloted with a child and adolescent mental health nurse and a member of staff from a sexual exploitation agency. Suggestions included offering a comfort break, enabling the young person to use a symbol to signal their desire to stop the interview, offering the option of a member of staff to be present during the interview to offer support, replace the word 'concern' with 'worry', replace the word 'treatment' with 'health care' and avoid asking about treatment.

Justification for use of adapted semi structured interviews

As visual aids are frequently used by sexual exploitation services, they were likely to be familiar to the young people and staff supporting them. This was advantageous as new material may have discouraged participation in the research due to being perceived as complicated. Kirby (2004) recommended that researchers should avoid the use of boring and technical methods with young people and should try to be creative and flexible. Green and Hogan (2005) remind us that it has been recognised for a significant time that children's drawings may be usefully explored in phenomenological studies.

The adapted interview schedule aimed to provide a medium with which to give and receive information in a less intrusive and less direct manner. The intention was to avoid the use of direct questions. The use of a symbol (for example, a door) diverted the focus away from the young person. The visual aids were designed to enable a higher level of abstraction for the young person from the process. This was designed to partially address the power differential between the researcher and the participant by giving them more control in the process. The visual aids were designed in colours which may be visually rewarding to a young person.

Limitations of semi structured interviews

According to Bowling (2009) limitations of interviews may be that they are time-consuming and costly. It has been suggested that face to face interviews may promote under-reporting, particularly of mental health issues. This may be due to social desirability bias (McHorney *et al.* 1994; Bowling *et al.*1999), although in this study mental health issues were discussed.

Parahoo (2006) and Robson (2004) alerted researchers to the notion that tension may arise through trying to achieve both flexibility and standardisation whilst using semi-structured interviews. In this study the researcher used a list of prompts to steer the interviews in the direction of the study. On several occasions a tension arose between attempting to adhere to the focus of the interview rather than abandoning it. Robson (2004) also raised the issue of interviewer bias as a potential issue in interviews. (Bias is discussed in detail later in this chapter).

Procedure

Data collection

The interviews were arranged between the young person and the researcher by the agency key worker. Interviews were sometimes scheduled before a therapeutic session or an enjoyable activity in an attempt to support the young person following the interview. Interviews were avoided after a therapeutic session to discourage placing the young person under additional pressure in 1 day. Interviews were arranged during school holidays to avoid disruption to school attendance. Some of the young people had been excluded from or had left school.

The researcher collected all the data as this maximised consistency in the approach taken. Memos were recorded following each interview to serve as an *aide memoire* for the researcher. Robson (2004) considered this to be good practice as valuable material may be lost.

Data analysis

Data analysis was simultaneous with data collection to enable the researcher to alter the interview schedule slightly if required, taking into account participant feedback relating to the content or process of the interview.

Following each interview, the researcher transcribed each tape *verbatim* to avoid losing potentially valuable material. The rationale for this was to enhance familiarity with the data at each stage of the process of analysis and to promote a consistent and systematic approach. Also, through listening to each tape repeatedly it was possible to recall and contextualize the interview dialogue.

At each stage of data collection, data was organised into a logical system. This entailed assigning a numerical code to each respondent rendering them anonymous. The researcher held the original copy and stored it away from the rest of the data.

According to Polit and Beck (2006) the basic outcome of phenomenological analysis is the description of the meaning of an experience, through the identification of essential themes. This is achieved by analysis: extracting significant statements, categorizing and making sense of essential meanings of the phenomenon and description of the phenomenon by understanding and defining it (Polit and Beck, 2006).

The verbatim transcripts were analysed using Giorgi's phenomenological method (1985), based on his work on Husserl's philosophy of phenomenology. The analyses, applying the framework of Giorgi (1985) were based on de contextualization and re contextualization of data (Kosh, 1994). The researcher applied the following process:

Gaining a sense of the whole statement

The researcher read the entire set of transcripts several times to try and develop a sense of the whole picture and to become familiar with the respondent's language.

Discrimination of meaning units

Next the researcher attempted to discriminate *meaning units* from participants' descriptions of the phenomenon being studied. To aid this, the researcher initially re-read all the interview transcripts. This was done from a psychological perspective with the phenomena under study in mind. The researcher adopted the 'emergence of data' approach, which involved allowing categories to emerge rather than asking a set of pre determined questions of the data set that related to the research question. However, Burnard (Newell and Burnard, 2006) suggested that it is questionable to what extent categories actually emerge and researchers are able to allow that to occur, as opposed to looking for them.

Each meaning unit was assigned a number. The meaning units are referred to as constituents, as they are context laden according to Giorgi (1985). Giorgi (1985 p10) reminded us at this juncture that '*It is essential for the method that*

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the discriminations take place first, before being interrogated further.' The identified meaning units were isolated from the main text and stored in 3 thematic groups. The thematic groups were entitled vulnerability factors and consequences of sexual exploitation, risks to health and unmet health needs, health seeking behaviour and use of health services by sexually exploited young people. The researcher then distilled each of the 3 themes into categories.

<u>Transformation of respondent's description of phenomena studied into psychological language.</u>

The researcher articulated the psychological insight into each of the meaning units. In the context of this study this referred to the experiences of sexually exploited young people accessing health care. This was done through a process of reflection and imaginative variation. Moustakas (1994) referred to *imaginative variation,* as a means of exploring different meanings by imagination, varying the frames of reference, polarising and reversing findings and looking at the phenomena from a range of positions, roles or functions. Moustakas (1994 p98) stated that *'imaginative variation enables the researcher to derive structural themes from textural descriptions'.*

According to Giorgi (1985) the consistent statement of structure contains a specific description of the situated individual structure and a general description of the situated structure. The former is a verbatim portrayal of what was said by the respondent. The latter is the researcher's interpretation of what was said by the respondent.

The researcher attempted to be cautious, avoiding any commitment to theoretical concepts at this stage. This was partially achieved by retaining quotes. Gibbs (2007) alerted us to the limitations of making quotes too long or too short as quotes that are too short may de contextualize the data.

Synthesis of the meaning units into a consistent statement

The final stage of analysis involved the synthesizing of all meaning units into a consistent statement regarding participants' experiences. In the context of this study this referred to the experiences of sexually exploited young people accessing health care. This is referred to as the '*structure of the experience*' (Giorgi, 1985). This involved displaying the phenomena as a whole by combining the textural and structural descriptions.

A software package was used to assist in the analysis of data: Non-Numerical, Unstructured Data Indexing, Searching and Theorizing 6, QSR. QSR N 6 enabled the researcher to store, organize and retrieve data.

Reliability and validity in qualitative research

Introduction

A combination of strategies was used throughout the study to promote reliability and validity. Thorne (2000) reinforced the importance of rigor and stated that in health care research findings may influence clinical decisions.

Trustworthiness (rigor)

According to Robson (2004) trustworthiness is the extent to which one can have confidence in a study and its findings. To maximise the potential for the findings in this study to be viewed as credible the researcher adopted Lincoln and Guba's criterion for establishing trustworthiness (1989). This criterion encompassed credibility (internal validity), dependability (reliability), transferability (external validity) and bias (objectivity).

Credibility (internal validity)

Robson (2004) described validity as 'The truth status of research reports'. Bowling (2005) defined internal validity as 'The degree to which what is observed or measured is the same as what was purported to be observed or measured'.

The findings of the study indicated that the health needs of sexually exploited young people had been explored and full descriptions were offered to promote credibility.

Lincoln and Guba (1985) suggested that credibility is achieved by addressing 2 elements: believability of the study and the demonstration of credibility. Credibility was enhanced by the researcher being able to demonstrate that the research had been designed in a manner which accurately identified and described the investigated phenomenon. This was achieved by providing a detailed account of the methods used with a rational for their use, as recommended by Robson (2004). In terms of the credibility of the data, all 24 respondents had experience of receiving support from a sexual exploitation

agency, suggesting that the sample authenticated the data. A substantial amount of quotes were used to promote believability.

The use of semi structured interviews enabled exploration of phenomenon from the perspective of the respondent rather than the researcher (Perakyla, 1997). An interview schedule was used and this was proof read by 3 agency support workers, prior to use. In accordance with Lincoln and Guba (1989), the interview schedule was piloted with 2 young people and a nurse in order to elevate the level of credibility by asking the right questions in the interview.

Researcher interviewer behaviour also increased the credibility of the research. The researcher listened to and reflected on all tapes several times to gauge the extent to which she had encouraged the respondent's voice to emerge. Another researcher listened to 2 tapes in order to confirm or disconfirm the claims that the researcher had encouraged the respondent's voice to emerge during the interview.

Credibility may be enhanced by involving other researchers in the analysis and internal verification of data. However, Giorgi (1985) recommended that analysis is undertaken solely by the researcher. His view was that it is inappropriate to validate the findings or to use external judges to review the process or outcome of analysis by peer evaluation of data. Beck (1994 p258) stated that Giorgi (1985) concluded that validity, in a phenomenological sense, has been achieved if the essential description of phenomena truly

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captures the intuited essence. Reduction is the reason that no additional empirical judges are required'.

Whilst the researcher endorsed Giorgi's approach to analysis, in the context of this study, the researcher considered the issues of reliability and validity to extend beyond the researcher's sole interpretation of what constitutes rigorous research with credible findings. Therefore the researcher undertook the analysis of data independently initially and then enlisted support from another researcher to co-rate the themes and to collapse the categories into over arching themes.

A further strategy to enhance credibility was the researcher maintained a reflexive journal to facilitate an accurate record of decision making and events, as suggested by Robson (2004).

To promote validity of the findings Moustakas (1994) suggested that researchers check thoughts, feelings and perceptions of others relating to the findings. Moustakas (1994) suggested that researchers tend to conduct the *epoche* and *reduction* from their own vantage point. Some of the findings were discussed with the researcher's supervisor and a consultant paediatrician specialising in sexual exploitation of young people.

Memos were created and stored in NUDIST QSR N6 in order to facilitate contextualisation of data and to further reinforce credibility.

Dependability (reliability)

Dependability is defined as 'the extent to which a measuring devise, or a whole research project, would produce the same results if used on different occasions with the same object of study' (Robson, 2004). Lincoln and Guba (1985) stated that dependability cannot exist without credibility. According to Robson (2004) reliability is not a conventional concept in a flexible design as it is believed that an interaction that occurs between a researcher and a respondent is not reproducible.

Dependability was promoted by the researcher demonstrating an audit trail during data collection and analysis, as recommended by Kosh (1994). The audit trail represents confirmability, which is a process criterion and is a recording of time scaled activities that another person may undertake in order to confirm the dependability of the research findings. The audit trail included interview transcripts, memos, a research journal, records of data coding and analysis.

Reflexivity

As a strategy to promote dependability Ashworth (1997) recommended that the researcher discloses their personal orientation and context in which the research is being undertaken and acknowledges subjective judgement. The researcher achieved this through the use of a reflexive journal and Ahern's bracketing guidelines. Reflexivity according to Gibbs (2007) is 'the recognition that a researcher's background and prior knowledge have an unavoidable influence on the research they are conducting'. Through this process the

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researcher was able to explore and declare personal presuppositions as highlighted at appropriate points in the thesis.

A systematic approach was taken to analyse the data to enhance dependability. Giorgi's methodological interpretations and procedural steps were employed to analyse data (1985).

As suggested by Johnson (1997) iteration between and interpretation of the data was achieved through intense and prolonged engagement with the data. Interpretations of data were further demonstrated through the use of verbatim illustration.

Gibbs (2007) suggested verification of the source or accuracy of data through participant/member checking in qualitative enquiry. In contrast, Angen (2000) rejected this mechanism as an aspect of dependability. Angen (2000) suggested that member checking merely represents a fixed reality which is inconsistent with the notion that understanding and meaning may alter over time. In a phenomenological study member checking is discouraged (Giorgi, 1985) and is considered to be unnecessary as the process of reduction has been applied by the researcher.

Lincoln and Guba (1985) recommended inter-rater reliability as a technique to enhance dependability. Inter-coder reliability was undertaken by the use of 2 researchers to assist in collapsing themes into categories as recommended by (Erlandson *et al,* 1993). Silverman (2000) noted that phenomenologists

may view the engagement of more that 1 researcher in the analysis of data as unnecessary, therefore inter-rater reliability was not undertaken.

To enhance dependability of the data all interviews were tape recorded. Robson (2004) suggested that audio recording is a method used to promote accuracy and therefore reliability of the data. Technical accuracy in recording the interviews was ensured by the use of one trained person (the researcher). The researcher recorded and transcribed all the tapes, verbatim, as suggested by Lincoln and Guba (1985) and Perakyla (1997).

Dependability was further enhanced by the maintenance of an electronic thematic log (a list of NUDIST nodes) and accurate records as suggested by Lincoln and Guba (1985).

Transferability (external validity)

Bowling (2005), defined transferability as 'The extent to which research findings can be generalised to the wider population of interest and applied to different settings'

According to Lincoln and Guba (1989) transferability refers to the 'fittingness to another situation' and suggested that this was the consumer's rather than the researcher's concern. However, the researcher has the responsibility to provide adequate descriptive information to enable the research consumer to gauge the extent of applicability to different situations. Thick description was used to promote external validity by enabling the research consumers to make

judgements about the utility of the study findings to a clinical setting. Thick description refers to a thorough description of the research environment, the processes and transactions (Lincoln and Guba, 1985).

Whilst this research study is not claiming generalisability, the external validity was more likely to promote the use of findings from the study in clinical practice. Detailed information relating to the participants, selection methods, context and data generation and analysis methods were provided to enable the readers to decide the extent to which they may generalise the findings. Lincoln and Guba (1989) suggested that the extent to which findings may be applied to other settings is anchored in trustworthiness.

External validity was demonstrated by the use of data display in NUDIST QSR N6 codes.

A semi-structured interview schedule was used to allow respondent's voices to emerge, as opposed to the researcher's. The researcher tried to avoid leading participants and an exploration of participant's responses was encouraged. The interview schedule was flexible, closely related to the research aims and used consistently with each respondent.

According to Kvale (1996) a further mechanism to enhance validity in a study is to return either whole or partial transcripts to respondents to check for authenticity and accuracy of interpretation and meaning through analysis. The researcher chose not to do this as this is unconventional in phenomenological

research and would have been methodologically complex. Giorgi (1985) rejects this practice as a means to enhance validity.

Objectivity (Bias)

The researcher took steps to reduce bias at each stage in this study. Bowling (2005) defined bias as 'Deviation in one direction of the observed value from the true value of the construct being measured'.

Polit and Beck (2006), stated that bias is a significant factor in qualitative research as it has the potential to undermine the trustworthiness and validity of the study. Bias, according to Polit and Beck may be random or systematic, is unavoidable and may distort the study findings.

Kvale (2007) raised the concept of inter-subjectivity and acknowledged that several interpretations of an identified text may be a strength, in a study, so long as perspectival subjectivity has been acknowledged.

Interview bias

In order to reduce interview bias, an interview schedule was used with prompts. The interview guide related to the research aims and was used in a flexible, consistent manner with each respondent. The researcher encouraged the respondent's voice to emerge and tried to avoid asking leading questions as according to Kvale (2007) these may lead to biased answers. However, Kvale noted that leading questions may also be used to confirm the reliability

and verify the interpretation of the respondent's answers. To reduce interview bias, exploration of participant responses was undertaken.

Selection bias

Young people were recruited to the study using a selection protocol that had been designed and discussed with members of staff from sexual exploitation agencies. The researcher provided guidelines and explained the use of the selection protocol to avoid bias during the selection process (for example, selection of those most likely to respond). The research was designed with the intention of recruiting participants to enable the aims of the research to be addressed therefore it was important that they matched the selection criteria.

Researcher bias

Robson (2004) described researcher bias as any assumptions or preconceptions they may introduce into the research setting that may affect the researcher's behaviour. A reflexive approach was adopted by the researcher as a strategy to enable critical reflection of personal values and beliefs that may have an affect on the data collection and interpretation.

A further example of researcher bias, according to Gilbert (2001) is for the researcher to inadvertently introduce particular themes and exclude others. To avoid this, the researcher referred to prompts located on the interview schedule.

Data bias

Atypical case analysis enhances validity by challenging an explanation (Robson, 2004). An example of this was that one respondent reported 'All services are really good'. In contrast, the majority of respondents had reported that inadequacies in at least one service they had used. Atypical case transcripts were discussed with another researcher to promote internal verification of data.

Computer assisted coding and analysis of data was employed to discourage bias during coding and to encourage the researcher to address the research questions.

Negative case analysis was a strategy used to counter researcher bias. According To Robson (2004) negative cases are a means of disconfirming a theory.

CHAPTER 6: FINDINGS: Phase 1

Introduction

These are the findings reported by 24 participants from phase 1 of this study.

There were 22 females and 2 males ranging from 13 to 18 years. The ethnic

composition of the sample comprised of 1 Black British person, 1Pakistani

person and 22 White British people. Twelve were agencies invited to take part

in this study, 11 agencies participated. The reasons 1 agency declined the

invitation to participate in this study was due to other research taking place in

their agency at that time.

Table 6.1 Demographic characteristics of participants

Age of participants	Number of participants (Total: 24)
18 years	4
17 years	8
16 years	10
15 years	1
13 years	1

The emerging conceptual themes and categories for these participants have

been organised into 3 themes entitled: Vulnerability factors and consequences

of sexual exploitation, Risks to health and Unmet health needs, health seeking

behaviour and use of health services by sexually exploited young people.

Theme 1: Vulnerability factors and consequences of sexual exploitation

Physical health

Experience of physical health issues

The young person's personal experience of physical health was explored. Young people described their physical health in both positive and negative terms. Narrative accounts given centred around specific themes including drug and alcohol use, issues with diet and sexual behaviour.

A range of physical health problems were discussed including blood borne viruses. One person reported being Hepatitis B positive, and another was Hepatitis C positive. Two people had been physically assaulted and injured. However, some young people described their health as good.

Participant 2 reported 'Well I've got Hepatitis B and my kids did have it. They got immunised for it and they haven't got it now. But I've still got it I haven't had no treatment for mine. Yes I've had all my tests done, cos I found out I had it when I was pregnant.'

Drug use related health issues

 Illicit drug use was reported by 20 young people. One young person chose not to discuss drugs; one person did not state which drugs she used and 4 reported no drug use. Drug use may have been under reported due to the illegal nature of drug taking. The main mode of drug use was experimental and recreational. Two young people were dependent on heroin and both were intravenous drug users and funded their drug use through selling sex. One of whom had a deep vein thrombosis, possibly as a consequence of intravenous drug use. Both intravenous drug users were in receipt of substitute prescribing and 1 was waiting to enter a residential rehabilitation unit following opiate

detoxification. The most frequently reported illicit drugs used were amphetamines (n=8), ecstasy (n=9) and cannabis (n=12). The majority of drug use tended to be for recreational purposes. Whilst problems were identified with recreational use, most young people did not view this as an issue in relation to their physical health. Two young people stated that their mother was a dependent drug user. Two young people used non-prescribed benzodiazepines, 1 used amyl nitrate and 1 sniffed gas. Four young people declared previous heroin use, 3 crack cocaine use, 1 daily for a month and the other daily for 6 months. Cocaine had been used by 3 people, with one person declaring a previous addiction to dihydrocodiene (DF118) which she had taken from her relative. Fourteen young people in this study reported smoking tobacco.

Participant 22 reported 'I've got a dvt (deep vein thrombosis) and as you know I've got hepatitis c so it isn't in good shape. And I don't eat very much and I drink every day so, and I use drugs on top of that. I inject as well'.

Participant 19 reported 'Well I'm a recovering drug addict and I'm actually on a course for methadone at the minute, getting clean. Five months ago I was not eating, I was really thin. I know I'm still thin now but I was so pale. You could see my cheek bones. I wasn't eating, I was just using too much of the drugs and just not looking after myself really, due to the drugs and my lifestyle that I was living'.

Alcohol use related health issues

Alcohol use was reported by 16 people in this study, most of whom were below the legal age for alcohol consumption in England (18 years). Five people denied alcohol use but declared drug use. Four people reported no alcohol and no drug use. Seven people described being dependent on alcohol (evidence of tolerance and withdrawal), 7 people described high risk (binge) drinking (evidence of physical and/or psychological harm).

Reasons stated for alcohol use were to lower inhibitions sexually prior to exploitation, stave off withdrawal, for fun, due to being forced to drink and to combat emotional problems. One person had exchanged her drug habit for alcohol. Four women stated that they had been sexually assaulted whilst intoxicated and 1 had had her drink adulterated with a drug. One woman reported having been forced to consume alcohol by the men who had sexually exploited her, whilst other women reported accepting alcohol from older men, and had had insight into their intention to sexually exploit them. Alcohol was used as a coping strategy for some young people and for pleasure by others. The inherent physical harm involved in excessive alcohol consumption and subsequent withdrawal was recognised by some young people.

Parental problem alcohol use was reported by 2 people and 6 people stated that they had been violent whilst drunk with police involvement. Several factors influenced the ways in which the young people engaged in alcohol consumption.

Participant 3 reported 'About 3 or 4 months ago, I was constantly drinking every day. Once I was drunk I forgot everything then I'd wake up and it would be all there so I'd feel ill. But now I drink every so often'.

Participant 3 reported 'I still smoke and drink but to a level that I know that I'm OK and I can handle myself. Not to the level that I was made to do there, so I'm so paralytic that I can't even stand and I just wanted to go to sleep'.

Participant 4 reported 'It's like the pain is taken away by drink, cos you forget about it. But now I've realised even when you're drinking and it's gone, it's always there when you wake up the next morning. And that was only 3 and half weeks ago. I've started drinking more since I've been trying to cope with that sexual assault and the drink helps'.

Dietary related health issues

Food appeared to be an important feature in this study and was mentioned frequently. Inadequate diet and eating difficulties were described by 10 young people. The key issues appeared to be either being under weight (n=5) or over weight (n=2). Three of the 5 women described them selves as having anorexia. Stress and illicit drug use, in particular stimulants, were frequently cited as reasons for being under weight. Despite the physical health problems associated with food the majority of young people identified a healthy diet as an important factor in being healthy.

Participant 4 reported 'Being anorexic that is really bad. I'm a size 8 now, but every time I used to eat I used to be sick. Not making myself sick but your

belly shrinks to a certain size so you can only eat a certain amount of food and that's what my belly was like. Hence why I can't put on weight I've been the same weight for 2 years, but the support's there if I need it if it does start back up'.

Participant 24 reported 'I just feel horrible I've got this thing about food, I can be like that and I think I'm fat, but my boyfriend's like 'you've got to put weight on, you've got to put weight on, cos I'm scared that you'll lose so much weight that one night you're going to go to sleep and not wake up'.

Sexual practice related health issues

Sexual health was discussed with the young people in this study**.** The main themes included the experience of sexual exploitation and assault. Three women described themselves as a prostitute and 1 person was forced to have sex with a group of men. One person had had sex with men for shelter. Three women had been sexually assaulted, with 2 of these having experienced childhood sexual abuse. Previous sexually transmitted infections were reported by several people including Chlamydia, gonorrhoea, anal thrush and bacterial vaginosis. Seven women had had an unplanned pregnancy, with one having terminated the pregnancy and 2 having miscarried. The majority of young people in this study reported using genito-urinary medicine clinics, probably partially due to the agency staff influencing them to go.

Participant 3 reported 'When I was meeting with all them guys I fell pregnant to one of them then miscarried because of them, then caught a disease off

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one of them. I had to go to the GU (genito-urinary) clinic and get treatment for that. When they told me it was a shock and I felt disgusted. It was gonorrhoea'.

Participant 3 reported 'I miscarried , but in a way I was glad that I didn't have the kid because that would have been in my memory all the time that kid being there and I wouldn't have been able to bond with it because just that feeling that that was the kid made from one of them'.

<u>Understanding of physical health</u>

Young peoples' understanding of physical health was explored. Health was described by some in relation to well being. However health was also frequently understood and described by the absence of disease or illness.

Participant 22 reported 'Having a healthy body, eating good, not having any problems with your body, looking after yourself, staying out of hospital'.

Participant 18 reported 'health is about how you're feeling about your body and doing things to your body and then there's sexual health, diseases not using contraception, getting pregnant and things like that'.

Health problems were also alluded to and examples were given relating to the young persons personal experience or knowledge of health problems relating to another person:

Participant 7 reported 'My mum's gone through a lot. She's really ill at the moment with arthritis and my sister's got health issues, she's suicidal. But I haven't experienced a lot of things myself'.

Participant 7 reported 'My sister used to do it. She used to get a knife from the kitchen and just self harm. She still does it now but she's getting counselling for it. I wouldn't be able to do that I wouldn't know what to do'.

Health attainment was described. In particular suggestions were made which related to diet and exercise. These aspects of health and well being may be viewed by a young person as being in their locus of control and therefore attainable for some.

Participant 10 reported 'Being fit and eating well. I'd say being healthy is being average weight, making. Looking after yourself eating healthy food, eating the right portions of fruit and veg, minerals, iron and all that'.

Participant 12 reported 'Just looking after yourself, and if you don't look after yourself you get bad health and if you do you get good health'.

Young people explained influences in relation to the development of their understanding of physical health:

Participant 17 reported 'we had a nurse at school but I never seen her. A bit of health in biology lessons but there was nothing major that we did. I didn't

really discover about health until I left school. I don't think the education was available and also when I left school many of my health problems started to arise and that's when I found out quite a lot of health information'.

Participant 17 reported 'I remember we did do a bit of sexual health education. Only a little bit cos I went to a Catholic school and the perception on sexual health is a lot different from many other schools for instance they don't believe in using contraception or sex before marriage so it was quite controversial when we did have the education on sexual health. We received a bit of it but to be honest I was at that age 14, 15 where I didn't take a lot of it in and I was already sexually active so it was nothing to me it just went straight over my head.

<u>Importance of physical health</u>

Importance of physical health from the young persons' perspective was explored. The majority of young people viewed being healthy as important and examples of how to attain and maintain health were given.

Participant 9 reported 'I try and keep it my main priority. Just by keeping a healthy diet, eating as many fruit and veg, keeping healthy, I like to walk I like to go jogging, I drink a lot of water'.

Participant 14 reported 'Obviously your health it is important. I go to the doctors regularly and get checked and I go to the dentist. To me it is

important, but people don't look after their health. I mean like personal hygiene and things. To me it is important'.

The consequences of being unwell appeared to influence the young persons' attitude towards the value they assigned to being healthy.

Participant 2 reported 'It is important for me. Especially when I've got kids as well, so it's really important.

Participant 6 reported 'It doesn't really bother me, being healthy or not. I haven't really thought about it, it's not a big deal'. (Atypical case analysis)

Motivation to be physically healthy

The motivation of the young person to be healthy was explored. There was a range of influences including the desire to ameliorate existing physical health problems or to overt potential health problems. Behavioural and cognitive dimensions of motivation were explored. The activities undertaken to promote health included walking, jogging, gym, trampoline, dancing and horse riding.

Participant 7 reported 'I went to get a check up for sexually transmitt5ed diseases and stuff like that that's about it because one of the, my ex partner that I'd slept with he told me that he might have something so I went to get myself checked out'.

Participant 3 reported 'I just do it with one regular partner now and just do normal teenage things. Like being out with my friends and just going home. Well I don't want to have no diseases'..

One respondent with experience of negative consequences of crack cocaine and opiate use on her physical health recognised the need to abstain from these drugs. In particular skin problems and cognitive problems associated with reduced memory capacity and drowsiness served as a catalyst for change. Parental illicit drug use also served as a deterrent to this young person who had an opiate dependent mother. A desire to prove to other people that she was different to her mother was an incentive to change.

Participant 11 reported 'Crack and heroin. But I was the lucky one because I never got addicted. I never got addicted but I was taking it every day for about 3 or 4 weeks. My skin was going horrible and I was feeling drowsy all the time and I was forgetting things and I thought no I don't want to do this cos my mum, my mum was a smack head and she's got all scars on her arms, she can't even wear a short top. I thought I don't want to fall in my mums foot steps, I want to prove to every body I'm better'.

Motivation to alter behaviour sometimes arose from the identification of problems in other people.

Participant 7 reported 'They smoke it first thing in the morning and last thing at night and I thought I don't want to be like that so I just, I wasn't addicted but I didn't want to be so I just quit'.

Pregnancy was a motivating factor to becoming healthy for some respondents. In particular diet and exercise were used as strategies to achieve this. Stopping smoking was also cited as a motivation to becoming healthy; however this was not straight forward due to the pregnancy.

Participant 6 reported 'I've always tried to give them up as well but I haven't got the will power. It never used to it's just now that I'm pregnant I want to stop smoking. I have cut down a lot but I can't actually stop completely. I only smoke really when I'm bored. I'm bored most of the time so I smoke most of the time and I can't have nicotine patches cos I'm pregnant so. I went to my doctors when I found out I was pregnant to see if I could have some nicotine patches but he said I'd have to cut down first and just stop like that. Nicotine patches aren't good for the baby so he wouldn't let me have them'.

Participant 7 reported ' when I found out I was pregnant I drank a lot through depression and then I started my counselling again cos I quit for a while, and then I started counselling with the counsellor that comes here and she just told me what to do and she told me that I need to sort myself out for my child's sake and I just started doing that. I come here regularly now to take my mind off things and it's someone to talk to as well that's all'.

Being a parent was a reason given for adopting a healthier lifestyle by some respondents. All the women in this study who had children were lone parents and therefore the burden of responsibility was greater. This appeared to influence the women's attitude towards their own health.

Participant 2 reported 'I used to drink a lot. I used to go see my friends and I used to buy you know litre bottle of vodka and we used to drink that. I never used to buy it they used to buy it. So they bought it and I just drank it. But I didn't drink to an extent that I couldn't look after my kids'.

Geographical re- location from an urban to a rural town was cited by 1 respondent as a motivating factor in addressing problematic drug use. In particular reduced access and therefore availability of illicit drugs encouraged her to reduce consumption. This respondent also recognised the potential to address her drug use whilst her partner was in prison. The change of abode and temporary separation from a drug using acquaintance provided an opportunity for this respondent to live a healthier lifestyle. In addition to these influences, the young person also benefited from living with a relative who provided psychological and practical support.

Participant 19 reported 'It's improved with my partner being in prison and the fact that I'm now living at my Nana's which, I've always got clean clothes, a bath and it's a tidier lifestyle basically. I'm not living in a drug lifestyle. So, just not living in a drug lifestyle makes you feel better. Just like getting baths and like wanting to make an effort you know. Whereas 5 months ago I just couldn't

be bothered. I'd just stay in my pyjamas. I wasn't very clean and that is not like me. I'd just gone that much down hill; I just didn't care any more'.

Several respondents cited their age as an incentive to alter their behaviour. In particular, there was a desire to address problematic drug use as the young person matured chronologically. A strategy employed to achieve this was to avoid other drug users.

*Participant 6 reported 'Everyone I know smokes weed so matter whose house I go to they've always got a joint in their hand. So I just don't get in contact with them sort of people. I don't know. But obviously now that I've grown **u**p all I do take is weed. I used to take all sorts. Chickers and stuff like that. Well I stopped going down to the house I used to go to when I was taking it. There was only one place where I'd go to take it so I stopped going there'.*

One respondent described her motivation to reduce her alcohol intake as being to avoid the experience of alcohol withdrawal. A mechanism to achieve this was to stay at home and avoid acquaintances who consumed alcohol excessively.

Participant 3 reported 'Because I felt the hangovers and being right bad I won't drink till I get a hangover. I just drink until I'm on a level, but I won't get myself absolutely blathered where I'm being sick and then going to sleep and then waking up feeling even more rough. Just not going out as much cos if I was out I'd get the drink but if I was in my house then I'd not get the drink'.

One respondent viewed her involvement in sexual exploitation as a motivation to have regular sexual health screens.

Participant 22 reported 'I get checked out, with me working on the streets'.

One respondent who had been sexually assaulted whilst intoxicated with alcohol viewed this negative experience as a catalyst to change her behaviour in relation to her alcohol consumption.

Participant 4 reported 'I'm never drinking again. I want to try and stop drinking because it isn't good for me and it isn't good for anybody else. I'm figuring out what I'm going to do to stop myself'.

Psychological health

Experience of psychological health issues

Personal experience of psychological health was explored with the young people and a range of issues were identified. The spectrum of psychological problems spanned from mild and transient (for example, anxiety related to stressful life situations), to more serious problems such as paranoia and auditory hallucinations. Four young people reported the experience of excessive stress. Two people had suffered from anxiety, and 1 of these people reported being afraid to go out of her house. Two people reported panic attacks and 2 reported that they had emotional problems. Two people described having experienced paranoid ideas, with 1 of these suggesting this

was due to smoking cannabis. One young woman reported hearing persecutory voices.

Participant 9 reported 'Which made me more sad and paranoid. Actually I was locked up, I wasn't charged or anything but it wasn't for that, it was that I was scared for my health. They were called twice in an hour, I thought there were people in my house that wanted to kill me and no-one believed me, they didn't believe me cos there was no-one there. But because I was under so much stress and because people wasn't believing me I thought they were still there'.

Participant 20 reported 'The only reason why I've stopped smoking pot as well is because I'm really like paranoid. Like today I was paranoid when they walked into the office. It's just when they walk in I get really scared. The other day I was sat at my Nana's and I could hear voices saying 'I'm going to kill you' and that my Uncle walked in the door and I got paranoid so I went home. I think that's what it is, but now and again I get voices in my head and sometimes I don't know. I hear voices saying that I'm coming to kill you or something like that. I hear voices in my head that say slash your wrists and I have done it, slashed my wrists'.

The most common psychological problems cited were anxiety and lowered mood. Low mood was experienced by 5 people, 1 due to post natal depression, 1 due to cannabis and 1 due to cocaine use. This last person also had memory problems. Three people reported difficulties with sleeping patterns and 1 person suffered from nightmares.

Participant 7 reported 'Well I don't know where to start. Basically it started when I fell pregnant and I was having some issues with my daughter's dad. So that was getting on top of me. He was really aggressive and stuff, so it's just a little frustrating and it stresses me out a lot'.

Participant 1 reported 'It was the fact that I'd lost my family, living with strangers moving away from all my family, my friends, just things like that messed my head up'.

One young woman described intentional self poisoning due to low mood:

Participant 7 reported 'I have done a couple of stupid things in the past. I took an overdose which is a long time ago now, about 3 years ago. Yes and I overdosed on paracetamol, I took about 50 of them. I was just sat in my bedroom and I was feeling down and depressed and I didn't know what to do, I couldn't talk to any body. It was over a stupid thing but I didn't want to talk about it and then I just found the pills and I took it and the next day I was….it was the lowest point in my life'.

The experience of intentional self harm was also described by several young people. Three people had self-poisoned; 1 person had sniffed gas attempting to kill her self. Five people (1 of whom had a tendency to burn her arms intentionally) had cut themselves intentionally, and 1 had swallowed razor blades intentionally. The majority of the young people considered their self

harming behaviour to be a mechanism for coping with stress. Two young people described themselves as angry, 3 as violent and 5 had been arrested by the police. Eight people had experience of 'going missing' from home with some having truanted regularly from school. Five people were looked after by the local authority and 4 had been homeless at some point in their life.

Participant 11 reported 'I'd feel depressed, I'd weep in a morning, I'd start crying and that's when I thought no, I mean I've cut my arms up and I passed out, I've got scars on my arms. So that's why I just stopped it all'.

Participant 15 reported when I was living in D with my Dad I took an overdose and the child psychologist came round and got me an appointment for C House. My main problem why I took the overdose is because my Mum stopped me from seeing my brother and sister and my Mum told me that my Dad wasn't my Dad. They built up my self esteem again and that did help a lot and then when I moved back down to my Mums I could see the kids it stopped from there. I've took 2, when I took the first 1(overdose) I was 11, 12.'

Understanding and importance of psychological health

The understanding and importance of psychological health was discussed with the young persons. The concept of psychological health appeared to be more complex than the concept of physical health. Psychological health was generally recognised as important, although it appeared that the young people had probably not contemplated this aspect of health previously.

Participant 18 reported 'I understand emotional health by getting depressed feeling really bad about something If I'm ill I can't get up, can't go to college, can't do normal lifestyle things and the same if I'm not emotionally healthy as well. If I don't want to get up, I don't want to go out, I don't want to see people. It's quite important'.

<u>Motivation to be psychologically healthy</u>

Psychological health appeared to have been less understood and less articulated by young people in this study, apart from when psychological problems had arisen. There was some evidence of measures taken by a few young people to tackle psychological problems. Self help strategies were employed (for example, talking to a friend). Other sources of support accessed included seeing a GP or a counsellor.

Participant 14 reported 'I don't like going to the doctors at all, not after that. If it's just like something stupid like that then I would put up with the pain. I was supposed to go to the doctors cos I suffer quite a lot of panic attacks and anxiety. I was put on medication, Propanalol... yes for my anxiety and stress. It helps quite a lot, but it makes me sweat, and that's an issue with me cos if I'm going somewhere I don't want to have sweaty patches erm, , so I was supposed to go back to the doctors but I didn't'.

Theme 2: Risks to health

Beliefs about risks to health

<u>Perception of risk to physical health</u>

Young people's perception of risk to physical and psychological health was explored. Examples of risks in relation to physical health were cited more frequently than psychological health. Physical health risks included excessive alcohol consumption, illicit drug use, smoking, poor diet, self harm and risky sexual behaviour. Psychological health risks included the experience of stress and emotional distress and the potential to self harm. The perceptions of risks were borne out of personal experience and the experiences of other people. These remote experiences of risks to health stemmed from family, friends, acquaintances and people they had acquired anecdotal evidence about.

Drug use as a risk to physical health

Drugs were recognised as potentially harmful to physical health. The majority of young people in this study (n=18) described personal drug use either past or present. Whilst most of the drug use was illicit, one woman described her dependency on her relative's prescription drugs (DF118).

Participant 23 reported 'I starved myself for a few months. I was cutting my wrists and trying to take overdoses cos I was taking loads I got addicted to tablets and that shit (paracetamol and coproxamol)'.

Participant 8 reported 'Not eating three or four times a day and say eating once a day. Not drinking water Taking drugs, going out and getting pissed out of your head 'going missing' or like being given heroin or any kind of drugs like that, or going out and taking drugs'.

<u>Alcohol use as a risk to physical health</u>

Alcohol was cited frequently and considered to be a risk to physical health. Several young people stated that they had been exposed to parental and grand-parental alcohol misuse. In particular physical health deterioration and subsequently death of a relative had made an impression on these young people, who recognised alcohol as a contributory factor to poor health outcomes. Alcohol was also a feature in 1 young woman's experience of domestic violence from her partner whilst he was heavily intoxicated. This had served as a deterrent to alcohol consumption for her.

Participant 23 reported 'My Dad used to go to alcoholics anonymous. I looked at my Dad and I thought 'I'm not going to be like that' then I looked at my boyfriend and he beats me up when he's drunk, so I just stopped'.

Participant 12 reported 'I just don't go round town any more cos it's dangerous. You could get your drink spiked, you could get into a fight, you could get hit in the stomach, it's just silly things like that'.

<u>Smoking as a risk to physical health</u>

Smoking (of nicotine or cannabis) was raised frequently as a potential risk to health and the majority of young people in this study declared themselves as smokers.

Participant 21 reported 'Smoking's bad for your health. You can get like cancer, cos you can get lung cancer if you take it back'..

<u>Diet as a risk to physical health</u>

Excessive or inadequate food consumption was identified as posing a risk to physical health by several young people. Additionally, not eating a healthy diet was perceived to be a health risk in particular; reference was made to junk and fatty foods. Several young people in this study described difficulties arising from their diet. In particular under eating or over eating were identified as concerns. Women who were over weight also tended to feel under confident with a lowered self esteem. Excessive alcohol use seemed to be linked to obesity due to its high calorific value.

