

Evaluating the Health Implications of Child Sexual Exploitation on Parents

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Acknowledgements

Many thanks go out to the members of Pace who gave up their time to participate in the survey and / or focus groups upon which this study has been built. Hopefully, your views will play a part in changing the awareness levels and culture surrounding CSE, particularly in respect of the services needed by parents and the contributions that parents can make toward tackling CSE.

Executive summary

This report was commissioned by Parents Against Child Sexual Exploitation (Pace) to explore any health impact of Child Sexual Exploitation (CSE) on wider family members. The project was designed in partnership between the National Centre for the Study and Prevention of Abuse (NCSPVA) at the University of Worcester and Pace. The methods adopted for approaching this hitherto un-researched area consisted of an anonymised internet based survey followed by two focus groups held in Leeds and London. A literature search was carried out which failed to locate any previous studies relating to any collateral effects on family members of having a child involved in CSE, suggesting that this study represents new area of research.

After the development of the initial survey a pilot was carried out, leading to minor amendments in questions asked. In total 53 out of 150 parents (35%) contacted via the Pace email database completed the survey. The two focus groups were attended by three and six parents respectively to explore health impact issues in depth. Participants in the survey and the focus group were predominantly parents although they were able to give examples of the health impact of CSE as it affected siblings, partners and wider family members. Such examples included depression in siblings and partners, self-harm by a sister, guilt carried by a brother that necessitated counselling and stress levels that took a couple to the point of relationship break-up.

The key findings of the internet based survey were that 88% of the respondents felt that their experiences of CSE had impacted upon their general health. In terms of the main health impacts reported, 40% of parents reported that they suffered with frequent headaches and 30% reported that they suffered with stomach pain or discomfort. A further 28% of parents reported experiencing breathing difficulties or chest pain. In regard to psychological health, a majority of respondents agreed (56%) that they felt disconnected from everyday life and activities. When considering sleep patterns, 84% agreed that their patterns were disturbed with 70% reporting that falling to sleep was difficult for them. Secondary trauma was also considered with respondents reporting similar agreements for having self-harmed or having thought about self-harming (30%) and the ending of their life (39%). Furthermore, respondents agreed that they experienced a heightened sense of anger (76%), intrusive and unwanted thoughts (58%) and the replaying of CSE related events in their heads (74%). Finally, when considering help-seeking, 45% of respondents agreed that they had visited their GP more frequently since the occurrence of CSE, with 72% reporting that they had been prescribed medication intended to help them cope with the effects of CSE.

The above survey findings were supported by the themes that emerged from the two focus groups. Analysis of the focus group transcripts revealed that CSE impacted upon both the physical and psychological health of parents including their ability to manage existing illnesses. Immediate and long term health implications were separately identified. A significant theme was that parents often neglected their own health in response to time and work pressures whilst also caring for

their child. Additional stresses were identified regarding the systems surrounding CSE – multi-agency working, changes of personnel and a lack of overall communication/empowerment. However, over time, there was realisation of the need to address parents' own health needs in order to continue supporting their child's needs. The focus groups revealed inconsistencies between front line professionals in response to parents' health concerns that had arisen from CSE. For example, many health professionals were perceived to have a lack of knowledge or understanding regarding the nature of CSE and specialist resources were often non-existent.

The findings above underline the complex and insidious nature of CSE that differentiates it from other forms of child sexual abuse and add further to its complexity in considering the collateral effect of CSE on the health of wider family members, particularly parents. As such, the report makes a number of recommendations. Firstly, there is a need for all front line professionals (health, social care, police, educators) to have specific training with regard to the nature of CSE, its associated processes and an awareness of appropriate specialist services and agencies. Secondly, parents need to be seen as experts on CSE whose own health should be maximised and promoted in order to enable them to best care for their children. Thirdly, all agencies should adopt models that swiftly identify parents as protective or not and then ensure that they work in full partnership with those protective parents. Fourthly, further research might usefully explore the effect of CSE on the health of siblings and extended family, the current study having concentrated primarily on the views of parents. Finally, Pace are well placed to build on their current literature for parents and might design a web-based or hard copy information sheet for use by a range of professionals that specifically advises parents in regard to looking after their own health, even when their child's needs seem overwhelming.

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1

Background

Evaluating the Health Implications of Child Sexual Exploitation on Parents

Working Together to Safeguard Children (HM Government, 2015, p. 93) describes sexual abuse as behaviour which:

“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.” CSE is a specific form of child sexual abuse which has been particularly noted within the English context (Jay, 2014).

The definition of Child Sexual Exploitation used to inform this report is that found in the Department for Children, Schools and Families (2009 p.9) publication *Safeguarding Children and Young People from Sexual Exploitation. Supplementary Guidance to Working Together to Safeguard Children*:

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

In March 2015, after a number of high profile cases of child sexual exploitation (CSE), the Prime Minister of the UK described child sexual exploitation as a national threat. Consequently, it was announced that the same priority would be given to child sexual exploitation by police that is given to serious and organised crime. However, despite this, CSE continues to be on the rise in the UK. Using data from The National Crime Agency and ChildLine, the NSPCC (2015) reported that the sexual abuse of children, including CSE, seemed to be increasing although this may be, in part, due to a greater willingness to report abuse following the high profile of sexual abuse cases in the media. More sexual offences against children (over 36,000) were reported in 2013/14 than at any time during the last decade alongside a gradual increase in child trafficking within the UK from 2011 to 2013, mainly for the purposes of sexual exploitation. ChildLine is reported to have experienced a 124% increase in referrals regarding sexual abuse and online sexual abuse since 2013/2014 with almost 12,000 counselling sessions (calls, online chats and emails) having taken place. Services such as ChildLine are clearly designed to support the direct victims of all forms of sexual abuse, including CSE in ways that are not available to parents of children involved in CSE,

although a lack of support services for the direct victims of CSE is still apparent across England (Association for Young People's Health, 2015).

An array of international research has been conducted regarding the direct health implications of various types of sexual exploitation and abuse which have been found to include post-traumatic stress disorder, depression, anxiety, low self-esteem self-harm and suicidal behaviours as well as sexually transmitted disease. Such research has considered the health implications for trafficked women (Muftic and Finn, 2013), experiences of interpersonal violence (Ouellet-Morin et al., 2015), of rape (Sachs-Ericsson et al., 2014) and of child sexual abuse (Herrenkohl et al., 2013). Over the last decade, there has been a 'conceptual shift' (Jago et al., 2011, p. 4) within the UK towards defining the sexual exploitation of children and young people as a serious form of abuse in which children and young people are constructed as victims. Child sexual exploitation has received increasing attention due to high profile cases reported in England's towns and cities – Rotherham (Jay, 2014), Rochdale (Griffiths, 2013), Oxford (Bedford, 2015), and Derby (Galley, 2010) by organised groups of men against girls. The media coverage frequently focused on the ethnic background of the perpetrators, the group based nature of the perpetration and the predominantly white female victims. There is a growing base of research /social policy imperatives (e.g. Brodie et al., 2011; Berelowitz et al., 2013; Cockburn and Bailey, 2014) that ranges from consideration of the prevalence and incidents of CSE, of the potential for re-victimisation in later life once CSE has been experienced and of the impact of CSE has on the child's physical and psychological health.

No research, however, exists on the collateral effects of family members who care for victims of child sexual abuse. Parallels regarding collateral impact on other family members might be found in the work of Cleaver et al. (2011) and Swanston et al. (2013) who have explored issues of the collateral effects on children hearing or witnessing domestic violence and found that this can traumatise children in ways that lead to emotional or psychological abuse. Evidence from the mainstream of caring research in the UK also suggests that very high percentages of all carers experience collateral negative health impacts arising from their caring roles. For example, Carers UK (2012) surveyed 3400 carers and found negative impacts reported regarding both their mental health (87%) and their physical health (83%). A YouGov (2013) report *Are Parents in the Picture? Professional and Parental Perspectives of Child Sexual Exploitation*, drew attention to the marginalisation in general of parents in the field of CSE and supported the notion that parents should be treated as partners and experts in tackling CSE rather than as failures who are to blame for their children's plight. This present study places parents of CSE victims centre-stage and is designed to fill in the research gap regarding the effect of CSE involvement on their own health, as further detailed in the following section.

Research question and aims of the project

The core research question of this study was:

What are the potential implications of involvement in child sexual exploitation on the health of parents?



The key aims of the study were:

- **To examine the direct impact of CSE on the physical and psychological health of family members.**
- **To explore the help-seeking practices of family members in relation to their own health and well-being.**
- **To gain an understanding to the barriers associated with seeking and achieving help.**



3

Methodology

The project employed an explanatory sequential, mixed-methods design (Creswell and Clark, 2010). This consisted of two stages – the first stage consisted of a quantitative survey distributed using Bristol Survey Online and the second stage considered qualitative aspects further through in-depth focus groups. As such, the first stage informed the second in relation to the key aspects/questions for consideration. Ethical approval was received from the University of Worcester's, Institute of Health and Society Ethics Committee; Approval Code PRPU240216. The target group for the survey were those members on the Pace database who had email contacts. Contacting this target group via email was seen as the most efficacious way of capturing a large amount of quantitative data, although this did exclude Pace members without email.

Pilot questionnaire

Developing the questionnaire

Following a review of the literature, it was established that whilst questionnaires existed considering the health of victims, there were no existing questionnaires that concerned the collateral health impacts of any type of abuse. Therefore a customised questionnaire was developed from previous literature and other questionnaire surveys exploring health and sexual crimes, academic peer review and through discussion with Pace staff the Collateral Health Impact Scale (Stephens-Lewis and Unwin, 2016) was developed. The final questionnaire consists of 36 items that are divided into five sub-sections. These sub-sections consist of:

1. General Health
2. Physical Health
3. Psychological Health
4. Secondary Trauma
5. Help-Seeking

A copy of the questionnaire can be found in appendix A.

Following this, the questionnaire was piloted with members of the target population via email distribution accessed through the Pace database. In total, nine parents completed the questionnaire providing comments on issues they believed to be of importance. Following analysis of this, the survey was adapted to add two new statements ('isolation from friends' and 'prescribed medication in order to cope with CSE') and some minor grammatical and layout errors corrected.

Questionnaire survey

Participants

The survey was distributed to parents on the Pace email database (150 out of a total of 336 parents with whom Pace are actively engaged). All respondents had direct current or previous experience of caring for a family member subject to CSE. A total of 53 (35%) responses were obtained.

