The Role of Alcohol in Child Sexual Exploitation: Developing a model to inform practice

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Abstract

Alcohol has been linked repeatedly to child sexual exploitation (CSE) in the media and in reports of CSE enquiries. However, there is a lack of research that focuses on this relationship in any depth and especially research that considers its implications for alcohol service providers. This study aims to develop a better understanding of the nature and extent of the relationship between alcohol and CSE and the implications of alcohol-related CSE for alcohol service interventions, principally from the perspective of service providers but also through the voices of a small number of young people.

Two qualitative approaches have been adopted to explore the role of alcohol in CSE and to establish what current intervention provision looks like: semi-structured interviews with alcohol and drug workers and CSE workers and a focus group to incorporate the voices of young people. Thematic analysis (Braun and Clarke, 2006) is used to highlight the key themes discussed by both professionals and young people.

This is the first study of its kind to focus specifically on the relationship between alcohol and CSE and contributes to the evidence base in several areas. It demonstrates the complexity of the roles that alcohol can play leading up to, during, and after sexual exploitation. Alcohol is used by perpetrators during the grooming process; it is used by young people both during and after CSE, as part of an emotional response to the trauma they are experiencing. However, alcohol is also a 'normal' part of growing up for many young people, which adds complexity to the assessment of, and response to, alcohol-related CSE. An explanatory model is presented to demonstrate the role of alcohol in CSE. Supporting young people around alcohol and CSE can be challenging, not just because of the complexity of this relationship but also because of difficulties getting young people to engage in the support process. This research is the first of its kind to speak to alcohol service providers specifically on this topic, to gain an insight into their response to alcohol-related CSE and to identify how young people experiencing it can be better supported.

Dedication

This thesis is dedicated to my big brother, Adam Oyston, who passed away during my time carrying out this research.

Thank you for always asking how my work was going, even when you had so much to contend with. Thank you for showing me true strength and determination. It will always be an honour to be your sister.

'…[it is] the extraordinary autumn weather that always comes as a surprise, when the sun hangs low and gives more heat than spring, when everything shines so brightly in the rare atmosphere that the eyes smart, when the lungs are strengthened and refreshed by inhaling the aromatic autumn air, when even the nights are warm, and when those dark warm nights, golden stars startle and delight us continually by falling from the sky.' (Leo Tolstoy, War and Peace)

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Figures and Tables

Glossary

Child sexual exploitation (CSE):

> Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology. (Department for Education, 2017:5).

Child sexual abuse (CSA):

> Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children (Department for Education, 2018:107).

Consent:

> Section 74 of the Sexual Offences Act 2003 defines consent s ‘if he agrees by choice and has the freedom and capacity to make that choice‘. Where breaches of consent have taken place, prosecutors consider:
>
> - Whether a complainant had the capacity (i.e., the age and understanding) to make a choice about whether or not to take part in the sexual activity at the time in question.
> - Whether he or she was in a position to make that choice freely and was not constrained in any way. Assuming that the complainant had both the freedom

and capacity to consent, the crucial question is whether the complainant agrees to the activity by choice.

The question of capacity to consent is particularly relevant when a complainant is intoxicated by alcohol or affected by drugs (Crown Prosecution Service, 2018)

Domestic minor sex trafficking (DMST) and Commercial child sexual exploitation:

Both phrases ‘commercial sex exploitation of children’ (CSEC) and ‘domestic minor sex trafficking’ (DMST) are used interchangeably and generally refer to the sex trafficking of minors, stipulated to be individuals under the age of 18. Unlike the US federal definition for adults, sexual exploitation and trafficking crimes against minors do not require any element of force, fraud, or coercion. This term also targets any parent, legal guardian, or person having custody or control of a minor who knowingly permits or assist a minor to engage in sexual acts for financial gain. (Gerassi, 2015:592)

Hazardous alcohol use:

A pattern of alcohol consumption that increases someone's risk of harm. Some would limit this definition to the physical or mental health consequences (as in harmful use). Others would include the social consequences. The term is currently used by the World Health Organization to describe this pattern of alcohol consumption. It is not a diagnostic term (National Institute for Clinical Excellence, 2010:12).

Terms such as ‘substance misuse’ and ‘substance abuse’ will be used when citing the wider literature and in direct quotes from participants.

‘Alcohol-related CSE’ will be used when alcohol is linked to CSE.

Part One

Introduction and background

Chapter 1
Introduction

This research focuses on the link between alcohol and child sexual exploitation (CSE), an important area of study that has lacked attention. A better understanding is needed of how alcohol contributes to CSE, how perpetrators use it to sexually exploit young people and how young people themselves use alcohol to cope with their experiences of sexual exploitation. Young people who experience alcohol-related CSE deserve expert specialist support that goes beyond treatment for alcohol and CSE separately. Service providers need to understand the complex relationship between alcohol and CSE if they are to provide person-centred rather than problem-focused support. Their approach to providing this support needs exploration, so that good practice can be identified and shared and gaps in knowledge and skills addressed. This research will focus on filling these gaps in the knowledge base by listening to the voices of the service providers who know most about current alcohol service provision and the young people whom they support.

This chapter will place the study of the links between alcohol, CSE and alcohol services for young people in context. The aims and objectives of this study will then be described, followed by a summary of its research methodology and its anticipated contribution to knowledge.

1.1 Rationale

This research focuses on the link between child sexual exploitation (CSE) and alcohol and the responses of alcohol services that support the children and young people who experience alcohol-related CSE.

CSE is a complex form of child sexual abuse that takes many different forms and exposes the young people subjected to it to considerable physical, social and psychological danger (chapter 3). Our understanding of CSE, especially its impact on young people subjected to it, has developed considerably over the past decade because of high-profile criminal cases, an active research

community and UK Government policy development (ss.3.1, 6.1, 6.2, 6.3). However, there continue to be many aspects of CSE that need further exploration, one of which is the role played by alcohol.

Various features of young people's alcohol consumption also receive national attention. For example, the NHS commissions a biennial survey of secondary school pupils up to the age of 15, focusing on smoking, drinking and drug use. The most recent survey, for 2018 (discussed more fully in s.2.1), explores aspects of alcohol consumption that may be relevant to alcohol's role in CSE: where pupils get alcohol; the attitudes of pupils and their families to drinking; the impact of school lessons and other sources of information about drinking; where and with whom pupils drink; their experiences of drunkenness (NHS Digital Lifestyles Team, 2019c). These factors, along with associated social pressures, may place a young person at greater risk of CSE, but the link between alcohol and CSE is often only recognised when this drinking develops into hazardous alcohol or other substance use. Young people often enter substance support services with other related problems, one of which can be sexual exploitation (s.4.2).

Treatment for hazardous alcohol use is usually provided by specialist alcohol and drug services for young people that are separate from adult services. Their aim is to help young people reduce the harm caused by their alcohol or drug use and to try to prevent it from becoming a more serious problem (Public Health England, 2019). How they deal with associated problems such as sexual exploitation is less clear and requires further exploration. A recent survey of stakeholders, including service users and professionals, points to the difficulties being experienced by alcohol services in England (Alcohol Concern, 2018). It warned that the alcohol treatment sector was in crisis, with cuts to public sector funding having a significant impact on alcohol services, reducing their ability to cope with the wider issues that contribute to hazardous alcohol use. A key finding in the report was that only 12% of 154 completed responses suggested that there were sufficient resources within their areas, with cuts to funding between 10% and 58% reported. The report also referred to alcohol treatment specifically as a 'Cinderella' service compared to drug treatment (Alcohol

Concern, 2018:6). It is important to understand the impact of these funding cuts on marginalised groups and those who are at risk because of their alcohol consumption.

1.2 Aims and objectives

1.2.1 Aims

This study aims to develop a better understanding of the relationship between alcohol and CSE and the implications for alcohol services:

1. To develop a better understanding of the nature and extent of the relationship between alcohol and CSE, through the voices of service providers and young people.
2. To identify the implications of alcohol-related CSE for alcohol service interventions, through the voices of service providers and young people.

1.2.2 Objectives

1. Identify alcohol's role in CSE through the voices of alcohol and drug and CSE service providers.
2. Identify alcohol's role in CSE through the voices and experiences of young people who have experienced CSE.
3. Determine the responses of alcohol and drug service providers to CSE.
4. Identify what is needed to support those who have experienced CSE.
5. Develop an explanatory model to explain the relationship between alcohol and CSE.

1.3 CSE - definitions and interpretation

This research will use the current UK Government definition of CSE:

> Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation

> does not always involve physical contact; it can also occur through the use of technology. (Department for Education, 2017:5).

This definition identifies CSE as a form of child sexual abuse (CSA), but what differentiates CSE from other abuse is not straightforward. This ambiguity is reflected in published literature. Therefore, while my review of the literature focuses on CSE, it also includes CSA where it can offer an insight into CSE or where it is possible to make comparisons between the two.

Beckett et al. (2017) make a distinction between CSE and CSA:

> If someone takes advantage of an imbalance of power to get a child/young person to engage in sexual activity, it is child sexual exploitation if: (1) The child/young person receives, or believes they will receive, something they need or want (tangible or intangible gain or the avoidance of harm) in exchange for the sexual activity. AND/OR (2) The perpetrator/facilitator gains financial advantage or enhanced status from the abuse. (Beckett et al., 2017:8)

The key difference, therefore, is that CSE requires some form of exchange or gain (e.g., financially or in terms of status). In this context, alcohol and other substances represent some of the most tangible examples of exchange. Beckett and Walker (2018) recognise the centrality of exchange to CSE, but they suggest that its prominence obscures a variety of other important aspects of abuse. The authors argue for a ‘reconceptualisation’ of CSE and CSA to reflect their overlapping nature and recognise young people’s experiences more accurately.

The terminology used to describe CSE is varied and has changed over time, in line with how it is understood. This is especially so in describing commercial forms of CSE that are based on financial gain: ‘survival sex’, ‘adolescent prostitution’, ‘selling sex’, ‘trading sex’, ‘domestic minor sex trafficking’ (USA) (see Glossary). In this thesis, commercial CSE will be the preferred term for commercial forms of CSE. However, when discussing studies and reports, the language of the original texts will be used. Beckett and Walker (2018) have suggested that a lack of consensus on the meaning of some terms and

definitions relating to CSE has led to significant issues in many key areas, including the development of policy and legislation, inadequate monitoring and poor service provision.

There has also been debate about the terminology used to refer to young people who have experienced CSE, such as ‘victim’ and ‘survivor’. The current research will refer to ‘young people who have experienced CSE’ to encapsulate all young people and how they view their experiences of CSE. When referring to the research literature, the terminology will reflect that used in individual studies and reports. However, whatever the terminology used, my standpoint is that where a young person has been sexually exploited, they are not complicit in what has happened to them.

‘AOD workers’ will be used to describe research participants whose specialism is alcohol and other drugs. ‘CSE workers’ will be used for research participants who are CSE specialists.

1.4 Research methodology: an overview

1.4.1 Epistemology and ontology

A critical realist position is adopted for the engagement of service providers and young people. It is important to bear in mind that everyone will have had different experiences. The views of service providers are unpredictable and dependent on the young people who are referred to them. A critical realist approach assumes that reality is independent of human knowledge and that knowledge is socially constructed (s7.2). This is complemented by Ecological Systems Theory which highlights the importance of the relationship between systems in constructing knowledge (7.3). Similar approaches have been used by Martinello (2020) who applied Ecological Systems Theory to the prevention of CSA.

1.4.2 Methods

A review of scholarly sources, grey literature and policy documents was conducted to gain an insight into what is known about the relationship between alcohol and CSE and to identify gaps in knowledge.

Semi-structured interviews were conducted with AOD and CSE workers with experience of working with young people who have experienced CSE and have issues with alcohol. These interviews explored the workers' views on the role of alcohol in CSE, their experiences of supporting young people around CSE and alcohol use and their confidence in doing so. It also identified what training and skills development they felt were needed to improve the support they offer (Objectives 1, 3, 4).

Qualitative research with young people who have experienced CSE was included in the research design to ensure that their voices are heard, both to understand their views on the role of alcohol in CSE and to identify what support they feel young people require around this (Objectives 2, 3, 4). While data collection with young people was unfortunately very limited in this study, it has been included to ensure young people's voices have some representation. This was based on a focus group discussion underpinned by a topic guide containing four broad questions (Appendix 1), to allow the young people to direct the conversation and focus on the issues that they considered important around alcohol and CSE. Individuals with lived experience were included as advisors in the planning of the methodology, to minimise the risks to the young people taking part and to acknowledge the gaps in my own expertise and knowledge.

Braun and Clarke's (2006) approach to thematic analysis, using NVivo11 software (QSR International, 2015), was used to identify the common themes and recurring patterns of meaning that arose during the interviews and focus group discussion.

1.4.3 Researcher identity

Serrant-Green (2011) explains that it is important for a researcher to identify their relationship to the research, as this is central to identifying ‘silences’ within it. In other words, the researcher’s relationship is often unspoken and undocumented. Identifying their position enables those reading the research to understand the researcher’s viewpoint and to gain insight into what might have driven their decisions throughout the research.

I identify myself as someone who has neither any direct experience of CSE nor hazardous alcohol use. Professionally, I have been a volunteer counsellor at Childline, a national helpline for children and young people in the UK since 2011. Within this role, I have spoken to young people who have been sexually exploited, some of whom realised that this was happening and others who did not. However, none of the conversations that I remember have discussed their alcohol consumption. Similarly, I have spoken to young people who consumed alcohol, but CSE was never mentioned or discussed as a concern in these conversations. These Childline experiences have contributed to my ongoing interest in child protection. I carried this interest into my MSc. study, with my research dissertation focusing on the risk assessment of ‘indecent images of children’ offenders. Both experiences have stimulated a research interest in CSE. With regard to alcohol, I had been working for two and a half years as a research assistant in public health at the time that my PhD research commenced. In this role, I had undertaken research projects that involved interviewing both alcohol service providers and those who attended them. From this, I gained an interest in, and learnt about, the importance of the work of alcohol services. I also became aware of the impact of funding levels on service provision.

I have never conducted research on the role of alcohol in CSE, but it is possible that the interest and knowledge I have gained from my work experiences and my reading could influence my assumptions going into this research. Moreover, having never been subject to CSE, my thoughts and knowledge are somewhat removed from the empirical reality of lived experience, which again could lead me to have preconceived ideas on the role of alcohol in CSE. I have, however,

talked to young people about their experiences of CSE and while I am aware that I must not generalise from individual accounts, I do have some awareness of the different situations that young people may experience. Additionally, the training for my role at Childline includes the importance of listening carefully to those that I interview and not making assumptions about a young person's life and experiences.

1.5 Research Contribution

Alcohol is often referred to in government policy documents and research as a risk factor or indicator of CSE. However, its role is often assumed, rather than clearly evidenced. There is little research that investigates this relationship in any depth. There is also a lack of published evidence that explores how young people experiencing alcohol-related CSE are supported by specialist services. My research aims to address these gaps in research and understanding and is the first in the UK to focus solely on the role of alcohol in CSE. In doing so, it adds depth to our understanding of alcohol as a risk factor in CSE and the different ways that it is used before, during and after CSE.

Previous research reporting on alcohol and CSE has often drawn on large quantitative datasets (discussed in s.2.4) that use only a small number of elements relating to this topic from a much larger questionnaire. In contrast, this study utilises qualitative methods to capture the views of service providers and young people on the relationship between alcohol and CSE.

My research is also the first of its kind to seek the views of AOD and CSE workers on how they respond to people with experiences of alcohol use and CSE. This adds to the current understanding of the support currently available to young people around CSE more broadly. I also make recommendations for service improvement and future research.

Finally, I reflect on the process of conducting research with young people who are considered vulnerable and are receiving support from specialist services. I offer suggestions for future research and highlight the levels of flexibility

required for conducting research of this kind. It therefore adds to current knowledge of research practice with marginalised groups and the problems that researchers can encounter.

1.6 Chapter summary

The purpose of this introductory chapter has been to set the scene for my research by stating its rationale and outlining its aims and objectives and intended research contribution. I have also introduced myself as the researcher.

Chapters 2 and 3 continue this introductory theme by providing overviews of young people and alcohol and young people and CSE, as a precursor to bringing these two topics together in my literature review of alcohol-related CSE in Part 2 of this thesis.

Chapter 2
Young People and Alcohol

While there is a substantial amount of research literature relating to young people and alcohol, only a relatively small proportion is relevant to this study. Most of the literature included in this review is UK-based and related specifically to young people up to the age of 18. The usefulness of non-UK studies can be compromised because of cultural differences, such as the differing ages when a young person is legally allowed to drink alcohol. Searching for 'young people' can often return literature related to university students and other young adults that are outside this study's scope. Some studies bridge adolescence and young adulthood and so it can be difficult to identify relevant findings. Some studies that cross the adolescent/young adult boundary have been reviewed where it is possible to distinguish results for the younger age range.

2.1 Prevalence

The 2018 NHS report on smoking, drinking and drug use among young people recognises that it is difficult to gauge the level of young people's alcohol consumption in the UK (NHS Digital Lifestyles Team, 2019a). However, a sense of its scale is provided in this report. It found that 23%[1] of 15 year olds reported having been drunk in the previous four weeks and 44% of pupils aged 11-15 reported having drunk alcohol, increasing from 14% for 11 year olds to 70% for 15 year olds (NHS Digital Lifestyles Team, 2019a). The report also places these figures in a longitudinal context:

[1] N's not included in original report

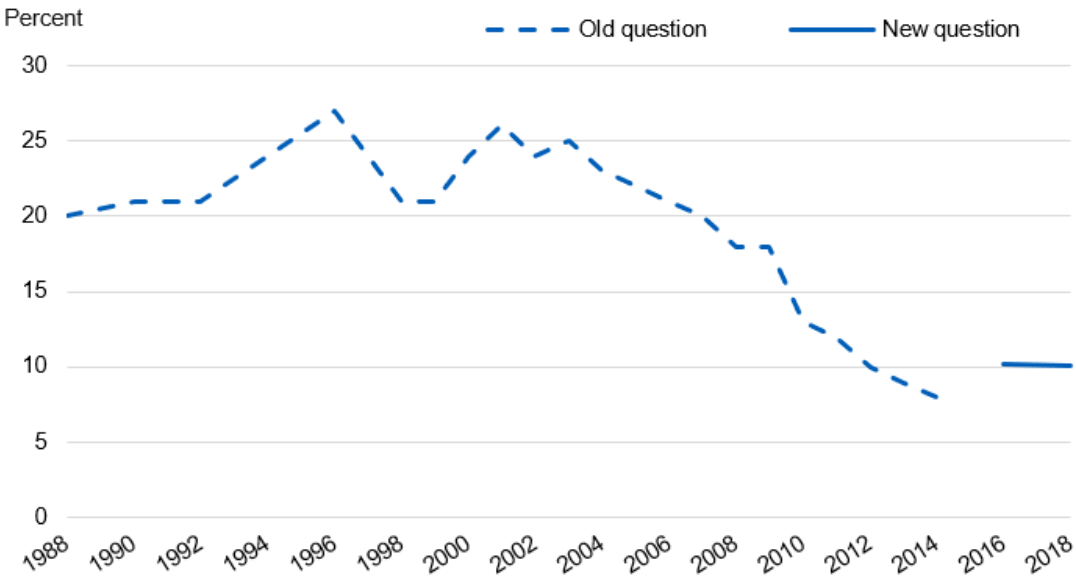

Figure 1: Pupils who reported having a drink of alcohol in the past week, by year (source: NHS Digital Lifestyles Team, 2019c: online)

These figures show a marked decline in alcohol consumption from the early 2000s. Several studies note a similar decline in alcohol and drug use among teenagers in other European countries, Australia and the USA and present a range of reasons for this. For example, In an Australian-based study based on semi-structured interviews with 50 young people aged 16–19, Caluzzi et al. (2020) placed this trend within a social climate that respected individual choice-making, in which young people were more socially and ethically aware, had a better understanding of the health risks associated with heavy drinking and could experience a greater variety of lifestyles. Torronen et al. (2019) refer to previous studies that identified factors such as changing parenting styles, the influence of social media, changes in gender stereotyping and a greater awareness of health and fitness. In their study, based on qualitative interviews with 49 young Swedish people, the authors propose that today's young people show a greater level of maturity and responsibility in their decision making. The authors of both studies suggest a weakening of the cultural power of alcohol as a rite of passage to adulthood. Their findings are broadly consistent with those of a UK study of 16-25 year olds conducted by Herring et al. (2012), which also downplayed the role of alcohol as an automatic rite of passage. Participants did not regard alcohol as integral to their identity and tended to choose activities that were not related to alcohol. All of these studies do, however, share a

significant limitation, in that their small study samples are based on young people who either abstain from alcohol or are light drinkers and are therefore unlikely to be representative of the general population of young people. Participants in Herring et al.'s study referred to a widespread assumption that drinking heavily was part of growing up (Herring et al., 2012).

2.2 Risk factors

Newbury-Birch et al. (2009) conducted a review of 102 articles relating to the impact of alcohol on children and young people, focusing mainly on the 5-19 age group but also including young adults aged between 20 and 25. The authors (pp.39-40) identified risk factors associated with drinking, including:

- Genetic predisposition
- Mental health, including childhood physical or sexual abuse
- Personality – sensation-seeking and impulsive personality types
- Early behavioural problems and antisocial behaviour
- Age of first drinking
- Family history of drinking problems and consumption behaviour
- Sexual risk-taking – while a causal relationship between alcohol and risk-taking could not be clearly demonstrated, the 'weight of evidence' suggests that alcohol can contribute to misjudgements about sexual behaviour
- Adverse childhood experiences, including suffering and/or witnessing abuse, having a family member with a mental illness, addiction or imprisoned, and losing a parent (for example, through separation or divorce).

The review identified sexual risk taking as a risk factor associated with drinking. However, it was unable to demonstrate a causal relationship between the two. It is possible that sexual risk taking can also be linked to CSE. This will be discussed further in chapter 4, along with commentary around the causal vs contributory relationship between alcohol and CSE.

2.3 Drinking practices

Many young people regard alcohol as a normal and expected part of their social life. Evidence for this view can be found in the 2018 NHS report on smoking, drinking and drug use among young people up to the age of 15. (NHS Digital Lifestyles Team, 2019c). It provides an insight into young people's attitudes to drinking by people of their own age. In 2018, 47% of 15 year olds thought it was

OK to drink alcohol once a week, 19% thought it was OK to get drunk once a week; both figures represented a small increase compared to 2016 (NHS Digital Lifestyles Team, 2019c). A parental perspective is provided from an analysis of the questionnaire responses of 185 parents of 11-18 year olds in the West Midlands. While most recognised that underage drinking is detrimental to health and wellbeing, over 60 per cent believed that alcohol consumption is a 'natural part of growing up'. Stronger agreement with this belief was associated with higher reports of alcohol consumption in their children (Fulton et al., 2019).

This 2018 NHS report also provides information about where young people usually drank alcohol. In 2018, 60% of 15 year olds said that it was at someone else's home and 55% that it was at parties (NHS Digital Lifestyles Team, 2019b). In their summary of research into where young people drink, Saunders and Rey (2011) suggest young people often begin to consume alcohol in their social circles of friends at parties, rather than at home with their family. They give examples of young people beginning to drink with other young people on streets and at house parties. Percy et al. (2011), however, found that young teenagers are often introduced by older siblings or other family members at home and then share this new experience with close friends. This study is based on interviews with 41 Belfast-based young people, made up of eight friendship groups, about their drinking experiences between the ages of 12 and 18.

This study by Percy et al. also gives some insight into how young people's drinking practices can develop. Its findings suggest that young people often intend to get drunk, have fun with their friends but to sober up before going home. Getting too drunk did not reflect well on them in the eyes of their friends, although most appeared to develop self-control over their consumption through trial and error. In their qualitative study of drinking behaviour of young UK adults, MacArthur et al. (2017) report how drinking during their participants' teenage years changed from a focus on getting drunk, to a more mature drinking culture where they avoid getting too drunk or losing control.

The extent to which young people use drinking 'etiquette' to define their social identity, including acceptable behaviour, can be seen in a study of 13-17 year olds in North East England by Scott et al. (2017). The authors found that this could extend to the level of identification with a particular brand and choice of drink, whether promoted by the alcohol industry or used by young people to secure their position in a particular peer group and to exclude others. The authors conclude that to be properly understood, drinking by young people needs to be seen as part of a broader cultural and social environment 'which helped to build early social identity, drive learning and shape what individuals and others around them do' (Scott et al., 2017:9). It should be noted that all participants in this study were drinkers and from a part of the UK identified with a heavy drinking culture.

For many underage drinkers, commercial premises are off limits, often being replaced by unsupervised outdoor venues that allow them to drink and socialise more freely and consume cheaper alcohol (Wilkinson, 2015).

We are left with a picture where rates of alcohol consumption in the UK are reducing among young people. Some studies clearly state alcohol consumption is not about identity development while others suggest it is. This demonstrates the importance of factors other than alcohol consumption, such as the environment and cultural context that inform patterns of drinking. This is particularly important for environments where CSE takes place.

2.4 Motivation and Influences

For many young people, drinking is regarded mostly as a social activity for enjoyment and bonding with friends. It can also be consumed to change or enhance emotions and feelings, as a coping mechanism, or as part of the desire to conform. The 2018 NHS survey results indicate a range of mood changing and social purposes. When asked about why young people of their own age drink alcohol, responses included: to look cool in front of their friends, to be more sociable with their friends, to give a 'rush or buzz' (NHS Digital Lifestyles Team, 2019c). MacArthur et al. (2017) found that the start of drinking

was driven by curiosity, social conformity and a view that ‘everybody else was doing it’ (p.36). Young people wanted to share this experience with their friends, be part of the social group and in doing so gain social capital and status. When they were older adolescents, participants spoke about alcohol enhancing their confidence in social interactions, making them feel less self-conscious and making the evening out with friends more enjoyable (MacArthur et al., 2017).

Boys et al. (2001) included alcohol as one of several substances in their UK study examining the reasons why young people used drugs. They conducted structured interviews with 364 poly-drug users aged between 16 and 22, with no history of treatment for substance use. The most identified reasons for consuming alcohol (n=312) were: to get intoxicated (89.1%), to relax (82.2%), to enjoy company (74%), to increase confidence (70.2%) and to feel better (69.9%). Of the substances consumed, alcohol offered the broadest range of effects; of the 17 variables listed by the authors, 11 were identified by more than 50% of those who had consumed alcohol in the previous year. Participants in a study by de Visser et al. (2013) associated drinking with how they saw themselves, in terms of their image and reputation, including as ‘a marker of being mature or cool rather than boring’. Even hangovers caused by excessive drinking could be celebrated, whether as ‘shared suffering’ or as evidence of a good time with friends.

Several UK studies (Bremner et al., 2011; Seaman and Ikeguonu, 2010; Percy et al., 2011) published by the Joseph Rowntree Foundation agree that the strongest predictors of whether and how much a young person drinks are their family and friends. For example, Bremner et al’s. survey of 5,700 young people aged 13–14 and 15–16 in English schools found that important factors included level of adult supervision received, exposure to drinking and drunkenness by close family members, positive attitudes towards and accessibility of alcohol. An analysis of questionnaire responses from more than 6,000 young people aged 11-16 in Wales found that parental monitoring and family closeness were positively correlated with one another and associated with significantly lower levels of drinking (Moore et al., 2010). Support for this conclusion can be found in a Scottish study of 600 young people, which associated a supportive family

environment with lowered alcohol use (Shucksmith et al.,1997). The authors also note that, from the young person's perspective, an unsupportive family environment together with extremes of parental control (high or low) is associated with raised levels of alcohol use later in adolescence. Percy et al. (2011) found that parental attempts to restrict their teenager's alcohol consumption was often ineffective and sometimes counterproductive.

Percy et al. (2011) also found that the amount of time spent with, and the drinking behaviour of, their friends were also found to be influential factors, potentially the strongest. Having friends who drink was found to significantly increase the likelihood of a young person drinking. Strong support for this can be found in a review of 22 longitudinal studies examining the effects of peer influence on adolescent alcohol use between 1997 and 2011 (Leung et al., 2014). Twenty-one studies identified a link between alcohol-using or 'delinquent' peers and the development of alcohol consumption, with use beginning after meeting or actively seeking out drinking peers. Participants in a study by de Visser et al. (2013) talked about this pressure in the broader context of how their decision to start drinking was influenced in part by societal and peer group expectation. MacArthur et al. (2017) use the term 'internalisation of peer norms' to describe how peer behaviour can influence individual behaviour, finding that this influence was most apparent in adolescence, at the initiation and experimentation stage.

Alcohol consumption as part of growing up points to social pressures that can include sexual experience:

> The desire to become older, and be seen as older, means that many young people imitate adult behaviours, such as drinking, smoking and sexual behaviour, all of which are strongly linked. (Velleman, 2009:22-23)

In these situations, alcohol may not be just another independent activity alongside smoking and sexual behaviour. As Velleman (2009:23) suggests, they can be 'strongly linked'.

2.5 Excessive and harmful drinking

Drinking may be seen by many young people primarily as a social activity. However, for some, occasional heavy drinking can develop into a longer-term problem that can affect their health and behaviour. In their UK study of why underage people get drunk, Coleman and Cater (2005) interviewed 64 people aged between 14 and 17 who described experiences of 'risky' drinking, defined by the authors as getting drunk in unsupervised settings. They characterised young people's motivation for getting drunk under three broad headings, which are similar to their reasons for drinking generally:

Social facilitation - to increase confidence and enjoyment in a social situation, often as a bonding experience and sometimes to facilitate a sexual relationship (which was often regretted afterwards).

Individual benefits - including getting drunk to 'escape' and forget problems, or just for 'something to do', often alone.

Social norms and influences - getting drunk seen as completely normal, with the influence of friends playing an important role; getting drunk to establish an image - to appear more mature or rebellious, for example.

Most of the respondents in this study regarded getting drunk as a positive experience, although they also acknowledged harmful outcomes, including the consequences of loss of inhibitions and control and impaired judgement.

When consumption becomes harmful to a young person is not straightforward. For many young people, alcohol and drug use is not necessarily problematic. The Royal College of Psychiatrists (RCP) (2012:42) has taken a staged approach to identify the pathway that can lead from what it regards as 'normative' use to dependence. Sanchez (2018) has adapted this pathway:

Stages of substance use.

- **Experimental stage**: The reason for consumption is curiosity and risk taking. The young person consumes on rare occasions, either alone or with peer group with very short-term effects of alcohol or drugs on their emotions. At this stage there is no active seeking behaviour and relatively little impact on functioning
- **Social stage**: When either alcohol or illicit drugs are taken with peer group for social acceptance or feeling the need to fit in the group. The frequency is still occasional but mind-altering effects of drugs are clearly recognised at this stage
- **Early at-risk stage**: The consumption is usually facilitated by the peer group and the reasons for intake may be social acceptance, peer pressure, beliefs valuing the experience caused by the substance or previous pleasurable experiences. At this stage, the frequency is variable depending on the peer group. Even though there is no active seeking behaviour, this stage is characterised by developing a regular pattern of use. Acute intoxication leads to associated significant dangers
- **Late at-risk stage**: At this stage, the substance is used to cope with negative emotions or to enhance pleasure through wider experimentation, using it to alter mood or behaviour. The setting here changes to either being alone or with a selected peer group, becoming more frequent. Active seeking behaviour characterises this period, and there may be an impact on functioning in some areas, such as school or family
- **Stage of harmful use or substance abuse**: At this stage the consumption is the primary method of recreation, coping with stress or both, it is used regularly despite detrimental effects. At this stage, there are negative effects on the teenager's emotions and ability to function, and there is an impact in almost all areas of life or distress within families or close relationships
- **Stage of dependence**: This is the stage where the young person consumes to deal with withdrawal symptoms and stop craving. Now the use has become compulsive, with often daily use to manage withdrawal symptoms. There is loss of control over use and behaviour may lead to crime

Sanchez (2018:602). Adapted from: Royal College of Psychiatrists (2012).

The RCP considers the experimental and social stages to be normative or recreational (Royal College of Psychiatrists, 2012:41). This is a useful summary to provide context for alcohol consumption related to CSE, but it should be noted that CSE does not fit neatly into one of these stages. It can occur at any of these stages of alcohol use. Furthermore, whilst alcohol may feature within CSE, this does not mean that it is necessarily physically harmful to a young person, or that a young person is dependent on that alcohol use.

It is difficult to quantify the extent of hazardous alcohol use among young people, as the national statistics produced by Public Health England's National Drug Treatment Monitoring System (NDTMS) only relate to young people who have been in contact with alcohol and drug services. Its report for 2018-2019 showed that 44% of the 14,485 young people who had been in contact with these services during that year said they had problems with alcohol. Alcohol was the second most common substance used after Cannabis (Public Health England, 2019). An insight into heavy drinking among early adolescents is provided in the findings of an analysis of 11,046 11 year olds from the UK Millennium Cohort Study (Kelly et al., 2016). Participants who reported drunkenness were more likely to be boys (1.6% vs 0.7%), to have socioemotional difficulties (2.6% vs 1.0%), to report antisocial behaviours (none = 0.6%, 1 = 2.0%, 2 or more = 7.0%), report truancy (6.0% vs 1.0%). Parental drinking was not found to be associated with drunkenness, compared to: having friends who drank; having positive expectancies towards alcohol; ever having smoked cigarettes; the mother-child relationship not being close.

2.6 Chapter summary

UK and international research and surveys suggest that fewer young people are consuming alcohol than 20 years ago. Several studies propose that one reasons for this is that alcohol is no longer regarded as 'a rite of passage' by many young people. Other UK research sustains the view that alcohol remains integral to the social identity of young people. For some, alcohol consumption becomes problematic, progressing from an experimental phase, through increasingly risky consumption, to harmful use and dependence.

Having reviewed alcohol use by young people, chapter 3 now explores young people and CSE.

Chapter 3
Young people and CSE

This chapter provides a short overview of CSE. It places CSE in the context of historical and recent developments, provides estimates of its prevalence and a summary of current understanding about the profile of those experiencing it. It outlines some of the different forms CSE can take, summarises risk factors that may lead to sexual exploitation and discusses the impact of CSE on young people. The chapter concludes with a discussion of an ongoing debate – how to reconcile the inherent concept of exchange, where abuse is linked to something the victim needs or wants, with the importance of not apportioning blame to the young person who experiences CSE.

3.1 Introduction

CSE is a complex and evolving form of child sexual abuse that takes many different forms and exposes the young people subjected to it to considerable physical, social and psychological danger. While it is likely that evidence of the sexual exploitation of children and young people can be identified at any stage of human history, the degree to which it is recognised, how it is regarded and described has developed and changed. Discussing developments in the late nineteenth and twentieth centuries, Hallett (2013) shows how the problem was reflected in legislation and policy relating to child prostitution and notes that legislation about child prostitution before 2000 did not make a clear distinction between adults and children exchanging sex. It is the high-profile exposure of cases of CSE in the UK in places such as Rotherham, Manchester and Oxford over the past decade that has heightened public awareness and established Child Sexual Exploitation as widely accepted terminology (Jay, 2014; Newsam and Ridgway, 2020; Bedford, 2015). These cases have contributed to the understanding of CSE, along with subsequent inquiries such as those conducted by the Independent Inquiry into Child Sexual Abuse (IICSA) (IICSA, 2018) and a study of CSE involving gangs and groups (Berelowitz et al., 2013). How CSE is perceived and understood and addressed has also been driven by recent research and UK Government policy development.

3.2 Prevalence and profile

The complexities of defining CSE precisely and the underreporting of cases mean that it is difficult to estimate the extent of the sexual exploitation of young people. Instead, two aspects of prevalence are often reported: young people who have been identified as experiencing CSE and those who are deemed to be at risk of CSE. For example, Berelowitz et al. (2012) estimated that in England between April 2010 and March 2011, 2,409 children and young people had experienced CSE in a gang or group setting and that 16,500 were at high risk of CSE. The authors reached these estimates by collecting data from localities in England on the number of young people who had shown warning signs of CSE in this period. The authors then held four evidence hearings to help them understand the gaps in the data. In a more recent attempt to gauge the scale of the issue, Sen (2017) examined different prevalence estimates, together with official data, and estimated that at the time of writing approximately 40,000 children and young people in England were known to children's social care with CSE as a 'notable concern'. Sen suggests that an accurate estimate is likely to be higher, given that those who are not known to children's social care, or where concern has not been identified by children's social care, are not included.

The average age for children and young people being subject to sexual exploitation has been estimated to be 15 (Health Working Group Report on Child Sexual Exploitation, 2014). Beckett et al. (2017) express this in a slightly different way, identifying 12 to 15 years as the average age at which concerns are first identified. However, it is evident that this masks the exposure to CSE of a much wider age band. The Health Working Group on Child Sexual Exploitation (2014) found increases among 10-14 year olds. Beckett et al. (2017) analysed studies that together showed that referrals for 8-11 year olds were increasing, linked especially to online sexual exploitation. Beckett et al. (2017) also refer to the heightened risks to 16-17 year olds and the likelihood that these cases may not be fully recognised because of an assumption that young people of this age have given consent.

Much CSE is hidden, it can take many different forms and boys and young men constitute ‘a sizeable minority’ of CSE cases (McNaughton-Nicholls et al., 2014:6). However, Eaton and Holmes (2017) does make the point that CSE predominantly concerns male violence against females.

3.3 Models of CSE

One aspect of the complexity of CSE is the many different forms that it can take. Inevitably, various attempts have been made to categorise and group them into a small number of ‘models’ (e.g., Barnados, 2011:6; Shepherd and Lewis, 2017:8-15; Health Working Group on Child Sexual Exploitation, 2014:14). While this approach can be criticised as too simplistic and misleading for trying to fit complex and overlapping situations into neat boxes, it does provide an accessible route to understanding CSE. The following forms or models of CSE are helpful for this study:

- *Boyfriend/girlfriend.* The perpetrator befriends a young person, making them feel special and wanted and believing that they are in a relationship with the perpetrator. The perpetrator will then take advantage of the trust that the young person has in them and begin to exploit them.
- *Party scenario*. Young people are lured to houses or other venues by the prospect of a party and provided with alcohol and drugs and sexually exploited by one or more perpetrators.
- *Peer exploitation*. Young people are sexually exploited by others of a similar age who may be friends or acquaintances who they have met at social gatherings. Alcohol and drugs are given in exchange for sex.
- *Commercial CSE*. This covers a range of activities, including child prostitution and trafficking, in which a young person exchanges sex for payment of some kind – money, alcohol or drugs, for example.
- *Gang-related CSE.* This can encompass many of the forms of CSE described above. CSE can occur within gangs for a variety of reasons – as part of initiation into the gang, in return for the protection of the gang

and to generate money for the gang. Alcohol and drugs are often available.

These models cover such a wide spectrum that it is difficult to identify a common set of risk factors that draw them together. The range and complexity of these risks will now be discussed.

3.4 Risk factors and harm

The starting point in assessing risk is to acknowledge that all young people can potentially be exposed to sexual exploitation and occurrences may be overlooked by practitioners if they focus too much on known risk factors in their assessment. Beckett et al. (2017) also note that this remains an aspect of CSE that is still not fully understood. Nevertheless, research and experience indicate what Beckett et al. (2017) and Sen (2017) describe as 'heightened risk factors', to which practitioners should be alert to in the context of a child needing early help (Department for Education, 2018). The following list represents a compilation of these risk factors:

- has a disability, particularly a learning disability
- has challenging family circumstances, such as drug and alcohol misuse, adult mental health issues and domestic abuse
- has connections with young people who are being sexually abused
- is in the care system
- is showing signs of being drawn into anti-social or criminal behaviour, including gang involvement
- frequently goes missing
- is at risk of modern slavery, trafficking or exploitation
- has substance misuse issues
- has a prior experience of neglect, physical and/or sexual abuse.
- is socially isolated or experiencing social difficulties.
- lacks a safe environment to explore sexuality, sexual or gender identity
- family members or other connections are involved in adult sex work
- poverty.

A recent research study has discussed the difficulties of identifying risk within the social contexts where CSE takes place. Radcliffe et al. (2020) conducted focus groups with 36 professionals from different professional backgrounds who

worked in multi-agency teams focusing on CSE in three coastal towns in England. The authors found that where a group of perpetrators exploited young people, there was often already an existing relationship between the offenders and young people. The study provides the example of an older group of males who might invite younger females to a party, to illustrate the challenges of distinguishing between a situation where a young person is at risk of CSE within the social setting and one where the young person is socialising with young people of different ages as part of the norm.

Young people who experience CSE can suffer life-changing harm. According to Scott et al. (2019) studies suggest that sexually exploited young people frequently experience mental ill health. The authors refer to the study conducted by the Office of the Children's Commissioner, which found that 85 per cent of sexually exploited young people interviewed said they had either self-harmed or attempted suicide (Berelowitz et al., 2012). The impact on a young person's mental health can include anxiety, depression, conduct disorder, eating disorders, low self-esteem, post-traumatic stress, self-harm and suicide attempts (Health Working Group on Child Sexual Exploitation, 2014). Physical health implications can have a serious short and long- term impact, from contracting Sexually Transmitted Diseases (STDs), unplanned pregnancy and gynaecological problems, to physical injury and genital injury (Health Working Group on Child Sexual Exploitation, 2014). Behavioural implications can also be harmful - age-inappropriate sexual activity, alcohol and drug misuse, involvement in adult sex work, lack of ability to trust others and build relationships, youth offending and involvement in the sexual victimisation of others (Sen, 2017; Beckett et al., (2017).

3.5 Victim blaming

The stigma attached to CSE is one aspect of harm that merits attention. Young people who have experienced CSE can be perceived as having contributed in some way to the abuse they have suffered.

The UK Government's aim is that:

> Child sexual exploitation is never the victim's fault, even if there is some form of exchange: all children and young people under the age of 18 have a right to be safe and should be protected from harm (Department of Education, 2017:6).

It does, however, appear that there is still some way to go before this ideal position is reached. Eaton and Holmes (2017) draws attention to the importance of language that, consciously or not, can underpin the attitudes of practitioners and others, placing responsibility and blame on those experiencing CSE – 'risk taking' behaviour, 'sexually active,' using 'boyfriend' to describe the abuser, making 'risky choices' – to suggest that they are consenting agents to some degree. In some cases, this may mean that CSE is not recognised. At the heart of this approach is what makes CSE different from other forms of sexual abuse – the role played by 'exchange', whereby the young person engages in a two-way transaction from which they can be seen to gain something they want and therefore be seen as less deserving. Both Eaton and Holmes (2017) and Beckett et al. (2017) make the point that this perception overlooks the power imbalance between young person and perpetrator and that any 'choice' on the part of the young person should be accepted as very limited or constrained, or even as just a survival strategy. Beckett and Walker (2018) draw attention to the complexity of the circumstances surrounding exchange, which can be based on coercion, the needs of a young person, or their feelings towards and desire to satisfy the perpetrator. In some situations, the young person can be regarded as the 'initiator'.

Beckett (2019) argues for a more balanced approach to this issue, where young people are no longer seen as *either* the passive victim of abuse *or* an active agent in it but can be recognised and treated as a victim while showing initiative and exercising choice, albeit constrained by their circumstances. This is not just necessary to make progress towards a better understanding of CSE but also to influence if and how young people receive treatment. Beckett (2019:35-36) provides an example of constrained choice that is of particular relevance to this study, relating to a 14 year old female, who offered sex to several men for

money, which she used to buy alcohol or to pay for a taxi. She can be seen as initiating the sexual encounters and therefore actively making choices that put her at risk. However, the context in which she makes these choices is one of survival. Having been abused by her father and others from an early age, she was receiving treatment for alcohol misuse that, in turn, had been driven by her need to supress the impact of this abuse. Beckett (2019) suggests that this behaviour could better be described as resourceful and self-protective.

3.6 Chapter summary

CSE is now a widely recognised term to describe one aspect of child sexual abuse and has been the subject of significant research and policy development. However, this increased awareness and understanding has not extended to a reliable figure for its prevalence. Attempts have been made to categorise CSE into different forms or models, although these should not be regarded as definitive. The complexity of CSE can be seen in the wide range of risk factors that have been identified and the impact of CSE on individuals is evident in the mental, physical and behavioural harm they can suffer and the stigma they still face.

The aim of part 1 of my thesis has been to introduce my study and provide overviews of the existing evidence on the topics of young people and alcohol and young people and CSE. Part 2 moves the focus on to my research topic with a review of the literature exploring the relationship between alcohol and CSE.

Part Two

Literature review: alcohol and CSE

Chapter 4
Alcohol and CSE – establishing the link

This part of my literature review has three aims. Firstly, it examines the published knowledge base to identify evidence of the extent of the link between alcohol and CSE and to assess its strength. Secondly, it seeks to understand what is known about the nature of the relationship between alcohol and CSE. Thirdly, it explores the national and local context to determine the extent to which alcohol-related CSE is recognised and addressed in policy and strategy development. In meeting these aims, my literature review will seek to identify the gaps and limitations of the evidence base, to provide the focus for my research.

After introducing my literature review and describing the process that I followed in conducting it, this chapter focuses on the first of my aims for the literature review, to identify evidence of the link between alcohol and CSE. It introduces several forms, or models, of CSE in which alcohol can play part before discussing the evidence for the prevalence of CSE, alcohol consumption and alcohol-related CSE. The chapter then examines the strength of evidence linking alcohol to CSE, firstly by examining studies that compare alcohol consumption in CSE to that into other forms of CSA, and then by assessing evidence for this link more generally.

4.1 Introduction and approach to literature review

The literature review consists of three elements. A search of peer-reviewed literature was undertaken to identify research that had been conducted into the nature and extent of the relationship between alcohol and CSE. Relevant grey literature was then incorporated into the results of this search. UK Government and related documents were reviewed to provide the policy context for the second aim of the research, to identify the implications of alcohol-related CSE for alcohol service interventions.

4.1.1 Peer-reviewed literature

The literature review examined the relationships between alcohol, other substances and CSE. While the primary focus of this study was on alcohol, the small number of studies addressing the specific relationship between alcohol and CSE meant that the literature search needed to be extended to include other substances, such as illicit drugs. This was often unavoidable, as some studies examined 'substances' without further explanation, making it impossible to distinguish alcohol from other drugs. This broader approach was also helpful because in many instances, alcohol and other substances seem to play a very similar role in CSE and are often used simultaneously by young people.

The literature search sought to address the following questions:

- What are the experiences of young people regarding the role of alcohol at different stages of CSE?
- What current models exist to explain this relationship?
- What current grooming models include both CSE and alcohol?
- What does the literature say about the frequency of alcohol use by those who experience CSE?
- To what extent is alcohol a vulnerability/risk factor for CSE?

An initial search of the literature was carried out and then refined after consultation with a member of MMU library staff. The literature search was carried out in the following databases, which were considered to have relevant subject coverage:

- Scopus
- ASSIA
- Web of Science
- Academic OneFile
- Social Care Online

The initial search was conducted in 2016 on peer-reviewed articles published from 2011 onwards in the English language. A limit on the period covered by the search was necessary to deliver a manageable number of results within the timescale of the research. The 2011 start date aligned with a UK Government action plan for tackling CSE (Department for Education, 2011). In the

introduction to this report, the Minister for Children and Families referred to a 2011 Barnardo's report that called for a national action plan to tackle CSE (Barnardo's, 2011) as 'a wake-up call' (Department for Education, 2011:2)

The articles retrieved in this search included references to other relevant secondary citations. The search was updated in both December 2018 and February 2020.

The following search terms were used for this review of the literature:

1. (Child* OR adolescent) AND ('sexual exploitation' OR prostitution OR 'commercial sexual exploitation' OR 'sexual abuse' OR 'sex trafficking' OR 'sex tourism) AND
   (alcohol OR drugs OR substance)
2. (Child* OR adolescent) AND ('sexual exploitation' OR prostitution OR 'commercial sexual exploitation' OR 'sexual abuse' OR 'sex trafficking' OR 'sex tourism') AND
   (grooming)
3. (child* OR adolescent) AND ('sexual exploitation' OR prostitution OR 'commercial sexual exploitation' OR 'sexual abuse' OR 'sex trafficking' OR 'sex tourism') AND ('risk factors')
4. (Alcohol OR drugs OR substance) AND
   (grooming)

This search identified 10,753 research articles from the five major databases. These results were filtered by both title and abstract. This included removing all irrelevant articles, e.g., animal grooming, and then excluding studies on CSE, alcohol, drugs and substances where the average age of the population sample was over 18 years old. The age of 18 years was chosen as the cut-off point to match the age given in the definition of CSE (Glossary, p.xi). Twenty-four articles met the criteria for alcohol use, with a further 25 covering substance use more generally. An additional 17 articles were identified after being cited in the articles identified in the search of the literature.

4.1.2 Grey literature

Given the small number of relevant peer-reviewed studies, I decided to broaden my search to other literature, including case studies. Serrant-Green makes the

point that identify and show the ‘silences’ of voices seldom heard in the evidence, ‘the exploration of the research subject should also value ‘personal experiences alongside the established theoretical debates’ (Serrant-Green, 2011:352).

The starting point for this part of the literature search was the National Working Group website (https://www.nwgnetwork.org/), which gathers resources on CSE from government and third sector websites. The search was then based on a scoping exercise of the websites of relevant organisations such as Barnardo’s, NSPCC and the Children’s Society.

4.1.3 Policy and practice context

The initial purpose of this part of the literature search was to identify UK Government alcohol policy, strategy and guidance in relation to CSE and to do the same for UK Government CSE policy and strategy in relation to alcohol. The search was then broadened to include recent UK Government drug policy and strategy that included alcohol in their scope. Related documents that review and develop UK Government alcohol and CSE policies were also identified. An examination of how national policies are implemented locally was also conducted.

4.2 CSE and alcohol: prevalence

The literature search identified sources that give some estimation of the prevalence of alcohol-related CSE. However, one of the consequences of this complex relationship being hidden and poorly understood is that the estimated statistics are likely to underestimate the scale of this problem.