Participant 21 reported 'Eating constantly, fatty foods with no like vegetables or anything involved and not eating at all like being anorexic'.

<u>Sexual behaviour as a risk to physical health</u>

Physical health risks in relation to sexual health centred on not wearing condoms, having random sex with different people rather than one regular partner and having an unplanned pregnancy.

One woman described how she had attempted to offset the vulnerability of being homeless as a result of 'going missing' from home by engaging in other risk-taking behaviours including trading sex with several men for shelter.

Participant 18 reported 'When I run away I was sleeping with a lot of people so that was bad as well. What it was, we needed somewhere to stay so we'd sleep with men so we'd have somewhere to stay and that made me feel

emotionally dirty and bad but on the other hand I needed, there's things you have to do to have a place to stay, a place to sleep, so that was risky to me, emotionally as well yes, no it wasn't good, I didn't want to do it. Sometimes, someone would be nice and you'd think 'not bad' so it would be alright but there's other times when I've slept with people and I've just not wanted to do it, I've just wanted to turn over and just go to sleep or, I just felt really bad, I just felt dirty for doing it and a bit of a slag but there was nothing else I could do and I was scared to go home so I'd just do it anyway'.

<u>Perception of risks to psychological health</u>

Young people in this study appeared to identify risks to physical health more readily than risks to psychological health.

Participant 1 reported 'My mental health; the thing that encouraged me was, I was at risk of harming myself again which I really didn't want to do, so that is why, that encouraged me to seek help. I had the nurse and every one encouraging me to seek help and sexual health wise it's just a thing that I do'.

<u>Insight into risk behaviours</u>

The degree of insight into behaviours undermining both physical and psychological health was explored. Insight into detrimental consequences of drug and alcohol misuse, 'going missing' and the experience of sexual exploitation was demonstrated.

<u>Insight into drug use as a risk to psychological health</u>

The extent of insight into risks associated with drug use was explored. Some drugs were used recreationally by young people (for example, amphetamine, ecstasy and cannabis) and generally considered to be fairly innocuous. Insight seemed to be apparent and fairly realistic. Harms associated with ecstasy were related to regular use and this knowledge stemmed from the media. Class A drugs (for example, crack cocaine and heroin) were considered to be more harmful and avoided by the majority of young people, sometimes after experimental use.

Participant 4 reported 'I've taken ecstasy before. I've always been alright on that, to tell you the truth I like ecstasy. It's not a thing that I do every day, but I think once in a while it's not going to harm you, but sometimes you can only take one and you can die can't you? But you see I've been lucky. Weed, I do smoke weed, I enjoy smoking weed that chills me out and relaxes me. Crack, I've tried crack, I've tried heroin and I've tried cocaine. That was when I was younger.'

Participant 7 reported 'I used to take cannabis that kind of thing but I don't anymore, cos it used to get me into accidents, get me paranoid. I've seen people like smoking it and they smoke it first thing in the morning and last thing at night. I don't want to be like that. I wasn't addicted but I didn't want to be so I just quit.'

An awareness of the negative effect of drugs on mood was described and served as motivation to cease drug use. There appeared to be recognition by this young person of the link between drug use and mood.

Participant 13 reported 'I didn't start taking drugs to think I was big. I took them for my own benefit, but then after I'd finished I felt depressed. So it feels good and bad at the same time. But then the depression started getting a bit worse and then I felt really low so I just stopped'.

Insight into alcohol use as a risk to psychological health

Recognising the negative effects of excessive alcohol served as a catalyst to reduce alcohol consumption for several young women. One young woman explained that she used alcohol excessively in order to combat psychological and physical pain following a sexual assault.

Participant 4 reported 'It's like the pain is taken away by drink, cos you forget about it. But now I've realised even when you're drinking and it's gone it's always there when you wake up the next morning. It's also since I got sexually assaulted as well that I've been drinking a lot. I've started drinking more since I've been trying to cope with that. It is hard and with it being on my mind and with me thinking about it it's hurting more and more cos I'm going through my life every day but it's still there, it's not been sorted and the drink helps'.

Insight into problematic alcohol use was described retrospectively by one young woman whose opportunities for feedback about her drinking had been

reduced as she had lived alone. Therefore her capacity for problem recognition had been limited at that time. A compounding factor in her alcohol use had been a partner who drank excessively.

Participant 12 reported 'When I was drinking a lot it was when I was drinking at my flat, so I had no one there to tell me like, don't do it cos you'll make your self look like a prat. The bloke I hung around with that's the father of my baby and he was a pretty bad alcoholic, so that was just the norm, all I knew'.

Participant 9 reported 'I was using drugs and alcohol. Alcohol in the main but it was making me worse in the morning. That's probably why I lost weight more; I was just crying myself to sleep. I couldn't cope at all. I was drinking 2 big bottles of cider a night or a big bottle of vodka which is the kind of things an alcoholic would drink. I was worried about liver problems, but other people weren't worried'.

Awareness of the physical health implications of binge drinking were alluded to, although infrequently. The propensity to be sexually uninhibited or to behave in a violent manner towards other people was raised as concerns.

Participant 4 reported 'It destroys your liver. But not only that I get violent when I drink, really bad. But it just isn't good for you really So you do stupid things when you drink like sleeping with men for instance or breaking and entering into a shop, Oh no I haven't done that, but the sleeping around I have

been. And some times end up being racist. You lose your self control once you've had a lot to drink like you can't control what you're doing or saying'.

Participant 23 reported 'I'd wake up and I wasn't thinking right, well first thing I'd think was can of beer just to wake myself up and stuff and then I'd go on to the vodka and the wine of a night, I don't know, it really did mess me up so I just stopped it'.

<u>Insight into sexual behaviour as a risk to psychological health</u>

One young woman talked about unsafe sex and the consequent risks she had been exposed to. This woman learned later in life that she was Hepatitis C positive. Insight into the risks inherent in unsafe sexual behaviour was apparent. Unfortunately, this insight was developed retrospectively.

Participant 2 reported 'I used to run away from home I did used to run away a lot and that was when my dad passed away and I stopped running away. When I ran away I wish I'd used a lot more protection though; condoms when having sex. I was only like 14, doing what all, most teenage girls do'.

Behaviours associated with risks to health

<u>Engaging in risk taking</u>

Young people described personal accounts of behaviours involving risks. These behaviours included illicit drug use, alcohol misuse, smoking, poor diet, unsafe sexual behaviour and 'going missing' from home. Behavioural components of engaging in risk taking were explored in the context of active

and passive risk. Active risk suggested that the young person had a degree of autonomy. Passive risk suggested that the young person did not have the autonomy to avoid the activity relating to the risk. This implied an economy of choices and that either socio-economic circumstances or another person promoting the risk for the young person. A further dimension of the engagement in behaviours associated with risk was explored: young people discriminated between spontaneous risks and calculated risks, with an implied awareness of possible consequences.

Autonomous involvement in risk taking

Young people were invited to describe behaviours they had engaged in autonomously that may have been detrimental to their health. Examples given related to excessive alcohol use, illicit drug use and unsafe sexual behaviour. Frequently, a combination of all of these factors compounded the young person's level of risk taking. Involvement in risk appeared to be either spontaneous or calculated. Insight into the risks these behaviours posed to the young person's health and safety did not appear to serve as a deterrent at that time. However, insight tended to be gained retrospectively as a consequence of a negative experience. One young woman suggested that boredom was often a factor in young people putting themselves at risk.

Participant 24 reported 'There's nothing for them to do round here, so a lot of young people are putting them selves at risk'.

Participant 24 reported 'When I drink I get violent, I can be violent, or I can be nice. It depends how on the day I've had. The last thing on a night I drink is beer. The first thing I'd do on a morning is drink. I used to go to S, and rob big bottles of vodka and drink myself absolutely gone. I got arrested for drunk and disorderly but they never pressed charges cos I was only young at that point but my Mum talked them out of it, the police officers. I threw up on a police officer, which she wasn't very happy about at all. I used to get violent and trash things and fight all the time and cause really big trouble in the town centre. I was constantly drunk. I can't remember. But I hate it now cos I've got drunk and I've done something with someone but I don't know what and I can't remember anything and I'm like racking my head trying to think what I've done cos I don't like not remembering. Well there was a lad that I was seeing for a bit and I slept with him one night when I was very, very drunk and I don't remember doing it I don't remember anything. I came back and I had all cuts and bruises all over me I don't remember, I don't know how I got them. I still don't remember where I'd been that night or nothing, but I'd been taking coke that same day as well, which wasn't very good. But I've learn my lesson, I just stopped all together. It was making me sick and I just couldn't take it no more'.

Participant 23 reported 'I never hung around people my own age it was all older people and usually always with lads. So they was like, they just used to try and out drink each other. I was always on sambuka. I started on vodka but that just didn't effect me any more and then tequila and that used to make me throw up anyway and then sambuka, oh I could drink gallons of the stuff, and

then beer, but I just used to drink anything. We used to go in and they'd say right what do you fancy?'

<u>Non-autonomous involvement in risk</u>

Non-autonomous involvement in behaviours with the potential to undermine health was explored with young people. These behaviours included coercing young people with alcohol and drugs in exchange for sexual favours. In this context these risks were imposed on the young person by an abusive adult.

Participant 3 reported 'I got in with a girl and I made like good friends with her and she had a lot of problems going on so I treat her well and she started abusing that friendship by starting taking me this place that place making me do things with this guy, that guy and basically making me not have a good relationship with my Mum and then things happened between me and my Step-dad and that was about it. Now, I still smoke and drink but to a level that I know that I'm ok and I can handle myself. Not to the level that I was made to do there, so I'm so paralytic that I can't even stand and I just wanted to sleep'.

Participant 4 reported 'since I got sexually assaulted as well that I've been drinking a lot. I was drunk when I got sexually assaulted. Cos he got me drink and I got sexually assaulted and then the next day cos I hadn't slept I still had drink in me.

Participant 23 reported 'I used to take it out on my Mum, I used to hit my Mum. I don't now I just keep my cool and I just go for a walk. At night it's risky

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though. It was a lad I already knew, I was a bit drunk and he got me on the race course and he did sexually assault me'.

Calculated risk taking

Despite an awareness of the risks inherent in certain behaviours, young people engaged in them. Some young people explained that whilst they had an awareness of the implications of engaging in these risky behaviours, the concerns were frequently over-ridden by a perception of levels of harm being minimised by other behaviours (for example, using alcohol excessively), although not in front of children. Calculated risk taking was sometimes seen as necessary to offset vulnerability (for example, smoking to reduce stress levels). Several young people described the temporary and brief nature of risk taking (for example, making a decision to use and abstain from illicit drugs intermittently in recognition of the potential to develop drug dependency). Drugs were used essentially hedonistically or as a self-defeating coping strategy to deal with emotional problems. In relation to planned risk-taking from a sexual health perspective, one young woman felt that being homeless was more detrimental to her health than having unsafe sex with a stranger, apparently considering her choices to be 1 of 2 poor options.

Participant 23 reported 'I just like to be on the streets all the time. M's told me that I could get picked up any time and it's a risk. If someone picks me up I could be murdered in a ditch or something. Not 3 o'clock in the morning I know I shouldn't do that. Cos sometimes I do it on my own, I just walk out on the streets I don't know I just get really stressed and angry so I go for a walk'.

Participant 3 reported going to that house drinking all the time and then taking drugs and having sex with all of them different guys, cannabis, smoking drinking and having sex with all different people'.

Participant 14 reported 'I used to exploit myself. I used to go to the bus station and have sex with anybody I could have sex with. I don't do that anymore. A has helped me cope with it. I used to go out and exploit myself, I used to go out with that intention and once I'd been drinking. I lived in D then. I'd been drinking and I thought I want to have sex with somebody, I thought I was invincible. There was 1guy and thought possibly. I should have known at the time he didn't want to have sex with me. He walked down an alley way and I followed him. He came round the corner and said 'why are you following me'. I said 'I want to know the time' he went 'get away or I'll kill you'. I couldn't get away, I had no where to hide. I did that because I'd been drinking. I thought nothing could go wrong. It was scary'.

<u>Spontaneous risk taking</u>

Spontaneous risk taking appeared to take place in peer groups and in isolation. The motivation for taking unplanned risks in relation to being with abusive men seemed to be anchored in the desire to obtain alcohol and/or drugs and for excitement. The potential consequences of engaging with this level of risk appeared to be over ridden by the desire to have fun. The opportunistic nature of this form of risk taking rendered the young person extremely vulnerable and often awareness seemed to develop retrospectively.

Participant 10 reported 'We just used to mess about. Someone would pull over in their car and say do you want to go for a drink. We used to say yes and jump in the car. We didn't even know 'em, we used to just go and get our drink like a bottle from the shop or something. And we used to just sit and get steaming with them. Sometimes we used to go over to X which is miles away, anything could have happened. Because you're drinking you relax more and you don't take note of who they are or what they're doing, anything could happen to you, anything'.

Participant 12 reported 'I've took loads of risks, stupid ones. Me and my friend were just stood there with these 2 guys and you're just like I don't believe I just did that. Like looking back they could have just dropped us off and left us and that would have been a lucky escape. Then they could have assaulted us anything could have happened. But we didn't think that at the time we thought we could take on the world and it was better on the streets than in our house'.

<u>Avoiding and reducing risks to health</u>

Young people were invited to describe any strategies they had employed to avoid or reduce harms associated with risks to their health. These strategies ranged between independently changing their behaviour (for example moderating alcohol or drug use), to accepting support from another person. Risks were avoided by some young people. However, a harm minimisation approach was also employed by others and this was apparent where a decision had been made to continue taking risks. However, there appeared to be an adjustment to frequency and duration (for example, having one sexual

partner and practising safe sex by using protection). The motivation to reduce, harm frequently stemmed from the young person. However, a family member or criminal justice system involvement was sometimes the genesis of the motivation to change.

Participant 24 reported 'I was taking phet, coke, pills, smoking weed and smoking draw. And then I just stopped taking them, well my Mum thought if you're going to move back into the house I want you to stop taking it but I used to smoke weed every day, I take pills on the odd occasion but I used to rely on it to get me to sleep on a night and I'd been on it for like a year and then my Mum just said right 'you've got to stop taking it'. So I couldn't sleep on a night I thought 'I need a joint, I need a joint', my hair got bad, where I was pulling my hair out. I'd scream and I'd cry and I couldn't be left in the house on my own I had to be with my Mum all the time cos it was that bad.

Participant 23 reported 'I got really drunk one night and I started fighting for no reason and when I woke up in the morning it made me think 'shall I get drunk today or not and do what I did last night or shall I just leave it ?' I left it that day and didn't touch vodka again. I drink now and then on a night'.

Theme 3: Unmet health needs, health seeking behaviour and use of health services by sexually exploited young people

Self help

<u>Effective self-help strategies</u>

Young people in this study described a range of self help strategies they had employed to avert or ameliorate physical and/or psychological health problems. Rather than enlisting support from other people for a health matter, many young people mobilised their own resources. Self help strategies were used in conjunction with support from other people and also when the young person perceived previous support to be ineffective or none existent. There were examples of effective self help strategies related to problematic use of drugs, alcohol and food and management of anxiety and lowered mood.

A significant influence in the patterns and trends of illicit drug use amongst the young people was the shared experience with other young people. Frequently the predominant peer group was other young people who used drugs. Most of the young people either abstained from or controlled their drug use by avoiding other drug users. The development of insight into the consequences of drug use also served as a deterrent to using them. One young person cited her positive relationship with her mentor as motivation to stop using drugs.

Participant 7 reported 'I stayed away from all the people that take drugs. I just took my mind off it and tried to keep my self occupied and started eating healthy. It was just inner strength.'

Participant 6 reported 'I enjoy smoking it (weed). But I do need to stop smoking with me being pregnant. Stop seeing the people I hang out with. Every one I know smokes weed, so matter whose house I go to they've always got a joint in their hand. So I just don't get in contact with them sort'.

Alcohol was used problematically by a significant number of young people in this study. Alcohol using acquaintances were a factor influencing continued excessive consumption and, as with drug use, avoiding other users was an effective strategy in reducing alcohol consumption. Parental alcohol use posed additional concerns for a couple of young people who were keen to state that they had addressed their alcohol consumption as they recognised the possible consequences on their own children. The main strategy used seemed to be to cut down on the amount of alcohol consumed by buying less.

Participant 2 reported 'I used to drink a lot but I've stopped now I've calmed down a lot now. I just cut it down cos you know when I was drinking I couldn't get out of bed you know cos I was tired and I had a headache and I thought well what's the point. If you drink once a week it means I've got more time with my kids. I didn't need no help I just did it myself.'

Managing an ideal weight was alluded to by several young women. The 2 main strategies employed were eating a healthy diet and exercising.

Participant 23 reported 'They gave me a piece of paper with healthy food on it and I stuck to it. I lost 3 stone. I just, when I've done my jogging I just potter around the house to keep myself moving'.

Participant 9 reported 'A healthy diet, eating as many fruit and veg, I like to walk I like, to go jogging, I drink a lot of water. I believe that you've got to get some exercise, walking or going on your bike somewhere'.

Anxiety and panic were frequently reported and related to stressful life events. Varying levels of insight into the causes of stress were discussed. Strategies used to combat anxiety and panic attacks were described (for example, relaxation, breathing exercises and guided fantasy). Two young people in this study preferred not to take prescribed medication and had experimented with other options. One young person described her use of self taught anxiety management techniques.

Participant 14 reported 'I went to the library and got a book on stress and there were (self help) things in the books like close your eyes and count down to a 100, you feel like you're going down some stairs, like go to a big open room, with a chandelier in and at the end you are more relaxed. There's pressure point in your fingers; you press them and think good thoughts'.

Another young person described how he had learnt to do breathing exercises to help him cope with stress.

Participant 1 reported 'When I'm really stressed I've got my own room and I go up there and I calm down and I chill out. But sometimes I start shouting and ranting and raving and stuff like that which I shouldn't really do. X that I told you about that helped me with my smoking she helped me with my stress

as well. She learnt me a breathing exercise. I can just relax and chill out and do my breathing exercises'.

Lowered mood, including a range of symptoms, was cited by a significant number of young people in this study. There appeared be a tendency to internalise and externalise bad feelings. Young people reported intentionally injuring themself whilst others had directed anger towards other people.

One young person preferred to buy over the counter herbal medicine rather than taking anti-depressants.

Participant 2 reported 'I don't take no depression tablets from the doctor, I just take kalms, you know, you can buy them from the chemist. It's only like a herbal remedy so it's alright. Yes they work my friend takes them as well. I went to the doctors and I talked to the doctor and he, gave me anti-depressants. But I didn't want to take the tablets that the doctor give us cos sometimes you can get addicted to it and I didn't want to be taking tablets for the rest of my life. And these kalms came out and I started taking these and I've been taking them for about 5 months and they're fine they work'.

<u>Ineffective self help strategies</u>

Young people in this study offered examples of self defeating coping strategies they had employed. These included the use of illicit substances to combat psychological pain and distress. Whilst the immediate effect of the substance may have achieved the desired effect, these effects were

temporary with an inevitable emergence of undesired effects from the drugs. Several young people described self harming behaviours they had used to alleviate emotional pain including cutting and self poisoning.

Participant 6 reported 'I just put it to the back of my head and forget about them. When I was younger to deal with my emotional health to get the pain out I used to cut myself when I was a kid but I haven't done that in about 2 years now. So that's how I used to deal with it, just forget about it. I just got a bit older and realised there's no point really, it's not exactly helping. It just makes you look a bit mad so I stopped doing it'.

Support from others

Factors influencing support seeking

Help seeking behaviour in relation to health was explored and there appeared to be 2 patterns. Young people seemed to seek help proactively in order to prevent a health problem or reactively as a consequence of an existing health concern. The factors that seemed to influence young people's behaviour towards seeking help were other people and the style, presentation and knowledge of services.

Reactive support seeking was described by this young person in terms of his motivation to seek help

Participant 18 reported 'If I've had nothing to eat, I get something to eat, a shower, anything really. If you want to talk there's always someone around to

talk to I'd just had enough and I just rang and said can you help me find somewhere to stay?'

Family members, carers, friends and support workers were cited as influences on decisions to seek help. Young people appreciated assistance in arranging and attending a health based appointment. The attitude and behaviour of staff in the services used were identified as important and appeared to have a significant impact on the young person's decision to access a particular service on subsequent occasions. When young people were asked who they considered to be providing them with valuable support they tended to describe the person by name rather than their professional identity.

Participant 1 reported 'My Grandmother, my boyfriend and his mum support me. I've got L the nurse who supports me. I've got M here that supports me. I've got quite a few people who support me in everything really. My mental health, the positive side of that is that I knew I was getting help. I knew that I'd be able to sort it out eventually. If I had any problems I had someone to go to. My sexual health, I didn't exactly feel good about it but I knew that I'd done right because I'd gone. My mental health, the thing that encouraged me (to seek help) was, I was at risk of harming myself again which I really didn't want to do, so that encouraged me to seek help. I had the nurse and every one encouraging me to seek help'.

One young person described her relationship with her school teacher as instrumental in her support seeking behaviour

Participant 17 reported 'For me it was easy cos I had a good relationship with my teachers, I knew there was a lot of teachers I could confide in and it was actually those who helped me first get involved in S. They thought it would be good for me and as it turns out it was and it helped'.

Peer influence may have a positive or negative impact on the young person's decision to seek support

Participant 24 reported 'My mate needed a pregnancy test so I went with her and I learned about it and then I spoke to my…well I can't remember, but somebody mentioned going for counselling and I agreed to it and eventually it stopped and I was going to go back again but I though no I don't need it any more, so I haven't gone back since'.

These young people described their desire to have an escort to their out patient appointment

Participant 18 reported 'At that time I don't think I'd have gone on my own, I'd have been too embarrassed, you know too shy to go first time on my own, but now when I go, I don't mind going on my own to get checked, its just what I do and I don't think I'd have gone on my own that first time, if someone didn't come with me'.

Participant 13 reported 'J came with me, it was erm, I don't know what it was really, it was just in the town and I got an AIDS test done there. I was dead

nervous about that but it was dead quick, over and done with you know with me it's like sometimes I do go to the GUM (genito-urinary medicine) clinic like regularly, just for reassurance, I am careful, but I just like to go for reassurance. I think if they had somebody, not necessarily family or friends, somebody who they could trust and who they could talk to, to go with them. Cos I couldn't have went if it wasn't for J I couldn't have went with anybody else, or my social worker, I couldn't go with anybody else'.

Knowledge of services available was a factor in seeking support:

Participant 19 reported 'I think it's important that you know that's there's someone you can go to I think just to let a person, if a person has got health problems just to let them know that there is help there if they have got health problems sometimes people might not know where to go' .

Participant 19 reported 'When I used to run away from home this was the biggest help because of what they offer. For a young run away, like I was, erm, and sometimes I wasn't always in the best situation. I could have been somewhere where I couldn't get a bath or some clothes, so when they offered me help, I could come and get a shower and wash my clothes, ring somebody to let them know that I was safe, you know chill out for a while. I know from my experience that when I used to run away, I know I used to feel sad thinking 'Where can I go?' you know, not knowing where to go'.

Young people described seeing benefits in going to a service:

Participant 13 reported 'Now I've started coming here I think it's alright my emotional health. I join in with the other young people who come here but J mainly comes to mine, at my house. I've just done work on the computer. When I talk to J we usually go for a walk. Well she's been helping me look for a job and we've done a target plan. We did it for the year and for 4 year into the future starting from now. I talk to someone; I try not to bottle it all up cos it makes you depressed. It's just some of my past. If I've got someone to talk to I don't think about it.

The style and presentation of a service was important and these young people preferred to access all services together:

Participant 4 reported 'It's a sexual health clinic but you can have drugs help. I started going there once a week and I'd sit there and tell him everything that I needed to get off my chest, cos I used to hold it in for weeks and weeks and eventually I was like a ticking time bomb and I'd just blow and just do all sorts but I went there and I'd kick off once every 6 months after that but now I don't do it I've calmed down. I'm clean; I do everything that I've never done before'.

The choice and range of services available was also alluded to:

Participant 4 reported 'I'll probably go to the doctor's or something or go with M. because they have a drinks worker as well. There's a load of them who

work in a group, they all cover different things. Like there's a drugs worker, alcohol. I even think there's a sexual health person as well'.

Participant 4 reported 'People are not pushing you unto taking one thing. Like, you have the coil, the implant the pill or what ever or the injection. They don't push you into having anything you don't want to'.

Factors influencing support avoidance

Support avoidance for a health problem was explored. According to the young people in this study the main reasons health services were avoided was due to a lack of trust in confidentiality and anonymity offered by the service.

Participant 4 reported 'I like the confidentiality so nobody finds out, that's good cos my Mum won't find out about the stuff I've been up to. She doesn't know about my previous pregnancies, I've had 2 pregnancy scares but I didn't tell my Mum. I was afraid to tell her. They've never grassed me up for anything which is good, Thank God'.

Young people who went missing from home, tended to avoid health services where they believed they may be recognised.

Participant 18 reported 'I wouldn't have gone anywhere if I knew there was a chance of me getting caught going there or if they were going to call somebody or yes, picked up by the police taken home when you didn't want to go home or….so I wouldn't have gone if there was any chance of anything like

that happening at the time. If I needed to go somewhere or if something had happened and there was a chance of me being recognised I wouldn't have gone even if it was my health or if it was about my health I wouldn't have gone if I'd have got recognised just dealt with it'.

Confidentiality was compromised for school children when rigid appointment systems required them to obtain parental permission to be absent from school during school time. Barriers to health care in terms of service configuration related to inconvenient opening times with inflexible appointment systems and services that were not designed to meet the specific needs of young people.

Participant 2 reported 'If you have an appointment and you're at school they might not be able to give you anything during the school. Yes, but like with the GUM clinic though, they've given me appointments you know during the school times, so, you have to have parent's permission, you know to leave the school, so if I went and showed them an appointment card, I still have to have my parents permission'.

In relation to staff characteristics, the young people interviewed implied that cognitive and behavioural elements contributed to their ability and willingness to access services. In particular the way a young person thinks and feels about a service may influence their decision to access it or not. In relation to people as a barrier to accessing health care this referred to the young person or other people.

Characteristics of the young person were cited as a potential barrier (for example, age, in terms of being mature enough to navigate the health care systems and also in terms of the eligibility criterion for particular treatments).

Participant 17 reported 'A lot of young people are scared that they'll not be taken seriously because of their age. You hear things off your friends, who've had bad experiences happen to them. There is a lot of factors that will put young people off but I think those are the 3 main ones, confidentiality, age and bad experiences by word of mouth'.

Timing and motivation were cited as reasons for avoiding seeking help for a health problem. The young people seemed to have become acclimatised to using self defeating behaviour as a means of coping with a health problem (for example, drinking alcohol to offset anxiety). The processes in place seemed to be linked to readiness to change and varying degrees of insight into problem recognition.

Participant 18 reported 'Teenagers know best, I did not want to listen'.

Participant 18 reported 'I didn't want to take notice of them because in my eyes at that age (13) I didn't really know what I was taking, all different kinds of drugs, that's what I wanted to do. It was to block everything out in my head, take drugs and to have a good time. What ever they said it didn't really matter to me. I didn't want to change though at that age. That's all I knew to deal

with…..be on different kinds of drugs. To just have a good time with my mates; that's all I had to look forward to, I didn't want to change'.

Help was avoided by several young people who were apprehensive about the outcome of the assessment and intervention (for example, one young woman was worried that her GP would invoke the Mental Health Act and have her compulsorily detained if she disclosed how she was feeling). Another young woman described her concerns about the reaction of her counsellor.

Participant 7 reported 'I only told one person and that was my sister she was angry and she was like 'oh lets take you to the doctors'. But I said no I'm fine. But I know I should have gone to the doctors to make sure everything was alright but I was just scared cos if my mum found out that I'd taken it (50 Paracetamol) she' get really mad, I don't know what she'd have done.'

Participant 17 reported 'I think I'll have been about 14, 15, I was going through a lot of mental health issues. I was scared of going to the doctors thinking they were going to lock me away, like in the films. And it was X who just went through everything and just made everything so normal, even though at that time in my life I felt completely not normal'.

Staff were cited as the most significant factor in influencing a young person's attitude towards accessing a health service. Young people gave examples of positive and negative experiences they had had. Young people described being intimidated by staff that they considered to be behaving in an

unprofessional manner. Young people were concerned about being judged negatively particularly in genito-urinary clinics when they felt vulnerable. In particular a 14 year old was worried about how the staff felt towards her being sexually active at 14. One young person left the clinic without her sexual health screen due to the way she perceived she had been treated.

Participant 18 reported 'It depends on what the problem was like for what service I was going to, but at that age you think I'm only 14 what if they say this and what if they think of me in that way. If I'd have gone to a sexual health clinic when I was 14, they would have said, they would have said 'you shouldn't be doing that, you're not old enough', but obviously they didn't know my circumstances. So you'd feel like they was just like ganging up on you, saying you shouldn't be doing this, and there's other people as well like social services and police and things like that saying 'you shouldn't be doing that' and you just think everyone was getting at you, but they didn't understand.'

Participant 7 reported 'The way that some people talk to you. Sometimes, I don't know sometimes they don't mean to be rude, but if your working all the time it's pretty understandable but. I think most young people get scared because of the person that they're talking to. You need to be able to understand the young person and where they're coming from and their situation. If you were afraid to talk to that person that would make me not want to get in touch with them. If I don't feel comfortable with a person and I know I have to see them, I won't go and phone somebody and ask for their help. I think it's more the atmosphere and if you feel comfortable talking to a person.

If you've had bad experiences with that person as well, which makes it even worse. I think it's most important if you can talk to somebody and if you can't talk to somebody it's going to be a bad experience'.

Gender issues were a deterrent to some young people accessing services

Participant 15 reported 'I think that, sometimes I won't go cos my doctor's male, and I think its better talking to a female rather than a male, yes but that's like when I phone up or when I go in to make an appointment I do ask to see a nurse if it's like stuff and I go see the nurse but I wont go and speak to a male doctor about anything'.

One young person stated that the age of the helper was important and she felt like she was discussing her sex life with her parents, which she did not like.

Participant 22 reported 'I think young people feel intimidated when there are older people around, cos it's like you don't want to talk to your Mum and Dad about stuff do you, so if you're going in and seeing older people it might put you off a bit'.

Participant 7 reported 'It's like if you go there and you want help and they're not supportive it makes you not want to go there again. It makes you think, I'll be fine, when you really need to go and get yourself sorted out'.

Another young person did not want to have counselling with a stranger and preferred to talk to her key worker at the sexual exploitation agency she was attending, due to the sensitive nature of the topics and trust issues.

Participant 11 reported 'No point sitting and talking about past to a stranger'.

Factors influencing support acceptance

Young people were asked to discuss factors influencing their decision to accept help. Young people differentiated between needing help, for a health problem and wanting help. An important element was valuing the service on offer. However, several young people stated that they had accepted help and subsequently rejected it as they had been disappointed.

Participant 3 reported 'There are loads of places for you to go. And if you don't want your parents to find out they don't find out. That they explain things properly to you and help you and are reasonable'.

Participant 6 reported 'They have groups to talk about sexual health and stuff like that. Say if one of you had a problem like a sexually transmitted disease or something, they will book an appointment for a check up'.

Participant 3 reported 'A nurse she used to come to my old care home and she gave me nicotine patches and she gave me advice and told me what I needed to do'.

Family members, peers, teachers, support workers and other people involved in the young peoples' lives had influenced them to accept help.

Participant 18 reported 'Sexual health clinic just in town, I go there regularly to get checked, cos when I was younger and I was like sleeping with a lot of people, I'd never been there, it was after, once I'd stopped and I was put in my other care placement my social worker said shall we go, so I went there so now I go regularly'.

Participant 11 reported 'It just wasn't helping me. To tell you the truth I wasn't really interested, I enjoyed drinking. I was young, I just enjoyed messing around. But it wasn't until I met my boyfriend when I was 15 and he helped me like stop my drinking and stopped me on the streets and everything. I just thought to myself I don't want to live this life any more I'm better than that. That's when I thought I don't really want this life any more, that's when I got myself to college'.

Young people preferred to receive support from a person with whom they had a relationship as it was easier to trust them. Trust in a person was frequently interpreted as trust in the services confidentiality. The person offering support was equally as important as the type of support being offered.

Participant 12 reported 'At first I didn't tell x anything, nothing, but as I've got to know her and I feel I could trust her then I started to open up more to her. I don't know, x she's really nice. I don't know I can't explain it. I feel I could tell

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her anything, she's like a mum to me. I don't know I just wouldn't talk to her, I didn't know her, I just thought I don't want to sit and tell all my problems to some one I don't even know. But now I feel comfortable talking with x yes, trust is the main thing'.

Participant 11 reported 'It's quite scary at first it's just the chair it's dead daunting... yes the chair you have to sit on a chair and it has 2 things out here and you have to put your legs up, and they only have a little thing to put over you. You can either have a male doctor or a female doctor but sometimes you haven't got a choice. It's quite scary at first but now I'm alright when I go there and like there dead good with you and like x my worker she comes and sits in with me, I don't mind her sitting in with me and like she'll hold my hand and everything, so it makes me feel more at ease yes, I've booked an appointment before for myself, erm, I've never actually gone there on my own, I've either gone with x or I've gone with a friend. I've never actually gone on my own. I'd feel a bit scared going on my own'.

Professional, positive and interested staff were preferred by the young people in this study.

Participant 18 reported 'When I first went to get checked I went with my social worker and she was really nice and she took me and she stayed with me like through my appointment and that, and I felt better for going and getting checked cos I knew even if I had been missing before and someone had seen

a picture of me and they recognised me, I knew that nothing could happen, cos everything, all my circumstances had changed'.

Participant 18 reported 'because she knew my situation, I knew she wasn't judging me, but if you just go in on your own and you're quite young and people are looking at you, you feel intimidated'.

Other professionals' attempts to form a relationship with this young woman had been unsuccessful. However the key worker's persistent approach was effective. The young woman allowed her key worker to dress her wounds and she stopped cutting herself eventually.

Participant 11 reported 'If it wasn't for A I don't think I would have managed to get through it. Well it was my first children's home who rang a because they were dead worried about me, and she come and I was like I don't want to know, go away, yes, and then, I don't know, A thought, A said to my social worker, I don't want to give up on her', so she kept coming and trying and trying and trying and I was like 'no, no, no', and then I think, the children's home I'm in now, that's when I started seeing her and ever since then we've been close and she's working with me, it's nice. She seemed like such a nice woman and genuine and she wanted to help me, she didn't just want to get information out of me to get me into trouble. She seemed genuine and I thought 'yes I'm going to give it a try, maybe she can help me' and I tried it and she has helped me. It's made me into a lot stronger person'.

A preferred approach was to combine challenging and enjoyable interactions (for example, counselling followed by a meal).

Participant 15 reported 'When she needs to talk to me about things that upset me, she takes me to Scarborough. So we talk about it in Scarborough and enjoy ourselves at the same time so it makes me feel really happy'.

Participant 15 reported 'P who works here, she's the counsellor, she's just one of them people that you can talk to. Like one week we'll talk about stuff that's happened and the next week we'll talk about good stuff or problems. It's like not all at once like problems, problems, problems. She likes to know what I've been doing and stuff like that'.

Young people preferred to be asked rather than told what to do and were more likely to accept support from a service they considered to be able and willing to meet their needs.

Participant 13 reported 'It was someone to talk to really. She wasn't saying to me 'oh you shouldn't take this, don't take this'. She was warning me of the risks and what could happen and how I would be in 30 years time if I carried on. So it made you think, what she was saying was right'.

<u>*Factors influencing support rejection*</u>

Support rejection referred to help having been available to the young person and subsequently rejected. This differed from support avoidance, which

referred to the young person not having attempted to access available support.

Young people were invited to discuss reasons for rejecting health support. The timing of the help was mentioned by several young people and referred to the chronological time in the young person's life and the amount of time spent waiting for support.

Participant 11 reported 'I don't think anybody could have persuaded me. I think if my family took me out of care I would have been a lot different, I wouldn't have been like this it's the fact that I'd gone into care into a children's home and you mix with all different people, people who's on remand, people who run away, prostitution, drugs. I didn't smoke; I didn't drink before I went into care. I went into care, first children's home, it was just like a youth club, staff had no control. I was doing, I started prostitution, started drinking, mixing with lads, like having sex with different lads, getting beat up by them. Then I moved into my children's home I'm in now on X road and I was wild up until the age of 15, I was just doing everything. I don't know, I think if it wasn't for the fact, if I hadn't been put into care I would have been a lot different'.

Participant 3 reported 'They offered me to come back sometime for some talking if I wanted. But I just didn't feel up to that. I just don't think I wanted to talk about it because I was over it by then, so it was a month or 2 after they wanted me to go back and by then I'd got over it. There was my Mum there, she was there if I felt upset, but in a way I was glad that I didn't have the kid

because that would have been in my memory all the time that kid being there and I wouldn't have been able to bond with it because just that feeling that that was the kid made from one of them.'

Some young people reported having experienced difficulties in accessing support when they actually wanted it and being offered it when they did not.

Participant 11 reported 'I kept rejecting it (counselling), then I said alright I'll have it, I went for about 2 sessions and that's about it, I thought I don't see the point in sitting here talking about my past and I thought no that's not for me'.

The person offering the support was sometimes a reason to reject it (for example, a person's age, gender, negative attitude or narrow perspective regarding the needs of young people).

Participant 11 reported 'I had that at X with somebody called X but that didn't work, for me I didn't feel that worked, because things have happened with my family and everything like sexual abuse, and I saw somebody called X twice, I spoke to him and everything. He was nice but it's like I said to him and the staff I don't want to waste your time coming here. Cos I don't really need to talk to X when I've got Y to talk to cos I'm dead close with Y. She's been working with me for like 3 or 4 years.'

Participant 18 reported 'my workers, they didn't know what I was going through. Obviously they knew I was taking drugs and what that was going to

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do to me but they didn't know how I was feeling cos nobody had been there before. They'd never been in that situation so why would, why would I listen to someone that didn't know what I was going through?'

Satisfactory/effective support

Satisfactory experiences of health support were discussed by the young people. These mainly related to the staff and the approach taken to provide the support. Empathy, friendliness and effective interpersonal skills were regarded as important.

Participant 3 reported 'They treat me like any normal person. When I went there, there was like older people there and I thought it was just like you know there going to see young girls and think she's this, that. But I went in, the doctors were really nice with me, the nurses were alright and they just didn't treat me like a silly little girl. They treat me like an adult. Then it didn't scare me to go back for other check ups.'

The guarantee of confidentiality, choice and negotiation of care, clear instructions and written information were favoured approaches to the provision of support.

Participant 17 reported 'I went there for the morning after pill and I found it was very confidential, supportive and I did find that a good experience. And I left feeling happy and understood and safe and confidentiality and stuff, I knew they weren't going to phone my dad and tell my dad'.

Participant 4 reported 'It's like they won't push you into doing anything you don't want to do. Basically to them you're your own person, you've got your own mind and you're free to make your own decisions. Unless it's something that's life threatening, they'd have to take that decision into their hands.'

Participant 24 reported 'Instead of people telling you what to do they just give you some ideas and then I can figure out for myself what I want to do'.

The majority of young people stated that they preferred gender specific services in sexual health clinics with rapid results following a sexual health screen. Long term support and 'walk in' services, as opposed to requiring an appointment, were important to the young people. Services that provided a range of health interventions such as counselling and sexual health alongside practical, recreational and vocational activities were considered to be valuable in meeting a range of needs simultaneously.