Procedure

The final version of the Collateral Health Impact Scale and supporting documentation (Participation Information Sheet / Consent Form / Support Networks) were uploaded to the survey software, Bristol Survey Online and distributed to all parents on the Pace Data base.

Accompanying the survey were details of the scheduled focus groups which individuals were invited to attend, regardless of whether they filled in the questionnaire.

4

Focus groups

Focus group schedule

Following analysis of the survey data, a focus group schedule was developed in order to consider some key issues in more depth (see appendix B). The schedule consisted of five open ended questions designed to enable the participants to discuss their personal experiences in depth and expand upon themes that emerged from the survey data. Guide areas of focus group questioning explored issues such as how individuals prioritised their health when it was revealed that their child/family member had experienced CSE; what impact this revelation of CSE involvement had upon their health; whether they sought out any medical help or support from a GP or other health professional; the response of such professionals and how the help and support provided by agencies could be improved.

Participants

Two focus groups were conducted in Leeds and London during February and March. There were a total of nine participants recruited. The first group consisted of three female participants and the second consisted of six participants; three men and three women. All participants were parents of the child who had experienced / were currently experiencing the effects of CSE.

Procedure

On the day of the focus groups, the two research staff from the University of Worcester met the participants through introductions made by a Pace staff member. Once introductions were completed, the Pace representative left the room but was on site to provide support if needed.

Before proceeding with the focus groups, the facilitator introduced the participants to the study and its aims once again, explaining the issues involved in taking part in the project and their rights as participants. This information was also presented to them in written form (see appendix C for information sheet). Participants were then asked to complete and sign their consent forms (see appendix D) and return these to the assistant facilitator. Participants were also provided with a sheet of confidential support agencies (see appendix E).

Focus groups were recorded via the use of an electronic dictaphone and subsequently transcribed verbatim. The groups ran for approximately two hours per session, amounting to approximately 84 pages of data once transcribed.

Analysis

In order to generate themes relating to the key aims of the project, transcripts were analysed following Braun and Clarke's (2006) six stages of thematic analysis which examines raw data and then breaks it down into sub themes, using a coding method to analyse complex information.

Findings

Survey (Collateral Health Impact Scale)

A total of 53 (35%) parents responded to the Collateral Health Impact Scale. As regards gender, the large majority of respondents were female (89%, n. 29).

General health

Overall, there was a significant consensus across the respondents that their experiences around CSE had impacted upon their general health (n 44, 88%), with only 10 percent of parents agreeing that there was little to no impact (see figure 1). On assessing their perceptions of their health, 52 percent of parents reported that they did not ‘feel well and in good health’ (n.26) whilst 30% maintained that they felt in good health (n15). Finally, 84% (n42) of parents agreed or strongly agreed that both their physical and emotional health had been affected by CSE (see figure 2) whilst 43% (n 21) of parents believed that they had not moved on in life since the initial CSE.

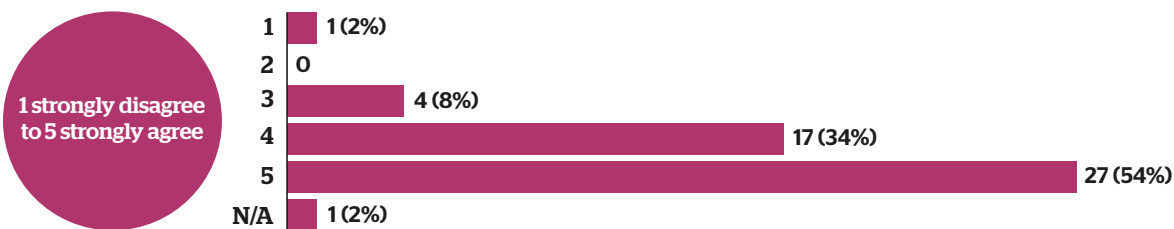


Figure 1. The sexual exploitation of my child has impacted upon my general health

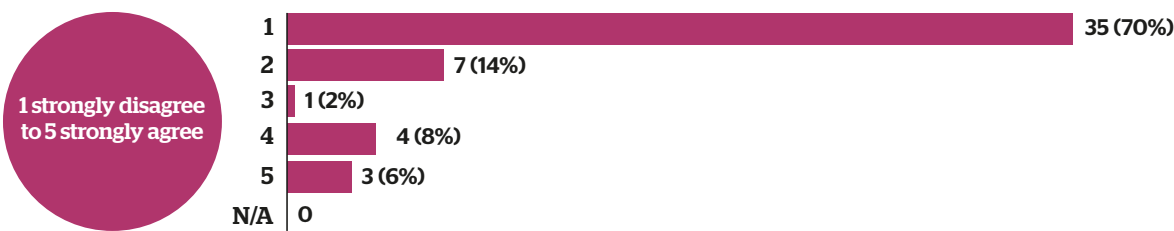


Figure 2. I feel that both my physical and emotional health have been affected by CSE

Parents were also asked whether they gave attention to their general health and self-care. Forty-eight percent and 44 percent of parents respectively agreed or strongly agreed that they paid attention to their own health and self-care, with 22 percent and 28 percent of remaining parents reporting that they ‘disagreed’ or ‘strongly’ disagreed that their physical and emotional health had been affected.

In assessing parents ‘abilities to manage day-to day activities’, two items were developed on the scale; ‘I feel that I am managing in day-to-day activities’, and ‘managing day-to-day activities can be difficult’. For the first of these items 36% (n 18) of parents reported ‘disagreement’ or ‘strong disagreement’ that they are managing daily activities (see figure 3) whilst for the second item, 54%

Findings

of parents reported agreement or strong agreement with the statement that their management of daily activities was sometimes difficult (see figure 4). Additionally, when considering parents' employment, 46% of parents reported agreeing or strongly agreeing that they took time off work due to ill health attributed to the impact of CSE.

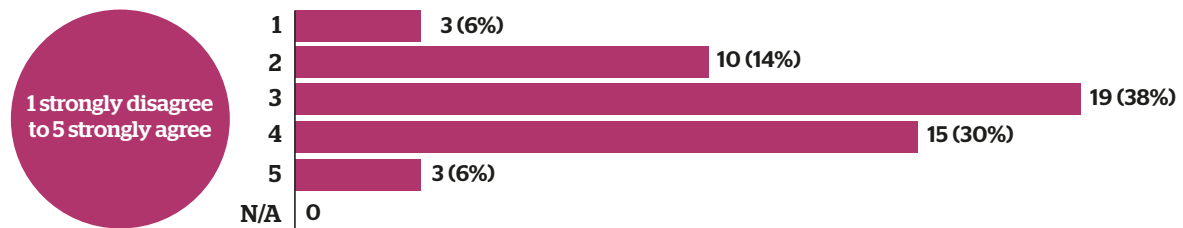


Figure 3. I feel that I am managing in day-to-day activities

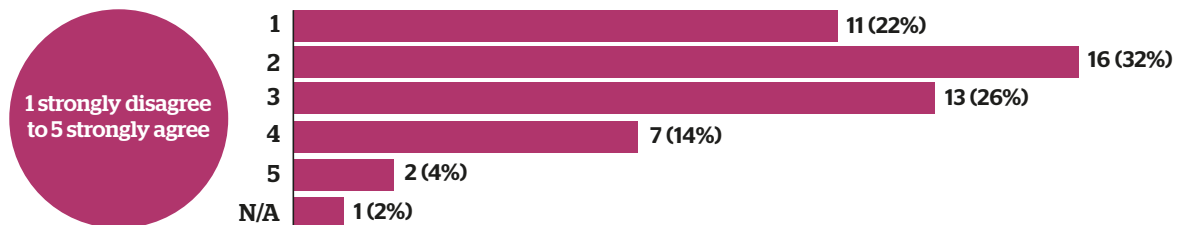


Figure 4. Managing day-to-day activities can be difficult

Physical health

When considering the sub-section relating to physical health, 78% of parents agreed or strongly agreed with the statement 'I often feel physically exhausted' (see figure 5). Within this sub-section, parents were asked if they agreed or disagreed with a number of statements relating to their physical health. Whilst 40% (n20) of parents agreed or strongly agreed that they suffer with frequent headaches, 30% (n15) agreed or strongly agreed that they suffered with stomach pain or discomfort. Finally, 28% of parents reported experiencing breathing difficulties or chest pain whilst 50% (n25) reported experiencing panic attacks.

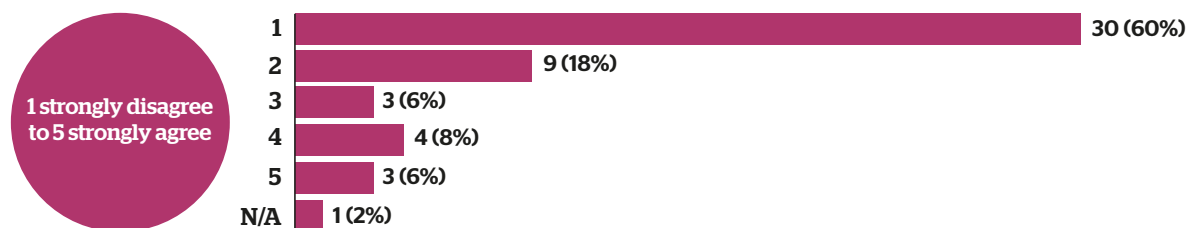


Figure 5. I often feel physically exhausted

Psychological health

A large proportion of parents who responded agreed or strongly agreed (56%, n28) that they felt disconnected from everyday life and activities with only 12% (n6) reporting that they disagreed or strongly disagreed with this statement (see figure 6). Additionally, when asked if they found it hard to relax and unwind, 70% (n35) of parents agreed or strongly agreed with this statement.