Berelowitz et al.’s (2012) UK inquiry into CSE in gangs and groups found that 41%[2] of the children and young people identified had issues with alcohol and other substances as a result of experiencing CSE. These percentages were based on the responses to a call for evidence; the total numbers are not provided. In her report on CSE in Rotherham, Jay (2014) referred to a

[2] No n’s given in original document

'conservative' estimate of c.1400 children who had been sexually exploited between 1997 and 2013. Jay estimated that almost 50% of the children who were sexually exploited or at risk of CSE had alcohol or other substance use problems. In a three-year mixed methods inquiry into sexually exploited young people in Wales, Hallett et al. (2019) found that young people who had experienced CSE were almost nine times more likely to have a substance misuse problem, compared to those who did not experience CSE.

It is also difficult to differentiate the extent to which alcohol is involved in CSE from that of other substances. However, an analysis of 539 closed Barnardo's cases of children and young people who had experienced CSE found that of those with hazardous use of alcohol and other substances, 45%[3] concerned only alcohol, 26% other substances only and 29% both alcohol and other substances (Thwaites et al., 2011). These substantial percentages add weight to the need for further research into the role of alcohol in CSE.

The National Drug Treatment Monitoring System (NDTMS) statistics provide a breakdown by gender of young people who access alcohol and drug services in England. The figures for 2018-19 reported that 10,410 young people started treatment, of whom 4% (n=375 female, n=84 male) reported CSE, compared to 5% in 2017-2018 (Public Health England, 2019: data table 5.1).

Table 1: Young people reporting CSE by age and gender (Source: Public Health England, 2019: data table 8.1)

	Female		**Male**	
Age	Number	%	Number	%
Under 14	38	10	11	13
14	68	18	9	11
15	96	26	25	30
16	87	23	15	18
17	86	23	24	29
Total	375		84	

[3] No n's given in original document

It is important to note that these figures relate to new cases of individuals who entered treatment in 2018-2019. Furthermore, as these figures refer to cases where the young person has disclosed CSE, the actual figures are likely to be higher, given young people's hesitancy to disclose CSE.

4.3 Alcohol, CSE and CSA

Research that compares the use of alcohol in CSE to other forms of CSA is rare and mostly superficial. The literature search identified only three relevant studies. All are concerned with various forms of commercial CSE, rather than CSE more generally. Alcohol and drug use was only one of a number of variables examined in these studies. However, all three report differences between the role of alcohol in CSE compared to other forms of CSA.

Varma et al. (2015) aimed to identify dissimilarities between adolescents who had experienced commercial CSE and adolescents who had experienced CSA. This was a retrospective USA study of 27 young people between 12 and 18 years of age, who had presented to one of three pediatric emergency departments, or one child protection clinic between 2011 and 2013 and who were suspected of being involved in commercial CSE. This sample was age matched to a control group of 57 young people who had a diagnosis of CSA with no indications of commercial CSE. A medical record review of the 84 participants identified 11 variables that were found to differ significantly between the two groups, one of which was drug and alcohol use (Varma et al., 2015). Of those thought to have experienced commercial CSE, 70% (n=16) reported drug/alcohol use, and 50% (n=10) multiple drug use in comparison with 19% (n=10) and 6% (n=3) respectively for those who experienced CSA. The study provided no indication of when the young people's alcohol and drug use started within the sexual abuse or sexual exploitation they experienced, making it difficult to draw any conclusions about how substance use and CSA/CSE are linked. However, the authors discussed possible reasons for the increase in substance use among those experiencing commercial CSE, suggesting that the use of alchol and drugs could make it difficult for the young people to recognise

risk (Varma et al., 2015). The authors also suggested that young people may be more susceptible to commercial CSE if they were already using alcohol and drugs but were unable to acquire them due to a lack of money (Varma et al., 2015). The authors qualified the significance of their findings, noting that there was no legal confirmation of CSA for inclusion in the control group and that there was a possibility that some of the adolescents might have experienced commercial CSE but not disclosed it.

In a second study from the USA, Shaw et al. (2017) also found dissimilarities between commercial CSE and CSA when they compared the mental health records of 25 young people who had experienced commercial CSE to those of 25 young people who had experienced CSA. All were under the age of 18 years. Those who had experienced commercial CSE were significantly more likely to be older, to have run away and to have a diagnosis of drug abuse. While the study offers no explanation of the reasons for these differences, it provides further evidence that there can be differences in the consumption of alcohol and drugs between those who experience CSA and those who experience commercial CSE. However, the study's small sample size makes it difficult to generalise the results to larger populations.

Large datasets, by contrast, do enable more general comparisons to be drawn between different groups. Cole et al. (2016) took this approach in their USA study. The authors used data from the National Child Traumatic Stress Network Core Dataset (NCTSN CDS) to examine the indicators, behaviour and characteristics of 43 young people (aged 10-20 years, median 14.5 years) who met the definition for commercial CSE. They matched this sample to one containing 173 young people who had been sexually abused or assaulted (aged 10-19 years, median 15 years) but not exploited. Those in the commercial CSE group were found to have significantly higher levels of substance use and clinical problems relating to that use (65.9% in comparison to 32.3% in the CSA group) (Cole et al., 2016).

4.4 Alcohol consumption and CSE

There is a significant body of evidence that can be used to establish the link between alcohol consumption in CSE, although in one respect, it has similar limitations to that comparing alcohol consumption in CSE with that in CSA. Much of this evidence comes from studies of commercial CSE. However, these tend to be large scale studies and so their sample size adds statistical power to their findings.

There is evidence to suggest that there is a correlation between the selling of sex, defined as 'selling sex for money or other reimbursements' (Svedin and Priebe, 2007:21) and higher levels of alcohol consumption and drug use. In their study of the prevalence of the sale of sex within a community sample of Norwegian young people aged 14 to 17 years, Pedersen and Hegna (2003) highlighted the association between selling sex and alcohol and drug use as their most significant finding and suggested that other studies had not focused on it sufficiently. While responses in the study indicated a very small percentage (1.4%) of young people had 'sold sex', it was based on a large sample (10,828). The authors also acknowledged that it did not include the group who are most likely to 'sell sex', who they identified as those who did not attend school.

Further evidence to support the association between CSE and higher levels of alcohol consumption was found by Hickle and Roe-Sepowitz (2018), who carried out a comparative study examining the relationship between commercial child sexual exploitation and substance use in a sample of girls aged between 11 and 17 years (mean age 15.5 years) who lived in residential care in the US. The case files of 73 girls who had experienced commercial CSE were compared to 62 who had not. There were significant differences between the two groups regarding their consumption of alcohol and other substances, with higher levels being found in those who had experienced commercial CSE. However, no significant difference was found between the two groups regarding the forced use of drugs.

Domestic minor sex trafficking (DMST) is used in the US to describe the 'commercial sexual abuse of children by selling, buying, or trading their sexual

service' (Hornor, 2015:88). Large datasets relating to DMST have been mined by analysing responses to a small number of selected questions. One example is the study by McNeal and Walker (2016) that examined the risk factors for adolescents exchanging sex in return for money and drugs, based on the responses to two questions on the frequency of alcohol and drug use from the 1994-1995 US National Longitudinal Study of Adolescent to Adult Health. The questions were i) 'Have you ever given someone sex for drugs or money?' and ii) 'Over the past 12 months, how many days did you drink alcohol?' Their analysis of responses for young people in grades 7 to 12 (aged 12 to 18 years) identified a link between DMST and increased drug and alcohol consumption (McNeal and Walker, 2016:717).

The USA National Survey of Child and Adolescent Wellbeing II (NSCAW) also evidences a strong link between DMST and increased substance use. O'Brien et al. (2017b) used it to examine young people within the welfare system who said that they had been paid for sex over a period of six months. The population sampled included 814 children and young people aged between 10 and 17 years (mean age 14.62 years), 38 of whom had previously reported DMST and 776 who had not. The authors identified DMST based on a positive answer to the question 'in the past 6 months, have you been paid for having sexual relations with someone?'. They received a positive response from 38[4] of the sample. Slightly over half of these young people identified as female. A statistically significant number of those who had experienced DMST were identified as being within the clinical range for having a 'substance abuse problem' (53.32% of those experiencing DMST compared to 17.27% of those who had not) (O'Brien et al., 2017b).

The NSCAW has also been used to examine risk indicators for commercial CSE. Panlilio et al. (2019) used the same question as O'Brien et al. (2017b) for this purpose, based on a sample of 1063 females and 1355 males. They found that the use of drugs and alcohol was one of four significant factors that could be used to screen for those at risk of commercial CSE (the others were running away from home, being sexually active before age 14 and having hitchhiked).

[4] Percentage not reported in original document

While accepting the evidence of a link between DMST and substance use as identified in these two studies (Panlilio et al., 2019; O'Brien et al., 2017b), it should be recognised that their use of only one question may not have captured everyone who had experienced DMST. Bearing this in mind, the accuracy of this comparison may not be as strong as it appears. For example, the question only covers a six-month timeframe and relies on a young person realising that they have been 'paid'. The sensitivity of the question could also lead to some young people not answering the question honestly.

Moore et al. (2017) took a different approach to the association of alcohol consumption with commercial CSE by examining the medical records of 25 patients under the age of 18 years (mean age 15.4 years) who had disclosed DMST to a medical professional in the USA. The authors examined the psychosocial features of these records and found that 92% (23 of 25) of the sample had consumed alcohol or another substance. Of this group, 20% (n=5) stated that they had become involved in DMST to acquire drugs or alcohol (Moore et al., 2017). This study does more than some to understand the sequential nature of the relationship between alcohol and CSE, by providing some explanation of how young people attributed their alcohol and substance use to DMST. However, there is room for further investigation of the young people's views of their alcohol and substance consumption throughout their experiences of DMST, especially regarding the frequency and quantity of alcohol consumed. This could include exploration of how many of the 92% had prior alcohol and drug consumption and how many began using drugs and alcohol during or after experiencing DMST.

O'Brien et al. (2017a) provided a different perspective on DMST and substance use by using a sample of male 'adjudicated' youth (someone who has been found guilty of committing a crime in USA courts). Their study aimed to measure experience of sexual exploitation through just one question; 'Prior to your arrest, have you exchanged sexual acts for money?'. The authors applied secondary analysis to data from 800 'adjudicated, residentially-based' males between ages 12 and 20 years (mean age 16.7 years). A Substance Abuse Proneness

subscale was used to analyse ‘substance abuse’, which was completed by 617 of the 800 males. Of those who were known to have experienced DMST, 11.5% (n=7) indicated ‘substance abuse’ and 49.2% (n=30) reported ‘severe substance abuse’. The authors concluded that those who had experienced DMST were significantly more likely to have clinically concerning levels of substance use. This study adds weight to other evidence that those who experience CSE are more likely to have greater ‘substance abuse’ issues than the general population. However, its results should be interpreted with caution. Its use of only one question to measure sexual exploitation provides only a limited perspective. It relies on the young people themselves to identify that they have exchanged a sexual act for money and to provide an honest answer to the question. It also asks about exchanging sex for *money* rather than substances or items. It could, therefore, underestimate the numbers of those in the sample who had experienced sexual exploitation. Furthermore, some of those in the sample who may have exchanged sex for alcohol or other substances may not identify themselves as experiencing sexual exploitation.

Most studies included in this section of the literature review found that, to some extent, there is an association between ‘selling sex’, CSE, alcohol and other substance use. However, some studies did not. A comparative study by Nadon et al. (1998) in Canada came to different conclusions. It compared 45 female ‘adolescent prostitutes’ (mean age 16.3 years), along with a control group of 37 female ‘nonprostitute adolescents’ (mean age 15.7 years) from the same locations. The authors found that both groups had similar amounts of drug and alcohol use (82% of those who had sold sex reported drinking heavily compared to 77% of the control group). Furthermore, 83% of the adolescents who sold sex and 82% of those who did not used both drugs and alcohol (Nadon et al., 1998).The study found only one difference in substance use, as the control group was more likely to use marijuana, while those who sold sex were more likely to use a range of other drugs. The findings of this study suggest that it may be the background and previous experiences of victimisation that impact alcohol and drug consumption, rather than the sale of sex. One of the weakenesses of the study is that over half of those who had sold sex (68%) and those who had not (57%) had previously experienced CSA

(Nadon et al., 1998). This limits the validity of the comparison, as CSA is also known to be related to alcohol and drug consumption.

4.5 Chapter summary

There appears to be no robust published evidence that alcohol consumption in CSE is significantly different from alcohol consumption in CSA. The small number of studies on this subject provide only a limited body of evidence. Their broad focus on CSE and CSA means that alcohol and other substances are referred to only briefly and superficially, without much explanation of why they might be more prevalent in CSE. Their focus on commercial CSE also means that a great deal of caution is needed when interpreting the relevance of their results to CSE more generally. The most that can be said of these studies is that they suggest that young people experiencing commercial CSE may have higher levels of substance use than those experiencing CSA.

There is more robust evidence that alcohol and other drugs are a factor in commercial CSE and that there is a link between CSE and increased levels of alcohol consumption. The quantitative studies examined tend to be large scale. Some results, therefore, may be statistically significant and provide a basis for broader interpretation. However, their focus on commercial CSE needs to be noted.

Alcohol can be an important contributory factor in CSE. The next chapter will discuss published evidence that helps to explain the nature of this relationship.

Chapter 5
Alcohol and CSE – understanding the nature of their relationship

The literature review did not identify any major studies that explore the nature of the relationship between alcohol and CSE specifically. Alcohol is usually discussed as one of a number of factors that feature at various points in CSE. Furthermore, studies that discuss the relationship between alcohol and CSE do not often explore the sequential nature of this association. However, it is possible to identify three consistent themes from this limited body of evidence: alcohol as a risk factor contributing to CSE; alcohol consumption as part of the grooming process and during CSE; prolonged alcohol consumption as a coping mechanism. This chapter will explore each of these in turn. It will conclude with a summary of the methodological limitations of the research literature relating to alcohol and CSE.

5.1 Alcohol as a risk factor contributing to CSE

Alcohol and drug use are commonly listed as factors that may lead to an increased risk of CSE. This section explores the nature of this relationship by examining evidence that explains the ways in which alcohol can contribute to CSE.

The environments frequented by young people seem to be one factor that can contribute to increased alcohol consumption by young people experiencing CSE. This was one finding of a study by Lung et al. (2004) that aimed to identify risk factors for ‘prostituted girls’ (children and juveniles up to the age of 17 years) by comparing 158 of them in a Taiwanese ‘half-way house for adolescent prostitutes’ with 65 high school girls matched by age. Substance use was one of the factors examined. Significant differences in alcohol use were found between the two samples, with 41.9% of the girls in the ‘prostitute halfway house’ reporting using alcohol compared to 8.3% of the high school girls. The authors suggest that one reason for this difference was that the ‘adolescent

prostitutes' with substance use problems were more likely to go to nightclubs where they would be influenced by their peer group and that this may have been a pathway into prostitution. While the comparative nature of this study makes it useful, the lack of clarity in its use of the term 'substance' is problematic. In some places it seems to cover illicit drugs, alcohol and tobacco, in others just illicit drugs. The study does not provide more in-depth information about the nature of alcohol as a risk factor in CSE beyond making a connection between alcohol, nightclubs and the lives of those who the authors refer to as 'adolescent prostitutes'.

Young people who need to fund their substance use can put themselves at risk of being sexually exploited by perpetrators. This was noted by Klatt et al. (2014) in their examination of the case files of 175 young people who had attended a UK voluntary organisation that supports young people experiencing, or at risk of, sexual exploitation. The authors found that the main risk factors associated with sexual exploitation were running away, drug and alcohol use and poverty or debts. The study suggests alcohol and drug use may increase the risk of being sexually exploited and may lead to implicit, or explicit, 'pimping', where the young person's 'boyfriend' or 'girlfriend' might pimp them out to fund their addiction to drugs or alcohol.

A correlation between prior alcohol consumption and CSE was also found in a study of 'survival sex', defined in the study as 'the exchange of sex for food, money, shelter, drugs, and other needs and wants' (Walls and Bell, 2011:24). The study examined a sample of 1,625 homeless young people aged between 10 and 25 years from 28 different USA states who had been involved in 'survival sex'. The data was collected using a survey that included questions on both lifetime drug use and drug use within the previous month. A baseline model was then developed to predict the likelihood of survival sex and further models were built on this to examine variables that included recent and lifetime drug use. The results indicated that the lifetime usage of four drugs was significantly associated with an increased likelihood of selling sex (Walls and Bell, 2011). Alcohol was one of these drugs, with those who used it being 2.5 times more likely to be involved in survival sex than those who had not.

Reid and Piquero (2014) also explored factors that increased the risk of young people being subject to CSE in their longitudinal USA study examining how young people became involved in CSE, their substance use, sexual behaviour and the selling of drugs. In this study, 114 young people (86% male and 14% female) were interviewed every 6 months for three years and then once a year for four years, totalling 10 time points over seven years, with a total of ten follow up assessments. The majority were found to have first used alcohol and drugs prior to experiencing CSE, with the average being five years earlier (Reid and Piquero, 2014). The authors also found that those who sold drugs had done so prior to CSE, with an average of three years before. At eight of the ten assessment points, the young people who experienced CSE were found to have higher levels of substance dependency than those who were not experiencing CSE at that time. This suggests that there is also a relationship between alcohol and CSE during CSE, as well as before. At five of the assessment points, there was also a significant association with selling drugs for those experiencing CSE at that time (Reid and Piquero, 2014).

These findings are supported in a quantitative study by Brawn and Roe-Sepowitz (2008), which aimed to examine substance abuse in a sample of ‘juvenile prostitutes’ and the associations between this substance use and ‘juvenile prostitution’ in the USA. The case files of 128 juveniles who had been charged with a prostitution offence were examined, with 57% of the sample reporting either occasional or chronic substance use. The authors suggest that substance use took place before the juveniles entered ‘prostitution’, as the average age for substance use was a year younger than that for entering ‘prostitution’. However, this is just an inference and cannot be confirmed (Brawn and Roe-Sepowitz, 2008). The significant differences between those who consumed alcohol and drugs and those who did not suggest that the drug and alcohol use of this sample may be due to other life circumstances, rather than just being connected to prostitution. For example, the study found that those who used alcohol were more likely to have a more unstable living situation and parental supervision than those who did not.

An insight into the sequential relationship between alcohol and CSE is provided in a qualitative USA study by Perkins and Ruiz (2017), which found that alcohol and drug use can often be a pathway into CSE. The study explored factors that led to the pathways in and out of DMST, using qualitative interviews with 40 'adjudicated' females between the ages of 14 and 19 years (mean age 16.3 years) in a rural southern US state. The authors found that a significant number became involved in DMST to acquire drugs, with many feeling forced to do so. As one participant stated:

> Yes, I gave sex four times to two different people for heroin. But then one time I went to get some heroin from these people and they forced me to give oral sex, anal sex...they physically forced me and threatened me. I knew these people, they were like family (Perkins and Ruiz, 2017:177).

The authors reported that 57.5% of participants spoke about having a substance use problem. This is likely to be a low estimate, as it only represents those who mentioned substance use unprompted (Perkins and Ruiz, 2017). The study did not ask about substance use specifically.

In a UK study of the psychological and health issues experienced by young people who have been sexually exploited, McClelland and Newell (2013) found that alcohol could be used in several ways: to lower inhibitions before being sexually exploited, being forced to drink, as a coping mechanism and for fun. The authors interviewed 24 young people under the ages of 19 who had been sexually exploited and 61 professionals who supported them. Of the 24 young people interviewed, only four reported not consuming drugs or alcohol.

A Barnardo's online grooming survey in the UK provides a valuable perspective on how a young person's need for money for their substance use can lead to the exchange of sex for alcohol or drugs. This includes an example of a boy aged 15 years who needed money to pay a debt for cannabis and was offered it in return for sex by a man he met on Facebook. At first, the man just gave the boy money to buy more drugs, but then asked him for sexual favours in return for the money. The boy was further exploited when the man encouraged him to

sign up to a dating website and was made to meet up with men who also sexually exploited him (Fox and Kalkan, 2016).

5.2 Alcohol consumption as part of the grooming process and during CSE

Casey (2015:5) referred to grooming as being 'like brainwashing'. A more considered definition of grooming is provided by Craven et al. (2006):

> [Grooming is] A process by which a person prepares a child, significant adults, and the environment for the abuse of the child. Specific goals include gaining access to the child, gaining the child's compliance and maintaining the child's secrecy to avoid disclosure. This process serves to strengthen the offender's abusive pattern, as it may be used as a means of justifying or denying their actions (Craven et al. 2006:297).

Grooming occurs both before sexual abuse, to make contact with a young person and after, to maintain contact and ensure that a young person does not disclose what has happened (Randhawa and Jacobs, 2013). After targeting a young person, often based on an identified vulnerability, a perpetrator befriends them to establish a trusting relationship in which the young person feels 'loved and special' (Shepherd and Lewis, 2017:15). Alcohol and drugs can be used as 'gifts' for this purpose. The perpetrator 'progressively sexualises' (Shepherd and Lewis, 2017:15) the young person, with this process developing into an abusive relationship characterised by manipulation, coercion and control. A perpetrator can ensure a young person does not disclose what has happened by grooming them to make them feel that the abuse was their fault (Randhawa and Jacobs, 2013).

A number of models have been created to help understand the different techniques that perpetrators use to groom young people (s.3.3). Alcohol can play a part in each and is used for a variety of purposes. This section of the literature review draws on the published literature – peer-reviewed studies, reports and case studies – to identify and discuss some of the ways that perpetrators use alcohol during this stage of CSE: as a gift, as payment or a means of exchange, or to manipulate and control.

5.2.1 Alcohol as a gift in CSE

A perpetrator can use alcohol as a gift to befriend a young person, both to persuade them to be compliant and to make them feel special and wanted, believing that they are in a relationship with the perpetrator, rather than being sexually exploited by them. The perpetrator will then take advantage of the trust that the young person has in them and begin to exploit them sexually. The use of alcohol can be seen in the early stages of the boyfriend/girlfriend model. The independent review into CSE in Greater Manchester identified this as the most widespread model of CSE and found that alcohol and drugs were the most common gifts (Coffey, 2014). This was exemplified in the 2012 Rochdale case of CSE where nine men were found guilty of grooming young girls with drugs and alcohol, after which they were forced to have sex with different men (Coffey, 2014).

Further evidence of how alcohol is used to entice young people into what they see as a relationship can be seen in a Children's Society case study in England (Crellin and Pona, 2015). A group of five girls aged 16 and 17 years were befriended by a group of men aged 24 and 25 years in the hostel where they had been placed. After providing the girls with drugs and alcohol, the men sexually exploited them. The girls were unaware of what was happening because of the relationship that they thought they had built with the men (Crellin and Pona, 2015).

Perpetrators can use alcohol to 'break the ice' and make friends when a young person feels isolated or misunderstood by family and friends. A Barnardo's case study gives an example of a young male called Jimmy who was gay and from the traveller community, who experienced CSE within it (Smeaton, 2013). Jimmy realised that he was sexually attracted to men but knew that his family and community would not accept this. At the age of 14 he befriended a man in his mid-twenties from another family within the community, with whom he would drink alcohol and smoke cannabis in the man's caravan. The man told Jimmy that there was nothing wrong with being gay and they began a sexual relationship. The relationship became violent when Jimmy did not do what the

man wanted. The man then used photos to blackmail Jimmy into having sex with other men (Smeaton, 2013).

5.2.2 Alcohol as 'payment' in CSE

In some cases, alcohol and drugs are given to a young person in exchange for sex to satisfy a pre-existing dependency on a substance. In others, the perpetrator introduces the young person to the substance, leading to them becoming reliant on the perpetrator for it, in exchange for sex. Crawley et al. (2004) conducted research into young people at risk of, or experiencing, CSE within a UK city, using unstructured interviews and structured questionnaires with young people and professionals. The authors discuss how at times the young people are not only exchanging sex for alcohol and drugs for themselves but also for others who they believe care about them. This was the case for a 17 year old girl who became dependent on drugs after her boyfriend introduced her to them. He then told her that if she did not find a way to make some money to buy drugs for both of them, their relationship was over. He even told her where to go to make the money (Crawley et al., 2004). Another example can be found in a Beckett et al.'s (2013) study into gang-related sexual violence and sexual exploitation, which explored the scope of this sexual violence and the effectiveness of multi-agency responses, through interviews and focus groups with 188 young people and 76 professionals. This research included an example in which a 17 year old girl described how this type of exchange initially involved being given drugs for sex and how she was later made to have sex with more men for money. Most of this money was then taken by the perpetrator and replaced with drugs (Beckett et al., 2013).

Further evidence that alcohol and drugs can be a means of exchange as part of a financial transaction was found by Edinburgh et al. (2015), whose USA study provided examples of perpetrators using the promise of alcohol and drugs as 'payment' for sexual exploitation. Once a young person was sexually exploited and given money, the money would be taken from them in return for drugs. This study examined the experiences of adolescents who had been sexually exploited and had run away from home. The authors analysed forensic interviews and other data collected from 62 adolescents, aged 12-19 years who

attended a child advocacy centre. The young people discussed how pimps provided them with food, cigarettes, marijuana and alcohol. Some explained how they had to pay for their drugs from the money that they earned, which was taken from them by the pimps.

Although the transaction is often offered by pimps and perpetrators, there are also examples of the young person 'offering' to perform sexual acts in return for money to buy drugs or alcohol. One Barnardo's report includes an example of a girl who met a man outside a pub and offered to perform oral sex in return for money, which she then used to buy cider. She then went back to the pub to offer sexual acts in return for money from two other men (Beckett, 2011). This exchange can also be a matter of survival, when the young person has run away or is living on the streets, for example. Shuker (2013) provided evidence of this in an evaluation of a project for specialist placements who were at risk of or had experienced CSE or trafficking. The evaluation was based on interviews and quantitative analysis of outcomes data. It described the case of a young girl who at the age of 12 years was going missing for several days at a time and on one occasion told her social worker that she had survived by having sex with older men in exchange for shelter and drugs (Shuker, 2013).

5.2.3 Alcohol to manipulate, control and coerce

Alcohol and drugs can be used by a perpetrator to facilitate sexual activity with a young person, without the young person necessarily viewing the perpetrator as their boyfriend, girlfriend or even their friend. In a Childline report, a Childline volunteer, describing her experiences of CSE as a child, spoke of being groomed and bribed with cigarettes and alcohol (Childline, 2015). Other young people can be given alcohol in a social situation to facilitate sexual exploitation. Whilst this method of grooming is used for both male and female young people, Beckett (2011) found that within a survey with 786 respondents, nearly twice as many females as males reported being groomed with alcohol (7.7% and 4.3% respectively). One in 15 respondents reported being given drugs or alcohol before being 'taken advantage of sexually' (Beckett, 2011:42).

Perpetrators can use a social setting, often a private property, in which to use alcohol and drugs to facilitate sexual exploitation as part of the 'party' model of CSE. This facilitation is often a precursor to the young people being coerced to take part in sexual activity or being sexually assaulted. Beckett refers to this model in her analysis of risk assessments conducted by social workers of known or suspected cases of CSE. The house party model was present in 63 (42.9%) of these cases (Beckett, 2011).

This party model is often driven by a network of perpetrators who use drugs and alcohol to keep young people compliant, before moving them to different properties where they will continue to be exploited (Shepherd and Lewis, 2017). Perpetrators can also ply young people with alcohol and drugs to take advantage of their incapacitating effects. Young people often have only limited memory of what has happened to them. This lack of recall was identified in Barnardo's reports, with one young person attributing it in part to alcohol and drugs but also to not wanting to remember (Skidmore, 2004).

Edinburgh et al. (2014) provide an in-depth picture of how alcohol can contribute to manipulation and control in their study of single event multiple perpetrator rape and single perpetrator sexual assaults. The authors used forensic interviews and physical examinations to collect data from 32 adolescents who had experienced single event multiple perpetrator rape and 534 who had experienced single perpetrator sexual assaults, with a focus on the former. Participants had an average age of 14 years in both groups. Alcohol was found to have a role in all but one of the multiple perpetrator rape cases that were examined, some of which took place at parties. Some adolescents discussed how they were given alcohol before being assaulted; in a number of cases this was under the pretence that it was not alcohol. Some reported being unable to stand and lacking awareness of what was going on around them. They associated this with not being used to drinking alcohol or to the quantities that they drank. The grooming process can be very short in these circumstances. Alcohol can be used coercively within a single perpetrator assault, being introduced to a young person by a perpetrator to gain control of them and to ensure that they are unable to resist. The authors also state that

perpetrators appeared to use a young person's prior alcohol consumption against them in the sexual exploitation of many who experienced multiple perpetrator rape. The report also notes that intoxication at the time of the assault also impacted on the young people afterwards, with a number not remembering details of the assault or the perpetrators. They also blamed themselves for what happened because they had been drinking (Edinburgh et al., 2014).

5.3 Prolonged alcohol consumption as an emotional response and coping mechanism

Discussion of the use of alcohol in the grooming stage of CSE has focused on the different ways a perpetrator uses it to entice, manipulate and coerce a young person. Alcohol can also be used by a young person who is being sexually exploited to cope with the trauma they are experiencing. This can be seen in young people's accounts of their experiences in Hallett's UK study that explored the challenges faced by nine of them who experienced CSE and 25 professionals who were responsible for the identification of CSE and referral (Hallett, 2013). In semi-structured interviews, the young people talked about how they used alcohol and drugs to cope with their emotions, feel that they are in control and able to take risks, providing 'a way of asserting one's presence' and 'a way to not have to think or care' (Hallett, 2013:78-89).

A study by Scott and Skidmore (2006) provides some evidence that emotional responses to sexual exploitation can often play a large role in the development of alcohol and other substance issues for young people who have experienced CSE. The authors collected data from 557 young people in the UK who accessed support from Barnardo's. The young people ranged from age 10 to 27 years, with a mean age of 16 years; 387 were under the age of 18 years. More detailed information was collected for 42 participants. Case workers for 30 of these 42 young people expressed concern about the young person's alcohol and other substance misuse, which at times they saw as a response to the emotions that a young person was experiencing because of sexual exploitation.

The young person's use of alcohol and drugs as a coping mechanism can create a vicious cycle, in which their need for something to help them cope may lead to their ongoing sexual exploitation, as a way for them to access the alcohol and drugs they need to help them cope. Hwang and Bedford (2004) found this to be the case in their qualitative research with young people. This study, which included conversations around the role of alcohol in CSE, contained findings about the longer-term role of alcohol and drugs for young people remaining in a sexually exploitative situation. The study conducted secondary analysis of interviews with 49 adolescents who were in Taiwanese government-run rehabilitation centres in 1990-1991, 1992 and 2000, after they had been arrested and remanded for prostitution. Participants were aged between 13 and 28 years with an average age of 16 years. The study examined why adolescents remained in what the authors referred to as 'prostitution'. It found that most of the girls mentioned one or more of four motivations for this: financial/lifestyle, emotional, drug related and identity related. Of those interviewed, 21 (64%) mentioned that drug abuse was a reason for not leaving 'prostitution', with amphetamines and hallucinogens being common. Drugs made the girls feel trapped and contributed to a loss of self-esteem. The girls believed that they did not deserve to do anything else and therefore lacked motivation to change their circumstances. One participant described how drugs kept them within the situation:

> …they were like a tool to help me be depraved and gave me an excuse. For example, when I was of getting out of this circle, I would tell myself that I had used amphetamines for so long, I was a wastrel. What did it matter if I continued to be bad?... I had no goals, I felt like a walking corpse (Hwang and Bedford, 2004:140).

Girls who had been 'indentured' into 'prostitution' by their families spoke of starting to use drugs for several reasons: when they found out what their families had done, when they felt like they would not be able to get out of 'prostitution' and as a form of self-harm. After finding out that her father had indentured her for five years, one girl said 'I began hurting myself, abusing alcohol, cigarettes, and amphetamines' (Hwang and Bedford, 2004:142). This group also spoke of using amphetamines to work the long hours required.

Barnert et al. (2020) also reported that some participants in their study described how they felt that their substance use led them to feel trapped within sexual exploitation, as they needed to stay in contact with the perpetrator to maintain access to drugs. In this USA study, the authors conducted qualitative interviews with 21 adolescent females aged between 15 years and 19 years, who had experienced CSE. Participants were recruited with the help of community partners who worked with the young people. The young women explained how this need for drugs could trigger the cycle of sexual exploitation, with drugs acting as a coping mechanism for what they were experiencing.

A more indirect link between selling sex, being sexually abused and the consumption of alcohol as a coping mechanism can be found in a study by Tyler et al. (2013). In this USA study 249 homeless youths aged between 14 and 21 years (137 females; 112 males) were interviewed in shelters and on the streets and asked about their alcohol consumption in the previous six months. More than half (69%) of the participants stated that they had consumed alcohol, with 45% saying they had smoked marijuana (Tyler et al., 2013). Sexual abuse was reported by 43%; slightly more than 20% reported ‘trading sex’ at least once and referred to sexual victimisation (where participants responded that they had been forced to do something sexual, sexually assaulted or raped). All of these experiences were positively correlated with alcohol and marijuana use. The authors suggested that some young women turn to substances as a way of coping or as a way to ‘dull the pain from taking part in the behaviour’ (Tyler et al., 2013:487).

5.4 The limitations of current research literature

CSE is challenging to research because it is difficult to define precisely and clearly and not always recognised by professionals who work with young people. Some of the methods used in studies are consequently open to criticism. Methodological weaknesses in research of this nature have been described in a review of research methods into child/adolescent parent abuse by Holt (2012). These include, first and foremost, the problem of researching a

topic where the terminology is diverse, can change over time and can vary depending on geographical location. It is therefore hard both to find relevant research and for participants in studies to identify their experiences precisely. In areas such as CSE, where it may be hard to obtain a representative sample of children and young people who have experienced it, large datasets are often used to identify a sample of a sufficient size to be analysed statistically. Commenting on methodology, rather than CSE specifically, Holt points to strengths associated with the statistical analysis of large subsets of datasets, such as having comparator groups to the sample of interest. For CSE, these methods can help to compare young people who have experienced alcohol-related CSE to those who have not, as a way to examine how the relationship with alcohol differs between the two groups. However, large-scale surveys may give a good-sized sample, but their scope is often limited to those who are easy to reach, such as those who attend schools, and thus may exclude young people who may be more vulnerable. As results are often based on self-reported perceptions, it is also possible that a young person may not recognise that they are being or have been exploited and so the data might not reflect reality. These studies often lack the context for their results, which would help to explain why and how relationships occur (Holt, 2012).

Beyond establishing that there is a link between CSE/CSA and alcohol/drugs, many of these broad studies are of only limited use to my study:

(i) A large-scale survey approach can be useful in identifying general issues and trends, but it is only of limited value in drawing out the richer detail. Qualitative research with adolescents who have experienced CSE/CSA is necessary to explore the complexity of its link to substance use. A further limitation of these studies in their examination of the relationship between alcohol and CSE/CSA is that it is difficult to draw broad conclusions because they focus on different samples, often from different countries and cultural environments.

(ii) These broad studies do not usually identify at what point in the sexual exploitation alcohol and drugs may feature. Furthermore, they tend

not to give much detail about the volume of alcohol consumed and do not include the voices of young people and their thoughts on the role of alcohol within their experience.

(iii) Research often focuses on CSE/CSA broadly and it can therefore be hard to know if the relationship with alcohol consumption varies across the different types of abuse.

(iv) The value of much of the peer-reviewed literature on CSE is reduced because there is often no comparison group from a similar background to that of the study population; this shortcoming was highlighted by Nadon et al., (1998). There is, therefore, no way of knowing if the factors that are found to be significant amongst those who have been involved in CSE are due to what they have experienced, rather than being attributable to other events and situations in their lives. This weakness also applies to studies that are based on case files. Some large-scale research does, however, go some way to address this limitation, as can be seen in comparative studies into the sale of sex (e.g., Hickle and Roe-Sepowitz, 2018; McNeal et al., 2016; O'Brien et al., 2017a, 2017b; Panlilio et al., 2019).

(v) Large, pre-existing datasets (e.g., Cole et al., 2016; McNeal et al., 2016) may provide large samples, but the questions that can be asked of them are limited by the predetermined nature of the data. In practice, only one or two general questions may be relevant.

(vi) There is a lack of longitudinal studies and therefore most findings only provide a snapshot. It is hard to examine how a young person's use of alcohol changes overtime.

The contribution of many studies can be limited because of their narrow focus on young people in 'difficult social circumstances' or in institutional contexts. These weaknesses mean that it is hard to identify variables and characteristics regarding CSE and alcohol use across the population of children and young people more generally (Pedersen and Hegna, 2003). Large scale studies are usually based on recorded cases, often of young people who have been

through the criminal system, which tends to give too much emphasis to commercial CSE.

A common weakness of studies that I have examined to identify the association between alcohol consumption and CSE is that they may find a link but do not give any explanation of its cause. One reason for this is undoubtedly the lack of in-depth qualitative research with young people who have experienced CSE.

5.5 Chapter summary

The published literature provides evidence that alcohol features at all stages of CSE, as a risk factor contributing to its existence, as a tool to groom and coerce young people into CSE and to keep them in it, and as a means for young people to cope both during and after CSE. Numerous studies have identified a link between alcohol and CSE at these various stages, but only a small number focus on the reasons for this association.

Alcohol's role in CSE is, therefore, acknowledged and has, to a limited extent, been explored in peer-reviewed studies, reports and case studies. The degree to which this association is recognised in UK national and local policy and service provision also needs to be explored. This is the subject of the following chapter.

Chapter 6
Alcohol and CSE: policy and practice

The quality and nature of the response of alcohol and drug services to CSE is to a considerable extent dependent on the link between alcohol and CSE being recognised and addressed in national policy and local planning and implementation. A national approach is needed to provide the framework, resources and direction for local policy makers to put in place effective arrangements and support services for young people around both alcohol consumption and CSE. I will examine national and local frameworks, firstly from the perspective of alcohol and drug policy and then by looking at relevant CSE policy and strategy documents, to determine a CSE perspective on policy and practice in relation to alcohol and other substances. The chapter will conclude with a discussion of how the relationship between alcohol and CSE has been used in the UK legal system.

6.1 Alcohol and drug policy

6.1.1 National policy

The most recent UK Government strategy that addressed alcohol specifically (Home Office, 2012) was focused primarily on curbing excessive adult drinking behaviour, but it did recognise the problem of young people's alcohol consumption. It compared binge drinking by UK 15-16 year olds unfavourably with peers in many other European countries and estimated that in a community of 100,000, 400 11-15 year olds drank weekly. It identified young people as being particularly susceptible to alcohol advertising. One of the ambitions of the strategy was to achieve a 'sustained reduction' in the number of 11-15 year olds drinking alcohol and in the amounts they consume (Home Office, 2012:5) and proposed measures to achieve this, including a youth marketing programme, the provision of guidance for parents and a review of Personal, Social, Health and Economic (PSHE) education.

More recently, the UK Government has incorporated alcohol in its broader strategies to address drug misuse. The measures proposed in the 2017 Drug Strategy (Home Office, 2017) were based around four themes: reducing demand; restricting supply; building recovery; global action.

In 2020, the Department of Health and Social Care commissioned an independent review of illegal drugs by Dame Carol Black. This report described public provision of prevention, treatment and recovery as not fit for purpose (Black, 2020, 2021) and called for increased funding, building capacity and greater accountability and coordination at both national and local levels. The Government accepted many of the recommendations of this review and published a policy paper in December 2021 that presented a 10-year drugs plan with the subtitle ‘to cut crime and save lives’ (HM Government, 2021). Its ‘saving lives’ aims include ‘a world-class treatment and recovery system in England’ (Executive summary), supported by additional funding of £780 million over three years and a renewed emphasis on a school-based prevention programme. It also states an intention to treat addiction as a chronic health condition and to break down the associated stigma.

6.1.2 Service provision framework

Perhaps the most significant aspect of the 2012 alcohol strategy for current alcohol service provision was the emphasis placed on a devolved approach to commissioning, design and delivery. Since 2013, commissioning has been the responsibility of local authority public health services, working in partnership with other local agencies, such as social care and criminal justice. Service delivery is provided mainly by NHS trusts and various voluntary sector organisations. Local authorities therefore have considerable autonomy to develop their own approaches to service provision to meet local need. This local, integrated approach to treatment services was confirmed and further developed in the 2017 Drug Strategy (Home Office, 2017), which included alcohol in its remit.

It is evident that this model of provision is failing to deliver what was expected of it. The Black review (2020, 2021) identified many gaps in local provision and

found that the quantity, quality and morale of the workforce was poor, characterised by heavy caseloads, insufficient training and inadequate clinical provision. It also criticised a lack of coordination, oversight and accountability and inadequate joined-up specialist services working. Analysis by the Royal College of Psychiatrists identified a 37% real terms cut in funding for youth addiction services between 2013/14 and 2019/20 (Royal College of Psychiatrists, 2021). The most recent UK Government statistics for the number of young people in contact with alcohol and drug services show a 7% reduction on the number in the previous year (15,583) and a 40% reduction on the number in treatment in the years 2008 to 2009 (24,053) (Public Health England, 2019).

The Government's current 10-year plan accepts these issues and recognises that local arrangements are not working as intended. Its aspirations for local provision include 'rebuilding' local authority commissioned services and the professional workforce (including lower caseloads) and developing better service integration (HM Government, 2021).

6.1.3 Interventions for young people

Guidance on the principles that should inform the local commissioning of specialist substance misuse services for young people has been provided by Public Health England. The most recent statement defines specialist substance misuse interventions as:

> individual packages of care-planned support, which can include medical, psychosocial or specialist harm-reduction interventions that build young people's resilience and reduce the harm caused by substance misuse (Public Health England, 2018b:3.1).

The indicators associated with this statement include the provision of a full range of evidence-based treatment (psychosocial, harm reduction, pharmacological), a quality governance framework, a range of interventions that vary in intensity and duration according to changing needs and a joined-up approach across children's services using care and referral pathways.

Guidance on the assessment and referral of children and young people aged 10-17 years for whom problematic alcohol use is identified has been provided by the National Institute for Health and Care Excellence (National Institute for Health and Care Excellence, 2011). After an initial brief assessment, where alcohol use is associated with physical, psychological, educational or social problems, it recommends that all 10-15 year olds are referred to a specialist child and adolescent mental health service (CAMHS) for a comprehensive needs assessment. For those aged 16-17 years, referral criteria should be the same as for adults. The guidance provides a list of topics to be covered in this assessment and identifies specific treatments (National Institute for Health and Care Excellence, 2011:1.3.7.4). It also specifies a range of additional treatments and therapies, including family therapies, that can be used.

One significant change for specialist alcohol and drug services for young people is that their previously ring-fenced budgets are now absorbed into the local authority public health grant (Alcohol Concern, 2018). The state of specialist alcohol and drug services for young people in 2016 can be seen in an evidence review commissioned by Public Health England. Its main findings described a 'mixed landscape of provision', in which increased autonomy had led to significant differences in provision, with some services evolving in a 'piece-meal', rather than integrated manner (Children's Society, 2017:5-6). It also acknowledged a reduction of expenditure in some areas, including services to young people.

The Black review (2020, 2021) reinforced this message of inadequate provision and highlighted the need for improvements to specialist substance misuse services for young people, which had suffered an even greater funding reduction than adult services, in the face of growing unmet needs. It called for improved performance in the early identification of young people at risk, a trauma-informed approach to treatment and a broad treatment package that combined specialist treatment with more general health and social care services. The current Government response to the review recognises the need to improve provision for young people and includes a target of 50% more young

people receiving specialist treatment for substance misuse and an aspiration to improve school-based prevention programmes and early intervention performance (HM Government, 2021). Following publication of its 2021 Drug Strategy, the Government commissioned the Advisory Council on the Misuse of Drugs (ACMD) to provide advice on preventing drug use among vulnerable groups of people. Among the findings of ACMD's review was that the UK lacks a functioning drug prevention system and that workforce competence was a key failing in current provision (Advisory Council on the Misuse of Drugs, 2022).

6.2 CSE within UK alcohol and drug policy

6.2.1 National policy

National alcohol and drugs policy has not connected alcohol and drugs with CSE until recently. The 2012 UK Government alcohol strategy (Home Office, 2012) showed little awareness of this. Covering England and Wales, it only referred to children and young people in relation to how parenting style and the marketing of alcohol impact their alcohol consumption. There was only a minor reference linking alcohol to sexual behaviours, which was contained in a statement of intent to educate young people about the risks associated with alcohol, 'to drive further reductions in regular smoking, drinking, drug use and risky sexual behaviour during the teenage years' (Home Office, 2012:21). The extent to which this initiative has been rolled out is unclear. Thomas (2020) highlights the lack of safeguarding measures in place for young people in the night-time economy. The author explains how policy focuses on the more 'traditional' problems relating to alcohol associated with 'older' young people aged 18+ years, such as anti-social behaviour, rather than sexual harm and safeguarding.

In 2016, the UK Government released its 'Ending Violence Against Women and Girls Strategy', which again refers to addressing issues such as substance use but does not make any clear connection between CSE and alcohol and drugs (Home Office, 2016). The most recent alcohol-specific policy initiative, an overview of alcohol-related harm in England and possible policy solutions, produced by Public Health England, adds little to address the needs of young

people, discussing them only in the context of reducing their exposure to alcohol advertising (Public Health England, 2018a). The Scottish Government published a strategic alcohol framework in 2018, which refers to the impact of alcohol and drugs on risky sexual behaviour but only in the context of school education on this subject (Scottish Government, 2018). The Northern Ireland Executive also published an alcohol and drugs strategy in 2018 (Northern Ireland Executive, Department of Health, 2018), but this only discusses alcohol and other drugs in relation to sexual violence generally.

The UK Government's 2017 Drug Strategy (Home Office, 2017) represents a significant shift in government awareness of the link between young people, drugs (including alcohol) and CSE, referring to CSE on several occasions. Its proposals to inhibit drug use include combining 'universal action' with a more targeted approach for those at particular risk and building resilience in young people to enable them to resist the risks to which they are susceptible, including exploitation (not specifically sexual) and hazardous drug and alcohol use. The emphasis of the strategy in relation to young people appears to be mainly on reducing demand and restricting supply rather than on harm reduction; it does, however, make some positive comments about education and awareness. It suggests that schools are a good place to develop confidence and risk management through PSHE sessions.

This strategy also recognises the known connections between young people misusing drugs and other vulnerabilities that can heighten their risk of exploitation. It also acknowledges that young people attending an alcohol and drug service may present with underlying issues such as sexual exploitation and mental ill health, which can often drive substance use. An important recommendation made within this strategy is that the various local agencies involved in supporting vulnerable young people should ensure that each contact with them is used as an opportunity for intervention, to identify and provide support for both 'substance misuse' and other issues (Home Office, 2017).

6.2.2 Local policy and service provision

The literature search for the current study did not identify any published reports that analyse how local specialist alcohol and drug services are responding when presented with alcohol-related CSE. However, the criticisms of funding cuts, a lack of local coordination and diminished workforce levels and quality discussed above apply equally here.

Guidance on what this service provision should look like can be found in several sources. A Children's Society review is helpful in its guidance on the commissioning of specialist alcohol and drug services to address 'complex needs', such as CSE (Children's Society, 2017:19). It lists among its requirements for good commissioning practice: recognition that links between substance use and other issues, including CSE, require 'professional curiosity and response'; a multi-agency approach based on 'clear roles, responsibilities, lines of communication and responsibility and accountability' and, for CSE specifically, 'structured identification and assessment of risk' (Children's Society, 2017:19). The PHE guidance on commissioning young people's substance misuse services makes specific reference to the need for staff to understand and respond to CSE and abuse and the expectation that commissioners ensure that there is a joined-up response across children's services by using care and referral pathways for children who are being sexually exploited (Public Health England, 2018b).

6.3 Alcohol and other substances within UK CSE policy

While the focus of this study is on alcohol interventions where CSE is involved, the CSE perspective on policy and practice in relation to substance use more generally helps to provide a more rounded picture.

6.3.1 National policy

The UK Government policy framework within which CSE sits is provided by child protection legislation, including the 1989 and 2004 Children Acts (Children Act, 1989; Children Act, 2004). Current statutory guidance on responding to CSE and child abuse is contained in 'Working together to safeguard children'

(Department for Education, 2018). This guidance, for all local agencies involved in the protection of children, addresses their duties and how they need to work in partnership. References to alcohol in the document are limited to a recognition of the role of alcohol and drugs services in safeguarding children and young people and a reminder for practitioners to always have an awareness for children and young people who are 'misusing' alcohol or drugs (Department for Education, 2018). The UK Government also published supplementary non-statutory advice, focused specifically on CSE, to help practitioners and others who work with children to identify sexual exploitation and take appropriate action in response (Department for Education, 2017). It mentions alcohol and drugs in relation to CSE only in passing, as a means of exchange in return for sexual acts; it does not include them in a list of 'vulnerabilities' identified in the original extended text of this document (Beckett et al., 2017). They are identified as risk indicators for CSE only in the sense of 'returning home under the influence' (Department for Education, 2017:9).

6.3.2 Local policy and service provision

At a local level, CSE policy supports a strong practice framework for responding to CSE where young people have associated problems such as hazardous substance use. Child protection is based on a multi-agency response to provide a coordinated approach to safeguarding. Until 2019, this was the responsibility of Local Children Safeguarding Boards (LCSBs), multi-agency bodies set up by local authorities that brought together representatives from the police, health services, probation services and local youth offending teams. In June 2019, LCSBs were replaced by Local Safeguarding Partners (local authorities, clinical commissioning groups and police) to strengthen collaboration and multi-agency working.