Participant 22 reported 'There's a load of them who work in a group, they all cover different things. Like there's a drugs worker, alcohol I even think there's a sexual health person. All the sexual health checks you can have done, it's done all in one time, so that's good and then you get the results in one week'.

A significant number of young people raised age as an issue in main stream health services they had used and considered the ability to spend time with other people in a similar age group beneficial whilst having their specific

needs addressed. The importance of an aesthetically pleasant service was raised by several young people.

In particular, environmental cleanliness with comfortable furniture (and toys for their children to play with) was important.

Participant 2 reported 'They keep it clean and stuff and tidy, so it's really nice. They have rooms where you can go and sit down and wait which is good cos most places don't have nice chairs you can sit on, which is really good. It was all clean you know, with kids toys to keep kids happy and they was all tidy'.

Unsatisfactory/ineffective support

Unsatisfactory and ineffective aspects of health service utilisation were discussed with the young people. As health care is provided from a variety of public organisations, not all are specifically health oriented (for example, from a police station). Therefore a broad range of examples were given. Examples from past personal experience and from the experiences of people they knew were cited. The main aspects of unsatisfactory support evolved from the staff and the style and presentation of a service. In relation to staff, age and a choice in the gender of the staff were deemed to be important.

Participant 4 reported 'When I got sexually assaulted I went to see a police doctor and I asked for a lady cos considering what I'd gone through you can understand that not many girls would want to be around males at that point and I thought that there was going to be a lady doctor and it wasn't, it was

actually a man and I was disgusted. It might have been the only doctor available but they could have taken me to the hospital and got a nurse to do it. There were 2 other ladies in the room that were police officers who deal with sexual assaults but it's not the same. I said to him what are you doing in this room? Get out I want a lady doctor. It was like sorry there are no lady doctors who do this. I know people who have got sexually assaulted before and they've got it done by a lady doctor. Because I've gone through being sexually abused I said to him, if you even touch me in the wrong way I will swing for you and at that point the lady doctors pulled back both my arms and put me in handcuffs while he was examining me, because I threatened to hit him. I still had drink in me. I was drunk when I got sexually assaulted'.

Other areas of concern were a judgemental attitude and limited empathy towards the young person.

Participant 14 reported 'When you go to the GUM clinic you're sat around for quite a while and they're always sat about and they're always talking and joking. They're having a laugh and you're sat there nervous and you want them to come and talk to you at least come and sit down yes it does and it feels quite daunting, that they can have a laugh about what ever they're laughing about. One of the things that narked me and upset me while I was having an examination and other things done was the next room was an office. I could hear them, I had a student, male for my examination. I would have preferred a female. The nurse I was speaking to was a female. They were talking about what they thought I had and they were like shouting about

it and I was like what are you doing. I don't know whether the door was closed or whether everyone else heard it, it was quite upsetting really, they weren't talking to me. The nurse came in and she said right you've got an infection , you need to take this, then she gave me this medication. I felt alienated in a way, like I was being talked about, like I wasn't there.'

With regards to unsatisfactory elements relating to the style and presentation of a service, waiting times, geographical location, and the perception of a service failing to be young person centred were cited as unsatisfactory.

Participant 1 reported 'The only down side thing to that is I'd have to wait 2 weeks for a (sexual health) blood test to come back. I'd be constantly thinking 'What's it going to come back like, I want to know now'.

Participant 4 reported 'They don't seem to have time for young people. You can get some people that are talking and they say it in their words and the older person is saying it in their words and it's totally different, they're changing your words for you'

The young person's perception of service seemed to be important as this was their reality, based on thoughts and feelings and it may serve as a deterrent to asking for or accessing help in the present and in the future. Additionally impressions formed as a child may continue into adulthood. The young person may also have anticipated a negative treatment response, based on this perception.

Participant 3 reported 'When I was there women that came in were sat there giving me like dirty looks and just kind of talking about me and that. You know like women who went there. They were saying things though. They kind of made sure that I could hear what they were saying (for example, 'you know what she's here for don't you?)' Obviously they could see that I was still crying. They looked in their thirties or forties. I hated being there.

Services used by sexually exploited young people to address health needs.

Young people were asked to identify the places they had typically used to address any aspect of their physical or psychological health, either to promote good health, prevent ill health, reduce risk or to address an existing health problem. A range of examples were given including services that were specifically health oriented such as a dental practice, the accident and emergency department of a hospital, a medical/health centre to see a general practitioner, pharmacies, problematic substance use services and rehabilitation, sexual health clinics, family planning clinics, counselling services and child and adolescent mental health teams.

Public services which were not specifically health oriented, but provided health support, were also cited as examples of places the young people had had contact with for a health matter. These included schools, sexual exploitation services, youth offending teams and the police.

Participant 15 reported 'I get support from Barnardos but that's it. They have helped a lot. They've got me a counsellor, they actually brought me and my Mum closer, but that just broke down again but they've helped with like social service and just somebody to talk to'.

Participant 17 reported 'Since I've been coming to X I've received support from Y, which is an independent ne2rk through housing and I've experienced support through a teen housing group. When I was 16 I started to live independently in my own flat. And through S they got me a floating support worker to help me with budgeting and things like that. I was very wary about trusting other people I would only trust people from S who I knew'.

Suggestions from sexually exploited young people

<u>Service design and delivery</u>

Young people were asked to suggest how they thought services with a remit to provide health care or advice may be improved to make them more appropriate and effective for young people. The main ideas to emerge were grouped under three headings. These headings were suggestions relating to the staff offering support, the style and presentation of the service and the approaches taken to providing support in each service. Regarding staff, skilled, empathic and interested people were preferred. The age and gender of the staff member was also important to most young people seeking help for a health problem.

Participant 6 reported 'Women behind the counter not to look down their nose at them (young people).Talk to them as if they were on an adult's level. If you talk to someone like they're a kid, they are going to act like one and cause trouble so they won't go back again. They think she's just a kid so just talk to her like a kid. They don't realise that most kids these days are more intelligent than they think. They might not have been brought up in the best way but they're more street wise'.

Participant 1 reported 'Somebody that understands what people are trying to say. Get younger staff so they understand what the teenager really says. So that they're near their age and they understand and what they mean when they try to put it into their own words they're not saying it totally different'.

Suggestions were made regarding the improvement of the style and presentation of services including accessibility, adequately advertising the service, extending support to other family members, age specific service and the provision of support through telephone help-lines.

Participant 12 reported 'Quicker appointments, I know it's hard for them cos they've got loads of people going but quicker appointments or those open day things where people can just walk in and just get checked up. You don't have to make an appointment. It just takes a long time you know, I think they should get more doctors'.

Participant 5 reported 'More help lines for people who are getting abused. Sexual health help lines, problems help lines, what cover all different things'.

Participant 4 reported 'Get a centre and have all sorts of activities going on. I'm on 'Positive Activities' for young people. It's to do with social services giving counselling and stuff. You meet other children with all sorts of, like whether they've been in foster care or adopted or whatever. In those circumstances you will meet young people. They do stuff like go out on a trip once a week, but you've got to attend Monday, Tuesday, to be able to go on the trip on Thursday. But they do all sorts of stuff and it takes your mind off… also it keeps you out of trouble. It helps people get off drugs because they haven't got time to take them, drink because they haven't got time to drink and you won't be allowed in the group if you drink. And the smoking's not really something that they try and stop. It's something that if you want help with they can help you stop smoking. They should do a group for like health, sexual health. Like drinking and stuff and get people in like yourself into a group, all sat down and get somebody in to talk and give them information about it. What's bad what's good for your health and offer them support if they want it. If they want the support it's there for them. It's not fair if somebody needs help and there's nobody there to help them. A youth club even. Put a youth club up in one of the centres. And make it attractive for young people to go to. Make it look interesting. if it's something like sexual health aimed at 13 to 16 they want something classier than that. I know it's not talking about trouble and keeping people out of trouble but it does help and it will help with health. It also helps keeping the kids off the street. They're not going to get into trouble;

they're not going to go sleeping with every person that's walking cos they're not going to have the time to.

Suggestions relating to the approach taken included age appropriate information, consultation with young people in terms of the way services are designed, good confidentiality policies, autonomy for the young person, chaperoned to appointments by a familiar person and a talk/trip approach

Participant 18 reported 'If they knew (for young like teenagers that are in the situation I was in), like confidentiality and if they went there, nothing would get said, like if they was missing and there was a poster up, they're not going to go cos they're going to know that they're going to call the police or who ever to come and collect them so they're not going to go so maybe a service that wasn't going to…..cos like here its confidential'.

Participant 9 reported 'You've got to feel that there's someone there to talk to and who you can trust'.

Participant 17 reported 'I think if they do start doing something with schools when they're young, I think they should have young people there with them delivering that programme what ever it is and that way the young people will take more notice. Not just an adult stood there with a black board telling you what to do. I think they should have more young people involved, more young people campaigning for it. No that's it, I think they should start early and let

young people know their views are important and that they are taken seriously regardless of their age'.

Participant 21 reported 'don't use big long fancy words cos there's a lot of people out there nowadays with learning difficulties that can't understand them. But they won't say anything cos they'll probably think that they're stupid. So they won't say anything so try and use smaller words than the long words, trying to put it in words that people can understand instead of like really long confusing words'.

Young people described their experience of sexual health education in school and made suggestions how to improve it

Participant 17 reported 'We were sat in the school hall, there was a big projector screen put up and there was a few rows of chairs and we were all sat there. And I mean trying to keep quiet 14 to 15 year old girls and boys is not easy and everyone knows it. So if you're going to speak about sex, they're all going to giggle about it. I mean I do now I still find it one of them subjects it just doesn't….Its a hard job do you know what I mean, and you do sympathise with the person whose doing the talking. But it was a case of a few slides that was pretty much it, a bit of information and a few handouts. They'd have been better off taking the young people off into smaller groups, speaking to them, not asking them personal questions I think just delivering general information. I think its important to give them….I mean they're not going to really take note of leaflets, so maybe if they had some young people who worked in sexual

health as well, maybe do some sort of a drama production with it or something like that cos you're going to take it in more when its actually happening rather than a load of paper, and make sure enough sign posting is done for people who do find them selves in that situation'.

Summary of findings: Phase 1

The findings from phase 1 of this study represent responses from 24 young people involved in or vulnerable to sexual exploitation. The findings were organised into 3 overarching themes entitled: Vulnerability factors and health consequences of sexual exploitation, Risks to health, and unmet health needs, health seeking behaviour and use of health services by sexually exploited young people.

The findings relating to theme 1: 'Vulnerability factors and health consequences of sexual exploitation', provided evidence to suggest that sexually exploited young people are vulnerable to a range of physical and psychological health consequences. These findings both increase and support existing knowledge. In particular issues relating to substance misuse, sexual and mental health and intentional self harm were reported. Whilst behaviours associated with sexual exploitation may be seen as a vulnerability factors in terms of health, additional social vulnerabilities were located in phase 1 data. These included the experience of young people 'going missing' from home, being in local authority care, homelessness and absenteeism from school.

Recreational drug use was prevalent amongst the majority of young people, with cannabis and amphetamine most commonly used. Dependent and higher risk alcohol use was reported as frequent occurrences. The rationale for alcohol use was to avoid withdrawal, to cope and for hedonistic purposes. A healthy diet was seen as important, although several young people reported being overweight, under weight or anorexic. Age appeared to positively influence health behaviour.

Sexual behaviour related health issues included sexual assault, sexually transmitted infections and unplanned pregnancies.

Common mental health issues were reported and included lowered mood and anxiety. This dimension of health appeared to be more challenging to understand than physical health and was generally considered when mental health issues were present. Intentional self harm was reported as significant with several examples offered. These included the experience of self-poisoning; burning, cutting and 1 person had swallowed razor blades. The rationale for self harming behaviour tended to be to cope with stress.

The findings relating to theme 2: 'Risks to health' related to existing knowledge. This study has added new and detailed knowledge in terms of a closer examination of a taxonomy of the risks to health from the unique perspective of young people involved in or vulnerable to sexual exploitation. This detailed information has enabled a better understanding of the rationale for engagement in a range of risks by sexually exploited young people. In

particular, young people described risk taking in terms of the presence and absence of autonomy and calculated and spontaneous risk taking.

Examples of risks in relation to physical health were cited more frequently than risks associated with psychological health. Physical health risks included excessive alcohol consumption, substance misuse, smoking, poor diet, self harm and risky sexual behaviour. Psychological health risks included the experience of stress and emotional distress. The perceptions of risks were borne out of personal and peer experiences. Concerns relating to risk behaviours were frequently rationalized and minimised.

Young people differentiated between spontaneous and calculated risks. Calculated risk taking tended to be viewed as serving a function (for example, using cannabis to reduce stress), whereas spontaneous risk taking tended to be impulsive and not premeditated. Young people described strategies to avoid or reduce harms associated with risks to their health. The motivation to reduce, harm often stemmed from the young person and family members.

The findings relating to theme 3: 'Health seeking behaviour and use of health services by sexually exploited young people', provide evidence to support existing knowledge and offer new insights relating to the patterns of health service utilisation by young people involved in or vulnerable to sexual exploitation. Service delivery and organization and staff were identified as significant factors influencing a young person's decision whether to use a

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service. Family members, carers, friends and support workers were cited as influences on decisions to seek help.

Services used by sexually exploited young people to address a health issue include dental practices, accident and emergency, a medical/health centre general practitioner, pharmacies, substance misuse services, contraception and sexual health clinics, and child and adolescent mental health teams. Schools, young people's sexual exploitation services, youth offending teams and the police are also reported as used by sexually exploited young people for health matters.

Health was understood in relation to well being and as absence of illness. Motivation to be healthy was to ameliorate current health problems and to overt potential health problems. In relation to help seeking behaviour young people seemed to seek help proactively to prevent a health problem or reactively to address an existing health problem.

Facilitators in health seeking behaviour include the guarantee of confidentiality and anonymity and the promotion of autonomy. Staff who are non judgemental and empathic were cited as the most significant factor in influencing a young person in accessing a health service.

Barriers to help seeking related to the style and presentation of a service, waiting times, geographical location, and the perception of a service failing to be young person centred. Characteristics of the young person were cited as a

potential barrier (for example, low self esteem). The implications of these findings will be examined in the discussion chapter.

CHAPTER 7: METHODOLOGY: Phase 2

Study Design

Phase 2 of this study employed a self-completion questionnaire survey with professionals supporting young people involved in or vulnerable to sexual exploitation. The rationale for the survey was to enable the development of additional insight into the health, risks and health seeking behaviour of young people involved in or vulnerable to sexual exploitation, from a different perspective.

This study used a postal questionnaire as according to Robson (2004), Newell and Burnard (2006), questionnaires are a relatively efficient and economic method of acquiring a substantial amount of information about a large number of people. An information sheet outlining how to complete the questionnaire was designed and accompanied by a covering letter (Appendix 11)

Data from phase 1 of this study elicited through interviews with young people, was used to inform the questionnaire for phase 2 and this linked the 2 phases.

Setting

Professionals located in specialist services for young people involved in or vulnerable to sexual exploitation in the North of England, were invited to take part in this study. Agencies that had been engaged in phase 1 of this study were approached to participate in phase 2. One hundred and two questionnaires were administered to professionals in 11 agencies in the North of England.

Sampling approach

Professionals supporting young people involved in or vulnerable to sexual exploitation were requested to complete a respondent administered postal questionnaire. Newell and Burnard (2006 p181), stated that

'*The better the sample conforms to the population from which it is drawn, the more we can be confident that the findings in that sample are generalisable to the population*'.

A population sampling approach was used to recruit respondents to phase 2 of this study. According to Polit and Beck (2004) the term population relates to 'the aggregate or totality of those conforming to a set of specifications'. In the context of this study the population referred to all workers in 11 identified sexual exploitation agencies in the North of England. The rationale for this approach was that the researcher had an existing relationship with members of staff from agencies who had participated in phase 1 of the study. The research protocol and an information leaflet for phase 2 of the study, was sent to each potential respondent (Appendix 12).

Considerations to secure a good response rate

According to Polit and Beck (2006 p509) the response rate refers to '*The rate of participation in a study, calculated by dividing the number of persons participating by the number of persons sampled'*. Sapsford and Jupp (2006) argued that there are several factors that influence the response rate. This research was related to an area of mutual interest and importance to the

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researcher and the respondents, so a reasonable response rate was anticipated. The questionnaires were posted to potential respondents following Research Ethics Committee approval. A covering letter was sent with each questionnaire informing people how and why they had been selected highlighting confidentiality and sponsorship.

Preparatory and practical measures were taken by the researcher to promote a good response rate. Careful consideration was given to the design, quality and length of the questionnaire as according to Robson (2004) these factors may encourage respondents to complete it. Attention was given to the appearance of the questionnaire as this had the potential to influence the response rate. McColl *et al (*2001) stated that whilst question wording and sequencing have been widely considered in the literature, in contrast formatting has been inadequately addressed.

Robson (2004) suggested that timing of the administration of a postal questionnaire is important and may influence response rates. Robson suggested that consideration is given to when the questionnaire is distributed. The researcher sent the questionnaires out to each agency on a Friday, avoiding holiday periods. The researcher gave clear instructions to the respondents about when and how to return the questionnaire. A stamped addressed envelope was sent out with the questionnaire. In addition the researcher discussed the sending of the questionnaire with a member of staff from each agency to inform them that it was imminent to enable them to schedule this into their workload. The questionnaire was administered on a

second occasion after 2 months from the initial administration to respondents who did not complete it first time. A telephone call was made to the agencies with low response rates from the initial administration of the questionnaire.

Selection criteria

- Professionals in identified specialist agencies supporting young people involved in or vulnerable to sexual exploitation
- Willing to participate

Exclusion criteria

- Professionals who do not have current experience of supporting young people involved in or vulnerable to sexual exploitation.
- Unwilling to participate

CHAPTER 8: METHODS: Phase 2

Measures

The researcher considered the use of a pre-existing instrument. However as there were no pre-existing instruments available that were appropriate to use in this study, a specific questionnaire was designed (Appendix 9).

Questionnaire design

The respondent administered questionnaire was developed to include issues raised by respondents to the interview study with young people in phase 1 of the study. The Health Technology Assessment review of design and administration issues in survey research (McColl *et al,* 2001) was used to guide instrument construction.

The questionnaire consisted of 10 elements in a combination of Likert scales (2), ordinal level frequency scales (4), a demographic question (1) and open ended questions (3).

In terms of questionnaire construction, Bourque and Fielder (1995) suggested that the postal questionnaire should be short, simple to complete preferably with closed ended questions. A combination of open ended and closed questions were used. The open ended questions allowed respondents to elaborate their answers and to expand the responses beyond those considered by the researcher. However, according to Moser and Kalton (1992) they are more complex to analyse. McColl *et al.* (2001) recommended

a blank space for respondents to freely comment and this was included on the questionnaire. Each question was underpinned with a rationale.

Moser and Kalton's (1992) guiding principles were used to design the questionnaire for this study. The convenience of the person completing the questionnaire was used as a driver. Attention was given to the wording, content and sequencing of the questionnaire. Moser and Kalton (1992) cautioned against the temptation to ask too many questions and recommended that the researcher is clear about what they need to know. A further point was that the respondents needed to be able to answer the questions in terms of their knowledge of the subject and in relation to the likelihood of them remembering the subject.

Sudman and Bradbury (1982) suggested a set of principles governing the use of non-threatening questions: be specific, include all possible response options and match the questions to the likelihood of remembering the material. Sudman and Bradbury (1982) suggested minimising the socially undesirable aspect of a question by framing it in an authoritative context (for example, 'doctors suggest'), and by asking about frequency or other factual information.

The researcher informed the potential respondents of the approximate time it would take them to complete the questionnaire to enable them to factor this into their work schedule.

In accordance with De Vaus (1991) the questionnaire was printed as a single sided document to avoid respondents missing questions printed on the other side. Regarding font size, 12-point font was used as suggested by Dilman (1978). In line with Bourque and Fielder (1995), bold, underlining and uppercase were used to emphasise specific aspects of the questionnaire, with double line spacing.

Piloting the questionnaire

Moser and Kalton (1992) suggested that the design of the questionnaire is not complete until after it has been piloted. The questionnaire was piloted with a combination of 6 clinicians and educationalists, using a template designed by Bell (1999). The comments included that the questions were generally clear and unambiguous apart from the terms 'self help', 'each of' and 'emotional problems'. The length of time taken to complete the questionnaire ranged from 7 to 20 minutes. Only 1 person stated that this was too long. Positive comments included the fact that there were spaces to write additional information and that it was easy to use. Some aspects of the questionnaire were amended in line with the results from the pilot, prior to administration.

Limitations of questionnaire surveys

Robson (2004) suggested that there are several disadvantages in postal questionnaires including a potentially low response rate and misinterpretation of the questions. Robson (2004) pointed out that a questionnaire may be unsuitable for people with special needs (for example, dyslexia) and may reduce the completion rate.

Bourque and Fielder (1995) described 3 groups of disadvantage of self administered questionnaires: 'sample related', 'questionnaire construction' and 'administration'.

In terms of sampling, Bourque and Fielder (1995) highlighted potential low response rate as an issue. However, the questionnaire may be sent again at a later date. In terms of questionnaire administration Bourque and Fielder (1995) suggested that the researcher cannot confirm who completed the questionnaire or whether there was conference between respondents.

Data analysis

Quantitative data

Questionnaires were collated and analysed using software Statistical Package for the Social Sciences, Version 16. The main analysis was presentation of descriptive statistics as no hypothesis testing and no inferences about a wider population were sought (Sapsford and Jupp, 2006). Descriptive statistics were used to describe examples of health issues, risks and health seeking behaviour of young people receiving support from sexual exploitation agencies. The researcher examined themes and patterns from the questionnaire completed by professionals and compared them to the information given by the young people interviewed in phase 1 of this study.

Numerical data were displayed using graphs and charts. The graphs displayed central tendency (typical values) and variability (spread) amongst the values of the variable. A minimal amount of text was reported highlighting

salient information, as according to Sapsford and Jupp (2006 p198) 'the researcher should offer an explanation of the interpretation of the statistics'.

Qualitative data

Qualitative data generated from 3 open ended questions on the questionnaire were analysed using Burnard's 6 Stage Analysis to qualitative data (Burnard, 2006), adapted from Glaser and Stauss (1967). Thematic content analysis was used to organize the textual data. The researcher adopted the emergence of data approach by allowing categories to emerge rather than asking a set of pre determined questions.

NUD*IST QSR 6 was used to assist in the analysis of data. NUD*IST QSR 6 is a soft ware programme that enabled the researcher to store, organize and retrieve data.

In accordance with the first stage of Burnard's 6 Stage Analysis following data collection the researcher transcribed each questionnaire *verbatim*. The rationale for this was to facilitate familiarity with the data at each stage of the process of analysis. There were 61 questionnaires in total with 3 open ended questions. The researcher created memos as an aide memoire.

Stage 2 in the analysis involved the researcher familiarising herself with the data through repeated reading of the transcripts and making notes relating to themes.

Stage 3 of the process involved re-reading all the transcripts several more times and making headings to describe all aspects of the content (open coding). An example of a code from data from this study was *chaperone to appointments*.

The codes selected related to the questionnaire item. Question 4 enquired about behaviours a young person may engage in that may impact negatively on their physical health. Question 6 enquired about behaviours a young person may engage in that may impact negatively on their psychological health. Question 10 invited professionals supporting sexually exploited young people to suggest how meeting the health needs of sexually exploited young people may be improved.

Stage 4 of analysis was to formulate category codes by identifying phrases from the data (for example, *location of services*). The researcher identified codes that were similar and discarded 1 of them. Higher order codes were formulated using phrases from the data as the category code heading (for example*, living arrangements).*

The researcher generated 11category codes, to promote manageability and to avoid duplication. To reduce researcher bias and to enhance validity of the study, the researcher invited another researcher to assist in the generation of higher order codes and for this process to result in a consensus.

Stage 5 in the process involved the researcher returning to the original transcripts with the related category codes. This was done using NUD*IST QSR 6. The rational for doing this was to view the category codes in their original location to gauge whether they had been de-contextualized from their original meaning. As there were only 3 open ended questions on the questionnaire the qualitative data set was relatively small, reducing the scope for de-contextualization from their original meaning. The researcher did not return to the respondents to verify the validity of the analysis as the questionnaires had been returned anonymously and this would not have been viable.

The final stage in Burnard's 6 Stage Analysis is concerned with writing the report and incorporating the findings from the data. The data generated from the qualitative questions were combined with data from the quantitative questions. Data from phase 1 and phase 2 of this study were further combined in the discussion chapter. This approach promoted the opportunity to gauge similarities and differences in the findings from respondents from phase 1 and 2 of this study.

Reliability and validity: Phase 2

The questionnaire was designed specifically for use in this study as no instrument with established validity and reliability existed. The questionnaire was not a validated instrument therefore the researcher has identified steps taken in order to increase the robustness of the questionnaire by addressing reliability and validity aspects.

Parahoo (2006) noted that a questionnaire may be reliable but lack validity. However, it cannot be valid if it lacks reliability. Reliability and validity were enhanced by constructing the questionnaire with care and taking the needs of the respondents into account.

Parahoo (2006) suggested that the reliability and validity of the questionnaire may be affected by the context of its administration. This was reduced as the researcher was asking questions related to health issues and health care provision from other providers. Therefore the potential for a socially desirable response was low as there appeared to be no conflict of interest for the respondent.

Validity

McColl *et al* (2001) stated that validity refers to 'whether a question and it's associated response options are actually measuring what they purport to measure'. The researcher attempted to maximize validity by the designing the questionnaire to enable the aims and objectives of the survey to be addressed, as suggested by McColl *et al.* (2001). Face and content validity were investigated in this study. As the questionnaire lacked previously tested and validated questions, the researcher piloted it to ensure face and content validity.

<u>Face validity</u>

Face validity refers 'the extent to which an instrument looks as though it is measuring what it purports to measure' (Polit and Beck, 2008). Face validity

was enhanced by piloting the questionnaire with a combination of 6 clinicians and health lecturers. Then asking a series of open ended questions related to health access in the context of sexual exploitation. This was done with 1 clinician and 2 health lecturers. As suggested by Polit and Beck (2008), this procedure enabled the researcher to assess the similarities between the answers given and the items on the questionnaire in order to gauge the congruence of key constructs.

Content validity

Content validity relates to 'the degree to which the items in an instrument adequately represent the universe of content for the concept being measured' (Polit and Beck, 2008). Content validity was enhanced by designing the questionnaire based on data obtained from a qualitative enquiry during phase 1 of this study and from a comprehensive review of relevant and contemporary literature. Expert opinion was also sought from professionals working in the specialist area of sexual exploitation during the instrument construction phase as a strategy to increase content validity.

A further aim of the pilot was to gauge how the respondents dealt with the questionnaire and instructions. As a result of the pilot the questionnaire was altered by rewording and reformatting some aspects of it.

Internal validity

Internal validity refers to 'the degree to which it can be inferred that the experimental treatment, rather than uncontrolled, confounding factors, caused the observed effects' (Polit and Beck, 2008).

According to Robson (2004), the internal validity of a questionnaire survey may be reduced by a badly designed questionnaire with ambiguous questions. The researcher paid particular attention to the wording of questions, in line with the suggestions from De Vaus (1991), using a rationale for each question. Simple, neutral words were used, with the use of 'neither' and 'nor' to enable a neutral response option.

Newell and Burnard (2006) suggested that the internal validity of the survey may be reduced by time constraints, interviewer behaviour and respondent perception of the value of the study. Conversely internal validity may be enhanced when the questionnaire has been well designed and asks questions which enable investigation of the areas intended to be investigated.

External validity

External validity refers to 'the degree to which study results can be generalised to settings or samples other than the one studied' (Polit and Beck, 2008). External validity may be compromised if the sampling strategy is inadequate as this compromises generalisability (Robson, 2004, Newell and Burnard, 2006). A population sampling strategy was used in this study to increase external validity.

Construct validity

Construct validity refers to 'the degree to which an instrument measures the construct under investigation' (Polit and Beck, 2008).

Criterion-related validity

Criterion-related validity refers to 'the degree to which scores on an instrument are correlated with some external criterion' (Polit and Beck, 2008).

Construct and criterion -related validity were not investigated in this study. The rationale for this was that it was not feasible to do a full validation of the research instrument due to time constraints. As validation is an ongoing process, the initial stages only were performed in this study.

Reliability

Reliability refers to 'the degree of consistency with which an instrument measures an attribute' (Polit and Beck, 2008). Robson (2004) reinforced the importance of trying to achieve an unbiased and accurate account of what is being measured. Robson suggested that often respondents answer the questions in a way that they perceive the researcher wants them to rather than saying what they really think. The researcher phrased the questions neutrally so the respondent could not anticipate the answer the researcher may have expected.

Careful attention was paid to the wording and structure of the questionnaire, as Parahoo (2006) remarked that this may significantly affect the reliability

aspect. This may occur if the potential for misinterpretation of the questions by respondents is high due to the wording or if the structure lacks clarity. Furthermore, McColl *et al.* (2001) raised the point that lack of consensus of the definition of 'quality of life', as used in many health based studies, may reduce validity and reliability. This phrase was avoided in this study to discourage misinterpretation.

Reliability may be reduced by interviewer behaviour (Newell and Burnard, 2006). However, the questionnaire was self completion and posted to respondents therefore the researcher did not reduce reliability during this stage of the process.

Sudman and Bradbury (1982) recommended that questionnaires are designed to reflect careful consideration of memory, motivation, communication and knowledge, as all of these aspects have the potential to undermine the reliability and validity of the questionnaire. Memory distortion as a source of inaccurate self reporting was possible, although improbable as the questions related to the current work of the respondents rather than to historic events. In contrast there may have been a tendency to exaggerate the severity or frequency of occurrence of health issues encountered, using the research as a marker to draw attention to particular issues. These issues may have reduced the reliability of the results.

Bias

Bias refers to 'any influence that distorts the results of a study and undermines validity' (Polit and Beck, 2008). It was possible to introduce bias during the sampling process. To avoid bias, a population sampling approach was employed in order to provide an adequate representation of the underlying population. In line with McColl *et al.* (2001) the researcher reduced sampling frame bias as the target population for the questionnaire survey had an equal chance of being involved in the survey.

'Non-response bias' was low in this study as a member of each agency was contacted in advance of the questionnaires being posted out and all the questionnaire were sent out on the same day to each agency. Questionnaire completion instructions were available in writing to each respondent. All agency staff were English speakers, therefore the likelihood of 'non response bias' due to a language barrier was unlikely.

The questionnaires were self completed therefore as suggested by Newell and Burnard (2006) the potential for interviewer bias was reduced significantly. Also McColl *et al.* (2001) suggested that respondents are more likely to provide truthful, authentic answers to sensitive questions if they complete the questionnaire independently as they will feel less pressurized to provide what they consider to be a 'socially acceptable answer'. Parahoo (2006) suggested that bias may be evident in a low response rate. In this study 102 questionnaires were administered and 61 were returned. This suggested minimal non-response bias as the response rate was considered to be reasonable. According to Mangione (1995) a 60-69% response rate is

considered to be an acceptable response rate, although views differ on this. Saliency positively influenced response rates in this study.

CHAPTER 9: FINDINGS: Phase 2

Introduction

These are the findings reported by 61 respondents from the questionnaire survey from phase 2 of this study. Eleven agencies supporting young people involved in or vulnerable to sexual exploitation were recruited to phase 2. One hundred and two questionnaires were administered to professionals in 11 agencies in the North of England. Sixty one questionnaires were returned by 10 agencies. Twenty one respondents described their agency as statutory and 40 respondents described their agency as non-statutory. Reasons for questionnaires not being returned are not known to the researcher. The number of questionnaires returned by each agency is outlined in Table 9.1.

Table 9.1: Demographic data and questionnaire return rate

Agency	Agency type	Questionnaires sent	Questionnaires completed
Bradford (1)	Statutory	1	0
Bradford (2)	Non-statutory	2	2
Bradford (3)	Non-statutory	9	7
Derby	Non-statutory	10	8
Doncaster	Statutory	33	17
Huddersfield	Statutory	11	3
Hull	Non-statutory	10	7
Keighley	Non-statutory	1	1
Leeds	Non-statutory	10	6
Middlesbrough	Non-statutory	10	6
Sheffield	Non-statutory	5	4

Figure 9.2: Questionnaire item 2: Physical health problems encountered by young people who use your service.

N=61
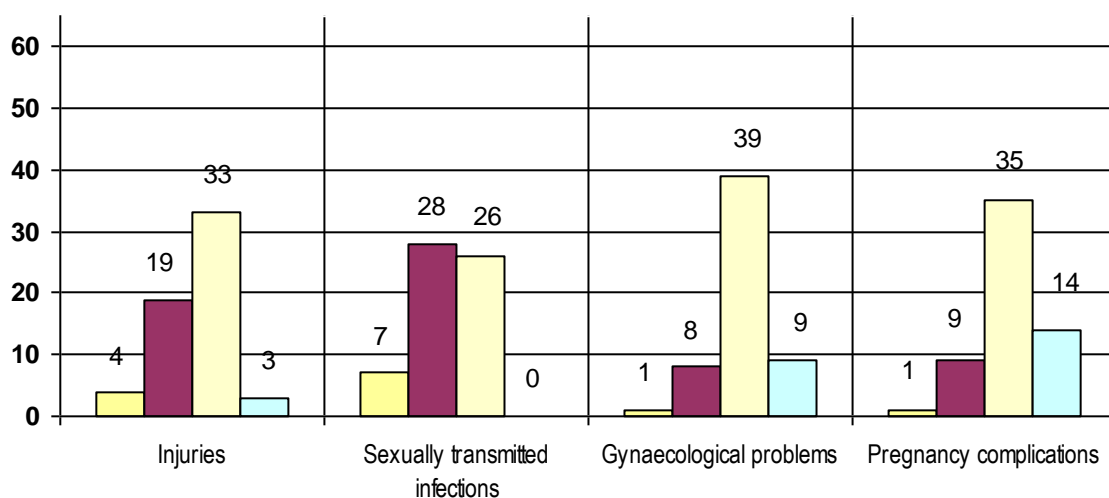
	Injuries	Sexually transmitt infections	Gynaecological problems	Pregnancy complications
Mean	2.6	2.3	3	3.1
Median	3	2	3	3
Mode	3	2	3	3

Figure 9.2: Questionnaire item 2: Physical health problems encountered by young people who use your service.

N=61
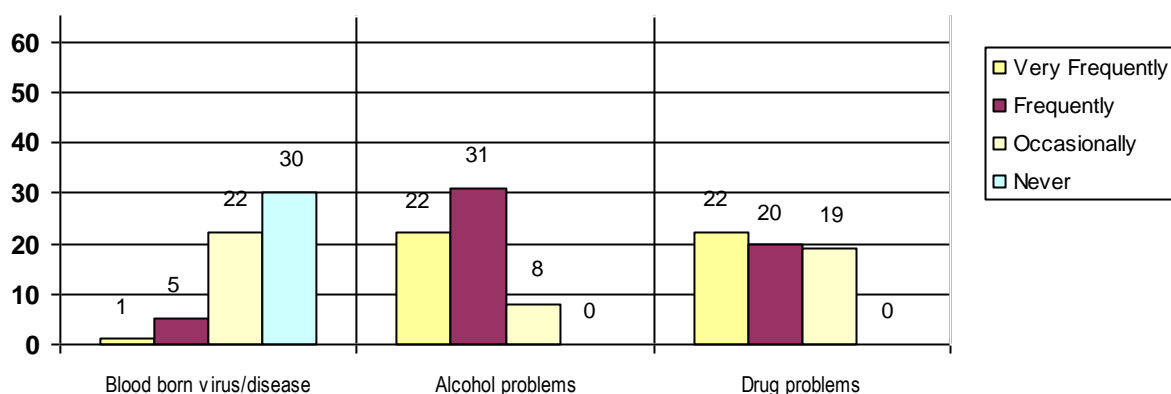
	Blood borne virus/disease	Alcohol problems	Drug problems
Mean	3.4	1.8	2
Median	4	2	2
Mode	4	2	1

Physical health problems encountered by young people who use your service

The majority of respondents reported having ever seen injured young people in their service, predominantly on an occasional basis.

Sexually transmitted infections were reported as the overall second most frequently occurring issue in the physical health category, with all respondents having knowledge of young people in their service with sexually transmitted infections.

Alcohol and drug use were reported jointly as the most very frequently occurring issue on the physical health scale (n=22) with all respondents citing alcohol and drug use as an issue (n=61).

Other physical health problems reported included dental and optical problems, scabies, stomach pain and poor uptake of immunizations.

Figure 9.3: Questionnaire item 3: Psychological health problems encountered by young people who use your service.
N=61
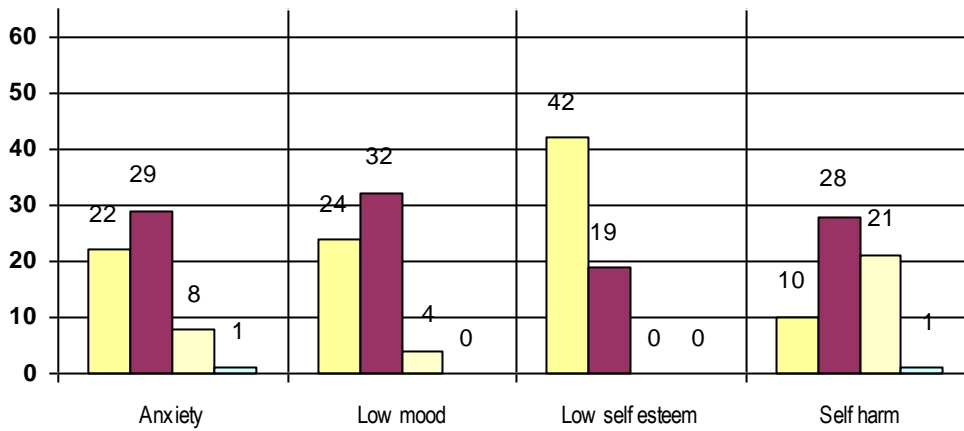
	Anxiety	Low mood	Low self esteem	Self harm
Mean	1.8	1.7	1.3	2.2
Median	2	2	1	2
Mode	2	2	1	2

Figure 9.3: Questionnaire item 3: Psychological health problems encountered by young people who use your service.
N=61
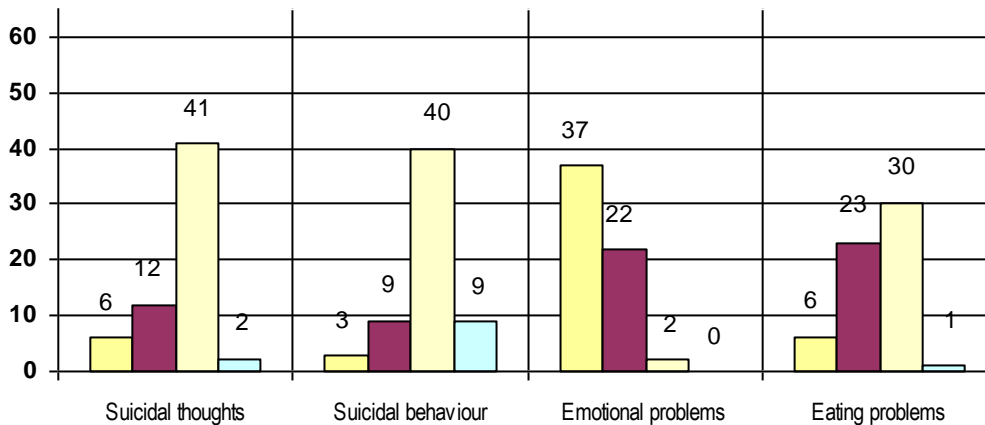
	Suicidal thoughts	Suicidal behaviour	Emotional problems	Eating problems
Mean	2.6	2.9	1.4	2.4
Median	3	3	1	3
Mode	3	3	1	3

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Figure 9.3: Questionnaire item 3: Psychological health problems encountered by young people who use your service.
N=61
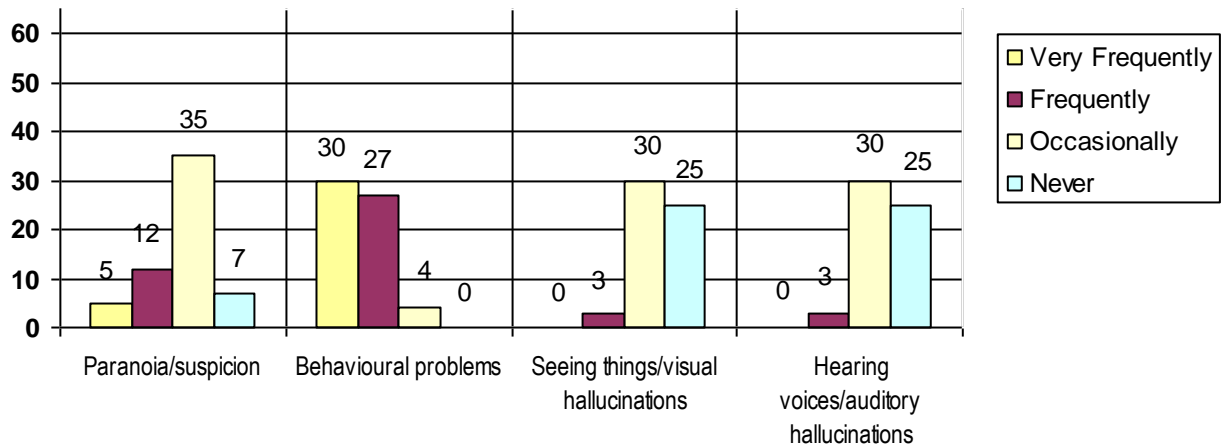
	Paranoia/suspicion	Behavioural problems	Seeing things/visual hallucinations	Hearing voices/auditory hallucinations
Mean	2.7	1.6	3.4	3.4
Median	3	2	3	3
Mode	3	1	3	3

Questionnaire item 3: Psychological health problems encountered by young people who use your service

Anxiety was reported as an issue by nearly all respondents (n=60). Nearly half of the sample reported anxiety as a frequently seen issue (n=29) and (n=22) reported anxiety as a very frequently seen issue.