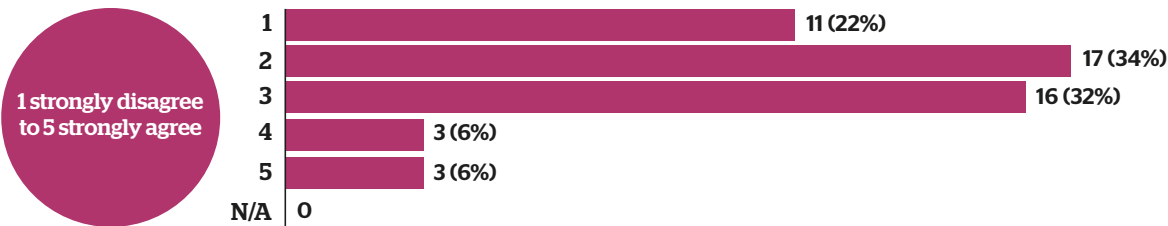


Figure 6. I feel disconnected from everyday life and activities

Parents were also asked a series of questions surrounding their eating habits and sleeping patterns. Overall, whilst 36% (n18) of parents agreed or strongly agreed that they had been eating more than they would usually, 47% (n23) reported missing or avoiding food. When considering sleep patterns, the large majority of parents who responded agreed or strongly agreed that their patterns were disturbed (84%, n42; see figure 7). With regard to disturbed sleep patterns, 70% (n35) of parents strongly agreed that they experienced disturbed sleep patterns with 52% reporting strong agreement that they experienced difficulties in falling asleep and staying asleep (see figure 8), although 34% (n17) reported that they were sleeping more than usual.

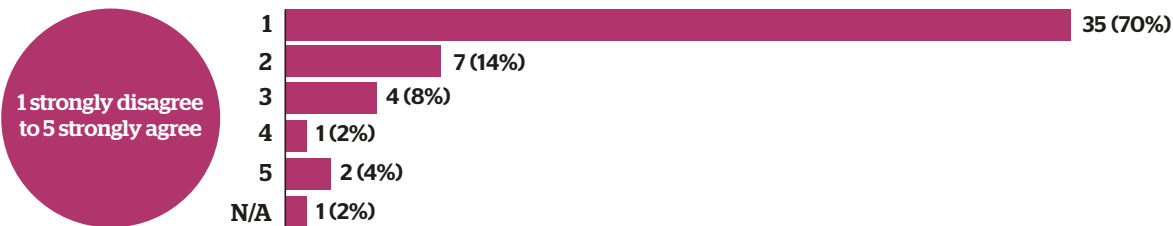


Figure 7. I have disturbed sleep patterns

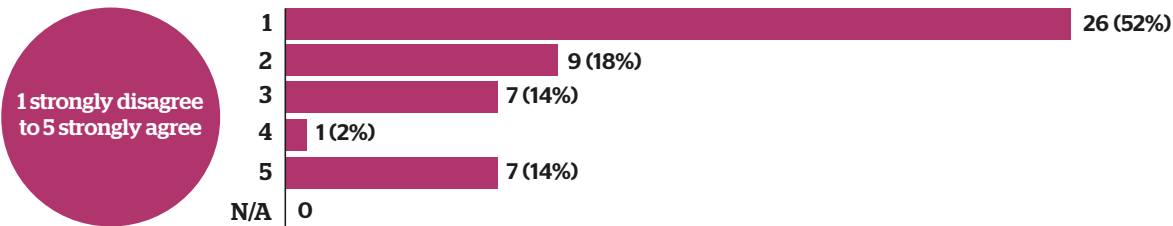


Figure 8. I have difficulties falling asleep and staying asleep

Secondary trauma

Parents were asked if they had or had considered self-harming or considered ending their life. Figure 9 shows that 30% (n15) of parents had either had self-harmed or had considered self-harm whereas Figure 10 indicates that 39% (n19) had considered taking their own life as a result of CSE.

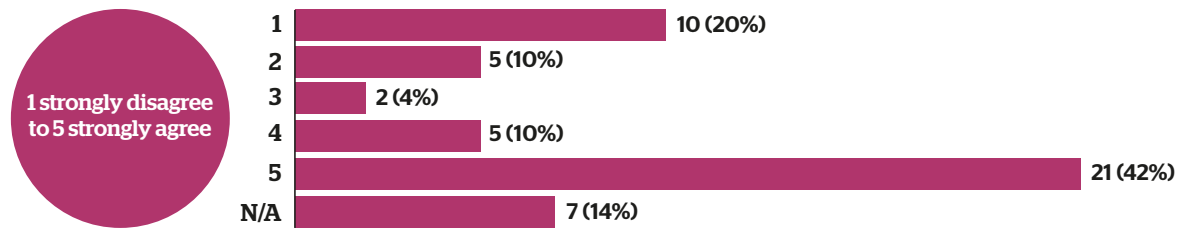


Figure 9. I have self-harmed or have considered self-harming

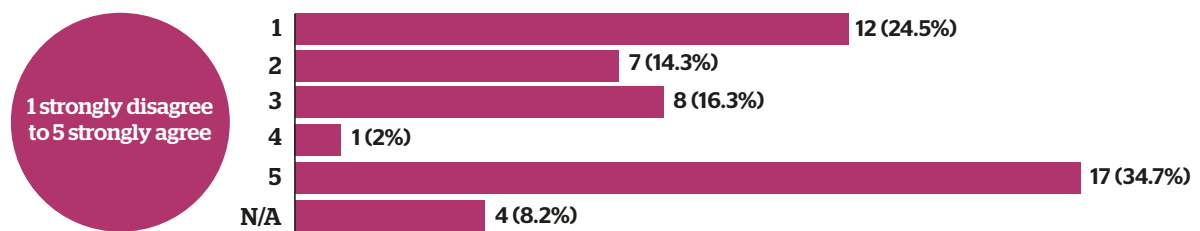


Figure 10. I have considered ending my life

Whilst 82% (n30) of parents reported that they felt helpless when thinking about their family member, 60% (n30) of parents also agreed or strongly agreed that they blamed themselves for the CSE. A large proportion of the parents who responded reported that they agreed or strongly agreed to experiencing feelings of shame (52%, n26) and of guilt (72%, n36). Furthermore, parents agreed or strongly agreed that they experienced a heightened sense of anger (76%, n38), intrusive and unwanted thoughts (58%, n 28) and the replaying of CSE related events in their heads (74%, n37).

Help-seeking

When considering parents’ help-seeking practices, 72% (n36) reported to agree or strongly agree that they actively sought out support from agencies whilst 34% (n17) reported that they preferred to keep their experiences to themselves. Additionally, 45% (n21) of parents agreed or strongly agreed that they had visited their GP more frequently since the occurrence of CSE with 72% (n36) agreeing that they had been prescribed medication intended to help them cope with CSE. Finally, a number of parents reported feelings of isolation from friends and family (64%, n22; 60% n20, respectively).

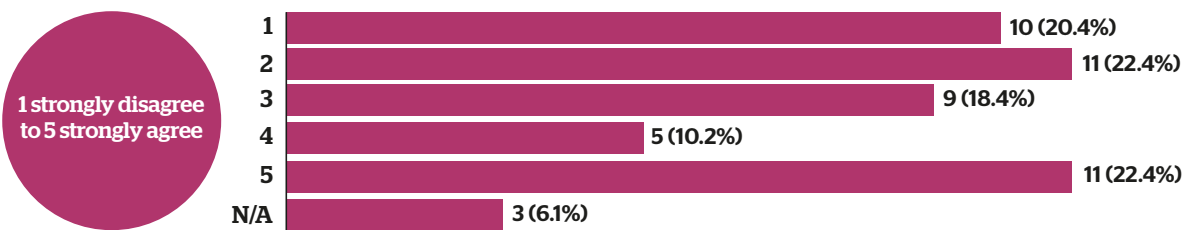


Figure 11. I have visited the GP more frequently

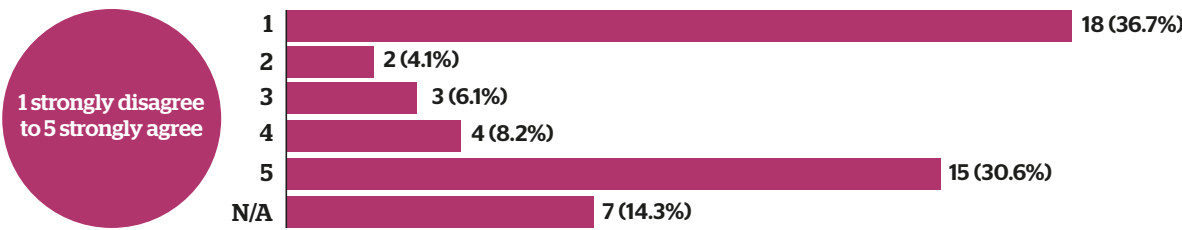


Figure 12. I have been prescribed medication intended to help me cope with CSE

Summary of qualitative comments

Out of the 53 parents that responded, a number took the opportunity to leave comments relating to their experiences of CSE and its impact upon their and their wider family's health. A number of key themes came up from across these comments which are summarised below.

Firstly, some parents commented on the lack of acknowledgment from their employers and their children's school regarding CSE concerns having an impact upon their health:

“...dealing with unsympathetic and confrontational child's school meant I was barely able to work, fielding emails.... Led to anger and frustration. Repeat low level infections.”

“My employer is NHS and has been slow to acknowledge impact on my health until I got to Employee Health and Wellbeing Dept.”

It was also apparent that some parents felt that due to the time spent dealing with issues relating to the CSE, in addition to the health and well-being of their own child, there was often no or very little time available for them to consider their own physical and mental health:

“Also as a CSE parent you spend all your time and energy worrying about your child's mental and physical health you forget about your own.”

“No time to be ill or think of yourself.”

The implications of CSE and its impact upon the family and other members within the family were also noted throughout participants' comments:

“My partner's health has also been adversely affected – including emergency hospital admission for severe hypertension and now on meds.”

“It has had a huge impact on the relationship not only with me and my child, but my eldest child as well.... Their estranged father and my relationship with my partner, now separated.”

“Myself [mum of CSE daughter] and my son [aged 18] are both sensitive to any trauma and are on alert and err on the side of caution, feeling we are vulnerable.”

“Husband now has depression, second daughter had depression and self-harmed and son has high anxiety and has stopped school.”

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The lack of help or understanding provided by agencies was considered to be a key factor in adding to stress. Additionally, some parents noted that many agencies have no options regarding help and support for any wider family members, suggesting that whilst the child of CSE might be provided with help and support, parents and other siblings are often ignored:

“It’s a constant battle to get the right help and it’s so worrying not knowing if you are doing the right thing and you are basically on your own.”

“There is never enough time given by professional agencies to listen to what the impact of CSE has on one’s being.”

“My experience was that I found it very difficult to access the help I needed. Various agencies were involved with my daughter and she was receiving the appropriate help. There seemed to be nothing to help me. There is still nothing specific that is aimed at all extended family, in our case we are secondary victims.”

There were a number of other health issues that emerged from parents’ comments that complement the survey findings:

“I have two on going health problems anyway – acid reflux and anal fistulas both which are aggravated by stress so they have been awful.”