My literature review identified evidence of good practice. Awareness training on the identification of CSE in relation to alcohol has been found to be important and effective for the professionals who work with young people. For example, Barnardo's multi-agency training for professionals on young people's drinking behaviours led to an increase in the identification of those who are at risk of CSE, with one example of the impact of training showing that five times more

young people were being identified post-training in a three-month period (Berelowitz et al., 2013). Training such as this is highly valuable in ensuring that a young person's alcohol use is considered when identifying indicators of risk in their life. It is not, however, always seen as being at the forefront of safeguarding. For example, the perceived importance of alcohol and drug services for young people can be questioned when looking at the strategic plans that Local Safeguarding Partnerships coordinate. Some do not mention these services at all. Alcohol and drug services might be invited to attend sub-group meetings (e.g., Hertfordshire Safeguarding Children Partnership, 2019) but do not seem to be regarded as key players.

6.4 Alcohol, CSE and the courts

The impact of alcohol consumption on CSE may not be given due recognition in UK government policy, but it has been referenced by legal counsel to undermine the credibility and testimony of young people. The Rotherham serious case review referred to new guidance for prosecutors issued by the Crown Prosecution Service (CPS) in October 2013 that identified 'stereotypical behaviours' considered to undermine the credibility of young people who experienced CSE. One of these behaviours was the 'myth' that because young people used alcohol or drugs they were sexually available, (Jay, 2014:75).

A finding of a 2015 study exploring why older teenagers are more at risk of CSE suggests that the 2013 CPS guidance did not go far enough to ensure that the consumption of alcohol by young people did not undermine the credibility of what they have experienced (Pona and Baillie, 2015). This study used several approaches: analysis of police data where CSE had been flagged for 16-17 year olds across 30 police forces; structured interviews with ten professionals on specialist CSE projects; analysis of 30 case notes on direct work with 16-17 years olds from five specialist CSE projects. The authors suggest that when a young person is aged 16 years and above during the criminal justice process, the case can increase in difficulty, as 16 years is the legal age of consent for sex in the UK. They explain that this is because professionals view young people of this age as being individuals who have chosen to be in a relationship

with the perpetrator, rather than being sexually exploited by them. From anecdotal evidence, the authors believed that in court cases, a young person's consumption of alcohol and drugs was perceived as constituting consent for sexual activity. They cite Section 74 of the Sexual Offences Act 2003 definition of consent in support of this:

> A person consents if he or she agrees by choice and has the freedom and capacity to make that choice. (Pona and Baillie, 2015:31)

This definition of consent recognises that consent can be impaired when alcohol or other substances have been consumed, but this does not seem to be considered sufficiently within the law. From their interviews with CSE specialists and the case notes of the 30 young people on CSE projects, Pona and Baillie recommended that the UK Government make clear for prosecution and sentencing purposes that consenting to drug and alcohol use does not mean that a young person has also consented to sexual activity (Pona and Baillie, 2015).

The CPS revised its guidance on prosecuting cases of child sexual abuse in 2017, stating that:

> Police and prosecutors should therefore look to build a case which looks more widely at the credibility of the overall allegation rather than focusing primarily on the credibility and/or reliability of the child or young person (Crown Prosecution Service, 2018: paragraph 50).

6.5 Chapter summary

There is a lot we do not know about the use of alcohol within the sexual exploitation of children and young people. It is often alluded to and acknowledged, but the nature and extent of this relationship has been given insufficient attention in national and local policy. On a UK level, this has resulted in there being insufficient attention given to CSE within Government drug and alcohol strategies. However, specialised support services do undoubtedly provide much needed advice and support for either substance use or CSE, but they are often organised and operate separately. The lack of published

research on the experiences of service workers supporting young people experiencing CSE and hazardous alcohol use is a notable omission from the evidence base, with no studies focusing specifically on this.

6.6 Alcohol and CSE literature review: conclusion

My literature review has identified methodological limitations and gaps in the evidence base for alcohol-related CSE. My research seeks to address some of these weaknesses, primarily by taking a qualitative approach that enables both alcohol and CSE service providers and young people who have experienced CSE to explain how, or whether, alcohol has played a role in CSE. This approach will also give a stage for the voices of service providers and young people and contribute to an understanding of what best practice means when working with children and young people who have experienced, or are experiencing, sexual exploitation and who need support for their alcohol use.

The research presented in this thesis aims to develop further an understanding of the association between alcohol and CSE and of the support and service provision that is needed for the young people affected by it. I take the standpoint that whatever role alcohol plays within CSE, blame is always firmly with the perpetrator, not the young person who experiences CSE.

Part 3

Methodology

Chapter 7
Methodology: theoretical considerations

This chapter considers the theoretical perspectives and guiding frameworks that have influenced the different stages of my research. After placing the research aims in the context of the findings from the literature review, I discuss the epistemological and ontological perspectives that underpin my research methodology and provide the theoretical framework that will be used in my analysis and discussion chapters.

7.1 Research aims and objectives

The literature review indicated that there is very little research focusing specifically on alcohol's role in, and relationship with, CSE. Studies often note a link between alcohol and CSE but do not explore the nature and impact of alcohol in CSE in any depth. I was unable to identify any published information on how alcohol and drugs services support young people who had also experienced CSE and the nature of the relationship of these services with CSE support services. Where the relationship between alcohol and CSE is discussed, it usually concerns the frequency or quantity of alcohol consumed. I felt that it was important that my research concentrated on the relatively unexplored areas of this relationship, to add to and deepen understanding. It also needed to focus on those who support young people in a professional capacity.

These findings provide the focus and priorities for my research in developing a better understanding of the nature and extent of the role of alcohol in the sexual exploitation of children and young people and the implications of this for interventions by alcohol and drug services. The objectives for this research are:

1. Identify alcohol's role in CSE through the voices of alcohol and drug and CSE service providers
2. Identify alcohol's role in CSE through the voices and experiences of young people who have experienced CSE

3. Determine the responses of alcohol service providers to CSE
4. Identify what is needed to support those who have experienced alcohol-related CSE
5. Develop an explanatory model to explain the relationship between alcohol and CSE

I will now discuss the theoretical perspectives that have steered the conduct of my research.

7.2 Epistemological and ontological position

Any qualitative research process is underpinned by philosophical assumptions and the stance of the researcher. It is important that a researcher provides their ontological and epistemological standpoint so that the reader is aware of the assumptions on which their research is based, including their perspective on its approach to reality and how knowledge is formed (Scotland, 2012).

7.2.1 Critical Realism

A major focus of this study concerns the perspectives of AOD and CSE workers on their role in supporting young people experiencing alcohol-related CSE and on the support that is in place to enable them to deliver this service. I also wanted to explore how they and young people make sense of the role of alcohol within CSE. At the same time, I wanted to understand the factors and social processes that underpinned these perceptions. Workers' perceptions of their role and remit are conditioned by the structures of society, the organisations for which they work and their own views of how they interpret their roles.

Critical Realism is an appropriate research philosophy to underpin this study, as it acknowledges that there are multiple causal mechanisms involved in an individual's interpretation of any given situation (Oliver, 2012). By focusing on these mechanisms, a critical realist approach allows for an exploration of human agency and the decisions that individuals make, whilst also considering the wider social structures that influence what is observed empirically (Easton, 2010). According to Oliver (2012), taking this view and 'rejecting simple linear

causality, Critical Realism describes a social world in which there are ‘multiple opportunities for intervention and change’ (Oliver, 2012:375).

Realism has become a popular alternative approach to positivism and constructivism in social science research (Sayer, 2000). Critical Realism is useful in social research as it ‘better explains the nature of causation in complex social interactions and accounts for the fact that outcomes are not predictable’ (Morton, 2006:1). From Bhaskar’s perspective, there is a reality that is independent of our experiences (Bhaskar, 2008). Critical Realism identifies three domains of reality: empirical, actual and real. The empirical domain contains what we can perceive and includes how we use these observations to interpret events and our experiences (Alvesson and Sköldberg, 2018). The actual and real domains are beyond our observations and interpretations at the empirical level and are independent both of the individual who may experience an event and the researcher. The real domain includes the underlying social structures and mechanisms that cause and have an influence on events and social processes at the actual level. For example, social structures and systems such as the welfare state, the National Health Service and social policies such as government-led austerity, generate systems and practices that influence how services in relation to CSE and alcohol use are developed, and how and by whom they are delivered. This, in turn, influences professional responses to, and interactions with, young people who may be experiencing CSE and alcohol use; these responses are observable in the views and experiences of the professionals and young people in this study. A critical realist approach in social research contends that it is the social structures at the real level and social processes at the actual level that influence what we observe and experience at the empirical level of everyday life (McEvoy and Richards 2003; Meyer and Lunnay 2013). Figure 2 below illustrates Fletcher’s interpretation of Critical Realism.

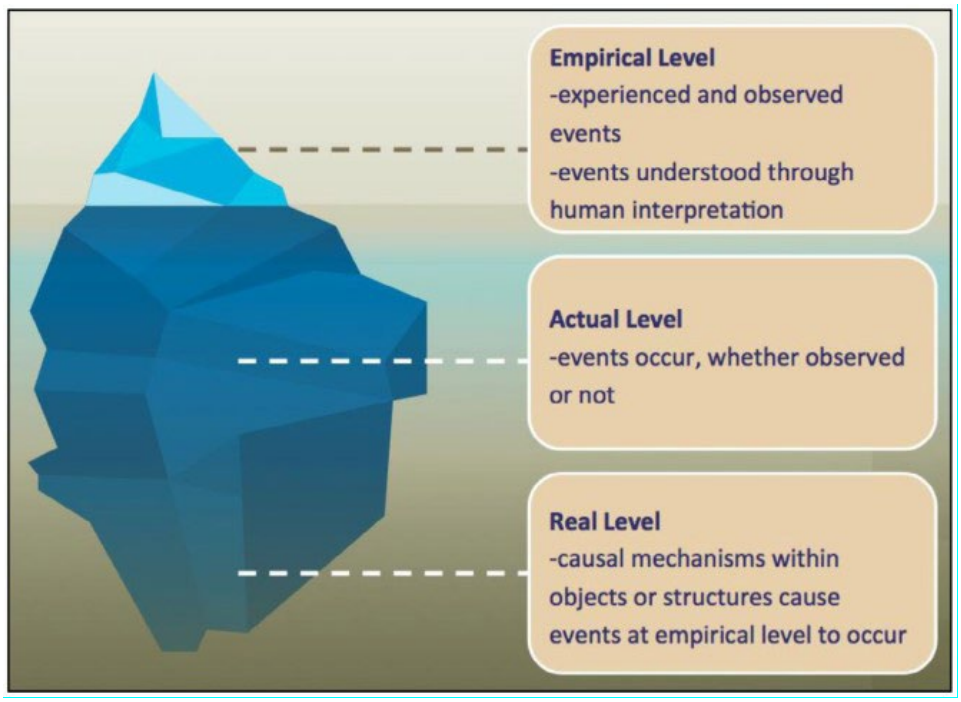

Figure 2: Critical Realism (Fletcher, 2017:183)

Critical Realism believes that it is important to acknowledge and seek to understand the influences of the real and actual domains, to understand their influence in the empirical domain. Simply exploring events and experiences solely from the empirical domain is not sufficient, as it does not consider the unobservable causal mechanisms at play. The exploration of these different realms of reality, and how they influence everyday experiences, requires the engagement of data analysis methods that include what Fletcher (2017:188) refers to as the 'theoretical re-description' of data, building an explanatory critique to examine the 'complex networks' involved across the levels of 'reality'. In this way, Critical Realism incorporates a realist ontology and an interpretivist epistemology (McEvoy and Richards 2003; Meyer and Lunnay 2013).

A crucial aspect of Critical Realism is that the social world is made up of heterogeneous structures, which means that we cannot accurately predict the outcome of a situation (Houston, 2001). Instead, Critical Realism contends that the effects generated by causal mechanisms can vary and are more accurately described as 'tendencies' (Houston, 2001: 850). The outcome of the constant

changes in these generative mechanisms is that all knowledge must be seen as fallible (Oliver, 2012).

Cruickshank (2003) describes an ontology for human beings that takes into account social, personal, emotional and rational factors, in order to 'understand the inner dialogue of agents to understand how agents are (empirical) conditioned by, and respond to, the enablements and constraints that they face (actual), which in turn are furnished by the emerging structural emergent properties and cultural emergent properties' (actual/real) (Cruickshank, 2003:4). An agent relates to the individual. For example, alcohol workers may provide support solely around a young person's alcohol use (empirical) and the reasons for this may be that there is an assumption that this is all that they are able to do. For this reason, they may only be given training (actual/real) and session times that allow them to provide interventions and information on reducing alcohol use or drinking safely. Similarly, for a young person, we may see them drinking and believe that they have chosen to do so because they want to (empirical). What we don't see is the peer pressure they feel, borne from the cultural norm of young people drinking when socialising (actual/real).

This critical realist perspective aligns with the starting point of this research, in which service providers and each young person's experiences and opinions are seen as true for them. It acknowledges that the role of alcohol will vary across young people's experiences of CSE, and different approaches and interventions provided by service providers have different impacts on young people. For service provision, it acknowledges that at the real level, services and interventions are determined by policy makers and commissioners, who in turn are constrained by concepts such as value for money. Critical Realism is also appropriate for this study as it considers reality as going beyond the material, recognising that ideas and discourses can also have causal effects in the social world. It is important to emphasise that Critical Realism acknowledges that the effect of a causal mechanism is not always apparent at the empirical level, meaning that it cannot always be observed: 'Causality thus should not be understood in terms of universal, predictable patterns, but rather as contextual and emergent, in changeable societies. (Alvesson and Sköldberg, 2018:51).

Research into CSE has raised questions about young people's agency regarding CSE, when it may appear that an individual is complicit or is prompting the exchange for items such as alcohol (Beckett, 2019). However, analysis solely at the empirical level, focusing on the observable behaviour of a young person, does not capture the influences that generative mechanisms have on the events that are taking place at this level, such as their wider world. For example, observing that a young person is drinking alcohol, we could assume that they are drinking because they enjoy it. If we explore their wider world and their reasons for drinking, we may discover that what seemed like a decision to drink for enjoyment is actually a coping mechanism to deal with what they are experiencing. Critical Realism provides the rationale for investigating the different layers of reality. It enables an exploration not only of the instance of CSE and professional responses to it, but also of the generative mechanisms and constraints occurring within the social structures, processes and interactions that can lead to the exploitation of a young person and influence the responses of professionals. For these reasons, Critical Realism is a particularly good framework for this study of the everyday experiences of the professionals who support young people around alcohol and CSE and the young people experiencing alcohol in relation to CSE. It allows us to consider the generative mechanisms at play in the actual and real domains, to understand what is happening in them and how this may be influencing 'everyday' experiences and practices in the empirical level. For example, by assuming a critical realist standpoint, as a researcher I can analyse data from a situation where a young person may be viewed as 'putting themselves at risk' through a critical lens. I can acknowledge that whilst it might appear this way at the empirical level, there are structural, system and process influences within the actual and real levels that can reasonably be said to be influencing a young person's options and decisions.

The researcher must not assume that general critical realist theory can be used to explain the ontology of their specific research area fully and directly. Vincent and O'Mahoney (2018:7) describe critical realist theories as 'at best approximations of reality, not least because all social theorising involves

simplification'. Critical Realism theory can, however, provide the researcher with a sound theoretical basis and language to explore and develop a reliable and accurate ontology specific to their research area.

Critical Realism allows for a detailed analysis of the data. The first step in this analysis involves a preliminary thematic analysis of the data, by coding it to construct both 'data driven' and 'theory driven' themes and provide a description of the data (Fletcher, 2017: Ch. 10). The further stages of a critical realist analysis are abductive analysis and retroductive analysis (Meyer and Lunnay, 2013: Ch. 13). Within a critical realist approach, abduction and retroduction are necessary to examine both the empirical and the real domains (Vincent and O'Mahoney, 2018). Firstly, abduction entails 'redescribing that which is observed (interviews, observation, documents) in terms of theory in order to describe the sequence of causation that gives rise to the observed regularities in the pattern of events' (Vincent and O'Mahoney, 2018:12). This involves considering all possible theoretical possibilities for the data in order to identify the most credible explanation (Oliver, 2012). Observations are then combined with the literature to explain the mechanisms of causation. Retroduction involves taking these mechanisms and understanding if any other mechanisms need to be in play for a certain event to take place. In this research, inductive theme analysis will be used to conduct abduction and its results will be further analysed alongside the findings of the literature review.

I considered taking a subtle realist approach to this research, given its focus on the experiences of professionals and young people. The appropriateness of Subtle Realism lies in its assumption that individual experience is based on the belief that we can only know reality from our own experiences (Angen, 2000). A subtle realist perspective considers that a researcher cannot be completely certain of their results and focuses more on findings that seem realistic and in which they can be confident (Duncan and Nichol, 2004). As this research is based on individual experiences, it would be inappropriate to generalise opinions and experiences as being representative of all those who have experienced CSE. Instead, my research examines the insights and experiences of a small number of individuals, focusing on a plausible relationship between

alcohol and CSE. This is consistent with the view taken by Pope and Mays (2006) that all observations and interpretations are subjective and often dependent on the methods that are used. Furthermore, according to Hammersley (1992), qualitative research often does not aim to apply findings to a wider population but rather attempts to understand certain behaviours of interest.

Although Subtle Realism might have provided a relevant perspective for my research, I decided against it, as it would not capture the complexities of CSE and some of the influences on the work of AOD workers. Whilst it is true that we can only know experiences from the perspective of our own experiences, we can have some awareness outside of this. For example, we have an awareness of austerity and funding cuts. Critical Realism can capture these complexities and highlight the mechanisms below the surface that an individual might not always be conscious of or have control over.

7.3 Theoretical framework: Ecological Systems Theory

Ecological Systems Theory has been chosen for this research as it sits within Critical Realism, adding a framework to focus on complexities such as relationships, mechanisms, which are discussed within this section. The framework allows for an analysis of these mechanisms, some of which are more controllable by the individual than others.

Young people's use of alcohol and CSE are both complex issues, in terms of causes, behaviours and their impact on victims. This complexity increases when the relationship between alcohol and CSE is examined. A proper understanding requires more than just a focus on the individual and must include an examination of the interacting factors that influence their lives and behaviour interactions – not just their immediate social environment but broader social and cultural factors. For the purposes of this study, this broader perspective is especially helpful in understanding the interventions of alcohol and CSE services. Ecological Systems Theory, which is often applied to child development, provides a useful theoretical framework for understanding the

factors and relationships relevant to the interventions of support services. Rigby and Whyte (2015:39-40) provide a useful description of an ecological perspective, which ‘’looks at a child’s development from within a context of the systems of relationships that exist between children and their environment, and the way in which individuals interpret and perceive these relationships’.

Bronfenbrenner‘s (1977) ecological framework placed a child at the centre of ‘nested’ or multi-layered environments that interact to influence an individual’s development. This study will use the framework in relation to both young people and AOD workers:

- *Microsystem*

- AOD worker: the influence of their place of work and the individual experiences on an AOD worker
- A young person: the young person’s interactions with their immediate social contacts – family, peer groups, school

- *Mesosystem*

  – AOD worker: the interplay between alcohol and drug services, CSE support services and other agencies that support young people. The impact and influence of multi-agency working
  – A young person: the interactions between two or more of these contact groups and the impact of these interactions on the young person

- *Exosystem*

- AOD worker: the societal level and structures that are in place largely because of the national policies and belief systems that exist at the macro level.
- A young person: external to the young person but can affect the microsystems of which they are a part and therefore indirectly influence their life – the nature of the local area, parent’s work and social and kinship networks, local and national government agencies

- *Macrosystem*

- AOD worker: the influence of government policy and strategy on alcohol and CSE
- A young person: the society and culture within which an individual lives and the associated beliefs, attitudes, lifestyles and institutions that can influence the other layers, e.g., role expectations of parents. Hong et al. describe this as the 'cultural blueprint'

In a discussion of the influence of external environments on the family, Bronfenbrenner (1986) added a fifth environment, the Chronosystem, to describe the influence on an individual of the events and changes that occur over their lifetime. For an AOD worker, this would be the progressive or cumulative impact of high-profile cases, serious case reviews and development of policy and strategy

I will refer to this model where relevant in the findings of my research relating to understanding the relationship between alcohol and CSE (chapter 10). Ecological systems will be integral to my discussion of the second aim of my research that examines the implications of alcohol-related CSE for alcohol service interventions, where it will be used as the organising principle. The application of an ecological framework to this study is appropriate, as it has been part of social care practice for some time. In their review of literature relating to alcohol use among South Korean youth, Hong et al. (2011) show how an ecological approach can demonstrate how interaction at all levels in the ecological system is relevant to understanding these behaviours and can inform interventions. For Siporin (1980:516), it enables the profession 'to gain…a more unitary and comprehensive unit of attention, for a holistic and dynamic understanding of people and the socio-cultural-physical milieu' and 'avoid blaming the victim'. Jack (2000:713) describes its application to social work as 'the cultural environment within which all other practices and policies should be developed'. The ecological model has been applied to the delivery and development of support services for young people. Galvani (2017) places the model at the core of social work education and practice in relation to substance

use, identifying issues of concern and proposing solutions. Algood et al. (2011) used the model to make recommendations for practitioners working with families with disabled children. Cook and Kilmer (2010) make the case that professional service providers should adopt a broader perspective or ‘system of care’ that encompasses the diverse factors that affect the lives of young people and their families and extend their focus beyond formal structures to include informal social networks such as neighbours, friends and extended families. Rigby and Whyte (2015) use an ecological approach in their study of child trafficking, to provide a framework to understand the associated risk factors.

7.4 Chapter summary

This chapter has discussed Critical Realism and how this has informed the conduct of my research. The philosophical and theoretical orientation of this research focuses on the interactions between systems and their influence on the construction of knowledge. This standpoint has led me to embed Ecological Systems Theory in my research, in order to examine structures and systems in relation to the agency that an individual may hold. AOD and CSE workers and young people were interviewed to gain an understanding of the role of alcohol in CSE and the support provided, This allowed me to obtain a perspective both from those who are providing support around alcohol and CSE and those who are receiving support. By doing so I can examine AOD workers’ responses to CSE, whilst also examining young people’s perspectives and how these impact upon support needs and their ability to engage with this support.

Critical Realism as a framework for this research suggests that my research design will need to consider a methodology that enables access to the empirical, actual and real levels. In the next chapter I will discuss this design in greater depth.

Chapter 8
Methods

The methods chosen for my study are aligned with the theoretical approach outlined in Chapter 7. Their rationale is derived from its research aims. The underlying research philosophy discussed in the study's epistemology and ontology informs the research design and defines the researcher's standpoint.

This chapter starts with an outline of my research design, to provide the reader with an overview of my methodology. It then describes how each participant group – AOD and CSE support workers, young people and advisors with lived experience – was identified and recruited. It discusses the associated data collection and analysis methods for AOD and CSE support service providers and young people. The chapter concludes with a summary of the limitations of the research methods used.

8.1 Research design

A critical realist standpoint for my research with AOD and CSE professionals required a method that enabled the professionals to share their views and opinions on what they had experienced and how they understand these experiences. The questions I asked them needed to capture their views and encourage them to share how they had arrived at their viewpoint. I conducted semi-structured interviews with these workers, to gain an understanding both of how they viewed the relationship between alcohol and CSE and of how alcohol services support young people who have experienced alcohol-related CSE.

Inclusion criteria for the involvement of AOD and CSE workers in this study were that they supported young people up to the age of, and including, 18 years around alcohol and CSE. The inclusion of both AOD and CSE workers was important to compare their respective remits: what AOD workers considered to be their role and their ability to support young people before referral, in contrast to how a CSE worker viewed their remit regarding alcohol and when a referral might be needed. The literature review highlighted the importance of

multiagency working and so it was important that this study was also able to capture this aspect, and in doing so, capture a wider view of the structures and systems in place to support young people around alcohol and CSE.

One of my original aims was to focus on the lived experience of young people who had experienced CSE and to ensure that their voices were included within my research. This aim was strengthened by the results of the literature review, which showed that very little published research on the relationship between alcohol and CSE incorporates the voices and experiences of the young people themselves. I therefore wanted my research to explore the experiences of young people, rather than just looking for causal explanations for the relationship between alcohol and CSE. This required a method that allowed them to share their experiences and enabled them to guide the conversation and be free to discuss what was important to them on the topic of alcohol and CSE. After exploring several approaches, I decided that a focus group discussion would be a good fit. The rationale for this choice is discussed in s.6.3.3. I offered the young women the option of a focus group or interviews, to ensure that they could take part in a way with which they were comfortable. They expressed a preference for a focus group.

The inclusion of vulnerable people in research, and particularly young people, has always been a contentious issue. As Aldridge (2012) states:

> The reason for their omission from such studies lies precisely in their vulnerability – their lives are often difficult and painful, and, in empirical terms, these children are hard to reach and often do not have the necessary verbal skills and confidence to take part in conventional qualitative methods that use, for example, interview techniques (Aldridge, 2012:48).

The challenges of recruitment led to a minimal representation of the voices of young people in this study. However, the involvement of young people is important if we are to understand their viewpoint more fully. The voices of young people who have experienced CSE need to be heard. Some research methods may therefore not be appropriate, but there is evidence that co-productive

research may help to provide some understanding of a situation from the point of view of the individuals experiencing it, capturing valuable insights that other methods might miss (Aldridge, 2012) .

This research therefore comprised two strands: interviews with alcohol service providers and CSE support service providers and a focus group with a small number of young people who had experienced CSE. These two strands will be analysed individually before being combined to address the aims of the research.

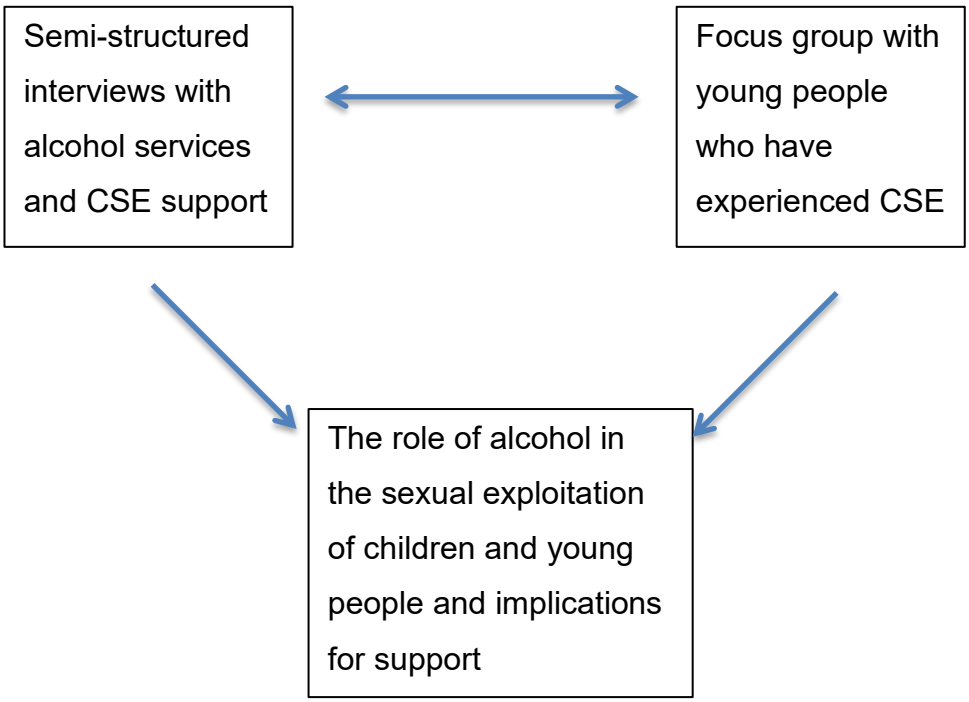

Figure 3: Research design

8.2 Participants – AOD and CSE workers

8.2.1 Sampling and Recruitment

The aim of engaging service providers was two-fold:

1. It was the principal means to achieve Objectives 3 and 4 of the research - to determine current alcohol services' responses to CSE and identify what is needed to support those who have experienced CSE effectively.

2. The views of service providers also contributed to Objective 2 - understanding the different roles that alcohol may play in CSE.

The initial inclusion criteria for participants in this part of the study were professionals working in alcohol and drug services who had experience of supporting young people experiencing CSE. Inclusion was later extended to professionals based in other services who supported young people experiencing CSE, to gain an understanding of their views and experiences of the role of alcohol in CSE and ways to support young people. Purposive sampling was used to recruit participants. It involves a non-random method of selecting participants from a population based on certain characteristics of interest for the study (Robinson, 2014). It helps to ensure that participants are a good match for a study (Campbell et al., 2020), thus supporting the generation of views and ideas about a specific issue (Robinson, 2014). As the aims and objectives of my research focused specifically on alcohol and CSE, the remit for participating within the study was quite specific and therefore was suited to purposive sampling. Purposive sampling was supplemented with snowball sampling, where research participants recruit other potential participants who are within their network (Naderifar et al., 2017). This was useful both in identifying services within the geographical area and in encouraging the engagement of participants through the endorsement of others.

8.2.2 Data collection methods

I conducted semi-structured interviews (SSIs) with staff from both alcohol and drug services and CSE support services (see Appendices 2 and 3 for interview schedules). SSIs allow for a structured approach that is flexible enough to allow the researcher to ask supplementary questions, through which participants can be encouraged to extend their responses beyond the specific questions asked (Adams, 2015). A semi-structured approach is less formal and restrictive than fully structured interviews. It enables the researcher to plan and address key topics and gives the participant some freedom to talk about what is important to them (Arksey and Knight, 1999). A semi-structured interview uses a combination of open and closed questions. The open-ended questions often have associated probes to gain more information (Adams, 2015). They allow for

a degree of flexibility whereby participants can explain their thoughts fully and the interviewer can clarify any uncertainties (Horton et al., 2004). Arksey and Knight (1999) suggest that developing appropriate probes can be just as important as the main questions, as they can act as prompts for the researcher.

I originally intended to hold all interviews face-to-face. However, the need to extend the geographical reach of my research beyond North West England to meet recruitment targets meant that telephone interviews were also conducted. Locally-based participants could opt for whichever approach they felt most comfortable with.

Telephone interviews have previously been regarded as less desirable than in-person ones (Novick, 2008). It is more difficult for the researcher to build a rapport with the research subject and the absence of visual cues removes contextual information that might help the researcher to interpret responses. However, they are now becoming more popular, partly due to the geographical distance that can be covered, which means that they are more time and cost effective. Novick (2008) searched the literature on telephone interviews and identified several strengths, including: they allowed the participant to take part in the interview at their chosen location; participants were given more anonymity and privacy, and experienced less social pressure.

8.2.3 Participant recruitment

Recruitment for service provider interviews followed several stages:

1. I used links to two alcohol and drug services that I had developed early in the research process to arrange interviews with members of their staff.
2. The original focus was on alcohol and drug services in the North West, to keep recruitment manageable and in the geographical area in which I am based. However, the lack of response made it necessary to increase the sample size by extending recruitment across the UK.
3. I contacted alcohol and drug services and services that provide support to young people who have experienced CSE, asking managers to identify staff members who would be suitable for the research. I also used ‘Snowball’ sampling (Naderifar et al., 2017) with staff members who took part in an

interview. This entailed alcohol and drug workers suggesting colleagues in the substance use field and specific CSE support workers with whom they had a professional relationship.

4. A national CSE charity also included my study within their newsletter, encouraging service providers to get in touch. I also encouraged both alcohol and drug and CSE workers to get in touch with me on Twitter (Appendix 4)
5. I emailed service provider staff who expressed an interest, attaching the participant information sheet and consent form (Appendices 5 and 6). I asked them to respond within two weeks, either with their availability or to say that they did not want to take part. If they had not responded after that time, I sent another email. If this failed to produce a response, I followed up with a phone call where possible before I excluded them from the recruitment process.

I sought and was granted ethical approval to interview CSE services staff (Appendix 7) to gain a broader insight into the role of alcohol in CSE. Ethical approval was also sought and given to expand recruitment via Twitter and through the CSE network newsletter.

Recruitment of staff from alcohol and drug and CSE services presented difficulties. Services were not able to take part because of workload and some support workers were reliant on their services releasing them to take part. As with young people, recruitment relied on being able to identify suitable services to contact and in turn, the services identifying suitable members of staff to participate in the research. It is possible that services may only give access to staff who they believe will give a positive view of the service, rather than those who may be more critical.

8.2.4 Procedure

I arranged face to face interviews at the participants' places of work. On first meeting, I provided them with a participant information sheet and an informed consent form (Appendices 5, 6, and 8) I took them through the information sheet and asked them to sign the consent form if they were happy to take part.

Prior to any telephone interviews, I sent participants the participant information sheet and consent form via email and asked them to email me a copy of the signed consent form before the interview. At the beginning of the telephone call, I asked them if they had read the participant information sheet and gave them the opportunity to ask questions. I then asked them to confirm that they were still happy to take part in an audio recorded interview.

I planned for interviews to last for up to an hour, but they varied in line with how much participants had to say. The interview durations ranged from 17 minutes to 1 hour and 15 minutes. After each interview, I uploaded audio recordings onto my secure University drive and subsequently transcribed and stored them on a secure University drive.

8.2.5 Participant profiles

Tables 2, 3 and 4 below present an overview of the 12 participants from alcohol and CSE services.

AOD workers

The eight AOD workers interviewed (Table 2) came from six different services across the UK and had a range of experience. Six worked specifically with young people who had experienced or were currently experiencing CSE; the other two had limited experience with CSE. Two of the eight workers were based within adult alcohol services but supported those aged 18 years; one also had experience of working with the local young people's alcohol and drug service to support young people transitioning from that service into the adult alcohol and drug service.

Table 2: AOD worker participants

Name (pseudonym)	**Role**
Laura	Alcohol worker – 18+
Emily	Alcohol worker – 18+ working mainly in criminal justice
Rebecca	Alcohol worker in young people service
Jenny	Alcohol worker in young people service working with those who have experienced CSE
Tina	Alcohol worker in young people service working with those who have experienced CSE
Eleanor	Alcohol worker
David	Alcohol worker
Mark	Alcohol worker

CSE workers

Four service providers (Table 3) who supported young people at risk of, or who had experienced, CSE, were interviewed. Two were based in alcohol and drug services, with a role to support young people where CSE had been identified. The third had a broader role supporting young people's sexual health more generally. The fourth had only recently started work in CSE but had previous experience in frontline child protection.

Table 3: CSE worker participants

Name (pseudonym)	**Role**	
Nina	CSE worker in specialist CSE social work team.	In post for 6 weeks; previously a social worker for 3.5 years on a frontline child protection area team.
Beth	Sexual health nurse	Clinical lead for sexual health for two areas within a large city.
Kate	CSE worker – based within an alcohol and drug service	Works with young people who are deemed to be at risk of sexual exploitation either online or in person.
Rhiannon	CSE worker contracted to work for an alcohol and drug service	Acts as a referral point for young people experiencing CSE

8.2.6 Data analysis

I chose inductive thematic analysis based on Braun and Clarke's (2006) framework because it is a robust form of analysis that is data-driven, rather than having predetermined themes. Braun and Clarke (2006) describe the framework in six steps:

1. *Familiarisation with the data* – this involves thoroughly reading through all transcripts and listening to audio recordings, to become familiar with all of the data. Whilst doing this, notes are made on anything of relevance to the research questions. I listened to all interview and focus group recordings in full twice – once while transcribing them and again when I also made notes on the interviews. I also read through the transcripts to familiarise myself with the data further.

2. *Generating initial codes* – the codes generated can either be semantic (close to what participants appear to mean) or latent (what the researcher identifies beneath the surface level of what participants are saying). I imported all transcripts into NVivo (version 11) (QSR International, 2015) and generated codes.
3. *Searching for themes* – themes are created by reviewing the coded data and identifying patterns in the codes, creating themes that relate to the research question. I completed the initial coding for each participant group, reviewed the codes and merged them to create themes and subthemes.
4. *Reviewing themes* – involves rereading all of the data to assess if the themes identified represent key parts of the data that relate to the research question. I identified the themes, reviewed them against my research question and objectives and identified the key themes related to the research.
5. *Defining and naming themes* – each theme needs 'a clear focus, scope and purpose' (Braun and Clark, 2006:66) that link to other themes to provide a narrative for the data. Within this step, extracts of data are identified to be included within the write up. I renamed my key themes in line with my objectives, along with a description of what each code contained (Appendices 9, 10, 11 and 12).
6. *Reporting of themes* – themes should be presented in an orderly way that tells the story of the data. Themes were then reported in a way that told the story of the data.

All interviews were audio recorded with the consent of the participants and were transcribed verbatim. I familiarised myself with the data by listening to and reading through all transcripts in full, in accordance with the first step of Braun and Clarke's framework. Whilst doing this, I made notes on each interview about what stood out as being important and relevant to my research aims and objectives. I then imported the data into and analysed it using NVivo (version 11) (QSR International, 2015) (computer software to aid qualitative analysis of data). This is consistent with stages 2-5 of Braun and Clarke's (2006) framework, to generate codes, review and determine themes. Initial codes were generated for each individual interview before being clustered together to make

sub-themes, which when reviewed were collapsed down further to create final themes across the data. After generating my codes, I reviewed a sample of them and discussed them with my supervisory team for quality control purposes, given my position as the sole researcher. Stage 6 of Braun and Clarke's framework is presented in the Findings (Chapter 11) and Appendices 9, 10, 11 and 12).

8.3 Participants: young people

8.3.1 Purpose

The involvement of young people in my research was important to both of my research aims. Exploring how they felt alcohol could be or was involved in their experiences of sexual exploitation provides an important perspective on alcohol's role in CSE. Their views on how specialist support services respond to young people presenting with alcohol-related CSE contributes to identifying the implications of this problem for alcohol and drug services.

8.3.2 Sampling

The inclusion criteria for the study were young people aged 13-18 years who had consumed alcohol before, during or after experiencing CSE. Exclusion criteria consisted of individuals over the age of 18 and individuals where it was felt that taking part in an interview would re-traumatise them. This decision would be based on the advice of service provider staff.

CSE relates to children and young people up to and including the age of 18. Including participants who were under the age of 18 and had experienced trauma made recruitment difficult. The hidden nature of CSE (Coffey, 2014) means that young people who have experienced it are hard to reach and, due to complex circumstances, hard to engage. As my research focused on those who had issues with alcohol and had also experienced CSE, identifying potential participants was even more difficult (s10.2.4), as I relied heavily on services being able to identify young people who matched this requirement.

8.3.3 Data collection methods

Focus group participants consisted of a group of young people who attended a CSE service group. After discussions with the group facilitator, a focus group was chosen as the most appropriate method because the group was already established and used to talking about their experiences together.

The choice of methods was influenced by several factors:

- Young people's voices and opinions should be integral to my research
- The methods had to capture information about the experiences of participants, while also being sensitive and respectful of what young people and service providers might want to share.

A focus group is a group interview with people who are of a similar background, experience or expertise, to discuss issues and opinions on a particular topic (Patton, 1990). It has been described as a 'direct method of obtaining rich information within a social context' (Robinson, 1999:905). Focus groups can be a more useful research tool than individual interviews because they enable participants' opinions to be directly compared in real time, rather than as part of an analysis of separate interviews (Morgan, 1997). Robinson (1999) also suggests that focus groups can help to facilitate conversation around criticisms of services and ways in which they can be improved. The researcher can use the group dynamic to observe shared knowledge and opinions as well as those that differ (Kitzinger, 1995). This can be useful when trying to establish the norm and common views. However, it is also important to acknowledge that one downside of group agreement is that individuals who have different opinions may not feel able to share their views (Kitzinger, 1995). As an interactive method, a focus group is more than just a researcher asking a question and participants answering. The researcher must act as a facilitator to the group discussion, encouraging participants to engage with one another to discuss the topics in depth (Kitzinger, 1995). A focus group discussion should allow participants to develop the responses of the others in the group and provide different viewpoints on the discussion topic (Liamputtong, 2011).

The ideal size for focus groups has been debated extensively. Discussing conducting focus groups with children and young people, Gibson (2007) suggested that it is difficult to pinpoint the smallest effective group size as rich data can still come from small groups. The author suggested that four may be the lower limit, as a very small group can lead to parallel interviews, rather than a more interactive focus group discussion (Gibson, 2007).

The topic guide for my focus group (Appendix 1) contained four open questions that were designed to capture the young people's views of alcohol and CSE more generally, so as to not make them feel under pressure to talk about their own personal experiences. I believe that adopting a minimally structured approach around four key questions gives participants more control over the process. This is particularly important when researching sensitive topics, as it may help minimise some of the risk, with participants controlling the pace of the interview and the amount of information that they share (Corbin and Morse, 2003).

8.3.4 Recruitment

Once ethical approval was granted (Appendix 10), recruitment for interviews with young people began in January 2019 as follows:

1. I began trying to recruit young people by using previously established links with an alcohol and drug service and contacting several CSE support services and participation groups.
2. When this was unsuccessful, a CSE network service provided me with a referral to a CSE support group in a city in the North of England, which agreed to engage with the research as a focus group.
3. I sought written gatekeeper consent before the focus group took place. Participant information and consent forms (Appendices 13 and 14) were arranged via the CSE support group facilitator in advance of the focus group meeting.
4. At the focus group meeting, I went through the participation information sheet with the young people and gave them a chance to ask any questions.

8.3.5 Participant profiles

Three young women agreed to participate in the focus group. They attended a support group for young people who had experienced CSE and were accessing support for this. The purpose of engaging young people in my research was to ensure that the voices of some of those who had experienced CSE and received support for it were heard within the research, to compare with and contrast the views and opinions of professionals.

The findings from the focus group should be interpreted with several caveats in mind. Firstly, this is a small sample size, consisting of three young women. Secondly, only two participants took an active role in discussion; the third remained silent for most of the discussion, nodding occasionally. Thirdly, none of these young women associated their personal experiences with alcohol-related CSE.

Table 4: Young people participants

Name (pseudonym)	Age (years)
Jess	17
Amy	16
Kara	16

8.3.6 Procedure

The focus group took place where the young people's CSE support group usually met. Before discussion began, introductions were made and the group facilitator summarised the CSE support group rules to be followed. These included listening to everyone in the group and respecting what others had to say. I then talked participants through the participant information sheet, explaining the study and giving them the opportunity to ask questions.

During the focus group, I asked the four questions in the topic guide (Appendix 1), together with broad prompting questions, to let the discussion of the topic develop naturally and be driven by the young people themselves, to focus on the issues that they felt were significant. It was important to give them some

control over the discussion - as they are the ones with lived experience on the subject, their viewpoint is critical.

The CSE support group facilitator sat in on the focus group for its duration, as I felt that her presence would help the young people to feel more comfortable taking part. I made this judgement when the focus group met. I was aware that the presence of the facilitator could have some negative implications. The young people might feel unable to fully disclose and discuss their experiences in front of the facilitator, particularly about the support they had received from the service. It was also possible that the presence of the facilitator might alter the dynamic of the group, as the facilitator usually leads group discussion. I took these factors into account but decided that from an ethical standpoint it was appropriate, to help the young people feel more at ease.

After the focus group ended, I gave participants the opportunity to ask questions and thanked them for their time. The discussion lasted 50 minutes. I uploaded, transcribed and stored the audio recording onto a secure University drive.

8.3.7 Data analysis

I analysed the focus group data using thematic analysis following Braun and Clarke's (2006) framework (as described in s.6.1.6). The use of the same analytical method for both service provider interviews and the young people's focus group provided some consistency across my research.

8.4 Participants: advisors with lived experience

I intended to include a participatory advisory group in my research. This was particularly important for the development of the research methods that I would use with young people, to ensure that the approach chosen was informed by their personal experiences and sensitive to their concerns. This was an area in which I lacked knowledge. The inclusion criteria for the participation group were therefore individuals who had experienced CSE and who would share their

insights publicly. There was no age limit for this group. Those who had not experienced CSE were excluded from participating.

At the beginning of my research, I scoped some existing participatory groups that appeared to be suitable. When formally contacted, some did not respond to my email requests, while others replied that they were too busy to take part. I then discussed with one alcohol and drug service the possibility of forming an advisory group comprising young people who were attending the service. This also proved unsuccessful, as due to confidentiality reasons, the young people attending the service were seen only on a one-to-one basis and so there was no opportunity for them to meet as a group. My failure to secure the engagement of a formal advisory group in my research led me adapt my approach. Instead, I recruited three individuals with lived experience of CSE, who separately provided me with advice on the engagement of young people in my research.

The first of these advisors was employed by an organisation that trains professionals in working with young people who have experienced CSE. She offered to provide some informal feedback on my methods, which was detailed and very helpful.

I recruited the other two advisors through the social media forum, Twitter, when they offered to help me in response to my tweet targeted at CSE support services staff (s.8.2). As they replied personally, I asked them to confirm their age before sending them information sheets and consent forms (Appendices 15 and 16). On receipt of signed consent forms, I provided them with an explanation of my research and asked them to read and comment on the questions that I was planning to ask young people. After giving them options to provide feedback via skype, phone or email, both opted for email and provided their feedback in this form. On receipt of the feedback, I emailed to thank both individuals for helping me with my research.

8.5 Limitations of the research

One of the aims of my research was to capture the voices of young people who have experienced CSE. This has been achieved to a limited extent. While it was not my intention to generalise from this research, it was my intention to include the views of more than three young people. A cautionary approach is, therefore, needed when interpreting the findings of this research more widely. It is also important to recognise that the young women who took part in the focus group for this study did not identify alcohol as being part of their own experiences of CSE. Their comments should be seen as the views of young people who have experienced CSE and have some understanding of how alcohol can be involved in it. However, the young people's voices are still central to this research: they raised some important points worthy of further consideration and exploration. Similarly, the views and experiences of the service providers included in this study are not necessarily representative of those of the wider alcohol sector. This needs consideration because the AOD workers who took part in my research were to some degree self-selected in that they already had an interest in CSE and saw it as part of their role. Other AOD workers might have a different view. While CSE service provision was not the focus of my research, the small sample size of CSE workers should also be noted as a limitation. These limitations indicate that further research into AOD workers is necessary, using a larger and more representative sample.

8.6 Chapter summary

This chapter has described how I translated my epistemological and ontological standpoint into research methods and how I conducted the associated data collection and analysis. It has also outlined how I identified and recruited each participant group and the limitations of this recruitment on my research. Each of these aspects of my research required careful ethical consideration. I will now discuss how I ensured that my research was ethically robust.

Chapter 9
Ethical considerations

Ethical approval was granted by the Manchester Metropolitan University Ethics Board (Appendix 7) in September 2018, with ethical amendments granted in January 2019, March 2019, June 2019 and September 2019. These amendments were considered appropriate in response to: feedback from those with lived experience of CSE, who raised concerns over my initial choice of methods; changes in recruitment methods to maximise participation, including advisors accessed via Twitter; a change from individual interviews to a focus group with young people.

This chapter will discuss the ethical considerations that I considered before conducting my research. It examines the risks posed to each participant group and to me as a lone researcher.

9.1 Research with service providers

Given the nature of the topic being discussed, it was possible that the service provider interviewees could have become upset. Re-engaging with accounts of sexual abuse and violence can take an emotional toll on even more experienced workers (Chynoweth and Martin, 2019). They may even have experienced CSE themselves. I informed all participants that they could stop the interview at any time should they need to and I provided them with contact details where they could seek specialist support.

There was also a risk that service provider interviewees might disclose experiences that raised safeguarding concerns about themselves or the people they support. More generally, it is possible that service professionals may be critical of the services for which they work or, alternately, be defensive of the services they provide and of their professional expertise.

9.2 Feedback from advisors with lived experience

Ethical consideration was needed when I was contacted by two adults with lived experience of CSE who offered help after seeing my tweets to recruit service providers (s.8.4). It was possible that they could be re-traumatised through advising on my research. The online nature of communication with them was a consideration, especially as I knew very little about them and there was no way to ensure that support was easily accessible should they become upset. These issues were discussed with my research supervisor and submitted for ethical approval, which was granted. There were several reasons that I decided to go ahead with this. Firstly, they had contacted me on their own initiative to express a willingness to contribute. Their personal experiences could provide a useful perspective. Secondly, I was able to signpost them to national organisations that could provide support. Furthermore, at this point in my research I had already received feedback on, and had made amendments to, the four questions for the young people's focus group topic schedule; I believed that I had already eliminated some potential triggers for the advisors. I also asked them to confirm their age before providing them with the information for the study.

Online recruitment and feedback of this kind is not without risk, as it is impossible to establish the identities of online participants definitively. The associated ethical issues are discussed in s.10.2.6. However, at the same time, this method does allow individuals to take part and have their say without making themselves uncomfortably visible, as I am the only person who knows that they have been a part of the research process.

9.3 Research with young people

Ethical research practice is especially important when vulnerable groups such as young people and those who have experienced trauma are involved: 'With any expanding field, proper focus needs to be given to ethical dilemmas that may arise when studying a sensitive topic' (Rosoff, 2018:91). The ethics of a study must take into consideration its impact on those who are the subjects of the research. There are strict ethical procedures associated with young people,

which intensify when combined with the added trauma that the young people within my research had experienced. Therefore, extra care and attention to ethics was necessary.

My research with young people was grounded in the principles developed by the NSPCC (2012):

1. Voluntary participation based on valid informed consent
2. Enabling participation where possible and avoiding the systematic exclusion of particular sections of society
3. Avoidance of personal and social harm to participants and researchers
4. Non-disclosure of identity and personal information
5. Ethical application and conduct of research methods

Young people are often considered a vulnerable group. It is therefore important to understand what is meant by the term vulnerable and to consider the implications of identifying a group as vulnerable.

9.3.1 Vulnerability

Vulnerability is seen as a major ethical concern for certain groups, including the young people who participated in my focus group. I regarded them as vulnerable because of the potential impact of their emotional, psychological and physical experiences and because they could be re-traumatised by participating in my research. However, given the nature of my research, it was crucial that their voices were included to increase understanding and raise awareness of alcohol-related CSE. It was important that individuals who had lived experiences were able to share their thoughts and feelings on the topic and to contribute to enhancing the knowledge of others. They can often hold important, sometimes unique, information. The inclusion of a vulnerable population who have been through such traumatic events was called into question during the University ethical approval process. However, after discussion, approval was given on the grounds that it could be unethical to exclude individuals because of what they have been through, without giving them the opportunity to have their say on a matter that they have experienced. Without the input of those with lived experience, there is a gap in the voices of experience being heard.