All respondents reported low mood as an issue amongst young people using their service and this tended to be seen either very frequently (n=24) or frequently (n=32).

All respondents reported low self esteem as an issue amongst young people using their service. Low self esteem was reported as being the most prevalent very frequently occurring psychological issue (n= 42).

Sixty respondents reported having seen young people at least occasionally in their service with a tendency to self harm with only (n=1) respondent reporting having never seen this.

Fifty nine respondents reported an awareness of suicidal thoughts, on at least an occasional basis, amongst young people using their service. (n=52) respondents reported an awareness of suicidal behaviour, on an occasional basis amongst young people using their service.

Emotional problems were considered to be the second most very frequently occurring issue in this category. Eating problems were considered to be an issue by (n=60) respondents. All respondents reported behavioural problems (n=61) as an issue amongst young people using their service, mainly very frequently or frequently seen.

Table 9.4: Questionnaire item 4: In your opinion what behaviours may young people who use your service be involved in, that impact negatively on their physical health?

Risky behaviours that impact negatively on physical health: Categories	Risky behaviours that impact negatively on physical health: Sub-categories
Problematic substance use	
Living arrangements and 'going missing'	
Sexual behaviour	Sexual risk taking
Neglecting health and well being	Not accessing health care
	Inadequate diet
	Reduced/non-attendance at school

Questionnaire item 4: In your opinion what behaviours may young people who use your service be involved in, that impact negatively on their physical health?

Professionals supporting young people involved in or vulnerable to sexual exploitation were asked to describe the behaviours young people engaged in that had a negative impact on their physical health. The responses identified the following key areas: problematic substance use, 'going missing' leading to inappropriate living arrangements, sexual behaviour and neglect of health and wellbeing.

Problematic substance use

Drug and alcohol use were described in the context of other behaviours that appeared to support and reinforce consumption. They were seen as both a cause and a consequence of other behaviours. For example, it was suggested that drugs and alcohol were used as a coping mechanism to 'going missing' and sleeping rough, exposure to domestic and stranger violence and to facilitate engagement in sexual acts in an exploitative relationship. Non-school attendance tended to create more unstructured time for the young person to spend using drugs and alcohol and to associate with other young people not in school, people who had a negative influence on them and others using and supplying drugs and alcohol to them. The substance cited as used most frequently was alcohol. Alcohol consumption was referred to in the context of episodic binge drinking and heavy frequent use. Drug and alcohol use were seen as a factor contributing negatively to other situations (for example, placement breakdowns for young people residing in the looked after system).

Participant 46 reported 'Young people are often involved in drug/alcohol use which severely impacts on their physical health. Young people often go missing from home where they are at risk of or involved in sexual exploitation which effects their physical health/sexual abuse, pregnancies, sexually transmitted infections but also may affect their self esteem which in turn may lead to the young person neglecting their own physical health needs'.

Participant 49 reported 'Depends on the individual but drugs/alcohol taking can be more prevalent in this client group therefore presenting associated physical health risks. Also more at risk of physical harm in certain situations. Generally less access to GP/dentist services to support physical health due to living circumstances'.

Living arrangements and 'going missing'

According to respondents from phase 2 of this study, the living arrangements of some of the young people they were supporting contributed to compromised physical health. 'going missing' was also seen as a factor associated with poor health outcomes for sexually exploited young people.

Participant 57 reported 'Running away and putting themselves at risk of violence both physical and sexual. The effect of degrading lifestyles on self esteem and no significant other to relate to and trust. All made worse by alcohol use, depressive drug. Lack of family structure and care. Lack of parenting. Poor education- no value in life seen as nothing to contribute to

society. No real friends or positive peer group. Involvement with criminal justice system also adds to this lack of self worth'.

Participant 57 reported 'Often missing from home /LA care. Issues around keeping safe and eating correctly, sleeping patterns. Drug and alcohol use and impact of this on the body. Self harm injuries often not dealt with in the correct way'.

Participant 19 reported 'Homelessness, some young people do not have a safe place to stay and will sleep anywhere available. This puts them at risk of physical abuse. No regular meals often junk food and fizzy drinks or alcohol, unhealthy eating patterns'.

<u>Sexual behaviour</u>

Sexual behaviour was cited as a contributory factor in potentially undermining the physical health of young people involved in or vulnerable to sexual exploitation. Sexual behaviours tended to be described in 2 ways. These were abuse of the young person through sexual exploitation and the autonomous engagement in risky sexual behaviour.

Participant 18 reported 'Estrangement from families. Low self esteem, controlled by others. Drug use, unsafe sexes usually no choice self harm alcoholism, violence, usually from frustration aggression.

Participant 45 reported 'Risk behaviours, not seeing risky situations or people who exploit them and putting themselves in dangerous places ie cars with more than 1 male, in the middle of a field where no one would hear them scream'.

Participant 40 reported 'Abusive relationships with males. Risk behaviours with strangers which reinforce feelings of low self worth. Alcohol dependency compounding these feeling'.

Participant 45 reported 'Association with some dangerous adult men who have assaulted, sexually assaulted, abused and kidnapped young people. Poverty and poor diet affect the general physical health. Particularly those who are homeless frequently have appalling feet problems'.

Participant 31 reported 'inappropriate relationships with adult males. Drug misuse, running away, selling sex for cash, goods, bed'.

Participant 28 reported 'Associate with others involved in prostitution and drugs. Running away, sofa-surfing. Frequenting homes of sex offenders'.
Autonomous sexual risk taking

Participant 12 reported 'Multiple sexual partners, basing their self esteem on how many men they have sex with, running away from home, family'.

Participant 12 reported 'Multiple sexual partners, unprotected sex, domestic violence, heavy alcohol use, regular drug use'.

Participant 10 reported 'Sexual intercourse with multiple partners, fights, drug and alcohol abuse'.

Participant 36 reported 'Absent from home staying with strangers associating with adult men in houses across the country. Drinking and smoking in these houses. Not using condoms and having sex with groups of men'.

<u>Neglecting health and well being</u>

Young people were described by respondents from phase 2 of this study as neglecting their physical health and well being, namely, through not accessing health care, and having an inadequate diet. Reduced or non attendance at school was considered by some respondents to be linked to poor physical health outcomes.

Not accessing health care

Participant 53 reported 'Not registered with GP so no easy access for routine appointments. Chaotic lifestyles mean routine health screening not followed up. Young people unwilling to wait for appointments need easy access'.

Participant 45 reported 'Physical health is frequently neglected by young people. Alcohol and drug use effect physical health'.

Participant 57 reported 'Not eating healthy, not seeing a doctor/dentist until symptoms are serious'.

Participant 59 reported 'Depends on the individual but drugs/alcohol taking can be more prevalent in this client group therefore presenting associated physical health risks. Also more at risk of physical harm in certain situations. Generally less access to GP/dentist services to support physical health due to living circumstances'.

Inadequate diet

Participant 17 reported 'Not looking after general personal health i.e. not eating properly-dentist; generally engaging with an unhealthy lifestyle'.

Participant 56 reported 'Poor diet and general transient lifestyles impacting on their welfare'.

Participant 4 reported 'Not eating properly, missing from homes prevents eating healthy. Eating and drinking the wrong foods can negatively impact on physical health and teeth'.

Reduced or non school attendance

Participant 50 reported 'Not attending school leads to low self esteem/confidence, having relationships-sexual or friendships with unsuitable people (for example, those who have a negative impact on their lives)'.

Participant 35 reported 'Most of my contacts are out of full time education. They may or may not be accessing alternative education provision but appears to have a lot of free time. This enables them to mix with older teenagers/younger adult groups who often have issues with alcohol, substance use and are often immature with more sexual experiences'.

<u>Questionnaire item 5</u>

Figure 9.5: How effectively are the physical health needs of sexually exploited young people met by statutory and non-statutory agencies?
N=61
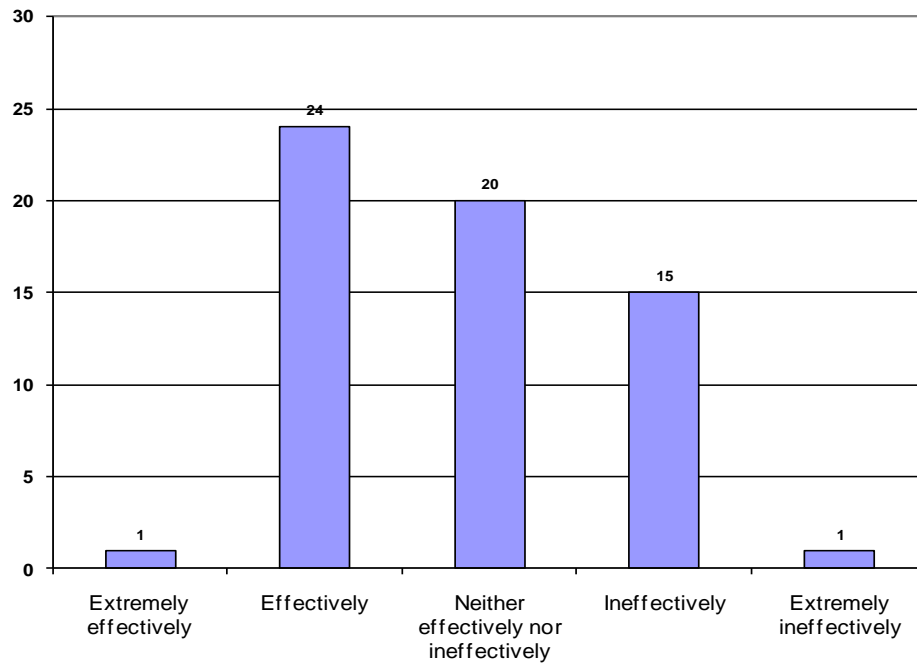
<u>Mean: 2.8</u>

<u>Questionnaire item 5: How effectively are the physical health needs of sexually exploited young people met by statutory and non-statutory agencies?</u>

Respondents were asked how effectively the physical health needs of sexually exploited young people were met by statutory and non-statutory agencies.

Approximately 26% reported that physical health needs were either ineffectively or extremely ineffectively met. Approximately 41% reported that physical health needs were either effectively or extremely effectively met.

Table 9.6: Questionnaire item 6: In your opinion what behaviours may young people who use your service be involved in that impact negatively on their psychological health?

Risky behaviours that impact negatively on psychological health
Alcohol and drug use
Inadequate living arrangements
Harmful relationships

Questionnaire item 6: In your opinion what behaviours may young people who use your service be involved in that impact negatively on their psychological health?

Professionals supporting young people involved in or vulnerable to sexual exploitation were asked to describe the behaviours young people engaged in that they considered to have a negative impact on their psychological health. The responses identified the following key areas: problematic substance use, inappropriate living arrangements and harmful/damaging relationships.

Alcohol and drug use

Participant 25 reported 'Drinking too much alcohol and smoking cannabis increases the young person's vulnerability and impacts on their physical well being. Smoking cannabis may also lead to feelings of paranoia'.

Participant 46 reported 'Drugs/alcohol misuse to cope with effects of sexual abuse/emotional abuse they have experienced throughout their lives. Self harming behaviours used as a coping strategy. Risk behaviours such as 'going missing' from home; young people may be fleeing from or running to abusive situations'.

Participant 34 reported 'Socialize in networks which promote excessive drinking patterns of behaviour usually in the home. Therefore never really mix/mingle in society to deviate from this routine pattern of behaviour into new healthier behaviours and social interests, resulting in low mood, self esteem and depression'.

Inadequate living arrangements

Participant 53 reported 'Frequent placement breakdowns for looked after children, compounding attachment/relationship difficulties. Unresolved issues regarding loss, grief abuse, etc which have not been addressed or counselling provided'.

Participant 46 reported 'Risk behaviours such as 'going missing' from home. Young people may be fleeing from or running to abusive situations'.

Participant 31 reported 'Inappropriate relationships with adult males. Drug misuse, running away, selling sex for cash, goods, bed'.

Participant 32 reported 'Sexual relationships with abusive partners. Exchanging sex for money, drugs, alcohol, somewhere to stay.'

Participant 17 reported 'Searching for their identity, a sense of belonging, low self esteem. Not attending school or being the victim of bullying. Unsettled at home not getting on with Mum or no relationship with immediate family. Being abandoned by parents and local authority'.

<u>Harmful relationships</u>

Participant 21 reported 'Sexual activity, drug and alcohol misuse, poor relationships, family relationships, bullying at school, academic learning abilities, and peer pressure'.

Participant 27 reported 'Sexually and physically abusive relationships. Binge drinking and drug taking. Sleeping rough. They also lack basic nurture and remain isolated from their peer group. By not being able to express difficulties they are not able to have emotions validated or safely explore relationships healthily. Difficulties around male masculinity and sexuality cause anxiety and confusion'.

Participant 24 reported 'Associating with abusive men, women. Low level crime, for example shop lifting. Not enough sleep up all night, running away'.

Participant 12 reported 'Controlling abusive relationships. Unstable housing, alcohol and drug abuse, multiple sexual partners, basing their self esteem on

how many men they have sex with. Running away from home, family breakdown'.

Participant 16 reported 'Relationships, poor choices. Peer groups male/female. Exploitative older friends. Co-dependent parents. Physical and emotional are linked'.

Participant 45 reported 'By associating with abusive adult dangerous men young people develop very low self esteem and a complete disregard for them selves. High risk and dangerous situations'.

Participant 4 reported 'Being fully dependant on an abusive adult who will look to harm them and not to look out for their best interests'.

Questionnaire item 7

**Figure 9.7: How effectively are the psychological health needs of sexually
exploited young people met by statutory and non-statutory agencies?
N=61**
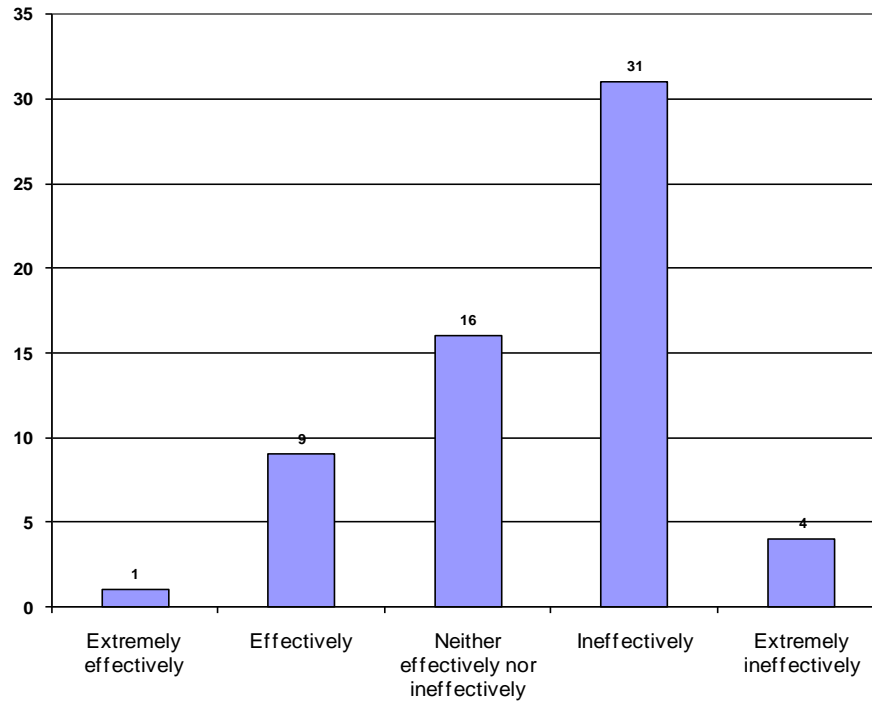
Mean: 3.5

Questionnaire item 7: How effectively are the psychological health needs of
sexually exploited young people met by statutory and non-statutory agencies?

Respondents were asked how effectively the psychological health needs of

sexually exploited young people were met by statutory and non-statutory

agencies. Approximately 57% reported that psychological health needs were either ineffectively or extremely ineffectively met. Approximately 16% reported that psychological health needs were either effectively or extremely effectively met. This suggests the majority of respondents reporting an unsatisfactory situation regarding meeting the psychological health needs of sexually exploited young people.

Figure 9.8: Questionnaire item 8: Which services do the young people you support tend to use and how frequently? N=61
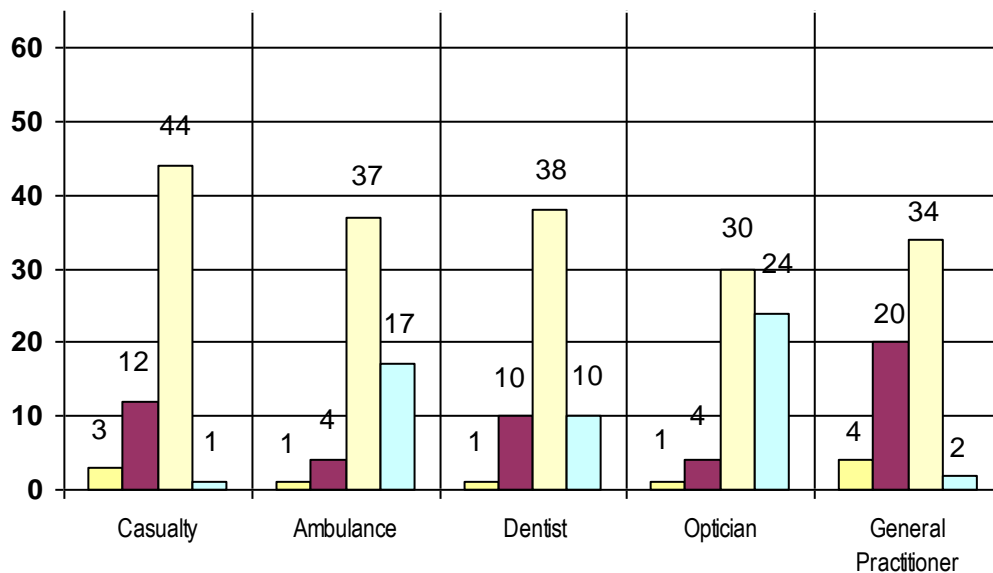
	Casualty	Ambulance	Dentist	Optician	General practitioner
Mean	2.7	3.2	3	3.3	2.6
Median	3	3	3	3	3
Mode	3	3	3	3	3

Figure 9.8: Questionnaire item 8: Which services do the young people you support tend to use and how frequently?

N=61
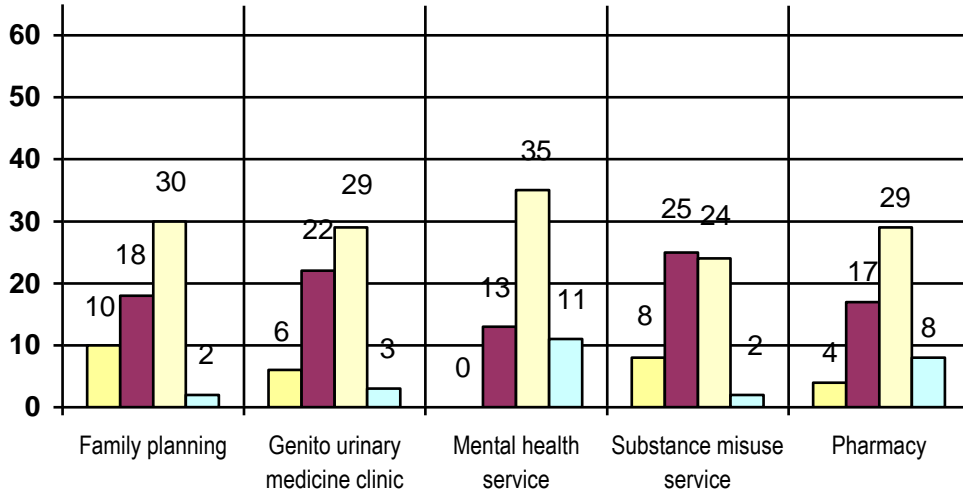
	Family planning	Genito urinary medicine clinic	Mental health service	Substance misuse service	Pharmacy
Mean	2.4	2.5	3	2.3	2.7
Median	3	3	3	2	3
Mode	3	3	3	2	3

Figure 9.8: Questionnaire item 8: Which services do the young people you support tend to use and how frequently?

N=61
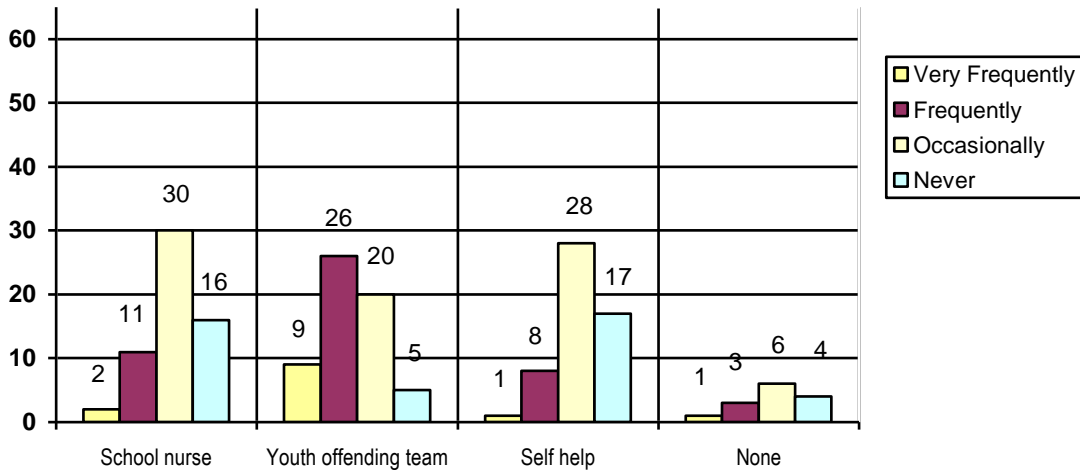
	School nurse	Youth offending team	Self help	None
Mean	3	2.4	3.1	2.9
Median	3	2	3	3
Mode	3	2	3	3

Respondents reported that accident and emergency departments tended to be used by sexually exploited young people on an occasional basis and was the most popular service used as occasionally in this category (n=44). Use of the general practitioner by young people was reported to be the fourth most frequently used service (n=20). Only (n=2) respondents reported the GP as never used by young people in their service. Family planning services were reported as being the most very frequently used service in this category (n=10).

The genito-urinary clinic was reported to be the third most frequently used service (n=22) by young people, in this category.

Occasional use tended to be the prevailing pattern of use (n=35) of mental health services by young people supported in a sexual exploitation service.

Problematic substance use services were reported to be the third very frequently used service (n=8) and the second most frequently used service (n=25).

More than half the respondents reported the school nurse as used occasionally by young people they support (n=30).
The youth offending team was reported as the second most very frequently used service (n=9) and the highest frequently used service (n=26). Other

services used by young people included youth services, sexual health outreach and services offering relaxation therapy, counselling and free meals.

Figure 9.9: Questionnaire item 9: How important is each of these factors in influencing a young person to seek help for a health problem?
N=61
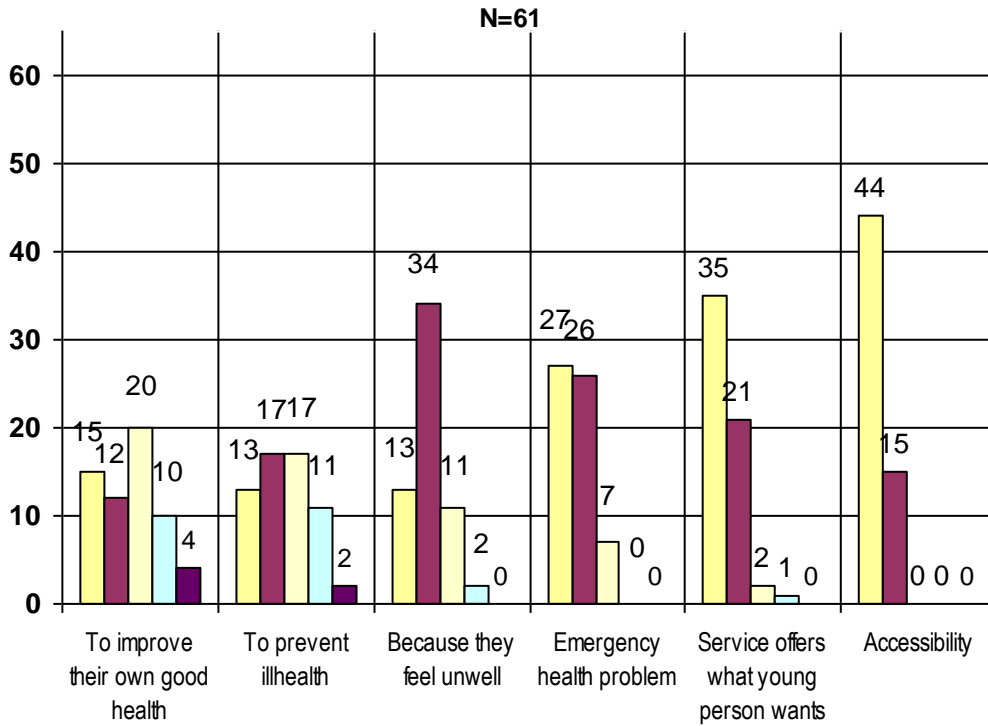
	To improve their own good health	To prevent ill health	Because they feel unwell	Emergency health problem	Service offers what young person wants	Accessibility
Mean	2.6	2.5	2	1.7	1.5	1.3
Median	3	2.5	2	2	1	1
Mode	3	2a	2	1	1	1

Figure 9.9: Questionnaire item 9: How important is each of these factors in influencing a young person to seek help for a health problem?

N=61
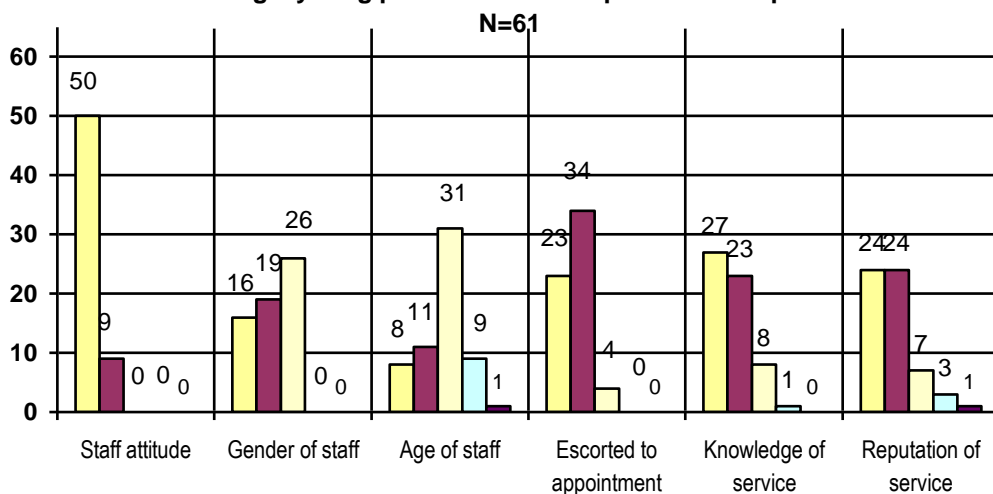
	Staff attitude	Gender of staff	Age of staff	Escorted to appointments	Knowledge of service	Reputation of service
Mean	1.2	2.2	2.7	1.7	1.7	1.9
Median	1	2	3	2	2	2
Mode	1	3	3	2	1	1a

Figure 9.9: Questionnaire item 9: How important is each of these factors in influencing a young person to seek help for a health problem?

N=61
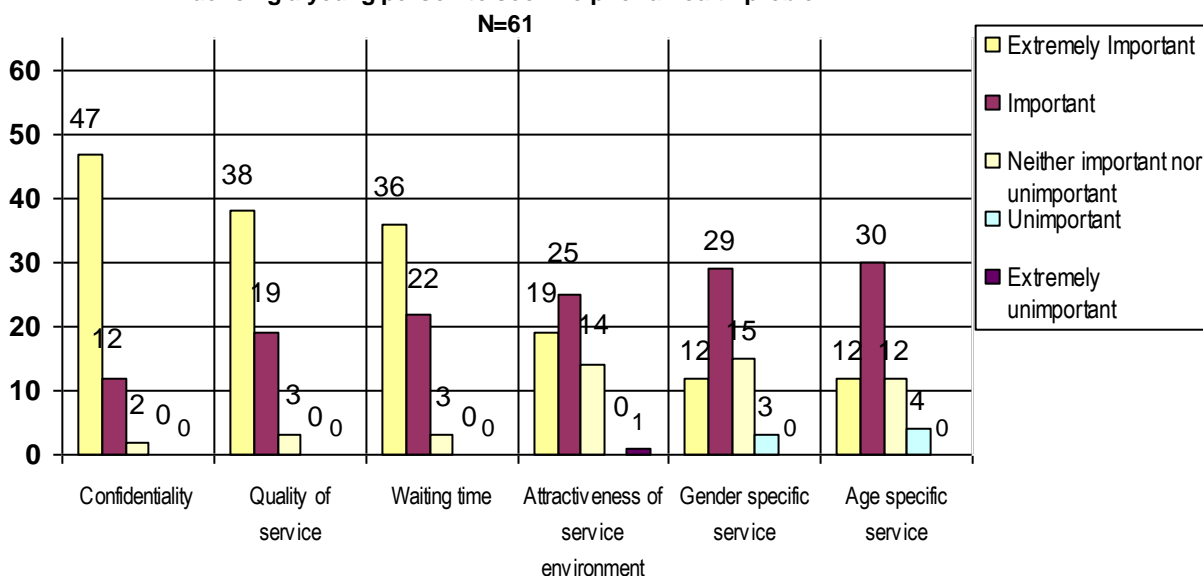
	Confidentiality	Quality of service	Waiting time	Attractive service environment	Gender specific service	Age specific service
Mean	1.3	1.4	1.5	2	2.2	2.1
Median	1	1	1	2	2	2
Mode	1	1	1	2	2	2

Questionnaire item 9: How important is each of these factors in influencing a young person to seek help for a health problem?

To improve own health was the second **most frequently** reported **unimportant** issue (n=10). To prevent illness was the most frequently reported unimportant issue (n=11).

Using services due to feeling unwell was reported as the primary joint **most important** issue (n=34) in this category. (n=27) respondents reported using services due to an emergency health problem as **extremely important** and (n=6) as **important.** Service offering what the young person wants was considered to be either important (n=21) or extremely important (n=35) by the majority of respondents.

Accessibility was reported to be extremely important by the majority of respondents (n=44) and was the third most **extremely important** issue (n=44).

Staff attitude was considered to be the most reported **extremely important** issue (n=50). Gender or ages of staff were both reported as **neither important nor unimportant** predominantly. Being escorted to appointments was reported as the joint **most important issue** (n=34) in this category. Knowledge of service was considered to be **extremely important** (n=27) or **important** (n=23).

Reputation of service was reported as **extremely important** or important by (n=24) respondents respectively. Confidentiality was considered to be the second **most extremely important** issue in this category.

Waiting time was reported to be **extremely important** (n=36) or **important** (n=22).

Gender specific service was reported to be the third **most important** issue (n=29) in this category. Age specific service was reported to be the second **most important** issue (n=30) in this category. Other elements of a service considered to be important were flexible opening times and a non-judgemental approach.

Table 9.10: Questionnaire item 10: How may meeting the health needs of sexually exploited young people be improved?

Improving service utilisation: Categories	Improving service utilisation: Sub categories
Accessibility	location of services
	Timing
	Support to attend appointments
Staff characteristics	
Service design and delivery	Multi agency approach
	Providing information
	Meeting specific needs of sexually exploited young people
Raising awareness and levels of support	Promoting awareness of sexual exploitation

<u>Questionnaire item 10: How may meeting the health needs of sexually exploited young people be improved?</u>

Improving service utilisation

<u>Accessibility</u>

Location of services

Location of services was considered to be an important factor in use of a service:

Participant 46 reported 'Taking services directly to young people in an environment where they feel safe, respected and listened to'.

Participant 21 reported 'Take the health care to them; they are reluctant to seek help for health problems due to stigma, fear, unable to socialise, poor communication skills, vulnerable or they just don't know where to go'.

Participant 21 reported 'Having services available that the young person feels comfortable going to, nice environment which is young person friendly and the staff attitudes must not judge or look down or be patronising'.

Participant 35 reported 'Drop in centres which have professional and volunteer workers and can support young people in a non-threatening and relaxed environment may improve access for the most vulnerable. Premises need to be homely and non-clinical without pressure to speak to workers but where opportunistic discussion could be encouraged. Access would be available at weekends and as safety will be an issue, negotiated opening until evening time. Premises need to be homely and non-clinical without pressure to speak to workers but where opportunistic discussion could be encouraged'.

Participant 24 reported 'Young people tend to access services that are community based and child centred (for example, a youth service works well in our area, whereby a young person's sexual health service is provided)'.

Timing

Timing was raised by several respondents in the context of the service being available to young people:

Participant 21 reported 'Time to engage young person-more than 2-3 failed appointments and case is often closed'.

Participant 46 reported 'Being creative in how to engage with young people and listening to young people on how they would like services to meet their needs'.

Participant 40 reported 'Out of hour's availability as young people exist outside 9-5 Monday to Friday'.

Participant 38 reported 'Services need to be able to be more flexible in responses (for example, can meet there and then cover expenses, escort service, no waiting). Chaotic style of life needs young people's needs to be worked with there and then'.

Participant 46 reported 'Young people are not usually awake early enough to make appointments with GP's as they are asked to ring at 8.30am. It would help if this was more flexible'.

Participant 55 reported 'Drop in facilities important as first point of contact. These need to be professional, age appropriate with clear boundaries and flexible and responsive to need'.

Participant 35 reported 'Drop in centres which have professional and volunteer workers and can support young people in a non-threatening and relaxed environment may improve access for the most vulnerable'.

Support to attend appointments

Respondents reported that offering support to young people to attend appointments was a significant factor in whether they went or not:

Participant 10 reported 'Support in attending appointments by someone in a service the young person has built up a relationship (professional) with'.

Participant 4 reported 'To ensure the service is fully accessible to them in terms of non judgemental approach, outside office hours, patience, someone who is willing to escort them and work on a 1 to 1 basis. I know unless I support and escort to services, sexual health or medical they do not have the confidence or motivation to go themselves and usually do not have

parents/carers to support them or encourage them to access medical or sexual health needs'

Participant 45 reported 'To get volunteers to buddy up with people, thus attending more appointments and build self esteem'.

Participant 32 reported 'Phone calls/ text to remind them about appointments'.

<u>Staff characteristics</u>

Staff characteristics were raised as significant in terms of young people opting to use a particular service or not:

Participant 2 reported 'We have a worker/nurse who comes to our service who is part of our team. She has her own room at the service which all the young people know is there. They are used to seeing her around the building and know they can ask to see her when ever needed. She is a friendly young person focused; non-judgemental nurse and the young people who come here see her as a member of the team who happens to be a sexual health nurse. This helps young women ask for help themselves in an environment that meets all their needs'.

Participant 42 reported 'Fully trained adequate staffing for such a sensitive group of people'.

Participant 35 reported 'All workers would have to be capable of giving a range of advice and support or not fall into the trap of 'shutting up and referring on'.

Participant 9 reported 'Staff from all service areas need to access training eg via local safeguarding children's board to gain much better knowledge/needs of sexually exploited young people'.

Participant 21 reported 'Understanding of grooming and abuse in sexual exploitation'

Participant 28 reported 'Health professionals to be more patient and be aware and understand some of the issues'.

Participant 39 reported 'Agencies to understand more about sexual exploitation and not to judge/make assumptions'.

<u>Service design and delivery</u>

Multi-agency approach

A multi-agency approach was considered to be important by respondents from phase 2 of this study:

Participant 23 reported 'Multi agency approach so that sexually exploited young people can access multiple services under the same roof. Interagency working is crucial particularly when a young person is being supported by a

number of services. This prevents duplication of support plans and promotes good practice'.

Providing information

Providing clear and good quality information was regarded as an important element of service provision:

Participant 54 reported 'Better information for parents/carers around what is exploitation and prevention'.

Participant 21 reported 'Better communication from some professionals towards young people'.

Participant 23 reported 'Appropriate literature, young people in sexual exploitation often do not see themselves as being exploited so service literature needs to reflect this'.

Meeting the health needs of sexually exploited young people

Reference was made to the importance of addressing the health needs of sexually exploited young people in a holistic way to ensure their needs were being adequately addressed:

Participant 6 reported 'By listening to what the young person may want and what they need. By giving them choices and not being forced to do something they don't want to do'.

Participant 21 reported 'Providing support that meets the needs of young people, not making young people fit the service provision'.

Participant 55 reported 'All health needs are addressed. Access to dentist, GP, optician, dietician, S/S promotes healthy lifestyles and have access to a sexual health nurse for sexually transmitted infections'.

Participant 46 reported 'Young people will initially present with lots of health needs as well as other complex problems. I feel that young people make their own priorities in their lives and health issues are often bottom of their list. Young people are only able and ready to address health needs when other crises have been dealt with. Crisis such as housing, relationships with coercers, money issues, drug and alcohol problems. Only when these issues are stabilized will young people be in a position to access health services'.