“Grind teeth. Stomach cramps, headaches, bones ache. Vivid nightmares. Suicidal thoughts.”

“Physical health problems include dizziness, hearing problems, back pain and high anxiety.”

Finally, some of the parents noted their engagement in adverse health behaviours as coping mechanisms for coping with the stress and worry caused by the CSE:

“I have, on occasion, used alcohol to manage my emotional disturbances due to CSE.”

“...smoke and drink excessively to block out and calm nerves. It’s an ongoing battle. Initial shock is horrific but the living with it is never ending. Medication is necessary otherwise cannot function to go out to work, look after children.”

Focus groups

The following section provides verbatim quotes from parents who attended focus groups. Any explanation regarding the narrative is provided by the authors in brackets [] and any abbreviated passages are denoted by a series of dots.

No participant is identified by gender or location and care has been taken not to provide too much particular case information that may lead to identification of an individual family.

A number of key themes emerged from the transcripts. These included 'Neglecting own health', the 'Multiple impacts on health', 'Indirect health consequences' and 'Impact upon wider family members' (see appendix F for the Overview Table of Themes and Sub-Themes).

Neglecting own health

A significant theme drawn from the focus group data was that of 'Neglecting own health'. This theme resonated with a number of the qualitative comments left at the end of the survey. A number of parents revealed across both focus groups that, since the occurrence of the CSE, they had not actively thought about their own health needs:

“I didn't give my own health any thought, absolutely.”

“Forgot about them.”

“No, it wasn't uppermost in my thoughts.”

“So your own health needs just... They just go completely out the window.”

There was a general consensus among all of the respondents that when the CSE was initially revealed, their health was not a key aspect of their thoughts and priorities. Rather, parents revealed that their health needs and concerns would often be ignored or forgotten in order to prioritise the care and protection of their child:

“The time when it was happening to my family I didn't think about me at all. It was all about my daughter and to keep her safe.”

“I know that's what I need, it's just shock. But my body took over. And I didn't want that to happen because I wanted to cope for my daughter who'd just been through a police interview in the home and told that she's telling lies. And the other two had witnessed that, and I wanted to protect them but my body took over at that point and I couldn't do it.”

“I think you tend to hide it as well, because you know that they're hurt.”

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Some parents noted that in addition to the protection of their child experiencing the CSE, they had to forgo focusing on their health in order to care for their family and other children:

“... you squash it down because you’ve got to get on, because you’ve got to focus on your kids. So you don’t think about yourself. You know what’s happening but you don’t think about it, well I didn’t.”

“...you deal with it and then you have to get on, on autopilot, and you have to deal with your other children. And there’s a good side to that, but also you neglect yourself because of that.”

One parent suggested that the coping mechanism of going on ‘autopilot’ and just dealing with the ramifications of CSE could be advantageous in enabling parents to provide appropriate care and focus on the children in the short term. Many parents revealed within the focus groups that they would sometimes engage in adverse coping behaviours in order to help or enable them to deal with their situation. For example:

“I basically was drinking a lot more to try and drown everything out what was happening.”

“Comfort eating – every time I felt that something would go wrong or worried about something I’d go straight to the cupboard and start eating. And it was just like a trail from the sofa to the kitchen continuously. I put on about one-and-a-half stone in weight.”

“I lost a lot of weight – I went right down to seven-and-a-half stone. I used to cook every day for my children but I couldn’t eat.”

“I withdrew I stopped going out and socialising because we used to go out and socialise but if ever people asked me to go out I felt like I couldn’t go out....I’d put so much energy into sorting this out, that’s why I withdrew, because I didn’t have anything else to give anywhere else.”

The above quotes clearly highlight the numerous strategies that parents adopted at some point in order to help them cope with their situation. Whilst enabling the parents to cope in the short term, however, such coping mechanisms have significant implications upon both their physical and psychological health and well-being in the longer term. Whilst behaviours such as smoking, drinking and eating more or less can have direct implications for the physical health of individuals, the coping mechanism of social withdrawal can also impact individuals’ emotional and psychological wellbeing.

However, over time, the adverse consequences of such above behaviours and constant neglect of their care became apparent to some participants. For example, some of the parents came to the realisation that, if they were not healthy, they would not be able to care and support their child through the processes around the CSE and in respect of their health and well-being;

“I know now I need to think about my health because if anything happens to me, and this is stupid, but my thought is if anything happens to me who’s going to look after her?”

“Then it got to the point when I knew my health was going down the pan and I had to look after myself in order to be able to be strong enough to help her.”

“You’ve got to keep yourself ticking over, not just physically but emotionally eventually, hopefully they’ll come out of it. And they want to come to a parent that is strong and steady, not to a parent that’s crumbled. So I’m thinking that you’ve got to pull yourself together, and that’s what I did.”

Multiple impacts on health

The survey data and the focus group transcripts clearly demonstrate that caring for a child who has experienced or is experiencing CSE has a very significant impact upon the health and wellbeing on parents, not least because of the extreme effects on family life that CSE brings with it such as threats to personal safety and the adoption by parents and children of defensive measures such as sleeping with knives under pillows and having a bucket of water by the front door in case of an arson attack.

A wide variety of impacts on both physical and psychological health were highlighted during the focus groups, including dizziness, palpitations, backache, falling, deafness, high blood pressure, depression, anxiety, insomnia, paranoia, anaemia, a drop in liver function, migraines and stress related immune system deficiency:

“I had migraines, horrendous migraines at one point and that’s probably because I kept going all week, and with regular occurrence I’d wake up on a Saturday morning and I’d just have to stay in bed because I couldn’t even lift my head off the pillow.”

“Stress related immune system deficiency. So trauma-related.”

“I’ve been tested a number of times because I’ve had palpitations and I was convinced I was having heart problems. It was just stress, just the stress of it.”

“But I ended up with high blood pressure.”

“Because I’d gone slightly deaf, and the reason I’d gone deaf...is because I was listening all the time every day for the cars going outside the house; listening all the time for my daughter’s bedroom window to see if she was climbing out the window again in the middle of the night and not sleeping.”

“After two or three years of going through what I did my body shut down basically...it’s just that I was exhausted basically.”

“What it helped me do was recognise that the dizziness, the backache and the hearing problems were actually post-trauma. It wasn’t that my body was falling to bits; it was that it was reacting to a trauma.”

“I was really stressed at one point with work and dealing with [child’s name] and I ended up actually being off for about three days because I couldn’t even drive [due to being dizzy].”

Sleep and the disruption of normal sleep patterns was a consistent theme across both the survey and the focus groups. Parents repeatedly attributed the disruption of their sleep cycle to the experiences associated with CSE:

“... we went through it all, and then went home emotionally drained. And they said “oh it’ll be a couple of weeks before you hear anything”, and we’d only just got in the door and they said “right we’re coming to pick you up tomorrow to do a video”. ... you don’t sleep, you’re thinking about it all. And then they pick you up and spent the whole day doing this, all afternoon doing this, it seemed to go on forever and ever. And the emotional, it’s just totally draining.”

“If my daughter’s at home it’s even worse because you’re constantly listening out because she wakes up during the night screaming. And the slightest noise and you’re up, was that her? You go down and you open the door and you wake her up, and you think oh god. I wake up hearing her scream and she’s not even there.”

“Even if I was in bed I was getting up to check, checking she was there all the time. If I heard the slightest pin drop I’d be up and out of bed and probably like you said I’ve probably gone for days and sometimes weeks without any proper sleep.”

Findings

In addition to the cyclical patterns surrounding parent anxiety and sleep disturbance, the focus groups revealed that this issue was usually long term, often lasting years following the initial CSE incident:

“Since this has happened [Four years since the initial CSE] I don’t think I’ve had very many really good nights’ sleeps.”

“I haven’t had a decent night’s sleep in the last decade, at least 10 years. I wake up at three o’clock every morning, I don’t know why. I have no idea. And I’m finding it more distressing than just being up all night.”

The unique stresses of living with CSE were directly cited as causing certain health problems:

“I’d have to get up and check they were all in their beds ...Yeah, and also yeah, I’d have to do a pillow sweep. I don’t know if you’ve done pillow sweeps. Where they’re in bed and they’re asleep, but you have to do a pillow sweep underneath just to check there’s no knives there because they used to take knives to bed to protect themselves.”

“Getting my sleep pattern. Which you can’t always do because if you’re worrying about the door opening, or not even that, just getting out of bed to go and find a sharp object to cut herself because she self-harmed too.”

Such practices added to a heightened anxiety amongst the parents and carers which further impacted upon their psychological health and well-being. These themes highlight the complex nature of CSE which invades all aspects of families’ lives, twenty-four hours a day. As such, numerous parents reported that they had been diagnosed with depression, stress or anxiety related disorders:

“So really I started recognising the symptoms fairly soon and initially when it first started off, this was four years ago, I always managed myself quite well. And I think as time wore on and the situation became progressively more serious and lasted for longer and longer, I just started to. I was just so tired all the time, I just stopped doing anything really to manage it, and I didn’t do anything about it until I found it was starting to affect my work.”

“I went into an actual depression. I went from borderline anxiety depression to over that line and I was offered either tablets or some kind of counselling.”

As a result of such stressors, some parents also experienced panic attacks which were set off by the CSE:

“Yeah, I was getting panic attacks. Never had them before and I was getting them driving in the car. And it was when I was getting closer to home I was getting these panic attacks. I was in control outside of the home but when I was in the home I wasn't in control.”

As well as new health consequences that developed as a result of CSE, several parents revealed that their experiences with CSE had impacted upon existing health conditions. For example, a number of parents noted a negative impact upon the symptoms or severity of their pre-existing conditions:

“It did affect my health... I was stressed. I have a condition anyway which is fibromyalgia, so obviously that affected that, fatigue. I found myself falling asleep at work.”

I was having routine blood for anaemia and they came back to me with the routine bloods three months after finding out, and they were saying “oh your white blood count has gone down, there's a problem here”.

From the focus groups it is clear to note the multiple direct health implications associated with the experiences of CSE upon parents. Not only are these experiences detrimental to the psychological health and well-being of parents, but the insidious nature of CSE was also shown to have direct significant implications upon their physical health and existing health conditions. We will now move on to consider the effects on health brought about by the complex and unique nature CSE which leads to families having to adopt extreme lifestyles in order to cope with the environmental realities of CSE.