However, I was also aware that while a group may be deemed vulnerable, it is hard to use such a blanket term to cover everyone in the group. As suggested by Peter and Friedland (2017), vulnerability is often a combination of several factors and to accurately identify someone as being vulnerable can only be achieved through knowledge of the individual themselves, rather than a more general assessment of a population to which they may belong. Understanding an individual's own views of their situation can contribute to a full assessment by helping to gauge not only their vulnerability but also their resilience (Peter and Friedland, 2017). If a judgment of an individual's vulnerability and ability to take part in research is based purely on membership of a group to which they have been assigned for the purpose of research, there is a danger that such assumptions may be misleading (Dubois et al., 2012). A closer discussion around the term 'vulnerability is needed:

> 'Vulnerability' is generally a highly contested term, and in regard to childhood in particular there are a range of possible positions about the extent to which children are conceptualized as vulnerable, merely by virtue of being children. (Daniel, 2010:236)

The concept of vulnerability appears throughout my thesis, both in terms of recruiting young people who are viewed as 'vulnerable' and in the comments of participants within the study when they discuss vulnerabilities and what may make a young person vulnerable to CSE. The concept of vulnerability has been widely critiqued and its terminology questioned. It is often used by both academics and policy makers alike without being clearly defined (Brown, 2011). Without a clear definition of what they mean when they talk about vulnerability, it is left to the reader to exercise their own opinions and apply them to the term. The differing opinions of who should be classed as vulnerable and on what basis are problematic, given that as Brown (2011) explains:

> The concept of vulnerability informs how we manage and classify people, justify state intervention in citizens' lives, allocate resources in society and define our social obligations, it has important implications for ethics, social welfare and, ultimately everyday life (Brown, 2011:313).

Being categorised as vulnerable has implications for an individual in all areas of their life. While the label indicates that there is an element of protection for an individual, the perception that someone is vulnerable can have negative consequences for them. It can lead to individuals being excluded from research, so that they are not given the opportunity to share their views and contribute to an evidence base that is directly linked to them. The result of this is that there can be large gaps in our knowledge.

Further criticism of the concept of vulnerability comes from Hollomotz (2009), who explains how, when someone is identified as vulnerable, assumptions are made about their 'self-defence' skills because there is a focus on risk. Hollomotz explains that 'vulnerability takes insufficient account of the social formation of self-defence skills and the impact that environmental, cultural and social factors have on the formation of risk' (Hollomotz, 2009:110). Viewing a whole population as vulnerable can result in individual abilities and characteristics being overlooked or ignored. Within research such as mine, services that are supporting young people can often make this broad generalisation and prevent individuals whose contribution could be valuable from taking take part. The services might believe that what they are doing is in the young person's best interest and that they are protecting them from harm, but it might also be diminishing the young person's ability to have control and make their own decisions. Vulnerability can often be subjective and dependent on individual opinion of what vulnerability means. Given this critique of vulnerability, it is difficult to apply a simple definition of what it is; this thesis does not attempt to do so.

9.3.2 Informed consent

Ethical research requires that all participants fully understand the purpose of the study, why they are being asked to take part, what will be required of them and how the information they provide will be used. Care and attention need to be focused on content, language and the nature of consent where young people are involved. I developed two sets of information sheets and consent forms for potential young people participants. One set was targeted at those aged 13-16

years (Appendices 17 and 18); the other at those aged 16-18 years (Appendices 19 and 20). This was necessary for two reasons: firstly, to ensure that the information was easily understandable by, and appropriate for, each young person; secondly, because people under 16 years old generally need to give their *assent* to participate, as they are not considered of age to give *informed consent*. Assent has been defined as a 'relational process whereby children's actions and adult responses taken together, reflect children's participation decisions' (Dockett and Perry, 2011:231). For those under the age of 16, therefore, parental consent also needs to be sought. I distributed participant information sheets and consent forms in advance of the focus group to ensure that there was sufficient time for informed consent to be given. The young people in the CSE support group had time to consider whether they wished to participate and those under the age of 16 were able to seek parental consent ahead of the scheduled meeting. I also produced a separate information sheet and consent form for parents and guardians (Appendices 21 and 22). This approach also meant that those who did not feel comfortable taking part could opt not to attend the support group on the night of the focus group and thus avoid the potential embarrassment of declining to participate in my presence. The CSE support group facilitator went through the participant information sheet with the young people in the group and returned the consent forms of the three young people (all aged 16 years and over) who were happy to take part in the research prior to the focus group. I took copies of the information sheet to the focus group and went through it with the young people prior to starting the discussion. In doing so, I gave the young people the opportunity to ask any questions and to change their minds about taking part if they wished to do so.

9.3.3 Avoiding re-traumatising participants

To be ethical, research into sexual violence must be conducted in a trauma informed way:

> When weighing up the risks of children and young people's participation in research, the potential benefits of their involvement and the risks of non-involvement should be considered equally. (Bovarnick et al., 2018:7)

There are both logistical and ethical barriers to young people taking part in research regarding sexual violence. Bovarnick et al. (2018) have suggested that this is partly due to the stigma that is attached to sexual violence, which can lead to a young person feeling unable to take part and their family not wanting them to. When conducting research in the field of sexual violence, it is often important for both ethical and logistical purposes to engage specialist services to support the research and its participants. However, the perceived vulnerabilities of young people that are the reason they are attending a service can also lead to services becoming protective of them and not seeing young people's engagement in the research as a priority (Horwath et al., 2012). This issue of protecting children and young people taking part in research regarding sexual violence stems from some aspects of the UN convention of the Rights of a Child conflicting with children's rights to participation.

Previous research has put measures in place to enable young people to take part in research around sexual violence by reducing the risk of harm to them. An example of this is where researchers work with the agencies supporting young people, with the agency providing advice on potential risks to the young people and providing support to them after the research if required (Beckett et al., 2013). This was a measure I adopted in my research. Like Beckett et al., I acknowledge that including services can lead to some bias, but this is outweighed by the importance of their involvement in helping to support and safeguard the young people. I worked with a service to conduct a focus group with an established group of young people.

A young person talking about their experiences of CSE, even in general terms, might be traumatised or upset again. To minimise this risk, I sent the proposed methods, questions and participant information sheets to one of the advisors with lived experience, who at that time provided sessions on how best to support young people around CSE. Her feedback was crucial in moving the questioning away from young people's direct experiences and making the questions on the topics of alcohol and CSE more general and less personal. I refined the questions further, changing the format to four open questions

(Appendix 1), so as to give young people the opportunity to talk about their own experiences if they wanted to and to avoid bombarding them with questions.

I encouraged participants to seek support from the service from which they were recruited and I included the details of other services that they could contact for support in the participant information sheets. The group facilitator agreed to this ahead of the focus group and the information was included within their gatekeeper information and consent form (Appendices 23 and 24). The location of the focus group within the service accommodation and the attendance of the CSE support group facilitator at the focus group also ensured support was available if needed.

9.3.4 Focus groups with young people

The use of group-based methodologies comes with risks, including issues of anonymity (Kamberelis and Dimitriadis, 2011). This is something important to consider when using a focus group with young people. However, the risk of this in my study was offset by the fact that the young women met regularly, with the ground rule that what was said in the group stayed within the group. I therefore felt that each member would have an idea of how much they would like to disclose, given that their regular group discussions prior to the focus group would have been on the same topic. I also encouraged the young people to share only what they felt comfortable sharing and I did not ask questions directly about their own experiences. There is also the risk in a group setting that some participants may be more dominant, or that some participants may want to share something but do not feel comfortable doing so in front of the group. To address these issues, I provided paper, post-its and pens to the participants and encouraged them to write down anything that they might not want to say out loud, or if conversation had moved on and they later thought of something else that they wished to say.

9.4 The researcher – reflexivity and safety

There was a risk that I might find some of the information provided by participants distressing. I made sure that I stayed in contact with my

supervisors, so that they were aware how the research was going and I could raise any concerns about the research or the way that I was feeling. I was also aware that I had access to the University counselling service if I needed further support. I had been a Childline counsellor for over five years when I started this research. I had also conducted research on sensitive topics in my job as a research assistant. I therefore felt confident in my ability to talk about issues around CSE without becoming distressed and to have an awareness of how I feel afterwards. I appreciate the ability to debrief with supervisors when I feel it is needed.

Working alone is an ethical consideration in terms of physical safety. I ensured that someone was always aware of where I was, both before and after the research had taken place. Lone working also carries emotional risks, if the researcher becomes upset by the research and needs access to advice and support. Before conducting any research, I ensured that I knew who I could talk to if I became upset. I have extensive experience of conducting these conversations and using debriefing sessions where necessary.

9.5 Anonymity and confidentiality

Maintaining the anonymity of participants was an important part of my research. Names and any other identifiable information, such as specific locations, were removed from the data.

I discussed anonymity with participants, explaining that the recording would only be accessed by myself and my supervisors and that the source of any quotes used in output would be anonymised. To aid this process, I also removed any other identifiable information from quotes, such as the names of the services where an individual may have worked or accessed.

Confidentiality was also discussed with all participants. I explained when confidentiality would have to be broken and what would happen. For example, this would be necessary if I felt that the participant or another individual's life was at risk, or if the participant disclosed that they were going to harm someone

else. I also included this information in all participation information sheets along with an explanation of data protection.

The Manchester Metropolitan University (MMU) is the Data Controller for this research. The University manages data in accordance with the General Data Protection Regulation (GDPR) and the University's Data Protection Policy. All information provided during this study is treated confidentially and stored securely in locked or password protected files in accordance with the Data Protection Act 1998. It will be stored for five years and will only be listened to by my supervisors and myself as the researcher. It is the University's policy only to publish anonymised data unless participants have given their explicit written consent to be identified in the research.

I gave full and proper consideration to all of the preparatory aspects of my research. I developed a theoretically sound methodological approach and identified and recruited participants appropriately. I gave considerable attention to ethical considerations to minimise harm to both me and the participants.

9.6 Chapter summary

This chapter has discussed the ethical considerations and procedures that preceded engagement with each group of participants in my research. It demonstrates the complexity of the issues involved and the care that must be taken when vulnerable young people are involved. The chapter also addresses ethical considerations that are relevant to the researcher.

Part 3 of this thesis now concludes with reflections on the researcher's journey from the design and planning stage of research to its management.

Chapter 10
Moving from research design to research practice: journey, reflections and learning points

My research evolved over time in response to the feasibility of its methodological approach, feedback on the most appropriate methods to engage and safeguard vulnerable young people, issues surrounding identifying and recruiting young people, service providers and advisory groups and the data resources available.

This chapter describes this journey, including how the main focus of my research changed to service providers due to the challenges of recruiting young people. My approach to the research also changed because of the feedback from an advisor with lived experience. I discuss some of the learning points that I drew from my methodological approach and suggest ways in which future research can encourage service and participant engagement.

10.1 Service providers

This study originally aimed to conduct focus groups with AOD workers. However, after reflecting on their workloads, changes were made to the research methods and CSE workers were included. The reasons for these changes will be discussed below.

10.1.1 Research methods

I originally intended to base my research with service providers on focus group discussions. However, I decided that conducting individual interviews in person and over the telephone would be more appropriate for this participant group for several reasons. Firstly, conducting individual interviews at times that were convenient for interviewees would be more likely to encourage service providers to take part. Secondly, I felt that interviews would provide a more reliable source of information that reflected the views and experiences of individuals from a range of service providers. Individual interviews would also offer a greater

variety of input because they would allow for the engagement of staff from a wider range of services. I decided that the benefits of this approach outweighed those provided by the group dynamic of a focus group. Focus groups can be useful in promoting discussion and group conversations, but some participants may feel uncomfortable and unable to share their views, particularly if they are critical of their service. Furthermore, as service providers are often very busy, with little time to take part in extra activities, finding a time and place that would be convenient for all who wanted to take part in a focus group might prove difficult. Individual interviews also increased uptake, as it provided greater flexibility for those who wanted to participate.

10.1.2 Recruitment

The broadening of service provider representation in the study to include CSE workers was introduced to capture CSE workers' understanding and ways of working when alcohol is involved within a young person's exploitation. Incorporating their views also contributed to a better understanding of the range of support that is offered to young people experiencing alcohol-related CSE.

10.2 Young people

10.2.1 Research methods

My original intention was to take a participatory approach to my research with young people, based on power minimisation and participant input to guide my research. It was not possible to involve participants in the development of the research questions, aims and objectives, as these had been included in the details of my sponsorship. Instead, I aimed to ensure that participation from young people who had experienced CSE was present at various stages of my research, especially in the development of my research methods. The extent to which I could make my research participatory was also restricted because one of the gatekeeper services suggested that the young people attending their service would be unlikely to attend more than one session. My choice of method for engaging young people also evolved after consultation with a service gatekeeper, who questioned the practicality and effectiveness of my preferred visual methodology, PhotoVoice (Wang et al., 1998). I then decided to base my

research on life stories (Etherington, 2007), creating a guide to facilitate the production of life stories with participants. However, following feedback from one of my advisors with lived experience, I decided to centre the focus group with the young people on four open questions that asked about the topic more generally, rather than focusing on their direct experiences (s.9.3.3; Appendix 1).

10.2.2 Learning points: research methods

Key learning points concern both the circumstances in which a young person makes a decision about taking part in research and whether they choose to take part or withdraw while the research is being conducted.

Service gatekeepers can pressure a young person to participate in the research or prevent them from being involved. My focus group was planned to replace a regular meeting of the CSE support group to which the young people belonged. I provided advance notice of the focus group so that they need not attend if they did not want to take part. The young people did not have to verbally decline; this might have given them more confidence to say no (s.9.3.2). What is of most importance when considering the participation of young people in research is that they feel in control of their decisions and know that even when they have agreed to take part, they can withdraw at any time. Three young women took part in my focus group, although only two participated for most of the time. It was possible that the third person had different views on some topics to them but lacked the confidence to express them. However, she appeared to be listening actively to what was said and expressed her agreement with what the others said non-verbally at various points in the discussion.

Overall, the experience of balancing ethics, timescales and the participation of young people and those with lived experience was challenging and raised many questions about how and when young people are included in research. My experiences have highlighted the importance of including both gatekeepers and the research population at the very start of a research project, in the planning stages, and throughout every other stage of the research.

10.2.3 Young people - service provider engagement

One of the major barriers to the inclusion of young people in my research came when the services that act as gatekeepers declined to take part from the outset. Several explanations were given as to why it was not appropriate for the young people attending their services to be involved in the research. For example, the services were concerned that my talking to young people about CSE would re-traumatise them. Heath et al. (2007) conducted interviews with researchers about their experiences of working with services to include young people within research. They found that services had declined for reasons including 'assumed inappropriateness of a proposed research topic and/or its methods' (Heath et al., 2007:410). The authors state that researchers rarely contest a service's refusal for young people to take part, something that I did not do myself.

This is something that I will consider more thoroughly when researching groups of young people on sensitive issues. It is a balance of the risk that taking part may pose, against the implications of denying them the choice. It is imperative to include young people in research so that their voices can be heard.

Some service providers were interested in my research but did not feel that the young people attending their service were in a suitable emotional or psychological place to participate. For example, one service had been very supportive, had provided input during the early stages of planning and was interested in taking part in service provider interviews. It was agreed that once I had ethical approval and was ready to talk to young people, I would contact them. However, when I was ready, they said that none of the young people attending the service were appropriate for inclusion in the research. This is particularly relevant when support workers may not be routinely asking young people about their CSE or alcohol experiences and so may be unaware of them.

10.2.4 Recruitment

I had planned to recruit young people through the alcohol and drug services with which I had established a relationship early in my research and which had shown an interest in taking part. However, it became difficult to recruit

participants in this way. Furthermore, after discussions with service providers and reflecting on the service provider interviews that I had conducted, I concluded that there could be significant difficulties in talking to young people about their experiences of CSE if they did not believe that they were being exploited. It was at this point, after being in contact with a service about its CSE support group advising on my research that I decided to change my approach. I discussed and agreed with the group facilitator that group members would participate in the research instead of acting in an advisory capacity (s.8.4).

10.3 Advisors with lived experience

I had originally planned that advice would be sought from an established advisory group of individuals with lived experience of CSE, at all stages of my research. A group was identified, but the service provider withdrew, stating that the group did not have the time to take on this role. The change of approach to include individuals with lived experience of CSE in this advisory capacity (s.8.4) compensated for this problem to a considerable extent. The feedback I received from the individual who had experienced CSE and was providing training to professional services staff proved to be vital to my research because of her clear critique of my method for engaging with young people (s.9.2).

10.4 Learning points – approaches to recruitment

The recruitment process for this research was tough and ever changing. It required constant flexibility in approach and constant questioning of ethics. One of the key points for ethical reflection was when the two advisors with lived experience contacted me on Twitter asking if there was anything that they could do to help with my research (ss.9.2, 10.4). I felt that it was important to include these advisors but was also aware of the ethical issues that their involvement would present. For example, I was only aware of their online identity and that they had said they were over the age of 18. I was unable to confirm this. There were also issues around ensuring that they had appropriate support should anything they were reading about my research trigger upset or trauma relating to their CSE experiences.

The use of social media was a useful learning point. Using Twitter and other social media platforms to recruit young people with lived experience can open research up to a wider group that might not usually be accessible when services and groups are used as gatekeepers. However, this comes with its own ethical challenges, including taking social media users' privacy into account and the researcher being honest about who they are and the nature and purpose of their research (Gelinas et al., 2017). The learning that I take from this part of my research is that social media can add to the value of research, providing ethical issues and risks are addressed prior to its use.

The feedback from my first advisor shaped my final methods and led to changes in my choice of methods and the questions that I asked. These changes show the importance of including people with lived experience and that even a small number of advisors can play a vital role in influencing the choice of research methods. This may be only one person's view, but their lived experience and explanations for their viewpoint, made it important to take on board their advice.

A major learning point for me about recruitment within services is that in future I would spend more time with potential research participants before the research began. The importance of doing so is evident in Hallett's (2013) research. She based herself within the services that young people attended for one day a week for a year, to introduce herself and get to know the young people. Spending time with potential research participants enables the researcher to build rapport with the young people and enable them to make an informed decision about taking part. This was not possible in my study due to time constraints and the strict confidentiality policies of the alcohol service that I was working with.

A single session with young people at the point of data collection can feel rushed and leave participants feeling that they have not got as much out of the research as their time and input merited. In future, I would want to build multiple visits into the research design, although I also recognise that this comes with important points to consider. For example, researchers need to be careful not to

hijack a group and undermine its main purpose, as the needs of the group should always come before those of the research.

10.5 Reflections on future research with services and people with lived experience

Agreement from both services and young people is important if young people are to participate in research. Such research would be incomplete without the input of young people sharing their experiences of the support that they have received. Where feasible, services and young people should be included in the research planning process from the bid writing stage. Previous research has suggested that the inclusion of young people as co-researchers may improve engagement, given that they may be of a similar age to participants and therefore able to build a rapport that an adult researcher might find difficult (McLaughlin, 2005).

One of the major learning points from my research is that it is not just the choice but the phrasing of questions that is of the upmost importance. I considered my phrasing carefully and consulted a service that supported young people. However, an advisor with lived experience explained that my questions were similar to those that the services would ask and would be off-putting. This issue can be addressed if interview and focus group topic guides are developed jointly, with the researcher, service staff and advisors with lived experience all present.

10.6 Chapter summary

My original aim of conducting research with young people who have been subject to CSE was challenging, in terms of research methods and recruitment. These difficulties resulted not just in significant changes to how young people engaged with my study but also resulted in a shift in the balance of my research towards service providers. Moving from research design to research practice was an important learning experience that will inform my approach to research in the future.

Part 4

Findings

Chapter 11
Findings: themes

11.1 Introduction

The fourth part of my thesis contains two chapters that present the findings of the interviews with AOD and CSE workers and the focus group discussion with the young women. I will also include a preliminary discussion of these findings, with a view to drawing out their implications for alcohol services further in Chapter 13, Discussion.

The limitations of published literature in explaining the nature and extent of the relationship between alcohol and CSE have been noted in Chapters 4 and 5. One of the aims of engaging AOD and CSE workers in this research was to deepen understanding of this relationship by drawing on their experiences of supporting young people experiencing alcohol-related CSE. This will also have the benefit of determining areas for practice improvement for alcohol services.

This chapter outlines the themes produced by the thematic analysis of the interview and focus group responses. As discussed in s.7.2, this approach is consistent with Critical Realism, the starting point being abductive analysis in which the data is coded to provide a description of the data. This chapter will take this approach.

11.2 AOD and CSE worker themes

Thematic analysis of the interview data from each AOD and CSE worker was undertaken according to Braun and Clarke's (2006) framework (s.8.2.7). The results of the analysis were then consolidated into two separate thematic structures, one for the AOD workers (Appendix 9) and one for the CSE workers (Appendix 10). Thematic analysis of the AOD workers' data identified 14 main themes, 10 of which were found to be relevant to the aims of my research. Eleven main themes were identified from the CSE workers' data, with nine found to be relevant to these aims. These are presented in Table 5 below.

Given the considerable overlap of main themes and sub-themes between these two participant groups, I reviewed, merged and consolidated their contributions to provide a more coherent analysis. This process produced eight main themes (Table 6 below), which will be presented in my analysis of findings, subdivided into their associated sub-themes (Appendix 11). The four themes that relate to the first aim of my research, to develop a better understanding of the nature and extent of the relationship between alcohol and CSE, will be presented in chapter 12. The four that relate to the second aim, to develop a better understanding of the implications of alcohol-related CSE for alcohol service interventions, will be presented in Chapter 13.

Table 5: AOD and CSE worker themes relevant to research aims

Alcohol and drug workers		**CSE workers**	
Understanding alcohol and CSE	**Service responses**	**Understanding alcohol and CSE**	**Service responses**
Drinking culture	Identifying CSE	Social and wider context	Assessments
Perpetrator use of alcohol	The nature of support	The role of alcohol in the grooming process	The nature of support
Young people's use of alcohol in CSE	Multi-agency working	Young people and CSE	Collaborative working
Alcohol and other substances	Skills and training	Young people and alcohol	
	Challenges		Challenges
	Service improvements		Service improvements

Table 6 AOD and CSE workers – merged themes presented in Findings

Understanding alcohol and CSE	**Service responses**
Social context	Identifying and assessing CSE
The role of alcohol in grooming	Supporting young people around alcohol and CSE
Young people's use of alcohol in CSE	Collaboration and multi-agency working
Alcohol and other substances and CSE	Training provision and skills development

11.3 Young people themes

Thematic analysis of the data from the young women's focus group identified five themes, three of which are presented here. A full list and description of themes can be found in Appendix 12. Themes were chosen based on their alignment with the research aims and objectives, whilst also taking into account what was important to the young women.

Table7: Young people themes

Understanding alcohol and CSE	**Service responses**
Alcohol and CSE	Support for young people experiencing alcohol-related CSE
Young people's recognition of alcohol-related CSE	

11.4 Chapter summary

This chapter has outlined the results of thematic analysis on the data collected, which will be used as the organising principle for the discussion of findings in Chapters 12 and 13.

Chapter 12
Findings: the relationship between alcohol and CSE

This chapter contains an analysis of responses from AOD and CSE workers and young women relating to the first aim of this study, to develop a better understanding of the nature and extent of the relationship between alcohol and CSE. These are organised under four themes: Drinking culture; Perpetrator use of alcohol; Young people's use of alcohol before and after CSE; Raising awareness of Alcohol and other substances and CSE.

The main contributions from the young women here relate to their concerns about a general lack of awareness among young people and others about CSE, its relationship with alcohol and how to access support for these problems.

Where necessary, the academic literature and evidence from previous studies have been used to better understand the role of alcohol in CSE through a critical lens.

12.1 Drinking culture

The social norms that influence the consumption of alcohol by young people provide an example of the macrosystem element in Ecological Systems Theory (s.7.3). Social settings, such as parties where alcohol is available and perpetrators attend, can provide a particularly risky environment for young people and expose them to sexual exploitation. The views of the AOD and CSE workers on this are therefore helpful in furthering this understanding.

My research findings are consistent with the findings of published surveys and research (s.2.3) that for young people and often their parents, alcohol is regarded as an integral part of the life of many young people. The young women in the focus group regarded alcohol as not just accepted but expected

among young people: ‘I think just ‘cause it’s like a norm to do it’ and not to do so ‘was a bit weird in a way’ (Jess).

Eleanor (AOD worker) explained how experimenting with alcohol is part of growing up, suggesting that drinking alcohol is deep rooted in this youth culture. There is a danger that this assumption can contribute to a sense of complacency that there is little need to be concerned about underage drinking. The young women were certainly alert to this danger, expressing concern that the acceptance of drinking alcohol as a normal behaviour for teenagers might encourage them to accept it without understanding what a perpetrator wants out of the transaction:

> I think there’s a lot of people who don’t realise how vulnerable you can get and just accept being given it and don’t really… yeah understand why that person is giving it to them and what they’re getting out of it … (Jess)

The young women made explicit reference to the connection between the consumption of alcohol and the increased vulnerability of young people. They spoke about how drinking alcohol may start as an enjoyable experience but can also expose young people to sexual exploitation:

> Like the person might say, like say I’m the victim, I might find it fun to like, drink and smoke and then if someone’s using that against me I won’t really know because it’s like ‘oh yeah, I’m just getting drunk, it’s fine. (Amy)

Eleanor made the point that young people’s alcohol culture had changed over time and linked it to increased risk taking, with young people now consuming more alcohol and using a range of different substances. These extended beyond alcohol and cannabis, she said, to lesser known and more dangerous substances:

> So, when a kid is just doing this experimenting, ‘I want to be grown up, fitting in with me peers’, all that, for some of them, not all of them but for those that then move to just poly drug use and

> take random things, it can be risky… So yeah, there is a shift in the concern over young people's drug and alcohol. And I think there's a lot of binge drinking [and drug use]. So, it's not like, I don't know, when maybe a bottle of lambrini between 5. You know, these kids now they want litre bottles of vodka. (I: yeah) So it's like, they can be really, really intoxicated. (Eleanor)

Kate (CSE worker) also drew attention to the vulnerabilities associated with the UK culture of drinking alcohol to excess and the effect of this on a young person's thoughts about the impact of alcohol and their susceptibility to sexual exploitation. In her view, young people often do not understand or bother thinking about their health and the damage that sustained heavy drinking can do. She also spoke about how being unable to recognise risk leads some young people to continue drinking and expose themselves to danger:

> …we've got obviously in the UK this culture of drinking to excess and binge drinking and university students getting absolutely wasted, a lot of young girls think it's absolutely fine to carry on doing so and that it's not going to do any kind of long-term harm to their bodies and like most teenagers do, they think they're immortal, they think nothing's going to happen to them. So, they do continue to drink and then do continue to get themselves into risky situations. (Kate)

The AOD and CSE workers brought a distinctive perspective to the role of place in young people's drinking culture that focuses on its active contribution to sexual exploitation. They regarded social settings, such as parties where alcohol is available and perpetrators attend, as providing a particularly risky environment for young people. AOD workers identified this social drinking culture among young people as a factor contributing to alcohol consumption prior to CSE and viewed this as something that perpetrators can exploit. One AOD worker suggested that habits change according to the setting. Social settings were also seen as places where young people encourage their peers to drink:

> I'd very much see that alcohol comes prior to that [CSE] 'cause you look at the age of the young people as well. It's part a culture of young people, so it's you know, young people being involved with peers

> encouraging them to drink. Alcohol is obviously very sociably available for young people as well. So, I would say it comes before. (David, AOD worker))

The CSE workers also moved discussion away from a ‘normal’ drinking culture. They talked about youth drink culture more in terms of what young people regard as social norms, including the dangers of seeing alcohol consumption as just part of growing up. Rhiannon talked about how attending parties and going out with men young people regard as their ‘boyfriend’ can seem to be very similar to that of the adult world and that socialising and drinking are entrances to that world. Rhiannon gave an example of one young person who believed that dating meant meeting someone online, talking to them online, meeting them in person and having sex with them. After that, ‘the hope is that you are promoted to girlfriend status’ (Rhiannon). Rhiannon compared this to how the adult world can be viewed through the television programme ‘First Dates’, where, with wine available, participants meet in a social setting. A young person who she was supporting would meet a man in a social situation that would involve either alcohol or drugs. Rhiannon did not say how old these males were, but she wondered whether they were making a conscious decision to use alcohol to sexually exploit her or if they also thought that was what dating consisted of:

> This is one of the things that troubles me with all this is does everybody think this is just what we’re supposed to do and is anybody actually stopping and thinking about what they actually want to do and what they’re trying to achieve? (Rhiannon)

Young people can be placed at risk of CSE when a social setting in which alcohol is available is combined with a drinking culture that regards alcohol consumption as a normal part of growing up. AOD workers in this study were clearly aware of how drinking culture and norms can influence a young person’s alcohol consumption. Their ways of working would be informed by discussing with young people what they saw as ‘normal’ regarding consuming alcohol. This would help AOD workers to gauge a young person’s motivations,

or the factors that influenced them to drink. How perpetrators can exploit this risky environment for young people will now be discussed.

12.2 Perpetrator use of alcohol

All of the AOD and CSE workers identified alcohol as one of the tools used by perpetrators in the early stages of CSE to build a relationship with young people, as part of a grooming process. The workers also discussed the grooming process with reference to different models of CSE. The young women offered several valuable perspectives on this topic, especially about peer exploitation.

12.2.1 Alcohol as a grooming tool

This aspect of the use of alcohol sits mainly in a young person's microsystem – their immediate social contacts - where the strongest influences on their behaviour are felt. The use of alcohol as a 'gift' to entice young people into a relationship was described by Coffey (2014) and Crellin and Pona (2015) (s.5.2.1). The AOD workers also referred to this as part of their experience, where alcohol was used as a tool by a perpetrator to facilitate building a relationship with a young person and as a 'gift' to help a perpetrator manipulate them into thinking that they care about them:

> Well, it's used as a gift first and foremost. You know, it's a way of like opening up relationships with erm, with those who are intent on exploiting young people… (David)

The idea that alcohol is seen almost as a requirement when young people meet socially can place those who provide the alcohol in an influential position and strengthen the link between alcohol and CSE. Jess, one of the young women, recognised that in these circumstances the alcohol may be seen as a gift, for which something should be given in return:

> …If you have been a victim of CSE you're likely to know a lot of older people – older men that could have got it for you so you could – it's quite easy to get these days. (Jess).

Jess also offered an example of how alcohol can be used more opportunistically as a gift, which also provides an illustration of how a young person's mesosystem can impinge on their behaviour, through the interaction between parental influence and peer group pressure. Jess described how a perpetrator could make use of the restrictions on alcohol use imposed by a young person's parents against the young person as a vulnerability that could be sexually exploited. In this situation, a perpetrator makes alcohol available to the young person as a means of exchange for something the perpetrator demands:

> Like I feel like people would – men could use it as a – 'I'll give you this' – as well 'cause if parents are really strict on 'no alcohol until you're 18' and 'you're not having it while you're underage…. I feel like you're more vulnerable to it. (Jess)

Nina (CSE worker) spoke about how perpetrators can use alcohol as a 'gift' to make themselves indispensable to young people prior to sexual exploitation. Nina described how they exploit their ability to buy alcohol to entice young people, telling them 'I can get you this, I can get you that. Meet up with me and a couple of friends' (Nina). Perpetrators suggest to a young person that if they meet them at a shop, they can buy them alcohol. When someone wants to drink with their friends, the perpetrator can exploit this, encouraging them to go to their house where they provide alcohol:

> …she would want to go out with her friends or want to have a drink in the park and the perpetrator would exploit that and say 'well I'll get it for you, come round to my house'. (Nina)

The AOD workers also provided examples of the role of alcohol as a payment (s.5.2.2), whereby perpetrators build dependency on alcohol prior to sexual exploitation. Jenny explained that once in the grooming process, the potency of the alcohol consumed by a young person may increase, from WKD to vodka for example, with vodka often being the substance of choice. Others spoke about how, when alcohol is consumed outside their friendship group or

positive support network, young people can become much more vulnerable to CSE. Other AOD workers discussed how perpetrators use alcohol to gain as much control as possible over a young person by, for example, encouraging and developing a desire for alcohol, with the only means of getting it being from the perpetrator. This is especially the case when a perpetrator uses alcohol to feed into a young person's emotional vulnerability:

> …it is still key that it is a great engineering thing from a groomer's perspective feeding into that emotional vulnerability of a child. And then also it's a tool for them to blackmail with. (Eleanor)

Tina (AOD worker) illustrated how the use of alcohol as a 'gift' and its use as a payment are not necessarily two separate processes but can be used together progressively. She likened alcohol to a 'hook' for young people in care with limited finances, who are unable to access alcohol unless someone else buys it for them. Tina described how the perpetrator can incorporate alcohol into the relationship building stage with a young person. She suggested that the relationship between alcohol and CSE then moves to the young person becoming reliant on the alcohol.

Skidmore (2004) and Edinburgh et al. (2014) discuss how perpetrators can use alcohol to incapacitate and make young people more susceptible to sexual exploitation. Several AOD workers provided evidence that this aspect of grooming is not unusual. They discussed how alcohol is used to reduce a young person's inhibitions and make them more pliable and cooperative:

> [young people are] more likely to say yes to something if you're under the influence than you would if you were sober. (Jenny).

Tina explained how alcohol is 'a really effective substance of choice for groomers and people who want to exploit children' because of its impact in making a young person unable to move, speak or consent to what is happening or to negotiate the situation.

Shepherd and Lewis (2017) discuss how perpetrators use a perceived vulnerability to target a young person to build trust. These vulnerabilities might contribute to prior exposure to, or consumption of, alcohol and to young people wanting to spend time away from their home. Eleanor (AOD worker) expressed this in terms of how perpetrators may identify young people who are more likely to engage with them, such as those who have experienced relationship breakdowns or have difficulty sustaining their relationships, including those with support services:

> Because while a child is very unhappy at home, they don't want to be there. And that's where they'll go out more. That's where they'll connect with other children who are drinking and taking drugs. And they will continue to drink and take drugs with them. (Eleanor)

Several AOD workers placed this unhappiness and the absence of a loving relationship at home in the context of a vulnerable young person's need for love. Eleanor discussed how this is particularly the case for 'very vulnerable children who have difficult lives and extremely low self-esteem'. The AOD workers also identified several other vulnerabilities, including young people going missing from home, having mental health problems or being unhappy at home.

> Just the fact that they're in this loving relationship – or so they see it to be loving, if they're not getting it from elsewhere. Perhaps there's something going on at home that's, quite chaotic so they can't – they just want to kind of like get away from it really. And then they're just more susceptible to being groomed. (Jenny)

12.2.2 Models of grooming: the boyfriend/girlfriend model, parties and peer exploitation

All of the AOD and CSE workers were familiar with the boyfriend/girlfriend model of grooming (s.3.3), which illustrates the relationships that can exert a strong influence in a young person's microsystem. Tina (AOD worker) summarised it as:

> young people might be introduced to alcohol, they might be kind of thinking about like the boyfriend sort of model… going to parties, being introduced to alcohol, plied with alcohol and, and the heavy kind of high levels of intoxication. Sometimes young people being unconscious, waking up to find that they've been sexually assaulted, sometimes by multiple men.

The AOD and CSE workers' experiences add to existing evidence (ss.3.3; 5.2.1; 5.2.2; 5.2.3) to explain how perpetrators operate this and other models of sexual exploitation and its impact on young people. The CSE workers provided examples that illustrate a broader range CSE models, including peer grooming, the involvement of older peers, organised/planned inter-city exploitation and drinking to excess. Kate mentioned that 'nine times out of ten' a young person will believe that they are in a relationship with the perpetrator. This is often linked to attending parties together. Nina referred to a young person who would meet her 'boyfriend', who would then give her alcohol before taking her to a hotel or casino where she would be raped by numerous men. Rhiannon spoke about how young people attend parties with their 'boyfriend', where there would be drinking and socialising. She saw this model as a part of the UK drinking culture. She felt that it mirrors the adult world, enticing a young person and making them feel more grown up:

> I think most of my young people who have been in those real-world situations, it's been about going to parties, going out with men that they feel are boyfriends and the aspect of it is, you know the social aspect. Very similar for us in the adult world really which is you're socializing, you're drinking, you're smoking weed, you're going to someone's house to chill and that's the aspect of it that I see. (Rhiannon)

Three CSE workers spoke about the boyfriend model in the context of the parties that young people attend, with similar outcomes to those described by Coffey (2014) and Crellin and Pona (2015), where girls are provided with alcohol and drugs by men and then sexually exploited. Nina gave examples where girls were plied with alcohol and then moved to different properties within the city and 'sold' to adult males for several days in a house 'where

they would say to her erm, ‘we’ve got alcohol, we’ve got drugs. Come here and have a bit of a party’.’ (Nina).

Young people were encouraged to go to these houses for a party where they were told alcohol would be available. Rhiannon gave an example where young people would groom each other, as they would be told to bring friends to the party where there would be free drugs and alcohol. This is perhaps an indirect, less deliberate example of peer grooming where young people are being used by perpetrators to attract other young people without being fully aware of the consequences of what they are doing. The young people might say that these parties are with their peers, but Rhiannon believed that there must be older individuals present to provide the free alcohol and drugs. She also gave an example of 16 and 17 year old girls who were picked up by men in uninsured cars and driven to a different city to a university hall of residence. Kate spoke about young people going to parties, not knowing their limits.

Randhawa and Jacobs (2013) found evidence that one aim of the grooming process is defensive, to ensure that a young person keeps quiet about their sexual exploitation or feels that the abuse was their fault. Kate went further, touching on another kind of link between alcohol and CSE that is related to the grooming process, where a young person’s alcohol or drug intoxication is used by a perpetrator to defend themselves in the criminal justice process by undermining the reliability of victim statements (s.6.4). She also explained how perpetrators may encourage a young person to drink to excess, so that it would be difficult for them to report an incident of rape if they could not remember giving consent:

> But it’s definitely like encouraging the young person to drink to the point where they won’t really remember what’s happened so you know, reporting an incident of rape the next morning, or assault of any kind might be more difficult for the young person because they can’t quite remember whether they said yes or not. (Kate)

This is a widely recognised aspect of CSE, contributing to the understanding of alcohol as a tool of exploitation and abuse rather than just part of the context of grooming.

The theme of alcohol and peer exploitation was present within the data for this study, both in terms of what distinguishes peer exploitation from other models and especially the implications of how young people perceive risk when with their peer group.

Peer exploitation is recognised as a distinct form of CSE, although it could also be regarded as a variation of the boyfriend/girlfriend model. The starting point for the exploration of peer exploitation in these findings was the comment from one of the young women in the focus group that young people may view the offer of alcohol differently if the perpetrator is a friend or peer acquaintance, rather than a stranger:

> I think it depends on the situation. (I: yeah) Like an older man would be buying it for you but if you were with your friends you might kind of split it. (Jess)

Because of this, young people can lack an understanding of the reasons why a perpetrator may offer them alcohol and, in some situations, peers may pose a greater risk to a young person than older men regarding CSE. This is something for alcohol services to be mindful of when conducting risk assessments. Amy, another focus group participant, referred to a level of trust within a peer group of friends and acquaintances that puts young people at ease and therefore less likely to see any risk in this situation. She felt that there would be more awareness of risk if it is an older man buying them alcohol:

> I think that if I was with someone who was older than me, like an older man and he was like ‘oh, I’m just going to go and get some drinks and probably some drugs’. I’d see more warning flags. But if I was with someone my own age or like a bit older and they were like ‘oh, I’m just going to buy some drugs and alcohol just to chill’ I’d be more relaxed

> about it because they're my own age. But then I wouldn't really know because like, people – like if they were like trying to pimp you out you wouldn't know would you? (Amy)

If this is so, the peer-on-peer model of sexual exploitation can be built on a relationship between perpetrator and subject that makes it in some respects more dangerous than other models. This is because drinking alcohol can be an integral and accepted aspect of a trusted peer group. It may therefore be more difficult to identify risk in this situation.

Previous research (Firmin et al., 2016) suggests that peer groups can play a role in normalising sexual exploitation, due to a young person's feelings of wanting to belong. A young person may also be coerced by their peer group into a situation that might lead to them being exploited; they can also feel coerced into abusing other young people though peer pressure. I will explore how alcohol and sexual behaviour interact more generally with reference to other peer groups and relationships in s.14.1.2.

My study provides evidence that young people are less likely to recognise sexual exploitation by their peers when consuming alcohol, as their awareness of risk would be lowered in these situations. What it adds to previous studies is a focus on the implications for alcohol services. Given the well evidenced role of alcohol in the grooming process, alcohol services need to offer routine information and education about alcohol as a grooming tool amongst peers and adults. For this to be possible, there are implications at a wider systems level, where relevant training needs to be provided to enable AOD workers to have the knowledge and confidence to do so.

12.2.3 Agency and victim blaming

Discussion of a young person's agency in their sexual exploitation is not just sensitive and complex but also potentially damaging to them. In the case of alcohol, relationships with perpetrators can be obscured to some degree by the presence of exchange because they are 'connected with desires of young people, and complex perceptions of risk and rewards' (Brown, 2019:632).

Kate (CSE worker) believed it to be more difficult to support a young person when they have received something in return because it ‘makes it not kind of straightforward sexual abuse, if you like’. Young people may feel that they have agreed to what they believe to be a fair exchange. It may therefore take them a while to realise and understand that they have been sexually assaulted. Rhiannon (CSE worker) said that often young people do not think that they have been sexually exploited because they believe that they were having a good time.

The study conducted by Radcliffe et al. (2020) raised concerns about a young person’s agency in the consumption of alcohol. The authors discuss how the professionals they interviewed only referred to alcohol in relation to negative issues that young people might be experiencing, rather than a young person simply wanting to consume alcohol. This is something I also found in my research. It is important to acknowledge that for alcohol to be a tool within the grooming process, it is often something that a young person shows interest in and consumes through choice. This does not, however, excuse a perpetrator’s intentions or the way that they can use this interest to manipulate a young person.

The AOD workers provided examples that illustrate the point made by Eaton and Holmes (2017) and Beckett et al. (2017) (s.3.5) relating to the power imbalance between young person and perpetrator and the constrained nature of any ‘choice’ on the part of the young person. Choosing to drink alcohol or use substances can be perceived as a young person’s sense of agency and that it is this that puts them at risk. This is a very tenuous assumption, however, as a young person’s circumstances, constraints and relationships may mean that choosing to drink alcohol feels the best option to them when other options are limited and none are desirable. How perpetrators exploit a young person’s circumstances and vulnerabilities (s.12.2.1) is relevant to a discussion of the extent to which they can be considered to have agency. AOD and CSE workers should explore these constraints to better understand why a young person may appear to enjoy drinking.

Agency must not be confused with victim blaming, a damaging aspect of a young person's macrosystem. One of my advisors with lived experience highlighted the importance of ensuring that young people recognise that the blame for exploiting alcohol in sexual abuse must always lie with the perpetrator:

> I believe it is important, when talking to young victims, to always place the blame firmly on the adult exploiting them and not leave it ambiguous as if the drink was the exploiter and reason for the abuse, and not just a tool used by the actual abuser. When blame isn't firmly laid on the abuser, the child automatically takes it onto themselves, and with the knowledge that they have been drinking underage, they may already be feeling like it was their fault. (Rosie, advisor to the research)

Section 6.4 has discussed how victim blaming can occur in the legal process, where a young person's credibility in court cases relating to CSE can be undermined because they have consumed alcohol. Evidence for this is found in the current study. Amy, a member of the focus group, demonstrated an awareness of this issue when she discussed how perpetrators can use a young person's alcohol consumption at the time of sexual exploitation to question their credibility, as part of their defence in court proceedings:

> They could say like in evidence or whatever they could be like 'well she chose to drink, like I didn't give it to her, like she wanted to' do you know what I mean? So, like – so that kind of makes it – who do you believe more? If it's in a CSE situation like you don't really know. (Amy)

The young women highlighted that young people may not always recognise the risk of CSE when alcohol is involved, partly because consuming alcohol is normalised for some young people and also because they may not be aware of risk when it is posed by one of their peers. For AOD workers, this is another argument not to make assumptions about why a young person is drinking, without exploring their world, their feelings about alcohol and having an awareness that there may be a number of factors contributing to a young

person consuming alcohol. The next section explores the topic of this lack of awareness.

12.3 Young people's use of alcohol before and after CSE

This microsystem theme focuses specifically on a young person's use of alcohol before and after experiencing CSE. It explores the views of both AOD and CSE workers on how prior alcohol use can be a risk factor in CSE and how young people use alcohol to cope with their experience of CSE. It then considers a theme that emerged from the interview data of AOD workers, the susceptibility of young people to CSE after drinking. Here, the AOD workers offer an insight into how alcohol can make young people more at risk of CSE.

12.3.1 Young people's previous substance use

Young people's family environment and personal circumstances featured strongly in the responses of AOD and CSE workers. This is valuable because it reflects many years of practitioner experience and gives some depth to these topics. It also helps to move focus away from the social aspects of alcohol-related CSE towards much more private and personal issues.

Laura (AOD worker) suggested that alcohol use may be generational. She gave an example of a young person whose grandfather and father had both been referred into their service previously. She believed that a young person's exposure to alcohol in a family drinking environment is influential in their drinking, where exposure may lead to starting to drink at home:

> There may be a link with dad. I'm not hugely sure what role dad played in her upbringing aside from recruiting her into this grooming but whether he has more of an issue with alcohol – like I say he's referred but he never engaged with us.... (Laura)

Rhiannon (CSE worker) provided an informative example of how one young person's family environment contributed to their views on both alcohol and relationships. The young person was being groomed through the party model, in which young people are invited to parties where alcohol and other

substances are available. Rhiannon explained that for this young person, ‘her world through her parents and family is very much centred around drugs and criminality’. Having grown up within this drug-using environment, the young person viewed drinking and taking drugs while socialising as a normal activity.

Rebecca (AOD worker) suggested that in her experience the link between a young person being missing from home, hazardous alcohol consumption and subsequent CSE was not uncommon:

> I think we - what we've noticed in our service in recent sort of times, even in the last 6 months, there's a lot of use that was alcohol related for young people who are at risk of CSE using excessive alcohol [use] when they're missing... (Rebecca)

The CSE workers’ perspectives on the sequential nature of alcohol use and CSE were provided in response to the question: which came first, alcohol or CSE? Three of the four CSE workers discussed how young people can often have previous or current substance use at the time that they meet a perpetrator. Perpetrators are then able to exploit this to draw them in, using the dependency as leverage:

> I mean from a CSE point of view we know the people erm, who are the perpetrators are very manipulative and so you know, they use whatever hook, you know whatever hook they can and we also know that a lot of the time the vulnerabilities allow, sort of, addiction to thrive. (Beth)

Nina linked prior alcohol use to place, explaining how young people know that if they go to a particular location and do certain things, they will be given free drugs and alcohol. Perpetrators then exploit whatever substance a young person uses, to lure them into sexual exploitation. Nina illustrated this point with an example of an individual with a £30 a day cannabis habit:

> …exploiters know that for a young person they can’t get access to that level of money to fund that so they then exploit the young person’s, I suppose need in their mind to attain the alcohol or drugs… (Nina)

12.3.2 Alcohol as a coping mechanism

The power of the examples of coping behaviour provided by the AOD and CSE workers lies in how they draw on young people's painful experiences to demonstrate how habitual, hazardous alcohol use develops during and after CSE into a coping mechanism for young people to manage what they are experiencing because of sexual exploitation. Some of their comments also provide rich detail about the complexity of the reasons why young people use alcohol to cope.

At the most basic level, alcohol can develop into a mechanism for a young person to get them 'through the weekend' (Jenny, AOD worker). For some young people, its use is related more explicitly to managing stress. Laura (AOD worker) described how one individual used alcohol not just to cope with CSE but to manage the process of providing video recordings for the police as evidence of the exploitation that they were experiencing. Mark (AOD worker) offered an interesting perspective on why young people can turn to alcohol when he said that they use it not just to shut out what is happening to them, but also because 'you turn into someone who you want to be'. Jenny (AOD worker) related the use of alcohol to a particular point in sexual exploitation, to shut out uncomfortable or distressing feelings when a young person may be questioning their relationship with a perpetrator and reflecting on what is happening to them. This might be at the point where they start to realise that what is happening is not right:

> …they then tryna shut out certain feelings and thoughts that could potentially like – like question the whole relationship. Like is this supposed to be happening? (Jenny)

Alcohol was also described as being part of a cycle that starts with its use by a perpetrator against a young person, to gain control of them but is then used as a coping mechanism by the young person themselves. Tina (AOD worker) suggested that alcohol's use to escape whatever might be going on in their lives is related to the difficulties a young person experiences in trying to

process these feelings. Tina described this as ‘a desire to remove’ themselves from what was happening in the room in which they were being sexually exploited:

> …so they’re trapped then in a cycle of alcohol being given to them by the perpetrators but equally sometimes it’s playing a role of helping them get to that point of oblivion where they don’t have to think or feel anything because these feelings and emotions are so difficult to deal with for a young person that’s kind of developing and… being exposed to things way beyond what they should be and way beyond their, their years of what a child should ever kind of experience or see. (Tina)

Nina (CSE worker) introduced the idea that dependency on alcohol and other substances is often used by young people to cope not just with anxiety but also with the anger caused by their experiences. She emphasised the importance of this role, suggesting that alcohol use is a ‘trauma response’ for ‘nine out of ten young people:

> …the dependency on drugs or alcohol is around managing trauma and being able to cope I suppose. I’ve had young people both female and male say to me that that’s the only way they can get to sleep, that’s the only way that they can stop feeling anxious and angry and process to a degree some of the experiences that they have had and the experiences that they’re having at the moment. (Nina)

Beth (CSE worker) added further depth to alcohol’s role as a coping mechanism when she gave an example of a young person who used alcohol to help them endure, even enjoy, situations that they would not want to be in when sober. She also explained how, for this individual, these experiences and alcohol use were also linked to how she coped with the death of her grandfather:

> …it helps her kind of get braver into situations that she might not want to sober but she thinks they’re great fun when she’s drunk and erm, yeah, she regrets them in the morning but she doesn’t mind feeling regretful and embarrassed because it gives her emotions again that aren’t related to feeling sad about granddad. (Beth)

Alcohol has been found to be a coping mechanism for other forms of abuse, both in childhood and as adults. Galvani (2012) explains that the relationship between domestic abuse and alcohol and drug use is complex:

> The relationship between the two is not as simple as one issue leading to the other. The relationship between the two is, however, firmly rooted in evidence and demonstrates the damage that abuse can have at any age and the potential for substance use to be a coping mechanism. (Galvani, 2012:121-122)

Stressful events can occur in a young person's microsystem, mesosystem and exosystem. The relationship between alcohol and drugs and stressful events, including abuse does not only go in one direction whereby a stressful event leads to alcohol consumption. This was identified in a review of the literature by Lijffijt et al. (2014), who surmised that stressful events were more frequent after an individual consumed drugs or alcohol. The authors also concluded that stressful events can lead to alcohol and drugs being consumed at an earlier age and to an increase in the frequency of use (Lijffijt et al., 2014). A study by Clarke and Foy (2000) supports the suggestion that alcohol can be used to cope with traumatic events that have happened in both childhood and in adulthood. The authors found this to be the case in their study of domestic abuse, which was based on a sample of 78 women who had experienced domestic violence. The authors assessed a range of measures including exposure to violence, childhood abuse and alcohol use and found that there was a relationship between 'battering severity' and alcohol use (Clarke and Foy, 2000). The authors also found that childhood sexual abuse was a predictor of the level of alcohol consumption, with the study finding a positive correlation between the two.