Participant 53 reported 'Physical, mental health needs of sexually exploited young people must be addressed as part of a common assessment framework/section 17, child in need assessment/Section 47 child at risk assessment'.

Participant 12 reported 'Sexual health education more sexual health group work in children's residential units. More emphasis on healthy relationships and the option of not having sex, given to young people'.

Participant 16 reported 'Better sex education. More together work with young men about sexual relationships and consent'.

Participant 55 reported 'Sexual health groups bring in specialists (e.g. sexual health nurse, drug workers, who are open and receptive to young people).

Participant 36 reported 'Suitable mental health services, where the young person is the focus, not the family. Improved access to quality counselling'.

Participant 34 reported 'More accessibility to listening services, i.e. counselling, can then be signposted to relevant authorities/agencies for specific needs being met'.

Participant 35 reported 'Offer food at a minimal, non-profit making price, may also help and act as an incentive to drop in, offering support in this way may offer an alternative option to those about to develop exploitative lifestyle as well as those who are further along the road in exploitation'.

Raising awareness and support for sexually exploited young people

Promoting awareness of sexual exploitation

Raising awareness of the issues encountered by sexually exploited young people was seen as important:

Participant 23 reported 'Need for awareness around sexuality issues especially for boys i.e. not all boys/young me involved in sexual exploitation

identify as gay/bisexual. Services need to be more understanding of the chaotic nature of these young people'.

Participant 53 reported 'Increased training, awareness raising amongst teachers, school nurses, social workers etc. regarding signs and symptoms of sexual exploitation'.

Participant 54 reported 'Improve collaboration between services, education in schools regarding positive friendships to prevent sexual exploitation and raise awareness of grooming'.

Participant 50 reported 'Education about health needs for sexually exploited young people so they are aware of their own needs'.

Participant 31 reported 'Greater awareness of staff around issues sexually exploited young people experience'.

Participant 28 reported 'Health professionals to be more patient and be aware and understand some of the issues'

Participant 50 reported 'By identifying health needs of young people at an earlier stage e.g. prevention rather than getting to a critical stage'.

Participant 16 reported 'More work with young people in schools about respectful relationships'.

Additional funding was cited as a requirement to adequately meet the needs of sexually exploited young people.

Participant 7 reported 'More funding for health services for sexually exploited young people'.

Participant 55 reported 'Increase in funding to provide specialist services'.

Summary of findings: Phase 2

The questionnaire was designed following interviews with 24 young people involved in or vulnerable to sexual exploitation; during phase 1 of this study. Sixty one professionals from 11 agencies supporting sexually exploited young people completed the questionnaire. The reasons for non completion of questionnaires are not known. Whilst these findings represent authentic accounts of health, risks and health seeking behaviour from the experiences of professionals supporting sexually exploited young people, they are essentially personal perspectives rather than empirical experiences of sexually exploited young people. Therefore these findings may be less credible than those presented in phase 1.

Respondents from phase 2 of this study reported a broad range of physical and psychological health problems and associated risk behaviours undermining health encountered by sexually exploited young people whom they had supported.

In terms of common physical health problems amongst sexually exploited young people, the majority of respondents reported having seen injuries, sexually transmitted infections and substance misuse. Dental and optical problems, scabies, stomach pain and poor uptake of immunisations were also reported.

In terms of mental health issues amongst sexually exploited young people, the majority of respondents reported having seen low self esteem, anxiety, low mood, self harm, suicidal thoughts, emotional problems, eating disorders, and behavioural problems.

Respondents identified other factors such as 'going missing', homelessness, harmful relationships, risky sexual behaviour, self neglect and not accessing health care, as having a negative impact on physical and psychological health and wellbeing generally.

Forty one percent of respondents reported that physical health needs were effectively met and this is suboptimal whereas 26% felt that physical health needs were ineffectively met.

Approximately 57% of respondents reported that psychological health needs were either ineffectively or extremely ineffectively met. Approximately 16% reported that psychological health needs were either effectively or extremely effectively met. The majority of respondents reported an unsatisfactory

situation regarding meeting the psychological health needs of sexually exploited young people.

The use of youth offending teams was reported as a frequently used service to address health issues and this was a novel theme that emerged from phase 2 of this study.

Frequently used services included substance misuse services, accident and emergency, general practitioners and contraception and sexual health services.

In contrast mental health services and the school nurse were reported as being used less frequently. Unimportant issues relating to health and unlikely to stimulate health seeking behaviour included improving personal health and preventative health initiatives.

Issues considered to be important and therefore likely to promote health seeking behaviour included feeling unwell, an emergency health problem, the service being valued and accessible with explicit confidentiality arrangements, the knowledge and reputation of the service, a gender and age specific service, being escorted to appointments and positive staff attitudes.

Integrated summary of findings from phase 1 and 2

The physical health issues described were generally similar in both phases of this study and were also located in the literature. Although there is limited

information relating to the mental health of sexually exploited young people, these findings were similar to existing knowledge on this topic.

The incidence of sexually transmitted infections was not raised as a significant issue by the young people interviewed. In contrast this was considered to be a significant issue by the professionals supporting sexually exploited young people. Sexual health has a high profile in services supporting sexually exploited young people and whilst staff appeared to be proactive in promoting a sexual health in order to reduce the incidence of sexually transmitted infections and unplanned pregnancies, young people may have been less aware of this agenda.

Described risk behaviours relating to substance misuse and sexual behaviour provided evidence to support accounts given by respondents from phase 1 and 2 of this study and knowledge located in the literature.

Factors that influence a young person to seek help for a health problem were described. Suggestions by respondents from both phases of this study predominantly supported existing knowledge. The new knowledge was that the gender of a person providing health support appears to be important to a young person, whereas respondents from phase 2 considered this to be unimportant. The rationale may be that young people may not be routinely offered a choice of gender of staff and may not request a male or a female. Therefore this may not have emerged as an issue.

Additional new knowledge was that the age of a person providing health support appeared to be important to a young person, whereas respondents from phase 2 considered this to be unimportant. This aspect of the care intervention may not have been raised as significant by the young person and staff may be unaware that it is important.

The range of services used by sexually exploited young people to address a physical or psychological health problem was reported similarly by respondents from both phases of this study. The exception was that the youth offending team was reported as a service where young people access health support, by professionals and not by young people. It is possible that young people in contact may be benefiting from health support there; however, the support may not be viewed as health support by the young person due to the non traditional style of support. The use of youth offending teams as an arena to address the health needs of sexually exploited young people was also not located in the literature reviewed. Data from both phases of this study suggested that the effectiveness of health services in meeting the physical and psychological health needs of sexually exploited young people is generally inadequate. The implications of these findings will be examined in the discussion chapter.

CHAPTER 10: DISCUSSION: Phase 1 and 2

Introduction

The research study question will be addressed in this chapter:

What are the health risks, health needs and health seeking behaviors of
young people involved in or vulnerable to sexual exploitation?

The health risks, unmet health needs and health seeking behaviours of young people involved in or vulnerable to sexual exploitation will be discussed from the perspective of young people involved in or vulnerable to sexual exploitation (phase 1 respondent data) and integrated with themes identified by professionals supporting sexually exploited young people (phase 2 respondent data). The study aims will be discussed in relation to the findings and the themes will be examined in the context of the wider literature. Reference will be made to the contribution that this study makes to gaps identified in the literature. The strengths and limitations of this study will also be highlighted.

Youth sexual exploitation and associated risks to health

The literature review identified gaps in relation to sexual exploitation and associated risks to physical and psychological health. A study aim was formulated to address this gap 'To explore the young person's perspective of risks to health'. Risks to health will be discussed in the context of physical and psycho-social factors and typology of risk behaviours. New knowledge relating

to sexual exploitation will be highlighted.

The research question explored the health risks of young people involved in or vulnerable to sexual exploitation. Risk taking is linked to sexual exploitation in several ways. The young person may have existing vulnerabilities that may pre-dispose them to being sexually exploited (for example a mental health issue); also sexual exploitation may heighten the young person's vulnerability to associated risks (for example, injury).

Risks to physical and psychological health were explored with respondents from phase 1 and 2. Alcohol and drug use were raised as significant in elevating vulnerability and linked to poor health outcomes (for example, cannabis use and paranoia). Problematic substance use tended to be co-terminus with harmful sexual behaviours, sometimes resulting in sexual assault or unplanned pregnancy. According to their own accounts young people who relied upon harmful adults to supply alcohol and drugs, also increased their vulnerability to sexual exploitation. Violence with resultant injuries was reported and often linked to 'going missing' from home, being homeless and associating with people with a tendency towards anti-social behaviour. Neglect of basic needs such as a healthy diet and personal hygiene were also reported by respondents from both phases and appeared to contribute to compromised health generally.

The types of risks identified amongst young people and professionals in this study concurred with the Risk Behaviour Concepts outlined by Colemann and

Hagel (2007) in terms of 'risk factors' (for example, homelessness), the young person 'at risk' (for example, sexual exploitation), 'risk behaviour' (for example, unsafe sexual behaviour), and 'being a risk to society' (for example, anti-social behaviour). All of the categories were located in this study. According to Pearce (2009) sexually exploited young people may be represented in each of these risk behaviour categories. The attitude towards risk taking by a young person is important because if the potential or actual risks to health are viewed as innocuous this is likely to influence health seeking behaviour by rendering the consequences insignificant. Additionally the issue of how risk to a young person is defined and interpreted by persons offering support is important as this will have an impact on their response.

Pearce (2007 p89) stated that whilst it is generally accepted that sexual exploitation constitutes abuse, it is debateable whether all young people consider themselves to have been abused. This is particularly pertinent to young people aged 16-17 years who may view selling sex as exercising choice and autonomy, possibly acquiring resilience to isolation and poverty. Notably, 2 young women in this study described themselves as sex workers and did not imply that they had engaged in abusive relationships. An alternative interpretation may be that young persons who sell sex are experiencing an economy of alternative options due to their circumstances.

Gill (2007) raised concerns about society becoming 'risk averse' in the endeavour to protect young people. Gill argued that a normal part of adolescence is to experience difficult situations and this helps a young person

to build resilience. Rutter (1985 p90) defined resilience as "the capacity to transcend adversity". Examples of resilience were located in this study (for example, several young people were engaging in further education).

The relationship between sexual exploitation, risk and resilience were examined by Pearce (2009). Pearce purported that whilst it is important to protect young people, it is equally as important to support young people in the development of resilience and protective strategies as this engenders "self help, agency and self-determination", both in the short and long term. Croom (2009) suggested that there are three groups of protective factors that help adolescents build resilience in adverse situations. These factors are individual, familial and community. Individual factors include: self-esteem, autonomy and sociability. Familial factors include: warmth, lack of discord and compassion. Community factors include social support systems. Sexually exploited young people from this study tended to lack many of these protective factors. This often resulted in a negative impact on their health.

Social factors that heighten risk and vulnerability and adversely affect a sexually exploited young person's health

Young people in Local Authority care.

Several young people in this study reported their experience of the Local Authority looked after system including foster and residential care. It has been recognised that being in the looked after system may heighten a young person's risk of being sexually exploited partially due to vulnerability factors that existed prior to being placed in care (Coy, 2008, Department for Children,

Schools and Families, 2009) and partially due to young people in residential care homes being targeted for sexual exploitation (Coy, 2008). Whilst being in the looked after system is not necessarily a pre-cursor to poor health outcomes, the added threats to health associated with sexual exploitation are likely to impact negatively on health and health seeking behaviour. Health and the experience of being in the looked after system, is linked in several ways. The young person may have experienced trauma prior to entering care and these may have manifested as physical and/or psychological health problems (for example, anxiety or behavioural problems (Department for Children, Schools and Families, 2006, 2009).

Alternatively, the young person may have been re-located several times reducing their ability to access health support from a familiar place. Guidance published to ensure that health needs of young people in the looked after system are adequately addressed (Department for Children, Schools and Families, 2009) identified that the health risks associated with looked after young people are similar to their peers albeit heightened. It has also been noted that young people in the looked after system tend to have experienced poverty, poor parenting, family discord, chaos, abuse or neglect. Other contributory factors to poorer psychological health may be frequent placement and educational changes and reduced access to support and advice.

Meltzer *et al* (2003) undertook a national survey of looked after children on behalf of the Office for National Statistics and found significant levels of mental health issues amongst looked after children up to the age of 15 years.

Forty five percent of looked after children were considered to have a mental health disorder with higher levels evident in those cared for in residential homes (72%). Haywood and James (2005) noted that the longer term health outcomes relating to looked after children are inferior to their peers. The Department for Children, Schools and Families (2009) made a recommendation that all local authorities are responsible for placing young people in a safe and healthy environment and for the provision of training for carers relating to health and safety, substance misuse and skills relating to managing challenging behaviour.

'Going missing' and homelessness

Several young people in this study stated that they had gone missing from home and had been homeless. The health and health seeking behaviour of young people who go missing from home and are homeless are negatively linked to sexual exploitation (Scottish Executive, 2002). Homelessness is linked to poor health outcomes amongst young people and the combination of homelessness and sexual exploitation increases vulnerability to compromised health. This may be as a consequence of difficulties accessing health care due to their transient and often chaotic lifestyle. The Department for Communities and Local Government (2007) stated that homeless young people are vulnerable to compromised physical and mental health and that favourable health outcomes are enhanced through joint planning and delivery of health, social care housing and voluntary sector agencies. This policy briefing highlighted the need for health services to be accessible to homeless young people and is pertinent to sexually exploited young people. According

to Cusick (2003) a homeless young person may be at an increased at risk of being sexually exploited as they may exchange sex for shelter. As stated previously this behaviour may be considered to be a viable option based on an informed choice by the young person, particularly if their options are limited.

Threats to physical and psychological health

Physical health

Behaviours that undermined physical health tended to also affect psychological health negatively. However, psychological health consequences were seldom mentioned by young people in this study and this suggested that physical health tended to be assigned a higher priority than psychological health. In contrast respondents from phase 2 of this study reported a range of mental health issues experienced by sexually exploited young people they had supported (for example low mood, anxiety and intentional self harm).

Psychological health

The ways in which young people view mental health were examined by Secker *et al.* (1998). Secker *et al.* (1998) found that young people tend to define health in physical rather than psychological terms, tend to separate out the words 'mental' and 'health' and view 'mental' as meaning illness. In this study young people appeared to be more able to articulate experiences of being physically unwell than psychologically unwell. Secker *et al.* (1998) also reported that young people consider factors that promote mental health to be:

personal achievement and feeling positive about yourself, family and friends and someone to talk to.

Croom (2009) identified three categories of risk relating to adolescent mental health problems.   These included individual factors (for example, low self esteem), environmental risk factors (for example, socio-economic disadvantage) and family risk factors. Negative characteristics associated with poor mental health in adolescents include parental physical and mental health issues or substance misuse problems, familial criminality, abusive relationships and a stressful psychological environment. All of these factors may be implicated with sexual exploitation and increase a young person's risk of being sexually exploited. Whilst families may contribute to poor mental health in some adolescents, in the context of sexual exploitation, the family may provide a protective function for the young person. Both negative family dynamics and the supportive role of family members were mentioned several times by young people and professionals in this study.

Several young people in this study described experiences of being psychologically unwell, self harming and suicidal ideation. Whilst the term 'hopelessness' was not mentioned by respondents, symptoms of lowered mood were described (for example, loss of confidence). The links between felt hopelessness and lowered mood is strongly associated with personal risk in terms of suicidal ideation (Barker and Buchannan-Barker, 2005). Respondents from phase 2 reported suicidal ideation and behaviours amongst sexually exploited young people they were supporting.

The relationship between stressful life events and psychological difficulties frequently appeared to be unrecognised by young people in this study. Problematic drug and alcohol use were cited as threats to psychological health with examples articulated (for example, anxiety whilst using cannabis). It was possible that the young people in this study, whose lives were particularly stressful, had become acclimatised to high levels of stress and therefore rationalised and normalised it. Recognition of the physical health problems manifested from psychological stress was described by several young people including symptoms of anxiety such as palpitations.

Levy (2004) noted that mental health problems tend to be reported considerably less than physical health problems in literature relating to youth sexual exploitation with a paucity of research relating to mental health. However, several examples of mental health issues were located in this study. Levy (2004) suggested that a sexually exploited young person may assume their identity through sexual exploitation resulting in feelings of self hatred, worthlessness and low self esteem, although insight into these consequences may be minimal. An alternative perspective to Levy may be that self hatred, worthlessness and low self esteem may precipitate the sexual exploitation rather than be a consequence of it. Examples of these negative attributes were located amongst some of the young people in this study. Young people and professionals reported the use of alcohol and other drugs to relieve emotional issues although this often contributed to increased levels of stress.

Frisher *et al.* (2007) suggested that a young person may use substances

prolifically to offset negative mood states through intoxication. According to the Social Exclusion Unit (2005)*,* lowered self esteem in a vulnerable young person may encourage self neglect and promote risky behaviours (for example, alcohol use, precipitating unsafe sex). Aggleston *et al.* (2000) also noted that low self esteem and low self worth may be a consequence of perceived lack of control and may undermine healthy sexual development in a young person being pressurised into having sexual intercourse.

Taxonomy of risk behaviours and youth sexual exploitation

An examination of risk taking was an aim of this study and was described in terms of presence or absence of autonomy in engaging in the behaviour associated with risk. The level of autonomy the young person had (or perceived themself to have) in a relationship with peers or an adult seemed to influence risk taking. Young people also described risk behaviours in terms of spontaneous and calculated risk. Conceptually, risk has many dimensions (Coleman and Hagel (2007), Croom, 2009) and at an individual level is highly subjective and organic rather than static. Therefore, it is likely that young people in this study may have altered their perceptions of risk in given situations and over time.

<u>Non-autonomous involvement in risk</u>

Non-autonomous involvement in risk was explored with young people in this study. This related to drug and alcohol consumption and sexual behaviour. Several young people described their experience of having been coerced with alcohol and drugs by another person in exchange for sexual favours. One

young woman reported that she had been physically restrained and forced to drink alcohol by several men and then sexually assaulted.

Three young women in this study reported having been sexually assaulted whilst intoxicated. Moore (1998) suggested that sexual assault is a common occurrence amongst sexually exploited young people although they tend to be underreported. This may be due to fear of the judicial process and anxiety about not being believed, especially if the person was sexually assaulted whilst procuring rewards for sexual favours. The incidents of sexual assault experienced by young people in this study may have exceeded the level of reporting.

As noted in the literature review, ideally, health professionals supporting young people should be alert to the possibility of substances having been used to facilitate sexual exploitation and to be able to recognise drug related risks (for example, intentional self poisoning).

Autonomous involvement in risk taking

Autonomous involvement in risk was discussed with young people in this study and tended to be linked to hedonism and as an antidote to emotional problems. Examples given related to excessive alcohol use, illicit drug use and unsafe sexual behaviour. Unsafe sex tended to occur whilst under the influence of drugs and/or alcohol. Frisher *et al.* (2007) argued that it is important to understand the context in which a young person takes drugs as this will be an indicator of how risk and protective factors influence

experimental and prolonged drug use. Frisher *et al.* (2007) suggested that preventative interventions targeting young people need to take into account the age of the young person and the associated risk factors as adolescents are exposed to risk throughout their life, some transitory and others persistent, and the impact of these varies at different points in time.

Calculated and spontaneous risk taking

Autonomous risk taking was described as either calculated or spontaneous. The consequences of engaging in behaviours which have the potential to undermine health and safety tended to be recognised retrospectively and usually following an incident (for example, sexual assault). However, negative experiences did not always deter the young person and appeared to be understated as a strategy to validate and sustain the risk taking behaviour.

Calculated risk taking was characterised by evidence of insight into some of the consequences. Calculated risks included problematic alcohol and drug use, unsafe sexual behaviour and 'going missing' from home. Some young people described engaging in risky behaviour to alleviate emotional problems (for example, binge drinking to combat stress). Several young people recognised the temporary nature of using substances remedially and attempted to minimise the harmful effects by monitoring and time limiting consumption. However, attempts at minimising harm were not necessarily successful as the degree of realistic insight into the harm varied with frequent understating of the resultant harm.

One young woman in this study described the calculated risk she had taken whilst homeless to secure a place to stay. This young woman described how she and her friend had exchanged sex with several men for shelter. Despite their insight into the risks to their health and safety, the women believed that they were limited in their options and had decided to take these risks rather than sleeping rough or returning home, which they perceived to be more harmful. According to Green *et al.* (1999) there is a negative correlation between selling sex, poverty linked to the young person's situation and the length of time they have been homeless. In relation to Green's suggestion, the young woman in this study who had sold sex had been homeless for a considerable time and was economically disadvantaged. Pearce *et al.* (2002) suggested that risk taking and vulnerability are related and often characterised by 'going missing' from home and becoming sexually active, rendering them identifiable to potential abusers.

Respondents from phase 2 of this study also reported ''going missing'' as risk behaviours they had encountered amongst young people they were supporting. This often resulted in inadequate and inappropriate living arrangements increasing other risk behaviours and undermining health. Homelessness tended to promote association with other sexually exploited young people, drug users and frequenting homes of sex offenders. These young people were also at increased risk of physical and sexual violence.

Young people in this study described risks they had taken spontaneously. Insight into the potential dangers tended to be considered retrospectively. The

motive tended to be hedonism (for example, accepting a ride in a car with unknown men in exchange for alcohol). Young people also described their hedonistic behaviour in terms of 'normal' teenage behaviour rather than in terms of risk.

Substance misuse as a risk to physical and psychological health

The majority of young people in this study had experience of drug use. Drugs such as cannabis and ecstacy were predominantly used recreationally. However, several young people reported being dependent upon heroin and crack cocaine. The links between sexual exploitation and substance misuse have been documented several times and tend to be linked as a pre-cursor to sexual exploitation or as a consequence of it, Frisher *et al. (*2007), Department of Health, Home Office and the Department for Skills (2000) Home Office (2004), Scott and Skidmore (2006).

Risks associated with drug use were generally known and had emerged from knowledge of peers who had encountered physical health problems (for example, contracting a blood borne virus) and from campaigns targeting young people. Although physical health problems associated with drugs tended to be considered after, rather than before, a physical health problem had arisen.

Parental drug use was reported by several young people in this study and according to the UK Advisory Council on the Misuse of Drugs (2003) children of drug users often have knowledge of their parents drug use and may

witness harm associated with the drug use. This knowledge may reinforce the damaging consequences drug use may have upon physical health, although being raised in a drug environment may acclimatise the young person to the inherent risks and promote personal drug use (UK Advisory Council on the Misuse of Drugs, 2003). One young woman interpreted the physical health issues encountered by her mother (an intravenous drug user) negatively and this deterred personal drug use.

Insight into the negative aspects of drug use was evident mainly amongst dependent drug users, with recreational drug users citing knowledge of other people's drug dependence as a deterrent to heavier personal use. Generally, cannabis, amphetamine and ecstasy were regarded as innocuous rather than risky, other than when harm had occurred. Problem recognition had prompted positive action in the form of seeking treatment for opiate dependent young people. However, 1 young woman had intentionally raised her levels of drug use related risk by injecting rather than smoking heroin in order to be eligible for a methadone prescription. This suggested a lack of insight into the risks associated with intravenous drugs (for example, contracting a blood borne virus). Alternatively, the young woman may have had sufficient insight into these risks and her motivation may have been ulterior (for example, to use it simultaneously with heroin). Notably, the research base in the UK for problematic substance use treatment for people below 18 is limited in particular pharmacological treatments for drug dependence and withdrawal. In a study by Melrose *et al.* (1999), young people displayed a considerable level of insight into the relationship between problematic substance use and sexual

exploitation by citing drug and alcohol detoxification as a route out of sexual exploitation.

The undesired effects of stimulants may be depression or suicidal ideation (NAC, 2003). Insight into the relationship between stimulants and low mood was apparent in some young people in this study and had influenced a reduction in consumption in most cases.

Alcohol and youth sexual exploitation

The majority of young people in this study described personal high risk alcohol use with several young people describing patterns associated with dependent alcohol consumption. Attitudes relating to alcohol appeared to be influenced by a range of factors including exposure to excessive familial (particularly parental) alcohol consumption and peers. Young people in this study who did not use alcohol tended to use drugs instead. The negative consequences upon physical and psychological health were recognised by several young people and this had encouraged them to modify their alcohol consumption and for some to seek help. However other young people had ignored the harmful effects of alcohol and continued to binge drink. Whilst young women were able to articulate the potential risks associated with accepting and procuring alcohol from adults, they stated that at the time the benefits seemed to out weigh the risks. Excitement, boredom and 'self medication' were cited as reasons to drink excessively. Whilst these reasons to drink are also typical amongst young people generally, there appears to be a relationship between the experience of sexual exploitation and alcohol consumption. From their

study, Scott and Skidmore (2006) reported the use of alcohol amongst sexually exploited young people both as a contributory facilitator and as a consequence of sexual exploitation.

Some young people viewed high risk alcohol use as a normal aspect of adolescent life, whilst others recognised the links between alcohol use and physical health problems.

Negative consequences of alcohol use reported included the experience of blackouts, accidental and non-accidental injuries, withdrawal symptoms such as vomiting and shaking and chronic physical health complications (for example, gastro intestinal problems). Perceptions of the physical health implications associated with alcohol were varied and seemed to stem from the young person's experiences. One young woman who had been sexually assaulted had felt anxious about reporting the assault to the police as she believed that her level of intoxication during the assault would undermine the credibility of her statement. This woman articulated that alcohol had heightened her vulnerability towards being sexually assaulted.

The UK Advisory Council on the Misuse of Drugs (2003) further reinforced the role of alcohol in sexual exploitation and stated that alcohol and/or drug use may be used to combat feelings of isolation and lowered self esteem, both are believed to increase the young person's vulnerability to exploitation.

Young people frequently obtain alcohol form their parents (Department of Health, 2007b), and this was cited in this study. In addition to possible legal consequences in providing alcohol, the parent may be inadvertently lowering the harmful aspects of alcohol and influencing the young person's attitude towards alcohol consumption.

The majority of young people in this study stated that they smoked tobacco, with many smoking cannabis and a minority smoking crack cocaine. The risks relating to smoking both tobacco and cannabis seemed to be recognised although many young people continued to smoke. Pregnant women in this study appeared to be the most committed to stopping smoking to reduce the potential risks to their baby.

The Health Development Agency (2004) suggested that young people are less likely to smoke if adults in their environment do not smoke. Perceptions of risks associated with smoking seemed to emanate from school and the media. Anecdotally, insight into the risks associated with a particular behaviour may encourage risk taking in an alternative form. According to the Department of Health (2007b) it is estimated that young people are drinking more now than young people were a decade ago and speculatively, this may be due to peer pressure and the changing insight and attitudes towards the harms related to smoking.

Sexual behaviours as a risk to physical and psychological health

Insight into high risk sexual behaviour varied amongst young people in this study and this seemed to be influenced by their personal experiences and those of other people. Harmful sexual behaviour included exchanging sexual favours for alcohol, drugs and shelter. Prevention of unplanned pregnancy and protection from transmitting or acquiring a sexually transmitted infection were the most frequently cited concerns relating to sexual health.

However, despite a comprehensive level of knowledge and insight into sexual health and pregnancy there were several examples of personal experiences of acquiring a sexually transmitted infection. Seven of the women in this study reported an unplanned pregnancy. Sexual health knowledge appeared to have been acquired retrospectively by the majority of young people in this study with experience of a sexually transmitted infection precipitating the knowledge.

Pearce *et al.* (2002) recognised that teenagers are prone to taking risks and testing authoritative boundaries; sexual risk taking may be a means of rebelling and generating fear amongst those around the young person.

Three of the women in this study described themselves as 'prostitutes' and viewed sexual health problems as a potential occupational hazard and therefore had regular sexual health screens. Sexual health was seen as a priority by the staff in the agencies supporting the young people. Young people in this study had been informed about, or escorted to sexual health clinics by staff. Sexual health screening was regarded as a routine aspect of

health care by agency staff and this attitude appeared to be adopted by the majority of young people they were supporting which positively influenced their behaviour in terms of using condoms and engaging with sexual health services.

Psychological consequences of risky sexual behaviour were recognised when an adverse event had occurred (for example, police intervention). Whilst the risks were often recognised, the benefits appeared to outweigh the risks at that time. Reported psychological consequences of risky sexual behaviour included lowered mood, anxiety and reduced self worth. Pearce (2009) raised the point that in supporting sexually exploited young people it is not uncommon for the sexual activity to be the main area of concern for the professional, with the emotional and psychological health of the young person receiving a lower profile.

Personal strategies to avoid and reduce risks to health
Strategies employed to avoid and reduce risks to health were discussed with young people in this study. Whilst it was not always possible for young people to avoid or minimise harm to themselves, some examples were given (for example, using contraception). Harm minimisation and risk avoidance were initiated both by the young people and in conjunction with supportive people in their lives, such as family members and staff from agencies they were engaged with. The genesis of the motivation to avoid or minimise risks typically came from the young person themselves, usually following a negative experience such as an assault. Other people in the young person's lives were

also reported to have been a catalyst to change including the police or a peer.

Youth sexual exploitation and unmet health needs

The literature review identified gaps related to sexual exploitation and unmet health needs. A study aim was formulated to address this gap 'To identify the physical and psychological health needs of young people involved in, or vulnerable to, sexual exploitation'. Unmet physical and psychological health issues will be discussed in the context of sexual exploitation with an emphasis on significant levels of intentional self harm, and higher risk and dependent alcohol use as new knowledge located in the sample data.

Unmet physical health needs

Physical health tended to be described in terms of absence of illness or disease by most of the young people in this study and was frequently contextualised by the experience of other people's health problems. This concept of health and illness resonates with the biomedical disease model which tends to be disease rather than health focused and is anchored in the value of detecting and curing diseases (Bradby, 2009). Limitations of the biomedical disease model are evident in its concern with symptomology as evidence for the existence of a health issue rendering less visible health issues as less significant (for example, depression).

Several young people described their health as good, apart from a variety of childhood illnesses they had experienced such as German measles. Notably, the absence of routine childhood immunizations was reported by respondents

from phase 2 of this study. Other physical health problems reported included non-accidental injuries, blood borne viruses (namely hepatitis B and C), dental and optical problems and scabies.

Motivation to be healthy was discussed and whilst there appeared to be a desire amongst most of the young people in this study to be healthier, the levels of motivation to engage in a healthier lifestyle varied. This seemed to stem from ignorance, apathy, low self esteem and having to prioritise other needs (for example, feeling safe). All respondents from phase 2 reported low self esteem as an issue amongst young people using their service and as being the most prevalent, very frequently occurring, psychological issue. Beck linked lack of motivation and hopelessness with depression. All of these negative characteristics are likely to affect a sexually exploited young person's ability to access health support.

Motivation was described in several ways by young people in this study. For example, motivation to be healthy by refraining from behaviours harmful to health, and motivation to promote healthy behaviours were discussed. Motivation to seek support for a health problem was also described. Young people in this study reported having been offered an intervention they did not want at that time and that services had not been available when they had needed them. These were examples of a mismatch in the motivation of the young person in accessing health support and the timing of the support being offered. These factors potentially undermined the young person's ability to access health support.

The intentions of some of the young people in this study appeared to have indicated a desire to be healthy, although this was not necessarily supported by behavioural actions. Robson (2004) pointed out that there is a lack of relation between attitude and behaviour, with intention not necessarily resulting in action.

A range of activities undertaken to promote physical health were described by young people in this study (for example, jogging). Exercise tended to be linked to weight management and was also described as a strategy used to combat low mood and stress. These positive health actions may be explained by 2 constructs located in the Health Belief Model (Becker, 1974) which suggest that threat appraisal and behaviour evaluation are central to the decision making process in terms of protecting one's health.

Eating problems were considered to be a common physical health issue by all respondents from phase 2 of this study and several young people from phase 1. Health problems associated with food were mentioned with 5 young people describing being under weight, 3 of whom said they were anorexic. Two of these young people stated that they were overweight. According to the National Institute of Clinical Excellence (2004a), sexual abuse is linked to lowered self esteem and mood which are related to eating disorders. However, the relationship between these matters is complex and requires further exploration to examine what the direction of causality may be.

Unmet sexual health needs

Sexual health was the most frequently discussed health topic amongst respondents from both phases. Young people in this study described their experience of sexual assault, sexually transmitted infections and termination of unplanned pregnancy and miscarriage. The majority of young people were able to discuss common sexually transmitted infections and stated that they used genitourinary clinics. This knowledge seemed to have been acquired through personal experience of having contracted a sexually transmitted infection and having subsequent contact with genitourinary medicine clinics. Despite young people in this study reporting an awareness of sexually transmitted infections, respondents from phase 2 reported sexually transmitted infections as the second most frequently occurring issue in the physical health category. This suggests that awareness is not necessarily a pre-cursor to preventative action. The increased prevalence of sexually transmitted infections amongst sexually exploited young people has been frequently documented (Shepherd *et al*, 1999, Department of Health, 2001a). The Home Office (2004) stated that under usage of condoms and sporadic use of genitourinary medicine and contraceptive services are commonplace amongst sexually exploited young people. According to the Department of Health (2001a), complications relating to sexual health may include pelvic inflammatory disease, HIV, cervical cancers, Hepatitis and chronic liver disease and unplanned pregnancy.

Respondents from phase 2 reported that gynaecological and pregnancy complications tended to be seen on an occasional basis amongst the young women they were supporting. However, there were 7 reported unplanned

pregnancies, 2 resulting in a miscarriage and 1 in a termination of pregnancy. To address the issue of escalating teenage pregnancy rates in England, the Government set a target in 2004 to reduce teenage pregnancy amongst under 18s by 50% before 2010 (Department of Health and Department for Education and Skills, 2004).

Regarding unmet sexual health needs the Department of Health (2001a) pointed out that despite targeted sexual health campaigns to reduce sexually transmitted infections in England, these have escalated amongst young people. Earle *et al.* (2007) pointed out that whilst communication is the bedrock of public health action, it is more complex than simply imparting knowledge and facts to others. They suggested that effective public health communication requires consideration of power differentials and relationships. This is very pertinent with young people, particularly those who have been sexually exploited, and requires consideration of how sexual exploitation is defined by the young person and the professional offering support, as these factors will influence the approach taken.

Unmet needs relating to substance misuse and psychological health
Substance misuse
Substance misuse and sexual exploitation is co- terminus; with one reinforcing the other (Cusick, 2003). Combined, the two may heighten a young person's vulnerability to compromised health and social issues (for example, homelessness) (Department for Children, Schools and Families, 2009). Substance misuse is implicated in sexual exploitation in several ways. Drug or

alcohol dependency may exist prior to the abusive relationship or be a consequence of it (Chase and Stratham, 2004).

Sexually exploited young people who use alcohol and /or drugs are considered to be a special group, requiring a proactive response by professionals, due to the inherent risks associated with these behaviours. Notably, a young person who does not consider themself to be sexually exploited is likely to resist unwanted interventions. An additional dimension may be a mental health issue, arising from the use of alcohol and/or drugs, such as: lowered mood, anxiety, paranoia, psychosis, self harm and suicidal ideation, as reported in this study. According to Kofoed (1997) people with mental health and substance misuse issues often also experience a sense of hopelessness. The presence of hopelessness may affect health seeking behaviour with the young person less likely to seek help.

Problematic drug and alcohol use were cited with varying patterns of use, from experimental and recreational use to dependency. Respondents from phase 2 reported drug and alcohol use, as the most very frequently occurring issue amongst young people they were supporting. The findings in this study are similar to those located in a study by Aust *et al.* (2002). Aust *et al.* (2002) found cannabis and ecstasy to be the most commonly used drugs followed by cocaine, with crack and heroin used by only a minority of young people. In concordance with this study, Aust *et al.* (2002) also found that most of the reported drug use was recreational rather than dependent use.

The majority of drug and alcohol use tended to be harmful rather than dependent use. Twenty young people from a sample of 24 declared drug use, one did not discuss drugs and 4 reported no drug use. The most commonly used drugs were cannabis, ecstasy and amphetamine, with a minority of young people reporting use of benzodiazepines, crack, cocaine, dihydro-codeine, amyl nitrate and gas.

The National Institute of Clinical Excellence (2007) identified physical and behavioural consequences of substance misuse such as skin complaints, weight loss, poor appetite or eating binges, irritability, impaired concentration, relationship difficulties, reduced school performance, fatigue, lethargy and uninhibited behaviour.

Drug and alcohol use may increase a young person's vulnerability to becoming engaged in an exploitative relationship due to reduced inhibitions and the effects of the drugs (Department of Health, Home Office and Department for Education and Skills, 2000, Home Office, 2004, Home Office, 2007). However, interpretations and definitions of sexual exploitation vary and the young person may be exercising autonomy and choice. Additionally drugs and alcohol may be offered to a young person in exchange for sexual favours (Levy, 2004, Palmer, 2001, Campbell and O'Neill, 2006). The UK Advisory Council on the Misuse of Drugs (2003) stated that young female drug users are more likely to pay for drugs by exchanging sexual favours for money. Several young people in this study reported funding personal drug use

through selling sex. These behaviours may be viewed as a viable economic choice or as a lack of alternative options.

Cusick *et al* (2003) suggested that dependency is a significant factor in facilitating a young person's entry and retention in sexual exploitation. Early engagement with drug treatment services is central to breaking the cycle of drug dependency and sexual exploitation, and discouraging movement into formal prostitution.

Amphetamine (a stimulant drug) was used by approximately one third of the young people in this study. Several young people reported symptoms related to undesired effects of amphetamine including anxiety, exhaustion, low mood, extreme weight loss, psychosis, hallucinations, delusions and aggression (National Addiction Centre, 2003 (NAC).

May *et al.* (1999) suggested that, in the context of sexual exploitation, stimulants may be a contributory factor in lowered mood and also used to offset negative mood states. Scott and Skidmore (2006) and the Home Office (2007) suggested that young people may use drugs and alcohol to enable them to cope with emotional pain associated with abuse and this was reported in this study.

Crack (a stimulant drug), is a smokeable form of cocaine hydrochloride (NAC, 2003), and was reported to be used by a minority of young people in this study. Crack has been associated with sexual exploitation for a considerable

time and may be used as payment for sexual favours, although this was not reported in this study. According to the Home Office (2002) crack cocaine is commonly used by sex workers due to its stimulant and disinhibitory properties, and being less readily detected through a drug screen.

Alcohol was used by the majority of young people in this study; either for pleasure or to alleviate emotional problems. A couple of young people had exchanged alcohol use for drug use. According to the respondents from phase 2 of this study, alcohol use tended to be a very frequent feature and was reported as the most frequently occurring issue on the physical health scale. The Health Advisory Service (2001) stated that substances (including alcohol) are used by young people for: enjoyment, curiosity, as a defence mechanism, to rebel and due to their promotion and availability. Only 3 young people reported no alcohol or drug use with 5 using drugs and no alcohol.

The Department of Health (2007b) argued that there is a correlation between alcohol dependency in adulthood and alcohol use below the age of 14. Young people in this study described established patterns of alcohol use from as early as 14 years. May *et al.* (1999) examined the relationship between sex markets, alcohol and drug use and discovered that young people, typically as young as 14 years, tended to have an established pattern of regular alcohol use.

According to the Department of Health (2007b) alcohol is commonly used by people who have experienced sexual violence or abuse as a coping strategy.

However, Levy (2004) argued that the ameliorating effects of a substance are time limited and eventually the person will experience problems with the substance use. Negative consequences of alcohol use were located in this study (for example, sexual assault whilst intoxicated). The implications of binge drinking may be accidents, health problems, including alcohol poisoning, unsafe sex and school exclusion and being a perpetrator or victim of violence (Prime Minister's Strategy Unit, 2004, National Treatment Agency, 2007). All of these consequences were reported by young people in this study.