Indirect health consequences

In addition to the direct physical and psychological implications associated with experiences of CSE within a family, the multiple processes that families have to engage with during CSE were perceived by participants as constituting an extra series of stresses, some of which were avoidable. In addition to dealing with their child, parents must also communicate with the police, social, educational and healthcare professionals as well as facing the intimidation presented by the perpetrators. All of these processes were highlighted as very difficult and stressful in themselves, sometimes resulting in detrimental health consequences. These difficulties often arose from the intimidation techniques perpetrators used when knowing the home address of the children. The following participant had endured some ten years of intimidation by a group of Asian men:

Findings

“The area I live in is quiet; I always felt like that offered me an element of protection because if a car full of Asian men pulled up on my street half the street would be out wanting to know who they were and what they were doing. But we went through a really sticky period. I stapled all my curtains together thinking if something was coming through the window. I lived with a bucket of water under my letterbox [in case of an arson attack].”

“It isn't paranoia when the man's knocking on my front door. That is not paranoia. That is a man in a car with a 14-year-old girl knocking on my front door demanding to search my house to look for my child. Do you know what I mean? I'd open the door and say “she isn't here”; well he was coming in and looking. And they would come in and look.”

Situations such as the above proved difficult and upsetting for parents, often causing them to experience high levels of anxiety and further stress. Subsequently, these would then impact upon their physical health. For example, the parent below reflects on how moving home enabled them to relieve some of the previous stress and associated physical symptoms:

“... two years later when I moved house to get away from them driving up and down outside, I don't know if you've had that intimidation where they drive up and down and they're looking in your window and threatening your family, and telling you what's going to happen to your family. When we moved house to get away from that, three months in, three or four months and lo and behold my blood returned to normal because we were away from that, and the stress and the relief of moving meant that that went back to normal. So for me that's a real physical thing.”

Additionally, a key issue drawn out by parents across both focus groups was the lack of response, awareness and knowledge of professionals:

“Doctors should be made to have a proper awareness of the problem because my doctor, I know, has no comprehension.”

“Social workers and policemen [need to] get a proper awareness of the problem.”

“We had family therapy through CAMHS as well, but they had absolutely no understanding. ...a policeman told me..., it is far too big a can of worms, they're never going to open it.”

There was some evidence from the focus groups that individual professionals showed compassion and understanding towards parent's whose health had been affected by CSE involvement:

“My GP was pretty good to be honest. He said why didn't I come before to see him and that. And he offered pills. I said I don't want to go down that road. And spoke to him regarding going onto counselling to get some counselling. And he got straight onto it, so he was very supportive. And he left the door open for me to come back and see him no matter what, do you know what I mean? So I didn't have to because I knew he was there if I needed to, do you know what I mean?”

“... he is our family GP... I don't think I could say his understanding of CSE was of any great depth, but he was very much focusing on my mental health. So, certainly from that perspective the fact that he was very much trying to help me.”

However, despite seeking help and support from a number of professionals, a large majority of parents were often ignored, treated adversely or let down by the systems put in place to protect them:

“I'd been awake for a fortnight and I was hallucinating. And I daren't phone police from my house... I didn't want these people knowing that I'd phoned police on them. And I had a strange reasoning that if I went to A&E I'd be able to phone police from relative safety. I went into A&E and they treated me like just another heroin addict looking for a free high. I sat on a chair and a doctor came in. And I told him what was going on, and he held out his hands. There was the tiniest little yellow tablet in the palm of his hand. And he went “take this tablet”. And I can remember taking the tablet and I woke up six hours later sitting on the chair that I was sitting on when he gave me that tablet. I was awake approximately 10 minutes and I was back out on pavement outside. That was the extent of the help I got at A&E”

“I mean the police come out and they say “Oh there's this”, they maybe give you one agency or something to contact, or a couple. They never give you any support. Once you've been through that, you've reported it, you're waiting for it to go to court, nobody actually says to you “how are you feeling, how are you dealing with it, have you got any help?” They're not interested.”

Findings

“The first policeman that came round said “Oh you should think yourself lucky; it’s happening all over the place, you’ve caught it nice and early, it’ll not be a problem. Think yourself lucky”. ”

The experiences above reveal several differing scenarios where parents felt let down by the agencies put in place to both protect and support them. Parents often detailed having to struggle and fight to receive any or the correct form of support and care, such a culture adding to the stress and anxiety experienced by parents, disabling their ability to care and protect their children:

“there’s a real, there’s a very curious disconnect, and the professionals have got to overcome that, because they’re never going to get the proper cooperation of parents as long as you’ve got an adversarial relationship. ”

“They wanted this power, there’s this power thing against parents. ”

Such perceptions were further impacted by the exclusion of parents from meetings and planning for their child despite their parental responsibilities. Such scenarios are described by the parents below:

“We’re having a professionals meeting and you’re not allowed to be there. ”

“Oh well you don’t have to go to this core meeting – you have to demand to be there as well sometimes. ”

The above forms of stress and anxiety were intensified by the inconsistencies or explicit mistakes made by professionals when help and support was provided:

“When you finally think you’re getting somewhere, which is what we did earlier last year, and you think “Oh we’re really actually finally getting somewhere, we’re having some psychological help here” the woman goes off on mat leave. The idea was she was supposed to continue on with psychology and they refer her back to a counsellor once a month who re-traumatises her. ”

“She [Police Officer] went through the whole, nearly all day we were there. I think we went at 10 o’clock in the morning; we got home at about four o’clock in the afternoon. And they came knocking on our door two weeks later to tell us they’d done it wrong. She’d to go back and do it again. Well, of course, she point blank refused. It had taken us forever to get her to go in the first place and because they’d messed up that was that, done. ”

Negative perception and reception from some professionals were also apparent when parents attempted to seek help once they had realised that their own health was being impacted by the CSE:

“One doctor told me to pull myself together, just pull yourself together – well I wanted to drag her over the desk and I’ve never been to see her again.”

“It’s horrendous. But they just keep telling me “Oh, you’ve got an inner ear infection”. And it’s not an inner ear; I know it’s not an inner ear infection.”

“I went to see my doctor, a female doctor who knew about the situation. I said I’m really not coping with things. And she just said “Well I don’t want to sign you off, I think you need to carry on at work, you need to carry on as normal”.”

The above examples suggest that, in addition to the stress experienced through a child’s involvement in CSE, some parents were further prejudiced and stressed by a lack of knowledge/insight/ empathy on behalf of health professionals they had approached in their own right.

Impact upon the wider family

When discussing their own health and experiences during stages of the CSE, many parents also detailed its impact upon other family members, particularly siblings of the child who was the victim of CSE:

“My son got into trouble at school and he was sent to a pupil referral unit. And they recognised there that he was struggling with what was going on with his sister.”

“...sister was clearly affected, traumatised by the whole thing but not physically exploited as in the first daughter. So yeah I’d go and do a pillow sweep just to pick up the knives but then we had a big discussion about should I be picking the knives up because it made them feel safe.”

“Because we had to pull him out of school on the day that we found out, the police and everything came to school and he was pulled out of school on the day that we were informed. So he hasn’t felt able to go to school consistently since and hasn’t been to school for seven or eight or nine months. But really for the last three years I hadn’t been able to [attend school fully] because of that trauma.”

“I mean knock-on-effects, just to, sister, a lot of self-harm. She got some independent therapy and is absolutely, not absolutely, she’s much better now.”

A significant sub theme which appeared to have further added to parental stress in respect of other siblings was the amount of guilt felt regarding not having given full attention to other siblings’ emotional and educational needs due to the preoccupation with the child who was the direct victim of CSE. The parent below detailed how this perceived guilt affected their own physical and mental health as well as having had subsequent impact upon their son’s emotional health:

“I found it’s my older son that suffered more. And I’m always saying to him ... this is misplaced guilt. Because yes he’s [a man] now, but when all this started he was a 15-year-old boy. And he’ll say things like I should have done, I should have done, I should have been. He thinks he should have been her dad, you know.”

Another parental view was that CSE involvement of a sister had adversely affected a brother’s mental health:

“I’m quite surprised really that he [a brother] got through his education as well, because there were times when he was very depressed. We did go to see the doctor and they said “Oh yeah we’ll sort out some counselling for him”. We never heard any more. And as you say I feel bad because I feel like I should have pushed it, but because you’re dealing with that all the time you don’t necessarily push it, and he seemed to be OK and he seemed all right. And he did get through his qualifications ... and I’m just glad for him that he is, he’s away from it all.”

“... he worries about his sister, he worries about what’s going to happen to her. He knows she gets depressed and he worries if she’s really down, so he’ll spend time skyping with her or ringing her if he knows she’s really down. So yeah he’s having to think about something that, a normal teenager would be ... having fun, going out drinking, whatever, but he’s not, he’s got this constant worry about his sister.”

The parent below expresses the view that it was the realisation that she was growing away from her older daughter, the sibling of the child directly involved in CSE, which led her to seek help for their own psychological well-being:

“I’ve got an older daughter as well, and she was at home at the time, and I felt I was pulling myself away from her. And because I was able to identify what I was doing to my older daughter, that’s when I needed to sort myself out.”

The impact of the CSE situation upon siblings is, as ever with CSE, complex. Siblings not only experience adverse consequences from the knowledge and experience of their brother or sister being sexually exploited but they can also experience having their needs overlooked by their parents. This is a particularly interesting area that warrants further research in order to explore the impact of CSE upon siblings and how best to support them in dealing with their situations.



Discussion

The range and severity of the effects of CSE on parents and wider family members' physical and mental health were shown by this study to be extensive and paralleled the physical and mental health impacts reported by mainstream carers (Carers UK, 2014), both in prevalence and in nature. However, even if services for mainstream carers are often inadequate, mainstream carers do not operate under the 'blaming' culture so often experienced by CSE carers which is likely to exacerbate health problems such as stress and anxiety.

The key findings of the internet based survey were that 88% of the respondents felt that their experiences of CSE had impacted upon their general health. In terms of the main health impacts reported, 40% of parents reported that they suffered with frequent headaches and 30% reported that they suffered with stomach pain or discomfort. A further 28% of parents reported experiencing breathing difficulties or chest pain. In regard to psychological health, a majority of respondents agreed (56%) that they felt disconnected from everyday life and activities. When considering sleep patterns, 84% agreed that their patterns were disturbed with 70% reporting that falling to sleep was difficult for them. Secondary trauma was also considered with respondents reporting similar agreements for having self-harmed or having thought about self-harming (30%) and the ending of their life (39%). Furthermore, respondents agreed that they experienced a heightened sense of anger (76%), intrusive and unwanted thoughts (58%) and the replaying of CSE related events in their heads (74%). Finally, when considering help-seeking, 45% of respondents agreed that they had visited their GP more frequently since occurrence of CSE, with 72% reporting that they had been prescribed medication intended to help them cope with the effects of CSE.

