APPENIDX 1

Young People's Sexual Health and Wellbeing

Summary of Needs and Commissioning Strategy

April 2013

Version 3 FINAL DRAFT

Contents

What has prompted this review?

National NHS Changes

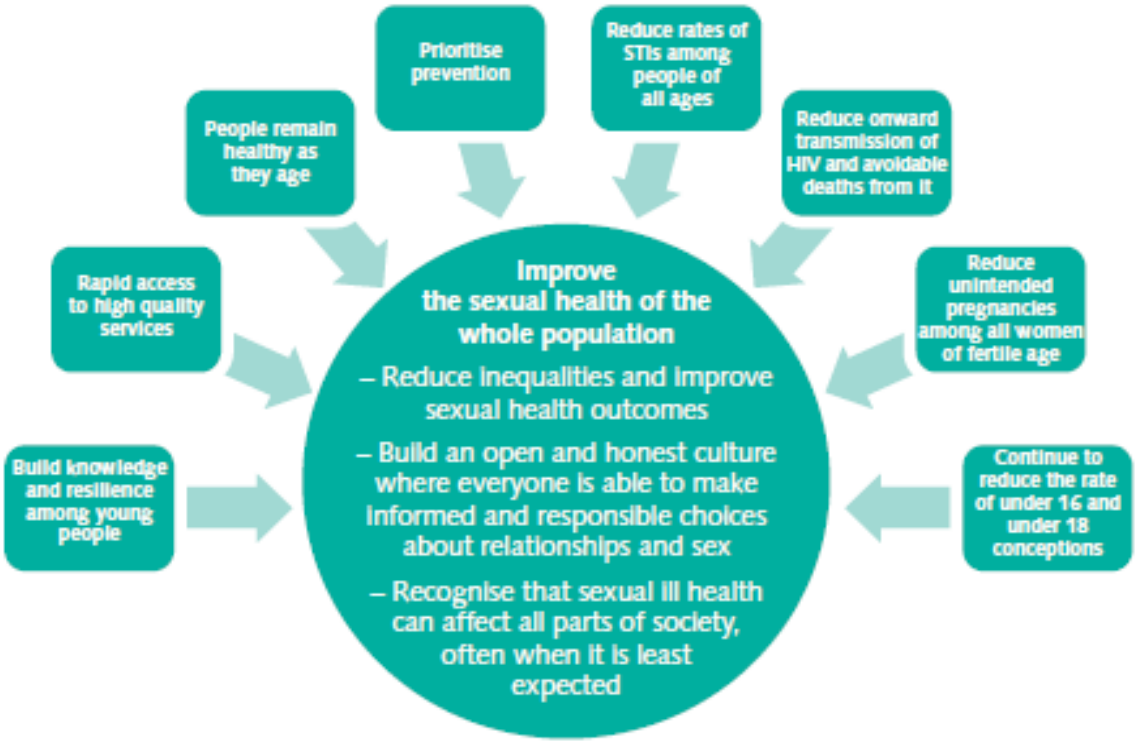
There are a number of key drivers which make a review of young people's sexual health and wellbeing services a timely undertaking:-

In March 2013, the Department of Health published *A Framework for Sexual Health Improvement in England*, setting clear priorities and ambitions for local commissioners and providers to work towards. The overarching objectives are set out in Figure 1.

The Framework sets out 3 specific sexual health indicators within the Public Health Outcomes Framework to drive improvements:

- Under 18 conceptions
- Chlamydia diagnoses in the 15-24 age group
- Late diagnosis of HIV

Figure 1: Key Objectives: Framework for Sexual Health Improvement, Department of Health



The Public Health Outcomes Framework *Healthy lives, healthy people: Improving outcomes and supporting transparency* sets out a vision for public health, desired outcomes and the indicators that will help local authorities understand how well public health is being improved and protected.

The framework concentrates on two high-level outcomes to be achieved across the public health system. The outcomes reflect a focus not only on how long people live, but on how well they live at all stages of life.

There are three specific outcome indicators for sexual health included within health protection (Chlamydia diagnosis and late diagnosis for HIV) and health improvement domains (under 18 conceptions)

Transference of Public Health in to Local Authorities
Due to the transference of public health into local authorities, Peterborough City Council will be required to commission a range of reproductive and sexual health services from 1st April 2013. Sexual health commissioning responsibilities are set out below (adapted from Framework for Sexual Health Improvement).

Figure 2: Sexual health commissioning responsibilities April 2013 onwards

<table>
<tr><th colspan="3">From April 2013</th></tr>
<tr><th>Local authorities will commission</th><th>Clinical Commissioning Groups (CCGs) will commission</th><th>The NHS Commissioning Board will commission</th></tr>
<tr><td rowspan="6">Comprehensive sexual health Services (CaSH). These include:
• contraception, including LESs (implants) and NESs (intra-uterine contraception) and all prescribing costs, but excluding contraception
provided as an additional service under the GP contract;
• sexually transmitted infection (STI) testing and treatment, Chlamydia screening as part of the National Chlamydia Screening Programme (NCSP) and HIV testing; •
sexual health aspects of psychosexual counselling; and
• any sexual health specialist services, including young people's sexual health and teenage
pregnancy services, outreach, HIV
prevention and sexual health promotion, services in schools, colleges and pharmacies.</td><td>Most abortion services (but there will be a further consultation about the best commissioning arrangements in the longer term)</td><td rowspan="2">Contraception provided as an additional service under the GP contract</td></tr>
<tr><td>Sterilisation</td></tr>
<tr><td>Vasectomy</td><td rowspan="2">HIV treatment and care (including drug costs for post-exposure prophylaxis
after sexual exposure)</td></tr>
<tr><td>Non-sexual health elements of psychosexual health services</td></tr>
<tr><td>Gynaecology, including any use of contraception for non-contraceptive purposes.</td><td>Promotion of opportunistic testing and treatment for STIs, and patient-requested testing by GPs</td></tr>
<tr><td>Cervical screening</td><td>Sexual health elements of prison health services
Sexual Assault Referral Centres</td></tr>
<tr><td>Specialist fetal medicine services</td><td></td></tr>
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Re-tendering of local sexual health services
The contracts for core reproductive and sexual health services will be re-tendered by Peterborough City Council during 2013/14 providing an ideal opportunity to shape future sexual health services for young people. This includes the Independent Sexual Violence Advocacy service (ISVAs). The raising of the participation age will mean more young people stay on in school or some form of learning until they are 18. Newly tendered sexual health services will need to take this into account to ensure services for young people remain accessible and at times and locations they want.

Government recognition of teenage intimate relationship abuse

As part of the Government's aim to end violence against women and girls the definition of domestic abuse changed in March 2013 to enable young people of 16 and 17 to be recognised as victims. This will require a joined up response from commissioners and local partners to meet the anticipated demand for victim and perpetrator services for young people.

Child Sexual Exploitation

Awareness of child sexual exploitation (CSE) has grown due to high profile cases in the national media and the CSEGG Inquiry by the Office of the Children's Commissioner. Procedures to identify and safeguard young people at risk of CSE have been established locally and services identified to support the small number of potential CSE victims. However, demand is likely to grow as awareness increases so a more sustainable level of service may be needed. Commissioner and providers must ensure local services are able to identify and respond to child sexual exploitation.