There is a body of international research that demonstrates how young people use alcohol and drugs as part of a trauma response to CSE, to help them feel that they are in control of a situation (Hallett, 2013), as an attempt to suppress distress and shame (Tyler et al., 2013), or as part of a cycle that involves

remaining in sexual exploitation to access the alcohol and drugs needed to cope with their traumatic experiences (Hwang and Bedford, 2004). The current study adds to this body of research in exploring the understanding of this relationship from the perspective of AOD workers.

The comments presented in these two sections (12.3.1,12.3.2) on young people's alcohol use prior to CSE, and how young people can use alcohol as a coping mechanism in response to CSE, are especially valuable because they present the perspectives of both AOD and CSE workers. Some additional findings under the theme of how young people use alcohol in CSE were identified only by the AOD workers. I will now present these.

12.3.3 Young people's susceptibility to CSE after drinking

This additional theme raised by the AOD workers related to how alcohol can affect a young person's resistance to CSE when its use extends beyond the grooming process into the exploitation itself.

The use of alcohol to lower inhibitions and make young people more susceptible to influence and exploitation can also affect the ability of a young person to give consent. Jenny gave an example of an individual who was coerced by an ex-boyfriend to 'do things' when they were being videoed. The videos were then sent to others without the young person's consent:

> …one young person that I can think of again is the, the one that had drank – well was made to drink alcohol – well was with an ex-partner, she drank a lot of alcohol and that's when she was asked to do certain things on, on the phone. (Jenny)

Several AOD workers reported that all young people who attended their service were at risk of CSE. This was expressed most directly by Mark, who said that these young people have the 'classic warning signs [of CSE]' and that 'drug and alcohol use is one of them'. The AOD workers also offered a nuanced view of how and when the connection between hazardous alcohol consumption and CSE develops; for some young people it is evident at an

early stage, while for others it is a much longer process. They offered several reasons to explain this variation, including how much access a perpetrator has to a young person, the level of control they can exert over them and the extent of a young person's exposure to alcohol. Tina likened hazardous drinking that occurs when a young person is experiencing CSE, to damaging their emotional and physical health:

> But I'd say definitely a significant percentage of the young people I've worked with were drinking in a problematic and damaging way to, to emotional health, physical health, risk of overdose from the quantity of alcohol that they were consuming and downing it in a really sort of short space of time. That not, not pacing drinks… just like [to] get to the point of oblivion as quickly as I can. (Tina)

The AOD workers were not alone in presenting their own additional topics. The young women in the focus group had a particular interest in the importance of raising awareness of CSE. I will now move on to explore this.

12.4 Raising awareness of alcohol and CSE

The susceptibility of young people to perpetrators engaged in alcohol-related CSE depends to some extent on their understanding of how alcohol can reduce their awareness of risk and what CSE would mean for them. The young women expressed concern about these problems and offered suggestions as to what can be done to improve awareness and understanding.

Jess's worry about this lack of awareness was informed by the response she received when trying to discuss her experiences of CSE with others. She was shocked by how few people had heard of CSE and did not understand grooming. This led her to believe that the only people who are aware of it are those who have experienced it and those who support individuals around CSE:

> It shocks me how many people I've told I went through CSE and they're like 'what's CSE?' and I'm like 'are you actually kidding?'

> There's a lot of even adults that just don't know. Don't even know what the word is. You say 'grooming' and they're like 'what?' and don't understand. Just no one knows about it unless you know someone who's been through it or you've been through it yourself, it's just – or you work with it. I feel like there's no awareness of it whatsoever. (Jess)

Amy went further, saying that she had not learnt anything about CSE or alcohol until she attended her current support service:

> We didn't learn anything at all until like… when I started getting involved with this and stuff. So, I didn't know nothing like – I didn't know bad stuff. (Amy)

The young women identified school as the best place to address this lack of awareness of CSE and alcohol. They acknowledged that they had received sex education and lessons on alcohol and drugs at school, but they were critical of the absence of any attempt to show that these topics were related. Young people were given a very limited overview of the consequences of consuming alcohol and no education at all on the role it could have in CSE:

> …all you get taught about really kind of sex education stuff; you never get taught about that side of it. You get taught about drugs and alcohol but you don't get taught about the actual implications of… drugs and alcohol… I remember at primary school we learnt about the implications of alcohol and it would be like a video of a lady falling over in the street…. It was just like you might fall over and hurt your head or whatever. I don't think there's enough kind of, what else can happen other than the basics. (Jess)

The young women felt that schools should cover CSE and with it, alcohol. Jess explained that she had questioned why nothing about this relationship was covered in school. She believed that education on this at an early stage can contribute to reducing the trauma experienced by young people:

> But if schools just did it then you wouldn't need as much Childline and (names of support group attending) and if it was put in place in the first place then like some of us might not be sat here today having gone

> through something because we would have known about it, we would have known the signs, we would have known it was wrong and have stopped it before something else happened. (Jess)

Both Jess and Amy thought that survivors of CSE are best placed to deliver these awareness sessions. They felt that children and young people are more likely to pay attention to survivors because of their first-hand experience. Survivors have a much better understanding of the problem and its impact on young people than others. Amy felt that at school, young people are more likely to be interested to hear what a visiting speaker has to say, rather than a teacher:

> I feel like they should get like survivors or stuff like that to go into school and like spread it to younger kids or teenagers because like when I was younger, I would listen to someone like who was my age now more than an adult. Because like an adult's just there like 'this is this' and they just talk really fast but if you're actually – and like they haven't really been through that and they're just like 'yeah, so you need to be careful and wary and stuff like that. But like if you get someone who's been through it and understands the whole process they can actually stand there and give it to you more emotionally and stuff like that. More like, you'll understand more and you'll want to learn more. (Amy)

Jess and Amy agreed that the involvement of a survivor who shares their experience would make it more real for students and might lead someone who was experiencing something similar to disclose what they were going through. They viewed this as a positive outcome:

> Amy: They'd just think what's the point if this is not going to happen to me but like, like I agree with her [Jess] like talking about survivors going in and explaining their story and saying like 'you have to be careful because this happened to me and I wanna just help you guys' do you know what I mean?
>
> Jess: Because you never – that's the thing because once you've been through it it's like 'oh, this has never happened to anyone before in the first place' because you've never had survivors come into school and

> you just – and then you get here and you're like 'oh, it actually does happen to other people'.
>
> Amy: It would make it like easier for them if they're going through that, it might make it easier for them to speak to someone (Jess: yeah) and get help. Because then they know that someone else has been through that (Amy: yeah) and they've been through services and they've asked for help (Amy: yeah) and they've told someone (Jess: yeah) so they're not alone.

Jess, however, acknowledged that schools are wary of survivors talking about their experiences in any detail because of the distress they may cause. She had been deterred from offering to do this. She explained that some level of detail is needed, as she felt that 'children need to be a bit scared' (Jess) about CSE:

> …they're quite wary of survivors going in and talking about it though because you could say something that really offends or upsets somebody and then they'll go home and be like 'oh we had somebody come into today, this happened.' When I talked to (name of support group attending) about going into a school they were like 'but you can't say anything about you. You've got to say it like – you can't really say anything about CSE' and I was like, right. (Jess)

Further exploration of the role of schools included at what point education around alcohol and CSE should begin. The young women did not specify a particular age but expressed a preference for sex education to be introduced early, with age-appropriate language:

> I think they should kind of have it [CSE and alcohol education] as age appropriate but I do think they should introduce it quite early that – as part of internet safety and whatever they do but yeah, I think it should be talked about quite early. (Jess)

School is not the only place for raising young people's awareness of alcohol and CSE. The young women suggested that social media has a role to play because of its ubiquity and its influence on young people:

> Probably social media, like having a social media site like Facebook or something ‘cause if you’re scrolling and you see something like about alcohol and drugs you might be like ‘oh, that does remind me that I’ve been drinking too much.’ But like phones are what people use aren’t they? (Jess)

The young women’s comments on the lack of awareness of CSE, and alcohol-related CSE more specifically, expose a significant issue that needs more attention. This is particularly of interest given the government strategy which focuses on educating young people in schools about alcohol but does not mention CSE. For AOD workers this means that whilst there may have been some education around alcohol, the relationship with CSE will not have been covered and they could be the first port of call in educating young people around this issue. It is therefore important that they have the confidence and knowledge to do so.

12.5 Other substances and CSE

While this study is focused primarily on alcohol, it is important to acknowledge the views of both groups of workers that other substances are also prevalent in CSE and can be used by both young people and perpetrators for similar purposes. The respective roles of alcohol and other substances in CSE and the relationship between alcohol and other substances in CSE have not received a great deal of attention in the published literature. Some studies make no distinction between alcohol and other substances (e.g., Berlowitz et al., 2012). Others do compare the extent to which alcohol is involved in CSE compared to other substances but do not explore this relationship further. Only a few studies were identified that discussed this topic in any detail (e.g., Hickle and Roe-Sepowitz, 2018; Boys et al., 2001). It is in this area that the experiences of the AOD workers especially make an important and even original contribution.

12.5.1 Prevalence of other drugs in CSE

The AOD workers did not claim that alcohol was especially unique in its relationship with CSE; they referred to similarities across all substances. Tina

talked about how they are all used by perpetrators both as disinhibitors and to create a dependency. A perpetrator gains power and control over a young person through their role as the provider of these substances. For a young person, 'seeking a high is seeking a high' (Tina), suggesting that all substances may be used by young people for the same reasons. They were 'seen as a way of trying to get young people involved and contacting them' (David). It was suggested that it is often a young person's own choice of substance that is used to groom them. Other substances are used in similar ways to alcohol, to entice and groom a young person.

This broad 'substances' perspective was also the view of two CSE workers, Nina and Beth. Both mentioned other substances when talking about alcohol and CSE. Nina said that in her experience, alcohol and other substances are regularly used in parallel, often for the same purposes. A perpetrator often promises a young person whatever substance they prefer:

> So, we've got one of the girls I've worked with or work with at the moment she has a cannabis addiction. So, she – the people that exploit her will say 'meet me here and I'll give you this' and alcohol is a part of that but in my experience they tend to co-exist rather than in isolation. (Nina)

However, the other CSE workers, Kate and Rhiannon, considered that other substances had not usually been a part of the CSE cases they had supported and that if they were, it tended to be cannabis. Even here, Kate said that the cannabis was being used socially rather than during the exploitation period. She acknowledged, however, that she might not be aware of the extent of the substance use, as her service was voluntary, and therefore the young people who attended could choose what to share with her.

12.5.2 Alcohol as a gateway drug in CSE

The link between alcohol and other substance use can, however, be more complex than which one is the preferred choice of the young person. It may also be misleading to regard alcohol as always being used in the same way

and for the same purposes as other substances. Most of the AOD workers considered alcohol to be a gateway to other substance use. They felt that it is often the starting point within CSE, followed by a progression to other substances, as part of a process that maintains the perpetrator's hold over a young person. The AOD workers viewed alcohol as being the substance that is generally given to young people first, to experiment with. When they become used to it, they can be offered other substances. Emily discussed how most perpetrators start by grooming a young person with alcohol as it is 'an easier tool to exploit with', before introducing them to stronger drugs. Tina had similar views, explaining that alcohol can be the first step and drugs the second, giving the example of young people being subsequently introduced to cocaine to keep them 'going for longer' (Jenny). David talked about two young people who attended his service some years previously for their use of alcohol and cannabis and who were known to CSE services at that time. Both had now been referred to his service again, for heroin use. David also gave an example to illustrate how this progression may happen quickly or can develop over a longer period:

> …we've had a referral through this week for an 18 year old who's also involved with adult services who's injecting heroin which is very unusual for an 18 year old. (I: yeah) he's previously been in service to us before but when we looked at the other referral, they were actually open to the exploitation team (I: right) but now they're closed to the exploitation team 'cause A. they're 18 – but what we find is now, it's almost 12 months now, 12 months down the line they're injecting heroin. (David)

One CSE worker, Beth, also viewed alcohol as a 'gateway' to other drug use for young people who did not normally use drugs. She said that she often found that a young person's first experience of drugs was when they had already been drinking: 'alcohol is where they start and … to some extent their first drug experience is when they have been drinking'. Beth also gave an interesting perspective on young people's substance preferences. Alcohol may come first, but she felt that it is easier for young people to get physically addicted to other substances, as they often drink alcohol just to get drunk, not

necessarily to enjoy it. However, once they try other substances they become hooked on the feelings that the drugs generate.

12.5.3 Other differences between alcohol and other substances in CSE

The value of the AOD workers' comments on the differences between alcohol and other substance use in CSE were particularly informative when they went beyond alcohol's gateway role. Jenny spoke about how more of those she supported use cannabis rather than alcohol for several reasons: they find it easier to obtain, it does not result in a hangover and they remember everything the next day:

> I've noticed that a lot of young people tend to smoke cannabis. And that's a very popular, popular substance when they're actually referred into (service) and only a handful of my clients actually drink alcohol. (Jenny)

Tina felt that alcohol and other substances can be used by perpetrators to achieve different ends. Alcohol may impair a young person's ability to escape from a situation, or the stimulant effect of other drugs may be used to make and keep them within the environment where young people are sexually exploited.

> …with alcohol I think that some young people, they can be that intoxicated they can't get away, whereas with stimulants it can be different in that it, it's so that you're more alert and you're more able to be sexually exploited by more men. (Tina)

The AOD workers also provided an insight into changes in drug trends, in terms of both time and place. They discussed how the young people they supported used more than one substance. Laura commented on how alcohol was always a feature, often alongside other substances such as cannabis and cocaine:

> …she's not just using alcohol, she's using cocaine and cannabis. But alcohol seems to be a feature regardless of what drug it is she's taking. (Laura)

Drug use can vary according to location. Laura gave the example of cocaine being used in one city at the time of the research, while other support workers spoke about Xanax being popular elsewhere. Although some young people may have preferences for one substance or another, some use multiple substances together. AOD workers spoke about changes in trends regarding this poly substance use. Eleanor commented on how it was much higher then than in the past and said that this led to young people being more at risk when experimenting with substances:

> …there's just more poly drug use now with young people than there would have been 12 years ago. And that they – you know because they're in that risky stage because when you first start to experiment with a drug you're more riskier than say somebody who's used heroin the last 15 years has got more knowledge, knows their tolerance of that drug. (Eleanor)

She explained how young people did not understand their drug tolerance, creating a risk of overdose. Poly substance use was considered to be common for young people experiencing CSE.

12.6 Chapter summary

All of the AOD and CSE workers identified alcohol consumption as a risk factor in CSE. Both groups of workers placed alcohol's role in CSE in the context of it being an integral part of young people's social norms and culture. The AOD workers also recognised how individual vulnerabilities and the need for love and affection can combine with a difficult home life and wider drinking culture to make young people susceptible to sexual exploitation. AOD and CSE workers talked about how individual circumstances and youth culture can feed into the grooming process where perpetrators use alcohol as a tool to entice a young person and build a relationship with them. Perpetrators can then use alcohol as a tool to manipulate them, removing their inhibitions and their ability to consent or escape from what is happening to them.

Both groups of workers discussed how, just as a perpetrator uses alcohol against a young person, the young person might use it themselves to cope with what they are experiencing. Some young people use alcohol to suppress their feelings and feel removed from the situation, others use it to block out what has happened to them and others. Some might use alcohol not just to endure but also enjoy situations that they would not when sober. The CSE workers also drew attention to the role of alcohol in a cycle where a young person may drink alcohol to boost their confidence, have a sexual experience and need to keep repeating this cycle to preserve their confidence.

The AOD workers focused more on the effects of alcohol on a young person's ability to resist or remember sexual exploitation and the relationship of alcohol to other substances. The CSE workers discussed CSE more in terms of the models of sexual exploitation where they felt that alcohol is likely to play a role within CSE. Peer exploitation was mentioned several times, where friends and acquaintances are the perpetrators. Young people may be groomed by their friends, who encourage them to attend parties where perpetrators offer free alcohol and drugs.

This chapter has discussed how alcohol and other substances contribute to the trauma experienced by young people subject to sexual exploitation. The next chapter addresses how AOD and CSE workers respond to and support these young people.

Chapter 13
Findings: the service response to young people experiencing CSE and using alcohol

One of the aims of this research is to seek to determine how alcohol and drug services respond to young people experiencing alcohol-related CSE – how they recognise CSE, the nature and extent of their support for young people and how they work with other support services. Their confidence in delivering this support and the challenges they face are also relevant. These issues relate principally to the microsystem and mesosystem within Ecological Systems Theory.

The CSE workers may be the first point of referral for young people experiencing CSE who also use alcohol. How they identify and provide support is therefore included where this adds depth to approaches to support or describes complementary working practices related to alcohol and drug service providers.

There is considerable overlap in the general themes derived from the interview data of the AOD and CSE workers, so these have been merged to provide a common overarching thematic structure for this chapter:

- identifying CSE
- supporting young people around alcohol and CSE
- collaboration and multi-agency working
- training provision and skills development.

There is, however, more variation between the two groups at the sub-theme level. As the focus of this part of the research is on alcohol and drug services' responses to alcohol-related CSE, the structure of this chapter will follow the sub-thematic analysis of the AOD workers. It will also include important points made by CSE workers that are helpful and relevant to AOD workers' practice.

The focus group with the young women also explored their views on several areas relating to support – what they saw as the main barriers to support, their own ideas and preferences for support and what, in their experience, made support good or bad. Whilst their support was focused on CSE without an alcohol element, their experiences of receiving support around CSE are still important and alcohol services can benefit from the experiences and knowledge that the young women shared. Their comments are included within the overall thematic structure of this chapter.

13.1 Identifying CSE

The first meeting between AOD professionals and the young people who are referred to them is important, both to establish if CSE is a factor in their alcohol consumption and to decide on the most appropriate support path for each young person. This section explores how the AOD and CSE professionals approach this process to obtain the information they use to support their decisions.

13.1.1 Assessment of risk

The AOD workers described the first step in the support process as an assessment of a young person's needs when they were referred to a service. This enabled the workers to understand them as individuals and the problems that they were experiencing. All were vigilant about any risk factors relating to CSE, demonstrated some understanding of the role alcohol played in it and were aware of many of the indicators that suggest CSE may be present. However, it is unrealistic to assume that all AOD workers across the country possess this level of knowledge, as the prevalence figures for referrals from alcohol services to CSE services suggest that individual workers may not have significant experience of CSE. This could be because other professionals supporting young people around CSE have the confidence and knowledge to support their alcohol use, or it could be that it is not identified often enough as an issue needing specialist support and therefore the appropriate referral to an alcohol and drug service is not made.

The quality of risk assessment for most of the AOD and CSE workers I interviewed depended to a considerable extent just on the quality of the generic tool they used to make a general assessment of any young person on referral to their service. They spoke about their assessments as holistic, covering all aspects of a young person's life, including family mental health, physical health, school, friendship circles and aspirations. CSE was therefore just one factor in this wide-ranging assessment:

> So, we undertake a holistic assessment with young people when they come into service. So even if they weren't known to CSE teams, we are asking those questions within our assessment processes. (Tina, AOD worker)

This may be a good starting point to flag up the risk of CSE, but it is unlikely to be sufficient to explore underlying issues. It was action taken by the AOD workers after this that defined the quality of the support they provided - did they regard themselves just as signposting to CSE specialist support and how did they explore the nature of the indicated sexual exploitation more fully? Assessment should be more than form filling. Some AOD workers used more targeted assessment resources to assess risk. These included screening toolkits provided by local safeguarding boards to identify safeguarding concerns, including CSE. Workers also referred to other areas of assessment, such as 'missing from home' interviews and reports. Kate (CSE worker) said that she often read a young person's plan on referral and talked to them about alcohol, if there was any indication that it might be linked to CSE.

Although risk assessments are generic standardised tools that help an AOD worker to assess risk, their application is inevitably subjective. The expertise of each worker has an impact upon the accuracy of the assessment completed. For example, one who is more aware of CSE may ask questions in a way that would elicit a more detailed answer from a young person that highlights risk. Baker and Kelly (2011) suggest that the quality of a risk assessment is not only dependent on the tool itself but also a practitioner's skills and resource availability (i.e., time and a skilled workforce). The views

and values of the practitioner conducting the risk assessment and their approach to working with a young person can also affect the outcome. Kemshall (2009) identifies some potential consequences of this:

> They may for example focus on resilience rather than risk, care rather than control and empowerment rather than marginalisation. (Kemshall, 2009:161)

Furthermore, a worker who asks questions as they appear on a tool and who does not dig deeper may not uncover some of the risks to which a young person may be subject. An Ecological Systems Theory perspective on the use of risk assessments would indicate that to be effective they need to consider all aspects of a young person's world, not just the circumstances of their immediate microsystem. They should explore the broader context and interactions that are present in the young person's life, especially in their mesosystems and exosystems. This is why it is important to ask questions beyond those in a generic risk assessment, which can just be an information gathering exercise. A young person should be given the space to tell their own story from their own perspective. Without this wider context, a worker will not have the required depth of understanding of what is influencing a young person's decision making. This includes what their options are and if their behaviour is reflecting their 'best option'.

Good practice can be seen in the way some of the AOD workers used this initial assessment as a prompt to investigate in more depth, engaging more interactively with clients by asking more detailed questions that would allow them to assess risk and support requirements in relation to the particular circumstances of each young person. These included variations of:

- Have you ever got in a car when intoxicated?
- What are you drinking and with whom?
- Do you blackout when drinking/remember everything?
- Do you have a phone/money when you go out?
- Where do you get the alcohol from/who from?
- Have you had sex under the influence?

- Who attends the parties?
- What substances do you take at parties/do you know what you're taking?
- Do you wake up clothed/unclothed?

They were also sensitive to other indicators, such as:

- Older boyfriend
- Unexplained gifts
- Designer clothes
- Sudden increase in substance use
- Repeatedly attending sexual health services

David (AOD worker) said '…the better questions you ask and the more you look into an assessment, the more you pick out'. This more invasive approach carries the risk that a young person's response might become defensive and questions might not be answered:

> So, they are really quite extremely invasive questions (I: Yeah). And, and you know sometimes people are really open about what's gone on or if there's been any issues. Sometimes people are obviously – don't see that as something that they, they are involved in. (Rebecca, AOD worker)

All AOD workers in my study conducted assessments that would identify a risk of CSE, but these workers are not necessarily typical. A report by Ofsted (2014) found completion of CSE assessments by local authorities to be inconsistent and at times lacking multi-agency input, which means that important information needed to make an informed judgement on a young person's level of risk may be missing. The extent to which multi-agency input was part of the assessment conducted by the AOD and CSE workers in my study appeared to be varied, with some discussing multiagency meetings they attend whilst others did not. This also points to a wider issue. Alcohol and drug services need to be considered a key service in supporting young people who are at risk of, or have experienced, CSE and need to be routinely included in multi-agency approaches. Multi-agency working is discussed further in s.13.3.

The AOD workers recognised that a young person's willingness to disclose this information can depend on the establishment of trusting relationship with them and that building this might take some time.

My findings suggest that best practice in assessing risk in relation to alcohol-related CSE requires more than just conducting standardised assessments. Effective risk assessment needs to identify and explore a young person's individual circumstances, to identify any risk that might not be immediately apparent. This is likely to require the development of a trusting therapeutic relationship.

The tension between acting on any identified risk identified in a risk assessment and building a trusting relationship with a young person is a difficult one. Yates (2009) discusses how this is especially difficult when building a trusting relationship with a young person can be jeopardised by the need to respond to an identified risk that requires an urgent response. The workers within the current study discussed some of the difficulties getting young people experiencing CSE to engage and trust adults. Lewing et al. (2018) emphasised that building trust with vulnerable young people was key to their engagement. It can be hard for workers to strike the balance between adhering to service protocols and causing no damage to the young person or to the relationship that they have built with them. The findings of my study relating to how the AOD and CSE workers set out to build trusting relationships with young people will now be discussed.

13.1.2 Building trusting relationships

Building rapport and developing productive conversations with a young person can be crucial for them to disclose information about their CSE experiences and to provide a strong foundation for their continuing engagement in the support process. Without this trusting relationship, the young person may not take ownership of the action needed to make changes in their behaviour, including accepting and responding to messages about safety and harm reduction.

> And that's - they've got to buy into it. They - that's why we try and encourage them to make their goals 'cause then they're setting them for themselves. So, it's not necessarily what their mum wants, or the social worker or school or whatever, it's about what they want to achieve. (Rebecca, AOD worker)

This is a generic skill not specific to CSE support, but it is informative to explore the different approaches to building relationships with clients that workers considered good practice. Each AOD worker seemed to have their own preferred approach to this process. Tina identified three aspects of her approach. Firstly, a level of credibility was needed before young people were willing to trust an AOD worker and accept that they were genuine. She expressed this as 'be human, be real', empathising and working in a way that a young person could relate to, to get them to engage. Secondly, clear boundaries were important, so that young people felt supported and knew that there was someone there for them in a professional capacity. Thirdly, ensuring that they recognised that their AOD worker wasn't there to judge them.

Eleanor's approach was to try to build an informal, personal ambience by removing formalities that young people might associate with being in a process or system. She did not take any formal assessments into a first meeting, just a notebook:

> …my first session is normally very informal, introductory session. I don't throw an assessment on the table but I will be getting information that will go onto the assessment. I just want that to be relaxed and it's me focusing on me trying to get a rapport, the best rapport I can with that young person …. (Eleanor)

Eleanor also discussed how she took a flexible approach with young people who had been subject to CSE. She explained that she kept the case open for longer if a young person was not engaging and attending appointments. She explained that this was because young people who experience CSE can be chaotic or might go missing, for example; the trauma that they experience can

also affect their ability to engage. She therefore tried to stay in contact with the young person for longer than was usual for her service, to obtain and maintain their engagement:

> [I will attempt to engage a young person] three or four times, that's when you start to close [a young person's case]. We don't do that here because quite often they're that chaotic with the drink, the drugs, they're going missing, you know, aggression in the home, going off whatever trauma might have happened – whether it's to do with exploitation or other. So, it's – we really try and stay in the loop longer trying to get them engaged. (Eleanor)

Mark took a similar approach to Eleanor, saying that he operated 'on the basis of being that other supportive adult in that child's life', rather than a figure of authority. For him, building a good relationship should not be based on telling a young person what to do. The main priority for his team was to provide the support appropriate for each young person, so they worked very flexibly, meeting with young people no matter what was going on for them at that time, or their emotional state. He illustrated the success of this approach by referring to a complex case of a young person who was experiencing CSE whilst accessing his service, where the need to maintain a good relationship with the young person he was supporting was particularly important:

> And typically because we're not a mandatory service, it's a voluntary, we're third sector, we're coming from that angle of – ok, we're supportive adults but we're not, not an authority. We're not like the teacher relationship you might have, we're not like the social worker relationship you may have, we're not like the relationship you may have with the police. So, we really try and you know, tap in on that. We're supportive, we're friendly, we're you know, we're not about telling you what to do, we're not about being in a dominant position and that's the thread that pretty much runs through this service so that we can have the relationship. (Mark)

Most of the approaches taken by the AOD workers represent good practice that could apply equally to any client experiencing trauma. The limitations of the small sample size noted in s.8.5 should be recognised, however. Good

practice may be limited to those who self-selected, or it could be that good practice is more widespread. However, given there is no standard training for alcohol and drug workers, this is highly unlikely.

The success of establishing this trusting relationship with young people depends to a considerable degree on the quality of the conversations between young people and the AOD and CSE workers.

13.1.3 Conversations about alcohol consumption and CSE

The conversations initiated by the AOD workers with young people around CSE and alcohol consumption did not follow a set pattern, varying in accordance with their own preferences and each young person's circumstances. Nevertheless, the practices of each worker highlight issues that need to be considered when talking about alcohol consumption and CSE.

Tina summarised the essence of these conversations succinctly, saying that each young person's goals are specific to them and so her approach was guided by the young person and dependent on their wants and needs: '…different approaches for different young people with the core essence of it being around their safety'.

The AOD workers took quite different approaches when talking to a young person about sexual exploitation. The quality of these conversations depended to a considerable extent on the accessibility and sensitivity of the language used by the workers. The variation in approach by the AOD workers does not, however, make it easy to determine what could be considered good practice. They were sometimes direct; at other times they were more creative and subtle. For them, it was about trying to ensure that a young person did not disengage. Eleanor was very clear that she would use the word 'exploitation' and she explained exactly what she meant by it, to facilitate a productive exchange and avoid misunderstanding. She also said that if she was confident about telling young people that they were being exploited, they were more likely to feel that they would be believed if they made a disclosure.

She then discussed how a lack of clarity in language might lead to a young person not fully understanding what was being said and perhaps feeling shame because of this. She was therefore not afraid to use ‘exploitation’ or tell a young person that a perpetrator was abusing them. She was aware that other workers might be afraid to be so direct and mused whether she took this approach because she was not afraid, or because she had worked with sexual exploitation for so long:

> I’m saying it as it is. You are at risk of exploitation... I will not move from saying they are being exploited to them. That is what I will always say they are. Because that is what they are, being exploited. Because if I try and waffle it and try and go around it, then – they may be thinking would anybody believe me. (Eleanor)

In contrast to this, Jenny said that she rarely used the term ‘exploitation’ because young people were unlikely to know what it meant. Instead, she favoured phrases such as ‘grooming*’* and ‘being asked to do something in exchange for something’. This was partly due to her CSE training, where ‘sexual exploitation’ was rarely used. Jenny said that she approached any conversation with young people about grooming sensitively, as she was aware that they could disengage at any time:

> …I always try and put it in layman’s terms to them (I: yeah) and then explore it that way. And I think (name of CSE team) try and do that as well because the training that they do deliver as a service, it was very rare that they would actually say sexual exploitation. (Jenny)

There was one common approach taken by all of the AOD workers: they would question the young person about a perpetrator’s behaviour, rather than explicitly label what was happening as sexual exploitation. Describing his approach as being ‘young person dependent’, David explained the need to be careful, as sometimes using the term ‘exploitation’ can put a young person in more danger if a perpetrator finds out that they are talking to services. His general approach was to ask a young person if they thought that a

perpetrator's behaviour was 'normal' and to discuss with the young person when they might be at risk.

To an extent, the AOD workers approach to supporting young people around alcohol-related CSE was similar to the way that they would support a someone who had not experienced CSE. It was still important to engage a young person in the work that they would be doing regarding their alcohol use. To be productive, these conversations need a clear focus and tangible outcomes. Several AOD workers discussed how they aimed to develop detailed plans for each session, to encourage the young person to buy into the process by developing their own goals. Eleanor spoke about how the workers in her service tried to develop emotional resilience in young people and encourage them to find coping strategies other than alcohol. She acknowledged that this could take time and that each young person needed to explore how long it would take for them. Mark described working with young people as a 'collaborative and supportive journey', a view supported by responses from other workers. Eleanor also spoke about how in each session she explained what she intended to cover and then asked the young person if there was anything else that they would like to focus on. She felt that this approach helped to empower young people, giving them some control and choice in their life. For those who were being exploited, this might be the first time that they were able to decide for themselves. Mark echoed these sentiments, explaining how he supported 'self-efficacy'.

Kate (CSE worker) said she approached conversations about alcohol consumption by asking young people to keep a drinks diary. Reflecting on the diary entries provided a good starting point for conversations about drinking. The entries helped one young person to realise that she would drink when she hung around with a certain group. This disclosure led to discussions designed to discourage the habit.

These conversations sometimes require a more robust approach. The CSE workers' conversations with young people about alcohol illustrate some of the

difficulties that workers can face when exploring the problems experienced by a young person. CSE workers often only knew that a young person was drinking alcohol if this was recorded in their notes or if the young person mentioned it. When discussing if and how CSE workers might talk to young people about their alcohol consumption, Beth explained that she sometimes felt that young people did not want to disclose that they drank alcohol. This was sometimes obvious, when an individual hesitated before answering the question, for example. In these cases, she gently challenged them, pointing out their hesitation before answering. She also felt that those most at risk had experience of the system and so knew how to respond to such questions. Beth said she found it more difficult when a young person did not answer a question about alcohol consumption, as persisting with questioning could drive the young person away. She could only signpost to and talk to other services, such as the alcohol service, with whom her service had a good relationship:

> And I'll ask again and obviously they'll either say no or they'll say yes. And if they say no again I'm not you know, I'm not going to push it, all that'll do is then scare that young person away and then they won't come back to that service and then you've got nothing. (Beth)

There did not seem to be a clear, consistent way that the CSE workers approached the topic of alcohol and other substances, with some appearing to ask more questions and have more of a discussion with young people about alcohol than others. This may partly be due to a CSE worker's level of confidence in discussing the topic and a young person's reluctance to disclose their alcohol consumption, in case it raised concerns with workers that would result in more attention to their behaviours.

13.1.4 Referral processes

Referrals to the AOD workers from other services formed an integral aspect of their practice. They, in turn, regarded referral to the Social Care Team based in Social Services as part of the assessment process, when a young person was identified as experiencing CSE. The Social Care team would then pass

on the case to the CSE team if they considered the risk met the required threshold:

> I've got to go through a social worker to make that referral, then they would deliver the work then and complete assessments… they complete more in-depth work with the young person and obviously they create a risk assessment and kind of like give them a rating of whether they're low risk or high risk. (Jenny)

AOD workers received alcohol-related referrals from elsewhere, to support a young person who was also experiencing or had experienced CSE. They explained that most of these CSE-related referrals came because of assessments made by other agencies: 'I think a lot of the time it's from information from other professionals that we're aware of' (Rebecca). Other sources of referral regarding CSE mentioned by the AOD workers included 'missing from home' interviews, drug and alcohol service school teams and disclosure by a young person or a parent concerned about their child's increased alcohol use.

Supporting young people who are referred to them for alcohol-related CSE adds an additional level of complexity to the work of AOD and CSE specialist workers. This is in part because they are used to dealing with single topics in an area in which they feel both knowledgeable and confident. As young people experiencing CSE can go missing for periods of time and it can be difficult to see them regularly when this happens, some AOD workers may find this difficult on top of the rest of their caseload. This will be explored further in the Discussion (Chapter 14).

13.2 Supporting young people around alcohol consumption and CSE

How AOD workers support young people after an assessment identifies alcohol-related CSE raises questions about how they see their support role, the extent to which their support is influenced by this more complex assessment and if the support they provide directly addresses problems associated with their non-specialist area.

13.2.1 Role perceptions

My study found that the AOD workers took a broad view of their role, beyond a sole focus on alcohol consumption, to include supporting young people emotionally and at times also supporting their family. This approach was common to all AOD workers included in the study, regardless of their relationship to local CSE support services. It may reflect the emphasis on safeguarding young people mentioned by several of them. One of the most interesting findings from this study was that all AOD workers interviewed were aware of and were responding to CSE in some way. It is possible that self-selection bias may have led to their involvement in this research, given their heightened awareness of CSE. A broader group of colleagues might have been less aware and confident. It is also difficult to assess if the AOD workers who participated were acting effectively in their responses to CSE.

The AOD workers viewed their role as revolving primarily around a young person's substance use but all conceded that this also meant dealing with other issues that a young person might present with. Several AOD workers also said that one of their main roles was safeguarding young people, helping them to keep themselves safe, particularly regarding their substance use.

Rebecca said it was necessary to understand whatever had happened since a young person's previous appointment and what was currently happening in their lives. This was essential to enable the young people to engage meaningfully with the planned session. She also recognised that young people may attend an alcohol and drug service when they need support for another issue. Rebecca felt that their attendance demonstrated that young people recognised their need for support and so it was important to show them that help was there for them, even if this was just emotional support:

> But they've come along to the appointment, so they obviously want some level of support, even if it's just a rant about whatever's gone on for them at that time (I: Yeah). I suppose it's just knowing you're sort of committed to their – to be there for them in a professional way,

> knowing what boundaries are… but knowing that we're there for them to sort of support them and their needs really... (Rebecca)

Effective support required the AOD workers to extend their role beyond working directly with the young people about their alcohol use. It required them to involve their families, explaining risks to parents and carers and working with them to develop safety plans and coping mechanisms. Eleanor explained how this could be important in helping the young person move away from sexual exploitation. She viewed the perpetrator as having a hold on a young person and spoke of how she tried to get 'behind' the young person to create a pull factor away from the perpetrator. Helping to rebuild a young person's relationship with their parent or carer could reinforce and strengthen the work of the support worker:

> ... we've got the groomer pulling that way, what we're trying to get is, behind the child with all this – whether it's my work with them, or another service is doing a piece of something, support with the worker or family, is getting behind to try and create a pull factor. And I find if we can rebuild the parent, carer, child relationship and improve it, then that give us a better chance of pulling back. (Eleanor)

Emily made the important point that a client-centred approach requires adaptability and professional judgement, to provide more indirect and flexible ways to support young people. She gave an example of an 18 year old within her service who would come to talk to an AOD worker about whatever was going on for her, not necessarily about her alcohol use. While her mother was generally aware of her circumstances, there were some things that the young person did not feel comfortable talking to her about but could express to the AOD worker. The AOD workers also helped this individual by ensuring that she came to collect her methadone script, which gave them the opportunity to check in with her and removed the need for her to contact other users or dealers for substances:

> I mean this, this girl's on a methadone prescription so ... she'd generally would come in and collect that from us so it was just for us about keeping her seeing us regularly, keeping on a script which was a

> big one ‘cause she dropped off regularly but if she’s at least on her script she isn’t having to contact old associates to get drugs to get dragged back into exploitation really. (Emily)

Work with young people continued after sexual exploitation, as the trauma associated with it remained. David explained that although there might be a formal statement that the risk had decreased, he did not feel that this was necessarily true, as there might be other factors that had not been properly considered. As an example, he mentioned the capability of a young person to formulate age-appropriate relationships with peers. They could be pulled back into exploitation if they were not able to do so. He went on to say that his work with a person only changed at their request, as his experience led him to believe that the risk did not automatically go away for vulnerable young people:

> But we tend to keep that – there’s flexibility in it but we’re consistent, we know them risks don’t automatically go away. It’s only a piece of paper, an assessment that’s telling us that risk has gone but we know from behaviours, and you know, from learning that young people are always vulnerable to you know, being exploited or other risks. (David)

However, the nature and extent of support provided by the AOD workers could vary in line with local policy and practice guidelines. Laura, who worked with those aged 18 years and over, took a different approach. Her service tried to encourage the young people they supported to remember that they were primarily an alcohol and drug service and to seek support for other issues from specialised services with the relevant expertise. AOD workers could then focus on the alcohol and drug-related issues that were the reason for the individual’s attendance at her service. However, she acknowledged that often when a young person had experienced CSE, their experiences and wider issues, including alcohol consumption were interlinked. Laura felt that in these situations she also had a role to help them understand how their decisions and behaviour could link to what they had been through. She went on to say that part of this was making people aware that their alcohol and drug use was linked to CSE.

> …primarily we're drug and alcohol workers and we do try and get people to remember that because people can come to us with all sorts of issues and it's like – it's not our area of expertise, we're not being awkward but it's not our area of expertise and you're better seeking out someone who knows what they're talking about as opposed to drug and alcohol workers whereas that's our speciality. (Laura)

There were occasions during these interviews when I found it difficult to distinguish between an AOD worker adapting their approach to the needs of a particular client and remaining in their 'comfort zone' by following their personal role perceptions and preferences.

A variation of practice was also evident in the responses of CSE workers. Nina, a CSE social worker, felt that her responsibility was to help a young person understand and manage their emotions. Alcohol use might not be her primary concern, but it was something of which she was aware and tried to reduce through her work:

> Our role is very much supporting a young person to understand process management – support the young person to process and manage those emotions without the use of alcohol. (Nina)

Beth worked in a sexual health clinic and so felt that her role was primarily focused on ensuring that young people were 'protected sexually'. She explained how the young people she supported could decide whether to engage with other services, but that they often needed to visit her for contraception. She used this as an opportunity to check in with them, which could lead to signposting to another service or providing a brief intervention.

Kate and Rhiannon were funded by, and worked within, alcohol and drug services. Like Nina, Kate felt that her role was to provide emotional support and to work with young people on healthy romantic relationships. Kate's experience gave her a more limited perspective. She said that she thought that working for the alcohol and drug service would mean that she would be

dealing with alcohol more often than was the case, but that 'I've not done any heavy work around alcohol, just 'cause it's not my remit'. Rhiannon seemed to deal with young people and their alcohol use more often, feeling that her role was to educate and support them to minimise risk. When CSE was disrupted, she felt that her role changed slightly, in that she then worked to explain safeguarding concerns to a young person, to provide a framework to help them understand the risks to which they could be exposed. If alcohol or other substances were involved, she made a referral to a support worker within her alcohol service.

13.2.2 Working practices and resources

Different role perceptions and preferences extended to working practices more generally. The AOD workers often had much in common, but they also had their own preferences, especially about the resources they used. Some used scenario examples to help young people recognise risk and to talk through different situations. Tina referred to a specific Barnardo's resource that she used:

> Barnardo's resources – The *real story* and also *The real love rocks*. And like the real story, it's like scenarios and, and young people perhaps are more likely to relate to – oh yeah that girl's being groomed, that's clear what's going on there because her boyfriend's doing this, this and this and that's not ok – but then kind of trying to bring that back and help them to relate to that themselves… (Tina)

Scenarios were seen to be particularly useful as an educational tool when young people had been groomed and could have been 'brainwashed'(Tina). A more indirect approach could be productive in these circumstances, enabling AOD workers to assess an individual's risk-taking behaviour through another person's situation. Rebecca talked about using scenarios that were close to a young person's specific situation.

David said he used visual methods to help a young person identify where they might be at risk, as they were often more accessible to them than words. He used a weighing scale analogy to evaluate the pros and cons of a situation

and other visual aids to record and measure recent drug and alcohol use by day and time, to provide tangible evidence that demonstrated how an individual's substance use developed, which he then linked to what they were doing at these times:

> So, we look at some of their behaviours and what they're doing and we'll look at maybe doing some mapping and saying to them 'look, can you see where you're potentially being at risk?' Because they often, 9 times out of 10 they don't see that risk you know, they don't see that risk which is why it's hard when they're exploited isn't it? (David)

Mark spoke about using an NSPCC resource, *Pantasaurus* (NSPCC, 2015), which contained a song for children to learn. He explained that this was helpful because it talked in a different, more simple way and used different words to help a young person understand how to stay safe from sexual abuse. This was particularly relevant for younger people, as the language was age-appropriate (although he did not specify what age).

The CSE workers gave the impression that there was not an accepted set of techniques and approaches that formed a basic skillset. Nina spoke of working in a trauma informed way. This is consistent with the recommendation of the 2021 Black review (s.6.1.3). She had considerable experience of trauma and its impact on brain development, emotional regulation and attachment and so she thought that she was able to help young people understand how to manage their emotions without alcohol. Her approach was to work on the emotional trauma first and that a 'positive consequence' of this should be a reduction in alcohol use. She referred to a young person who said that he drank a lot of alcohol to deal with the pain and anger he always felt because of the trauma he needed to process. Nina worked to help him understand his emotions and to find more positive ways to channel them. She also helped him build relationships with other people, describing it as 'scaffolding a support network for him'. A holistic approach was important to Nina, as focusing purely on alcohol could lead to only short-term success. She felt that without further work on emotional regulation and

coping, a young person could try to handle a traumatic experience by returning to their previous coping strategies: '…if you address it in isolation any…change would be short lived' (Nina).

Kate's approach was focused on education and awareness of how to keep safe in different situations, sex education and consent. She might talk about alcohol, but this was only an optional discussion, if the young person wanted to have it. Discussing her approach to alcohol specifically, Rhiannon explained that if a young person said that they were drinking, she did not tell them to stop immediately. It was something that she examined with them over time. In the short term, she explored alcohol use through general conversation, such as catching up on what had happened at parties attended by the young person over the previous weekend. Rhiannon asked questions within these conversations about what the young person was drinking, if they had a hangover and how they got access to alcohol. Her overall approach when working with young people around CSE was focused on consent, empowerment, assertiveness and choice.

13.2.3 Harm reduction

The AOD workers had valuable experience to offer here, as harm reduction has been an accepted approach in working with substance misuse for some time and was included as a core element in Public Health England's 2018 guidance on the commissioning of specialist substance misuse services for young people (s6.1.3). There is evidence that the AOD workers applied harm reduction principles to support young people subject to CSE.

Hickle and Hallett (2015:8) make the case that harm reduction can be an effective approach alongside other CSE interventions: '…we would do well to understand that CSE is not a simple case of rescue, abstinence or of victim-blaming when a young person doesn't willingly leave an exploitative relationship'. Harm reduction is a longer-term process that is based on open conversations to help understand underlying issues and places the client at the centre of support by acknowledging their agency to recognise their problem and respond to it. The authors also regard a harm reduction

approach as encouraging empowerment and strengthening self-esteem, while at the same time helping young people to move away from an exploitative relationship. Within the context of CSE, Hickle and Hallett also state that a harm reduction approach can be important when the safeguarding threshold for an immediate intervention has not been met. This view was supported by AOD workers in the current study.

Education and risk awareness around alcohol consumption and CSE was one aspect of their harm reduction approach. Education included explaining to young people what consent and self-esteem meant.

AOD workers highlighted the importance of understanding more about what a young person is experiencing, believing that their alcohol use could not be addressed in isolation. For harm reduction to be effective, it needs to incorporate social context and the development stage of the young person (Bonomo and Bowes, 2001). According to Pauly (2008), a harm reduction approach that focuses solely on reducing the harms around drug use will fall short when the wider context is not considered.

The AOD workers recognised that their role in providing support about substances could not always be done without addressing issues relating to the CSE. They aimed to raise a young person's awareness of what they were experiencing and to explore how CSE and substance use walk hand in hand. Tina explained this by saying that a large part of supporting a young person was focused on the traumatic experiences that they have had or are currently experiencing:

> I think that my primary role is to support a young person around their substance related needs but that's not stand alone and with CSE, alcohol, exploitation, it is so closely linked together… (Tina)

One consequence of this integrated approach was that the AOD workers also saw their role as taking a harm reduction approach to address CSE-specific issues more directly, including providing young people with an understanding

of topics such as grooming and CSE. This was considered relevant ‘because if it’s related to substance misuse then it does become part of it [the work done around substance use]’ (Jenny). Rebecca gave an example where she had worked with a young person about how to say ‘no’. This young person was subject to considerable peer pressure and knew that when she spent time with one individual she would get into trouble. Rebecca spoke about how helping her to recognise this was crucial for her to make changes to her behaviour.

Mark spoke about redefining social norms for a young person to reduce risk taking behaviour. This entailed talking to them about what would be considered ‘normal’, while acknowledging that the word normal might not always be appropriate. These conversations could centre around issues such as the amount of alcohol that individuals may drink:

> ... whether that person cares to hear it or understand it in that way initially is by the by ‘cause you’re just trying to say this - the impact to your health, the disregard for your safety, the level of risk taking isn’t considered normal. And then you start evidencing well what is normal? And it might not be that the normal word works in that situation you know, so you use a different word. (Mark)

The AOD workers integrated safety messages into harm reduction. For example, when they identified a risk with a young person, the conversation could then include safety messages about what to do if they were in that situation. Workers raised awareness of risks, such as going to a party where there would be alcohol and drugs and gave safety messages about making sure that the individual had money to get home, a fully charged mobile or ensuring that someone in the group was relatively sober, for example. Messages were also given on what young people could do if they were assaulted. Tina said she made ‘safety beads’ with young people so that they had a bracelet that had no sentimental value that they could snap to leave a trace if they were assaulted. She felt that it was important to give these safety messages consistently:

> …talking about things like safety plans and when you're out and having money on you and making sure that you know where you're going and you've got the name of the street and if you're keeping a tenner down the side of your shoe… (Tina)

Harm reduction associated with alcohol use was mentioned by all the AOD workers and was often their starting point when working with young people. Some said that this is necessary because alcohol always carries the risk of physical addiction. When a young person was being sexually exploited, harm reduction is often the only effective approach, as it can be difficult for them to stop using substances at that time. This could also be the case after exploitation. Laura remarked how it was not surprising that one individual with whom she was working wanted to 'numb' her feelings because of what she had been through. Laura considered education to be the best approach for this young person, 'making an informed decision, harm minimisation, keeping herself safe…' (Laura)

The AOD workers adopted a harm reduction strategy when young people did not want to make changes, so that 'they can make an informed decision around what choices they're making' (Rebecca). Much of Rebecca's work was about getting young people to understand and recognise risk and to realise how vulnerable they might be in certain situations where they were drunk. David highlighted an important factor in adopting harm reduction, that there should not always be the expectation that a young person wanted to stop consuming alcohol and other substances.:

> But we look at that young person because not every young person who comes in wants to stop using drugs and alcohol. (I: yeah) It's unrealistic to expect that that's going to happen if they're being exploited. So, we'll just look at like the impact that alcohol or you know, or that drug use may be having on them and give them some like harm reduction advice or harm minimisation advice. (David)

Some AOD workers suggested that it might be possible to consider reducing alcohol use when a young person is no longer being sexually exploited,

although they acknowledged that this may not always be feasible given the trauma they had experienced.