These above survey findings were supported by the themes that emerged from the two focus groups. Analysis of the focus group transcripts revealed that CSE impacted upon both the physical and psychological health of parents including their ability to manage existing illnesses. Immediate and long term health implications were separately identified. A significant theme was that parents often neglected their own health in response to time and work pressures whilst also caring for their child. Additional stresses were identified regarding the systems surrounding CSE - multi-agency working, changes of personnel and a lack of overall communication/empowerment. However, over time, there was evidence of some realisation of the need to address parents' own health needs in order to continue supporting their child's needs. The focus groups revealed inconsistencies between front line professionals in response to parents' health concerns that had arisen from CSE. For example, many health professionals were perceived to have a lack of knowledge or understanding regarding the nature of CSE and specialist resources were often non-existent.

While so little understanding and so few specialist services are offered, the health of CSE carers is likely to further suffer. Whilst it is important to care for the health of parents and wider family members affected by CSE in their own right, there remains also the critical consideration of what will happen to the child involved in CSE if parents and wider family members are no longer able to offer help and support due to ill health. Parents in particular, as highlighted in this present study, are variously acting as protectors, counsellors and systems negotiators in a world that to date has

not listened. Their contribution to working as partners in tackling CSE alongside professionals has been presented in this study as marginalised, a finding which supports the YouGov (2013) report. This marginalisation and accompanying lack of respect for parents having claim to expert status might be seen as a contributory factor to some of the psychological stresses described in this study.

Unlike the situation with other forms of child sexual abuse, which often emanates from within a family where parents may not be protective, CSE is essentially driven by forces external to the family via personal, peer and social media forms of grooming and intimidation (Berelowitz et al., 2013). Once parents do become aware that a child has become embroiled in CSE, they will often do their best to protect that child as evidenced in the survey data and focus group findings above. However, their ability to effectively protect their children from the external forces that perpetrate CSE is very limited – agencies often have low-level or non-existent knowledge about CSE / professional attitudes may be dismissive or inappropriate / specialist services are scarce with long waiting lists / agencies may not communicate effectively with each other and the systems surrounding CSE are complex and often not understood by parents. In the face of such problems, coupled with trying to protect and nurture a child, parents neglect their own health problems, both pre-existing problems and those brought about as a result of CSE. This present study suggests that such neglect can go on for years in some cases until a particular crisis forces a parent to seek medical help with a problem that may by then be chronic in nature. Some particular short-term health impacts of becoming a family with a CSE victim in its midst were noted by parents such as stress / poor diet / sleep disturbance and headaches but there was no particular evidence that short term health problems dissipated over time. It may be that the intimidatory and overwhelming nature of CSE over which parents and young people so often have no control, means that living with CSE does not get any ‘healthier’ as the years pass. Instead, particularly in the light of ineffective responses by policing and caring agencies, health problems seem to increase over time and some parents reported turning to unhealthy coping strategies such as drinking too much alcohol and comfort eating as a response to their helplessness. Some of the parents who attended the focus groups were able to reflect back on the point when they knew they had to seek help for their own health (e.g. realisation that the CSE was impacting on their ability to care for their other children or they had been drinking too heavily) and some were able to report effective and supportive responses. These responses, however, were idiosyncratic – ranging from the GP who advised that a parent should “pull yourself together” through to the GP whose door was always open. Police responses were largely not found to be helpful by participants – one police officer advised that there were other families far worse off, others refused to believe a child and another intimated to a mother that the problem of CSE would never be eradicated, all of which led to a lack of trust between parents and the police.

No examples were given by participants of their knowledge and experience having been respected as having expert status and in some cases parents reported having been excluded from involvement in professional meetings and care planning. Such approaches prevent the development of authentic partnerships alongside parents and wider family members. Organisations such as Pace are rare and resource-limited – parents who met each other for the first time in one of the focus groups above shared how helpful it had been to meet a fellow

parent who had been through similar problems. Generic services such as abuse helplines and mainstream counselling via GPs were welcomed by some parents but it was the access to specialist resources (Pace / women's services for post-traumatic stress disorders / specialist counselling) which were perceived as particularly helpful. There would appear to be something distinctive about specialist peer support, especially given the complex nature of CSE. The potential in wider networks of peer support would appear considerable, yet there are no such readily available resources in most localities.

Strengths and limitations

The strengths of this research are in its mixed methodology (online survey and focus groups). Data from the focus groups complemented and illuminated the data from the online survey. The research methods were designed alongside Pace staff to ensure that the areas being explored were pertinent to the particular phenomena of CSE. A pilot run of the survey that led to some amendments in questions is also seen as a strength in terms of the 'user-friendliness' of this research tool. The subsequent take-up of by 53 members from the Pace email database of 150 (35%) provided substantial amounts of data for analysis. Online surveys exclude participants who do not have ready access to the internet and several Pace members did ask whether they could take part in telephone interviews as an alternative. These telephone interviews are in process but, as a late request that required additional ethical approval from the University of Worcester, they have proven impossible to complete within the timescale demanded of the original commission. A separate analysis of the phone interviews will follow this report.

The fact that the University of Worcester research staff have no connections with Pace other than having been commissioned to carry out this independent piece of research is also seen as a strength.

Focus groups were conducted by two members of University of Worcester research staff, one male and one female and were arranged in London and Leeds to maximise take-up in this sensitive area. Focus group members did not previously know each other and hence information shared may have been guarded, despite the researchers having stressed the confidentiality boundaries around participation. The fact that two focus groups, albeit small in size at three participants and six participants in Leeds and London respectively, suggests that the approach of the research was appropriate in attracting participants, some of whom would have anonymously filled out the online survey prior to focus group participation. One unsolicited piece of feedback that followed a focus group was:

“I found it really useful and I felt really good talking about the way it has affected my health. I had sleepless nights and constant vertigo and I just kind of had to get on with things and it was good to hear other parents were affected by similar things. I have been so very, very tired. It has affected my health, but I never really thought about it. It's so important that this research is taking place and that people can start understanding how it does affect families.”

The qualification must be made that parents who find their way to the specialist services of Pace may not represent a majority of parents involved with CSE. Parents in contact with Pace may be the more resilient and resourceful parents and those who volunteer to take part in a survey and /or a focus group discussing the most sensitive of family matters may not represent the whole of the Pace membership. Some of the views presented in the course of the research, however, do refer to the period in families' lives before they had become aware of Pace. The majority of participants had several years of experience with the systems around CSE whereas a minority had only recently been introduced to Pace. However, a wide and varied range of experiences across a spectrum of health issues and the subsequent responses from professionals to those health issues suggest that the information gained from this study has value. It is an unexplored area of health need and as such warrants serious consideration.

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Conclusions

Conclusions

Although research has considered the health implications associated with sexual exploitation and abuse in a number of other areas, no research has been published considering the impact of CSE upon family members. As such, this study particularly explored the implications of CSE involvement on parents' physical and psychological health, explored the help-seeking practices of family members in relation to their own health and well-being and gained an understanding of the barriers associated with seeking and achieving help. Overall, it was revealed that a large majority of the parents involved with CSE experienced some form of negative impact upon their psychological and/or physical health.

Additionally, those who had existing health conditions found that their CSE involvement and its accompanying stressful processes both increased their symptoms and impeded their ability to deal with CSE successfully. In general, there was a consensus that this health impact was partly due to the lack of attention parents gave to their own health and wellbeing and the stressors associated with a number of uncontrollable factors directly linked with CSE. For example, many parents experienced the added stress of dealing with multiple agencies (which often lacked knowledge and understanding of the processes associated with CSE), direct intimidation from the perpetrators of the CSE and a lack of appropriate support and advice. All of these factors, whether directly or indirectly, impacted upon parents' health and ability to cope with both the CSE and the care of their child. Whilst much research has focused upon the impact of CSE on the survivor or victim, the findings from this project highlight the significant and detrimental impact such experiences have on those closest to victims, namely the parents who live through many of the traumas of the CSE environment alongside their children. A need has been highlighted regarding the need for further exploration of the implications of CSE upon other family members, particularly upon siblings. In conclusion, this research has broken new ground and has brought the wider ramifications of CSE to the forefront, highlighting its complex and insidious nature in causing upheaval and detriment across multiple areas of family health and family life.



Recommendations

Recommendations

The findings from this project have identified a number of key areas of concern regarding parents' health and their ability to care for their children who are experiencing CSE and also in regard to the agencies involved in their support. A number of recommendations can be made that are intended to better support parents' health and the furtherance of societal awareness of CSE:

- **Appropriate CSE training and awareness for frontline professionals:** An issue that affected parents in relation to both their experiences around CSE and the impact of CSE upon their health was related to the lack of knowledge, understanding and support of the professionals who were meant to be there to support them. Although the notion of professionals' lack of understanding and awareness of CSE is not directly related to parents' health, parents often revealed feeling anxious, stressed and frustrated due to these perceived deficits. These negative experiences can then have a knock-on effect upon both parents' physical and psychological health. It is recommended that all professionals who could come into direct contact with CSE situations should be provided with specific training around the nature of CSE and its underlying processes. This includes members of the police, health professionals (particularly GPs), social workers, social care staff and educators. Furthermore, such professionals also need to have an awareness of the appropriate services available to parents and/or the targeted children in order to signpost individuals on for appropriate support.
- **Parents as experts:** Parents often detailed issues surrounding professionals and their attitudes towards them as parents. This sometimes led parents to feel as though they were not listened to despite their first-hand experience of the CSE and their knowledge of their child. It is important for professionals dealing with cases of CSE to embrace a mind-set that can view parents as experts on CSE due to their lived experiences. Linked with this, it is recommended that a model is implemented amongst police and social workers whereby protective parents are identified from the initial outset of CSE concerns. Such an approach would enable agencies to build co-operative, collaborative relationships that would both benefit the parents and their families as well as the agencies involved with their support. It is critical that professionals ensure parents' health is maximised and promoted in order for them to care for their children appropriately and effectively. In doing so, this would also relieve some of the pressure placed upon professionals.
- **Further research:** During this project, the focus was on parents' health in relation to CSE. However, a key theme that emerged from both the qualitative aspect of the survey and the focus groups was the impact CSE had on brothers, sisters and sometimes wider members of the family. It is recommended that further research is conducted which considers the health implications experienced by such family members, specifically siblings.
- **Pace:** Finally, it is recommended that Pace build on their existing portfolio of information and advice resources for parents and consider devising both web-based and hard copy information leaflets or guides that can be used to advise families about the importance of maintaining their own health. Such information could be distributed on a wider scale to enable all frontline professionals to have ready access to material that could support families from the very outset of any involvement with CSE.