Review of Personal, Social and Health Education

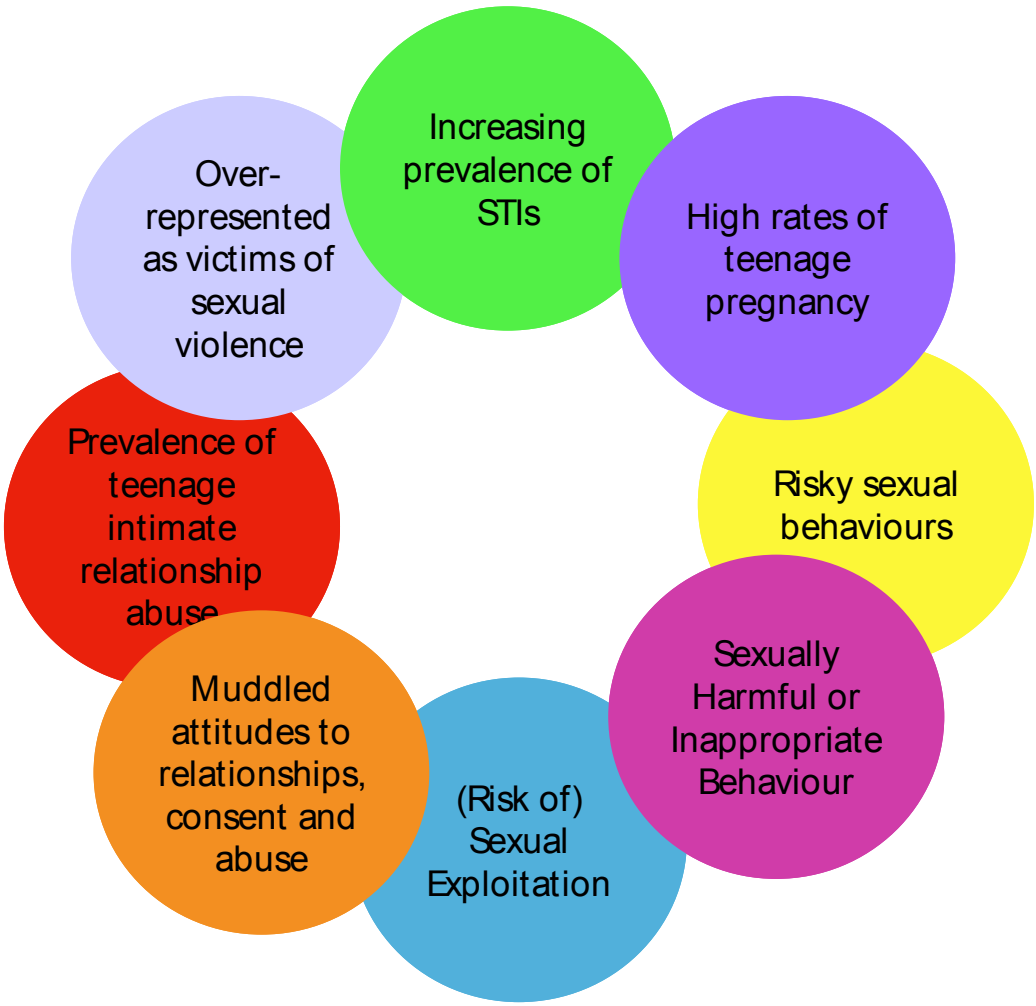
The Department of Education review into Personal, Social and Health education (PSHE) in March 2013 confirmed that schools will continue to decide on the content of their PSHE programme. This is important as the relationship between schools and the local authorities is changing. Schools are moving out of local authority control and funding previously administered by the local authority now directly given to schools. We must find new ways to encourage schools to invest sufficiently in SRE and preventative education and support them to commission high quality and value for money SRE provision.

Summary of Needs - Issues affecting young people's sexual health and wellbeing in Peterborough

Adolescence is a time of exploration, experimentation and risk taking behaviour as young people begin to develop intimate relationships with others and become sexually active.

In an ideal world, all young people would enter adolescence with the knowledge and resilience to develop respectful, loving intimate relationships and safe sexual practices. However, a significant proportion of local young people do not, resulting in a number of issues. These issues are set out below and have been identified through consultation with young people and the professionals working with them. They have also been informed by local datasets and academic research. The prevalence of these issues is explored in the following pages.

Figure 3: Current issues affecting young people's sexual health and wellbeing in Peterborough



Increasing prevalence of STIs

The prevalence of STIs is increasing and presents a key challenge for public health. Young people aged 15-24 experience the highest rates of STI diagnoses. Young people are also more likely to become re-infected with STIs (In Peterborough an estimated 6.7% of 16-19 year old women and 3.6% of 16-19 year old men treated for an acute STI by the GUM clinic in 2009 were re-infected within 12 months). Prevention efforts such as greater STI screening coverage and easier access to sexual health services should be sustained with greater focus on at risk groups.

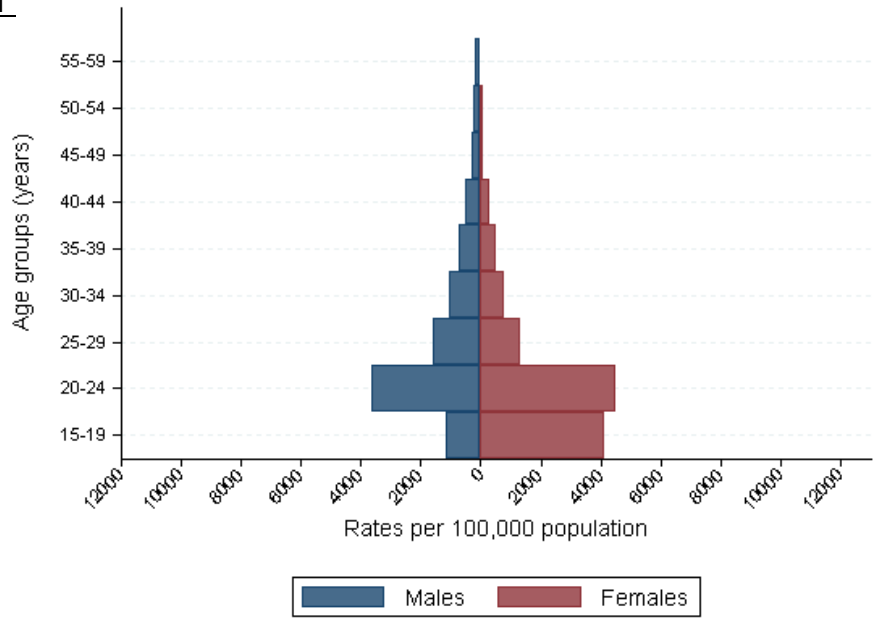
Chlamydia is the STI typically associated with young people. However rates of other less common STIs are on the increase particularly amongst young heterosexual people and gay and bisexual men. Nationally, rates of infectious syphilis are at their highest since the 1950s. Gonorrhoea is becoming more difficult to treat due to its ability to quickly develop resistance to antibiotic treatment[i].

Prevention of HIV remains a public health priority for local authorities. Early diagnosis is critical to reduce the spread of HIV in the local population. In 2011 47% of people diagnosed with HIV in the UK were diagnosed late.

Who is most at risk?

- Young people aged 15-24, young women in particular (no condom usage)
- Associated risk factors include deprivation, alcohol use, drug use and sexual violence
- Heterosexual males (compared to gay men)
- Nationally, Black African communities are associated with higher rates of STIs

Figure 4. Age group and gender of cases of acute STIs in Peterborough: 2011[ii]



Source: Data from Genitourinary Medicine Clinics and community settings (for Chlamydia only)

Local prevalence 2011
A total of 1232 acute STIs were diagnosed in Peterborough last year, a rate of 710.4 per 100,000 residents. Young people aged 15-24 accounted for 59% of all diagnoses locally. Rates of Syphilis (once relatively low) have more than doubled since 2009 and are above national and regional averages. Rates of Gonorrhoea have increased slightly since 2010 but re-infection rates amongst women in Peterborough are nearly double the national average (9.1% versus 3.8%). A HIV test was offered in 74% of attendances and a HIV test was done in 61% of attendances at GUM clinics by the residents of Peterborough. Nationally 77% of attendances at GUM clinics were offered a HIV test and a HIV test was done in 62% of attendances.
Peterborough has the 4th highest rate of Chlamydia diagnoses in the region (2201.7 per 100,000) whilst we should be aiming for a higher diagnosis rate of 2,400 per 100,000. A quarter of 15 – 24 year olds were tested for Chlamydia with a 9% positivity rate.

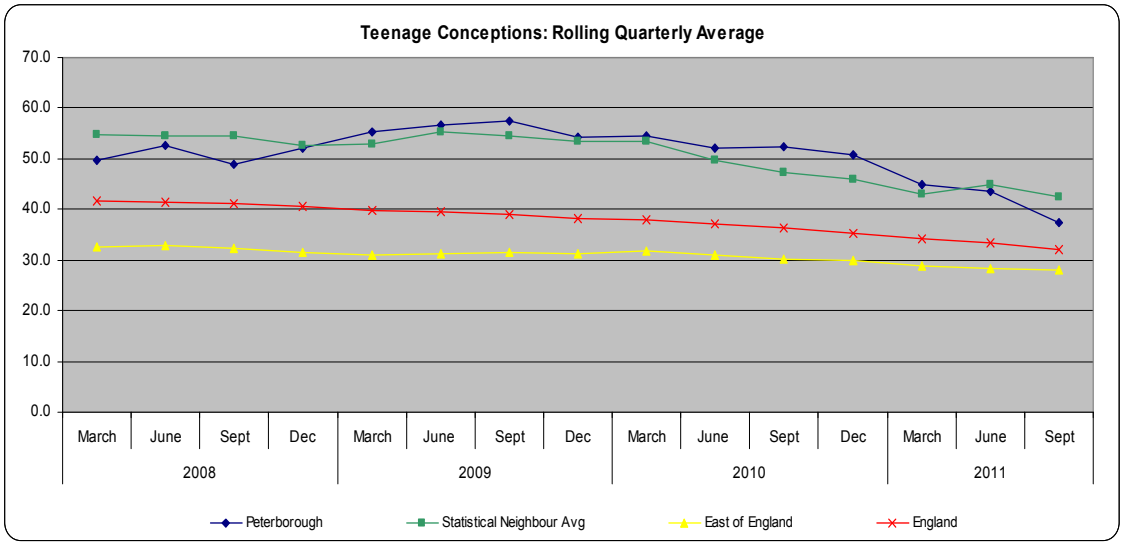
Please refer to the Health Protection Agency's report for a complete STI epidemiology for Peterborough.