Harm reduction had a more positive aspect. Mark and David tried to accompany safety messages with more encouraging ones that celebrated a young person's positive experiences and focused on what the young people perceived to be normal in a relationship. David described how he worked with a young person to look at constructive activities, to guide them towards positive behaviours. Mark gave an example of an individual who had sex while not under the influence for the first time, which was celebrated as it was progress for that person:

> …she had her first sexual experience not on drugs and it was like really celebrated as a thing because at the end of the day she's still a kid going through life and you have to try and take your victories as you can. (I: yeah) So in amongst this just nightmare, abusive, horrendous, dark experience that she's had in her life, that was one of the things that we took. (Mark)

By celebrating positive experiences, AOD workers were able focus on some of the positives for a young person, whilst also reinforcing and backing up the safety messages that they give.

13.2.4 Recognising risk, changing behaviour

The effectiveness of these safety messages depends to a considerable extent on a young person changing their behaviours. According to AOD and CSE workers, the likelihood of young people doing so depends to a considerable extent on them recognising their own circumstances in the messages and accepting that they are at risk.

AOD workers made the point that getting young people to engage constructively in a conversation about behaviour change is more challenging if a young person has difficulty recognising risk and understanding when they might be at risk both generally and with regard to CSE. Both Eleanor and David identified this as one of their main challenges. David said that it could

be a challenge for young people to see their drinking as a problem. He suggested that they might not realise how drinking contributed to their experiences: '…and that's the difficulty with sexual exploitation is that they don't often see them risks'. (David)

One challenge highlighted by the CSE workers is the difficulty of trying to persuade young people to engage with other services if they do not recognise that they are being sexually exploited. Nina felt that the support process could be very slow and gradual because of this and dependent on young people disclosing information. She explained that it could take months to get a young person to understand that what was happening to them was not acceptable. Kate agreed, explaining that because a young person receives something in return 'makes it not kind of straightforward sexual abuse, if you like'. Young people might feel that they have agreed to what they believe to be a fair exchange. It can therefore take them a while to realise and understand that they have been sexually assaulted. Rhiannon said that often young people do not think that they have been sexually exploited because they believe that they were having a good time.

The AOD workers found achieving behaviour change in young people a challenge, something that they worked towards but which was often not possible in a short space of time. Jenny contrasted the challenges caused by the addictive nature of alcohol to cannabis, where she could support a young person to find distractions from the habit. Support for alcohol use could take longer, as the risk of withdrawal symptoms could be decreased by encouraging young people to drink lower percentage drinks before gradually starting to reduce the number of days when they drank. David spoke about how it can be hard to challenge young people about their alcohol use when it is their coping mechanism for what they are experiencing. He explained that his team usually worked towards behaviour change, but that young people who had experienced or were experiencing CSE might not be in a place to make a change in behaviour because of other risks that they might currently be dealing with.

> We work under behaviour change but the young person might not be in a place to have behaviour change 'cause of them other risks. (I: yeah) Especially with exploitation so, that's probably the biggest barrier for us you know, for us. (David)

Another barrier to behaviour change was where the issue that a young person presented with was not within the workers remit, or where a referral was not needed. In this case, CSE workers were encouraged to use brief intervention, which will now be discussed.

13.2.5 Brief interventions on alcohol by CSE workers

The focus of the work undertaken by the CSE workers on alcohol was mainly to provide education on consent and safety, with a strong focus still on CSE and relationships. However, they also talked about how they might address alcohol use more directly by using brief interventions. Beth described her overall approach as 'young person positive', in which she worked to support them to 'make the right decision'. This often started with signposting to other services, including the local alcohol and drug service with which she worked closely. However, should a young person decline the referral, Beth might provide a brief intervention for alcohol. This covered topics such as how to keep safe, how much the young person drank, how drinking made them feel, at what point they could/could not stop drinking and safety plans. Once a brief intervention had been provided, it was recorded on a pro forma to inform other staff who might support the young person in the future. Beth also spoke about the changing landscape of services in times of austerity as another reason for providing young people with brief interventions. She felt that due to budgeting and cuts, there was an expectation on services to deliver brief interventions on all topics, not necessarily just on their specialist areas:

> …that's the way that sort of public health is moving really erm, in terms with austerity, budgeting and things, you know there is that expectation that every service will touch base. So, we do brief interventions for mental health as well …in today's society and landscape in terms of

> frontline services, we kind of all have to at least offer brief interventions on different …at least to be able to signpost and offer that. (Beth)

Kate spoke about a different kind of brief intervention on drinking that she provided to young people. This was in the form of a scratch card that asked questions such as how many units they drank or if they had ever been unable to complete tasks due to drinking the night before. It came with a scoring system where more than three on a scale of one to five placed an individual in the risk category for a dependent drinker. She felt that this brief intervention helped to make some young people more willing to engage with an AOD worker:

> And I've done that scratch card with two of my girls [that I work with] in the past just as a quick intervention to kind of show them erm, with like an official document if you want that we use with adults, just how serious their drinking is. And sometimes that's done well to open their eyes to the fact that they shouldn't be drinking as much as they are and then [they alcohol service is] …more willing to take on [an AOD] worker from my company after we finish the work. (Kate)

It is apparent from these comments that the working practices and approaches of the AOD and CSE professionals responded to the presence of both CSE and alcohol in young people seeking their help. However, they also recognised the boundaries of their own specialism and relied on referral to other professionals and agencies to complete the support needed by young people experiencing both hazardous alcohol use and CSE.

13.2.6 Agency and victim blaming

The assessment process and the subsequent conversations that AOD and CSE workers held with young people held the potential to touch on victim blaming, especially when discussing what some workers referred to as 'risk taking behaviour'. Mark (AOD worker) used the phrase 'the disregard for your safety' in this context. Some AOD workers approached this by keeping the focus on questioning a perpetrator's behaviour, rather than that of the young person. It was important for Tina that the young people were confident that she wasn't there to judge them.

One challenge for the workers was to counter the shame felt by young people who blamed themselves. The AOD workers saw their role as explaining to young people what consent meant and building up their self-esteem, to help them to feel able to say no and to realise that when things happened when they were drunk, it was not their fault, as they had not been able to consent:

> Do they understand what consent is?... I have lots of the girls and lads will say you know 'yeah well I was drunk so I wasn't fighting him off, I was drunk.' And then they will see that as 'that's my fault.' So, by learning about consent they then can go 'well let me re-evaluate that situation then when I thought I had consented. Well actually no, I hadn't consented. (Eleanor)

Recognising a young person's agency is important when encouraging them to engage with a service and make changes to their behaviour. A study by Dodsworth (2014) interviewed women involved in sex work within the UK who had been sexually exploited before the age of 18. The study found that 'perceptions of agency and choice were central to their sense of self, self-worth and ability to and right to access services' (Dodsworth, 2014: 189).

The young women in the focus group associated a reluctance to access alcohol and drug services with a concern that young people may feel '… a bit shameful' (Jess). It was therefore especially difficult for a young person with low self-esteem to access these services. Just talking about alcohol and drug issues with others could deter young people from accessing services for fear of being judged:

> Group facilitator: What do you think the consequences would be if you started talking to people about having alcohol and drug issues? How do you think people would react to you?
> Amy: They might judge you.

Jess discussed her own experiences of victim blaming. She felt that one of her counsellors took a victim blaming approach by asking her about what she had done, rather than focusing on what had happened to her:

> Like I had a counsellor once who was really, really victim blaming and like, just completely had the complete wrong effect that counselling should have on you and like it puts you off a bit. You just don't open up to them. Right from the off it was 'oh I hear you've done this' like, it was never like 'I hear this has happened to you.' It was always 'it's because of you.' I don't know, just have proper training clearly. (Jess)

A harm reduction approach supports young people to minimise the harm from their alcohol use, rather than having expectations about their future actions. When a young person does not have a desire to change their behaviour, a harm reduction approach can be more challenging. AOD workers made the point that getting young people to engage constructively in a conversation about behaviour change is more challenging if a young person has difficulty recognising risk and understanding when they might be at risk both generally and regarding CSE. Both Eleanor and David identified this as one of their main challenges. David said that it could be a challenge for young people to see their drinking as a problem. He suggested that they might not realise how drinking contributed to their experiences: '…and that's the difficulty with sexual exploitation is that they don't often see them risks'. (David)

13.2.7 Pressures on services

Galvani (2017) describes how budget reductions have hit services severely, leading to increased thresholds for intervention and unfilled jobs. The Black review (Black, 2020, 2021) described the provision of substance treatment as not fit for purpose. My interviews with the AOD and CSE workers gave an insight into the consequences of this situation for those working on the service front line. Eleanor, David and Mark, AOD workers who were in management positions, raised concerns about how various external pressures on their services made it difficult to deliver the range and quality of support necessary for young people at risk of or experiencing CSE or to obtain appropriate training for their staff.

Funding was a reoccurring issue for both voluntary and statutory services. Eleanor, David and Mark described how increased cuts to different

professional teams had resulted in higher service thresholds as services reached capacity. Furthermore, cuts to CSE services and rising referral threshold levels could leave AOD workers filling a gap in provision, managing and supporting young people at risk of CSE without support from other services:

> There's all budget cuts because the government is saying 'well the local authority's losing so many million this year.' … So, it then pushes further and further …to the frontline services. So, for example the (CSE) team, they have so many workers but as they're getting more and more referrals in…they'll get to capacity so they will start to say, 'well our threshold [is] coming up.' So, some of that now has to be managed by other professionals. (Eleanor)

David illustrated the impact of this problem with the example of cases where young people accessed an alcohol and drug service and CSE was identified as a risk, but this might not have been confirmed. As he explained,

> …those who are at risk of sexual exploitation, they've not met the threshold to be involved with the CSE team. So that doesn't pull in the multi-agency approach. (David)

David drew attention to the danger of treating alcohol misuse and CSE as separate rather than related problems. He believed that one reason why young people may not meet the CSE service threshold arises from the narrow view that alcohol and drug use is just about a young person drinking or taking drugs, not recognising that they may be doing so because they are being sexually exploited. Supporting young people at higher risk could be more time consuming, leaving workers massively stretched, stressed and having to complete work that previously was not part of their job. Mark made the point that workers felt that they were no longer able to do their job to its full potential. This could leave workers simply asking, 'is it [the service provided] good enough?*'* (Mark).

Boundary issues were also evident. Eleanor and Mark raised the challenge of support for young people moved out of area because of the risk that they

faced from CSE perpetrators. Eleanor, who was based in an area with one of the highest numbers of out of area child placements in England (although not in a large city), questioned who should give young people specialist CSE support in these circumstances. Because young people did not have access to the statutory CSE service, this 'leaves them out of area without that key CSE work being done' (Eleanor). She spoke about a social worker or care home referring a young person into the alcohol and drug service where she worked. She had the necessary training and experience to deliver CSE support and 'fill the gap' but questioned that if she was unable to do so, who would?

Concerns about time and resource constraints were common, with a reduced workforce leading to longer waiting times for young people and greater pressure on service providers. Mark mentioned how he had witnessed two teams of 16 in another service being reduced to one team of eight. He felt that a longer-term approach was needed along with better resources, as workloads were too high. He felt that while he and his colleagues still gave young people the best of what they had, it could be 'so much better and I often will say 'god if I had a clone of me I'd probably be able to get done what I need to get done' (Mark). David related these problems to cases where a young person was at risk of or experiencing CSE; these could often take up more time than other cases because of the meetings, conferences and reviews that workers needed to attend. The time needed for CSE cases also increased when those at risk did not meet the referral threshold for CSE referral. This could impact the support for other young people in their caseload. For David, the thresholds were unsatisfactory but could be handled with additional staff resources. Kate (CSE worker) felt that she received fewer young people referrals from her alcohol and drug service than she had initially anticipated. She explained that one reason for this might be that after significant funding cuts, there was only one AOD worker for young people within the service:

> So, it's all adult work, so I don't get referrals because everyone else is an adult worker with erm, like adults who have alcohol problems so I

> don't commonly see any of my colleagues working with anyone under the age of 20. (Kate)

One consequence of services being continually stretched was that when young people disclosed something for which they need to be referred, they often had to wait weeks before anything happened. Rebecca (AOD worker) acknowledged how difficult it must be for young people to be waiting and expecting someone to talk to them for this length of time. She also suggested that the point when a young person makes a disclosure is when they are in most need of help. Circumstances can change in the weeks of waiting and new situations can develop, which may lead to the young person no longer wanting the support. This wait for support and the nature of the response that a young person receives to a disclosure can also affect their future engagement: '…the response they get at the time can make all the difference between how much they engage with services'. (Rebecca).

13.2.8 Barriers to accessing services

One consequence of low levels of awareness and understanding of alcohol-related CSE is that young people are less likely to access the services that provide support for this issue. When asked if they were aware of the services that were available to them in their local area for alcohol and drug use, the young women were unable to name any. It was only when the group facilitator told them the name of the local young people's alcohol and drug service that they conceded that they had heard of it. They were also unaware that it was necessary to physically go into the building to receive support. None of the young women viewed it as somewhere they would visit. They were worried about being seen entering the building and of others being aware that they were getting support from the service:

> It's like in a really bait [obvious] place as well. Like everyone knows you're going to the (name of service) 'cause it's just there. (Amy)

The young women associated this embarrassment and reluctance to access alcohol and drug services with a concern that young people might feel '… a bit

shameful' (Jess). It was therefore especially difficult for a young person with low self-esteem to access these services. The young women thought that young people might regard having to phone a service as being a barrier to accessing support because they lacked confidence:

> I don't think people are confident enough to call numbers and speak to people who sound like arrogant and just well…, do you know what I mean. (Amy)

Difficulty in accepting or recognising the problems they were experiencing can present a more fundamental barrier for young people accessing support for alcohol and drugs. An individual might not think their alcohol consumption is hazardous unless someone such as a family member tells them, or they have 'a real addiction' (Jess):

> … you might just think 'oh, I'll just have a drink every now and then, it's fine.' And not realising that when you have a drink it's actually because you're stressed and you might actually need some support. (Jess)

The young women presented some ideas on how these barriers to support could be addressed.

Identifying where young people are likely to go for information and support is an important first step in accessing support. The young women expressed a preference for their first contact with an alcohol and drug service to be remote, with no direct interaction with the service:

> Well, there should be an email or something for like general questions, general advice and – or have a website with all 'this is how much you should be drinking, if you feel you're over, please contact' and have a message or something like that. (Jess)

However, the young women also recognised that young people experiencing CSE needed support before they got to a crisis point and began to use alcohol or drugs to cope with their trauma:

> You need something like beforehand, how to actually cope rather than having to turn to drugs and alcohol, rather than just 'here's the number to call'. (Jess)

When asked where they would go for advice about alcohol and drug concerns, Jess said she might contact a health practitioner: 'Couldn't you go to a GP… for drug and alcohol advice'. Amy suggested that she would not seek advice: 'I don't think I would speak to anyone. I think I'd just keep it to myself'. Amy's preference was to search for information online, as she felt that if she recognised that she had a problem she would prefer to deal with it herself:

> I'd prefer like information. 'cause then it's like I'm reading it and it's not someone telling me that 'oh, you have a problem.' It's me knowing that I have a problem and knowing how I can fix it myself without someone else saying you've got to do this and you've got to do that. (Amy)

Jess suggested that being able to talk on the phone might be the preferred first point of contact for advice for some young people. She believed that this might make them feel less uncomfortable, as body language and facial expressions can have a negative impact and can stop young people from talking:

> Probably having a phone line that you could talk to rather than having to go [in person]. You might feel less judged if you're on the phone and can't tell what they're… (I: yeah) 'cause if you're already feeling bad, if you even got one look off a person that you thought was a bit like a dirty look then you might be like 'alright, I'm not talking to anyone about it anymore then. (Jess)

Discussion of the support process then moved from seeking information and advice, to receiving support from specialists and more specifically to what the young women thought constituted good and bad support.

The young women characterised good support as having a supportive team that listens and responds to a young person's concerns:

> Well, the good support's like where you have a good team or network like supporting you around your needs, and a bad support is just neglecting everything that you're worried about or everything that's going on or your concerns and stuff. (Amy)

Jess suggested that the trauma associated with hazardous alcohol use gives young people a kind of maturity and that the support they receive should be the same as for adults:

> I think if you've got like a drug and alcohol addiction you clearly are, I don't know quite like, in a way mature to be – and I think you'd have an understanding and I think you should be given the same support as an adult 'cause you've clearly been through something quite traumatic to get you in that state… (Jess)

Good support also involved the workers being 'nice but not too nice' (Amy), 'just understanding you instead of like, judging you' (Amy), common courtesy and not making any false promises.

Amy summarised what bad support looked like to her:

> 'cause some people listen and then don't take it in and like say stuff. But then other people just let you talk and then interrupt and be like 'this, this and that' and I don't really find that helpful, it's like, will you let me talk? And then I can answer questions and stuff. (Amy)

For these young women, feeling listened to was of great importance. It is important to strike the balance between providing the young person with the necessary safety messages and relevant questions for a risk assessment but also ensuring that they have the space to explain their situation and feel that what they say has been considered.

13.3 Collaboration and multi-agency working

The limits that the AOD and CSE workers placed on the extent of their support is hardly surprising given the depth of specialist expertise required to

address hazardous alcohol use or CSE separately. The added complexity inherent in trying to deal with both together requires collaboration between specialists both informally with colleagues and within a framework of more formal multi-agency working. Public Health England guidance on local commissioning of substance misuse services for young people (s.6.2.2) includes the expectation of a joined-up approach across children's services using care and referral pathways (Public Health England, 2018b). Furthermore, CSE policy is embedded in a strong multi-agency framework (s.6.3.2).

The workers regarded informal consultation with, and referral to, other AOD and CSE colleagues as important and often the first step in collaborative working:

> If there was anything that I needed to check over, I'd speak to my manager, I'd speak to someone on (name of CSE team) or even members of my team may have come into contact with someone of a similar risk but yeah I do feel confident in speaking to young people about CSE. (Jenny, AOD worker)

As Jenny indicated, part of this confidence was knowing that if she was unsure about anything, she had colleagues and managers with expertise in CSE to whom she could talk. David knew that he could seek further support from a CSE specialist who was subcontracted into the alcohol service to work with young people when CSE was identified. The AOD workers recognised that they were not working in isolation and that their work fed into and drew from other services. Working with CSE services was seen to be part of their role. Jenny saw this as underpinning the information provided by CSE workers:

> I'll always like reinforce any learning that they've done with (name of CSE team) or reinforce their understanding of grooming and knowledge of it really. Or if they want more information then I can do that with them as well if they feel comfortable doing so. (Jenny)

The CSE workers reinforced the positive contribution of collaborative working across specialisms. Working for, or having close links with, alcohol and drug services gave them confidence in supporting young people around alcohol and drugs. Kate considered that because of this, she was sufficiently competent to have conversations with them about risks. She knew that if she was ever unsure, she could talk to one of her AOD colleagues in the service, rather than necessarily needing additional training. Nina attributed her confidence in talking to young people about their alcohol consumption to her previous experience in an alcohol and drug service. She said that before this, she had been unsure what she could and could not say about alcohol, or even to ask someone about their alcohol consumption:

> …if the worker doesn't know what that is [a brand of vodka] then they may not always feel confident to reply to that and say 'ok, how much are you drinking?'' (Nina)

The AOD workers also recognised the importance of more formal multi-agency working, whether signposting to appropriate services, attending local CSE agency meetings, or arranging child protection meetings for a young person. This included feeding back information to their own team. Rebecca found that it was easier to signpost to a service when she had built a good relationship with a young person, as this could help the young person to place more faith in the signposted service. For AOD workers based in youth services, multi-agency working also included working with adult services to facilitate a smooth transition for young people when they reached the age of 18 years.

David spoke about the important contribution his expertise brought to multi-agency working. He saw his role as to professionally challenge others, to ensure that young people receive the right support:

> 'So, we've - in the past - we've escalated cases where we're seeing an increased risk to young people'. This was particularly important when a case was being assessed to identify what was best for the young

> person: '…it's also the expertise we bring as well to multi-agency [working]…. 'cause we often have to challenge other services'. (David)

All of the CSE workers participated in multi-agency working. Nina referred to disclosures to a range of services including police, hospital and residential homes. Information sharing between these services, often at multi-agency meetings, raised awareness of CSE. She felt that multi-agency working generally worked well but alluded to difficulties when she said that each agency had its own viewpoint and priorities and so 'bringing that all together can be – it has its challenges…'. Nina highlighted the importance of identifying the most appropriate agency to work with each young person. In her view, it should be an agency that would look at the bigger picture, rather than merely focusing on the specific issue that a young person presented with.

Location was a factor in collaborative working. Beth's experience of multi-agency working was, to some extent, based on being in the same building as other services. She had a good working relationship with the local alcohol and drug service and mental health services for this reason. This made signposting easier to key people based in the other services. Kate, also a CSE worker, pointed to the advantages of being based in an alcohol and drug service. She said that it was not always appropriate to refer on to other agencies. Her location within an alcohol and drug service made it more straightforward to ask a young person if they were willing to work with an AOD worker alongside her work with them. Alternatively, she could signpost them to the alcohol and drug service after her work with them was completed. She mentioned that there were times when she would refer a young person to an AOD worker immediately, particularly if the young person's decisions always centred on alcohol:

> I think the biggest one for me is if their assaults have always – or like their online decisions have always centred around the amount they've had to drink, then that's an instant referral for me. (Kate)

Rhiannon also found working within an alcohol and drug service helpful, as referrals to and from AOD workers worked well. Rhiannon's approach to referral could be quite informal, as it sometimes just consisted of asking one of her AOD colleagues to come and talk to a young person with substance use issues. If the young person was unwilling for this to happen, she might then talk to an AOD colleague, who could provide her with information for her to use 'as a gateway to a referral' (Rhiannon).

All of the AOD and CSE workers appreciated the benefit of multi-agency working but also recognised that it was difficult to get right. For example, funding cuts had made referrals to other agencies more difficult, with the result that young people would have to wait longer to receive specialist support. The cuts had also affected other aspects of service provision, including training for AOD and CSE workers. This will now be discussed.

13.4 Training provision and skills development

Galvani (2017:469) draws attention to the shortcomings of social workforce education and training concerning substance use, to the extent that 'historical and current changes to social work education and practice in England continue to set up social workers to fail people with substance problems and mitigate against effective workforce development'. Associated with this unsatisfactory situation was the inclusion of substance use only as an option in qualifying social work programmes. Because of the devolved approach to service commissioning, design and delivery adopted in the 2012 alcohol strategy (confirmed in the 2017 Drug Strategy), the inclusion of substance use (and CSE) in skills development depended on the priorities of individual employers, to whom these programmes were devolved.

The AOD workers I interviewed appear to fall into the minority who have received training on CSE. They attributed much of their confidence in supporting young people who were experiencing CSE to the training on CSE that they received, which they generally considered to be sufficient: 'I go on regular training, I keep myself updated with like things that are going on within

the town' (Jenny). Some of this training was provided by their Local Safeguarding Children's Board (LSCB), often via online programmes. David also spoke of how service audits were helpful to share good learning and best practice with other members of the team.

Other AOD workers confirmed that some training had been brought in-house on trauma and adverse childhood experiences (ACEs), for example. Mark linked this change of provision to funding cuts to save on the time and cost of travel; he also identified a further disadvantage of this provision, regretting the loss of interaction with other practitioners:

> …what you lose in that is the connection with other people with other stories and other ways of working that you could take on and implement into your own service. (Mark)

The AOD workers also took personal ownership of their development. Several supplemented and developed the training they received with their own research, to give themselves a better understanding of what worked best for them and to identify what might be missing from the training. Discussion with colleagues about what they learned from training was also seen as helpful, as individual interpretations might differ and others might be able to offer a useful insight into what worked well or the best use of a particular resource. Eleanor linked the need for this supplementary research directly to the limitations of training on CSE, saying that workers needed to take 'a level of self-responsibility'. She said that while training might provide a reasonable understanding and knowledge of CSE and the need for empathy, it did not necessarily explain how to work effectively with young people to pull them through it. She felt that training was sometimes a 'tick box exercise' to help a worker spot some of the signs of CSE, without providing the important in-depth knowledge needed to complete good quality assessments. A relevant factor could be missed and the assessment underscored, which could mean that a young person's case was not taken to a multi-agency meeting:

> I know everybody could do an assessment and all score slightly different (I: yeah) but it [the assessment] could score quite dramatically differently. So – and you're not so worried if somebody over-scores it a bit but if you underscore it because of a lack of knowledge then that doesn't get put forward to a process. (I: right) So it doesn't get heard at the multiagency sexual exploitation forum. Because it scored too low. (Eleanor)

AOD and CSE workers identified a more specific limitation of training when they highlighted a gap in provision covering alcohol and CSE together. Laura felt that AOD workers like herself were left to attend CSE training on their own initiative and then make their own connections:

> We've had CSE training in isolation ran by (area) safeguarding board and I think I went on that about 12 months ago maybe, something like that. But we've never had any training in the link between the two. I don't know if that really exists. I suppose it's about us as alcohol workers to go to that training to then put the two together, if that makes sense – yourself. (Laura)

Beth and Rhiannon made similar comments on this problem from a CSE worker perspective. Rhiannon suggested that 'evidence-based' training covering both CSE and alcohol would be useful.

Keeping in touch with the constant change in the popularity of various alcoholic drinks and drugs could be difficult for alcohol and drug workers but was especially challenging for the CSE workers, who identified it as a particular training requirement. Nina explained how different types of alcohol and drugs could be 'flavour of the month' but quickly fall out of fashion. This constant change made it difficult to keep her own knowledge up to date. She also referred to the difficulties in alerting all services as to what they should look out for and to provide training on what alcohol and drugs were currently linked to CSE in the local area. Rhiannon used the example of the growing popularity of ketamine, of which she had no experience, to illustrate this problem.

Several AOD workers talked about how training and a good understanding of CSE, while necessary, needed to be underpinned by a broad skill set if they were to support young people experiencing CSE effectively, engaging them with the support on offer and assessing and managing risk. Each AOD worker offered their own suggestions for this skill set.

Sound experience was mentioned as essential by several AOD workers. This might seem obvious but in practice could be difficult to put in place. Tina said there were not enough skilled workers nationally and suggested one way to improve this situation would be to pair those with limited experience with a more experienced professional, who could share their knowledge and expertise:

> With advance practitioners supporting less advanced practitioners to help them develop their skill, knowledge, experience, bounce off one another and all of that will help to have another generation of people that haven't just walked out of university with, with a piece of paper that says I can do. (Tina)

Eleanor emphasised the importance of a commitment and ability to work with a young person sensitively. This included the language used and the questions asked, to avoid inciting feelings of shame. She also suggested that appropriate language should be used when talking with other professionals, even when a young person is not present.

Mark identified self-awareness as an important skill for workers. He explained that at times a situation might trigger a worker to think about something in their own life and want to save a young person from a particular situation. He felt that it is important that workers recognise when this is happening, keep their boundaries in mind and understand that they do not have sole responsibility for supporting a young person:

> ...it's tapped into - 'I have to save this situation' – which will come up for any worker you know what I mean? It really does. And you have to temper that too and really say it's ok to do enough in this situation. You

> don’t have to do it all, you have to trust other agencies that are involved that may not have the relationship that you have with the child, you know. (Mark)

Without a set of CSE guidelines for AOD workers, there is an element of workers judging for themselves the extent to which their remit involves supporting a young person around CSE. Where AOD workers do not have good relationships and communication with other agencies, they may be less confident in feeling that they have done enough to support a young person.

13.5 Chapter summary

AOD and CSE workers supported young people with alcohol-related CSE on a day-to-day basis. However, their individual approaches to it, their confidence in providing support and the degree to which their working practices were adapted to the specific needs of alcohol-related CSE varied considerably.

The initial stage of support, identification and assessment, was usually part of a generic assessment process that workers conducted with young people who were new to the service. The AOD workers recognised that their approach to asking young people these questions was as important as the questions themselves. They acknowledged that building a trusting relationship with each young person could be difficult but was essential to encourage them to engage in a meaningful way.

The AOD workers provided a wide range of support, much of it focused on harm reduction, to give young people safety messages about their risk whilst drinking. The AOD workers recognised that CSE is complex and that providing support could be challenging. They referred to the difficulties associated with achieving behaviour change, building engagement and trust, and getting young people to recognise risk. The time-consuming nature of this support meant that AOD workers could struggle to carry out the work needed with a young person, especially in the context of the increasing pressures on

services caused by funding cuts. The AOD workers felt that this was not just an issue within their service but also with the other services that might support young people around CSE.

It was clear that alcohol and drug services were overburdened. The AOD workers identified several challenges they faced, including shortcomings in multi-agency working and difficulties in accessing appropriate training and opportunities for skills development. These challenges were particularly severe for complex problems such as alcohol-related CSE, particularly when funding and service cuts made it more difficult to trigger a full multi-agency response. As a result, AOD workers could be the only service involved with a young person, providing support for both alcohol use and the safeguarding aspects of CSE.

The approaches of the CSE workers were linked to each CSE worker's view of their role around CSE and alcohol. Some did not feel that a young person's alcohol consumption was their remit and their work around it was limited; one CSE worker felt that they were there to help a young person manage their emotions, which could involve their use of alcohol. The challenges identified by CSE workers around alcohol use included information sharing, particularly regarding the impact of sharing confidential information provided by young people. This could cause the young person to stop engaging because they believed the CSE worker had broken their trust. They identified as a further challenge the difficulty of convincing some young people that they had been exploited.

Part 5
Discussion and Conclusion

Chapter 14
Discussion

My research seeks to develop a better understanding of the nature and extent of the relationship between alcohol and CSE. It is the first study of its kind to be focused on this specific relationship. My research also aims to identify the implications of alcohol-related CSE for alcohol service interventions. In doing so, it will identify what is needed to ensure a more informed alcohol service delivery to young people experiencing CSE. It is the first known study to speak to AOD and CSE service providers specifically on this topic, to gain an insight into their service response to alcohol-related CSE.

The following discussion will describe the contribution that this study makes to the evidence base for each of its two aims, with reference to the objectives outlined in Chapter 1:

1. Identify alcohol's role in CSE through the voices of alcohol and drug and CSE service providers
2. Identify alcohol's role in CSE through the voices and experiences of young people who have experienced CSE
3. Determine the responses of alcohol service providers to CSE
4. Identify what is needed to support those who have experienced alcohol-related CSE
5. Develop an explanatory model to explain the relationship between alcohol and CSE

I will re-introduce my theoretical approaches – Critical Realism and the ecological systems model – to provide a framework for my discussion. After abductive analysis, Critical Realism includes a second stage, retroductive analysis. This will provide a lens for my discussion. I will use Ecological Systems Theory to explain the systems and structures impacting on the 'real' level observations of the role of alcohol in AOD and CSE workers' responses.

The difficulties in recruiting young people to take part in this research have affected the balance of contributions, such that the findings are heavily weighted towards the views of the AOD and CSE workers. Nevertheless, three young women participated in my research, two of whom raised several issues that add to our understanding of alcohol-related CSE and are worthy of further research, particularly when added to the contributions of the AOD and CSE workers.

14.1 The nature and extent of the relationship between alcohol and CSE, through the voices of service providers and young people (Aim 1)

The starting point for my research was that while alcohol is acknowledged as having a role at each stage of CSE, there is a lack of research that focuses on the nature of this relationship. My research aimed to develop this understanding further through qualitative research, which is discussed in my Findings (chapters 12 and 13). My research contributes to this understanding as follows:

- It provides a focus on alcohol and CSE together that has hitherto been neglected in the literature, which has discussed this relationship only peripherally.
- It adds to understanding of this relationship by adding the unique perspectives of practitioners who deal with alcohol-related CSE on a day-to-day basis.
- It identifies implications of this relationship that need to be considered by alcohol service providers.

There are three diverse aspects of my findings on the nature and extent of the relationship between alcohol and CSE that merit further discussion: the social structures within which it sits, the role of alcohol in peer exploitation and the education and awareness of alcohol-related CSE among young people. I will also present an explanatory model to explain the relationship between alcohol and CSE to meet Objective 5.

14.1.1 Social structures

My discussions with professionals and the young women demonstrate that some young people view alcohol consumption as a social norm, an entrance into the adult world. The socially constructed views of what being a child entails mean that the way their actions are interpreted is influenced by these preconceived ideas of what it is to be a child or young person: ‘constructed cultural expectations around innocence, dependency and asexuality add complexity to debates about agency and sexual abuse when applied to ‘children’ (Beckett, 2019:32). The consumption of alcohol adds an extra layer to this difficult dynamic. It is necessary to study a young person’s world to understand what influences are at play. Adolescence is a time when young people are exploring and want to seem grown up, which clashes with expectations of innocence. For example, UK law states that alcohol is for those over the age of 18. For some young people consuming alcohol represents maturity and adulthood and they therefore regard drinking as part of the cultural norm within their peer group microsystem.

When a young person’s drinking is examined on a broader scale in their mesosystem or exosystem, where school life and the impact of national policies and cultural assumptions come into play, judgements on their actions and behaviours are made. For example, young people can be seen to be a part of the ‘wrong crowd’ or contravening the laws and policies that are applicable to their age group. Judgements are made on what a young person should or shouldn’t be doing, or what is right or wrong for their age, without paying attention to what is influencing a young person at a deeper, real or actual level. This can lead to victim blaming and can extend to a young person not receiving the support they need and deserve. Within this study, AOD workers demonstrated that they did have this awareness, for example in the recognition that young people were trying to emulate what they had seen on television programmes about adult dating behaviour. They showed awareness that young people may not be able to stop drinking alcohol due to their situation and so took a harm reduction approach to supporting a young person around their alcohol use. The AOD workers recognised that the systems and structures in place around a young person don’t always work for

them, for example where a young person requires more complex support, but waiting lists and lack of adequate resources mean that they do not always get what they need at the time that they need it. Although at times AOD and CSE workers did mention young people ‘putting themselves at risk’, they often referred to ‘risky situations’, or where a young person could ‘be at risk’, thus deflecting the blame away from the young person’s actions and focusing more on those of the perpetrator.

Within Critical Realism, the focus is not only on what is observable but what is also happening below the surface, at the actual and real levels. Regarding the consumption of alcohol during CSE, I have identified and discussed a number of contributory factors. However, I would draw attention to the importance of trauma. When a young person is experiencing trauma, they may need a coping mechanism to help deal with what has happened; this can be alcohol. Several AOD and CSE workers discussed trauma in relation to a young person’s alcohol consumption and experiences of CSE. As with alcohol’s role in CSE, where it could have influence at any time point, the workers recognised that trauma could influence alcohol consumption at any time. Alcohol can be a coping mechanism while going through or processing a traumatic event. Some AOD workers had received specific training around trauma, although they were in the minority.

Beckett (2019) and Woodwiss (2018) have called for a change in narrative around sexual abuse. I would also argue that there needs to be a new narrative around alcohol and CSE, one that acknowledges that alcohol can be involved in CSE and that a young person using it during exploitation does not translate into them putting themselves at risk. More attention needs to be given to the reasons why a young person might be consuming alcohol, beyond our preconceived ideas of when it is appropriate. This involves looking at what is going on for a young person beyond what can be observed and having an awareness of societal structures that may lead us to make assumptions about a young person and their behaviours.

In a young person’s microsystem, the social structures relating to them drinking with their peers lead to the blurring of boundaries of social interaction

and CSE. Grooming doesn't necessarily need to persuade a young person to believe that alcohol is a social norm, as it is normalised within the structures of society: drinking among young people is often not only accepted but also expected. This will now be explored in the context of peer exploitation.

14.1.2 The role of alcohol in peer exploitation

The purpose of my research has been to provide a dedicated focus on the role of alcohol in CSE – something that has been missing from the evidence base. I will now provide a similar, more focused, perspective on one aspect of CSE - peer exploitation. This may have received some attention, but the role of alcohol in peer exploitation deserves deeper and broader exploration. Peer exploitation is a useful example of the role of alcohol in CSE and it poses particular risks to a young person. This form of exploitation involves what is often an integral part of a young person's microsystem - their peer group. Within peer exploitation where alcohol is involved, what we see at the empirical level is a young person drinking and experimenting with their peers. From the outside looking in, a young person can be observed drinking and engaging in what can be viewed as sexual risk taking and making a considered choice to do so. However, without knowing the broader context of a young person's life and the factors influencing their behaviours (real/actual), we cannot gain a proper understanding of their situation.

The starting point for this exploration of peer exploitation was the comment from one of the young women in the focus group that young people may view the offer of alcohol differently if the perpetrator is a friend or peer acquaintance, rather than a stranger. If this is so, the peer-on-peer model of sexual exploitation can be built on a relationship between perpetrator and subject that makes it in some respects more dangerous than other models, with the abuse taking place within a young person's microsystem. The reason for this added danger is that drinking alcohol is an integral and accepted aspect among many peer groups, in which there is likely to be a level of trust (s.11.2.2). It might therefore be more difficult to identify risk in this situation as it can be observed as a 'normal' peer relationship. At the actual and real

levels there may also be an element of peer pressure, which is not observable but may be influencing the apparent choice to consume alcohol.

I am therefore going to explore this differentiating factor in more depth by developing the findings of my research in s.11.2.2. I will now discuss further its implications for the role of alcohol in CSE with reference to other peer groups and relationships: relationship violence (RV), adolescent dating violence (ADV) and gangs.

The role played by alcohol across different time points in sexual exploitation and violence can be seen in a study conducted by Waterman et al. (2019), in which survey data was collected from 1,322 young people at three time points across the space of a year. The authors found that adolescents who reported binge drinking at more of the time points were more likely to be perpetrators of sexual harassment and stalking or to have experienced stalking and dating violence themselves. Just as in peer exploitation, alcohol can be used by both perpetrators and those who are subjected to a form of violence throughout the relationship or exploitation. The studies by both Baker (2016) and Waterman et al. (2019) highlight the need for further in-depth research into the role played by alcohol within peer relationships, regarding sexual exploitation and abuse.

The literature on peer relationship violence (RV) has also found that alcohol can be used at different time points, in similar ways to the findings of my study. Walsh et al. (2017) examined RV and binge drinking through a series of telephone interviews over the course of three years with 3,614 young people aged 12 to 17 years in Wave 1 of their study. At the first interview, adolescents who had experienced RV were significantly more likely to report binge drinking compared to those that had not; however, at the follow up interviews they were less likely to report binge drinking than those that had not experienced RV (Walsh et al., 2017). This suggests that there is a relationship between alcohol and RV at the time of the violence, but that alcohol consumption does not necessarily continue after the

violence. Through eight focus groups with 39 high school aged young people, Baker (2016) found that in RV, alcohol was used by young people as a coping mechanism to deal with relationship break up.

Peer exploitation is often a part of gang culture and its associated hierarchies. Qualitative studies with young people within gangs have shown that alcohol and sexual activity can be linked in these circumstances. For example, Dickson-Gomez et al. (2017) examined high risk sexual behaviours within gangs, conducting 58 interviews. Both males and females discussed having sex under the instruction of, or organised by, an older gang member. For example, one male was told to have sex with a girl aged 16 or 17 years as part of his initiation into the gang; similarly, a female was ordered to have sex with some of the male gang members. Alcohol was present in both situations. All study participants reported sexual activity taking place at parties and involving alcohol and drugs; some participants associated the use of alcohol with lowering inhibitions to have sex (Dickson-Gomes et al., 2017). This study also has relevance to the use of alcohol as a coping mechanism. In the same way that AOD and CSE workers in my study commented on young people who have experienced CSE using alcohol as a coping mechanism, Dickson-Gomez et al. (2017) found that young people who were involved in sexual activity in gangs that they later regretted used alcohol to numb their feelings.

14.1.3 Young people - education and awareness of alcohol-related CSE

Educational programmes may be just one aspect of a wider approach. Bok and Morales (2000) suggest that when examining theories of behaviour change, educational programmes around drug use have been found to have a limited impact. The authors regard this as mainly due to the influence of peers: when peers positively reinforce behaviours around substance use, changes around this behaviour will be difficult. Instead, a more useful approach to keep young people safe should focus on harm reduction and prevention.

An important aspect of preventative action that needs improvement is helping young people understand the role that alcohol can play in CSE and the associated risks, particularly in peer settings.

The UK Government has identified schools as a good place for young people to receive educational messages around alcohol consumption. The young women in this study identified schools as a good place for young people to receive these messages around CSE and alcohol. More needs to be done in schools to raise young people's awareness about alcohol and CSE, including the potential relationship between them. The young women in my focus group considered that this would make a difference to young people's understanding of CSE and alcohol consumption, particularly if the two topics were dealt with together, rather than separately. Support for this approach can be found in a report by the Advisory Council on the Misuse of Drugs, which states that research has shown that for individuals with inter-related issues, interventions targeted at substance use alone are unlikely to be effective (Advisory Council on the Misuse of Drugs, 2022). The young women saw education on these topics in school as a precursor to accessing the support that would be needed if a young person experienced alcohol-related CSE. The absence of educational programmes that bring these topics together has an important implication for AOD workers because it is possible they will be the first person to provide messages around this. It is therefore important that they have the skills and time to provide this education to a young person, or to ensure that they can receive it elsewhere.

There is wider support for the views of the young women in this study. They are consistent with findings of research conducted by Yorkshire Men who have Sex with Men – Action in the Community (MESMAC), which was conducted in a consultation with a group of 22 boys and young men who were receiving support for CSE from Yorkshire MESMAC (Yorkshire MESMAC, 2017). Participants suggested that providing information on grooming and CSE in schools would have been helpful, as they had been unable to recognise it when they were being groomed. Schools are also an ideal place

to educate young people on where this support is available. The UK Government's 2017 Drug Strategy proposed that schools educate young people about alcohol and drug risks within their Personal, Social, Health and Economic (PSHE) sessions (Home Office, 2017).

The Department for Education recognises the need for early education for children and young people on CSE, stating that:

> Messages around child sexual exploitation should be delivered within a safe non-judgmental environment, by credible individuals who are confident discussing the issues and able to challenge unhelpful perceptions. Where specific vulnerabilities are identified (going missing, gang-association or drug/alcohol misuse, for example) more targeted educative work should be undertaken, while taking care to avoid stigmatisation or labelling. Accessible and appropriate support should be immediately available should any issues of concern be identified during education activity (Department for Education, 2017:21).

There are two relevant points in this guidance for the delivery of education on alcohol-related CSE. Firstly, the need for the messages around CSE to be delivered by credible individuals. Secondly, that more targeted support should be immediately available to young people where vulnerabilities such as alcohol consumption are identified. These two points will now be discussed in turn. They demonstrate that at the exosystem level, several important system changes are needed to ensure that the appropriate education and support is available for all young people.

It is open to question whether schoolteachers delivering education on alcohol and CSE as part of a broader PSHE curriculum will be regarded by young people as 'credible individuals who are confident discussing the issues'. The young women in my study suggested that schoolteachers would lack credibility and that that those with lived experience are best placed to deliver these sessions. The boys and young men taking part in the Yorkshire MESMAC study also thought that these sessions should be delivered by CSE specialists, rather than teachers (Yorkshire MESMAC, 2017). This an area

that might benefit from the input of AOD and CSE workers, together with teachers, school nurses and young people with lived experience, to ensure that those delivering the sessions have received appropriate training. A good example of how awareness of alcohol-related CSE can be promoted in schools is provided in a school nursing case study included in a Department of Health and Public Health England report (Department of Health and Public Health England, 2015). In response to an increase in the number of young people being sexually exploited for alcohol and drugs, all members of a school nurse team attended a CSE training programme, established links with specialist alcohol and drug services and the local child abuse investigation unit and provided CSE awareness sessions for school staff. When substance use among young people worsened, the school nurse worked with schools and alcohol and drug workers to provide 'whole school, targeted, and parent information sessions' (Department of Health and Public Health England, 2015:5) on drugs known to feature locally in CSE. The school nurses also worked directly with young people, through school PSHE programmes, by providing lessons on CSE to year 10 and 11 students. The school nurse reported that an evaluation of this work had increased awareness of CSE among the whole school community, improved safety planning for young people experiencing CSE and helped to contributed to early recognition of CSE.

The study by Dickson-Gomez et al. (2017) strengthens the case that interventions are needed to address the wider contexts within which alcohol and drugs and sexual activity are all taking place, of which parties are one example. This study also found that there is a need not just for education around alcohol and high-risk situations but also specific education covering alcohol and CSE together. However, the authors acknowledged that this would not tackle issues concerning young people using alcohol as a coping mechanism. The young women in my study suggested that this education is needed not just for young people but also for professionals such as teachers and counsellors to whom young people talk about their experiences.

Young people with lived experienced of CSE should work closely with schools and specialist workers to co-produce, design and deliver education about CSE, with the inclusion of topics that are often viewed as risk factors for CSE, including alcohol consumption.

Further research is needed into education and awareness-raising with young people about the impact of alcohol in relationships more broadly, to alert them to risks. This is supported by Waterman et al.'s (2017) findings on the need for awareness-raising sessions on alcohol and relationships for young people. The importance of awareness raising about alcohol has also been highlighted by the UK Government. The Department for Education has suggested that sex education in schools can be a key preventive factor for CSE, helping young people to 'stay safe and build resilience against the risks of exploitation' (Department for Education, 2015:2). This is an important point and one that the young people in my study felt needed improvement, particularly by including alcohol within this education.

The second important message within the Department for Education advice referred to above was for there to be targeted education and immediate, appropriate support available for young people where further vulnerabilities become apparent (Department for Education, 2017). Alcohol consumption should be recognised as one of these vulnerabilities, and immediate referral to specialist support for alcohol and drug use should be available where alcohol is identified as an issue during educative sessions on CSE. To be effective, this would require schools to have a good relationship with alcohol and drug services, so that there is a clear pathway for young people when alcohol use is identified. The school nurse case study described above shows that this can be achieved. The extent to which alcohol and drug services liaise with schools and whether this is effective is worthy of further exploration as part of a wider survey into alcohol and drug service practice in primary and secondary school education.

UK Government advice highlights the need for an immediate response by appropriate support agencies where a young person needs support for identified vulnerabilities (Department for Education, 2017). When we examine this through a critical lens, this study demonstrates that at the real level, due to service and funding cuts, such a response from services is not always possible. AOD and CSE workers said that funding cuts had led to higher thresholds for triggering a multi-agency response and reductions in the number of workers within a service. The young women illustrated the impact of this situation on young people when they talked about how pressures on services and higher thresholds for referral can mean that the inclusion of other specialist agencies only comes at crisis point. Tanskanen et al. (2011) found the same in their study of young people's help seeking for their mental health. An individual may not realise that they need help until they reach a crisis point, or their support service may not recognise a need for support regarding their mental health. Multi-agency working is often dependent on service providers being able to accurately identify risk, to decide if it meets the threshold required to instigate a multi-agency response. If intervention only happens when risk levels are higher, the work and support needed by a young person is likely to have increased and potentially become more complex. Assessing the current capacity of alcohol and drug services to support young people around CSE and the support that is needed to do so effectively should form part of the national audit recommended in s.15.3.

14.1.4 Explanatory model

The purpose of this model is to provide alcohol and drug services with a diagrammatic summary of the role of alcohol in CSE. As this study has highlighted to date, there is little formal training around CSE for them and nothing that sets out the alcohol-CSE relationship. Figure 4 (below) draws together all evidence reviewed within this research, combining the literature review (chapters 2-5) and the research with AOD and CSE workers and young women interviewed within this study (chapters 12 and 13), which together fulfil objectives 1 and 2 of my research. This model contributes to our understanding of the relationship between alcohol and CSE by drawing

together the different roles that alcohol can play within CSE and fulfils objective 5. It illustrates how the role of alcohol in CSE is not limited to one time point and that for some young people, its role can change throughout their experiences of CSE.