References

References

Association for Young People's Health (2015). *Right 2b safe project evaluation*. Available at: [www.cypnow.co.uk/digital_assets/761/R2BSafe-final-evaluation-report-April-2015\[3\]-copy.pdf](http://www.cypnow.co.uk/digital_assets/761/R2BSafe-final-evaluation-report-April-2015[3]-copy.pdf)

Bedford, A (2015). *Serious case review into child sexual exploitation in Oxfordshire: from the experiences of Children A, B, C, D, E and F*, pp. 1-114

Berelowitz, S, Clifton, J, Firmin, C, Gulyurtlu, S and Edwards, G (2013). "If only someone had listened" Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation. *Office of the Children's Commissioner*, pp. 1-96.

Braun, V and Clarke, V (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2). pp. 77-101.

Brodie, I, Melrose, M, Pearce, J and Warrington, C et al. (2011). Providing Safe and Supported Accommodation for Young People who are in the Care System and who are at Risk of, or Experiencing, Sexual Exploitation or Trafficking for Sexual Exploitation. *University of Bedfordshire*, pp. 1-28.

Carers UK (2012) *In Sickness and in Health. A survey of 3,400 UK carers about their health and well-being*. Available at: www.carersuk.org/for-professionals/policy/policy-library/in-sickness-and-in-health

Cleaver H, Unell, I and Aldgate, J (2011). *Children's needs: parenting capacity: child abuse: parental mental illness, learning disability, substance misuse, and domestic violence* (PDF). London: The Stationery Office. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/182095/DFE-00108-2011-Childrens_Needs_Parenting_Capacity.pdf

Cockbain, E and Brayley, H (2014). British Children can be Trafficked too: Towards an Inclusive Definition of Internal Child Sex Trafficking. *Child Abuse Review*, Vol. 23: pp. 171-184.

Department of Health / Chanon Consulting (2014.) *The range of health impacts which can result from child sexual exploitation*. Available at: www.barnardos.org.uk/health_impacts_of_child_sexual_exploitation.pdf

Galley, J (2010). *Derby Safeguarding Children Board Serious Case Review Executive Summary*. July 2010.

Griffiths, S (2013). *The Overview Report of the Serious Case Review in respect of Young People 1, 2, 3, 4, 5 & 6*, Rochdale Borough Safeguarding Children Board.

Herrenkohl, IT, Hong, S, Klika, BJ, Herrenkohl, CR, Herrenkohl, M and Russo, JM (2013). Developmental impacts of child abuse and neglect related to adult mental health, substance use, and physical health. *Journal of Family Violence*, 28(2), 191-199.

Jago, S with Arocha, L, Brodie I, Melrose, M, Pearce J & Warrington, C (2011). What's going on to Safeguard Children and Young People from Sexual Exploitation? *University of Bedfordshire*.

Jay, A (2014). *Independent Inquiry into Child Sexual Exploitation in Rotherham (1997-2013)*. Available at: www.rotherham.gov.uk/downloads/file/1407/independent_inquiry_cse_in_rotherham

Muftic, RL, and Finn, AM (2013). Health outcomes among women trafficked for sex in the United States: A closer look. *The Journal of Interpersonal Violence*, 6. doi:10.1177/0886260512469102.

National Crime Agency (2014). *NCA Strategic Assessment. The Nature and Scale of Human Trafficking in 2013*. Available at: www.nationalcrimeagency.gov.uk/publications/399-nca-strategic-assessment-the-nature-and-scale-of-human-trafficking-in-2013/file

NSPCC (2015). How safe are our children? The most comprehensive overview of child protection in the UK. Available at: www.nspcc.org.uk/services-and-resources/research-and-resources/2015/how-safe-are-our-children-2015

Ouellet-Morin, I, Fisher, LH, York-Smith, M, Fincham-Campbell, S, Moffitt, ET, and Arseneault, L (2015). Intimate partner violence and new-onset depression: A longitudinal study of women's childhood and adult histories of abuse. *Depression and Anxiety*, 32(5), 316-324.

Pace (2015). *Keeping it together. A parent's guide to coping with child sexual exploitation*. Available at: www.paceuk.info/wp-content/uploads/Keeping-it-together-PDF.pdf

Sachs-Ericsson, N, Kendall-Tackett, KA, Sheffler, J, Arce, D, Rushing, CN and Corsentino, E (2014). The influence of prior rape on the psychological and physical health functioning of older adults. *Aging & Mental Health*, 18(6), 717-730.

Swanston, J, Bowyer, L, Vetere, A (2013). Towards a richer understanding of school-age children's experiences of domestic violence: The voices of children and their mothers. *Clinical Child Psychology and Psychiatry*, 19(2), 184-201.

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Appendices

Appendix A: Questionnaire: The Collateral Health Impact Scale (CHIS; Stephens-Lewis and Unwin, 2016)

The following questionnaire assesses five key areas relating to your overall physical and psychological health and well-being. Divided into five sub-sections, these statements aim to explore individual's general health, physical health and psychological well-being in addition to secondary trauma and help-seeking. Please complete all questions as accurately as possible. Should you feel uncomfortable with any questions or feel that a statement does not apply to yourself or situation, please circle the option, N/A.

Please circle the number which best represents your experiences in relation to your general health since your involvement with CSE (with 1 being 'Strongly disagree' and 5 being 'Strongly agree')

	Strongly disagree		Neither agree nor disagree		Strongly agree	
CSE has impacted upon my general health	1	2	3	4	5	N/A
I pay attention to my general health	1	2	3	4	5	N/A
I pay attention to general self-care	1	2	3	4	5	N/A
I feel well and in good health	1	2	3	4	5	N/A
I feel that I am managing in day-to-day activities	1	2	3	4	5	N/A
I often feel physically exhausted	1	2	3	4	5	N/A
I suffer with frequent headaches	1	2	3	4	5	N/A
I experience stomach pain and discomfort	1	2	3	4	5	N/A
I experience difficulty breathing and chest pain	1	2	3	4	5	N/A
I have been eating more than usual	1	2	3	4	5	N/A
I have been missing or avoiding food	1	2	3	4	5	N/A
I have trouble sleeping	1	2	3	4	5	N/A
I feel disconnected from everyday life and activities	1	2	3	4	5	N/A
I have or have considered self-harming	1	2	3	4	5	N/A
I have considered ending my life	1	2	3	4	5	N/A

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	Strongly disagree		Neither agree nor disagree		Strongly agree	
I blame myself for what has happened	1	2	3	4	5	N/A
I sometimes experience anger for no apparent reason	1	2	3	4	5	N/A
I experience feelings of guilt	1	2	3	4	5	N/A
I experience feelings of shame	1	2	3	4	5	N/A
I often replay events related to the CSE in my mind	1	2	3	4	5	N/A
I feel I have moved on in life since the initial CSE	1	2	3	4	5	N/A
I feel helpless when thinking about my family member	1	2	3	4	5	N/A
I have visited my GP more frequently	1	2	3	4	5	N/A
I have actively sought out support from agencies	1	2	3	4	5	N/A
I prefer to keep my experiences to myself	1	2	3	4	5	N/A

Appendix B: Focus group schedule

1. Thinking back to when it was revealed that your family member (daughter/son/sibling/granddaughter) had experienced child sexual abuse, how would you say your health was affected /prioritised?
2. Did you seek any help from a GP or another health professional?
3. When seeking out help, did you receive help?
4. How could help and support be improved?
5. Is there anything that you think should be discussed that we have not covered? (prompt – effects on wide family?)

Appendix C: Focus group information sheet

Participant information sheet

Title of project: *Evaluating the health implications of Child Sexual Exploitation on wider family members*

Invitation

We would like to invite you to take part in a research project. Before you decide whether to take part it is important that you understand why the research is being done and what it will involve. Please take time to read this carefully and ask the researcher if you have any questions. Talk to others about the study if you wish. You will have at least 5 days to decide if you want to take part.

What is the purpose of the study?

To date, much research has considered the direct implications of Child Sexual Exploitation (CSE) on the health of the individual who has experienced it. However, little research has considered whether such health implications could also arise with individuals who have lived through the experience with a member of the family who experienced the CSE. As such, this research aims to consider the health of members of a family who have experienced the CSE of a loved one.

Why have I been invited to take part?

You have received this invitation because of your registration with the association, Parent's against child exploitation (Pace) and completed the first part of this study, a health related questionnaire. At the end of that questionnaire you indicated an interest in participating in further research. In total, we are hoping to recruit approximately 16-20 people for this study (i.e. 8-10 participants per focus group).

Do I have to take part?

No. It is up to you to decide whether or not you want to take part in this study. Please take your time to decide; we will wait for at least 5 days before asking for your decision. You can decide not to take part or to withdraw from the study until the point of publication. If you wish to have your data withdrawn please contact the researcher with your pseudonym and your data will then be excluded from the study. If you do decide to take part you will be asked to sign a consent form.

What will happen to me if I agree to take part?

If you agree to take part, focus groups will be held with approximately 8-10 individuals that will run for approximately 1-2 hours. During this session there will be discussion around health, well-being, experiences of healthcare and any other issues that may arise out of the discussion. The nature of focus groups is to enable members share thoughts, experiences and discuss key issues deemed particularly important. As such, I would like to assure you that there are no right or wrong answers to the questions asked and we are just exploring in-depth issues surrounding health. These focus groups will be recorded by a dicta-phone whilst all written data will replace names with the pseudonyms chosen before proceeding with the research.

Are there any disadvantages risks to taking part?

Due to the nature of the discussions, it may be possible that some sensitive issues may arise. If at any point you feel uncomfortable or that you would not like to answer or continue with the discussion, please let me know and we can pause or stop the focus group process. No coercion or duress of any form will be used to persuade you to explore anything that you may feel uncomfortable with. Also, support network contact details will be provided in the chance that you may feel you need to discuss issues further.

Will the information I give stay confidential?

