

SAFEGUARDING ADOLESCENTS: A PRACTICE GUIDE

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Foreword

In Waltham Forest, we have a strong desire to deliver services so that they respond effectively to vulnerable adolescents. National reviews and local experience have shown us that the primary focus of the child protection system is to prevent harm to younger children who may be at risk within their own family. We recognise that the system sometimes neglects the needs of adolescents where many of the risks are found outside of the family home.

Waltham Forest Safeguarding Children Board undertook to fundamentally review our approach to safeguarding adolescents. We have outlined the local challenges to the children's services system and developed a plan to better support our workforce to rise to these challenges, to apply new practice frameworks, and to improve outcomes for adolescents.

We aim to support the whole Waltham Forest partnership in its commitment to improve the collective response to adolescent risk, and to sign up to a shared set of values and principles for work in this area.

Safeguarding adolescents: a practice guide

The guide has been written for all practitioners who are working with adolescents in Waltham Forest. It aims to equip practitioners with up to date information on adolescent development, and to provide a consistent practice framework to improve our response to adolescents who experience risk of harm. The approach includes information on enforcement and support and recognises that safeguarding adolescents may involve different combination of these elements at different times.

The sections on good practice can help practitioners to examine the language, attitudes and beliefs for work with adolescents, and provide clear steps to avoid blaming adolescents for abuse they have experienced, and to make sense of adolescent decision-making.

We have given a focus in each section of the guide to the specific risks faced by adolescents with SEND as we recognise the need as a partnership for close attention to supporting this group.

Alongside our new Think Family approach to levels of need and thresholds document, we hope that this practice guide will provide opportunities for quality conversations that help us to build professional relationships, to reduce the risks faced by adolescents, and to keep children and adolescents safe.

***David Peplow, Independent Chair
Waltham Forest Safeguarding Children Board***

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PART 1: Introduction

Background

The need for new Waltham Forest guidance for safeguarding adolescents has increased with recognition across the sector that the child protection system is not working effectively enough for adolescents. Safeguarding services have typically been designed around younger children and their families, and not around the needs of adolescents experiencing risk of harm outside of the family home.

In 2018, the Department for Education circulated a new draft of [Working Together to Safeguard Children](#) guidance, which includes attention to adolescents who are “vulnerable to abuse or exploitation from outside their families”. Inquiries into serious failures in Rotherham, Rochdale and Oxfordshire have led to a national focus on improving our understanding of and response to the complex risks faced by adolescents.

The risks arising from situations outside the family interact with a wide range of needs such as social exclusion, poor physical and emotional health, barriers to learning, and SEND. Adolescents with SEND may remain dependent as they transition to adulthood, with a small group remaining totally dependent on others for their safety and wellbeing.

The growing sense that the current system of protection is not effective in meeting diverse needs and reducing risks is accompanied by an increase in understanding about adolescent development (Hanson and Holmes, 2014)

These findings ask us to think critically about the framework of values and principles that underpin all our work with adolescents. In doing so, we need to apply an understanding of adolescent development and the

distinctive risks that adolescents face consistently across our policy and practice so that we can:

- understand the drivers and contexts of adolescent risk, so that resources are used in the right places e.g. risk is understood to exist within peer groups and social networks as well as within families;
- maximise opportunities to plan effective work in teams with adolescents and often their families in combatting identified risks;
- avoid harmful assumptions about adolescent choices e.g. don't minimise the significance of adolescent choices, nor perceive them as adult 'lifestyle' choices;
- recognise and address the challenges involved in reducing adolescent risk and breaking cycles e.g. the challenge to engage adolescents in interventions and to support the full range of adolescent needs.

(Ibid, adapted)

What does this mean for practitioners in Waltham Forest?

This guide has been written in response to these important developments in research and policy, and it:

- draws on significant work undertaken across the Waltham Forest partnership to identify local challenges and capture best practice in safeguarding adolescents;
- aims to show practitioners how new frameworks such as 'Contextual Safeguarding' can be applied in every day work.

Our vision

In Waltham Forest we want to embed a culture of understanding about the complexity of safeguarding adolescents where we:

- identify adolescents as children first,
- understand the development needs of adolescents,
- understand the needs and risks for adolescents with SEND,
- understand the influences in adolescent lives, including those outside the family context,
- maintain a focus on the risks that adolescents are exposed to in contexts outside the family, and respond with the right conversation and the right action at the right time,
- consider the positive and negative impact of risks adolescents take in exploring their growing independence,
- recognise the constrained choices that adolescents may feel powerless to avoid,
- value the diverse range of experiences of the adolescents in Waltham Forest and respond to the needs of adolescents of all genders, ethnicities, sexual identities and beliefs, and those who are disabled.

Our aims

To achieve our vision, we will:

- consider the multi-faceted issues of adolescent development and safeguarding, and respond to these issues in a comprehensive way;
- respond to peer networks, pull factors, and the influence of individuals and groups that cause harm to adolescents and can lead them to make choices that increase the risks they are exposed to;
- act to reduce the gender bias reinforced by traditional approaches, particularly around harmful sexual behaviour, child sexual exploitation and gangs;
- respond to the needs of adolescents with SEND who may be at a higher risk of abuse due to physical frailty, early levels of communication, lack of understanding of social boundaries, limited sense of agency and/or self-esteem;
- respond to the risk factors that can have negative impact on adolescent outcomes including substance use, social media use, and mental health issues;
- provide a consistent and flexible practice framework and workforce development plan that creates a culture shift in the way we deliver services for adolescents;
- support practitioners across thresholds and disciplines to be brave and innovative, to hold and manage risk, and to eliminate language and responses that blame and stigmatise adolescents.