High rates of teenage pregnancy

Peterborough's historically high rates of teenage pregnancy have fallen recently but remain above national and regional averages (see figure below). The negative impact on outcomes for both mother and child are well documented including increased rates of infant mortality, post-natal depression and living in poverty.

Research shows some young women who have terminations continue to have unprotected sex despite knowing the consequences and not wishing to become pregnant. Others have poor understanding of their fertility, leading to inconsistent contraceptive use and some struggle to use their preferred method of contraception effectively (e.g. the pill and condoms)[iii]

Figure 5: Comparative Analysis of Teenage Conceptions (Source: Office of National Statistics)



Nearly half of pregnancies (to women of all ages) are thought to be unplanned and the numbers of terminations have remained stable. However, the number of repeat abortions has risen during the last decade. Nationally in 2011, 26% of women under 25 having a termination had one or more previous abortions[iv].

Who is most at risk?

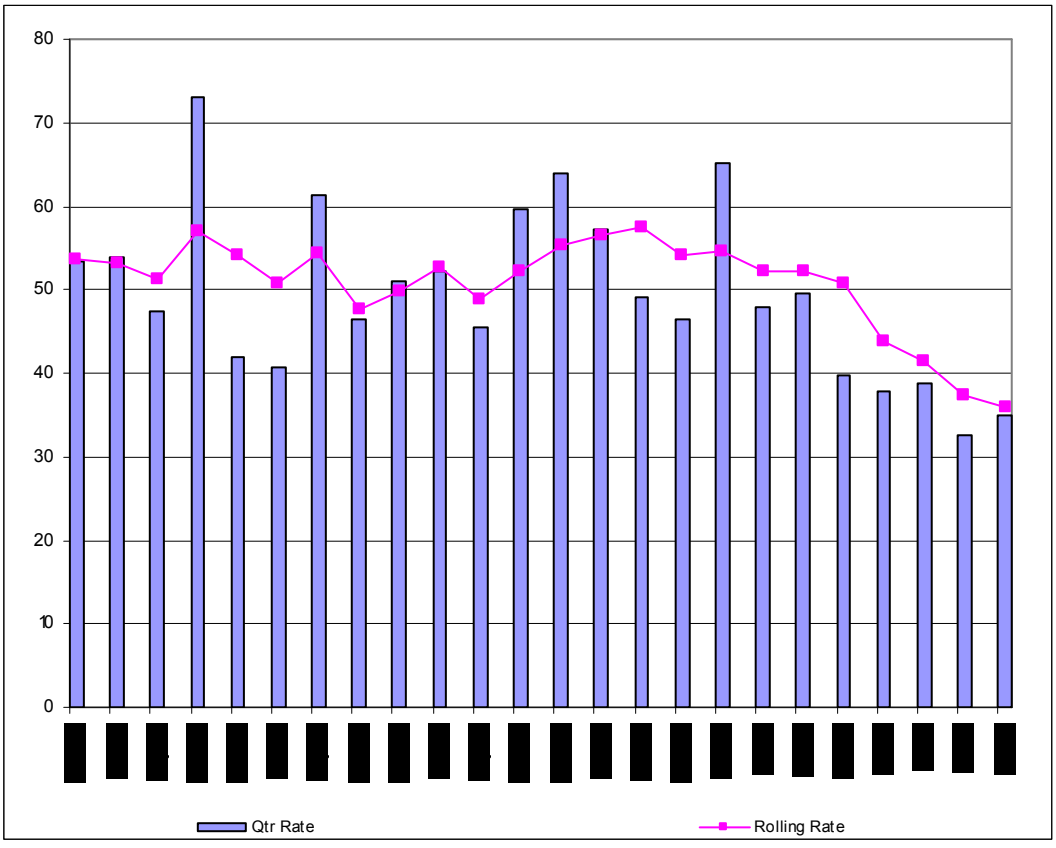
Associated risk factors for teenage pregnancy include:-

- living in a deprived area (four times more likely to become teenage parents)
- In or leaving care (three times more likely)
- Low educational attainment (twice as likely)
- Involvement in crime (twice as likely)
- History of sexual abuse (twice as likely)
- Daughter of a teenage mother
- Not in employment, education or training
- Low aspirations
- Poor school attendance/truancy
- Emotional/mental health problems

Historically, the overwhelming majority of teenage pregnancies in Peterborough were to White British young women. However, as the local community grows increasingly diverse professionals report early sexual activity and teenage parenthood amongst some newly established communities and ethnic minority groups (Lithuanian, Latvian and Portuguese) where it is culturally more acceptable.

Local prevalence
The latest data from the Office of National Statistics for December 2011 shows that the number of conceptions is remaining stable at a low rate of 34.9 in the quarter. The rolling quarterly average for 2011 is 36.0, which is what is used to compare to published data; the statistical neighbour average for the same period is 40.3 and England 30.9. Peterborough is between these two averages.
A complete set of local termination data was not available at the time of writing

Figure 6: Peterborough's rate of teenage conceptions per 1,000 females aged 15-17[v]



Risky behaviours and unsafe sexual practices

Alcohol and drugs

The links between alcohol and risky behaviour are well reported. Also, alcohol and drugs are commonly used during the grooming process of child sexual exploitation (CSE), either as payment or 'gifts'. Professionals reported the use of cocaine as a 'love drug' to make young people more receptive to sexual activity.

Local prevalence
Although alcohol admissions for under 18s in the city are below the national average professionals report a high prevalence of risky behaviours linked to alcohol. In particular is the 'YOLO' statement (you only live once) used as justification for risky and unsafe behaviour amongst young women identified by DrinkDrugSense through their work in HYPAs. The demand for alcohol education is clear. In one quarter alone over 727 pupils received alcohol risk information through HYPA clinics and a further 24 received brief interventions for problematic alcohol use.

Contraception

Contraception is vital to prevent pregnancy and transmission of STIs. In recent years, the investment has been made in promoting long acting reversible methods of contraception (LARC) to young people and making it more accessible.

Local prevalence
It is not possible to ascertain if young people's uptake of contraception has changed in recent years due to the way data is collected. We do know that the number of young people accessing the CaSH service has increased significantly following its relocation to Rivergate. The rate of emergency contraception (EHC) issued by the CaSH service has more than doubled between 2009 and 2012. HYPA clinics reached 3464 young people aged 11-19 in 2011/12 mainly for C-Cards and general advice. There has also been a steady increase in the uptake of LARC amongst young people.
Professionals report despite being signed up to the C-Card scheme, many young people still lack the motivation to use the condoms provided. Without condom usage, those fitted with LARC are not protected from the transmission of STIs and HIV. Local CaSH services report a wide range of risky sexual behaviours including 'text for sex' arrangements for casual sex, prevalence of multiple partners and a cohort of young people with multiple partners who refuse STI screening or contraception. This suggests risky sexual practices and a lack of motivation to use contraception are key issues to be addressed.

Victims of Sexual Violence and Abuse

Sexual violence encompasses a range of sexual offences against children and young people in a variety of contexts including:-

- sexual abuse at the hands of family members or other trusted adults
- highly publicised 'stranger' child abductions
- sexual violence/exploitation following internet/social media grooming
- sexual bullying and sexual violence perpetrated by peers, gangs and in teenage intimate relationships

Developments in online and social media present another context in which young people can become both victims and perpetrators of sexual violence, exploitation or abuse. Cyber-bullying in which peers post/circulate explicit images or videos of other young people is one common example. The CSEGG Inquiry has highlighted high levels of gang/group related acts of sexual violence between young people.

Sexual abuse can impact negatively on sexual behaviours in later life and increase propensity towards revictimisation. Sexual abuse in childhood is associated with high risk sexual behaviours in adolescence and adulthood including earlier onset of sexual activity, multiple partners and unprotected sex[vi]. Research shows those who experience rape or attempted rape in adolescence are nearly 14 times more likely to experience rape or attempted rape in their first year of college (age 18)[vii]. The most serious forms of sexual abuse (penetrative assault) are also associated with increased prevalence of prostitution[viii].

Theories suggest sexual abuse and violence interferes with social and emotional development, in turn creating negative coping behaviours and a lack of risk awareness[ix]. Timely, effective therapeutic support for victims can help to prevent further victimisation in adolescence and adulthood.