Everything you say/report is confidential unless you tell us something that indicates that you or someone else is at risk of harm. We would discuss this with you before telling anyone else. The information you give may be used for a research report, but it will not be possible to identify you from our research report or any other dissemination activities. Personal identifiable information (e.g. name and contact details) will be securely stored and kept for up to 5 years after the project ends on March 31st. 2016 and then securely disposed of. The research data (e.g. interview transcripts) will be securely stored.

What will happen to the results of the research study?

This research is being carried out as part of an evaluation commissioned by Pace and may also be published in academic journals or at conferences.

If you wish to receive a summary of the research findings please contact the researcher.

Who is organising the research?

This is a collaborative project between the organisation, Pace, and the University of Worcester. This research has been approved by the University of Worcester Institute of Health and Society Ethics Committee.

What happens next?

Please keep this information sheet. If you do decide to take part, please either contact the researcher using the details below.

Thank you for taking the time to read this information

If you decide to take part or you have any questions, concerns or complaints about this study please contact one of the research team using the details below.

If you would like to speak to an independent person who is not a member of the research team, please contact Dr John-Paul Wilson at the University of Worcester, using the following details:

John-Paul Wilson

Research Manager, Graduate Research School, University of Worcester,
Henwick Grove, Worcester WR2 6AJ

01905 542196

j.wilson@worc.ac.uk

Appendix D: Focus group consent forms

Participant consent form

Title of project: *Evaluating the health implications of Child Sexual Exploitation on wider family members*

Pseudonym for this study:

Name of researcher:

- ☐ I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions.
- ☐ I confirm that I have had sufficient time to consider whether
- ☐ I want to take part in this study
- ☐ I understand that I do not have to take part in this research and I can change my mind at any time. I understand that I may withdraw my data by contacting the researcher with my participant number before March 31st, 2016
- ☐ I agree to the research focus group being audio recorded
- ☐ I agree to my research data including anonymised quotations being used in publications or reports
- ☐ I agree to take part in the study.
- ☐ I have been made aware of support services that are available if I need them.
- ☐ I know who to contact if I have any concerns about this research
- ☐ I understand that my data will be held in accordance with the Data Protection Act (1998).

Pseudonym of participant

Date..... Signature

Name of person taking consent

Date..... Signature

Appendix E: Support agencies

Helplines

As research interviews can raise a number of issues for participants and researchers, the following list contains helplines for anybody who may wish to seek further help/ advice / counselling around sensitive issues. The prime source that relates specifically to child sexual exploitation is:

Pace

Web: www.Paceuk.info/support-for-parents/telephone-support
Tel: 0113 240 3040

In addition to any local sources of help such as your own G.P. you may find some of the more specialist organisations below of assistance:

British Association for Counselling and Psychotherapy

Produces a directory of counselling resources throughout the UK.
Web: www.bacp.co.uk
Tel: 0870 4435252

Careline

Telephone counselling service for children, young people and adults on any issue, including relationships, depression, mental health, child abuse, addictions, stress etc.
Web: www.careline.org.uk
Tel: 020 8875 0500

Depression Alliance

Charity offering information and self-help groups.
Web: www.depressionalliance.org
Tel: 0845 123 23 20

Disability Information Services (DISS)

National service providing information on all aspects of disability for disabled people, their families, friends and carers.
Web: www.diss.org.uk
Tel: 01306 875156 or 742130

Eating Disorders Association

Information and help on all aspects of eating disorders including anorexia, bulimia and binge eating.
Web: www.edauk.com
Tel: 0845 634 1414

Medical Advisory Service – General Medical Helpline

Telephone advice and information service covering all general medical inquiries.
Tel: 020 8994 9874

Mencap

Charity working with people with a learning disability and their families and carers.
Web: www.mencap.org.uk
Tel: 0808 808 1111

Mental Health Foundation

Information about how to get help with any mental health problem in your local area.
Web: www.mentalhealth.org.uk

Mind

A wealth of information about mental health issues and contact details for the nearest Mind group in your area.
Web: www.mind.org.uk
Tel: 0207 8020 300

NHS Direct

Advice and information on all health-related issues.
Web: www.nhsdirect.nhs.uk
Tel: 0845 46 47

No Panic

Support for sufferers of panic attacks, phobias, Obsessive Compulsive Disorder, General Anxiety Disorder and tranquilliser withdrawal.
Web: www.nopanic.org.uk
Tel: 0808 808 0545

Samaritans

Confidential help for anyone who is experiencing feelings of distress or despair, including those which may lead to suicide.
Web: www.samaritans.org.uk
Tel: 08457 909090

Saneline

Offers practical information, crisis care and emotional support to anybody affected by mental health problems.
Web: www.sane.org.uk
Tel: 0845 767 8000

Sense

Advice and services for deafblind children and young adults including self-help groups, residential and respite care and publications.

Web: www.sense.org.uk

Tel: 020 7272 7774

Sexual Health Helpline

Information, advice and counselling on all aspects of HIV, AIDS and sexual health.

Tel: 0800 567123

Skill

Promotes opportunities for young people and adults with any kind of disability in post-16 education, training and employment across the UK.

Web: www.skill.org.uk

Tel: 0800 328 5050

SupportLine

Confidential and emotional support on the telephone for children, young adults and adults who are socially isolated, vulnerable, at risk and victims of any form of abuse.

Web: www.supportline.org.uk

Tel: 020 8554 9004

Appendix F: Overview of themes and sub-themes from focus groups

Themes	Sub-Themes	Examples from Focus Groups
Types of Impact on Health	Physical -New Conditions	<p>'Stress related immune system deficiency. So trauma related'</p> <p>'My blood pressure also was very high.'</p>
	Existing	<p>'I was having routine blood for anaemia and they came back to me with the routine bloods three months after finding out, and they were saying oh your white blood count has gone down, there's a problem here.'</p> <p>'I have a condition anyway which is fibromyalgia, so obviously that affected that, fatigue. I found myself falling asleep at work. I also started comfort eating.'</p>
	Psychological - New Conditions	<p>'I lost a lot of weight: I went right now to seven-and-a-half stone. I used to cook every day for my children but I couldn't eat'.</p> <p>'Comfort eating, every time I felt that something would go wrong or worried about something I'd go straight to the cupboard and start eating ... and it was just like a trail from the sofa to the kitchen continually. I put on about one-and-a-half stone in weight.'</p>
Severity of Health Issues	Chronic	<p>'That feeling in your stomach, feeling sick, and that was every day I would say for three years.'</p> <p>'I ended up with high blood pressure, which they monitored for quite a few months. And as a result now four years down the line I've ended up on blood pressure tablets.'</p>
	Acute	<p>'I know at that point my body went into full shock and I was totally shaking.'</p>
Neglect of one's own Health	No time	<p>'I didn't give my own health any thought, absolutely'</p> <p>'...wasn't on the agenda.'</p>
	Child comes first	<p>'And I think you tend to hide it as well, because you know that they're hurt.'</p> <p>'The time when it was happening to my family I didn't think about me at all. It was all about my daughter and to keep her safe.'</p>
	Being healthy for your child	<p>'I know now I need to think about my health because if anything happens to me, and this is stupid but my thought is if anything happens to me who's going to look after her?'</p> <p>'...then it got to the point where I knew my health was going down the pan, and I had to look after myself in order to be able to be strong enough to help her.'</p>
Indirect Health Consequences	Environmental	<p>'Know if you've had that intimidation where they drive up and down and they're looking in your window and threatening your family, and telling you what's going to happen to your family.'</p> <p>'The first night we got a good night's sleep was when she was put into one stop down from a secure unit. And she was out of area, and we knew she was safe that night. Because like you said about a pin dropping, you're waiting for a phone call or any noises or for somebody to pass you some information. So your adrenalin is constantly going. So until you know your child's safe that doesn't stop. And then that's when for me the emotions I suppose came in, and the reality really hit.'</p>

Themes	Sub-Themes	Examples from Focus Groups
	Work/Employers	<p>'I also have quite a reasonably pressured job and sometimes I just can't cope with it.'</p> <p>'I lost 50% of my contract through work ... they said it was a conflict of interest, I still haven't been given a proper reason'.</p>
	Agencies' Failings	<p>'Well of course she point blank refused. It had taken us forever to get her to go in the first place, and because they'd messed up that was that, done.'</p> <p>F: I think in all of social care or anywhere where people are working with people. And so it becomes like Chinese whispers and the new workers...</p> <p>M: Yes, they never talk to each other.</p> <p>F: And as parents or for myself certainly, my stress levels have increased every time that happened, because there were more mistakes.'</p>
	Not being Listened to	<p>'It's horrendous. But they just keep telling me "oh you've got an inner ear infection". It's not an inner ear, I know it's not an inner ear infection.'</p> <p>'And we actually went in and again and again we explained what was going on. And they whatever... and they just didn't want to listen.'</p>
	Lack of Advice or bad advice	<p>'Driving home on the motorway she's having a flashback and she's trying to get out of the car. She's unlocking the seatbelt and getting out. And I'm thinking what do I do? Nobody's given me any advice.'</p> <p>'He suggested that I take her down to the red light area so she could see the young girls that were prostitutes and on drugs. That's what his advice was, and he was qualified'.</p>
	Adverse Coping Mechanisms	<p>'I basically was drinking a lot more to try and drown everything out what was happening.'</p> <p>'Comfort eating, every time I felt that something would go wrong or worried about something I'd go straight to the cupboard and start eating....and it was just like a trail from the sofa to the kitchen continually. I put on about one-and-a-half stone in weight.'</p>
	Seeking Help	
	Positive	<p>'...but the school offered to let me go there as well. And they also paid for me to go there. I think for the first four weeks I went there that man didn't get a word in edgeways.'</p> <p>'My GP was pretty good to be honest. He said why didn't I come before to see him and that. And he offered pills. I said I don't want to go down that road. And spoke to him regarding going onto counselling... he got straight onto it, so he was very supportive.'</p>
	Negative	<p>'I have mixed experiences with doctors. One doctor told me to pull myself together, just pull yourself together'</p> <p>'I've only been to the GP twice, both occasions relatively short consultations, and offered effectively antidepressants. And I just wouldn't take them.'</p>
	Self-Help	<p>'...eventually hopefully they'll come out of it. And they want to come to a parent that is strong and steady, not to a parent that's crumbled. So I'm thinking that you've got to pull yourself together, and that's what I did'.</p> <p>'I joined a gym as well, just more for my own wellbeing emotionally than particularly for fitness. It's more just to have a space for doing something positive, so it's not kind of drinking or eating.'</p>



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