The majority of the young people either engaged in high risk (binge drinking) or dependent alcohol use. Raistrick *et al.* (2006) defined harmful drinking as the consumption of alcohol exceeding medically recommended limits, with evidence of alcohol related problems including physical, psychological or social. Dependent drinking tends to be defined by evidence of tolerance and withdrawal symptoms, relief drinking and reduced control over drinking (Raistrick *et al*, 2006).

Young people in this study displayed varying degrees of insight into some of the harmful effects of binge drinking. According to the *Alcohol Harm Reduction Strategy for England* (Prime Minister's Strategy Unit, 2004) insight may stem from recognition of the relationship between alcohol, unsafe sex, injuries and offending behaviour. Six young people reported that they had become violent whilst intoxicated with alcohol resulting in criminal justice intervention. According to the Department of Health (2007b) under 18s are

identified as most likely to commit a crime or to harm themselves or other people as a consequence of excessive alcohol consumption.

Psychological health

Psychological health problems were identified by several young people in this study (for example, lowered mood). Understanding psychological health appeared to be more difficult than understanding physical health, with young people showing a tendency to rationalize psychological difficulties they had experienced. This may have been due to their limited frame of reference to psychological health issues. Whilst psychological health appeared to be regarded as important this seemed to be less important than physical health, apart from when psychological problems had been present.

Anxiety and lowered mood were reported as 'frequently' or 'very frequently' seen amongst young people, by all respondents from phase 2, with low self esteem being the most prevalent 'very frequently' occurring psychological health issue. Lowered mood, impaired memory, paranoia and auditory hallucinations appeared to be linked to cannabis and cocaine use although, according to respondents from phase 2, hallucinations were seldom seen. In contrast self harm tended to be a 'frequently' seen behaviour with suicidal thoughts reported as 'very frequently' seen. Knowledge of suicidal behaviour amongst young people using their service was also reported as seen by respondents from phase 2. Emotional problems were considered to be the second most 'very frequently' occurring psychological issue, with behavioural problems having been reported by 50% of the respondents from phase 2 as,

'very frequently' seen. Respondents from phase 2 generally reported that the psychological health needs of sexually exploited young people were inadequately addressed. This may be due to the general visibility of physical health problems and the, often, more discreet nature of psychological health problems.

The experience of anxiety and panic were commonly reported and linked to stressful life situations. Young people displayed varying degrees of insight into these links and those with a better understanding of anxiety described a range of self taught techniques they had employed successfully to combat anxiety and panic. These techniques were relaxation, breathing exercises and guided fantasy. A desire to avoid medication and side effects had prompted the exploration of alternative ways to manage anxiety by 2 young people

Lowered mood was raised as an issue amongst several young people in this study and seemed to be linked to life stressors and problematic substance use. Articulation of the symptoms of lowered mood varied. Some young people had recognised that they were feeling low, whilst others appeared to internalise their feelings of sadness, and externally expressed anger either towards themselves or other people. A combination of life stressors, in addition to the experience of sexual exploitation, seemed to have eroded self esteem and confidence. Despite challenging situations and experiences that many young people had had to deal with, there were examples of resilience in combating lowered mood. The main strategies used were talking to other people and writing about personal traumatic life experiences.

Several examples of ineffective coping strategies were given including: tolerating symptoms of lowered mood and anxiety. Examples of self defeating behaviour were described as a mechanism to combat lowered mood and anxiety. For example, illicit substances and alcohol were used to alleviate emotional distress.

According to Corby (2006) sexual abuse may be a catalyst for a range of psychological problems including lowered mood, low self-esteem, guilt, hostility and aggression, anxiety, suicide, problematic substance use and eating disorders. The manifestation of mental health problems amongst sexually exploited young people has been identified in several research studies (Harris and Robinson, 2007, Shepherd *et al*, 1999, Mind, 2007, Willis and Levy, 2002, Pearce *et al.* 2002, Itzin, 2006).

The Department for Children, Schools and Families (2009) also suggested that sexually exploited young people may be at increased risk of developing a range of emotional and behavioural issues including anti-social and aggressive behaviour (for example, offending), risk taking behaviour (for example 'going missing'), low self esteem, negative self image, intentional self harm and eating disorders. All of these issues were reported in this study.

The National Institute of Clinical Excellence (2005) stated that childhood sexual abuse may lead to the development of post traumatic stress disorder (PTSD). Within the paradigm of viewing sexual exploitation as sexual abuse, the symptoms of PTSD are an important consideration. Although PTSD was

not reported by any young person in this study, there was a description of symptoms by several young people in this study which may lead to a formal diagnosis of PTSD including: flashbacks, nightmares, emotional numbing, distress, hyper-arousal and avoiding anything that may remind the sufferer of the traumatic experience. A young person experiencing post traumatic stress may be more prone to both emotional and behavioural problems which in turn may disenfranchise them from accessing health care. The National Institute of Clinical Excellence (2005) suggested that the assessment of PTSD should be undertaken by a competent practitioner and should incorporate physical, psychological and social needs and an assessment of risk. It has been suggested that PTSD is difficult to diagnose in a young person and that treatments for adults with PTSD are better developed than those for young people.

According to respondents from both phases of this study, sexually exploited young people often present to health and social care services with emotional and behavioural problems. These behaviours may have contributed to criminal justice involvement and may have been interpreted as anti-social behaviour. Within a mental health system anti-social behaviour may be interpreted as related to anti-social personality disorder. However, the diagnosis of personality disorder is discouraged for persons below 18 years (National Centre for Clinical Excellence, 2010). Young people displaying anti-social behaviour may be difficult to engage and lack concordance with health services. Paradoxically sexually exploited young people tend to have significant levels of support needs with lower levels of capacity to marshal

support in these services (due to their behaviour) (Scott and Harper, 2006, Scott and Skidmore, 2006). Behavioural and emotional problems may be indicators of abuse, therefore it is important for staff to be able to respond effectively to young people who present this way to services. The Common Assessment framework is recommended as the tool to assess comprehensively the health and social care needs and risks of vulnerable young people such as sexually exploited young people (Department for Children, Schools and Families, 2009).

Pearce (2009) purports that a barrier to accessing support, for a sexually exploited young person experiencing emotional and behavioural issues, may be an absence of services and skilled staff able to address their specific needs.

Sexually exploited young people are considered to be at higher risk of attempting or completing suicide as they are more likely to match some of the identified risk factors. Risk factors include mental health difficulties, social problems and adverse life events (*National Suicide Prevention Strategy for England*, Department of Health, 2002a). Other consequences of sexual exploitation may be difficulties forming relationships, employment and parenting problems (Department of Health and Department for Education and Skills, 2004). Several young people in this study had attempted suicide, and respondents from phase 2 had knowledge of suicide attempts amongst young people they had supported.

Meltzer *et al.* (2002) suggested that self harm is more common in adolescence and young adulthood than in any other age group. According to Mind (2007) suicide is more common amongst young people who have experienced sexual or physical abuse. Meltzer (2002) and Hawton *et al* (2002) suggested that there are correlations between self harm and sexual abuse. The National Institute of Clinical Excellence (2004) stated that there are links between self harm and socio-economic deprivation, problematic substance use, mental illness, and domestic violence. All of these factors are associated with sexually exploited young people, which may heighten their propensity towards self harm.

Approximately 25% of the young people in this study reported intentionally cutting themselves, with 3 having self poisoned, 1 person had swallowed razor blades and another had sniffed gas with a suicidal intent. Several young people in this study stated that they had not sought support for their self harming behaviour. However, other young people did ask for help from teachers at school, rather than from health services staff due to a higher level of confidence in confidentiality.

It has been suggested that many young people's mental health needs tend to go unrecognised and therefore untreated (Department of Health and Department for Education and Skills, 2004). This is particularly pertinent to vulnerable young people who tend to avoid services, such as sexually exploited young people. A further barrier to mental health support may be the young person's reduced level of insight into their mental health issues. Mental

health difficulties may be an indicator that a young person is being sexually exploited therefore early identification and early interventions are important in terms of optimising positive outcomes (The Scottish Executive, 2004).

Examples of ineffective mental health support were discussed with several young people viewing a referral to a mental health service as medicalising emotional problems with a stigmatising effect. In relation to mental health support the Home Office (2006) raised the issue that accessing child and adolescent mental health services is often slow, despite the fact that mental health support is a key feature of support for children who have been abused.

The green paper entitled *Every Child Matters (*Department for Education and Skills, 2004) required all staff in all agencies supporting young people to be able to: recognise mental health problems, offer advice, support and to be able to refer to appropriate services when necessary. This was particularly pertinent to staff working in agencies supporting young people who are at risk of, or have been, sexually exploited. The Department of Health, Home Office and Department for Education and Skills (2000) stated that health professionals may be amongst the first to recognise that a young person is at risk of, or involved in, sexual exploitation and therefore have a vital role in offering physical and mental health support.

Health seeking behaviour of young people involved in or vulnerable to sexual exploitation

The literature review identified gaps related to the health seeking behaviour of young people involved in, or vulnerable to, sexual exploitation. Two study aims were formulated to address these gaps: 'To identify barriers to meeting the physical and psychological health needs of young people involved in or vulnerable to sexual exploitation' and 'to make recommendations regarding strategies to improve health service utilisation for young people involved in or vulnerable to sexual exploitation'. Health seeking behaviour will be discussed in the context of sexual exploitation with an emphasis on health service access and utilisation and the use of youth offending teams as new knowledge located in the sample data.

Young people and professionals in this study identified health seeking behaviour barriers and facilitators to meeting physical and psychological health needs. Personal, interpersonal and external factors were described in the context of seeking, avoiding, accepting and rejecting health oriented support. Effective, ineffective and preventative support strategies were also reported.

Young people described personal factors that may define sexually exploited young people as a 'special group' requiring specific responses in health terms. A sexually exploited young person may regard themself as a 'prostitute' and therefore avoid health services to discourage unwanted social welfare or criminal justice interventions. Additionally, the young person may be seen as a prostitute by others and considered to be less deserving of support. A further rationale for avoiding health support may be low self efficacy. According to

Ormrod (1999) Self efficacy refers to whether the person believes they can or cannot change their behaviour. Ormrod purports that people are more inclined to engage in behaviours that they feel able to do successfully. Conversely, a lack of self efficacy may be a deterrent to engaging in certain behaviours (for example, stopping smoking). Self efficacy is an important concept in the context of this study as low self efficacy may offer a rationale for poor health choices amongst sexually exploited young people. For example in this study 'reducing cannabis use' was cited as an example of high self efficacy, whereas continuing to use alcohol despite evidence of physical harm implied low self efficacy.

Young people described their experiences of seeking help a) proactively; as a preventative measure to optimise health and b) reactively; in response to an identified health issue. Factors which influenced a young person's decision to seek help included other people and the style, presentation and knowledge of services. Some young people cited recognising the benefits of asking for help, based on a positive personal experience or the experiences of acquaintances, as a factor motivating them to seek help.

The predominant themes to emerge from both phases related to the young person either needing, or desiring, help for a particular health problem. Feeling unwell and addressing an emergency health problem, were cited as important by respondents from phase 2. However, in contrast to the views of young people in this study, health improvement, illness prevention, age and gender of staff were considered to be less influential in health seeking

behaviour by respondents from phase 2. Young people described their experience of recognising that they needed support for a health problem, initially accepting the help available to them and then rejecting it. The rationale offered was that the service had failed to meet their expectations, which were occasionally unrealistic.

Young people who viewed the service on offer as valuable were more inclined to accept help. In particular practical support and offering the young person what they required, within an acceptable timeframe, was considered to be important. In addition to valuing the support, perceiving the quality of support and environmental aesthetics were cited as important.

Respondents from phase 2 reported factors that positively influenced health seeking behaviour in young people involved in, or vulnerable to, sexual exploitation. These factors included: good accessibility, a positive staff attitude and gender and age specific services. The reputation and knowledge of the service, clear confidentiality policies and acceptable waiting times were also considered to be important.

Young people were asked to state the places they had typically used to address a physical or psychological health issue. The catalysts for health seeking behaviour tended to be health promotion, disease prevention, risk reduction or to attend to an existing health problem. A range of services used were reported, including services that were specifically health oriented such as: a dental practice, casualty, a medical/health centre to see a general

practitioner, pharmacies, substance misuse services, contraception and sexual health clinics, counselling services and child and adolescent mental health services.

Respondents from phase 2 of this study reported that mental health services tended to be used infrequently by sexually exploited young people. Speculatively, this may indicate that the young person does not recognise they have a mental health issue or realise that support is available. Sexually exploited young people tend to experience a multitude of health and psycho-social issues characterised by high levels of risk and need. Feelings of hopelessness situated in lowered mood may further disenfranchise the young person from support services.

Phoenix (2003) suggested that agencies offering support to sexually exploited young people in Britain tend to develop from sexual health or drug services, partly due to the prevalence of sexually transmitted diseases and drug problems amongst this group. Phoenix raised the point that sexually exploited young people may present at any health service therefore staff require the skills to respond appropriately. Ideally, physical health problems ought to be addressed in a range of agencies, with the option of signposting the young person to an alternative health service.

Public services which were not specifically health oriented, but provided health support were also cited as examples of places the young people had contacted for support for a health matter. These included schools, sexual

exploitation services and youth offending teams. Respondents from phase 2 of this study reported that young people they were supporting tended to access support for a health problem from contraception and sexual health clinics, substance misuse services and youth offending teams.

Sexual exploitation and youth offending teams are linked in several ways. The young person may offend and the young offender may be at an increased risk of being sexually exploited partially as a consequence of their criminal involvement and exposure to abusive adults.

Historically, an emphasis has been placed on the need to disassociate youth offending and sexual exploitation. This stems from the shift in the legal and social welfare systems in regarding sexually exploited young people as victims of abuse requiring protection, rather than criminals requiring prosecution (Home Office, 2004). However, more recently, there has been a recognition of the utility of youth offending teams in offering health support to sexually exploited young people, through a tailored assessment of their needs and risks. It has been recognised that current assessments used in youth offending services do not necessarily identify sexual exploitation, although youth offending teams may be ideal to offer health support to sexually exploited young people and to signpost them to other health services (Paskell, 2010). The Department for Children, Schools and Families (2009) further highlighted these issues and stated that whilst sexually exploited young people should not be treated as criminals, youth offending teams have an important role in supporting those who offend and recommended clear

pathways between youth justice and local authority children's social welfare services. It has been suggested by professionals supporting sexually exploited young people that health interventions initiated from a youth offending team (for example, alcohol reduction regime) may contribute to breaking the cycle of re-offending by addressing underlying factors related to sexual exploitation.

The influence of family and other people on health seeking behaviour

Family members and other people involved in a sexually exploited young person's life may influence health seeking behaviour both positively and negatively. The Department for Children, Schools and Families (2009) stated that recognition of dysfunctional family dynamics and social relationships is important and may be indicative of sexual exploitation (for example, the young person's peer group may be other sexually exploited young people). Several young people suggested that support ought to be available for their families and significant others involved in their lives.

In this study young people cited the influence of their family and other people as a rationale for seeking help. Practical interventions (for example, arranging a health appointment) were frequently cited as an intervention that would encourage the young person to attend. People involved in the young persons' lives (for example, family and teachers) were frequently instrumental in influencing help acceptance. This was described in terms of an incremental approach and included encouraging the young person to accept help, making a referral on behalf of the young person, and/or escorting them to an

appointment. Appointments made by a trusted adult positively influenced the young person's decision to attend.

The role of schools in responding to young people involved in, or vulnerable to, sexual exploitation

Schools have an important role to play in improving health outcomes for young people involved in, or vulnerable to, sexual exploitation. The role and function of schools in the context of sexual exploitation are linked in several ways. Sexually exploited young people are at an increased risk of disengaging with school, going truant and under performing, resulting in poor educational attainment (Department for Children, Schools and Families, 2009). Primary and secondary schools play an important role in both the identification and prevention of sexual exploitation by educating young people to understand and manage risks and be able to make informed choices. There have been several developments in schools in terms of prevention of sexual exploitation, including the introduction of 'Sex and Relationship Education', delivered as part of the Citizenship and 'Personal, Social, Health and Economic' aspect of the curriculum (Department for Education and Employment and Qualifications and Curriculum Authority (1999). In 2000, the Department for Education and Employment published good practice guidance for schools relating to sex and relationship education. Sex and relationship education forms part of a standard within the National Healthy School standards. The aims of this guidance were: to advise schools of the legal minimum requirement, offer guidance to sex and relationship policy development, illustrate how to embed

sex and relationship education into personal, social, health and economic education, offer guidance to teachers regarding sensitive issues, suggest practical approaches to teaching and address confidentiality issues. Core components of 'Sex and Relationship Education' are safe and healthy relationships, staying safe and help seeking. A statutory duty will be placed on all schools in 2011, to deliver these aspects of the curriculum (Department for Children, Schools and Families, 2009).

Barnardos have been instrumental in delivering preventative sexual exploitation education in schools and pupil referral units with an emphasis on appropriate relationships. In 2009/2010 Barnardos provided this education to 10,337 young people in England (Barnardos, 2011).

The quality of the alcohol, drug and sexual health education in schools was identified as inadequate by respondents from both phases in this study. In addition to education, young people suggested more direct health support to be available in schools.

The National Institute of Clinical Excellence (2007) suggested that interventions targeting vulnerable and disadvantaged young people who use drugs are provided in a range of formal and informal settings to avoid stigmatization. As sexual exploitation and substance misuse are mutually reinforcing, these initiatives should prove beneficial to this group. Alcohol education in schools is a statutory requirement of the *National Curriculum Science Order* and is delivered through personal, social, and health

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education. In secondary schools alcohol education is delivered through the Citizenship initiative and is a theme within the *National Healthy School Standard* (Prime Minister's Strategy Unit, 2004).

Staff characteristics as an influence on health seeking behaviour

Young people appeared to formulate their perception about a service based on either personal experience or the reputation of the service. The reputation of a service was frequently anchored in the quality of the interpersonal skills displayed by the staff. The interpersonal skills of the service provider need to be commensurate with the needs of sexually exploited young people as they tend to have complex needs requiring skilled workers. Young people were more likely to accept help from staff whom they considered to be professional, skilled and having a positive attitude towards them.

Pearce *et al.* (2002) argued that service providers may encounter difficulties in supporting sexually exploited young people; with feelings of powerlessness to effect positive and sustainable change, lack of confidence, experience and skills. Pearce *et al.* (2002) recommended that support and supervision are available for all staff.

Young people explained the intrinsic value in receiving support from a person with whom a relationship already existed. Familiarity promoted trust and frequently young people were willing to accept help from a known person and in contrast reject help from a person unknown to them. It appeared that for

some young people, an important factor in accepting help related to the person offering the help rather than the type of help on offer.

In particular the young person's perception of how trustworthy and confidential a service was seemed to stem from the attitude of the staff who worked in that service. The approach taken by the person offering help was considered to be important and promoted the acceptance of help. The practice of balancing the positive and negative elements of an intervention was valued by many young people who felt able to address difficult issues more readily if they were integrated with a positive experience (for example, a meal or a trip). Young people frequently described the need for autonomy and were more inclined to accept help from people who employed a non-prescriptive approach and negotiated interventions with them.

A reason stated for rejection of support was the unacceptability of the person offering the support. Specific examples were given and tended to focus upon age and gender. Another characteristic that deterred several young people from accepting support, was the perception of the wrong person offering help. This was perceived as a credibility issue and the young person sensing a lack of empathy towards them. This was described as the person offering support failing to appreciate or understand the young person's situation, therefore having limited capacity to empathise with them. Young people also preferred staff that seemed to have a genuine interest in them and other young people.

The gender of staff providing direct care was raised as important, in particular in care involving sensitive issues (for example, contraception). Young people believed that there ought to be the choice between a male or female member of staff. Gender was raised in the Home Office *Prostitution Strategy for England and Wales* (2006), and highlighted the fact that service users had stated that they preferred gender specific services.

The characteristics of ideal staff identified by the young people appeared to be equally as important as their level of experience and competence, although these were mentioned. The importance of the competency of staff supporting vulnerable young people is further highlighted by the Department for Education and Skills (2003, 2004).

With regards to competency, the Department for Children, Schools and Families (2006) stated that all health professionals responsible for the promotion of the health and development of young people are expected to have knowledge of the local safeguarding children board procedures. This guidance stated that all professionals supporting young people ought to receive appropriate training and supervision to enable them to recognise and respond to welfare concerns. This is particularly pertinent to staff working in genitourinary medicine, obstetric and gynaecological services as they are amongst those identified as likely to be in contact with sexually exploited young people.

Confidentiality and health seeking behaviour

Confidentiality was raised as an important factor influencing a young person's decision to access a health service or not, by respondents from both phases of this study. A young person's perception of the degree of confidentiality within a particular service, tended to be based on the reputation of the service and personal experience. Lack of trust in confidentiality reduced the young person's confidence in the service.

Services with inflexible appointment systems undermined confidentiality for school attendees as parental permission to be absent during school time was required, which necessitated divulging private information to a parent. Confidentiality was particularly important for young people in this study who described their experiences of 'going missing' from home and the steps they took to avoid being recognised by an official person, believing that they may be reported to the police and then returned home. Despite the remote chances of this occurring, several young people refrained from using health services due to these beliefs.

Help lines targeting young people (to offer advice and information regarding health issues) was recommended by young people in this study as a strategy to uphold confidentiality. Telephone help lines and other information sources such as the internet, digital television, leaflets and posters were raised in the Department of Health (2001a) sexual health strategy as an effective method of supporting people. The anonymity of this form of communication is likely to be appealing to young people who may lack trust in mainstream services.

The importance of transparent confidentiality policies with clear protocols to enable appropriate sharing of information has been cited in many reports: The Department of Health, Home Office and the Department for Education and Skills (2000), The National Treatment Agency (2007), The National Institute of Clinical Excellence (2007), Department of Health (2001).

Age as an influence on health seeking behaviour

Age was cited by several young people as a deterrent to seeking help. Several young people felt that the service they had accessed was not young person centred and considered to be unprepared to meet the specific needs of young people. Young people recommended age appropriate information provided in a variety of formats to maximise understanding and interest for young people.

Scott and Skidmore (2006) made the point that many sexually exploited young people have limited experience of support from adults, and consequently find it difficult to trust professional adults.

Raistrick *et al* (2006) argued that young people have different needs to adults, requiring a different approach in terms of alcohol treatment. Furthermore, with regards to alcohol treatment the Department of Health (2006b) stated that age should not be a barrier to accessing appropriate support.

The impact of timing and motivation on health seeking behaviour

Several young people in this study offered timing and motivation as a rationale for avoiding seeking help for a health problem. Timing referred to a point in time in the young person's life and time spent waiting for help. Young people stated that they would like to have services where they did not have to wait too long to be seen or to receive results from health tests, particularly sexual health tests. In 2005, the Medical Foundation for Sexual Health published 10 good practice standards for sexual health services, all of which were significant to the health of sexually exploited young people. The recommendations included equitable access, sexual health promotion with hard to reach groups and provision of adequate support and information.

Suggestions from phase 2 of this study included operating a key worker system to promote relationship development, allowing adequate time for relationship to develop and to promote engagement and concordance with treatment. The knowledge that support was frequent and ongoing, rather than brief and time limited, was identified by several young people as important because prolonged engagement between the sexually exploited young person and the health support worker (if appropriate), enabled health related progress to be maintained.

Several young people stated that they had recognised that they needed help, although had made a rational choice to avoid help at that time. The key elements of these cognitive processes seemed to be viewing self defeating behaviour as familiar and a viable alternative to addressing health issues, and not being ready to change. Unpreparedness to change behaviour may be

explained using the Transtheoretical (Stages of Change) Model (Prochaska and DiClemente, 1984). Help avoidance was linked to pre-contemplation (insight into their behaviour appeared to be present, without the intention to change the behaviour). Jones (2005) suggested that treatment agencies focus upon 'fateful moments', which may be a positive or negative experience. 'Fateful moments' have been described by Jones as an important lever in altering problematic drug and alcohol behaviour of young people. The rationale, according to Jones, is that positive or negative experiences are often a catalyst in behaviour change.

Bandura 's theory of self efficacy suggests that an individual may expect a negative outcome and this may offer a rationale in terms of a sexually exploited young person's lack of motivation towards health seeking behaviour. Miller and Rollnick (2002) referred to 'self efficacy' as an individual's hope and faith that a specific change will occur. Miller and Rollnick highlighted that self efficacy is promoted by an individuals belief that they can change. Young people in this study described accounts of both low and high self efficacy when they had held the belief that they were able or unable to access help effectively.

Prevention of further health related harm related to sexual exploitation
The prevention of sexual exploitation of young people was highlighted in guidance published over a decade ago (Department of Health, Home Office, Department for Education and Skills, and National Assembly for Wales, 2000) and has been identified as important in subsequent guidance relating to

sexual exploitation (Department for Children, Schools and Families, 2009). This marked emphasis on the prevention of young people becoming involved in sexual exploitation runs parallel to the need to be able to identify those currently involved in order to prevent further health and social related harm.

Respondents from phase 2 of this study highlighted the need for anyone working with young people (for example, in health, social care and educational settings) to be able to recognise vulnerability factors and to have an understanding of grooming and sexual exploitation. The requirements for all agencies that provide services for young people, to safeguard and promote their welfare, are explicit in several key documents (Department of Health, Home Office, Department for Education and Skills, and National Assembly for Wales, 2000, Department for Children, Schools and Families, 2009).

The mechanisms for preventing sexual exploitation are through educational activities in schools and arenas for non-school attendees (for example, youth services) designed to reduce vulnerability and enhance resilience in young people (DSF, 2009). Respondents from phase 2 suggested delivering 'Healthy and safe relationships promotion' in schools as a preventative strategy to educate young people about the potential harms associated with sexual exploitation, and to enable the early identification of health needs of young people involved. The rationale being that early identification of health problems engenders early intervention and promotes better outcomes generally (Kennedy, 2010). A further advantage in early identification is that young people who are sexually exploited from a young age and over a long

period of time are more likely to enter formal prostitution, which is associated with chronic and complex health problems (Cusick, 2003).

The Department for Children, Schools and Families (2009) suggested that further health related harm may be reduced if all health centres that attract young people display sexual exploitation literature to raise awareness and signpost to appropriate support. The availability of information relating to sexual exploitation was identified as significant in this study.

Mechanisms of change in health care provision for sexually exploited young people across a range of services.

As identified in the literature review, there is a paucity of information regarding the health seeking behaviour, and experiences of health support, of sexually exploited young people. It is important to contextualise health care for sexually exploited young people within the wider health support framework for young people in general. In 2009 the Government commissioned a review of children and young people's services in England due to concerns relating to the quality of services provided. This report entitled *Getting it right for children and young people: overcoming cultural barriers in the NHS so as to meet their needs* (Kennedy, 2010), highlighted an overarching lack of quality, and inequality, in health services available to young people. The principles governing the approach towards health care provision for young people within this report apply equally to sexually exploited young people and were alluded to by respondents in this study. These were early intervention, health promotion and disease prevention. The main mechanisms of change in health care

provision recommended in this report included the integration of health services and collaborative working between NHS and other organisations. It is recommended that Local Partnerships should consult with young people and incorporate their views into the planning and delivery of health care services. A further recommendation in this report, pertinent to sexually exploited young people, was for urgent action to be taken to ensure access to mental health services for young people, including through self referral and schools; and for all health staff in contact with young people to be trained to be able to provide comprehensive care. These recommendations concur with other guidance published recently to enable ease of access to effective and efficient health care for young people (Department for Education and Skills and Department of Health, 2009: *Healthier lives, brighter futures, the strategy for young people's health*, Department of Health, 2007a: *You're Welcome quality criteria: Making health services young people friendly).*

Respondents from both phases identified raising awareness of sexual exploitation, increasing levels of support and partnership working between health, social care, criminal justice and schools, as changes required in order to improve access to health support for sexually exploited young people.

Service design and delivery

A range of suggestions were made by respondents in relation to service design and delivery. Local accessible services that offered a walk in facility, rather than an appointment system or a waiting list were considered to be more accessible and therefore more acceptable to the young people.

Advertising services that provide health support to young people in places frequented by young people was raised as important. It was suggested that whilst there are a plethora of health oriented services for young people to access, they are often unaware of them. Pearce (2009) stated that one cannot take positive action without knowledge of available choices; this reinforces a young person's vulnerability and dependence upon those with this knowledge. Conversely, Pearce (2009) suggested that knowledge of available choices are empowering for a young person, reducing their vulnerability and risk potential.

Services that combined a range of health interventions, such as contraception and sexual health, simultaneously with practical, recreational and vocational activities, were considered to be valuable; this enabled the young person to address a variety of health needs in a relatively understated, uncomplicated way. A multi-disciplinary approach, offering a holistic assessment of needs and risks was cited as valuable in responding to a sexually exploited young person who may have a multitude of complex needs.

Scott and Skidmore (2006) proposed the 4 'A's approach in terms of providing health care for sexually exploited young people. The 4 'A's refers to the promotion of access to services, assertive outreach as a means of establishing and maintaining contact with the young person, attention that is anchored in a positive relationship and advocacy, as many young people do not have the skills to access support. This approach was adopted by the Department for Children Schools and Families and incorporated into their guidelines in 2009.

Lowe and Pearce (2006) argued that it is important to increase our understanding of sexual exploitation generally, in order to create suitable and accessible services. Young people in this study suggested that there needs to be consultation with young people regarding the planning and delivery of health care services. This would promote compatibility between health service requirements and provision

Supporting young people to increase their understanding of health service provision and effective utilisation

Health seeking behaviour of sexually exploited young people was explored in this study and reasons why young people fail to have their health needs adequately addressed were identified. Whilst deterrents to meeting health needs related to external factors were identified (for example, service configuration), factors relating to the young person were also highlighted.

Cognitive elements related to the young person's awareness and understandings of what services were able to offer. Occasionally the young person's expectations regarding what a service could provide were unrealistic (for example, methadone below 16 years). Respondents from both phases suggested that clear, age appropriate, verbal and written information are useful in terms of making explicit what a service can and cannot provide. Respondents also suggested having advocates to support young people in accessing health support. A further role of an advocate would be to role model appropriate behaviour in health services.

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Strengths of the study

The strengths of this study are that it is original, it has not been done before and it has contributed to raising the profile of sexually exploited young people. It has been suggested that sexually exploited young people are a marginalised and vulnerable group with limited empirical data relating to their specific health needs. The findings from this study have contributed to existing knowledge relating to the health needs of this group.

This research enabled a cohort of young people to express their ideas relating to factors that undermined their health, and to make suggestions relating to the meeting of their health needs. Historically young people have been offered limited opportunities to contribute to matters which affect them directly. Currently, there appears to be a significant drive to consult with young people, particularly those who are disenfranchised from mainstream services.

In the contemporaneous context of sexual exploitation, the emphasis tends to be on the prevention of sexual exploitation, the protection of those affected and the prosecution of perpetrators. Health tends to receive a lower profile although health is an 'Every Child Matters' outcome (Department of Health, 2003). This research is novel, original and has examined an important element (health) of an under researched area.

Limitations of the study

Methodological approach

A phenomenological approach was employed in phase 1 of this study using Giorgio's approach to analysis. This was anchored in Husserl's work and required the researcher to bracket preconceptions in order to identify, declare and eliminate bias. The researcher found this challenging and acknowledged that it was only possible to bracket what one was aware of. Therefore if the study is considered to be biased, on the premise that bracketing was insufficient, this may lower confidence in the findings. The researcher enhanced confidence in the findings by effectively reducing bias through use of Ahern's framework.

Study design

The method chosen to collect data in phase 1 of this study was semi-structured interviews. On several occasions there appeared to be competing agendas between the researcher and the respondent and the researcher found it difficult to change the direction of interview from sexual exploitation to health. The researcher was cognisant of the need to consider the effect upon the respondent if she redirected the interview back to health. The respondent may have felt ignored or that the researcher was being dismissive of their attempt to describe/disclose sensitive material. A phenomenological approach supports the respondent in taking the lead. However the research question also needed to be addressed; to abandon the research agenda would probably have been unproductive. Occasionally the respondent wanted to talk about their experience of sexual exploitation, rather than their understanding of health, risk to health and experience of health care. The intention of the researcher was to avoid developing a therapeutic relationship with the young

person as Newell and Burnard (2006) suggest that research is not a therapeutic interaction. The role of the researcher was to react appropriately to the respondent in the event that they introduced themes similar to those located in a therapeutic context and to address the emotional element of a past traumatic event.

Ideally, a follow up interview would have been useful to enable further exploration and clarification of respondent interview data. This was not possible due to the researcher being able to meet with each respondent on 1 occasion only.

Eleven agencies participated in phase 2 of this study. Ten of the 11 agencies had more than 1 worker, the eleventh agency having 1 lone worker. The questionnaires were numbered and assigned a code relating to each agency. This enabled the researcher to uphold anonymity, having knowledge only of how many questionnaires were returned from each agency. The agency with the lone worker did not benefit from anonymity due to this system; this may have been the reason why this particular questionnaire was not returned.

Sampling strategy

The researcher relied upon service providers to access the sample. The service providers were extremely busy and whilst the research was generally considered to be important, it was not a priority. This negatively affected the recruitment for phase 1 of this study by delaying it. Consequently the

researcher expanded the sampling frame and allocated additional time to recruit participants to the study.

It was necessary for the research selection criteria to include young people involved in, as well as young people vulnerable to, sexual exploitation. This was due to the fact that agencies work with those at risk and those involved in sexual exploitation. There are clearly differences between the needs of these 2 groups. However, the research design did not permit the researcher to differentiate between the 2 groups as the focus was upon health rather than sexual exploitation and did not constitute part of the interview.

A further limitation of the sampling approach was the reduced scope to generalise the findings to a broader health and social care audience. This is due to the recruitment of young people to the study being from a particular source; agencies supporting sexually exploited young people. Ideally the sample would have been drawn from a wider community of sexually exploited young people in a variety of settings such as: schools, youth offending teams, looked after system, child and adolescent mental health team. Whilst an extension of the sample frame was not feasible in this study, this has been developed as a recommendation for further research.

The views of the most vulnerable group, i.e. currently sexually exploited young people, were not sought or obtained because the research was designed to access young people in support services, as they were considered to be less vulnerable and easier to access. Pearce (2009 p105) enquired 'whether

ethically sound research is able to access the broad spectrum of young people who are most in need'. The inference being that it is preferable to access young people for the purposes of research who are engaged with a support service. Conversely, those young people who are marginalised from support services tend to be ignored in research terms as their involvement may be interpreted as unethical.

The researcher attempted to be inclusive, but was only able to include young people who accessed support. The majority of the young people were female, white and British. Therefore the views and experiences of males and young people from diverse ethnic backgrounds were limited to 2 respondents

Literature review

Whilst the literature was searched for, retrieved, and reviewed in a systematic way, a conventional systematic review was not undertaken. The rationale was that the literature review was 1 aspect of the study and there were restrictions on resources and time. Consequently, whilst a systematic approach was taken to search for, retrieve and review literature, stringent quality criteria were not applied to each article selected and the researcher reviewed each article independently. This may have resulted in bias in terms of the articles selected. A further limitation of the literature review was that a formal data selection tool was not used. Therefore researcher bias may be present in the data extraction and data synthesis element of the literature review.

Dissemination of research findings strategy

Kirby (2004) and Alderson and Morrow (2004) stated that it is important for those involved in research to see the outcomes of their input to be able to see that their views have been taken into account and how they have made a difference.

The CRD dissemination framework was used to design and deliver a comprehensive dissemination of the results of the research findings from this study. The CRD dissemination framework (2009) is underpinned by 6 related elements. These are: the characteristics of the research message, the setting, the target audience, the research message source (i.e. researchers), and the presentation and communication channels selected.

CHAPTER 11: RECOMMENDATIONS

These recommendations are a combination of suggestions made by the young people interviewed during phase 1 and the professionals supporting sexually exploited young people from phase 2 of this study. The rationale for each recommendation refers to the study data. These recommendations also reflect the broader literature as described in the discussion chapter. 'Unlike this study, however, recommendations in previous studies were not based on the views of sexually exploited young people themselves.' Due to the non-generalisability of the study the recommendations have been presented in a tentative manner. A further consideration in the implementation of these recommendations may be the feasibility or otherwise of additional human and fiscal resources.

Implications for delivery of health support to sexually exploited young people

Sexual exploitation agencies offering health support

Recommendation: Services designed to meet the health needs of sexually exploited young people may consider advertising the service broadly and providing information suitable for a young person using a range of media and venues (for example, the internet, posters, leaflets, in schools, through youth services etc).

Rationale: Young people in this study stated that sexually exploited young people need to know where services are, what they offer and how to access them.

Recommendation**:** Services designed to meet the health needs of sexually exploited young people may consider increasing accessibility with flexible opening times, open access, and outreach services, depending on available resources.

Rationale: In this study young people reported that they are more likely to use a service with these systems in place.

Recommendation: Services designed to meet the health needs of sexually exploited young people may consider offering an aesthetically attractive environment (within resource limitations) that will appeal to a young person.

Rationale: Respondents from both phases of this study stated that an attractive environment was likely to project a positive image of the service and encourage utilisation by young people.

Recommendation: Services designed to meet the health needs of sexually exploited young people may consider offering a gender specific service or the choice of a male or female health professional if this is feasible and within resource limitations.

Rationale: Respondents from both phases of this study reported that behaviours and experiences relating to sexual exploitation are often sensitive and young people tend to respond to a person they feel comfortable with.

Recommendation: Services designed to meet the health needs of sexually exploited young people may consider offering a range of health services simultaneously (for example, sexual health and emotional support). This may

be achieved by the appointment of a sessional health worker through negotiation with the relevant, local health service providers.

Rationale: Young people from this study stated that they preferred to access several services at one location at the same time, as this was more convenient for them and involved contact with fewer services.

Recommendation: Services designed to meet the health needs of sexually exploited young people may consider combining practical and emotional support (for example, preparing food whilst discussing aspects of the young person's life).

Rationale: Respondents from phase 2 of this study reported that sexually exploited young people may not respond to a formal and structured approach to emotional support at a prescribed time in a particular place. They considered emotional support in an informal atmosphere a suitable alternative approach.

Recommendation: Services designed to meet the health needs of sexually exploited young people may consider offering support for families of sexually exploited young people or suggesting services that offer this.

Rationale: According to young people in this study, the sexual exploitation of a young person impacts upon their family. Therefore the family may need support.

Recommendation: Services designed to meet the health needs of sexually exploited young people may consider offering to escort the young person to

health oriented appointments and provide advocacy (depending on available resources).

Rationale: Respondents from both phases of this study reported that a young person may lack confidence to attend the appointment independently.

Recommendation: Services designed to meet the health needs of sexually exploited young people may consider allowing adequate time to interact in a meaningful way with the young person

Rationale: Young people from this study reported that they valued adequate time in order to assist in the building of relationships, trust and rapport.

Recommendation: Services designed to meet the health needs of sexually exploited young people may consider offering advice relating to healthy eating.

Rationale: Respondents from both phases of this study recommended advice relating to healthy eating, as sexually exploited young people tend to be either overweight, underweight and/or eat an unhealthy diet.

Recommendation: Services designed to meet the health needs of sexually exploited young people may consider offering smoking cessation support by signposting the young person to appropriate professional support via their GP.

Rationale: Respondents from both phases of this study recommended advice relating to smoking cessation, as a significant number of sexually exploited young people smoke and appear to experience difficulty in stopping smoking and in accessing appropriate support.