Who is most at risk?
Young women are at greatest risk of sexual assault[x]

Local prevalence
Children and young people make up a significant percentage of sexual offence victims. Over a third of all reported rapes are against children under 16 (36%)[xi]. An estimated 42% of victims of police reported serious sexual offences in the city between November 2011 and 2012 were under 18 with sexual assault being the most common offence. **The exact number of children and young people affected by sexual abuse and violence is not known. However we do know in 2012, 60 children and young people were seen at the SARC (of which 10 were under 13 and 50 were 13-18).**
The numbers of children on child protection plans with a category of sexual abuse range from around 8-14 in a year. They include both genders and ages range from under 1 to over 16.

Teenage Intimate Relationship Abuse (TIRA)

Teenage intimate relationship abuse refers to the domestic abuse that occurs between young people in (or previously in) intimate relationships. In line with the national definition of domestic abuse TIRA includes controlling, coercive or threatening behaviour, violence or abuse which may be psychological, physical, sexual, financial or emotional. It includes 'honour' based violence, forced marriage and female genital mutilation.

Domestic abuse between young people in intimate relationships is a growing child welfare issue. According to the British Crime Survey, young people aged 16-19 are the most likely to suffer abuse from partners. However research undertaken by the NSPCC suggests 13-15 year olds are just as likely to experience partner violence as those aged 16-19.

NSPCC research in 2009 found a quarter of girls and 18% of boys reported some form of physical partner violence and a third of girls and 16% of boys reported some form of sexual partner violence. Emotional partner abuse was widely reported by both sexes.

High levels of coercive control were noted. Surveillance via social media, online activity and location tracking was widely reported and one of the main instruments used to control and coerce partners.

The survey also highlighted the increased incidence of domestic abuse where girls have a boyfriend 2 years or more older. In these cases, 66-80% of girls reported experiencing emotional, physical and sexual partner violence.

Both national and local surveys have found the majority of young people would not report abuse to an adult or even friends.

Who is most at risk?

- Females 13-19
- Have an older boyfriend (2 years+ older)
- Same sex couples
- Generally White British with White Other (Lithuania, Poland, Portugal and Lativa) over-represented (based on local adult victim profile)[xii]

Local Prevalence
One in six teenage girls reported intimate partner violence[xiii]. However, it is likely to be an under-reported issue with demand for services for victims and perpetrators increasing as awareness grows. **In 2011-12, the Independent Domestic Abuse Advisor (IDVA) service which supports high and very high risk victims worked with 6 victims under the age of 18 (equivalent to 0.5% of overall caseload). The actual number of low, medium, high and very high risk victims under 18 is not known.** **There is no local profile of young people who are abusive or victims of domestic abuse.**
Young people aged 18-21 accounted for 18% of all Community Orders for domestic abuse cases in 2011-12. During 2011-12 the Specialist Domestic Violence Court successfully prosecuted 1 male under 18 and 44 aged 18-24. A further 18 prosecutions against young people aged 18-24 were unsuccessful. Two females

aged 18-24 where also successfully prosecuted. [xiv]

Muddled attitudes towards relationships, consent and abuse

" I've been raped so many times I'm addicted to sex"

National and local research along with feedback from professionals clearly shows many young people have confused understanding of what constitutes a healthy relationship. This may stem from a lack of appropriate intimate relationship modelling at home, prevalence of domestic abuse and the impact of learning disabilities on young people and/or parents' understanding of healthy relationship norms. It may also relate to wider societal factors such as easy access to (extreme) pornography through the internet and increasing sexualisation of media and advertising.

The legal framework around sexual activity (consent in particular) is not well understood. A significant percentage of young people (boys in particular) do not understand the law in relation to age of consent or the inability of an intoxicated female to give consent, thereby placing themselves at risk of committing offences. The wider definition of rape is not well understood (in that it now includes oral and anal rape).

There is widespread acceptance of abuse, (sexual) violence, coercion and control as norms of relationship behaviours. For example, 40% of boys surveyed locally did not think pressuring someone into sexual acts against their will was abusive[xv]. Many also minimised their use of violence as 'messing around'. Professionals report working with a minority of young people who are 'de-sensitised' to rape and interpret it as sex.

NSPCC research found that girls were unsure of the difference between caring concern and coercion. High levels of self blame where reported amongst girls who had been sexually coerced by their partners and feeling too scared to challenge. Surveillance of partners through online, social media and mobile telephones was considered normal. There is little recognition of the emotional, sexual and financial forms of domestic abuse.

Who is most at risk?

Associated risk factors may include dysfunctional family, exposure to domestic abuse, history of abuse and or violence, susceptible to negative peer and media influences, lack of positive role models, accurate information and resilience factors

(Risk of) Sexual Exploitation

Child sexual exploitation (CSE) occurs when children and young people engage in sexual activity often in return for gifts (money, alcohol, drugs, mobile phones etc) or 'affection'. The child/young person may consent but in reality has little choice. Violence, coercion and intimidation are commonplace, as are exploitative relationships in which the adult has significant power over the child/young person. CSE is a form of abuse.

CSE can occur in a number of contexts[xvi]:-

- through inappropriate relationships (where there is a significant age gap or power imbalance)
- Boyfriend model in which a perpetrator befriends and grooms a young person into a relationship before coercing them into sexual activity with associates
- Peer model in which sexual coercion occurs through peer groups or gangs
- Organised exploitation/trafficking in which young people are passed through networks and geographical areas and coerced into sexual activity with multiple men

Who is most at risk[xvii]?

- Young people aged 10-15
- Girls (six times more likely than boys)
- Have boyfriend more than 2 years older
- Experienced recent bereavement/loss
- Living in dysfunctional family
- Experienced sexual or other forms of abuse (sexual re-victimisation in adolescence appears to significantly increase the risk of sexual assault in adulthood[xviii])
- Peer or gang association with or attends the same school as young people who are sexually exploited
- Homeless or in temporary accommodation
- In residential care
- Young carer

National research suggests that young people involved in CSE have significant physical and emotional health needs too. Drug and alcohol use was found to be common, with dependence an issue for several. Many report significant mental health issues including self injury and depression along with being underweight and experiencing sexual assaults and unintended pregnancies[xix].

Sexually Harmful or Inappropriate Behaviours

Some children and young people display inappropriate or harmful sexual behaviours towards their peers or others in society. In many cases developmental issues, learning disabilities or a lack of appropriate parenting contribute to inappropriate sexual behaviours. Early intervention can support these children and their families in changing their behaviour.

However nearly half of adult sex offenders show the onset of sexual deviance in puberty and begin offending in adolescence. Specialist interventions are needed to manage this very small number of children and young people to prevent them becoming adult perpetrators in the future.

Who is most likely to exhibit inappropriate/harmful sexual behaviour?
(a.) Males aged over 11 (peak age of offending nationally is 15)

(b.) Children/ young people with Learning difficulties/disabilities or Autistic Spectrum Disorder[xx]

(c.) Children and young people who have been sexually, physically or emotionally abused[xxi]

How well does the current system meet the needs identified?

A SWOT analysis was undertaken and the strengths of the system are identified below.

Integrated and community approach to service delivery

Reproductive and sexual health services in Peterborough operate through an integrated model of provision including GPs, Walk In Centre and CaSH Service who offer a full range of contraceptive and STI screening services. The GUM department provides services from a hospital setting. This predominantly community based approach promotes ease of access and reduces stigma.

The relocation of the CaSH service from Wellington Street to the more modern and visible Rivergate complex has resulted in increased numbers of young people attending the service. The opening of Primark has drawn more young people to the city centre and a correlating increase in CaSH attendance, suggesting a highly visible city centre location is popular with young people

Easy access to termination services

Self referral routes for terminations are in place to avoid delay and offer improved accessibility and increased patient choice.

Improved support for victims of sexual violence

The Sexual Assault Referral Centre (SARC) has been in operation since 2009 set up in partnership with Cambridgeshire Constabulary and the NHS covering Peterborough and Cambridgeshire clients.
The local SARC has been a centre of excellence for partnership working to date, managed by the CASH service, however the responsibility from 1st April 2013 for commissioning of SARC lies with the National Commissioning Board and new links are currently being forged. Alongside this, there are independent sexual violence advocates to provide support to adult victims.

Robust approach to STI screening

There is a coordinated approach to STI screening as the Chlamydia Screening Programme and HIV prevention is now provided by the CaSH service (following withdrawal by Terence Higgins Trust). HIV testing is widely available for easy access through GPs, CASH and GUM services and is routinely carried out at the Maternity services. HIV testing is offered routinely with an 'opt-out' approach to all pregnant women at Peterborough City Hospital.

Young people can access STI screening and treatment through a community setting with familiar staff such as a HYPA or at the CaSH office rather attending than a hospital setting. All young people screened under through the Chlamydia Screening Programme are tested for Gonorrhoea. Results are coordinated through the CSP and treatment can be provided in community settings like HYPAs or CaSH if young people prefer.