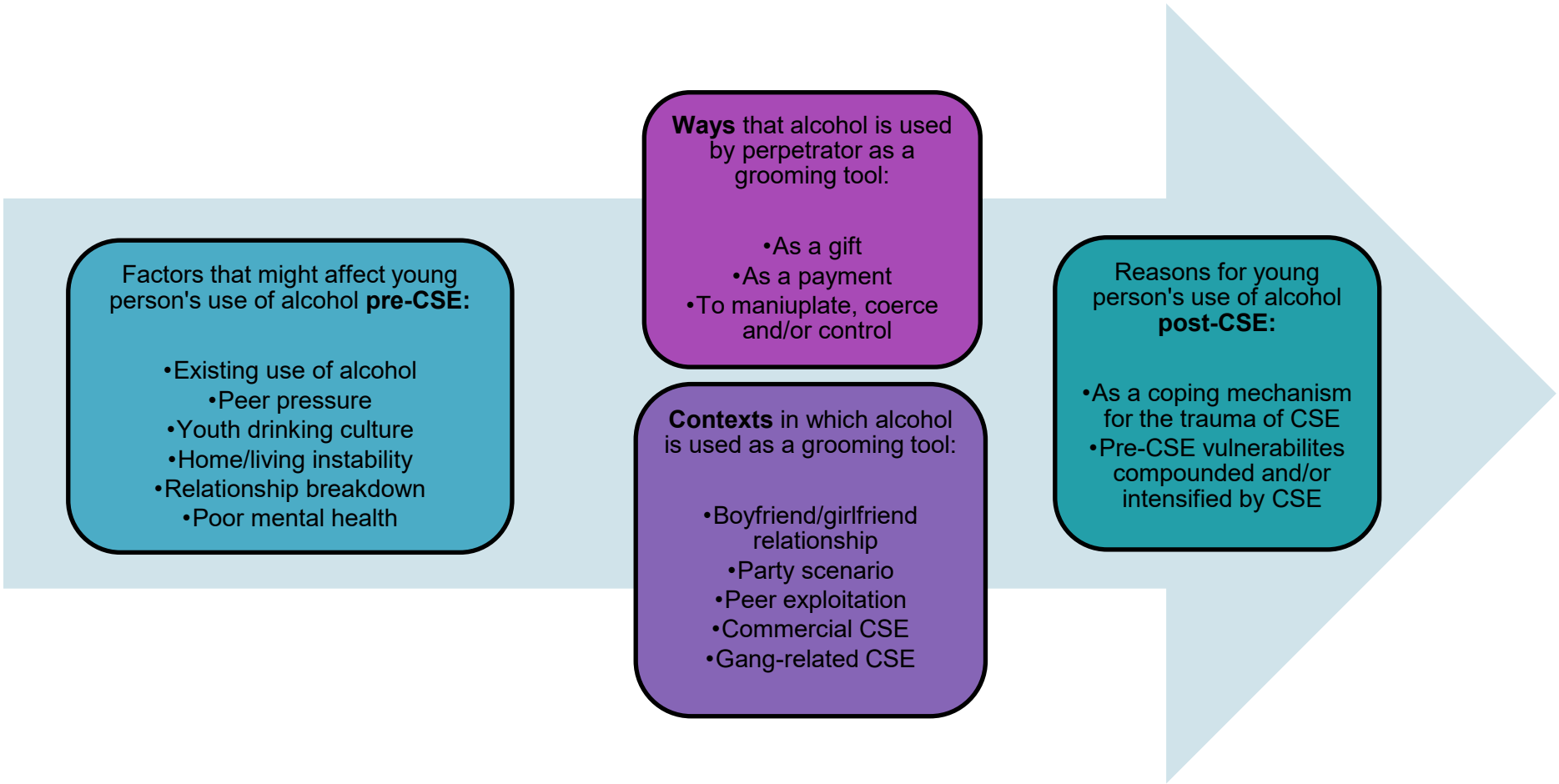

Figure 4: An explanatory model of the relationship between alcohol and CSE

The nature and range of factors cited on the left side of the model as affecting or influencing young people's use of alcohol prior to CSE demonstrate the complexity of this relationship. This part of the model illustrates how the link between prior alcohol consumption and CSE can become stronger when youth drinking culture is combined with peer pressure and underlying vulnerabilities in young people (summarised by one alcohol worker as 'difficult lives and low esteem' (Eleanor)), making the young people targets for perpetrators. The factors mentioned by the AOD workers as contributing to vulnerability, such as relationship breakdown (including with support services), the absence of a stable and loving home life, running away from home and poor mental health, are consistent with those identified in research literature (e.g. Eaton and Holmes, 2017). Galvani (2012:169) suggests that there may be 'several overlapping reasons' that a young person starts to consume alcohol and that these can change over time.

These factors can make a young person more susceptible to grooming. The centre of the model identifies a variety of contexts where a perpetrator can use alcohol as a tool to groom and sexually exploit a young person. It also illustrates how the role played by alcohol can change during the grooming process: as a 'gift' in the befriending and relationship-building stage, as payment during sexual exploitation and as means to manipulate, coerce and control both during and after sexual exploitation.

The right side of the model moves the focus of alcohol away from its use as a tool by the perpetrator, to its use as a coping mechanism by the young person subjected to CSE, as part of their attempt to manage the trauma that they have experienced because of the CSE.

This explanatory model shows how prior alcohol consumption can feed into the CSE process and then be used in various ways by perpetrators as part of the grooming process. It also recognises that alcohol consumption related to CSE does not necessarily stop after CSE and can continue to be a longer-term problem for young people.

I have discussed the complexity of agency in CSE, specifically referencing the added difficulties that alcohol consumption can add to this. By providing AOD workers with an explanatory model of the roles of alcohol in CSE, I aim to provide them with a tool to consider what else could be going on for a young person beyond their observable alcohol consumption. For example, it shows that where a young person could be perceived to be 'putting themselves at risk' at a party, their reasons for drinking could be part of a coping mechanism that is their best possible option in the circumstances.

14.2 The implications of alcohol-related CSE for alcohol service interventions (Aim 2)

The most important and original contribution of my research is its exploration of how alcohol and drug services support young people experiencing alcohol-related CSE. To recap, I have found that:

- The AOD workers who took part in my study were engaging with and responding to CSE when they encountered it.
- The AOD workers were confident in their ability to provide support for young people experiencing CSE, although this research was unable to assess the credibility of this claim.
- However, given that there are no policy, guidelines, role definitions or resource specifically focused on the relationship between alcohol and CSE, this support was not provided in a specific or consistent way. Instead, AOD workers often relied on their own experiences of supporting young people around CSE, or through applying generic CSE training to their role, using their own interpretations.
- The complexity of alcohol-related CSE means that there is a need for multi-agency working. There was some evidence of this in my research but participants often had to rely on informal networks to support young people.

I am not aware of any previous study that has examined the literature specifically relating to alcohol policy and practice relating to CSE or sought the perspective of specialists working in this area. This section will further

discuss my findings using an ecological systems framework for understanding practice. I will then explore one aspect of an individual worker's mesosystem – models of practice that relate to individual workers and their immediate colleagues - in more detail and propose an optimal approach for alcohol and drug services.

14.2.1 Service provision: an ecological systems framework

Ecological Systems Theory has been used as a framework for service improvement in a number of ways. Galvani (2017) applied it to workforce development relating to substance use. The Advisory Council on the Misuse of Drugs review of drug prevention (Advisory Council on the Misuse of Drugs, 2022) also recommends that the delivery of interventions should be embedded in an understanding of its relationship with wider systems. Bellis et al. (2015) argue that like many biological infections, violence is 'contagious' and that exposure to violence in childhood, makes individuals more likely to be affected by violence in later life. This suggests the need for early interventions for children and young people at risk. From a public health perspective, interventions in the individual and family microsystem need to be accompanied by measures at the other ecological systems levels to reduce social inequalities and change the cultural norms that accept violence. Key elements of such an approach would include: action at all levels, including media campaigns, to raise awareness and provide public information; steps to reduce situational risks such as the availability of alcohol, along with policing and enforcement measures; interventions to promote the resilience of young people, including individualised support for those at greatest risk.

I will now analyse the provision of support for alcohol-related CSE within the context of the wider systems and influences within which it sits. I will also identify what needs to be done to improve service provision at each level of this theoretical framework.

Chronosystem

The chronosystem relates to how changes over time impact on an individual, or in this case AOD workers. There have been several serious case reviews and high profiles cases of CSE that have mentioned alcohol (e.g., Jay, 2014; Newsam and Ridgway, 2020; Bedford, 2015). Several AOD workers within this study referred to them as having made an impact on their way of working. These cases have brought structural changes to how their alcohol services work with other agencies and support young people around CSE; they have also brought more awareness to the relationship: what may have been below the surface previously has in recent years been brought to attention.

Macrosystem

The macrosystem in relation to alcohol and drug services relates to the UK Government's standpoint on the issues of alcohol and CSE. Government policy demonstrates only a superficial understanding of the problematic relationship between alcohol and CSE. It is therefore unsurprising that there is little recognition that a targeted, joined up approach is needed to support young people experiencing CSE where alcohol is being consumed. Over the past decade the Government has produced numerous policies and commissioned reviews relating to substance use (Home Office, 2012; Home Office, 2017; HM Government, 2021; Public Health England, 2018; Black, 2021; Advisory Council on Drug Misuse, 2022). The 2012 Alcohol Strategy (Home Office, 2012) made only a brief and limited reference to children and young people; it did not extend to the role of alcohol and drug services for young people. It is only recently that UK Government policy (Home Office, 2017) has connected young people misusing drugs with other vulnerabilities that can heighten their risk of exploitation and acknowledged that young people attending an alcohol and drug service may present with underlying issues such as sexual exploitation. In some respects, the UK Government's 2021 Drugs strategy (HM Government, 2021) is a step backwards in recognising the connection between alcohol and CSE, making only one brief reference to sexual exploitation. However, we can hope that its aspirations to

‘rebuild’ substance misuse services and the professional workforce and deliver more integrated support services will have some impact on the treatment of young people experiencing CSE.

The findings of the Black and ACMD reviews (s.6.1.1) suggest that a decade of policy and strategy development has been largely wasted. The limited Government strategy around young people and alcohol fails to acknowledge and advise on the role of alcohol in CSE. The consequences of this can be seen in the mixed approach to supporting young people in different local authorities: there is no guidance on how to work with young people around CSE and there is evidence that some alcohol services are not regarded as a key service for a multi-agency response to CSE (Hertfordshire Safeguarding Children Partnership, 2019). This mixed response is evident in my research, with some local authorities adopting a joined-up approach to alcohol and CSE support and others taking a more siloed approach to service provision. Without clear guidance from the Government on a strategy around alcohol and CSE, the support that young people receive is a postcode lottery.

Exosystem

The exosystem in Ecological Systems Theory relates to the societal structures that are in place largely because of the national policies and belief systems that exist in the macrosystem. The past 10 years have seen an overt policy of austerity (discussed in ss.1.1, 6.1.2). Budgetary cuts have damaged both statutory and voluntary services, resulting in reduced specialist services such as those for alcohol and drugs (Galvani, 2017). Services can be understaffed and thresholds for support made higher. The Black review (2020, 2021) found that the quantity, quality and morale of the workforce was poor due to heavy caseloads and insufficient training.

Any significant improvement in AOD service provision is dependent on additional funding being made available. Most of the AOD and CSE support workers referred to the adverse impact of the current climate of funding cuts. In times of such cuts and pressures on services, it is important to understand

their impact on underserved groups and those who are at risk because of their alcohol consumption.

This study contributes to the evidence base on the impact of funding cuts by identifying what they can mean for day-to-day service delivery, an AOD worker's remit and the support experience for young people who are receiving support for alcohol-related CSE. The AOD workers identified several issues that deserve further attention, including the provision of specialist training and the impact of funding cuts on multi-agency responses. These are discussed below at the appropriate system levels

When reviewing service provision and funding requirements, senior managers and policy makers should seek to address funding issues as an urgent priority.

Without sufficient funding and adequate provision for children's services more generally, it is likely that the thresholds for implementing a multi-agency response will increase further, reinforcing the concern of one AOD worker that they may be left as the only local service providing support to a young person for both their alcohol use and CSE. This unsatisfactory situation puts more pressure on services and individual support workers to compensate for system failures when faced with young people with complex needs. It depends on AOD workers who are confident and have specialist knowledge in supporting young people around CSE and hazardous alcohol use. Without this, young people may not receive the quality of safeguarding and support they need to help them manage the complex circumstances they may be experiencing.

These budgetary constraints must be addressed to safeguard and support young people experiencing alcohol-related CSE. The Black review (2021) called for increased funding to help rebuild prevention, treatment and recovery services; the Advisory Council on Drug Misuse (2022) identified the need for long term public investment to support the needs of young people.

The UK Government has committed to this investment, including the employment of more specialist AOD workers. If this injection of funding were to include AOD workers who specialise in CSE, it could help move alcohol and CSE support towards the more optimal level (figure 5, s14.2.2). If and how this commitment is delivered remains to be seen.

The societal structures in place around alcohol and CSE support have a direct impact on the care provided to young people. Alcohol services fall under health systems, whilst support around CSE falls under welfare. They are governed by different policies and funding structures and have their own professional cultures. Guidelines need to be developed that encourage collaboration, to develop service provision that is coherent and consistent.

Mesosystem

The mesosystem relates to a collection of microsystems. For the purposes of supporting young people around alcohol-related CSE, the key agencies at this level are alcohol and drug services, CSE support services and other agencies that support young people. Multi-agency working and its associated training and skill development are therefore the focus within the mesosystem.

As discussed at the macrosystem and exosystem levels, the complexity of CSE and alcohol requires an effective joined up approach to working. The discussion of local policy and provision (s. 6.2.2) makes joined up, multi-agency engagement a critical component of support. The Children's Society guidance expresses what this should look like clearly and succinctly: 'clear roles, responsibilities, lines of communication and responsibility and accountability (Children's Society, 2017:19). CSE provision has a strong emphasis on a multi-agency response to child protection, which since June 2019 has been overseen by Local Safeguarding Partners that bring together local authorities, clinical commissioning groups and police to strengthen collaboration (s. 6.3.2).

The AOD workers I interviewed emphasised the importance of collaboration with colleagues in their support for young people experiencing CSE. Informal avenues of this kind have the potential to be very effective in terms of offering a relatively seamless, accessible and fast response to address the problems presented by young people experiencing alcohol-related CSE. However, the robustness of this process is questionable because it depends on local circumstances such as the co-location of services, individual expertise and interests and good interpersonal relationships. This was evident in my research. It cannot be a substitute for effective, formal multi-agency working.

My literature review identified evidence of good multi-agency practice and my own research found that the AOD workers I interviewed were all involved in multi-agency meetings. However, the comment of one AOD worker that agencies do not necessarily share perspectives and priorities and that multi-agency working can therefore be challenging, needs to be recognised. The AOD workers looked forward to having the opportunity to discuss individual cases of young people experiencing alcohol-related CSE. They felt attendance at these meetings is essential to build up an accurate picture of what is going on for a young person and ensure that they receive the appropriate support; alcohol services must have a seat at the table. AOD workers need these connections when they recognise that a young person may need support for CSE above the level that they are able to provide. Similarly, it will enable other agencies to recognise where alcohol is a risk factor and when more specialised alcohol support may be needed. For example, my research has shown that where CSE workers are subcontracted into an alcohol and drug service, they only have enough room to support a small caseload of young people. There is not enough resource to support all those in need. In a similar way, AOD workers' caseloads do not allow for intensive support around CSE. What we see is a binary, rather than cross-disciplinary approach to supporting young people around alcohol – regardless of the complexity of their situation or where CSE may be present.

Multi-agency working involves more than just attending meetings. It should offer the opportunity to attend training together to share experience and build lasting relationships. The CSE and AOD workers in my study discussed how there was insufficient time to attend such meetings and training. This is one factor that may contribute to the findings of the ACMD review that there is a lack of workforce competence in current service provision (Advisory Council on the Misuse of Drugs, 2022).

A discussion of the effectiveness of multi-agency working cannot avoid the issue of inadequate funding raised above. My research highlighted several consequences:

- A reduction in multi-agency engagement opportunities to share ideas and skills and networking more generally
- Higher threshold levels for drawing in a multi-agency response. At times, alcohol and drug services can be the only service supporting young people around CSE
- Lengthening waiting times for referral. A young person's circumstances, level of risk and willingness to engage with support could have changed by the time they secure an appointment

The alcohol workers also highlighted the importance of skills development and its role in turning training into practice through, for example, sharing experience and expertise by pairing experienced and inexperienced workers together. The importance of skills development is recognised in UK Government guidance relating to CSE: 'Training alone is not sufficient to ensure a skilled and confident workforce' (Department for Education, 2017:20). The guidance suggests that the workforce should be given opportunities to learn from other practitioners, through shadowing and peer observation, for example. This approach to shared learning would be particularly relevant for AOD and CSE professionals supporting young people experiencing alcohol-related CSE.

A cross-service approach of this kind needs an active multi-agency programme of training and skills development, something that the AOD workers felt was less commonplace, with more training now being provided in-house. UK Government advice is that individuals have access to training with others and that:

> Local safeguarding arrangements should provide high-quality training and other learning and developmental activities that are rooted in evidence, tailored to different professional groups and responsive to local learning needs (Department for Education, 2017:19).

Multi-agency training opportunities and engagement across alcohol and drug and CSE services should be a mandatory part of AOD and CSE workers' continuous development programmes (CPD), as they are necessary for the sharing of ideas and skills and to encourage networking between specialists.

It is clear from my study that currently there is not a specific alcohol and drug service response to CSE, which is often determined by individual service circumstances and resources. The finding that there is a lack of consistent response from alcohol and drug services, even across this small group of AOD and CSE workers, highlights the need for a better understanding of service provision in relation to alcohol-related CSE nationally, as I have recommended in s.15.3.

Because young people at the age of 18 are transitioned to adult services, AOD workers within these services are also using knowledge from training aimed at supporting the children of the adults with whom they work to support the 18 year olds who attend their services and are experiencing CSE. Without set guidelines, within this study we see adult services reaching out to young people AOD workers for support.

Microsystem

The microsystem concerns how an AOD worker relates to their role and their immediate peers. The national guidance discussed in s.6.1.3 states that all 10-15 year olds should be referred to a specialist child and adolescent mental health service (CAMHS) for a comprehensive needs assessment where physical, psychological, educational or social problems are identified as being associated with alcohol use. None of the AOD workers made any mention of this when discussing referral. One contributory factor to this could be the current constraints on alcohol services evident at the exosystem and mesosystem levels. An AOD worker's views of their role in supporting young people experiencing CSE depend largely on the practices of their place of work, their previous experiences and interests and the training they receive. It was clear that there were varying views amongst AOD workers I interviewed about what their role should be. Those who had received more training and who were involved within a multi-agency response to CSE believed that whilst their main focus was alcohol consumption, it was also within their remit to give messages around CSE. In contrast to this, workers who had less experience around CSE did not view it as central to their role, believing that a young person should receive this support from a different service. Their ability to support a young person around CSE is largely dependent on time, confidence and knowledge. The AOD workers in my research highlighted the need for more time than they would normally give when supporting young people who are experiencing CSE. Some workers also spoke about how these young people can go missing and disengage for periods of time, highlighting that there is a need to keep their cases open longer than for others. What came through in my research was that AOD workers want to support young people fully around their alcohol use and CSE, but the time and resource constraint deriving from the mesosystem and exosystem have an impact on what they were able to do, creating boundaries to their remit. Service provision for young people needing support around CSE and alcohol is piecemeal, dependent on their local authority provision.

AOD workers can only gain the knowledge and skills needed to support young people around CSE and hazardous alcohol use if they have the awareness of the connection and are provided with training about appropriate responses. Several AOD workers in this study commented that their knowledge came from their experience and mentioned a buddy system as a helpful approach to train and support newer members of staff. A system and group supervision such like this would certainly be useful to share best practice, along with appropriate individual supervision and support. However, this is not an adequate substitute for more formal training. It should be a high priority that AOD workers attend extensive training around CSE so that they have the knowledge and confidence to support a young person where the threshold for a multi-agency response has not been reached. Government guidance on the education and training of professionals dealing with CSE has been produced by the Department for Education (2017). AOD professionals should already be familiar with the more general topics identified, including those covering safeguarding young people and the development of practical skills in facilitating conversations with children and young people. The guidelines also identify important issues relating to CSE about which AOD professionals should be knowledgeable. These include multi-agency protocols relating to CSE, recognising that CSE is a form of child abuse and understanding the impact of trauma on a young person's behaviour. The findings of my study also suggest that assessing risk of CSE should be another important aspect for AOD worker training. My study has highlighted a gap in training covering the relationship between alcohol and CSE. This is relevant not just to AOD workers' ability and confidence in supporting young people but also to their credibility with young people and thus the willingness of young people to access alcohol and drug services.

A national training programme that covers the relationship between alcohol and CSE should be implemented. There should also be opportunities for local initiatives to meet local need.

It was apparent in my research that CSE training was not consistent and often limited to generic child protection training. One AOD worker also mentioned a transition to in-house training, reducing the range of topics covered and limiting information and experience sharing across services.

If AOD workers aren't given the time to attend this training, it is likely that support for young people will deteriorate further. Changes in the microsystem are only possible when exosystem and mesosystem changes are made. Where there is insufficient funding and provision to support an adequate number of specially trained AOD workers, microsystem changes are near impossible. This then seeps into an AOD worker's view of their remit and their confidence and knowledge to support a young person around CSE related to alcohol use. Many AOD workers may then take a very narrow view of their role. It is entirely unsatisfactory that the quality of support provided to young people is dependent on the initiative and commitment of individual workers. Local authorities should review their priorities regarding the resources they allocate to alcohol and CSE support.

In the current climate, where there are higher thresholds for multi-agency responses, funding cuts and decreasing retention of staff, greater demands on professionals mean that they need to have a broader knowledge and skills base than previously. Reduced availability of training raises questions at the mesosystem level. Further research is needed to examine how these changes to roles and job requirements impact on an alcohol and drug service, its workers and service users. This would require an exploration of the effectiveness of current structures, which are based on specialised workers with a specific remit for one issue such as alcohol, and whether these boundaries are becoming blurred and less relevant, perhaps requiring a 'hybrid professional' role.

14.2.2 Models of practice

As a result of the training gap identified above, an important finding of my study is that young people experiencing alcohol-related CSE are not benefitting from a consistent approach to the support they need from alcohol

services. There does not appear to be one accepted or recommended model of good practice that provides a robust framework for effective collaboration between alcohol and drug service providers and CSE services. A consistent approach would ensure that young people across the country are able to access equivalent, high quality support, regardless of location. Differing approaches to supporting young people can often be attributed to the complex nature of CSE, but this study found that they are also dependent on local practice and the resources available to an alcohol and drug service.

All of the AOD workers stated that they were vigilant to the presence of CSE for young people referred to them for harmful alcohol use and they tended to take a person-centred approach to support, tailored to individual needs. However, there were differences among the AOD workers' perceptions of their role that require further exploration to ascertain where the support for young people who have experienced alcohol-related CSE is best located. The AOD workers based in a young person's service were more likely to take a holistic approach compared to those who worked in adult services, who, like the CSE workers, believed that if young people wanted support for issues other than their own specialism, they should be accessing other services. It would suggest that working to a model of high CSE integration, whereby specialist CSE workers are situated within alcohol and drug services, would mean that young people would not have to be signposted between services, and would ensure that young people were receiving the best support needed.

There are a variety of models and relationships between AOD and CSE workers that exist on a spectrum. These are illustrated in figure 5 below, which is based solely on my research

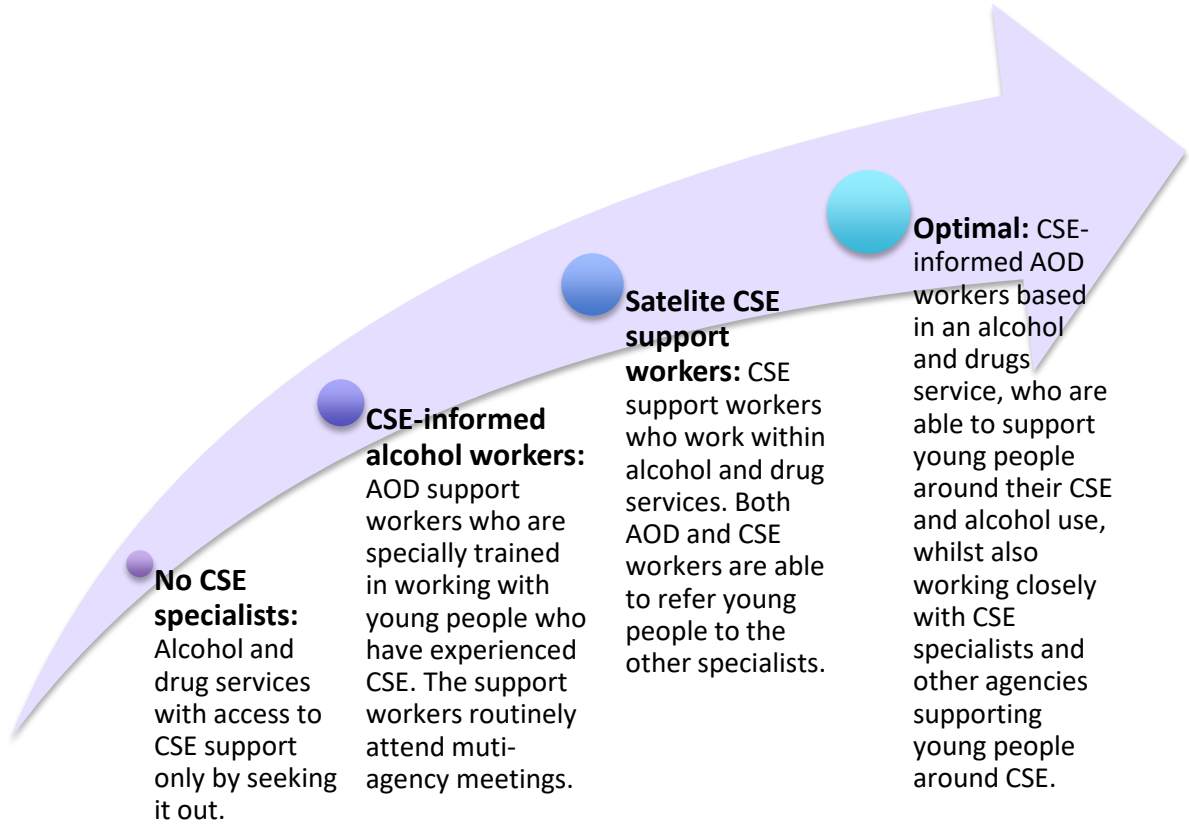

Figure 5: Models of CSE support within alcohol and drug services

No CSE specialists

Within this model, some AOD workers did not appear to have easy access to CSE specialists, relying more on formal referral processes. They took the view that if young people needed support for issues other than alcohol and drugs, they should seek help from specialists within those areas. This is not surprising, as they are likely to lack both expertise and confidence around CSE and good informal relationships with CSE specialists from whom they can seek advice. This model of practice is the least desirable for supporting young people experiencing alcohol-related CSE, as it is not conducive to the provision of the integrated, holistic approach that these young people require.

CSE-informed AOD workers

CSE-informed alcohol workers displayed confidence and knowledge in supporting young people around their alcohol use, together with an informed approach to supporting the young people around CSE. This model of service combines many of the features needed to provide effective support from the perspectives of both support worker and young person. On referral, young people receive an informed assessment that does more than just identify the possibility of CSE. A strengths-based approach may be effective when working with young people who have been exploited, to help them build resilience. This approach 'seeks to enhance positive development in youth' and takes a more holistic approach to an assessment of a young person, rather than only focusing on the risk factors in their life (Rhee et al., 2001:5). Garmezy (1993) states that it is important to look for the protective factors that counteract the risk factors present for a young person. The author suggests that the combination of protective and risk factors leads to a more accurate prediction of outcomes than assessments based solely on risk. The extent to which AOD services adopt a strengths-based approach could be explored in future research.

In this model, although support is focused mainly on alcohol-related issues, it is likely to be sensitive to any associated CSE and offer a more holistic approach and an understanding of what young people who have experienced CSE need. This approach would also support the comment of an AOD worker in my study, who talked about reinforcing the work of the CSE worker. It also acknowledges the comment made by another AOD worker that young people who have experienced CSE may need more investment of the AOD workers' time than other cases. Young people with alcohol-related CSE would benefit from access to these workers and other AOD workers would have more time for the other young people in their caseload.

To work most effectively, however, this way of working needs AOD workers who keep up to date with developments in CSE, have good working

relationships with local CSE specialists and integration into local authority multi-agency meetings.

Satellite CSE workers

My study included two CSE workers who were commissioned by alcohol and drug services to support young people around CSE. One of these workers was based in the same alcohol and drug service as one of the AOD workers who took part in the study, so having workers from both sides of this working relationship offers further insight into how it works in practice. At first glance, it should have provided an integrated approach to support. However, the services of which these CSE support workers were a part were similar in some ways to the AOD services with 'no CSE specialists' model. It was clear from the CSE support workers that they did not feel that they were able to support young people around their alcohol use and saw their focus as solely being on CSE, even though, or perhaps because, they were based within an alcohol service. While one of the CSE workers worked with young people who were referred to them by AOD workers for specialised support, the other CSE worker did not seem to have such a relationship with the AOD workers in the service for which she worked. Instead, it appeared that her work was very separate from that of her AOD colleagues and there were not many referrals from them. Although alcohol and drug services might have access to CSE workers who are notionally within the same service, this does not necessarily mean they are operating a joined-up approach.

White and Featherstone (2005) suggest that co-locating agencies does not automatically lead to better communication. Instead, training and time are needed for services and individual workers to understand how their different ways of thinking inform their working practices and to work with the other co-located agencies to understand how they work:

> The challenge for all involved in child welfare must be to encourage our 'lack of completeness' and thus our openness to each other's motifs and their 'rationalities'. Through this process we must subject our own and others' stories to ongoing reflection and scrutiny.

> Learning to listen, communicate and understand has to be a lifelong process, not a one-off training event (White and Featherstone, 2005:215).

Co-location on its own is unlikely to provide the answer to effective cross-specialist working. It can even detract from an integrated approach to support for alcohol-related CSE and result in a hardening of specialist boundaries and unnecessary referral.

The impact of this inconsistent approach to support for young people can be seen in the conclusions of a study by Gilburt et al. (2015). The authors found that pathways to support for harmful alcohol use can be fragmented and disempowering for young people who try to access them. Given that alcohol is used as both a facilitator of CSE and as a coping mechanism for the trauma caused by CSE, the support that young people require and respond to is varied and needs coordination across specialisms, extending beyond alcohol and drugs and CSE to mental health, for example. It requires services to have an awareness of the ways in which a young person is using alcohol and the most appropriate way to support each young person. This is exemplified in the comments of one AOD worker that it is sometimes not possible for a young person to reduce their alcohol consumption while still experiencing CSE when a perpetrator is supplying them with the alcohol. Even after the sexual exploitation has stopped, there is a high chance that a young person continues to experience the trauma. The requirements of support for one young person will differ from those for another.

Optimal

The need for a holistic approach to supporting marginalised young people has been highlighted by Robards et al. (2018), who suggested that professionals need to be better skilled in the issues for which marginalised young people may need support, including their mental health and trauma. This is relevant to young people who have experienced CSE, with several support workers in my study mentioning how the trauma that a young person has experienced impacts upon their drinking and the support that they need.

However, referral between services is inevitable for young people presenting with complex issues. Further exploration is needed of how these young people are signposted to other services and their engagement in those services after signposting, with a view to understanding whether this is an effective response to young people presenting with multiple issues, rather than one service dealing with multiple issues. This is particularly important in cases of alcohol-related CSE, where several support workers noted that the interlinking relationship can make it hard to focus on one without considering the other.

All young people attending alcohol and drugs services must have access to consistent and informed support, instead of it being a postcode lottery. My research spoke in depth to a relatively small group of specialist workers. It has served to highlight differences in practice. Further research is needed to determine what training, resources and collaborative working arrangements are needed by AOD services and how they can be targeted accordingly.

My suggestion for best practice in supporting young people around alcohol and CSE is represented in the ‘optimal’ model in Figure 5 above. This comprises CSE-informed AOD workers based in an alcohol and drugs service who can support young people around their CSE and alcohol use, whilst also having easy access to and working closely with CSE specialists and other agencies supporting young people around CSE. Co-location might help to alleviate some concerns. This may go some way to addressing the young women’s thoughts about being uncertain about where the alcohol and drug service was located and feeling uncomfortable in attending the service. This model may therefore work best when services are co-located, as identified by Robards et al. (2018) to help to alleviate problems of fragmented support. However, given the small sample size within this study, further research is needed to explore different models of CSE support within AOD services to determine which one is the most appropriate for each local area and how they can work together most productively.

Alcohol and drug services should consider the ‘Optimal’ model described above as a model of good practice, which is centred around specialist CSE-trained AOD workers who support young people around their CSE and alcohol use and work closely and seamlessly with CSE specialists and other agencies supporting young people around CSE.

14.3 Chapter summary

This discussion has summarised the contribution my research makes to understanding the relationship between alcohol and CSE and the implications of this for the delivery of support to young people experiencing alcohol-related CSE. The first part of my discussion has focused on several topics relating to the role of alcohol in CSE that my research has highlighted and which deserve further exploration or action – alcohol and the socially constructed views of childhood, the role of alcohol in peer group exploitation and the need for more effective awareness-raising of alcohol and CSE for young people. The second part of my discussion draws out from my research some important issues relating to the support for young people experiencing alcohol-related CSE that need to be addressed by alcohol services, ranging across national policy, funding, local service arrangements and delivery, training and skills development and the roles of AOD workers. I have also proposed an ‘optimal’ model of practice.

Chapter 15
Conclusions

15.1 Overview

The overall aims of my research were two-fold:

1. To develop a better understanding of the nature and extent of the relationship between alcohol and CSE, through the voices of service providers and young people.
2. To identify the implications of alcohol-related CSE for alcohol service interventions, through the voices of service providers and young people.

Ultimately, the goal was to contribute to a more informed alcohol service delivery to children and young people experiencing CSE.

The lack of research into the role played by alcohol in CSE was the rationale for my research focus. This is the first study to focus specifically on the role of alcohol in CSE. Research into CSE often refers to alcohol as a risk factor or coping mechanism but lacks the depth needed to inform the support that young people need when they are experiencing or have experienced alcohol-related CSE. Qualitative research involving young people experiencing alcohol-related CSE is very limited and no research has focused specifically on the views of alcohol and drug service providers on this relationship.

My research, therefore, aimed to explore the relationship between alcohol and CSE and to address the lack of attention paid to how alcohol service providers responded to it.

15.2 Research contribution

The most important contributions of my research derive from its status as the first study to focus specifically on the role of alcohol in CSE from the perspectives of AOD workers, both in terms of their understanding of this

relationship and their response to it when supporting young people. As such, this thesis offers an original contribution to knowledge about current CSE service provision in some alcohol and drug services. The contribution of my research extends further, proposing a new model for service delivery regarding alcohol-related CSE. It also provides the first explanatory model around alcohol and CSE directed at alcohol service practitioners, depicting the different ways that alcohol can be involved in CSE and the ways in which they can interact.

This study reports on the views of a small group of AOD workers. It pulls together the current evidence base for further studies to build upon, to strengthen the support that alcohol and drug services can provide to young people attending their services with alcohol-related CSE.

My methodological approach provides an original perspective on this topic by applying Ecological Systems Theory to the role of alcohol in CSE and the work of AOD workers around this topic. Its approach to placing the work of individual AOD workers in a broader ecological systems framework is unique. In doing so, this thesis has demonstrated the impact of wider social structures on the support that AOD workers are able to provide to young people around alcohol-related CSE. Previous research has commented on the impact of funding cuts on alcohol and drug services; my research contributes to the evidence base by reporting on its impact on alcohol and drug services in relation to the support that is available to a young person. It also highlights the enablers and barriers for AOD workers to provide appropriate support. It has highlighted what needs to change at all system levels to improve service delivery to people experiencing alcohol-related CSE.

Approaching the research from a critical realist standpoint has enabled my research to examine wider determinants of the way that AOD workers support young people with alcohol-related CSE and the role of alcohol for young people experiencing CSE. Critical Realism acknowledges that there are influences that cannot always be seen – something that is critical when considering a young person's agency and the decisions that they may make

in different situations.

By examining the role of alcohol in CSE and AOD worker responses, my study can propose recommendations for policy, practice and future research. These will now be discussed.

15.3. Implications for policy and practice

There are several implications for AOD services from this study.

1. *There needs to be greater recognition of, and a more consistent UK approach to, the way in which alcohol and drug services support young people with experiences of CSE*. There is a need for government policy and strategy to acknowledge alcohol's role in CSE more prominently and resource the training and education of AOD worker to a good standard. Policy also needs to resource implementation of a consistent service model similar to the 'Optimal' model identified in s.13.2.2.
2. *A nationwide audit of alcohol-related CSE responses within alcohol service provision should be undertaken*. The goal would be to determine the quality and consistency of current alcohol service provision relating to CSE and the capacity and capability of services to support young people experiencing alcohol-related CSE. The audit should include: how CSE is assessed; engagement with CSE services and specialists; the extent to which alcohol and drug services are engaged in multi-agency arrangements; how the cases of young people who experience alcohol-related CSE are managed; training and skills development for AOD workers.
3. *Greater emphasis and resource need to be provided for education and training of alcohol service professionals in CSE*. To ensure all AOD workers have the knowledge to support young people around CSE, a training programme that covers the relationship between alcohol and CSE should be implemented, with AOD and CSE professionals working together to develop the programme.

A national initiative led by an independent organisation such as an alcohol charity or a UK Government body such as the UK Health Security Agency (UKHSA) would ensure a more joined up and consistent approach. My research found that training opportunities were varied, with no specific training at all on the role of alcohol in CSE. This has meant that for some, while they may receive basic training on CSE, most knowledge and confidence comes from their own experiences, learning on the job.

4. *UK Government recommendations on using schools to deliver education to young people around alcohol should be expanded to include alcohol and CSE together*. The small number of young women who took part in this study believed that educating young people in schools and engaging the support of those with lived experience would help young people to be better aware of the role of alcohol in CSE. Young people with lived experienced of CSE should be invited to collaborate with schools and specialist workers to co-create, design and deliver education about CSE. This would include topics that are often viewed as risk factors for CSE, including alcohol consumption. Alcohol and drug services should be made aware of what education is on offer in schools as a reference point when beginning to support young people who attend their service, or to signpost them on to appropriate information and education.
5. *The UK Government should commission an awareness programme to increase understanding of CSE.* The views of the young women in the focus group present a different perspective on support and service provision, which also need to be taken into consideration. Their concern about the lack of understanding of CSE in the general population suggests that more education is needed not just for young people and the adults who work with them but also for people more generally, particularly when CSE-related issues are high-profile news.

15.4 Recommendation for future research

Larger scale studies are needed to determine practice and responses at a national level as well as expanding the evidence base. This thesis has highlighted the need for a better understanding of alcohol-related CSE to be reflected in national alcohol policy, local practice and the roles of individual practitioners. Further research could inform the implementation of service delivery by conducting larger studies with AOD and CSE workers. These studies might also substantiate the adverse impact of increasing pressures on the quality of service provision that have been caused by reductions in funding and growing pressures on service capacity and capability. The consequences of these pressures can be seen in how a reduction in funding can restrict training opportunities, with professionally delivered multi-agency training being replaced by in-house provision. This reduces cross-service engagement and the sharing of ideas. This, in turn, can contribute to lower levels of confidence and expertise for workers. When this is combined with higher threshold levels for referrals, my findings suggest that alcohol workers can find that they are the only service supporting a young person around CSE but may lack confidence to provide that support.

15.5 Concluding comments

This thesis is the first study to explore the role of alcohol in CSE, to inform alcohol service practice. Through interviews with AOD and CSE workers and a focus group with young women who have experienced CSE, this thesis has improved the understanding of the relationship between alcohol and CSE. It has investigated current practice and highlighted areas needing further research.

This thesis is also the first study to focus on alcohol services' support for CSE. It provides information and guidance to improve the support received by young people who have experienced, or are experiencing, alcohol-related CSE. It identifies areas needing further research and makes recommendations covering policy, models of practice, education, training and skills development.

Given the prevalence of CSE identified in s.3.2, it is vital that all services are adequately prepared to support young people. Alcohol and other drug services are no exception. They are well placed to do the work necessary, as they already work with people with histories of trauma and abuse. However, this needs to be consistent and informed by quality training and education. Young people who have experienced alcohol-related CSE deserve to have informed, empathetic and supportive responses and not rely on postcode lottery to determine whether they receive good care.

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Appendices

Appendix 1 – Young person discussion guide

1. Alcohol and drugs are often mentioned as being linked to the exploitation of children and young people. What do you think about this?

2. It's been suggested that perpetrators of CSE can use drugs and alcohol against a child or young person. How do you think a perpetrator might use alcohol?

3. You sometimes hear about drinking as a coping mechanism during and after exploitation. What are your views on this?

4. What kind of support do you think that children and young people who have been exploited need?

   We know that if people feel worried or frightened, they might use alcohol to numb these thoughts or feelings. What do you think about this?

Appendix 2 – Alcohol and drug worker discussion guide

Service provider discussion guide – Alcohol service

- What is your role?
  - How long have you been in this role?

- What do you think is the relationship between alcohol and CSE?
- In what ways do you think the two are related?

- What do you think is the interaction between alcohol and CSE?
  - *What comes first?*
  - *At what point in CSE do you think a young person may develop problematic drinking?*

- To what extent have you been involved in supporting young people with alcohol problems who have been sexually exploited?
  - *To what extent do you assess CSE and what does this cover?*
  - *How did you know that the young person had been sexually exploited?*
  - *Who defined it as sexual exploitation?*
  - *What kind of support did you provide in relation to….?*
  - *What are the main issues that they present with (apart from alcohol problems)?*

- How do you feel that the support you would provide to a young person with alcohol problems who has experienced CSE differs from that of other young people who have not experienced CSE?

- How equipped do you feel you are to support a young person who has been sexually exploited?
  - *Could you provide some examples?*

- What are the challenges you have experienced in supporting young people with alcohol problems who have experienced CSE?

- What do you feel your role is currently in supporting a young person who has experienced CSE?

- *What do you think your role should be in relation to CSE?*
- *What would you need in order to provide this service?*

- To what extent do you feel able to engage in discussions with a young person who has experienced CSE about their exploitation and alcohol use?

- What do you feel could help you to improve your service for young people who have been sexually exploited?
  - *Do you feel that you have enough information?*
  - *Do you feel that you would benefit from any training, if so what kind?*
  - *Have you had any specific training regarding CSE?*
  - *Does your service have specific policies on CSE? What are they?*

- Do you work with any other services around CSE?

- Could you recall a practice example of when you have supported a young person who has experienced CSE?
  - *How did you find out?*
  - *How did you work with the young person?*
  - *Did you feel confident in the support that you were offering?*

- Is there anything else that you would like to add?

Appendix 3 – CSE worker discussion guide

Service provider discussion guide – CSE professionals

- What is your role?
  - How long have you been in this role?

- What do you think is the relationship between alcohol and CSE?
- In what ways do you think the two are related?

- What do you think is the interaction between alcohol and CSE?
  - *What comes first?*
  - *At what point in CSE do you think a young person may develop problematic drinking?*

- To what extent have you been involved in supporting young people with alcohol problems who have been sexually exploited?
  - *To what extent do you assess alcohol use and what does this cover?*
  - *How did you know that the young person had problems with alcohol?*
  - *What kind of support did you provide in relation to problems with alcohol?*
  - *What are the main issues that they present with (apart from alcohol problems)?*

- How do you feel that the support you would provide to a young person with alcohol problems who has experienced CSE differs from that of other young people who do not have problems with alcohol?

- How equipped do you feel you are to support a young person who problems with alcohol?
  - *Could you provide some examples?*

- What are the challenges you have experienced in supporting young people who have experienced CSE and have problems with alcohol?

- What do you feel your role is currently in supporting a young person who has experienced CSE and has problems with alcohol?

  - What do you think your role should be in relation to alcohol problems?
  - What would you need in order to provide this service?

- To what extent do you feel able to engage in discussions with a young person who has experienced CSE about their exploitation and alcohol use?

- What do you feel could help you to improve your service for young people who have been sexually exploited and have problems with alcohol?
  - *Do you feel that you have enough information?*
  - *Do you feel that you would benefit from any training, if so what kind?*
  - *Have you had any specific training regarding CSE?*
  - *Does your service have specific policies on CSE? What are they?*

- Do you work with any other services around alcohol and drugs?

- Could you recall a practice example of when you have supported a young person who has problems with alcohol?
  - How did you find out?
  - How did you work with the young person?
  - Did you feel confident in the support that you were offering?

Appendix 4 - Email template, tweet, newsletter

Dear …,

My name is Jane Oyston and I am a PhD researcher at Manchester Metropolitan University. My PhD is examining the role of alcohol in child sexual exploitation (CSE) and is funded by Alcohol Change UK. The research will involve talking to young people aged 13-18 about their experiences of CSE and alcohol and also interviewing CSE service providers and also drug and alcohol service providers. The study has received ethical approval from Manchester Metropolitan University.

I am hoping to speak to staff from a number of CSE and alcohol and drug service providers and was wondering if this would be something that The BLAST Project would be interested in taking part in? Interviews would last approximately 30 - 60 minutes, depending on the amount that the individual has to say.

I have attached a copy of the participant information sheet which contains some more information. If it would be useful, I would be happy to discuss this further via email or over the phone (07966905376).

Best wishes,

Jane

Tweet: “Looking for services to take part in research on the role of #alcohol in #cse. Please DM if you are a CSE or alcohol professional within the UK who works with young people in these areas and would be interested in taking part.”

Newsletter: "My name is Jane Oyston and I am a PhD researcher at Manchester Metropolitan University. My PhD is examining the various roles alcohol may play in child sexual exploitation (CSE). The research will involve talking to i) young people aged 13-18 about CSE and alcohol, ii) professionals working in CSE services and iii) professionals working in alcohol and drug services. The study has received ethical approval from Manchester Metropolitan University.

I would like your help in three ways if possible:

1. I'd like some young people/young adults to take part in my research advisory group – these would need to be young people who have professional support already and feel able to talk about these issues without it harming them in any way.

2. I would like to speak to you and your colleagues if you are a CSE service provider – this can be done over the phone.

3. I would like your help to contact young people to talk to about their views on whether or not alcohol plays a role in sexual exploitation, and if so, what role it might play. I'm particularly interested in speaking to individuals and services in the Liverpool, Manchester and Sheffield regions so that this can be done face to face.

If you would be interested in taking part, please email me on jane.oyston@stu.mmu.ac.uk

Appendix 5 – Alcohol and drug worker participant information sheet

Participant Information Sheet for Alcohol Services Staff
The role of alcohol in the sexual exploitation of children and young people

I (Jane Oyston) am inviting you to take part in a research study. Before you decide, it is important that you understand why the research is being conducted and what it involves. Please take time to read the following information. Please ask me if there is anything that is unclear or if you would like more information. Take time to decide if you want to take part or not.

What is the purpose of the study?
You are being asked to take part in this study as part of my PhD studies to help gather more information on the relationship between alcohol and child sexual exploitation (CSE) and the support
provided to young people with these experiences. The project is funded by Manchester Metropolitan University and Alcohol Change UK.

Why have I been invited?
You have been invited to take part in this study because of your experience working within an alcohol service that may come into contact with children and young people who have been sexually exploited. I have approached the service for which you work, asking to be put in touch with people who might be willing and able to take part.

What will happen if I take part?
If you decide to be involved, you will be invited to take part in an interview with me. The meeting should only take a maximum of one hour and will be held at your office base or over the phone, depending on your preference. During the interview, you will be asked to share your experiences and opinions on supporting young people who have experienced child sexual

exploitation and on their relationship with alcohol and other substances. You will also be encouraged to share any thoughts on what support and resources you think would help you in this role.

Do I have to take part?
No. It is up to you to decide. Participation is entirely voluntary. I will describe the study and go through this information sheet, which I will give to you. I will then ask you to sign a consent form to show you agreed to take part. You are free to withdraw at any time, without giving a reason.
Ethical approval number (EthOS): 0463 Date: 16.01.2019

What are the possible disadvantages and risks of taking part?
As the interview will be discussing sensitive issues with regard to child sexual exploitation, there is a risk that you may get upset. If this happens at any stage, you will be free to pause or end the interview. After the interview, if you need any support, please speak to someone in your place of employment about the procedures that are in place to support your wellbeing or contact an external support service such as the Samaritans (08457 90 90 90).

What are the benefits of taking part?
The information provided will help to increase understanding of the role of alcohol in child sexual exploitation, and the resources needed by alcohol services to provide the necessary support.
It is hoped that the study will highlight important aspects of the relationship between alcohol and child sexual exploitation to raise awareness and inform the practice of professionals working in this area.

Will my taking part in the study be kept confidential?
Yes. The interview will be voice recorded (with your permission) to ensure that I am able to capture all of the information that is provided. This will be stored securely on an encrypted memory stick and computer and will only be listened to by me and my supervisors. All information that you provide during the study will be treated confidentially and stored securely in locked or password protected files in accordance with the Data Protection Act 1998. This will be stored securely for five years and will only be listened to by my supervisors and myself.
There may be exceptional circumstances when confidentiality may need to be broken – for example, if you suggest that you or someone else is at risk of, or is being harmed.

What will happen if I don’t carry on with the study?

If you decide to withdraw from the study after taking part, you should contact me. I will ensure that the information that you provide is not used within the research or any publications or events related to it. However, this will only be possible up to the point where the interview has been transcribed but not merged with information from other interviews. If you decide to withdraw it will not affect your role at your place of work.

What will happen to the results of the research study?
The information that you provide in the study will be incorporated into my PhD thesis and may also be included in academic publications and conference presentations. If you would like to receive information on the results of the study, I can send these to you if you give me your contact details and permission to use them.
Data from the study will be anonymised to ensure that participants or anyone else cannot be identified within any publications.
Further information and contact details:
For further information please contact Jane Oyston:
jane.oyston@stu.mmu.ac.uk

What will happen with the data I provide?

When you agree to participate in this research, we will collect from you personally-identifiable information. The Manchester Metropolitan University ('the University') is the Data Controller in respect of this research and any personal data that you provide as a research participant.

The University is registered with the Information Commissioner's Office (ICO) and manages personal data in accordance with the General Data Protection Regulation (GDPR) and the University's Data Protection Policy.

We collect personal data as part of this research (such as name, telephone numbers or age). As a public authority acting in the public interest, we rely upon the 'public task' lawful basis. When we collect special category data (such as medical information or ethnicity) we rely upon the research and archiving purposes in the public interest lawful basis.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained.
We will not share your personal data collected in this form with any third parties.
If your data is shared this will be under the terms of a Research Collaboration Agreement which defines use and agrees confidentiality and

information security provisions. It is the University's policy to only publish anonymised data unless you have given your explicit written consent to be identified in the research.
The University never sells personal data to third parties.
We will only retain your personal data for as long as is necessary to achieve the research purpose.
For further information about use of your personal data and your data protection rights please see the University's Data Protection Pages.