Recommendation: Services designed to meet the health needs of sexually exploited young people may consider identifying problematic alcohol use and offering support by signposting the young person to appropriate professional support locally or via their GP.

Rationale: According to respondents from both phases of this study problematic alcohol use is a significant issue amongst sexually exploited young people and tends to impact negatively on their health and well-being.

Generic health services

Recommendation: Staff working with young people in any health setting should acquire the ability to recognise indicators of sexual exploitation and to respond appropriately to a sexually exploited young person (Department for Children, Schools and Families, 2009).

Rationale: According to respondents from phase 2 of this study, most health staff are likely to come into contact with sexually exploited young people and are in a position to intervene and offer support.

Recommendation: Staff working in any health setting need to be aware of organisations and services available locally and nationally for sexually exploited young people, to be able to support them effectively.

Rationale: Respondents from phase 2 of this study reported that staff working in any health setting require an awareness of the organisations and services available locally and nationally for sexually exploited young people.

Recommendation: Staff working with young people in any health setting, should acquire the ability to convey a non-judgemental approach and to communicate effectively with young people.

Rationale: Respondents from both phases of this study reported that communication is an important aspect of interacting with sexually exploited young people and influences uptake of services. Respondents also reported that effective communication between staff and clients promotes a positive image and reputation of the service and is likely to increase service utilisation by sexually exploited young people.

Recommendation: Staff working with young people in any health setting require the skills to focus on a young person's strengths as well as their concerns/problems.

Rationale: Young people in this study stated that it was important for them to discuss their positive attributes, as focusing purely upon problems was considered to be negative and limiting.

Recommendation: Staff working with young people in any health setting, should respect the young person's autonomy through the negotiation of care and choices.

Rationale: Young people from this study reported that they prefer the negotiation of care to a prescriptive approach to care.

Implications for health service managers

Recommendation: Health service managers may consider working alongside sexual exploitation agencies to develop protocols to promote and enable joint working and appropriate sharing of information between agencies supporting sexually exploited young people.

Rationale: According to respondents from phase 2 of this study, a sexually exploited young person's needs are likely to require interventions from health, social care and criminal justice services.

Recommendation: Health service managers may consider novel approaches to consulting with marginalised and vulnerable young people regarding the design and delivery of health services to young people (for example, through young person advocacy services such as Barnardos).

Rationale: Respondents from both phases of this study suggested that consultation with young people would promote compatibility between provision and utilisation of health services.

Implications for education and training

Recommendation: All health and social care training courses provided in further and higher education institutions should include an awareness of sexual exploitation, both at undergraduate and continuing professional development level.

Rationale: According to respondents from phase 2 of this study it is important for health and social care providers to be able to recognise indicators of sexual exploitation and to be able to respond appropriately,

Recommendation: Sexual health education in schools needs to include information relating to sexual exploitation and young people.

Rationale: Young people in this study stated that a greater awareness of the consequences of risky sexual behavior might encourage safer sexual practices, reduce the rate of sexually transmitted infections and unplanned pregnancies and discourage young people from exchanging sexual favors for items.

Recommendation: Alcohol and other drugs education in schools needs to be improved and linked to sexual exploitation.

Rationale: According to respondents from phase 2 of this study, young people who use alcohol and other drugs problematically are vulnerable to grooming for sexual exploitation.

Recommendation: Staff working in agencies supporting sexually exploited young people require a basic awareness of common mental health issues to be able to respond effectively. Mental health education and training may be attainable through local training and education providers or through establishing links with the local mental health service providers.

Rationale: According to respondents from phase 2 of this study mental health issues are common amongst sexually exploited young people and difficulties in acquiring mental health support for sexually exploited young people are common.

Recommendation: Staff working in agencies supporting sexually exploited young people should acquire a basic awareness of problematic substance use

and how to respond effectively. Problematic substance use education and training may be attainable through local training and education providers or through establishing links with the local substance misuse service providers.

Rationale: According to respondents from both phases of this study, problematic substance use is common amongst sexually exploited young people and difficulties in acquiring problematic substance use support for sexually exploited young people are also common.

Implications for research

Recommendation**:** Research with young people should be undertaken to encourage young people to voice their views.

Rationale: Respondents from phase 2 of this study suggested that it is important to research marginalised groups in order to be able to design and promote uptake of health services around their particular needs and to promote equality and inclusion.

Recommendation: Further research in the following areas should be undertaken: sexual exploitation and young men, culture and ethnicity, physical and psychological health and problematic drug and alcohol use.

Rationale: These areas have been identified as gaps in the available literature and have not been fully addressed in this study.

Recommendation: Larger qualitative and quantitative studies relating to the health needs of sexually exploited young people should be undertaken.

<u>Rationale:</u> This study was a smaller study and a larger study will promote generalisability.

CONCLUSION

The following research question has been addressed in this study

'What are the health risks, health needs and health seeking behaviours of young people involved in or vulnerable to sexual exploitation?'

A significant issue relating to youth sexual exploitation is that the focus tends to be on prevention, protection and prosecution, in line with the key documents and the current national legislative framework. The knowledge base related to the physical and psychological health needs, risk taking and health seeking behaviours of sexually exploited young people is limited and this was a catalyst for this study. An additional important catalyst for this study was that it had not been done in the UK previously and was therefore original.

The genesis of this study was the current focus on social exclusion and marginalised young people, such as sexually exploited young people. A contemporary theme running parallel to this was a notable recognition at a governmental level of the rights of young people.

The study aims addressed the absence of empirical data regarding the health needs, risk taking and health seeking behaviours of sexually exploited young

people, using a novel approach by undertaking interviews with 24 sexually exploited young people and 61 professionals who support sexually exploited young people. Due to the pragmatic and ethical requirements inherent in researching marginalised young people this research study was complex and challenging. This may contribute to the general paucity of the current knowledge base.

The results of this study have contributed towards a greater understanding of factors that influence health, risk taking and health seeking behaviour amongst sexually exploited young people.

My original contribution to knowledge is a description of the physical and psychological health issues encountered by this group including the apparent high levels of self harming and alcohol dependence. A taxonomy of risk taking behaviour was also examined in detail and discussed.

A novel finding and new knowledge was the use of youth offending teams reported as services accessed by a significant number of sexually exploited young people for health support. Additional new knowledge relates to health seeking behaviours of sexually exploited young people and reasons why health services are avoided or accessed is reported in detail. The specific types of health services used have been examined alongside the significance of the characteristics of professionals offering health support (for example, gender and age).

Recommendations from this study relate to the design, delivery and management of health services, to facilitate better outcomes for sexually exploited young people whom they come into contact with. Recommendations were also made regarding the health oriented training needs of staff in any agency that might come into contact with sexually exploited young people (including a better understanding of different interpretations of what constitutes sexual exploitation). Additional insight into the health needs of sexually exploited young people will promote the implementation of evidence based, effective interventions. This is likely to contribute to reducing risk, increasing uptake of health services and enhancing favourable health outcomes for sexually exploited young people.

References

Abramson, L., Metalsky, G., and Alloy, L. (1989). Hopelessness Depression: A Theory-Based Subtype of Depression. Psychology Review, 96 (2), 358-372.

Abramson, I. Y., Seligman, M E, P., and Teasdale, J. (1978) Learned Helplessness in Humans: Critique and Reformulation. Journal of Abnormal Psychology, 87, 49-74.

Acheson, D (1998) Independent inquiry into inequalities in health [online]. London: Department of Health. Available from: http://www.doh.gov.uk/ih/ih.htm. [accessed 10th July 2008]

Aggleston, P., Hurry, J., Warwick, I. (2000) Young people and mental health. Chichester: Wiley.

Ahern, K.J. (1999) Ten tips for reflexive bracketing. Qualitative Health Research 9 (172), pp. 407-11.

Ajzen, I., & Fishbein, M. (1973). Attitudinal and normative variables as predictors of specific behaviour. Journal of Personality and Social Psychology, 27(1), 41-57.

Ajzen, I and Fishbein, M. (1980) Understanding attitudes and predicting social behaviour, Englewood Cliffs, NJ Prentice Hall.

Alderson, P. and Morrow, V. (2004) Ethics, social research and consulting with young people. Ilford: Barnardos.

Alford, B., Lester, J., Patel, R., Buchanan, J., and Giunta, L. (1995). Hopelessness Predicts Future Depressive Symptoms: A Prospective Analysis of Cognitive Vulnerability and Cognitive Content Specificity. Journal of Clinical Psychology, 51(3), 331-339.

American Psychiatric Association (2000) Diagnostic and statistical manual of mental disorders-Fourth edition-Text revision. A.P.A. Washington, DC.

Angen, MJ. (2000). Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue. Qualitative Health Research. 10(3) pp. 378-395.

Ashworth, P. (1997) The variety of qualitative research. Part one: Introduction to the problem. Part 2: Non-positivist approaches. Nurse Education Today (17), pp. 215-224.

Aust, R. Sharp., C. and Goulden, C. (2002) Prevalence of drug use: key findings from the 2001/2002 British Crime Survey. Research Findings, London: Home Office.

Ayre, P. and Barrett, D. (2000) Youth prostitution in Europe. The growth in sex work. Lyme Regis: Russell House Publishing.

Baker, C. Wuest, J., and Stern, P.N. (1992) Method slurring: the grounded theory/phenomenology example. Journal of Advanced Nursing, 17:1355-60.

Bandura, A. (1977) Social Learning Theory. New York. General Learning Press.

Barker, P and Buchanan-Barker, P (2005). <u>The Tidal Model: a guide for mental health professionals.</u> New York, NY: Brunner Routledge.
Barnardos. [online]. Illford: Barnardos Available from: http://www.Barnardos.org.uk/noson.pdf [accessed 11.June 2006].

Barnardos (2005) Parliamentary briefing report: <u>Appropriate support for sexually exploited young people</u> Illford: Barnardos.

Barnardos (2011) <u>Puppet on a string. The urgent need to cut children free from sexual exploitation.</u> Essex: Barnardos.

Barrett, D. and Melrose, M. (2003) 'Courting controversy – children sexually abused through prostitution – are they everybody's distant relation but nobody's children?' <u>Child and Family Law Quarterly</u>, 15 (4), pp. 371-382.

Barrett, D. (1998) Young people and prostitution: perpetrators in our midst. <u>International Review of Law, Computers and Technology</u>, 12 (3), pp. 475-486.

Beauchamp, T. and Childress, J. (2000) <u>Principles of biomedical ethics</u>. New York. Oxford University Press.
Beck, A., Steer, R., Kovacs, M., and Garrison, B. (1985) Hopelessness and Eventual Suicide: a 10-year Prospective Study of Patients Hospitalized with Suicidal Ideation. <u>American Journal of Psychiatry</u>, 142 (5), 559-563

Becker, M.H. (1974) The Health Belief Model and personal health behaviour. <u>Health Education Monographs,</u> 2 (4).

Beck, C.T. (1994) Reliability and validity issues in phenomenological research. <u>Western Journal of Nursing Research</u>, 16 (3), pp. 254-267.

Bell, J. (2001) <u>Doing Your Research Project</u> (3rd ed.) Buckingham: Open Uni Press.

Beresford, B. (1997) <u>Personal accounts. Involving disabled children in research.</u> University of York: Social Policy Research Unit.

Biddle,L., Gunnell, D., Sharp, D., Donovan, J (2004) Factors influencing help seeking in mentally distressed young adults: a cross-sectional survey. <u>British Journal of General Practice</u>, 54, pp. 248-253.

Bindel, J. and Kelly, L. (2004) <u>A critical examination of responses of prostitution in four countries: Victoria, Australia, Ireland, the Netherlands and Sweden</u>. Child and Woman Abuse Studies Unit, London Metropolitan University.

Bloor, R., Crome, I., Moss, J., Freeman, S., Okolo, D., and Astari, D. (2006) <u>The impact of treatment on female drug-using sex workers</u>. Research briefing: 14. London. National Treatment Agency.

Bowling, A., Bond, M., Jenkinson, C., and Lamping, D. (1999) Short form 36 health survey questionnaire: which normative data should be used? Comparison between the norms provided by the Omnibus Survey in Britain, Health Survey for Britain and the Oxford Healthy Life Survey, <u>Journal of Public Health Medicine</u>, 21, pp. 255-70.

Bowling, A. (2005) <u>Research methods in health: Investigating health and health services.</u> (2nd ed) London. Open University Press.

Bowling, A. (2009) Research methods in health: Investigating health and health services. (3rd ed) London. Open University Press.

Bourque, L.B. and Fielder, E.P. (1995) How to conduct self-administered and mail surveys. Thousand Oaks, CA: Sage.

Bradby, H. (2009) Medical Sociology: An introduction. London. Sage

Brown, A. and Finkelhor, D. (1986) Initial and long-term effects: a review of the research. Cited in: Finkelhor, D. (eds) (1986) A sourcebook on Child Sexual Abuse. London: Sage.

Brown, A. (2004) Mythologies and panics: twentieth century constructions of child prostitution. Children and Society, 18 (5), pp. 344-354

Brown, K. (2006) Participation and young people involved in prostitution. Child Abuse Review, 15, pp 294-312.

Calder, M. C. (2001) Child prostitution: developing effective protocols. Child Care in Practice, 7 (2), pp .98-115.

Campbell, R. and O'Neill, M. (2006) Sex Work Now. Devon: Willan Publishing.

Carter, D.J. and Dalla, R.L. (2006) Transactional analysis case report: Street level prostituted women as mental health care clients. Sexual Addiction and Compulsivity, 13, pp. 95-119.

Carter, B. (1998) 'Children-silent consumers of health care', Journal of Child Health Care, 2 (2), p. 57

Cawson, P., Wattam, C., Brooker, S., and Kelly, G (2000) Child maltreatment in the UK: a study of the prevalence of childhood sexual abuse and neglect. London: National Society for the Prevention of Cruelty to Children.

Central Office of Research Ethics Committees title [online]. Available from: http://www.corec.org.uk. [accessed 15th February 2006].

Centre for Reviews and Dissemination CRD (2009) Systematic reviews: CRD's guidance for undertaking reviews in health care. [online] http://www.york.ac.uk/inst/crd/systematic_reviews_book.htm. [accessed 10th June 2009].

Chase, E. and Statham, J. (2005) Commercial and sexual exploitation of young people in the U.K: a review. Child Abuse Review, 14 (1), pp. 4-25

Children Act (England and Wales) 1989 Part V, 43 (8). [online]. London: The Stationery Office. Available from: http://www.opsi.gov.uk/acts1989/Ukpga_19890041_en_1.htm. [accessed 23rd October 2006].

Children Act (England and Wales) 2004 (c.31). [online]. London: The Stationery Office. Available from: http://www.opsi.gov.uk/acts2004/20040031.htm [accessed 23rd October 2006].

Child Exploitation on Line Protection (2010) Strategic overview 2009-10. CEOP: London. [online]. Available from: http://www.ceop.gov.uk/ [accessed 2nd May 2011].

Clark, A. and Moss, P. (2005) Spaces to play: more listening to children using the Mosaic approach, London: National Children's Bureau.

Clutton, S and Coles, J (2008) Child Sexual Exploitation in Wales: 3 years on. Barnardos Cymru. Cardiff

Clutton, S and Coles, J (2007) unpublished report presented to Welsh Assembly Government and at Local Safeguarding Children Boards conference, March 2007.

Coleman, J and Hagell, A. (2007) in Adolescent risk and resilience: Against the odds, England, Wiley.

Coleman, J and Schofield, J. (2005) Key data on adolescence (5th ed) Brighton: Trust for the study of Adolescence.

Coombes, L., Allen, D., Foxcroft, D., and Guydish, J. (2008) Motivational interviewing for the prevention of alcohol misuse in young people. Cochrane Database of Systematic Reviews: Issue 2. Art. No.: CD007025. DOI: 10.1002/14651858. cd007025.

Corby, B. (2006) Child abuse, towards a knowledge base. (3rd ed). London. Open University Press.

Coy, M. (2008) Young women, local authority care and selling sex: Findings from research. British Journal of Social work, 38, pp. 1408-1424.

Crawley, M., Roberts, P., and Shepherd, W. (2004) Taking Stock: Young people at risk of or involved in abuse through prostitution within Stockton-on Tees. Building a better future together. Ilford: Barnardos.

Cresswell, J.W. (1998) Qualitative inquiry and research design: Choosing amongst five traditions. London: Sage Publications.

Cresswell, J.W. (2003) Research design: qualitative, quantitative and mixed methods approaches (2nd ed.). Thousand Oaks, CA: Sage.

Crotty, M. (1998) Phenomenology and nursing research. Melbourne: Churchill Livingstone.

Crotty, M. (2006) The foundations of social research. Meaning and perspective in the research process. London: Sage Publications.

Cusick, L. (2002) Youth prostitution: A literature review. Child Abuse Review, 11, pp. 230-251.

Cusick, L., Martin, A., and May, T. (2003) Vulnerability and involvement in drug use and sex work. Home Office research study 268. London: Home Office.

Data Protection Act. 1998 Chapter 29: Arrangement of Section Part 1 Preliminary. London: The Stationery Office.

Denzin, N.K. and Lincoln, Y.S. (2005) The Sage handbook of qualitative research: (3rd ed) London: Sage Publications.

De Vaus, D.A. (1991) Surveys in Social Science Research (3rd ed). London: UCL Press/Allen and Unwin.

Department of Health (1999) Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children, [online]. London:

Department of Health. Available from: http://www.dh.gov.uk/assetRoot/04/07/58/24/04075824.pdf [accessed 13th December 2006].

Department of Health (2000) The NHS Plan, A plan for investment and reform: CM4818, London: The Stationery Office.

Department of Health, Home Office, Department for Education and Skills, and National Assembly for Wales (2000) Safeguarding Children Involved in Prostitution. London: Department of Health.

Department of Health (2001) The National Plan for Safe guarding Children from Commercial Sexual Exploitation. London. Department of Health.

Department of Health (2001a) Better prevention, better services, better sexual health: The national strategy for sexual health and HIV. London: Department of Health.

Department of Health (2001b) Research governance framework for health and social care. London. Department of Health.

Department of Health (2002) Mental health policy implementation guide: dual diagnosis good practice guide. London: Department of Health.

Department of Health (2002a) National suicide prevention strategy for England. London: The Stationery Office.

Department of Health (2003a) National Chlamydia screening programme. London: Department of Health.

Department of Health (2003b) The Effective Sexual Health Promotion Toolkit for Primary Care Trusts, London: Department of Health.

Department of Health (2003c) Dangerousness of Drugs: A Guide to the Risks and Harms Associated with Problematic substance use. London: Department of Health, National Addiction Centre.

Department for Children, Schools and Families and Department of Health (2009) Statutory Guidance on Promoting the Health and Well-being of Looked After Children. Nottingham: DCSF publications.

Department for Education and Skills (2003) Every child matters [online]. London: Department for Education and Skills. Available from: http:// www.dfes.gov.uk. [accessed 10th September 2003].

Department for Education and Skills (2004) <u>Every child matters: next steps</u>. [online]. Nottingham: Department for Education and Skills. Available from: <u>http://www.everychildmatters.gov.uk</u>. [accessed 13th December 2004].

Department of Health and Department for Education and Skills (2004) <u>Getting the right start: national service framework for children. Standards for hospital Services.</u> [online]. London: Department of Health. Available from: <u>http://www.doh.gov.uk/nsf/children/hospitalstandard.pdf.</u> [accessed 1st May 2005].

Department for Education and Skills (2005) <u>Every child matters: change for children, young people and drugs.</u> [online]. London: Her Majesty's Government. Available from: <u>http://www.everychildmatters.gov.uk</u>.
[accessed 19th September 2005].

Department for children, schools and families (2008) <u>Staying Safe: Action Plan</u>. [online]. London: Department for children, schools and families. Available from: <u>http://www.dcsf.gov.uk</u>. [accessed 30th November 2008].

Department of Health (2005) <u>Research governance framewok for health and social care</u>. London: Department of Health.

Department of Health (2005a) <u>Medical Foundation for AIDS and sexual health: recommended standards for sexual health services.</u> London: Department of Health.

Department of Health (2005b) <u>Choosing Health: making healthy choices easier</u>*. London: Department of Health.

Department for Education and Skills (2006) <u>Youth Matters, next steps. Something to do, somewhere to go, someone to talk to. Every Child matters, change for children</u> [online]. London: Department for Education and Skills. Available from: <u>http://www.dcsf.gov.uk/consultations/downloadableDocs/Youth%20Matters%20Next %20Steps.pdf</u> [accessed 2nd February 2007].

Department of Health (2006a) <u>New Frontiers: Annual Report of the National Chlamydia Screening Programme in England 2005/2006</u> N.C.S.S.G. London: Health Protection Agency.

Department of Health (2006b) <u>Models of Care for Alcohol Misusers</u> (MOCAM). [online]. London: Department of Health. Available from: <u>http://www.dh.gov.uk</u> [accessed 29th August 2006].

Department of Health (2007) <u>Consent Key Documents</u> [online]. London: Department of Health. Available from: <u>http://www.dh.gov.uk/PolicyAndGuidance/HealtAndSocialCareTopics/Consent/fs/en</u> [accessed 8th March 2007].

Department of Health (2007a) <u>You're Welcome quality criteria: Making health services young people friendly.</u> London: Department of Health.

Department for Children, Schools and Families (2007) <u>Teenage Parents, Next Steps: Guidance for Local Authorities and Primary Care Trusts.</u> Nottingham: DCSF Publications, Department of Health.

Department of Health, Home Office, Department for Education and Skills and Department for Culture, Media and Sport (2007b) <u>Safe, Sensible, Social. The next steps in the national alcohol strategy</u>. London: Department of Health.

Department for Children, Schools and Families and Department of Health (2009) <u>Healthier lives, brighter futures. The strategy for young people's health</u>. London: Department of Health.

Department for Children, Schools and Families, The Home Office and Department of Health (2008) <u>Youth Alcohol Action plan</u>. Cm7387. London: The Stationery Office.

Department for Children, Schools and Families (2009) <u>Safeguarding Young people from sexual exploitation. Supplementary guidance to working together to safeguard children.</u> London: Department for Children, Schools and Families.

Department for Children, Schools and Families (2009a) <u>Statutory guidance on children who run away and go missing from home or care. Supporting local authorities to meet the requirements of National Indicator 71- Missing from Home and Care.</u> London: Department for Children, Schools and Families.

Department for Education and Employment and Qualifications and Curriculum Authority (1999) <u>The National Curriculum handbook for secondary teachers in England.</u> London: DfEE and QCA.

Department of Health (2009) <u>Tackling health inequalities: 10 Years on – A review of developments in tackling health inequalities in England over the last 10 years.</u> London: Department of Health.

Dillman, D.A. (1978) <u>Mail and Telephone surveys: the total design method</u>. New York: Wiley.

Earle, S., Lloyd, C., Sidell, M. and Spurr, S. (2007) <u>Theory and research in promoting public health</u>. London: Sage.

EPCAT: End Child Prostitution and Trafficking (2003) <u>EPCAT report of the agenda for action against the commercial sexual exploitation of children</u> 2001-2002. [online]. EPCAT International. Available from: http:// www.epcat.net. [accessed 2nd June 2007].

EPCAT: End Child Prostitution and Trafficking (2006) <u>Global monitoring report on the status of action against commercial sexual exploitation of children</u>. [online]. UK. EPCAT International.
Available from: http:// www.epcat.net [accessed 2nd June 2007].

Epling, M. and McGregor, J. (2006) Vulnerable young people and problematic substance use, Cited in Rassool, H. (ed) (2006) <u>Dual Diagnosis Nursing</u>. Oxford: Blackwell Publishing Chapter, pp 97-106.

Erlandson, D.A. (1993) <u>Doing naturalistic inquiry: a guide to methods.</u> Newbury Park, Calif: Sage

European Association for the treatment of addiction: EATA (2003) <u>Treatment works: Fact or fiction? A report into awareness of drug treatment and its effectiveness.</u> [online]. , EATA. Available from: http://www.eata.org.uk/
[accessed 9th August 2006].

Farrand, P., Parker, M., Lee., C (2007) Intention of adolescents to seek professional help for emotional and behavioural difficulties. <u>Health and Social Care in the Community</u>, 15 (5), 464-473

Fishbein, M. (1967). Attitude and the prediction of behaviour. In M. Fishbein (Ed.), <u>Readings in attitude theory and measurement</u> (pp. 477-492). New York: Wiley.

Fishbein, M., & Ajzen, I. (1975). <u>Belief, attitude, intention, and behaviour : An introduction to theory and research.</u> Reading, Mass. ; Don Mills, Ontario: Addison-Wesley Pub. Co

French, R., Mercer, C., Kane, R., Kingori, P., Stephenson, J., Wilkinson, P., Grundy, C., Lachowycz, K., Jacklin, P ., Stevens, M., Brooker, S., and Wellings, K (2007) What impact has England's teenage pregnancy strategy had on young people's knowledge of and access to contraceptive services? <u>Journal of Adolescent Health</u>, 41, pp. 594-601.

Frisher, M., Crome, I., Bloor, R., and Hickman, M. (2007) <u>Predictive factors for illicit drug use amongst young people: a literature review</u>. [online]. London: Home Office. Available from: <u>http://www.homeoffice.gov.uk/rds/pdfs07/rdsolr0507.pdf</u> [accessed 25th June 2008].

Gibbs, G.R. (2007) <u>Analyzing Qualitative Data</u>. London: Sage.

Gilbert, N. (2001) <u>Researching Social Life</u>. (2nd ed). London: Sage.

Gill, T. (2007) <u>No Fear: Growing up in a Risk Averse Society.</u> London: Calouste Gaul-benken Foundation.

Gillespie, A.A. (2005) Prostitution or Abuse? The Sexual Offences Act 2003. <u>Criminal Law Review,</u> pp. 285-289.

Gillick V West Norfolk and Wisbeck AHA (1985). 1 ALL E.R.

Giorgi, A. (1985) <u>Phenomenology and psychological research</u>. Pittsburgh, PA: Duquesne University Press.

Glaser, BG and Stauss, A.L (1967) The Discovery of grounded theory. Aldine: New York.

Goddard, C. and Saunders, B.J. (2000) The gender neglect and textual abuse of children in the print media. <u>Child Abuse review,</u> 9, pp. 37-48.

Goddard, C. and Saunders, B.J. (2001) Journalists as agents and language as an instrument of social control. <u>Children.</u> Australia, 26, pp. 26-30.

Goddard, C. and Saunders, B.J. (2001a) The textual abuse of childhood in the English speaking world: the contribution of language o the denial of children's rights. <u>Childhood</u>, 8, pp. 443-462.

Goddard, C., De Bortoli, L., Saunders, B.J., and Tucci, J. (2005) The Rapist's Camouflage: 'Child Prostitution'. <u>Child Abuse Review.</u> 14 (4), pp. 275-291.

Gorham, D (1978) The Maiden Tribute of modern Babylon'. Re-examined: Child prostitution and the idea of childhood in late Victorian England'. <u>Victorian Studies</u>, 21 (3): 353-379.

Gough, D. (1996) Defining the Problem. <u>Child Abuse and Neglect,</u> 20 (11), pp. 993-1002.

Gough, D. and Bell, M. (2005) Providing services for young people who have experienced sexual abuse. <u>Child Abuse Review</u>, 14 (1), pp. 1-3.

Gough, D. and Stanley, N. (2005) Being Aware of What we are Doing. <u>Child Abuse Review,</u> 14(4), pp. 217-219.

Green, S. and Hogan, D. (2005) <u>Researching children's experience. Approaches and methods</u>. London: Sage Publications.

Griffiths, M. (2001) Adolescents: a special case. <u>Young Minds magazine</u>: The Children's mental health charity (53).

Hanley, B, Bradburn, J., Barnes, M., Evans, C., Goodare, H., Kelson, M., Kent, A., Oliver, S., Thomas, S and Wallcraft, J. (2004).'<u>Involving the public in research and development in the NHS, public health and social care</u>: Briefing notes for reseachers', 2<u>nd</u> ed. [online].

INVOLVE. Available from:
<u>http://www.invo.org.uk/pdfs/Briefing%20Note%20Final.dat.pdf.</u>
[accessed 24<u>th</u> May 2006].

Harper Z, and Scott, S. (2005) <u>Meeting the needs of sexually exploited young people in London</u>. Illford: Barnado's.

Harris, J. and Robinson, B. (2007) <u>Tipping the Iceberg. A pan Sussex study of young people at risk of sexual exploitation and trafficking.</u> Illford: Barnardos

Hawton, K., Rodham, K, and Evans, E. (2002) Intentional self-harm in adolescents: Self report summary in schools in England. <u>British Medial Journal</u>, 325 (7374) pp. 1207-1211.

Haywood, J. and James, C (2008) <u>Improving the health of children in care and care leavers in London 2008/9</u>. Unpublished paper: Care Services Improvement Partnership.

Health Advisory Service (2001) <u>The Substance of Young Needs</u>. Review 2001, Brighton: Pavilion publishing.

Health Development Agency (2004) <u>Smoking interventions with young people. Better Health for Young people</u>-HAD Briefing No.6. London: Health Development Agency.

Health Protection Agency (2007) <u>Testing Times. HIV and other Sexually Transmitted Infections in the United Kingdom</u>. London: Health Protection Agency.

Her Majesty's Government (2006) <u>Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children. London:</u> Her Majesty's Government.

Hickerton, M (2001) Women with special needs and concerns. In: Andrews, G. (ed) Women's Sexual Health (2nd ed). London: Balliere Tindall; pp109-133

Hoggart, L. (2007) Young women, sexual behaviour and sexual decision making. Cited in Thom, B., Sales, R. and Pearce, J.J. (2007) Growing up with risk. Bristol: The Policy Press.

Hoinville, G. and Jowell, R. (1985) Survey Research Practice (2nd ed) London: Heinemann.

Home Office (2002) Tackling crack: A national plan. London: Drugs Strategy Directorate, Home Office.

Home Office (2002a) Updated Drug Strategy London: Home Office.

Home Office (2004) Tackling Drugs, Changing lives-keeping communities safe from drugs. London: Home Office.

Home Office (2004a) Paying the price: a consultation paper on prostitution. London: Home Office.

Home Office (2006) A Coordinated Prostitution Strategy and a summary of responses to Paying the Price. London: Home Office.

Home Office (2007) The UK Action Plan on Tackling Human Trafficking. [online]. London: Home Office and Scottish Executive. Available from: http://www.homeoffice.gov.uk/documents/human-traffick-action-plan. [accessed 12 November 2008].

Home office (2007a) Sexual Violence and Abuse Programme Implementation guide. [online]. London. Home office. Available from: http:/www.crimereduction.gov.uk/sexualoffences/sexual03.htm. [accessed 2nd March 2008].

Hudson, P. and Rivers, I. (2002) Men and Boys: Selling sex in the Bradford District. Social Inclusion and Diversity Paper No.1. Research into Practice. Yorkshire MESMAC Sexual Health Project. York S.T John. College of the University of Leeds.

Human Rights Act (1998). The Stationery Office, London.

Hunter, G. and May, T. (2004) Solutions and strategies: drug problems and street sex markets. London: Drugs Strategy Directorate, Home Office.

Husserl, E. (1970) Logical Investigations New York: Humanities Press. (J.N. Findlay, Trans).

Hickerton, M. (2001) Women with special needs and concerns. Cited in: Andrews, G. (ed) Women's sexual health (second edition). London: Bailliere Tindall.

Irwin, R. (2002) Psycho-sexual Nursing, London: Whurr Publishers.

Itzin, C. (2006) Tackling the Health and Mental Health Effects of Domestic and Sexual Violence and Childhood Sexual Abuse. University of Lincoln: Department of Health, Home Office.

Jago, S. and Pearce, J. (2008) <u>Gathering evidence of the sexual exploitation of young people: a scoping exercise.</u> University of Bedfordshire.

Jacobson, L., Richardson, G., Parry-Langdon, N., and Donovan, c (2001). How do teenagers and primary health care providers view each other. An overview of key themes. <u>British Journal of General Practice.</u> 51, 811-816.

Jeffrey, C.R. (1990). <u>Criminology: An Interdisciplinary Approach</u>. Prentice Hall,NJ.

Jenner, J (2004) Cited in Barnes, K. (2004) Paediatrics. <u>A clinical guide for nurse practitioners.</u> London. Butterworth Heinemann.

Johnson, R.B. (1997) Examining the validity structure of qualitative research. <u>Education</u>, 118 (2), pp 282-292.

Jones, G. (2005) <u>The thinking and behaviour of young adults (aged 16- 25): Literature Review for the Social Exclusion Unit, Office for Deputy Prime Minister and Social Exclusion Unit.</u> London.

Kehily, M. J (2007) <u>Understanding Youth: perspectives, identities and practices.</u> London: Sage.

Kennedy, I (2010) <u>Getting it right for children and young people: overcoming cultural barriers in the NHS so as to meet their needs.</u> The Stationary Office, Her Majesty's Government.

Kirby. P. (2004) <u>A guide to actively involving young people in research: For researchers, research commissioners and managers.</u> [online]. Hampshire. INVOLVE. Available from: http://www.invo.org.uk. [accessed 13th July 2006].

Knight, S (2002) Children abused through prostitution. <u>Emergency Nurse,</u> 19 (4) pp. 27-29.

Kofoed, L (1997) Engagement and Persuasion. In: <u>The Principles and Practice of Addictions in Psychiatry</u> (Miller, N.S., ed), 214-20. W.B. Saunders, Philadelphia.

Kosh, T. (1994) Establishing the rigour in qualitative research: the decision trail. <u>Journal of Advanced Nursing,</u> 19, pp. 976-986.

Kroll, L., Bailey, S, Myatt, T, McCarthy, K, Shuttleworth, J, Rothwell, J, and Harrington, R (1999) <u>The mental health screening interview for adolescents: Young persons' interview.</u> The University of Manchester Child Psychiatry Department and the Adolescent Forensic Unit, Mental Health Services of Salford NHS Trust. London. Youth Justice Board.

Kvale, S. (1996) <u>Interviews: an introduction to qualitative research interviewing.</u> London: Sage.

Kvale, S. (2007) <u>Doing Interviews.</u> London: Sage

Kvale, S and Brinkman, S. (2009) Interviews: <u>Learning the craft of qualitative research interviewing</u> (2nd ed.) London: Sage.

Lee, M (2007) <u>Human Trafficking</u>. Devon: Willan publishing.

Lee, M and R O'Brien, R (1995) 'The game's up', The Children's Society,

Levy, A. (2004) 'Stigmatised, marginalised and criminalised'. An overview of the issues relating to young people involved in prostitution. London: National Society for the Prevention of Cruelty to Children.

Lincoln, YS. and Guba, EG. (1985). Naturalistic Inquiry. Newbury Park, CA: Sage Publications.

Lincoln, Y.S., Guba, E.G. (1989) Fourth Generation Evaluation. Newbury Park, CA: Sage.

National Society for the Prevention of Cruelty to Children (2002) 'I think I may need some help with this problem': Responding to young people who display sexually harmful behaviour, London: National Society for the Prevention of Cruelty to Children.

Lowe, K and Pearce, J. (2006) Young People and Sexual Exploitation. Child Abuse Review. 15: pp. 289-293.

Mangione, T.W. (1995) Mail Surveys-improving the quality. Thousand Oaks, CA: Sage

Masson, J. (2004) The legal context. Cited in: Fraser,S., Lewis,V., Ding,S., Kellett, M and Robinson,C (Eds.) Doing research with young people London: Sage.

Matthews, S., Brasnet, L., and Smith, J. (2006) Underage drinking: findings from the 2004 Offending, Crime and Justice Survey. London: Home Office Research Findings No.277.

May, T. (2001) Social Research: Issues, Methods and Process (3rd ed). Buckingham: Open University Press.

May, T., Edmunds, M., Hough, M., and Harvey, C. (1999) Street Business: The links between sex and drug markets. Police research paper 118. London: Home Office Policing and Reducing Crime Unit.

May, T. and Hunter, G. (2006) Sex work and problem drug use in the UK: the links, problems and possible solutions In Sex Work Now (2006) Campbell, R and O'Neill, M (Eds). Devon: Willan Publishing.

McColl, E., Jacoby, A., Thomas, L., Soutter, J., Bamford, C., Steen, N., Thomas, R., Harvey, E., Garratt, A., and Bond, J. (2001) Design and use of questionnaires: a review of best practice applicable to surveys of health service staff and patients. Health Technology Assessment, NHS R and D, HTA Programme, 5 (31).

McNiff, J and Whitehead, J (2008) All you need to know about Action Research. London: Sage.

Medical Research Council (2004) MRC Ethics Guide. Medical research involving children. [online]. London: Medical Research Council. Available from: http// www.mrc.ac.uk. [accessed 10th October 2006].

Medical Foundation for Sexual Health (2005) Recommended standards for Sexual Health Services. London: Department of Health.

Melrose, M. and Ayre, P. (2002) 'Child prostitution in the 1980s and 1990s'. Cited in: Browne, A. and Barrett, D. (eds) Knowledge of Evil: Child Prostitution in Twentieth Century. Devon: Willan.

Melrose, M., Barrett, D., and Brodie, I. (1999) One Way Street: Retrospectives on Childhood Prostitution. London: Children's Society. University of Luton Press: Luton.

Melrose, M. and Barrett, D. (2001) Child prostitution in Britain: some reflections on context, causes and responses. Child Right, 174 (3), pp 10-11.

Melrose, M., and Barrett, D (2004) Anchors in floating lives: interventions with young people sexually abused through prostitution. Dorset: Russell House Publishing.

Meltzer, H., Lader, D., and Corbin, T. (2002) Non-fatal suicidal behaviour amongst adults aged 16-74 in Great Britain. London: The Stationery Office.

Miller, W. R. (1996) Research, practice, puzzles. Addictive Behaviours, 21, pp. 835-842.

Miller, W.R. and Rollnick S. (2000) Motivational Interviewing. Preparing People for Change. 2nd Edition Guilford Press.

Mind (2007) Information for better mental health. Suicide. [online].Mind. Available from: http://www.mind.org.uk/Information/Factsheets/Suicide/
[accessed 25th September 2007].

Mitscherlich A, Mielke F. Doctors of infamy: the story of the Nazi medical crimes. New York: Schuman, 1949: xxiii-xxv. Nuremberg Code (1947) [online]. Available from: http://www.ohsr.od.nih.gov/guidelines/nuremberg.html
[accessed 6th June 2006]

Moore,L.(1998) The experience of sexual assault. Nursing Standard 12 (48) pp. 49-56.

Moran, D. (2005) Edmund Husserl, Founder of Phenomenology. Cambridge: Polity Press.

Moser, C.A. and Kalton, G. (1992) Survey Methods in Social Investigation. (2nd edition). Surrey: Gower publishing company limited.

Moustakas,C. (1994) Phenomenological research methods. London, Thousand Oaks: Sage.

Murphy, E., Dingwall, R., Greatbach, G., Parker, S. and Watson, P. (1998) Qualitative research methods in health technology assessment: a review of the literature. Health Technology Assessment (2)16.

National Children's Bureau (2003) Guidelines for Research. London: NCB.

National Chlamydia Screening Steering Group (2006) New Frontiers: Annual Report of the National Chlamydia Screening Programme in England 2005/2006. London: Health Protection Agency.

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2010), Annual Report for England and Wales, July 2010. [online] University of Manchester (NCISH). Available from: http://www.medicine.manchester.ac.uk/psychiatry/research/suicide/prevention/nci/inquiry_reports

National Institute for Clinical Excellence (2004) Clinical guide 16. Self-Harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. [online]. London: British Psychological Society, Royal College Psychiatry, NHS, NICE. Available from: http://www.nice.org.uk/ [accessed 2nd December 2006].