Additional services for young people

An additional layer of interventions are targeted to those under 25, given the high proportion of STIs amongst this age group and the city's high rates of teenage pregnancy. The CaSH service has a small dedicated young people's team. Collectively they provide and coordinate:-

- A dedicated contraceptive nurse for females under 18 who have undergone terminations, miscarriages or given birth to prevent unintended repeat pregnancies
- Specialist outreach and school based clinics for young people (known as HYPAs)
- Dedicated condom distribution scheme for young people (known as C Card scheme)
- Input into sex and relationship education in schools
- Training for other professionals including schools, youth and community settings

Improved access to long acting methods of contraception

As part of the Teenage Pregnancy Strategy, long acting methods of contraception have been promoted to young people since 2009. As a result, up take has been steadily increasing. LARC fitting training and a GPSI (GP with Specialist Interest) clinic have resulted in an increased range of providers offering LARC. Further local LARC training for GPs and Practice Nurses is planned with a view to further increasing patient choice and access Further investment to improve LARC uptake has been commissioned through CaSH services which is community based and accessible to young people. In addition to be supported by by a GP champion with special interest and supported by nurse led clinics. As a result this will improve inappropriate referrals to Gynaecology department and provide consistency in provision of LARC via GP surgery or CaSH.

School based sexual health services

Most secondary schools host a HYPA clinic which provide easy access to contraception and sexual health services, information and advice. HYPAs also facilitate swift and easy access onto other services including CaSH, GUM, termination services and drug and alcohol treatment.

HYPAs are trusted and well attended by young people. Consistent staffing of HYPAs allows young people to build trusting relationships with staff and feel comfortable disclosing sexual violence, exploitation and abuse.

Easy access to free condoms

The C-Card scheme gives young people the opportunity to access free condoms easily around the city, including schools. Every young person signed up to the scheme receives good quality sexual health promotion as well as information on correct condom use. The C-Card scheme operates closely with the Chlamydia Screening service and CaSH service to give young people swift and easy referral into full sexual health services if required.

Recognition of domestic abuse

The needs of young people are visible in the Safer Peterborough Partnership's Domestic Abuse Strategy 2012-15. They include:-

- Improving input into local schools
- Provision of services for young people as victims
- Consultation with young people about their views and experience of domestic abuse

The priorities also focus on prevention and awareness raising, improving support services for victims and developing joint commissioning arrangements. Probation and Youth Offending Services are currently developing domestic abuse interventions for young adults aged 18-21 and 16-18 respectively.

Joint strategic response to Child Sexual Exploitation

Peterborough's response to child sexual exploitation has been rapid. Effective partnership working has resulted in the development of a clear procedures and identification tools. Joint working arrangements between the police and Children's Services for potential CSE cases are in place, along with a regular panel to allocate support services to victims and their families. The development of a Multi-Agency Referral Unit (MARU) 'Hub' in Peterborough will greatly improve intelligence gathering and action against child sexual exploitation.

Services for children and young people exhibiting sexually harmful or inappropriate behaviour

A pathway has been recently developed for children and young people demonstrating harmful or inappropriate behaviour. It is multi-disciplinary, working across Youth Offending Services, Children's Social Care, Adolescent Intervention Services and the Problem Sexual Behaviour Multi-Systemic Therapy (MST-PSB) team. A new policy is being developed to support this and briefings undertaken with local school headteachers.

Collaborative working

Historically, the local authority and NHS Peterborough have worked closely together on the teenage pregnancy agenda. This partnership approach continues as Public Health becomes part of the local authority. Effective joint working between Children's Services and Public Health, commissioners and providers means working together to make sure services are most responsive to young people's need.

Weaknesses

Shortage of Services

The consultation with professionals identified a number of gaps in provision:-

Lack of specialist psychological treatment for child and adolescent victims of sexual abuse or violence
Currently, there is no service in place to provide specialist treatment modalities for children and young people who have been victims of sexual abuse or violence through the SARC, CAMHs or any third sector organisation.
Lack of independent support/advocacy for children and young people (and their families) affected by sexual abuse, violence and exploitation
The SARC currently employs 1.5 Independent Sexual Violence Advisors (ISVAs) to work with adults but none to work with children and young people. The Department of Health includes Child ISVAs in its care pathway guidance[xxii]
Lack of independent support/advocacy for young people affected by teenage intimate relationship abuse
Independent domestic abuse advocates (IDVAs) provide advocacy, support and risk management advice to people experiencing domestic abuse. Currently, there are 2 IDVAs to work with adults and non to work with young people.
Lack of interventions for perpetrators of teenage intimate relationship abuse
There are no targeted level interventions to work with young people who are perpetrators of domestic abuse nor is there a specific evidence based intervention for convicted young perpetrators (such as an equivalent to the IDAP programme provided by Probation).
Shortage of sexual health promotion, education and early intervention
Following the loss of the Sexual Health Education Project (SHEP) there is limited PSHE enhancement by local agencies. Professionals report very little (if any) preventative or early intervention services for teenage intimate relationship abuse, sexual violence or sexually harmful behaviour. This is at both a targeted and universal level.

Limited access to CaSH services

According to You're Welcome, young people's CaSH services should be accessible and at times convenient to them. That means 7 days a week and at times and locations best for young people. Although 7 day a week access to free contraception is available through the integrated model of provision not all are necessarily young people friendly. However this will be addressed through new contracts for CaSH services and anticipated improvements.

The CaSH service currently operates 16.5 official hours of clinic time over 4 days (including Saturday mornings and some evenings) from its city centre base. Reception is open Mon-Fri 9-5 for appointments and condom collection. If a patient drops in outside of clinic times they will be accommodated if a nurse is available but this is described as 'hit and miss'. There is limited doctor availability and additional services tend to be ad hoc (for example nurse led LARC sessions).

HYPA clinics are term time only leaving a significant gap in holiday time. Outside of these times, young people must seek out alternative services which can be especially difficult at weekends or during school holidays.
We must remember that not all young people are motivated or confident enough to seek out alternative services such as GPs or the Walk In Centre so may go without.

HYPA Clinics – accessible and sustainable?

HYPA clinics are dedicated clinics for young people, mostly based in school settings. They are intended to be general health clinics which also offer sexual health and contraceptive services. Sustainability issues in other services such as School Nursing, and the 0-19 service has resulted in fewer agencies being present at the clinics. The CaSH service along with DrinkDrugSense (who are contracted to deliver in HYPAs) now 'hold' the HYPAs together. The commitment of other agencies is unclear meaning the HYPAs are not sustainable. There is no spare capacity to grow further HYPA clinics.

HYPAs are in most but not all secondary schools. One or two of our secondary schools with high need do not have any form of HYPA clinic. Specials Schools and alternative learning settings do not have HYPA clinics suggesting there is inequality of access, particularly amongst vulnerable and disadvantaged groups.

Sustainability of paediatric service for child victims of sexual violence

Historically, the acute paediatric service for child victims of sexual violence at the SARC was provided by CPFT. This service is currently being provided by the Forensic Medical Examiners (G4S) whilst a sustainable, long-term solution is being explored. Young people over 13/14 are also seen by FMEs at SARC. A routine child protection clinic delivered by CPFT has ceased but a long-term solution is being explored.

Limited health promotion and service publicity

Health promotion and service publicity is limited due to lack of capacity. Until 2010, Peterborough benefitted from a multi-agency Sex Health Education Project (SHEP) and Sexual Health Education Outreach Project (SHOP). SHEP and SHOP provided a coordinated programme of education, health promotion and targeted outreach for young people. It was delivered by youth workers, CaSH nurses, School Nurses, Drug and Alcohol Workers and HIV workers. It was offered free to schools and undertook an annual calendar of outreach events. In doing so, it engaged vulnerable groups and publicised local services directly to young people.

The capacity issues affecting CaSH mean there is limited health promotion work or service publicity. DrinkDrugSense are currently funded to promote the 'Z Card' service directory for young people via a separate alcohol contract with Public Health.
There is no annual calendar of events to raise awareness or promote services to young people. Feedback from some direct consultation with young people, particularly those who are vulnerable or newly arrived show a lack of awareness of where to access CaSH services.

Targeting of at risk groups

It is unclear from data returns how well sexual health services engage with at risk and diverse groups. There is limited evidence of targeted or differentiated approaches to publicity, health promotion and service delivery. Delivery is characterised by universal or open access settings which may exclude young people with physical, cultural, learning or communication barriers.

Services need to demonstrate a more proactive approach to engaging and meeting the specific needs of vulnerable young people. Innovation is needed to reach out to at risk groups and make better use of alternative settings in the community rather than relying on schools alone.