Who do I contact if I have concerns about this study or I wish to complain?
If you are worried about the study in any way, please contact me: (Jane Oyston:
jane.oyston@stu.mmu.ac.uk/ Brooks building, 53 Bonsall St, Manchester M15 6GX) and I will do my best to answer your questions.

If you feel that your questions have not been answered and you would like to complain about this, you can contact Professor Sarah Galvani, who is the Director of Studies for this research (0161 247 2579/ S.Galvani@mmu.ac.uk/ Brooks building, 53 Bonsall St, Manchester M15 6GX).

If you have any worries or a complaint about taking part in the study and want to talk to an independent person please contact Professor Juliet Goldbart, who is the faculty head of ethics (0161 247 2578/ J.Goldbart@mmu.ac.uk/Brooks building, 53 Bonsall St, Manchester M15 6GX).

This study has received ethical approval from Manchester Metropolitan University ethics committee. Reference: 0463

If you have any concerns regarding the personal data collected from you, our Data Protection Officer can be contacted using the legal@mmu.ac.uk e-mail address, by calling 0161 247 3331 or in writing to: Data Protection Officer, Legal Services, All Saints Building, Manchester Metropolitan University, Manchester, M15 6BH. You also have a right to lodge a complaint in respect of the processing of your personal data with the Information Commissioner's Office as the supervisory authority. Please see:
https://ico.org.uk/global/contact-us/

THANK YOU FOR CONSIDERING PARTICIPATING IN THIS PROJECT

Appendix 6 – CSE participant information sheet

Participant Information Sheet for CSE Services Staff
The role of alcohol in the sexual exploitation of children and young people

I (Jane Oyston) am inviting you to take part in a research study. Before you decide, it is important that you understand why the research is being conducted and what it involves. Please take time to read the following information. Please ask me if there is anything that is unclear or if you would like more information. Take time to decide if you want to take part or not.

What is the purpose of the study?
You are being asked to take part in this study as part of my PhD studies to help gather more information on the relationship between alcohol and child sexual exploitation (CSE) and the support
provided to young people with these experiences. The project is funded by Manchester Metropolitan University and Alcohol Change UK.

Why have I been invited?
You have been invited to take part in this study because of your experience working with children and young people who have been sexually exploited. I have approached the service for which you work, asking to be put in touch with people who might be willing and able to take part.

What will happen if I take part?
If you decide to be involved, you will be invited to take part in an interview with me. The meeting should only take a maximum of one hour and will be held at your office base or over the phone, depending on your preference. During the interview, you will be asked to share your experiences and opinions on supporting young people who have experienced child sexual exploitation and on their relationship with alcohol and other substances. You will also be encouraged to share any thoughts on what support and resources you think would help you in this role.

Do I have to take part?
No. It is up to you to decide. Participation is entirely voluntary. I will describe the study and go through this information sheet, which I will give to you. I will then ask you to sign a consent form to show you agreed to take part. You are free to withdraw at any time, without giving a reason.

What are the possible disadvantages and risks of taking part?
As the interview will be discussing sensitive issues with regard to child sexual exploitation, there is a risk that you may get upset. If this happens at any stage, you will be free to pause or end the interview. After the interview, if you need any support, please speak to someone in your place of employment about the procedures that are in place to support your wellbeing or contact an external support service such as the Samaritans (08457 90 90 90).

What are the benefits of taking part?
The information provided will help to increase understanding of the role of alcohol in child sexual exploitation, and the resources needed by services to provide the necessary support.
It is hoped that the study will highlight important aspects of the relationship between alcohol and child sexual exploitation to raise awareness and inform the practice of professionals working in this area.

Will my taking part in the study be kept confidential?
Yes. The interview will be voice recorded (with your permission) to ensure that I am able to capture all of the information that is provided. This will be stored securely on an encrypted memory stick and computer and will only be listened to by me and my supervisors. All information that you provide during the study will be treated confidentially and stored securely in locked or password protected files in accordance with the Data Protection Act 1998. This will be stored securely for five years and will only be listened to by my supervisors and myself.
There may be exceptional circumstances when confidentiality may need to be broken – for example, if you suggest that you or someone else is at risk of, or is being harmed.

What will happen if I don't carry on with the study?
If you decide to withdraw from the study after taking part, you should contact me. I will ensure that the information that you provide is not used within the research or any publications or events related to it. However, this will only be possible up to the point where the interview has been transcribed but not merged with information from other interviews. If you decide to withdraw it will not affect your role at your place of work.

What will happen to the results of the research study?
The information that you provide in the study will be incorporated into my PhD thesis and may also be included in academic publications and conference presentations. If you would like to receive information on the results of the study, I can send these to you if you give me your contact details and permission to use them.

Data from the study will be anonymised to ensure that participants or anyone else cannot be identified within any publications. For further information please contact Jane Oyston: jane.oyston@stu.mmu.ac.uk

What will happen with the data I provide?
When you agree to participate in this research, we will collect from you personally-identifiable information. The Manchester Metropolitan University ('the University') is the Data Controller in respect of this research and any personal data that you provide as a research participant. The University is registered with the Information Commissioner's Office (ICO), and manages personal data in accordance with the General Data Protection Regulation (GDPR) and the University's Data Protection Policy.

We collect personal data as part of this research (such as name, telephone numbers or age). As a public authority acting in the public interest we rely upon the 'public task' lawful basis. When we collect special category data (such as medical information or ethnicity) we rely upon the research and archiving purposes in the public interest lawful basis.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained.

We will not share your personal data collected in this form with any third parties. If your data is shared this will be under the terms of a Research Collaboration Agreement which defines agrees confidentiality and information security provisions. It is the University's policy to only publish anonymised data unless you have given your explicit written consent to be identified in the research. **The University never sells personal data to third parties.** We will only retain your personal data for as long as is necessary to achieve the research purpose.
For further information about use of your personal data and your data protection rights please see the University's Data Protection Pages.

Who do I contact if I have concerns about this study or I wish to complain?

If you are worried about the study in any way, please contact me: (Jane Oyston:
jane.oyston@stu.mmu.ac.uk/ Brooks building, 53 Bonsall St, Manchester M15 6GX) and I will do my best to answer your questions.

If you feel that your questions have not been answered and you would like to complain about this, you can contact Professor Sarah Galvani, who is the Director of Studies for this research (0161 247 2579/ S.Galvani@mmu.ac.uk/ Brooks building, 53 Bonsall St, Manchester M15 6GX).

If you have any worries or a complaint about taking part in the study and want to talk to an independent person please contact Professor Juliet Goldbart, who is the faculty head of ethics (0161 247 2578/ J.Goldbart@mmu.ac.uk/Brooks building, 53 Bonsall St, Manchester M15 6GX).

This study has received ethical approval from Manchester Metropolitan University ethics committee. Reference: 0463

If you have any concerns regarding the personal data collected from you, our Data Protection Officer can be contacted using the legal@mmu.ac.uk e-mail address, by calling 0161 247 3331 or in writing to: Data Protection Officer, Legal Services, All Saints Building, Manchester Metropolitan University, Manchester, M15 6BH. You also have a right to lodge a complaint in respect of the processing of your personal data with the Information Commissioner's Office as the supervisory authority. Please see:
https://ico.org.uk/global/contact-us/

THANK YOU FOR CONSIDERING PARTICIPATING IN THIS PROJECT

Appendix 7 – Ethical approval

Letter 1

09/09/2019

Project Title: The role of alcohol in child sexual exploitation

EthOS Reference Number: 0463

Ethical Opinion

Dear Jane Oyston,

The above amendment was reviewed by the Health, Psychology and Social Care Research Ethics and Governance Committee and, on the 09/09/2019, was given a favourable ethical opinion.

The approval is in place until 18/06/2020.

Conditions of favourable ethical opinion

Application Documents

Document Type	File Name	Date	Version
Additional Documentation	Gatekeeper PI	02/09/2019	2
Additional Documentation	Parent PI sheet	02/09/2019	2
Additional Documentation	YP 13-16 PI sheet FG	02/09/2019	2
Additional Documentation	YP PI sheet FG	02/09/2019	2

The Health, Psychology and Social Care Research Ethics and Governance Committee favourable ethical opinion is granted with the following conditions
Adherence to Manchester Metropolitan University's Policies and procedures
This ethical approval is conditional on adherence to Manchester Metropolitan University's Policies, Procedures, guidance and Standard Operating procedures. These can be found on the Manchester Metropolitan University Research Ethics and Governance webpages.

Amendments
If you wish to make further changes to this approved application, you will be required to submit an amendment. Please visit the Manchester Metropolitan University Research Ethics and Governance webpages or contact your Faculty research officer for advice around how to do this. We wish you every success with your project.
Art and Humanities Research Ethics and Governance Committee

Letter 2

20/09/2018

Project Title: The role of alcohol in child sexual exploitation

EthOS Reference Number: 0463

Ethical Opinion

Dear Jane Oyston,

The above application was reviewed by the Health, Psychology and Social Care Research Ethics and Governance

Committee and, on the 20/09/2018, was given a favourable ethical opinion.

The approval is in place until 18/11/2019.

Conditions of favourable ethical opinion

Application Documents

Document Type	File Name	Date	Version
Project Proposal	proposal	17/08/2018	2
Consent Form	Assent form for young people aged 13	06/09/2018	3
Consent Form	Gatekeeper Consent Form	06/09/2018	3
Consent Form	PAG Consent Form	06/09/2018	3
Consent Form	Parent consent form	06/09/2018	3
Consent Form	Service Consent Form	06/09/2018	3

Appendix 8 – Services consent form

Service Provider Consent Form: The role of alcohol in CSE

Title of project: The role of alcohol in the sexual exploitation of children and young people

Name of researcher: Jane Oyston

Please initial all boxes to confirm your understanding of the study and that you are happy for your service to take part.

1. I confirm that I have read and understood the participant information sheet provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time up until data analysis, without giving a reason and that this will not affect my legal rights. ☐

3. I understand that any personal information collected during the study will be made anonymous and remain confidential to the research team. It will only be used in the research, presentations and publications that are related to it. I understand that confidentiality will only be broken in the circumstances detailed on the information sheet that I have received. ☐

4. I understand that the meetings will be audio recorded and I am happy to proceed on this basis. ☐

5. I understand that parts of what I say may be used in future publications and presentations but that all quotes will be anonymised and identifying information removed. ☐

6. I agree to take part in the above study ☐

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

Jane Oyston: jane.oyston@stu.mmu.ac.uk

Appendix 9: Alcohol worker themes

(themes and sub-themes in italics were not considered to be relevant to research aims)

Theme	Description	Sub-themes
Drinking culture	The AOD workers spoke about the wider contexts in which alcohol was involved in a young person's life and how this could contribute to alcohol featuring in CSE, or to a young person being more susceptible to CSE when alcohol featured in their lives before CSE. This theme relates to Objective 2.	• Young people's drink and drug culture and CSE • *Environmental influences* • *Young person vulnerabilities*
Perpetrator use of alcohol	Codes that referenced grooming and the ways in which perpetrators would groom young people with alcohol were merged. This theme relates to Objective 2.	• Alcohol as a grooming tool • Boyfriend model and parties • Agency and victim blaming
Young people's use of alcohol in CSE	Young people's use of alcohol in CSE relates to Objective 2 and covers the different roles that alcohol can play. This ranges from the impact that alcohol can have on a young person in CSE, to the ways in which a young person might use alcohol to cope with what they are experiencing.	• Young people's previous substance use • Alcohol as a coping mechanism • Young people's susceptibility to CSE after consuming alcohol • Raising awareness of CSE
Alcohol and other substances	AOD workers were asked whether they felt there were differences in the way that alcohol was involved in CSE compared to other substances. Sub themes that compared alcohol to CSE were merged into this theme. This comparison is important, as although this study focuses specifically on alcohol, other research also discusses other substances. It is important to acknowledge their involvement but also to distinguish differences in use. This	• Prevalence of other drugs in CSE • Alcohol as a gateway to other substances • Other differences between alcohol and other substances in CSE • *Poly substance use*

	theme relates to Objective 2.	
Identifying CSE	The AOD workers discussed the ways that they would find out about and identify CSE. This could be from their own assessments or by receiving referrals from other services. This was important as it related to Objective 3 on AOD workers' response to CSE.	• Assessment of risk • Building trusting relationships • Conversations about alcohol consumption and CSE • Referral processes
The nature of support	Objective 3 focuses on AOD workers' responses to CSE. Their perceptions of their roles in relation to CSE are important in understanding their practices around CSE and the support that they offer young people.	• Role perceptions • Working practices and resources • Harm reduction
Collaboration and multi-agency working	Collaborative and multi-agency working focuses on how alcohol and drug services work with other services such as CSE services. This contributes to Objectives 3 and 4, focusing on what is currently in place and what needs to be improved for effective working.	
Training provision and skills development	Skills and training contribute to objective 4 in terms of what is needed for effective service delivery. Training and confidence in supporting young people is merged with staff with the right skills and training because they are interlinked by the need for good training, whilst also highlighting that in addition to training, there is a need for staff who can use their skills to put the training into practice.	• Training and confidence in supporting young people experiencing CSE and problematic alcohol consumption • Staff with the right skills and training
Challenges	Challenges around supporting young people regarding CSE and alcohol. The AOD workers mentioned recognition of risk and behaviour change as challenges that they face. Pressure on services is located here, as the time that is needed to work with a young person who has experienced CSE can be longer and more resource is needed to do so.	• Getting young people to recognise risk • Behaviour change • Pressures on services • Engagement and trust

Service improvement	Service improvement relates to Objective 4 and includes service specific needs for effective support for young people around alcohol and CSE.	
Trauma	*AOD workers talked about the impact of trauma on the work that they were able to complete with a young person and the need for workers to have an awareness of a young person's trauma if they were to support them effectively.*	• *Trauma bonding* • *Trauma informed practice*
CSE vs no CSE	*The AOD workers said their approach was person-centred and that there were few differences in their approach to young people who had not experienced CSE compared to those that had. Some workers commented about more time being needed to work with those who had experienced CSE.*	
Turning 18 and beyond aged 18	*AOD workers mentioned how turning 18 does not indicate an automatic change in the support that a young person needs regarding their alcohol use and experiences of CSE. The AOD workers spoke about the transitions into adult services and how it is not always appropriate.*	

Appendix 10: CSE worker themes

(themes and sub-themes in italics were not considered to be relevant to research aims)

Theme	Description	Sub-themes
Social and wider context	The CSE workers spoke about the wider contexts of alcohol use for both young people and adults. They described how this could often contribute to alcohol featuring in CSE, or to a young person not being aware of how alcohol was being used to groom them. This theme relates to Objective 2.	• Young person's drink and drug culture and CSE • *UK drink culture*
The role of alcohol in the grooming process	Codes referencing grooming and the ways in which perpetrators would groom young people with alcohol/entice young people with alcohol were merged. This theme relates to Objective 2.	• Alcohol as a grooming tool • Boyfriend model and parties
Young people and alcohol	This relates to Objective 2 and covers the different roles that alcohol can play, before, during and after CSE. The CSE workers spoke about how young people can use alcohol as a coping mechanism for the trauma that they experience.	• Young people's previous substance use • Alcohol as a coping mechanism
Young people and CSE	CSE workers discussed how alcohol was present in CSE, but not in all cases. The CSE workers also spoke about peer on peer sexual exploitation and how young people could use alcohol against each other. This theme relates to Objective 2.	• Perceptions of alcohol prevalence in CSE • Peer on peer exploitation • *Environmental influences*
Assessment	The CSE workers discussed alcohol consumption and CSE as part of a general assessment that they conduct when a young person first comes into their service. The CSE	• Assessment • Building trusting relationships • Conversations about alcohol

	workers also spoke about how they could also identify and discuss alcohol consumption and CSE once they had built rapport with a young person. This was important as it related to objective 3 on AOD workers response to CSE.	consumption and CSE
The nature of support	Objective 3 focuses on CSE workers' responses to a young person's alcohol consumption. This theme is important as is explains how CSE workers approach their work with young people who display hazardous drinking and what they see their role to be in relation to the drinking behaviour. This theme relates to Objective 3.	• Perceptions of role • Working practices and resources • Brief interventions
Collaboration and multi-agency working	Collaborative and multi-agency working discusses CSE workers' experiences of working with alcohol services and the need for collaborative working. This contributes to Objectives 3 and 4, focusing on what is currently in place and what needs to be improved for effective working.	
Training provision and skills development	Skills and training contribute to Objective 4, in terms of what is needed for effective service delivery. Training and confidence in supporting young people was viewed as important for the CSE workers to feel confident in being able to support young people who are experiencing CSE and hazardous drinking. This relates to Objective 4.	• Training and confidence in supporting young people experiencing CSE and hazardous alcohol consumption
Challenges	The CSE workers discussed challenges that they encounter when supporting young people around CSE. Challenges included getting a young person to engage with the support and trust the worker as well as behaviour change. Other challenges focused more on service provision and the pressures on services. This relates to Objectives 3 and 4.	• Information sharing • Getting young people to recognise CSE • Behaviour change • Engagement and trust • Pressures on services • Changes in alcohol and drugs usage

Service improvement	Service improvement relates to Objective 4 and includes service specific needs for effective support for young people around alcohol and CSE.	
Consent and positive relationships	*CSE workers spoke more generally of the importance of positive relationships and consent. Although this is an important discussion to be had around CSE and alcohol, it did not relate directly to my objectives and therefore was not included within the write up.*	

Appendix 11: Merged AOD and CSE worker themes and sub-themes presented in Findings

Understanding alcohol and CSE		**Service responses**	
Themes	*Sub-themes*	*Themes*	*Sub-themes*
Drinking culture		Identifying CSE	• Assessment of risk • Building trusting relationships • Conversations about alcohol consumption and CSE • Referral processes
Perpetrator use of alcohol	• Alcohol as a grooming tool • Models of grooming: the boyfriend/girlfriend model and parties • Agency and victim blaming	Supporting young people around alcohol and CSE	• Role perceptions • Working practices and resources • Harm reduction • Recognising, risk, changing behaviour • Brief interventions • Agency and victim blaming • Pressures on services • Barriers to accessing services
Young people's use of alcohol in CSE	• Young people's previous substance use • Alcohol as a coping mechanism • Young people's susceptibility to alcohol after drinking • Raising awareness of CSE	Collaboration and multi-agency working	

Alcohol, other substances and CSE	• Prevalence of other drugs in CSE • Alcohol as a gateway drug in CSE • Other differences between alcohol and other substances in CSE	Training provision and skills development	

Appendix 12: Young women themes

(themes and sub-themes in italics were not presented in Findings)

Theme	Description	Sub-themes
Alcohol and CSE	The young women spoke about how in the context of young people's drinking culture, a young person might not realise that alcohol is being used against them. They also discussed how the role of alcohol should not be overstated, as it is not always present. Perpetrator use of alcohol was combined within this theme, as the young people spoke of how age restrictions on young people buying alcohol could allow a perpetrator to purchase alcohol for them, which is linked to young people's drink culture. The relates to Objective 1.	• The relationship between alcohol and CSE • Perpetrator use of alcohol
Young person's recognition of alcohol and CSE	The young women spoke at length about the lack of awareness of CSE and how this was something that leaves young people at risk. They spoke of how more needed to be done in schools to address this. This theme therefore relates to Objective 4.	• Lack of awareness of CSE
Support for young people experiencing alcohol related CSE	The young women mentioned several reasons why young people might not seek help regarding their alcohol consumption. This theme explored these reasons and how they could be addressed. This relates to Objective 4.	• Barriers to accessing services • Overcoming the barriers to support

Appendix 13 – Gatekeeper participant information sheet

Gatekeeper Information Sheet

The role of alcohol in the sexual exploitation of children and young people

I (Jane Oyston) am inviting (*Name of service*) to take part in a research study as part of my PhD studies. Before you decide, it is important that you understand why the research is being conducted and what it involves. Please take time to read the following information. Please ask me if there is anything that is unclear or if you would like more information. Take time to decide if you want to take part or not.

What is the purpose of the study?

You are being asked to take part in this study to help gather more information on the relationship between alcohol and child sexual exploitation (CSE) from the perspective of children and young people.

The research project is funded by Manchester Metropolitan University and Alcohol Change UK.

What will happen if I decide to take part?

As a service that supports young people who may have experienced CSE, you have been identified as a potential gatekeeper for this research. I would like your support in identifying and recruiting children and young people with whom you work who have experienced CSE. This would include talking to them about my research and providing them with a participant information sheet. You would be the main point of contact for both myself and the young people.

I would contact you to report any safeguarding disclosures and concerns. If the concern cannot be dealt with appropriately, I will have a duty to contact the local authority or police, where appropriate, and will advise you of this action.

The perspective of staff working with these children and young people is also an important part of my study. If you agree, I may ask for your help in putting me in touch with any who might be willing and able to take part. This would take the form of a focus group.

Participation is entirely voluntary. If you decide to give consent for your service to participate you will be asked to sign a consent form. You may withdraw your consent at any time and without giving a reason. If you withdraw, all of the information that you have provided will be removed from the study up to the point where the interview has been transcribed but not merged with information from other interviews. If you decide to withdraw it will not affect yourself or your service.

What are the possible benefits of taking part?
The information provided will help to increase understanding of the role of alcohol in child sexual exploitation and the resources needed by alcohol services to provide the necessary support.

It is hoped that the study will highlight important aspects of the relationship between alcohol and child sexual exploitation, to raise awareness and inform the practice of professionals working in this area.

Will my taking part in the study be kept confidential?
Yes. The study will be voice recorded (with your permission) to ensure that I am able to capture all of the information that is provided. This will be stored securely on an encrypted memory stick and computer and will only be listened to by my supervisors and myself. All information that you provide during the study will be treated confidentially and stored securely in locked or password protected files in accordance with the Data Protection Act 1998. Confidentially will only be broken in exceptional circumstances, such as if your staff or service users suggest that someone is at risk of being harmed

Further information and contact details:
For further information please contact me (Jane Oyston: jane.oyston@stu.mmu.ac.uk)

What will happen with the data I provide?
When you agree to participate in this research, we will collect from you personally-identifiable information.

The Manchester Metropolitan University ('the University') is the Data Controller in respect of this research and any personal data that you provide as a research participant.

The University is registered with the Information Commissioner's Office (ICO) and manages personal data in accordance with the General Data Protection Regulation (GDPR) and the University's Data Protection Policy.

We collect personal data as part of this research (such as name, telephone numbers or age). As a public authority acting in the public interest we rely upon the 'public task' lawful basis. When we collect special category data (such as medical information or ethnicity) we rely upon the research and archiving purposes in the public interest lawful basis.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained.

We will not share your personal data collected in this form with any third parties.
If your data is shared this will be under the terms of a Research Collaboration Agreement which defines use, and agrees confidentiality and information security provisions. It is the University's policy to only publish anonymised data unless you have given your explicit written consent to be identified in the research. **The University never sells personal data to third parties.**
We will only retain your personal data for as long as is necessary to achieve the research purpose.

For further information about use of your personal data and your data protection rights please see the University's Data Protection Pages.

Who do I contact if I have concerns about this study or I wish to complain?
If you are worried about the study in any way, please contact me: (Jane Oyston:
jane.oyston@stu.mmu.ac.uk/ Geoffrey Manton Building, Rosamond Street West, Manchester M15 6LL) and I will do my best to answer your questions.

If you feel that your questions have not been answered and you would like to complain about this, you can contact Professor Sarah Galvani, who is the Director of Studies for this research (0161 247 2579/ S.Galvani@mmu.ac.uk/ Geoffrey Manton Building, Rosamond Street West, Manchester M15 6LL, Manchester M15 6GX).

If you have any worries or a complaint about taking part in the study and want to talk to an independent person please contact Professor Susan Baines who is the faculty head of ethics (0161 247 2511/ S.Baines@mmu.ac.uk/ Geoffrey Manton Building, Rosamond Street West, Manchester M15 6LL, Manchester M15 6GX).

This study has received ethical approval from Manchester Metropolitan University ethics committee. Reference: 0463
If you have any concerns regarding the personal data collected from you, our Data Protection Officer can be contacted using the legal@mmu.ac.uk e-mail address, by calling 0161 247 3331 or in writing to: Data Protection Officer, Legal Services, All Saints Building, Manchester Metropolitan University, Manchester, M15 6BH. You also have a right to lodge a complaint in respect of the processing of your personal data with the Information Commissioner's Office as the supervisory authority. Please see:
https://ico.org.uk/global/contact-us/

THANK YOU FOR CONSIDERING PARTICIPATING IN THIS PROJECT

Appendix 14 – Gatekeeper consent form

Gatekeeper Consent Form
Title of project: The role of alcohol in the sexual exploitation of children and young people Name of researcher: Jane Oyston

Please initial all boxes to confirm your understanding of the study and that you are happy for your service to take part.

I would require your support in identifying and recruiting children and young people with whom you work who have experienced CSE. This would include talking to them about my research and providing them with a participant information sheet. It would be envisaged that you would be the main point of contact for both myself and the young people, passing their contact details on to me if they were happy for you to do so. I would contact you to report any safeguarding disclosures and concerns.

1. I confirm that I have read and understand the gatekeeper information sheet provided for the above study. ☐

2. I understand that the participation of my service in the research is voluntary and that I am free to withdraw at any time up to the point of data analysis, without giving a reason and that this will not affect any legal rights. ☐

3. I understand that any personal information collected during the study will be anonymised and remain confidential to the research team. It will only be used in the research and in any presentations and publications that are related to it. I understand that confidentiality will only be broken in the circumstances detailed on the gatekeeper information sheet that I have received. ☐

4. I agree to my service and service users taking part in the above study. ☐

5. I agree to deal with safeguarding disclosures appropriately. ☐

Name of Gatekeeper: Date:
Signature:

Name of Researcher: Date:
Signature:

Jane Oyston: Jane.oyston@stu.mmu.ac.uk

Appendix 15 – Advisory group information sheet

Advisory group information sheet

The role of alcohol in the sexual exploitation of children and young people

I (Jane Oyston) am conducting research into the role of alcohol in the sexual exploitation of children and young people aged 13 – 18. I am looking for advice about what questions to ask from people who have also previously experienced CSE. I want to ensure that I minimise upsetting people and also ensure that carefully word the questions I ask. I am hoping you can help me with this.

I am therefore inviting you to provide feedback on these questions.

If, after providing feedback on the questions, you would still like to be involved in the research, there is an option to provide further feedback on the results of my study.

What are the possible disadvantages and risks of taking part?

You will not be asked about your own experiences but the questions may trigger difficult or painful memories in some way. If you become upset, you will be able to stop the discussion at any time and I will talk to you further about who you can contact if you feel you need support.

For support, you are able to contact Supportline on 01708 765200. You can also contact The Mix on 0808 808 4994 (under 25) or the Samaritans on 08457 90 90 90.

Will my contribution to the study be kept confidential?

Yes, although there are some exceptional circumstances in which I would need to break confidentiality – for example, if you disclose that you are at risk of harm, you are harming someone else or have harmed or intend to harm someone else.

With your permission, if you provide information over the phone or Skype, the discussion will be audio recorded to ensure that I am able to capture all of the information you provide. This will be stored securely and will only be listened to by my supervisors and myself. If you provide written feedback, with your permission this will also be included in my research. All information that you provide during the study will be treated confidentially and stored securely. This will be deleted after five years.

What will happen if I don't carry on with the study?
If you decide to withdraw, you should speak to me and I will ensure that the information that you have provided is not used within the research or any publications or events related to it. However, this will only be possible up to the point that I begin to write up my research.

What will happen to the results of the study?
The information that you provide for the study may be included in my thesis and may also be included in academic publications and events. If you would like to receive information on the results of the study, I can send these to you if you give me your contact details and permission to use them.
The findings of the study will be made anonymous to ensure that anyone who provides information cannot be identified. If any information does identify you – for example as a member of this group - you will be asked for consent for this and it will only be included if you agree.

What will happen with the personal information I provide?
When you provide advice, we will collect some personal information that identifies you, such as your name and contact details. We will not normally share this information with anyone else unless there are grounds to break confidentiality as identified above. If you would like to know more about how the University manages this information, please ask me.

Who do I contact if I have concerns about this study or I wish to complain?
If you are worried about the study in any way, please contact me: (Jane Oyston: jane.oyston@stu.mmu.ac.uk, Brooks building, 53 Bonsall St, Manchester M15 6GX) and I will do my best to answer your questions.

If you feel that I haven't answered your questions properly and you would like to complain about this, you can contact Professor Sarah Galvani, who is the Director of Studies for this research (0161 247 2579/ S.Galvani@mmu.ac.uk/ Geoffrey Manton Building, Rosamond Street West, Manchester M15 6LL).

If you have any worries or a complaint about taking part in the study and want to talk to an independent person please contact Professor Juliet Goldbart, who is the faculty head of ethics (0161 247 2578/ J.Goldbart@mmu.ac.uk/Brooks building, 53 Bonsall St, Manchester M15 6GX).
This study has received ethical approval from Manchester Metropolitan University ethics committee. Reference: 0463

THANK YOU FOR CONSIDERING THIS PROJECT

Data protection and GDPR

The Manchester Metropolitan University ('the University') is the Data Controller in respect of this research and any personal data that you provide as a research advisor.

The University is registered with the Information Commissioner's Office (ICO), and manages personal data in accordance with the General Data Protection Regulation (GDPR) and the University's Data Protection Policy.

We collect personal data as part of this research (such as name, telephone numbers or age). As a public authority acting in the public interest we rely upon the 'public task' lawful basis. When we collect special category data (such as medical information or ethnicity) we rely upon the research and archiving purposes in the public interest lawful basis.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained.

We will not share your personal data collected in this form with any third parties.

If your data is shared this will be under the terms of a Research Collaboration Agreement which defines use, and agrees confidentiality and information security provisions. It is the University's policy to only publish anonymised data unless you have given your explicit written consent to be identified in the research. **The University never sells personal data to third parties.**

We will only retain your personal data for as long as is necessary to achieve the research purpose.

For further information about use of your personal data and your data protection rights please see the University's Data Protection Pages.

Appendix 16 – Advisory group consent form

Advisory Group Consent Form

Title of project: The role of alcohol in the sexual exploitation of children and young people

Name of researcher: Jane Oyston

Please place your initials in all boxes to confirm your understanding of the study and that you are happy to contribute to it.

1. I confirm that I have read and understood the information sheet provided for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily ☐

2. I understand that my contribution is voluntary and that I am free to withdraw at any time up to the point of write up, without giving a reason and that this will not affect my legal rights. ☐

3. I understand that any personal information collected during the study will be made anonymous so that no one can be identified and remain confidential to the research team. It will only be used in the research, presentations and publications that are related to it. I understand that confidentiality will only be broken in the circumstances detailed on the advisory group information sheet that I have received. ☐

4. I understand that the feedback will be audio recorded and I am happy to proceed on this basis. ☐

5. I understand that parts of what I say may be used in future publications and presentations but that all quotes will be anonymised. ☐

Name of advisor Date Signature

Name of Researcher Date
Signature

Jane Oyston: jane.oyston@stu.mmu.ac.uk

Appendix 17 – Aged 13-16 participant information sheet

Participant information sheet for 13-16 year olds

Project title: the role of alcohol in the sexual exploitation of children and young people

I (Jane) am asking you and your parent or guardian if you would like to take part in my research. I am investigating young people's views on whether or not alcohol is involved in sexual exploitation. And if you think it is, in what way it might be involved. There are no right or wrong answers – I just want to hear what you have to say! This discussion will take place within a group.

Before you decide if you would like to take part, it is important for you to understand what my study is about, why I am doing it and what you would be asked to do. I have included some information here for you to read with your parent(s) or guardian(s) so that you can decide if you would like to take part – whether you do is up to you.

If you are unsure about anything or would like some more information you can contact me and we can chat about this before you make a decision.

I will ask you a few questions about your views on whether alcohol is linked with sexual exploitation of children and young people. I will also ask you for your views on what support children and young people may need for any problems with alcohol. I will not be asking you about personal experiences – I just want to hear what you have to say!

If you agree, I will audio record our discussion to help me remember what we have spoken about. The recording will be safely stored for 5 years. It will only be listened to by my

supervisors and myself.

If you would like to take part, we will talk at (name of service). It will take around 30 minutes to an hour, but this will depend on how much you want to talk.

If at any point you don't want to carry on, let me know and we will stop talking and I will ask someone from (name of service) to come and talk to you to make sure that you are O.K.
If you feel unhappy after you have taken part in the study, you should talk to your parent or guardian, someone from (name of service) or me. We will make sure that you have support for how you are feeling. You can also talk to Childline who you can contact for free on the phone on 0800 1111, you can also chat to them online by visiting their website: www.childline.org.uk

If you have any questions about the study, you can ask me and I will do my best to answer them and make sure that you have all of the information to help you to make a decision.

Below is some more detailed information about what you need to know:
What will happen to me if I take part?
If you agree, you will be asked to meet with me at (*name of service)* to talk about your views on alcohol and whether or not it is involved in sexual exploitation. To do this I will ask you a few questions for you to answer. This will be done with the other young people who attend the group with you There are no right or wrong answers. I just want to hear what you have to say. This should take between 30 minutes and an hour but it will depend on how much you want to say. If you agree, the discussion will be recorded so that I am able to listen back to it. The recording will be stored securely for 5 years and only my supervisors and myself will have access to it. It will then be destroyed.

What happens after I have taken part?
Other young people will also be taking part in this research and once I have spoken to all of them, I will listen to the audio recordings to help me write up my report for my University work. I will write up other reports from my research for people who provide support to read. Nothing you say will give away your identity in those reports.

Will I benefit from the study?
There are no direct benefits for yourself but the information you provide will help me to understand more about alcohol and sexual exploitation. I will pass this on to other people, for example, alcohol support services so they know how to support young people well.

What if I feel unhappy after I have taken part?
If you feel unhappy after you have taken part in the study, you should talk to your parent or guardian, someone from (name of service) or me. We will make sure that you have support for how you are feeling.
You can also talk to Childline who you can contact for free on the phone on 0800 1111, you can also chat to them online by visiting their website: www.childline.org.uk.

Why have I been invited?
You have been invited because (*Name of service attended*) has suggested you as someone who might have views on this subject and who may be willing to take part in the research.

Do I have to take part?
No - it is up to you to decide whether or not to take part. If you do take part, you will be asked to sign a form called a consent form giving your permission.

Will anyone know that I have taken part?
Only the service that told you about this study, other members of the discussion group, my supervisors at University, and myself, will know that you have taken part. Some of the things that you said to me might be used in my work, but I would not include your name or any other information that could identify you.

If you tell me something that makes me feel worried about you or someone else, I will tell (name of service) that I am worried to make sure that there is support for you.

What will happen if I don't carry on with the study?
You are free to stop talking to me at any time without giving a reason. If you decide that you don't want to be included in the study after taking part, please speak to me and I will make sure that what you have said is not used in my reports and conference talks. However, once the information you give me has been added to information from other people, I will not be able to delete it.

Who is funding the research?
The research is being funded by Manchester Metropolitan University and Alcohol Change UK.

If I need more information:

For further information please contact me: jane.oyston@stu.mmu.ac.uk

What will happen with the personal information I provide?
When you agree take part, we will collect some personal information, such as your name.
Manchester Metropolitan University will control this information to make sure it is managed safely and securely in accordance with national regulations (the General Data Protection Regulation) and the University's Data Protection Policy.
If you withdraw from the study, we will keep the information about you that we have already obtained.
We will not normally share your personal information with anyone else.
If it is shared this will be under the terms of a national agreement that guarantees it will be kept confidential and secure. The University will only publish information that cannot identify you, unless you have given your permission, in writing, to be identified in the research. **The University never sells personal data to other organisations or people.**
We will only keep your personal information for as long as is necessary for the research you have contributed to.
If you want further information about how your personal information is used and your data protection rights, you can go to the following link to the University's Data Protection Pages.

Who do I contact if I have concerns about this study or I wish to complain?
If you are worried about the study in any way, please contact me: (Jane Oyston: jane.oyston@stu.mmu.ac.uk/ Geoffrey Manton Building, Rosamond Street West, Manchester M15 6LL, Manchester M15 6GX) and I will do my best to answer your questions.
If you feel that I haven't answered your questions properly and you would like to complain about this, you can contact Professor Sarah Galvani, who is the Director of Studies for this research (0161 247 2579/ S.Galvani@mmu.ac.uk/ Geoffrey Manton Building, Rosamond Street West, Manchester M15 6LL, Manchester M15 6GX).
If you have any worries or a complaint about taking part in the study and want to talk to an independent person, please contact Professor Susan Baines who is the faculty head of ethics (0161 247 2511/ S.Baines@mmu.ac.uk/ Geoffrey Manton Building, Rosamond Street West, Manchester M15 6LL, Manchester M15 6GX).
This study has received ethical approval from Manchester Metropolitan University ethics committee. Reference: 0463

If you have any worries regarding the personal data collected from you, our Data Protection Officer can be contacted using the legal@mmu.ac.uk e-mail

address, by calling 0161 247 3331 or in writing to: Data Protection Officer, Legal Services, All Saints Building, Manchester Metropolitan University, Manchester, M15 6BH. You also have a right to lodge a complaint in respect of the processing of your personal data with the Information Commissioner's Office. Please see: https://ico.org.uk/global/contact-us/

THANK YOU FOR CONSIDERING PARTICIPATING IN THIS PROJECT

Appendix 18 – Aged 13- 16 assent form

Assent form for young people aged 13-15

Project title: The role of alcohol in the sexual exploitation of children and young people

Please circle ‘yes’ or ‘no’ to the questions below

Do you understand what this study is about? YES/NO

Have you had a chance to ask all the questions you want? YES/NO

Have your questions been answered in a way you understand? YES/NO

Are you O.K. with the researcher audio recording the session? YES/NO

Are you willing to take part? YES/NO

If you answered ‘no’ to any of the questions above or you don’t want to take part, don’t sign your name! If you do want to take part, please write your name below.

Your name

Date

Jane Oyston who is the researcher who explained this project to you needs to sign too:

Print Name

Sign

Date

Thank you for your help

Appendix 19 – Aged 16+ participant information sheet

Participant information sheet for 16-18 year olds

The role of alcohol in the sexual exploitation of children and young people

I (Jane Oyston) am inviting you to take part in a study that wants to hear the views of young people about alcohol and its relationship with sexual exploitation. There are no right or wrong answers and I will not be asking you about personal experiences – I just want to hear what you have to say! The research is part of my PhD studies at Manchester Metropolitan University. Before you decide whether or not to take part, it is important that you understand why the research is being conducted and what it involves. Please take time to read the following information or I can go through it with you. Ask questions if there is anything that is unclear or if you would like more information. Please take time to decide if you want to take part or not.

What is the purpose of the study?

The purpose of this study is to help people working in support services to understand more about the role that alcohol and other substances can play in the sexual exploitation of young people and to identify how they can improve their services.

Why have I been invited?

You have been invited to take part because (*Name of service attended*) has suggested you as someone who might have a view on this subject and may be willing to take part in the research.

Do I have to take part?

No. It is up to you to decide. You only take part if you want to. I will describe the study and go through this information sheet, which I will give to you. I will then ask you to sign a consent form to show you agreed to take part. You are free to withdraw, without giving a reason. Once I start writing up my study it is not possible to withdraw because peoples' views are then mixed in together. If you decide to withdraw it will not affect any services that you receive.

What will happen to me if I take part?

If you agree, you will be asked to meet with me at (*name of service)* to talk about your views of alcohol and give me your opinion on whether you think it is involved in the sexual exploitation of young people. This will be done with the other young people who attend the group with you. To help you do this, I will ask you a few questions around how alcohol and sexual exploitation might be linked. I will also ask you what support you think young people who have experienced this may need. This should take between 30 minutes and an hour, but it will depend on how much you want to talk about it. With your permission, the discussion will be audio recorded so that I am able to listen back to it and capture all of the information you provide. The recording will be stored securely for five years and only my supervisors and myself will have access to it. It will then be destroyed.

What are the possible disadvantages and risks of taking part?
When you are thinking about alcohol and sexual exploitation you may become upset. If this happens you will be able to stop the research at any time and we can talk about whether or not you want to continue and whether or not you would like some support.
After the interview, if you need any support, please contact (*name of service*). You can also contact Childline for free on 0800 1111 or chat online at www.childline.org.uk (up to the age of 19), The Mix on 0808 808 4994 (under 25) or the Samaritans on 08457 90 90 90.

What are the possible benefits of taking part?
There are no direct benefits for yourself but the information you provide will help people to understand whether or not alcohol is used in the sexual exploitation of young people, and if so, how. It will help to identify what alcohol services should do to provide good support. It will also help the professionals who support young people to be more aware of the relationship between alcohol and the sexual exploitation and hopefully improve the support they can provide.

Will my taking part in the study be secret?
Yes mainly. – This would only be broken if, for example, you suggest that you are at a) at risk of being harmed, b) harming yourself, or c) are harming someone else.

What will happen if I don't carry on with the study?
If you decide to withdraw from the study after taking part, you should contact me and I will ensure that the information that you have provided is not used within the research or any publications or events related to it. However, this will only be possible up to the point where the interviews from everyone are combined as it then becomes difficult to tell who said what.

What will happen to the results of the research study?
The information that you provide in the study will be included in my report and may also be included in articles, conferences or events. You will not be identified and anything you tell me will be made anonymous so that no one else can be identified. If you would like to receive information on the results of the study, I can send these to you if you give me your contact details and permission to use them.

Further information and contact details:
For further information please contact me: jane.oyston@stu.mmu.ac.uk

What will happen with the personal information I provide?
When you agree take part, we will collect some personal information, such as your name.
Manchester Metropolitan University will control this information to make sure it is managed safely and securely in accordance with national regulations (the General Data Protection Regulation) and the University's Data Protection Policy.
If you withdraw from the study, we will keep the information about you that we have already obtained.
We will not normally share your personal information with anyone else.
If it is shared this will be under the terms of a national agreement that guarantees it will be kept confidential and secure. The University will only publish information that cannot identify you, unless you have given your permission, in writing, to be identified in the research. **The University never sells personal data to other organisations or people.**
We will only keep your personal information for as long as is necessary for the research you have contributed to.
If you want further information about how your personal information is used and your data protection rights, you can go to the following link to the University's Data Protection Pages.

Who do I contact if I have concerns about this study or I wish to complain?
If you are worried about the study in any way, please contact me: (Jane Oyston: jane.oyston@stu.mmu.ac.uk/ Geoffrey Manton Building, Rosamond Street West, Manchester M15 6LL, Manchester M15 6GX) and I will do my best to answer your questions.
If you feel that I haven't answered your questions properly and you would like to complain about this, you can contact Professor Sarah Galvani, who is the Director of Studies for this research (0161 247 2579/ S.Galvani@mmu.ac.uk/

Geoffrey Manton Building, Rosamond Street West, Manchester M15 6LL, Manchester M15 6GX).

If you have any worries or a complaint about taking part in the study and want to talk to an independent person please contact Professor Susan Baines who is the faculty head of ethics (0161 247 2511/ S.Baines@mmu.ac.uk/ Geoffrey Manton Building, Rosamond Street West, Manchester M15 6LL, Manchester M15 6GX).

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THANK YOU FOR CONSIDERING PARTICIPATING IN THIS PROJECT

Appendix 20 – Aged 16+ consent form

Consent form for 16 – 18 year olds

Title of project: The role of alcohol in the sexual exploitation of children and young people

Name of researcher: Jane Oyston

Please place your initials in all boxes to confirm your understanding of the study and that you are happy to take part.

7. I confirm that I have read and understood the information provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily ☐

8. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and that this will not affect my legal rights. I understand that I am able to do this up until the end of April 2019. ☐

9. I understand that any personal information collected during the study will be made anonymous so that no one can be identified. It will remain confidential to the research team and will only be used in the research and in any presentations and publications that are related to it. I understand that confidentiality will only be broken in the circumstances detailed on the information sheet that I have been given. ☐

10. I give permission for the researcher to audio record the interview. ☐

11. I understand that parts of what I say may be used in future publications and presentations but that all quotes will be anonymised. ☐

12. I agree to take part in the above study ☐

Name of Participant Date Signature

Name of Researcher Date Signature

Jane Oyston: jane.oyston@stu.mmu.ac.uk

Appendix 21 – Parent participant information sheet

Information Sheet for Parents/Guardians

The Role of alcohol in the sexual exploitation of children and young people

I (Jane Oyston) would like to invite your child to take part in a study with Manchester Metropolitan University that is funded by Alcohol Change UK. The research is part of my PhD studies.

(*Name of service*), has agreed to participate in the study and is looking for children and young people who may be willing to take part. I would like your child to take part and for this to be possible I would need your consent. Here is some information on the study. Please read it carefully and if you are willing for your child to take part, sign below and return it to (*name of service*). If you do not provide consent, your child will not be able to take part in the study.

What is the purpose of the study?

The purpose of this study is to help to understand more about the role that alcohol and other substances can play in the sexual exploitation of young people and to identify how support services can help them better. We are interested in your child's views and opinions of alcohol and sexual exploitation.

What will happen if my child takes part?

If you and your child agree for them to participate, they will be asked to meet with me at (name of service) to take part in a discussion together with the other young people that attend the group. This discussion will be focused around four questions about how alcohol is involved in child sexual exploitation and also what support children and young people may need to help them with problems related to alcohol if they have been exploited. I will not be asking about personal experiences. Your child will be encouraged to talk on this topic for as long as they wish to do so. This should take between 30 minutes and an hour but it will depend on how much they want to talk about. If you agree, the discussion will be audio recorded so that I am able to listen back to it and capture all of the information your child provides. I will be present in the room with your child but I will make sure that service staff are on hand if your child needs someone to talk to. If you would like to come with your child, there will be

somewhere close by within the service where you will be able to wait whilst your child is talking to me.

Will the study be confidential?
Yes, although there are some exceptional circumstances in which I would be required to break confidentiality – for example, if your child suggests that they are at risk of being harmed or that they have harmed, or intend to harm, someone else.
The audio recording will be stored securely and anonymously for five years and then destroyed. It will only be listened to by myself and my supervisors.

Does my child have to take part?
No. Your decision whether or not to allow your child to take part will not affect the support that your child receives from (*name of service*). If you decide to allow your child to participate, you are free to withdraw your child at any time without affecting your relationship with (*name of service*). If you withdraw your child, all of the information they have provided will be removed from the study, up to the point where the interview has been transcribed but not merged with information from other interviews.

What will happen with the data provided by my child?
When you agree for your child to participate in this research, we will collect from them personally-identifiable information.

The Manchester Metropolitan University ('the University') is the Data Controller in respect of this research and any personal data that is provided by your child.
The University is registered with the Information Commissioner's Office (ICO) and manages personal data in accordance with the General Data Protection Regulation (GDPR) and the University's Data Protection Policy.

We collect personal data as part of this research (such as name, telephone numbers or age). As a public authority acting in the public interest, we rely upon the 'public task' lawful basis. When we collect special category data (such as medical information or ethnicity) we rely upon the research and archiving purposes in the public interest lawful basis.

Your rights to access, change or move your child's information are limited, as we need to manage their information in specific ways in order for the research to be reliable and accurate. If your child withdraws from the study, we will keep the information about you that we have already obtained.

We will not share their personal data collected in this form with any third parties.

If their data is shared this will be under the terms of a Research Collaboration Agreement which defines use and agrees confidentiality and information security provisions. It is the University's policy to only publish anonymised data unless you and your child have given your explicit written consent for them to be identified in the research. **The University never sells personal data to third parties.**
We will only retain personal data for as long as is necessary to achieve the research purpose.

For further information about use of personal data and your data protection rights please see the University's Data Protection Pages.

Who do I contact if I have concerns about this study or I wish to complain?
If you are worried about the study in any way, please contact me: (Jane Oyston: jane.oyston@stu.mmu.ac.uk/ Brooks building, 53 Bonsall St, Manchester M15 6GX) and I will do my best to answer your questions.

If you feel that your questions have not been answered and you would like to complain about this, you can contact Professor Sarah Galvani, who is the Director of Studies for this research (0161 247 2579/ S.Galvani@mmu.ac.uk/ Brooks building, 53 Bonsall St, Manchester M15 6GX).

If you have any worries or a complaint about taking part in the study and want to talk to an independent person please contact Professor Susan Baines who is the faculty head of ethics (0161 247 2511/ S.Baines@mmu.ac.uk/ Geoffrey Manton Building, Rosamond Street West, Manchester M15 6LL, Manchester M15 6GX).

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If you have any concerns regarding the personal data collected from you, our Data Protection Officer can be contacted using the legal@mmu.ac.uk e-mail address, by calling 0161 247 3331 or in writing to: Data Protection Officer, Legal Services, All Saints Building, Manchester Metropolitan University, Manchester, M15 6BH. You also have a right to lodge a complaint in respect of the processing of your personal data with the Information Commissioner's Office as the supervisory authority. Please see:
https://ico.org.uk/global/contact-us/

THANK YOU FOR CONSIDERING PARTICIPATING IN THIS PROJECT

Appendix 22 – Parent consent form

Parent/Guardian Consent Form

Title of project: The role of alcohol in child sexual exploitation: developing a model to inform practice.

Name of researcher: Jane Oyston

Please initial all boxes to confirm your understanding of the study and that you are happy for your service to take part.

1. I confirm that I have read and understand the parent/guardian information sheet provided for the above study. ☐
2. I understand that the participation of the child in my care in the research is voluntary and that I am free to withdraw at any time, without giving a reason and that this will not affect any legal rights. ☐
3. I understand that any personal information collected during the study will be anonymised and remain confidential to the research team. It will only be used in the research and in any presentations and publications that are related to it. I understand that confidentiality will only be broken in the circumstances detailed on the gatekeeper information sheet that I received. ☐
4. I understand that interviews will be audio recorded and recordings will be kept between the research team. ☐
5. I agree to the child in my care taking part in the above study. ☐

Name of Gatekeeper: Date:
Signature:

Name of Researcher: Date:
Signature:

Jane Oyston: Jane.oyston@stu.mmu.ac.uk