National Institute for Clinical Excellence (2004a) Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa, and binge eating disorders. [online]. London: British Psychological Society. Available from: http://www.nice.org.uk/ [accessed 5th December 2006].

National Institute for Clinical Excellence (2005) The management of PTSD in adults and   children in primary and secondary care. National cost-impact report. Implementing NICE Clinical Guideline no. 26. [online]. London: NICE. Available from: http://www.nice.org.uk/nicemedia/pdf/CG026costingreport.pdf [accessed 10th December 2006].

National Institute for Clinical Excellence (2009) Borderline Personality Disorder: treatment and management. [online]. London: British Psychological Society. Available from: http://www.nice.org.uk/ [accessed 15th May 2010].

National Institute for Health and Clinical Excellence (2007) Community-based interventions to reduce problematic substance use amongst vulnerable and disadvantaged young people. NICE public health intervention guidance 4. [online]. London: NHS, NICE. Available from: http://www.nice.org.uk/ [accessed 15th December 2007].

National Treatment Agency (2005) Young people's problematic substance use treatment services- essential elements. [online]. London: National Treatment Agency. Available from: http://www.nta.nhs.uk [accessed 23rd June 2007].

National Treatment Agency (2007) Assessing young people for problematic substance use. [online]: London. NTA. Available from: http://www.nta.nhs.uk [accessed 15th August 2007].

National Working Group for Sexually Exploited Children and Young People. (2009) Membership Survey [online]: Available from: http://www.nationalworking group.org.uk/ [accessed 11th April 2010].

Nelson, S. (1999) Psychosexual issues in sexual health care cited in: Weston, A. (ed.) Sexually Transmitted Infections. London: Nursing Times Books.

Newell, R. and Burnard, P. (2006) Research for Evidence-Based Practice. Vital Notes for Nurses. London: Blackwell Publishing.

Nursing and Midwifery Council (2004) Code of professional conduct: standards for conduct, performance and ethics. London: NMC.

Nutbeam, D. and Harris, E. (1998) Theory in a nutshell: A Practitioner's Guide to Commonly used Theories and Models in Health Promotion. [online]. Sydney: National Centre for Health Promotion. Available from: http://hpp.sagepub.com/cgi/content/abstract/2/1/43 [accessed 4th May 2009]

O'Connell, R. (2003) A Typology of Child Cyber-sexploitation and Online Grooming Practices. Preston: University of Central Lancashire.

O'Neill, M and Barbaret, R (2000) Victimization and the social organization of prostitution in England and Spain. Pp.123-137 in Sex for Sale, edited by R.Weitzer. London: Routledge.

Palmer, T. (2001) No Son of Mine: Children abused through prostitution. [online]. Ilford: Barnardos. Available from: http://www.barnados.org.uk/resources [accessed 3rd June 2007].

Palmer, T. (2002) Factsheet: Young people abused through prostitution in the UK. [online]. Ilford: Barnardos. Available from: http://www.barnados.org.uk/resources [accessed 23rd July 2007].

Patel, N. and Pearce, J (2004) Street Matters: A response to young people exploited through prostitution, in Anchors in floating lives: Models of practice with young people sexually exploited through prostitution, edited by Melrose, M and Barrett, D . Lyme Regis: Russell House Publishing.

Parahoo, K. (2006) Nursing Research. Principles, Process and Issues. (2nd ed). Hampshire: Palgrave Macmillan.

Pearce, J.J., Williams, M. and Galvin, C. (2002) It's someone Taking a Part of You: a study of young women and sexual exploitation, London: The National Children's Bureau.

Pearce J. J. (2006) Who needs to be involved in safeguarding sexually exploited young people? Child Abuse Review, 15 pp. 326-340.

Pearce, J (2007) Sex, risk and resilience in adolescence, in Coleman, J and Hagell, A. (2007) Adolescent risk and resilience: Against the odds, Chichester, Wiley.

Pearce J. J. (2007a) Risk and resilience: a focus on sexually exploited young people in Thom, B., Sales, R and Pearce, J.J. (2007) Growing up with risk. Bristol. Policy Press.

Pearce, J (2009) Young People and Sexual Exploitation. 'It's not hidden, you just aren't looking'. London: Routledge.

Peterson, T. and McBride, A. (2008) working with problematic substance users. London: Routledge.

Perakyla, A. (1997) Reliability and validity in research based on tapes and transcripts: Cited in Silverman D (ed) Qualitative research theory, Method and Practice. Thousand Oaks: Sage.

Phoenix, J. (2003) <u>Working with Youth Prostitution: A database</u>, Full report of research activities and results to the Economic and Social Research Council. [online]. Available from: <u>http://www.regard.ac.uk/regard/map/</u> [accessed 1st July 2007]

Piercy,H. and Hargate, M. (2004) Social research on the under-16's: a consideration of the issues from a UK perspective. <u>Journal of Child health care</u>, 8 (4) pp. 253-263.

Polit, D.F. and Beck, C.T. (2004) <u>Nursing Research. Principles and Methods</u>. Seventh edition. Philadelphia: Lippincott Williams and Wilkins.

Polit, D.F. and Beck, C.T. (2006) <u>Essentials of Nursing Research. Methods, Appraisal and Utilisation</u>. Sixth edition. Philadelphia: Lippincott Williams and Wilkins.

Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

Prime Minister's Strategy Unit (2004) <u>Alcohol Harm Reduction Strategy for England.</u> London: Cabinet Office.

Prochaska, J. O. and DiClemente, C. C. (1984) <u>The Transtheoretical Approach: Crossing Traditional Boundaries of Therapy,</u> Homewood, IL: Dow Jones Irwin.

Raistrick, D., Heather, N., and Godfrey, C (2006) <u>Review of the effectiveness of treatment for alcohol problems</u>. London: National Treatment Agency.

Rassool, H (2006) Dual Diagnosis Nursing. Oxford: Blackwell Publishing.

Reeves, C., Whitaker, R., Parsonage, R.K., Robinson, C.A., Swale, K and Bayley, L (2006) Sexual health services and education: Young people's experiences and preferences. Health Education Journal, 65 (4), pp. 368-379.

Release (2005) <u>Sex Workers and the Law</u>. London: Release.

Rethink and Turning Point (2004) <u>Dual diagnosis toolkit. Mental health and problematic substance use. A practical guide for professionals and practitioners.</u> London: Rethink and Turning Point.

Richards, S. and Mughal, A. (2009) <u>Working with the Mental Capacity Act 2005</u>. Second ed. Hampshire: Matrix Training Associates.

Robson, C. (2002) <u>Real World Research</u>. (Second ed). Oxford: Blackwell.

Robson, C. (2004) <u>Real World Research</u>. (Second ed. Oxford: Blackwell.

Robson, C. (2007) How to do a Research Project. Oxford: Blackwell.

Rollnick S., & Miller, W.R. (1995) What is motivational interviewing? *Behavioural and Cognitive Psychotherapy*, *23*, 325-334.

Royal College of Nursing (2004) <u>Research Ethics. RCN guideance for nurses.</u> London: RCN.

Royal College of Paediatrics and child health (2000). Guidelines for the ethical conduct of medical research involving children. <u>Archives of Disease in Childhood</u> 82, pp. 177-182. [online]. RCPCH. Available from: <u>http://www.rcpch.ac.uk</u>. [accessed 1st February 2007].

The Royal College of Paediatrics and Child Health (2003) <u>Bridging the Gaps: Health Care for Adolescents.</u> Royal College of Psychiatrists Council Report (CR114), London, UK.

Rutter, M. (1985) 'Resilience in the face of adversity: Protective factors and resilience to psychiatric disorders'. <u>British Journal of Psychiatry</u>, 1475 pp. 89-611.

Saks, M. and Allsop, J. (2008) <u>Researching Health: Qualitative, quantitative and mixed methods</u>. London: Sage.

Sapsford, R. Jupp, V. (2006) <u>Data collection and Analysis. (</u>Second ed). <u>London: </u>Sage.

Scott, S. (2001) <u>Barnardos PHASE project: a case study evaluation</u>. University of Liverpool: Barnardos.

Scott, S. and Harper, Z. (2005) <u>Meeting the needs of sexually exploited young people in London: s</u>ummary report. Essex: Barnardos.

Scott, S. and Skidmore, P. (2006) <u>Reducing the risk: Barnardos support for sexually exploited young people. A 2 year evaluation: summary report.</u> Essex: Barnardos.

Scottish Executive (2004) <u>Being Outside: Constructing a Response to Street Prostitution. A Report of the Expert Group on Prostitution in Scotland.</u> Edinburgh: Scottish Executive.

Secker, J. Armstrong, C. and Hill. M (1999) Young peoples understanding of mental illness. <u>Health Education Research, Theory and practice</u> 14. No 6 pp 729-739.

Shaw, I. and Butler, I. (1998) Understanding young people and prostitution: a foundation for practice? <u>British Journal of Social Work,</u> 28 pp. 177-196.

Shepherd, W.L., Scott, M., and Warwick, J. (1999) <u>'Naming the Game'</u> Children Abused through Prostitution (SECOS Project), Ilford: Barnardos.

Sheridan, M.D. (1997) <u>From birth to 5 years: children's developmental progress.</u> London: Routledge.

Silverman, D. (2000). <u>Doing Qualitative Research</u> London: Sage.

Skidmore, P. (2004) <u>What works in child sexual exploitation: sharing and learning.</u> Barnardos Research and Development, UK, Stade Advies, Netherlands: Barnardos.

Social Exclusion Unit (1999) <u>Teenage Pregnancy. Cm 4342</u>. [online] London: The Stationery Office. Available from: <u>http://www.dfes.gov.uk</u>
[accessed 23rd August 2007].

Social Exclusion Unit, Office of the Deputy Prime Minister (2005) <u>Transitions. Young Adults with Complex Needs</u>. A Social Exclusion Unit Final Report. London: Social Exclusion Unit.

Social Research Association (2003) Ethical Guidelines. [online]. SRA. Available from: http://www.the-sra.org.uk [accessed 14th September 2007].

Steel, R. (2003) 'Consultation document for involving marginalised and Vulnerable groups in research'. Hampshire: INVOLVE.

Stevenson, C. and Petrak, J. (2007) Setting up a clinical psychology service for commercial sex workers. International Journal of STD and AIDS, 18 pp. 231-234.

Streubert Speziale, H.H. and Carpenter, D.R. (2007) Qualitative Research in Nursing- Advancing the Human Imperative. Fourth ed. London: Lippincott Williams and Wilkins.

Sudman, S. and Bradburn, N. (1982) Asking questions: a practical guide to questionnaire design. San Francisco, C.A: Jossey-Bass.

Swann, S. (1998) Whose daughter next? Children abused through prostitution. Ilford: Barnado's.

Swann, S. and Balding, V. (2002) Safeguarding children involved in prostitution: Guidance review. London: Department of Health.

Taylor-Brown, J. (2002) More than One Chance! Young people involved in prostitution speak out, [online]. EPCAT International.
Available from: http:// www.epcat.net. [accessed 22nd July 2007].

The Sexual Offences Act 2003. London: The Stationery Office.

Thorne, S (2000) Data analysis in qualitative research. Evidence Based Nursing 3: 68–70.

U.K.A.C.D.M: (UK Advisory Council on the Misuse of Drugs on the Misuse of Drugs) (2003). Hidden harm- responding to the needs of children of problem drug users. London: Home Office.

UK Anti-Drugs Co-ordination Unit (1998). Tackling Drugs to Build a Better Britain: The Government's 10-Year Strategy for Tackling Drug Misuse, Cm 3945. London: The Stationery Office.

UK Anti-Drugs Co-ordination Unit (2002) Updated Drug Strategy, London: Cabinet Office.

The United Nations International Children's Emergency Fund (UNICEF) (2004) [online]. Available from:
http://www.unicef.org.uk/unicefuk/policies/printer_friendly.asp?policy=8
 [accessed 14th May 2006].

United Nations Committee on the Rights of the Child (1995, 2003). Consideration of Reports submitted by States Parties Under Article 44 of the Convention, Concluding Observations: UK of Great Britain and Northern Ireland. United Nations Geneva. [online].Availablefrom:
http://en.wikipedia.org/wiki/Convention_on_the_Rights_of_the_Child
[accessed 10th May 2007].

United Nations Economic and Social Commission for Asia and the Pacific. Commercial sexual exploitation of children. 1999 [online]. Available from:
http://www.escap-hrd.org/sae/csec.1.htm [accessed 13th September 2006].

United Nations High Commissioner for Human Rights. (2000) Optional Protocol to the Convention on the Rights of the Child on the sale of Children, Child Prostitution and Child Pornography. Adopted and opened for signature, ratification and accession by General Assembly Resolution A/RES/54/263 of May 2000. [online]. Available from: http://www.unhchr.chr.ch/html/menu2/dopchild.htm [accessed 3rd September 2007].

University of Bradford (2005). Code of practice for research students. UoB.

Walby, S. and Allen, J. (2004) Domestic violence, sexual assault and stalking: Findings from the British Crime Survey. Home Office research study 276. London: Home Office Research, Development and Statistics Directorate.

Walker, K. E. (2002) Exploitation of young people through prostitution. Journal of Child Health Care, 6(3) pp. 182-188.

Walters, H. (2005) A brief introduction to some of the key legislation that protects children in the U.K. [online]. London: NSPCC. Available from: http://www.nspcc.org.uk/Inform/research/questions/child_protection legislation_in_the_uk_PDF_wdf48953.pdf [accessed 30th October 2008].

Wells, M. and Mitchell, K.J. (2007) Youth sexual exploitation on the internet: DSM-IV diagnoses and gender differences in co-occurring mental health issues. Child and Adolescent Social Work Journal, 24 (3) pp235-260

Wilcox, D.T., Richards, F., and O'Keefe, Z.C. (2004) Resilience and Risk Factors Associated with Experiencing Childhood Sexual Abuse. Child Abuse Review, 13 pp. 338-352.

Wiles, R., Heath, S., Crow, G., and Charles,V. (2005) Informed consent in social research: a liteature review. [online]. National Centre for Research Methods Review Papers NCRM/001. Economic and Social Research Council National Centre for Research Methods. Available from: http://eprints.ncrm.ac.uk/85/1/MethodsReviewPaperNCRM-001.pdf [accessed 23rd January 2006].

Wilson, A and Williams, R (2000) Sexual health services: what do teenagers want? Ambulatory Child health, 6, pp. 253-260.

Willis, B.M. and Levy, B.S. (2002) Child prostitution: global health burden, research needs, and interventions. The Lancet, 359, pp.1417-1422.

World Health Organization (2002) Working definition of sexual health, [online]. W.H.O. Avalable from: http://www.cdc.gov/sexualhealth/ [Accessed 21st January 2011]

World Health Organization (2007) Factsheet No 110: Sexually transmitted infections, [online]. W.H.O. Avalable from: http://www.who.int/mediacentre/factsheets/fs110/en/rint.html [Accessed 28th January 2008]

World Medical Association. Declaration of Helsinki (1996) British Medical Journal, 313 (7070) pp. 1448-1449.

Appendix 1

Selection criteria protocol (Phase 1)

Research title

'The identification of barriers and solutions to meeting the physical and psychological health needs of young people involved in or vulnerable to sexual exploitation'.

Setting

Specialist agencies with a remit to support sexually exploited young people have been identified via the National Working Group for Sexually Exploited Young people and have been invited to take part in this research study.

Procedure

An information leaflet describing the research study, with researcher contact details will be distributed to all young people who attend the agency and are interested in participating in the study. It is anticipated that recruitment and selection of young people to the study will be undertaken by the researcher and a member of staff from each agency. Young people will be approached through agencies supporting them. Only young people receiving support from the agency will be approached.

All young people will be approached, using the selection and exclusion criteria protocol as a guide. However a young person will not be approached to participate in the study if they are considered to be *too vulnerable*, due to *additional factors* known to the agency staff supporting them at that particular time. The integrity of this decision lies ultimately with the young person and their support worker. The terms of engagement with the young person and the researcher will be determined in collaboration with each agency.

Selection criteria, any young person:

- With experience of sexual exploitation.
- Receiving support from sexual exploitation agency
- Below 19 years
- Able to give consent and willing to participate

Exclusion criteria, any young person:

- With no experience of sexual exploitation.
- Not receiving support from sexual exploitation agency.
- Above 18yrs
- Unable to give consent and unwilling to participate
- Considered to be *too vulnerable*, due to *additional factors known to the agency staff* supporting them, at that particular time.

Appendix 2

Information sheets for children aged up to 12 years (Phase 1)

Study title: How to get help for a health problem.

What is research?
Research is looking carefully at something.

Why is this research being done?
To find ways for young people to get the help to stay well.

Why have I been asked to join in this research?
You have been chosen because you are getting help from this agency. We are also hoping to talk with other young people.

Did anyone else check the study is OK to do?
This research project has been checked by people who make sure that the research is OK to do and will not hurt anybody.

Do I have to take part? No! It is up to you, you don't have to if you don't want to.

What will happen to me if I take part in the research?
You will be asked to come to this agency at an arranged time to meet Tracy, only once. We will be given a private room where we will talk about your health and anything that you think is a risk to your health. You will be asked how you usually get help for a health problem. The talk will be taped and will last less than an hour. What we talk about is private and the tape will be destroyed at the end of the study.

Might anything else about the research upset me?
The things we talk about may be upsetting for you, therefore we will arrange a person from this agency to be around to offer you support if you need it. We can stop at any time.

Will joining in, help me?
We cannot promise the study will help you but the information we get might help young people in a similar situation to you in the future.

Will anyone else know I'm doing this? Staff form this agency will know.

What happens when the research stops? Tracy will not need to see you again.

What if I don't want to do the research anymore?
If at any time you don't want to do the research anymore, just tell Tracy, your parents, doctor, nurse or staff at this agency. They will not be cross with you and you will still get the same support as before.

Thank you for talking with me, Tracy McClelland.

Appendix 3

Information sheets for young person aged 13 to 18 years (Phase 1)

Study title: '*Improving access to health services for young people who receive support from a sexual exploitation agency'.*

Why are we doing this research?
We are asking if you would agree to take part in a research project to find the answer to the questions:

- What are your physical and emotional health needs?
- What do you see as the risks to your health?
- What are the things that stop you getting help for a health problem?
- What can be done to help you to get support for a health problem?

Before you decide if you want to join in, it's important to understand why the research is being done and what it will involve for you. So please read this leaflet carefully. Talk about it with your family, friends or agency support worker if you want to.

Thank you for reading this.

It is believed by some researchers and support workers that more should be done to help young people to get help with health problems. It is important to listen to young people in order to learn from their personal experiences, this research is trying to do that.

Why have I been asked to take part?
You have been chosen because you are receiving support from this agency. Other young people in a similar situation to you are also being invited to join in this study. We are hoping to talk with other young people.

Do I have to take part?
'No'. It is up to you. If you do, Tracy McClelland (the researcher), will ask you to sign a form giving your consent. You will be given a copy of this information sheet and your signed forms to keep.

You are free to stop taking part at any time <u>during the research</u> without giving a reason.
If you decide to stop, this will not affect the care you receive.

What will happen to me if I take part?
You will be asked to attend this project at an arranged time to meet Tracy. We will be given a private room where we will talk. Tracy will be asking you about your health and anything you do that you think is a risk to your health. You will be asked about how you usually get help for a health problem. We are really interested in what you think is helpful or unhelpful. The interview will be taped and will last less than an hour. You will only be asked to do this once. You will be able to claim back your travel expenses. You may wish to discuss part of the talk with your family or friends. The information on the tape will be kept private and only the research team will be able to listen to it. At the end of the study the tape will be destroyed.

What will I be asked to do?

Tracy will explain the study to you and you will be given a chance to discuss it with your family, friends or key worker. An outline of the study will be given to you in writing as well. Tracy will ask you if you are prepared to join in the study. If you are going to join in, Tracy will ask you to sign a consent form. A convenient day and time will be arranged to meet Tracy to have the one to one talk.

The information from you and other young people in Yorkshire in a similar situation to your self will be carefully looked at by Tracy and another researcher. A report will be written at the end of the study. Recommendations on how to improve access to health services for young people will be made in this report. You will be given a shorter copy of this report if you like.

Is there anything else to be worried about if I take part?
The things we talk about may be upsetting for you, therefore we will arrange a person from this agency to be around to offer you support if you need it. Also we can stop at any time you like. Tracy has had training in supporting people emotionally.

What will the researcher do with the information about me?
The researcher will keep information about you on tape, in writing and on a computer. It will not be possible to identify you from the information you share with the researcher. The researcher has responsibility for looking after this information. The researcher may write about the research for other people to read. It will not be possible to identify you from what is written.

What are the possible benefits of taking part?
We cannot promise the study will help you but the information we get might help young people in a similar situation to yourself in the future.

Contact Details:
Tracy McClelland, researcher, University of Bradford.
Telephone number: 01274 236571. Email address: <u>g.t.mcclelland@bradford.ac.uk</u>.

Rob Newell, research supervisor, University of Bradford.
Telephone number: 01274 236593. Email address: <u>r.j.newell@bradford.ac.uk</u>
Thank you for reading so far – if you are still interested, please go to Part 2:
Part 2: Information you need to know if you still want to take part.

What happens when the research project stops?
You will not be contacted by the researcher when the research stops.

Will anyone else know I'm doing this?
Yes – Research inspectors will see the research notes to make sure the research is being done properly. Staff from this agency will be told you are taking part.

All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you which leaves this agency will have your name and address removed so that you cannot be recognised from it.

Who is organising and funding the research?
The University of Bradford

Who has reviewed the study?
Before any research goes ahead it has to be checked by an Ethics Committee. They make sure that the research is OK to do. Your project has been checked by an Ethics Committee.

Appendix 4

Parent/Guardian information sheet (Phase 1)
Part 1
Study title:
'Improving access to health services for young people who may have been taken advantage of sexually'.

I am writing to all young people who attend this agency to tell them about a research study that is taking place and your daughter/son is being asked to take part. The research will be done by Tracy McClelland and supervised by Rob Newell from the University of Bradford.

What is the purpose of the research project?
The research is being done to find out how to improve access to health care for young people who may have been taken advantage of sexually. We would like to look at the following issues:

The physical and emotional health needs of young people who have been taken advantage of sexually.

- What does your daughter/son see as the risks to her/his health?
- The things that stop your daughter/son from getting help for a health problem?
- What can be done to help your daughter/son to get support for a health problem?

Why has my daughter/son been chosen?
Your daughter/son has been chosen because she/he is receiving support from this agency. Other young people in a similar situation to her/him are also being invited to join in this study. We are hoping to talk to as many young people as possible.

Does my child have to take part?
'No'. It is up to them. If they do wish to take part Tracy McClelland (the researcher), will ask you and your daughter/son to sign a form to give consent.
You will both be given a copy of this information sheet and your signed forms to keep.

Your daughter/son is free to stop taking part at any time <u>during the research</u> without giving a reason. If they decide to stop, this will not affect the care they receive now or in the future.

What will happen to my child if we agree to take part?
If you are happy for your daughter/son to take part, and are satisfied with the explanations from Tracy McClelland, you will be asked to sign a consent form. If your daughter/son is able to understand the research and is happy to take part and can write their name, they will be asked to sign a consent form. You will be given a copy of the signed information sheet and consent forms to keep for your records.

What does my child have to do if she/he agrees to take part?
Tracy will ask your daughter/son if she/he is prepared to join in the study. If they are going to join in, Tracy will ask you and them to sign a consent form. A convenient day and time will be arranged to meet at this agency to have the one to one talk with Tracy. This agency will provide a room so that we can talk in private. This will be once only and for less than an hour. Tracy will be asking about their health and anything that they think is a risk to their health. We are really interested in what your daughter/son thinks is helpful or unhelpful. The interview will be taped and the

information on the tape will be kept private and only the research team will be able to listen to it. At the end of the study the tape will be destroyed.

The information given will be carefully looked at by Tracy and another researcher. A report will be written at the end of the study. Recommendations on how to improve access to health services for young people will be made in this report. You and your daughter/son will be offered a summary of this report.

Is there anything else to be worried about if my daughter/son takes part?
The things we talk about may be upsetting for your daughter/son; therefore we will arrange a person from this agency to be around to offer them support if needed. Also we can stop at any time. Tracy has had training in supporting people emotionally.

What are the possible benefits of taking part?
We cannot promise the study will help your daughter/son but the information we get might help young people in a similar situation in the future.

What happens when the research stops?
Your daughter/son will not need to see the researcher again.

Will my child's taking part in the research project be kept confidential?
Yes, all information which is collected about your daughter/son during the course of the research will be kept strictly confidential. Any information about them which leaves this agency, will have their name and address removed so that they cannot be recognised from it.

This completes Part 1 of the Information Sheet.

If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision.

What will happen if my child or I don't want to carry on with the research?

You have the right to withdraw from the research at any point and this will not affect the care your daughter/son is receiving.

What if there is a problem? You may wish to contact:
Tracy McClelland, researcher, University of Bradford.
Telephone number: 01274 236571. Email address: <u>g.t.mcclelland@bradford.ac.uk</u>.

Rob Newell, research supervisor, University of Bradford.
Telephone number: 01274 236593. Email address: <u>r.j.newell@bradford.ac.uk</u>

What will happen to the results of the research study?
A report will be written and parts of this report may be published. Any information relating to your daughter/son will be anonymous and therefore it will not be possible to identify them from it.

Who is organising and funding the research? The University of Bradford.

Who has reviewed the study? Before any research goes ahead it has to be checked by an Ethics Committee. They make sure that the research is OK to do. This project has been checked by an Ethics Committee.

Appendix 5

Researcher confidentiality statement (Phase 1)

Purpose: This document has been compiled by the researcher for the purpose of undertaking the following research study entitled:
'The identification of barriers and solutions to meeting the physical and psychological health needs of young people involved in or vulnerable to sexual exploitation'.

Scope: Sexual exploitation services in the North of England have been identified to be involved in the research study. The duration of the study will be between 4 and 5 years.

Legislative context: Data Protection Act (1998), Human Rights Act (1998), Freedom of Information Act (2000).

Key Activities: The researcher will ensure that all young people and other participants in the research study are made aware of the following:

- The researcher will be recording, documenting and securely storing information about the young person in writing, on a computer and on tape, in accordance with the Data Protection Act (1998).
- This information will be anonymous which means that it will not be possible to identify the young person from it.
- The young person has the right to see and alter this information and can request this by asking the researcher.
- The researcher has responsibility for looking after this information.
- At the end of the study the written, typed, tape recorded and computer stored information will be destroyed.

Roles and responsibilities of the researcher: Information sharing

- Information given to the researcher about the young person is confidential. This means that the information will not divulged to any other person by the researcher.
- Information shared between the young person and agency staff will not be shared with the researcher.
- Information shared between the young person and the researcher will not be shared with agency staff unless identified exceptional circumstances apply.

Exceptional circumstances

- When the client is in a serious, urgent or life threatening situation. This may include protection from self-harm or abuse.
- When the client's emotional or mental state suggests that they may endanger another person (for example, a member of staff or a member of the public).
- When information regarding another young person or child who is considered to be in a situation which may lead to serious harm or death is divulged to the researcher.
- If the young person goes missing and is known to be at serious risk.
- Where to take no action would threaten the security or wellbeing of others.
- In very rare cases, the police or courts may demand information. This would only take place at the discretion of the manager of the agency.

Taking Action

If the researcher needs to take action to protect the young person or other people she will try to discuss this with the young person first to gain their permission. If this is not possible, the researcher will restrict any information given to the minimum needed to avert the immediate danger. The researcher will disclose relevant information to the manager of this agency, who will take appropriate action. The young person will be informed and supported throughout the process and made aware of the outcomes.

Thank you for reading this confidentiality statement. If anything in this statement is not clear, please ask Tracy McClelland, the researcher, to explain it to you.

Appendix 6

Confidentiality statement outline to share with young person (Phase 1)

These notes have been put together by Tracy McClelland, the researcher to use when carrying out this research.

What will the researcher do with information about me?
- The researcher will keep information about you on tape, in writing and on a computer.
- It will not be possible to identify you from the information you share with the researcher.
- The researcher has responsibility for looking after this information.

Will I be able to see this information?

Yes, you have the right to see and change the information about you and can request this by asking the researcher.

What will happen to this information?
At the end of the study the written, typed, tape recorded and computer stored information will be destroyed by the researcher.

Who will share this information?
- Information given to the researcher about you is **confidential.** This means that the information will not be shared with any other person by the researcher. Information shared between you and agency staff will not be shared with the researcher.

- Information shared between the young person and the researcher will not be shared with agency staff or anyone else unless there is concern about yours' or someone else's safety.

Information will be passed on if:
- You are in a serious, or life threatening situation.
- It is believed that you may endanger another person, for example a member of staff or a member of the public.
- When information is shared with the researcher about another young person or child who is believed to be in a situation which may lead to serious harm or death.
- If you go missing and are known to be at serious risk.
- Where **doing nothing** may affect the safety or wellbeing of other people.
- Sometimes, not very often, the police or courts may ask for information. The manager of this agency would decide what to do about this.

Taking Action

If the researcher needs to take action to protect you or other people she will try to discuss this with you first to get your agreement. If this is not possible, the researcher will pass on as little information as possible that is needed. This information will be passed on to the manager of this agency, who will do what needs to be done. You will be supported and told what is happening whilst this is being dealt with.

Appendix 7

Consent form (Phase 1)

Title of Project:

Improving access to health care for young people who receive support from a sexual exploitation agency

Name of Researcher: Tracy McClelland.

Please initial line

1. I confirm that I have read and understand the information sheet dated 27.02.06 for the above study. I have had the chance to consider the information, ask questions and have had these answered satisfactorily

2. I understand that my involvement is voluntary and that I am free to stop being involved in the study at any time without my medical care or legal rights being affected.

3. I understand that information collected about me during the study, may be looked at by responsible individuals from the University of Bradford and other officials checking the study to make sure it is being done legally where it is relevant to my taking part. I give permission for these individuals to have access to my records.

4. I agree to take part in the above study

Name of Young person   **Date**   **Signature**

Researcher   **Date**   **Signature**

Tracy McClelland

Appendix 8

Interview prompt schedule (Phase 1)

Introduction and confidentiality
Rationale: To explain the procedure and to reinforce confidentiality and the possible disclosure of information.

Please could you say what do you understand by health?
Rationale: To establish the young persons understanding and perception of health.

Please could you say what you understand by illness?
Rationale: To establish the young persons understanding and perception of illness.

How would you describe your health?
Rationale: To elicit information relating to the young persons health status, from their perspective.

What do you consider to be risky to health?
Rationale: To encourage the young person to explore their behaviour in relation to risk taking and the impact of this upon their health.

How important is it for you to be healthy?
Rationale: To gauge the extent to which health is an important element of the young person's life.

Please could you describe your experiences of getting help for a health problem?
Rationale: To explore the positive and negative experiences of the young person seeking help for a health problem.

What things encourage or discourage you from getting help for a health problem?
Rationale: To offer insight into the reasons why young people do or do not use health services available to them.

How could things be improved for you to be able to get the help you need?
Rationale: The suggestions made by the young person may contribute to recommendations relating to future design and delivery of health services specific to their needs.

Is there anything else you would like to say?
Rationale: The young person may wish to offer additional information relating to the research questions but not covered in the interview. This information may be used to shape subsequent interview prompts with other young people.

Appendix 9

Questionnaire (Annotated version) (Phase 2)

1. Please tick how you would describe your agency.
    Statutory, Non- statutory, Private, Other please specify

2. Please tick any physical health problems encountered by young people who use your service:

   (Rationale: to establish information re: physical health issues
   encountered by young people in the service)

Frequency seen in service	Very frequently	Frequently	Occasionally	Never
Injuries				
Sexually transmitted infection(s)				
Gynaecological problems				
Pregnancy complicatio				
Blood borne virus/disease				
Alcohol problems				
Drug problems				
Other please specify				

3. Please tick any psychological/mental health problems encountered by young people who use your service?

   (Rationale: to establish information re: psychological health issues
   encountered by young people in the service)

Frequency	Very frequently	Frequently	Occasionally	Never
Anxiety				
Low mood				
Low self esteem				
Self harm				
Suicidal thoughts				
Suicidal behaviour				
Emotional problems				
Eating problems,				
Paranoia/suspicion				
Behavioural problems				
Seeing things : visual hallucinations				
Hearing voices: auditory hallucinations)				
Other				

4. In your opinion what behaviours may young people who use your service be involved in that negatively impact on their **physical** health?

You are welcome to answer in as much detail as you like. Please continue over the page if necessary.

(Rationale: to develop a profile of behaviours that pose risk to physical health)

5.   In your opinion how effectively are the **physical** health needs of sexually exploited young people met by statutory and non statutory agencies?

(Rationale: to gauge extent of how well physical health needs are met)

Please tick 1 box

Extremely effectively	Effectively	Neither effective nor ineffectively	Ineffectively	Extremely ineffectively

6.   In your opinion what behaviours may young people who use your service engage in that negatively impact on their **psychological/mental health?**

(Rationale: to develop a profile of behaviours that pose risk to mental health)

7.   In your opinion, how effectively are the **psychological/mental health** needs of sexually exploited young people met by statutory and non statutory agencies?

(Rationale: to gauge how well psychological/mental health needs are met.)

Please tick 1 box

Extremely effectively	Effectively	Neither effective nor ineffectively	Ineffectively	Extremely ineffectively

8.   *Please look at each type of service below and **tick in the appropriate box** to indicate **which service** the young people you support tend to use and **how frequently.***

(Rationale: to find out which type of health service young people use and how frequently)

Frequency of use of service:	Very frequently	Frequently	Occasionally	Never
Accident and emergency				
Ambulance				
Dentist				
Optician				
General practition				
Family planning				
Genito urinary medicine clinic				
Mental health service				
Problematic substance use				

service				
Pharmacy				
School nurse				
Youth offending team				
Self help				
None				
Other(s) please specify				

9. In your opinion how important is each of these factors in influencing a young person to seek help for a health problem?

(Rationale: to establish factors that encourages or discourages a young person to seek help for a health problem)

Level of Importance	Extremely important	Important	Neither important nor unimportant	Unimportant
To improve their own good health				
To prevent ill health				
Because they feel unwell				
Emergency health problem				
Service offers what young person wants				
Accessibility				
Staff attitude				
Gender of staff				
Age of staff				
Escorted to appointment				
Knowledge of service				
Reputation of service				
Confidentiality				
Quality of service				
Waiting time				
Attractiveness of service environment				
Gender specific service				
Age specific service				
Other please specify				

10. Please suggest how meeting the health needs of sexually exploited young people may be improved.

You are welcome to answer in as much detail as you like.
 (Rationale: to suggest ways to effectively meet the health needs of this group.)

 Thank you for taking the time to complete this questionnaire.

Appendix 10

Adapted interview schedule

(Explain confidentiality to the young person and outline interview process)

Theme: health

Traffic light picture

- Being healthy means….(by drawing or writing in the green circle)

- Things that are not good for your health are…..(by drawing or writing in the amber circle)

- Being poorly/unwell means….(by drawing or writing in the red circle)

- *(Discuss and explore the responses with the young person)*

- Theme: health care

- Door picture

- What is it like trying to get help when you are not feeling well?

- What things make it easier to get help when you are not well?(by drawing or writing on the open door picture)

- What things make it harder to get help when you are not well?(by drawing or writing on the closed door picture)

- What things would make it easier for you to get help if you were not well?(by drawing or writing on the open door picture)

(Discuss and explore the responses with the young person)

Appendix 11

Invitation letter to participants (Phase 2)

Title of project:

'Meeting the health needs of young people involved in or vulnerable to sexual exploitation'

Dear colleague

I am a researcher from the University of Bradford, undertaking doctoral study, under supervision from Professor Newell. I am writing to invite you to participate in phase 2 of the above research study. Phase 1 has been done and involved interviewing young people.

Phase 2 involves the completion of a questionnaire. I am inviting you to complete the questionnaire due to your experience of supporting young people aged 18 or below, either at risk of, or with experience of sexual exploitation and due to your agencies valuable involvement in phase 1 of the study.

The research is being done to find out how to improve access to health care for young people who attend an agency similar to yours. It is recognised that it is important to listen to young people in order to learn from their personal experiences and this research is trying to do that.

Please read the attached information sheet and if you are interested in completing the questionnaire please sign the consent form. A stamped, addressed envelope has been sent for you to return the completed questionnaire to Tracy.

We would appreciate it if the forms could be returned as soon as possible.

It is up to you to decide whether or not to join in this research. If you do decide to join in please note that any information you give to the researcher will be treated as confidential and only seen by the researchers. You are free to pull out of the research at any time without giving a reason.

If you have any questions about the research please feel free to contact Tracy either on: 01274 236571, or by email g.t.mcclelland@bradford.ac.uk, or in writing.

Thank you for reading this letter and for your valuable and continued support of this research study.

Yours Sincerely Tracy McClelland

Appendix 12

Research participant information sheet (Phase 2)

Study title: *Meeting the health needs of sexually exploited young people.*

Why are we doing this research?

We are asking if you would agree to take part in phase 2 of this research project. Phase 1 involved interviews with young people. We are trying to find the answer to these questions:

- What are the physical and psychological health needs of sexually exploited young people?
- How do sexually exploited young people perceive the risks to their health?
- What are the barriers to meeting the health needs of sexually exploited young people?
- What strategies may be employed to overcome the identified barriers?

Before you decide if you want to participate, it's important to understand why the research is being done and what it will involve for you. Thank you for reading this leaflet carefully.

It is believed by researchers and support workers that it is important to listen to young people in order to learn from their personal experiences and this research is trying to do that.

Why have I been asked to take part?

You have been asked because you support young people who are either *at risk* of or have *experience* of sexual exploitation. Other similar agencies are also being invited to join in this study. We are hoping to send out approximately 100 questionnaires.

Do I have to take part?

'No, it is up to you. If you do, you will be given a copy of this information sheet and Tracy McClelland (the researcher), will ask you to sign a consent form. You are free to stop taking part at any time during the research without giving a reason.

What will happen to me if I take part?

You will be asked to complete a questionnaire and consent form. The questionnaire should take approximately 20-30 minutes to complete. You will only be asked to do this once. The information on the questionnaire will be kept private and only the research team will have access to it. At the end of the study the questionnaires will be destroyed.

An outline of the whole study will be given to you in writing as well. The information from you and other agency staff will be carefully looked at by Tracy and another researcher. A report will be written at the end of the study. Recommendations on how to improve access to health services for young people will be made in this report. You will be given a copy of this report and invited to attend a presentation of the research findings.

What will the researcher do with the information?

The researcher will keep the information you give in writing and on a computer. It will not be possible to identify you from the information you share with the researcher. The researcher has responsibility for looking after this information. The researcher may write about the research for other people to read. It will not be possible to identify you from what is written.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get might help young people and those supporting them in the future.

Contact Details:

Tracy McClelland, researcher, University of Bradford.

Telephone: 01274 236571. Email address: g.t.mcclelland@bradford.ac.uk.

Professor Newell, research supervisor, University of Bradford.

Telephone: 01274 236593. Email address: r.j.newell@bradford.ac.uk

Information you need to know if you still want to take part

What happens when the research project stops?

You will not be contacted by the researcher when the research stops.

Will anyone else know I'm doing this?

The research may be checked by research ethics committee inspectors to make sure the research is being done properly.

All information which you give during the course of the research will be kept strictly confidential. Any information which you give will have your name and agency address removed so that you cannot be recognised from it.

Who is organising and funding the research?

The University of Bradford

Who has reviewed the study?

Before any research goes ahead it has to be checked by an NHS Research Ethics Committee, to ensure that the research is suitable to do.