Variable quality and content of PSHE in Secondary School

Schools are required to deliver the basic biology of reproduction and contraception. Inclusion of wider sexual health and wellbeing topics depends on the school and can

vary significantly in content and quality. Since SHEP ended, there has been no coordinated multi-agency input into PSHE offered to schools. Instead, schools opt to spot purchase input (or not) from local agencies.

Professionals have noted concerns about the rigour of SRE for pupils with learning difficulties and disabilities (both in mainstream and special schools). They felt input wasn't suitably tailored to the level and learning styles of this particular cohort. One Special School has developed excellent partnership arrangements with the CaSH service and School Nursing Service, this should be reflected across all settings.

Informal discussions with some local secondary schools suggest there is a worrying lack of awareness of emerging sexual health and wellbeing issues including CSE, sexual violence and teenage intimate relationship abuse. Schools would welcome briefings guidance and materials to ensure their PSHE content was reflective of current issues

Unclear if sufficient support is available for children and young people affected or infected with HIV

Until April 2013, Peterborough had a specialist HIV service in Adult Social Care, part funded by Children's Services. It undertook significant work with children and young people affected by HIV (e.g. where a parent/carer has HIV) and for children infected with HIV. The service ended and its work is now undertaken by Adult Social Care. There is a significant risk that the needs of children and young people affected or infected with HIV may lose visibility in an adult only service. This would limit any early intervention to support vulnerable children and HIV prevention public health work. We must ensure sufficient provision and clear pathways to support children affected or infected with HIV is available and actively used by all services.

Visibility of sexual health and wellbeing issues in safeguarding policies/practices

There is limited use of CAF and Team Around the Child to identify and support vulnerable young people with sexual health and wellbeing issues. This is particularly important for health professionals such as CaSH Nurses and School Nurses who may be first approached by young people for advice or treatment. Completion of CAF/TAC are essential to identify and tackle the causes of young people's risky behaviours that are a 'cause for concern' but do not reach safeguarding thresholds.

There is a lack of awareness amongst the children's and wider workforce of CSE, teenage intimate relationship abuse, sexually harmful behaviour and sexual violence.

There is no LSCB safeguarding guidance in relation to teenage intimate relationship abuse. LSCB guidance and safeguarding training should be revised to include sexually harmful behaviour, teenage intimate relationship abuse and sexual violence. Action is needed to raise awareness of these issues as safeguarding issues amongst wider settings including schools, GPs and hospitals. There is a need for 'whole school' awareness, not just the designated Child Protection lead.

Complex Commissioning and Delivery Model

The future landscape will operate in a four tiered commissioning structure. In addition to the formally designated commissioners (Local Authority, Clinical Commissioning Groups and National Commissioning Board) schools and third sector agencies will increasingly function as grassroots commissioners, purchasing and developing services themselves.

With the range of providers involved and multiple layers of commissioners, it is possible the wishes and preferences of local children and young people may be lost. Strategic

coordination, partnership working and involvement of children and young people in service design and delivery is needed to prevent this from happening.

Informatics and performance monitoring

It is difficult to obtain overall figures of young people's contraceptive and sexual health uptake due to the number of providers, different data collection methods and lack of a common dataset. This makes analysis of service demand, uptake and waiting times difficult. A more robust system which includes recording of age, gender, ethnicity, sexual orientation would be more informative for future service planning and commissioning.

At present, there is no Home Office code for CSE making identification and recording difficult. The Safer Peterborough Partnership has already identified the need to develop an offender profile analysis for CSE.

What do young people think?

Young people were asked about their experiences of sex and relationship education (SRE) through discussions and a simple questionnaire completed in youth clubs and HYPA clinics.

A total of 47 surveys were completed by young people from aged 11-20. The findings echo earlier, national surveys in many ways. Most young people rely on school as their main form of education about sex and relationships, followed by friends, the media and internet. This reinforces the importance of school-based SRE as the accuracy of the other SRE sources is variable. Few benefit from family or parent provided SRE.

Nearly all young people surveyed had received SRE and assessed it's quality as average to good. However, its not clear if this refers solely to school delivered SRE or additional input through youth clubs and HYPAs.

When asked where they would like to go for SRE HYPAs, sexual health centres and health clinics were more popular amongst those who already attended HYPAs. Those surveyed in youth clubs preferred youth clubs and sexual health clinics. This may reflect the trust and credibility built through forums such as HYPAs and youth clubs. A small number of respondents would like to go to their GP surgery. In terms of professionals, young people unanimously prefer school nurses, sexual health nurses and youth workers to deliver SRE than teachers.

More in depth discussions were held with the Youth Council, girls youth group, PYA Pakistani youth group and Voyager Dance & Century Arts group.

The Youth Council felt the quality of SRE is not good enough, that 'you are lucky if you get a teacher who can deliver it without being embarrassed and muddling through it'. Where positive experiences of SRE exist it is often due to outside agencies coming in to deliver. However, this 'whole school in one day' approach can mean students who are off miss out. Emphasis on staff training is needed, along with embedding SRE as a core part of PSHE curriculum – a curriculum for life.

Feedback from the girls group (which targets girls with risky behaviour) suggests they do not recall any of the SRE they received in Year 8. They did not know where to get tested/treatment for STIs and discussed pregnancy and abortion in a very casual sense, suggesting they did not appreciate the life changing effects of either. The girls also reported feeling unable to ask questions in mixed gender SRE sessions.

The discussion of SRE for this consultation was a first at the PYA Pakistani youth group. Although a mostly male group, they still considered sex a taboo subject and were fearful of discussing due to worries about confidentiality. They preferred not to discuss with the subject with professionals who are part of the Muslim community. The youth worker suggested future sessions would benefit from professionals from outside agencies including Islamic scholars to educate young people to make informed choices, rather than relying on prohibition.

The Voyager Dance and Century Arts group has a high proportion of young males from Eastern European/Roma cultures. Prohibition of sex before marriage is a religious and cultural norm, to the extent the youth worker had been advised not to discuss the issue. However, a number of the young men have approached the youth worker for information and advice about sex. Those who have been educated in the UK recall the basic reproduction aspect of SRE in Year 8/9 and had some limited understanding of STIs and contraception. They did not know about STI symptoms or how to get free

contraception. Most of them admitted to buying condoms from toilets in Tesco's or stealing them from shops. They also had some gaps in knowledge around sex and the law, not fully understanding consent or that it is illegal to have sex in public. They also showed tolerant attitudes towards domestic abuse saying 'it's the man's job to punish a woman if she's done something wrong'.

A Facebook survey completed by over 300 young people in 2009 in the city provides insight into how we can best raise awareness of contraception. Responses centred around:-

'Show us the consequences'

- Use graphic images/pictures
- Share people's real life stories/ experiences
- Give us the stats!

'Use the media'

- Use Facebook and other social networking
- Use viral emails/ videos etc
- Advertise in public spaces with posters and leaflets aimed at young people (with humour)
- TV advertising

'Use big events'

- Bring Embarrassing Bodies or The Sex Education Show to the city
- Have fun, interactive events in the city centre with free giveaways

'Education!'

- Do SRE earlier
- Deliver better SRE – regular talks in school not by teachers, use MTV programmes like Teen Mom or 16 and Pregnant

Learning Points for Commissioners
Use school as the main forum for SRE but enhance delivery by use of School Nurses, Sexual Health Nurses, Youth Workers and other outside agencies. The teenage pregnancy pilot (2009) showed that a programme of SRE delivered in school by these professionals raised the profile and uptake of their services, including a significant increase in HYPA attendance. These professionals appear to be more trusted and credible to young people than teaching staff when it comes to sexual health and wellbeing.
Health promotion and service publicity are much needed both universally and in a targeted way. Attention should be given to reaching vulnerable young people and those of different cultures and nationalities. Messages should be tailored reflect the different cultural and religious beliefs

What should the future service landscape look like?

We want all children and young people to have the knowledge and resilience to develop respectful and loving relationships and engage in safe sexual practices when they are ready. This requires significant emphasis on prevention, building resilience and targeting of at risk groups.

The range of services we provide for children and young people must evolve to reflect this. The proposed service landscape for 2014 onwards is illustrated in Figure 8. It is based on the ambitions of the Department of Health's Framework for Sexual Health Improvement in England.

Figure 7: Ambitions (relevant to under 25 population), Framework for Sexual Health Improvement in England, 2013

Sexual health up to age 16

AMBITION: Build knowledge and resilience among young people

- All children and young people receive good-quality sex and relationship education at home, at school and in the community.
- All children and young people know how to ask for help, and are able to access confidential advice and support about wellbeing, relationships and sexual health.
- All children and young people understand consent, sexual consent and issues around abusive relationships.
- Young people have the confidence and emotional resilience to understand the benefits of loving, healthy relationships and delaying sex.

Young people aged 16–24

AMBITION: Improve sexual health outcomes for young adults

- All young people are able to make informed and responsible decisions, understand issues around consent and the benefits of stable relationships, and are aware of the risks of unprotected sex.
- Prevention is prioritised.
- All young people have rapid and easy access to appropriate sexual and reproductive health services.
- All young people's sexual-health needs – whatever their sexuality – are comprehensively met.

Prevention

AMBITION: Prioritise prevention

- Build a sexual health culture that prioritises prevention and supports behaviour change.
- Ensure that people are motivated to practise safer sex, including using contraception and condoms.
- Increased availability and uptake of testing to reduce transmission.
- Increase awareness of sexual health among local healthcare professionals and relevant non-health practitioners, particularly those working with vulnerable groups.

Our future service landscape should continue to have an early intervention and prevention focus to reduce the number of young people with STIs, unwanted pregnancies and experiencing sexual violence or relationship abuse. However, our approach to sexual health and wellbeing should become holistic, taking account of the underlying and accompanying issues which contribute to sexual risk taking and victimisation.

It is proposed to align services around a stepped care model which reflects the universal, targeted and specialist tiers in the Vulnerability Matrix. Pathways are needed to ensure access to appropriate services is clear.

The key universal foundations of our service model are:-

- High quality PSHE and SRE
- Easy access to reproductive, sexual health and wellbeing services
- Widespread sexual health promotion and service publicity

Additional targeted approaches and interventions are needed to engage and support 'at risk' groups. These include:-

- Additional learning needs
- English as an additional language and/or newly arrived
- Lesbian, gay, bisexual and transgender
- Physical disabilities
- Cultural/religious beliefs
- Gender specific needs
- Experiencing high levels of deprivation
- Homeless
- Victims of sexual violence
- Victims of domestic abuse (including female genital mutilation)
- Those who demonstrate abusive behaviours in relationships
- Drug or alcohol misuse
- Mental health problems

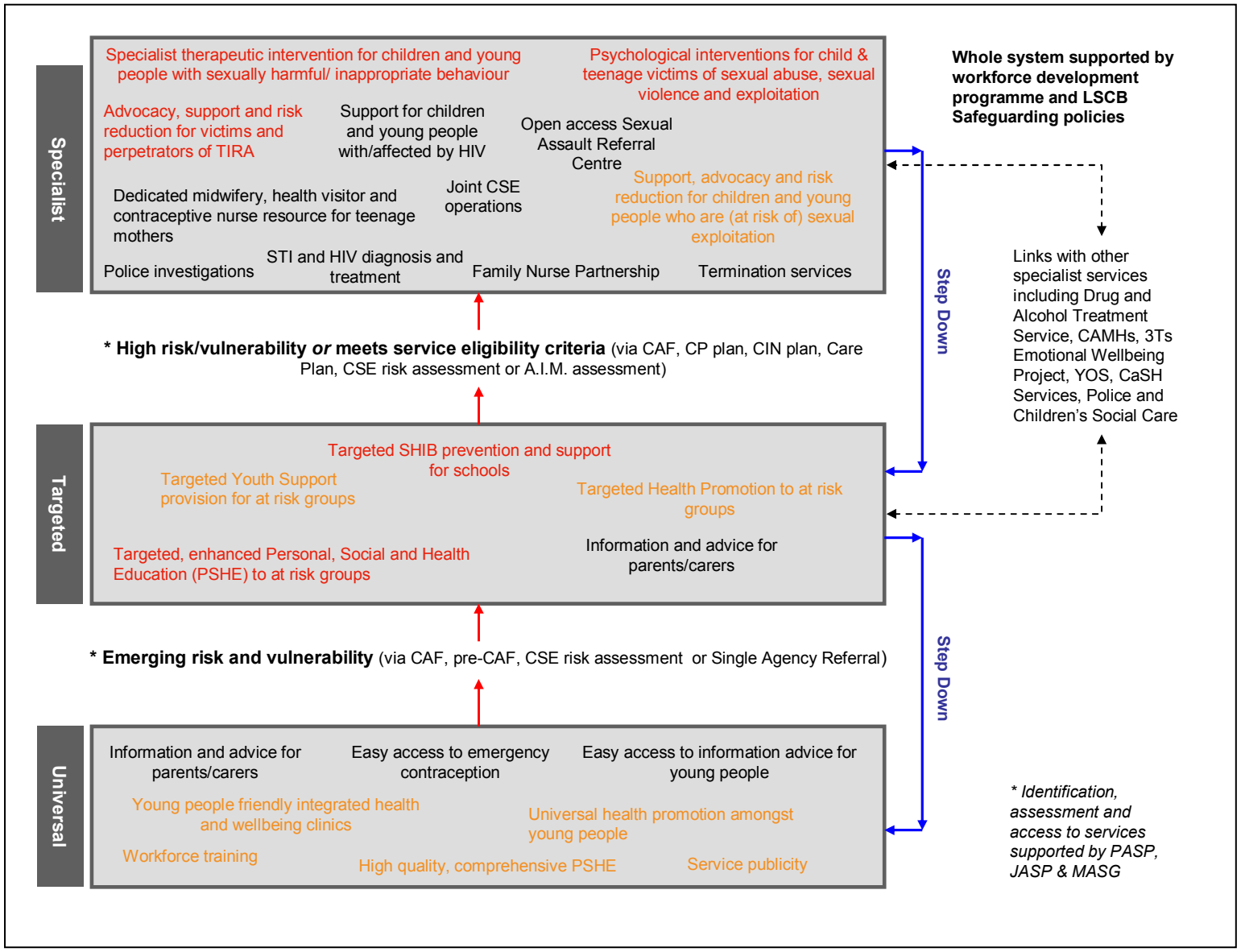
Targeted approaches should be differentiated to meet the needs of each group and take account of the risk taking and experimental behaviours associated with adolescence. Effective interventions should be based on behaviour-change theory[xxiii] and utilise the resilience [xxiv] and active choice of the young person[xxv].

We acknowledge young people are vulnerable to sexual violence and coercion by their peers (through bullying or intimate relationship abuse). Services to support young people to change abusive patterns of behaviours need to be developed.

Specialist interventions for children and young people who experience sexual violence, exploitation or relationship abuse should be developed to reduce distress and prevent repeat victimisation.

Central to our working model is effective early identification of needs and the use of recognised assessment processes to ensure young people receive the right intervention at the right time.

Figure 8: Future service landscape – young people's sexual health and wellbeing



Current gaps in provision are coloured red. Interventions shown in orange either lack capacity or require further development to meet the current needs of local young people.

Pathways need to be developed to ensure access to newly developed services is clear.

Commissioning recommendations

Develop sufficient and accessible sexual health and reproductive services for young people.
This should include:-
7 day a week and out of hours CaSH provision including:- • dedicated provision for young people during school holidays • assertive outreach and use of learning and community settings
Easier and timely access to emergency contraception and long acting contraception (including choice of provider)
Greater STI screening coverage and focus on high risk groups. Easier and timely access to STI screening and treatment. Focus on repeat screening
All provider settings to meet You're Welcome Quality Criteria
Support SRE delivery in secondary schools, specials schools and alternative learning settings (contraception, STIs, HIV prevention, delay)
Continued presence in Young People's Health and Wellbeing Clinics (HYPAs)
Further development of C-Card scheme
HIV prevention
Use of CAF and Team Around the Child/Family processes to assess need and broker support for vulnerable young people
Marketing and service publicity campaign to young people and local partners including digital/social media and assertive outreach methods
Annual programme of health promotion activity using digital/social media and assertive outreach methods
Targeted interventions (including assertive outreach) to reach vulnerable and at risk groups and tailored to the preferences of both genders
Young people's involvement in service design and development
Comprehensive data recording and analytics of demand & outcome
'Every Contact Counts' approach embedded in CaSH and primary care service specifications
Continued development of local National Chlamydia Screening Programme
Psychosexual counselling provision for young people
Increased HIV testing and prevention programmes (HPE)

Develop a multi-agency model of sexual health promotion and preventative education for young people
a. Open access YP health and wellbeing clinics in or clustered around every secondary school, college or learning centre offering information, advice and access to services for a wider range of health and wellbeing issues including:- • sexual health and reproduction, HIV, drug and alcohol use, emotional wellbeing/mental heath, obesity, smoking cessation, respectful

relationships and domestic abuse
- Meets You're Welcome
- Robustly recorded and monitored for demand and outcome

b. Targeted group, 1:1 or gender specific interventions for vulnerable/at risk young people based on behaviour change and lutogenesis approach

c. Promoted by integrated publicity campaign with annual calendar of events

d. PSHE guidance and supporting materials for schools, and list of programmes or speakers

Provide timely and effective support to children and young people (and their families) affected by sexual violence, abuse or exploitation

- Develop specialist support and advocacy service for children and young people affected by sexual exploitation, violence or abuse
- Commission clinical psychology interventions for children and young people experiencing distress as a result of sexual abuse/violence, exploitation or coercion:-
  - ✓ Provide a range of treatment modalities dependent on the child/young person's secondary problem[1]
  - ✓ Promote parental support/involvement
  - ✓ Clear, well promoted pathway to allow children quick access to therapy

Safer Peterborough Partnership and Children and Families Commissioning Board develop a comprehensive response to teenage intimate relationship abuse

- Develop targeted level interventions for young perpetrators providing education, support and risk reduction via targeted youth support
- Home Office approved intervention for convicted young perpetrators
- Develop specialist support and advocacy service for young people who are victims of domestic abuse

Review provision and pathways for children/young people affected by or with HIV

Undertake a review to identify need, current service provision and effectiveness of current pathways. Ensure robust pathways are in place with partners including midwifery, Dept of GUM, Adult Social Care, Children's Social Care, Kids (Young Carers Project), Contraceptive and Sexual Health Services and Public Health.

[1] CBT/abuse specific/supportive therapy in group or 1:1 formats for **behavioural problems**; CBT or family therapy for **psychological distress** and abuse specific/CBT/group therapy for **low self concept** - based on research by Hetzel-Riggin et al (2007)

Address sexually harmful behaviour exhibited by children and young people
Embed MST Problematic Sexual Behaviour programme and care pathway

Raise awareness of young people's sexual health and wellbeing issues
• Refresh workforce development programme to include CSE, teenage intimate relationship abuse, sexually harmful/inappropriate behaviour, STIs and risky sexual behaviour. Embed across wider partners (including schools)
• Consider dissemination of written 'briefing' for GPs and other clinical settings
• Create and embed LSCB procedures for dealing with teenage intimate relationship abuse

Development of new commissioning relationships
Establish working relationships with CCGs, schools and Local Area Team of the National Commissioning Board.

Consultation List

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Young people in HYPAs, Voyager Dance & Century Arts Group, PYA Pakistani Youth Group and Central Locality girls youth group.

Bibliography

Allnock and Hynes, NSPCC, 2011, *Therapeutic Services for Sexually Abused Children and Young People: Scoping the Evidence Base*

Barnardo's, *Puppet on A String: The Urgent Need to Cut Children Free from Sexual Exploitation*

Barnardo's, *Tackling Child Sexual Exploitation*

Barter, McCarry, Berridge and Evans, 2009, *Partner Exploitation and Violence in Teenage Intimate Relationships*

Berelowitz, Firmin, Edwards, Gulyurtlu, 2012, *Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation In Gangs and Groups, Interim Report*

Blumint Youth, 2012, *Domestic Abuse: Consultation with Peterborough's Young People*

Department of Health, 2011, *Quality Criteria For Young People Friendly Health Services*

Department of Health, 2012, *Protecting People, Promoting Health: A Public Health Approach to Violence Prevention for England*

Department of Health, 2012, *Public Health functions to be exercised by NHS Commissioning Board: Service Specification no.30 Sexual Assault Services*

Department of Health, 2013, *A Framework for Sexual Health Improvement in England*

Health Protection Agency, *Peterborough Local Authority Sexually Transmitted Infections Epidemiology Report 2011*

Lalor & McElvaney, Dublin Institute of Technology, 2010, *Child Sexual Abuse, Links to Later Sexual Exploitation/High risk Sexual Behaviour, and Prevention/Treatment Programmes*

Local Government Association & Public Health England, 2013, *Sexual Health Commissioning: Frequently Asked Questions*

Lovell, E, 2002, NSPCC, *Children and young people who display sexually harmful behaviour* http://www.nspcc.org.uk/inform/research/briefings/sexuallyharmfulbehaviour_wda48213.html

McClelland, G, University of Bedford, *'Meeting the physical & psychological health needs of young people involved in or vulnerable to sexual exploitation'* PowerPoint presentation

Melrose, M, Professor of Social Policy and Applied Social Research, University of Bedfordshire, *Young People as Victims of Trafficking and Sexual Exploitation PowerPoint presentation*

NHS Peterborough, 2010, *Sexual Health Needs Assessment*

NHS Peterborough, *Review of HIV and Sexual Health Services in Peterborough 2011-13*

NICE, 2010, NHS *Provision of Contraceptive Services for Socially Disadvantaged Young People Up to the Age of 25*

North West Public Health Observatory, *Local Alcohol Profile - Peterborough*

Peterborough Safeguarding Children Board, *Child Sexual Exploitation Matrix and Referral Flowchart*

Prevent (USA), 2012, *National Plan to Prevent the Sexual Abuse and Exploitation of Children*

Safer Peterborough Partnership, 2013, *Safer Peterborough Partnership Strategic Assessment*

Safer Peterborough Partnership, *Domestic Abuse Needs Audit 2012*

Safer Peterborough Partnership, *Domestic Abuse Strategy 2012-2015*

Williams, L, 2013, *Children & Young People displaying Sexually Harmful Behaviour: Prevention and Pathways to Intervention v1.1*

Glossary

CAF	Common Assessment Framework
CAMHs	Child and Adolescent Mental Health services
CaSH	Contraceptive and Sexual Health Services
CCG	Clinical Commissioning Groups
CSE	Child sexual exploitation
EHC	Emergency hormonal contraceptive (e.g. morning after pill)
GUM	Genitourinary medicine
HIV	Human immunodeficiency virus
HYPA Clinic	Health and Young People's Advice Clinic (HYPA for short)
IDVA	Independent Domestic Violence Advocate
ISVA	Independent Sexual Violence Advocate
LARC	Long acting reversible contraception (e.g. Implant, Injection)
LES	Local enhanced scheme
LSCB	Local safeguarding children's board
MASG	Multi agency support groups
NCSP	National Chlamydia Screening Programme
NES	National enhanced service
PSHE	Personal, Social, Health and Emotional Education
SARC	Sexual Assault Referral Centre
SHEP	Sexual Health Education Programme
SHOP	Sexual Health Outreach Project
SRE	Sex and relationships education
STI	Sexually transmitted infections
TAC	Team Around the Child
TIRA	Teenage intimate relationship abuse

References

[i] GRASP 2011 Report cited in Department of Health, A Framework for Sexual Health Improvement in England, 2013
[ii] Health Protection Agency, Peterborough Local Authority Sexually Transmitted Infections Epidemiology Report 2011
[iii] Hoggart and Phillips, 2010 cited in A Framework for Sexual Health Improvement in England
[iv] Department of Health, Abortion Statistics England and Wales 2011
[v] Adapted from ONS data by Performance Management & Information Team (Children's Services), Peterborough City Council

[vi] Lalor & McElvaney
[vii] Humphrey & White cited in Lalor & Mc Elvaney, Child Sexual Abuse, Links to Later Sexual Exploitation/High Risk Sexual Behaviour and Prevention/Treatment Programmes, Dublin Institute of Technology
[viii] Fergusson, Horwood and Lynskey (1997); Zierler et al (1991); Steel & Herlitz (2005) and Widom & Kuhns (1996) cited in Lalor & McElvaney
[ix] Ibid
[x] Smith, Coleman, Eder et al: Homicides, firearm offences and intimate violence 2009/10: Supplementary Vol 2 to Crime in England and Wales 2009/10, Home Office
[xi] Cambridgeshire and Peterborough Victim and Offender Needs Assessment July 2012
[xii] Safer Peterborough Partnership Domestic Abuse Needs Audit 2012
[xiii] Ibid
[xiv] Cambridgeshire and Peterborough Probation Trust, Safer Peterborough Partnership Domestic Abuse Needs Audit
[xv] Blumint Youth, 2012, Domestic Abuse: Consultation with Peterborough's Young People
[xvi] Adapted from Barnardo's, Puppet On A String
[xvii] Adapted from The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups, November 2012.
[xviii] Lalor and McElvaney,
[xix] Gabrielle Tracy McClelland Senior Lecturer and Research Fellow, 'Meeting the physical & psychological health needs of young people involved in or vulnerable to sexual exploitation', University of Bradford
[xx] Data from Children's Services Direct Intervention Service 2011
[xxi] Elizabeth Lovell, 2002, NSPCC Children and young people who display sexually harmful behaviour

[xxii] Department of Health, 2012, Public Health Functions to be Commissioned by NHS Commissioning Board – Sexual Assault Services
[xxiii] Downing, Jones, Cook and Bellis cited in A Framework for Sexual Health Improvement in England, 2013
[xxiv] Lutogenesis – identifies 'assets' of young people with resilience to help vulnerable young people develop these 'assets' (Prof Antonovsky) cited in A Framework for Sexual Health Improvement in England
[xxv] Margaret Melrose (Professor of Social Policy and Applied Social Research, University of Bedfordshire), Young People as Victims of Trafficking and Sexual Exploitation,