Seven principles to improve our responses to adolescent risk

The Association of Directors of Children's Services (ADCS) and Research in Practice (RiP) have investigated the evidence on adolescent risk and development. They use examples from the sector to show how research can be implemented in practice. They argue that there is a wealth of knowledge within agencies, adolescents and their families, that must be galvanised and used to improve risk prevention and protection (Hanson and Holmes, 2014). ADCS/RiP propose 7 principles and this present practice guide seeks to follow each of them:

1. ***Work with adolescent development*** – particularly perception, autonomy, aspiration, and skills
2. ***Work with adolescents as assets and resources*** e.g. draw on strengths to build confidence and resilience
3. ***Promote supportive relationships between adolescents and their family and peers***
4. ***Prioritise supportive relationships between adolescents and key practitioner(s) through service design***
5. ***Take a holistic approach both to adolescents and the risks they face*** – e.g. avoid labelling adolescents according to risks they face
6. ***Ensure services are accessible and advertised*** – respond to adolescent autonomy, advertise the benefits and provide outreach
7. ***Equip and support the workforce***

Waltham Forest Think Family approach

In Waltham Forest, our approach to understanding levels of need and risk faced by adolescents is aligned to our Think Family principles, which are:

Right Conversation, Right Action, Right Time

Working with whole families in their networks and communities

Quality conversations

Helping people to help themselves and each other

Early Help is a commitment to collaboration: it's everyone's responsibility

A clear offer in response to identified need

Evidence based prevention and action

We believe Contextual Safeguarding is a vital extension of Think Family principles in its attention to peer networks and communities.

More information on our approach to thresholds and levels of need and risk for working with children, families and communities can be found at:

[LINK TO THRESHOLDS GUIDANCE]

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Definitions

These definitions aim to ensure that all practitioners have a shared understanding of key terminology relating to work with adolescents:

Children refers to individuals between 0 and 17 years of age; **adolescents** to those roughly between 10 and 18. **Parents** is used as shorthand to include also carers and parental figures. (Hanson and Holmes, 2014)

Special Education Needs and Disabilities (SEND) A child or adolescent has a special educational need if they have a learning difficulty or disability which calls for special educational provision to be made for him or her. Click [this link](#) for further definitions

Risk refers specifically to the experience of a significant adversity or abuse that would seriously threaten an adolescent's life or health. Risk also refers to the likelihood of experiencing such adversity, or the experience of a wider range of adversities including poor education and poverty, involvement in minor crime, and mental health problems. We recognise that 'risk-taking' can often serve positive functions in the life of adolescents. (Ibid, Adapted)

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

Harmful sexual behaviour (HSB): Sexual behaviours expressed by children and adolescents under the age of 18 years old that are developmentally inappropriate, may be harmful towards self or others, or be abusive towards another child, adolescent or adult. (Hackett, 2014)

Grooming is when someone builds an emotional connection with a **child** to gain their trust for the purposes of sexual abuse, sexual exploitation or trafficking. Children and adolescents can be groomed online or face-to-face, by a stranger or by someone they know - for example a family member, friend or professional.

Contextual safeguarding: an approach to understanding and responding to adolescents' experiences of significant harm beyond their families. It recognises that the relationships adolescents form in neighbourhoods, schools and online can feature violence and abuse. Parents have little influence over these contexts, and adolescents's experiences of extra-familiar abuse can undermine child-parent relationships. Practitioners must engage with individuals and sectors that have influence within extra-familiar contexts and recognise that working within these spaces is a critical part of safeguarding practice. Contextual safeguarding expands child protection systems in recognition that adolescents are vulnerable to abuse in a range of social contexts. (Adapted from Firmin, 2017).

Missing: Anyone whose whereabouts cannot be established and where the circumstances are out of character, or the context suggests the person may be subject of crime or at risk of harm to themselves or another (ACPO, 2013)

County lines: A group (not necessarily affiliated as a gang) establishes a network often between an urban hub and county location, into which drugs (primarily heroin and crack cocaine) are supplied. A mobile phone line is established in the market, to which orders are placed by introduced customers. The line will commonly (but not exclusively) be controlled by a third party, remote from the market.

The group involved in County Lines exploits young or vulnerable persons, to achieve the storage and/or supply of drugs, movement of cash proceeds and to secure the use of dwellings (commonly referred to as cuckooing). The group or individuals exploited by them regularly travel within and between the urban hub and the county market, to replenish stock and deliver cash. The group is inclined to use intimidation, violence and weapons, including knives, corrosives and firearms. (National crime agency, 2017)

N.B For the purposes of this practice guide, 'County lines' will be referred to as Child Criminal Exploitation (CCE) when discussing children who have been groomed into this activity. We are clear that County Lines is a form of exploitation and trafficking that can happen in any local authority area (is not restricted to the either rural or urban locations) and as such, children who have been groomed into this will not be treated as perpetrators of this crime.

Modern Slavery

Modern Slavery is the term used within the UK defined within the Modern Slavery Act 2015. These crimes include holding a person in a position of slavery, servitude forced or compulsory labour, or facilitating their travel with the intention of exploiting them soon after. Although human trafficking often involves an international cross-border element, it is also possible to be involved with modern slavery within your own country. It is possible to be harmed by modern slavery even if consent has been given to be moved. Children and adolescents cannot give consent to being exploited therefore the element of coercion or deception does not need to be present to prove an offence (National Crime Agency, 2017)

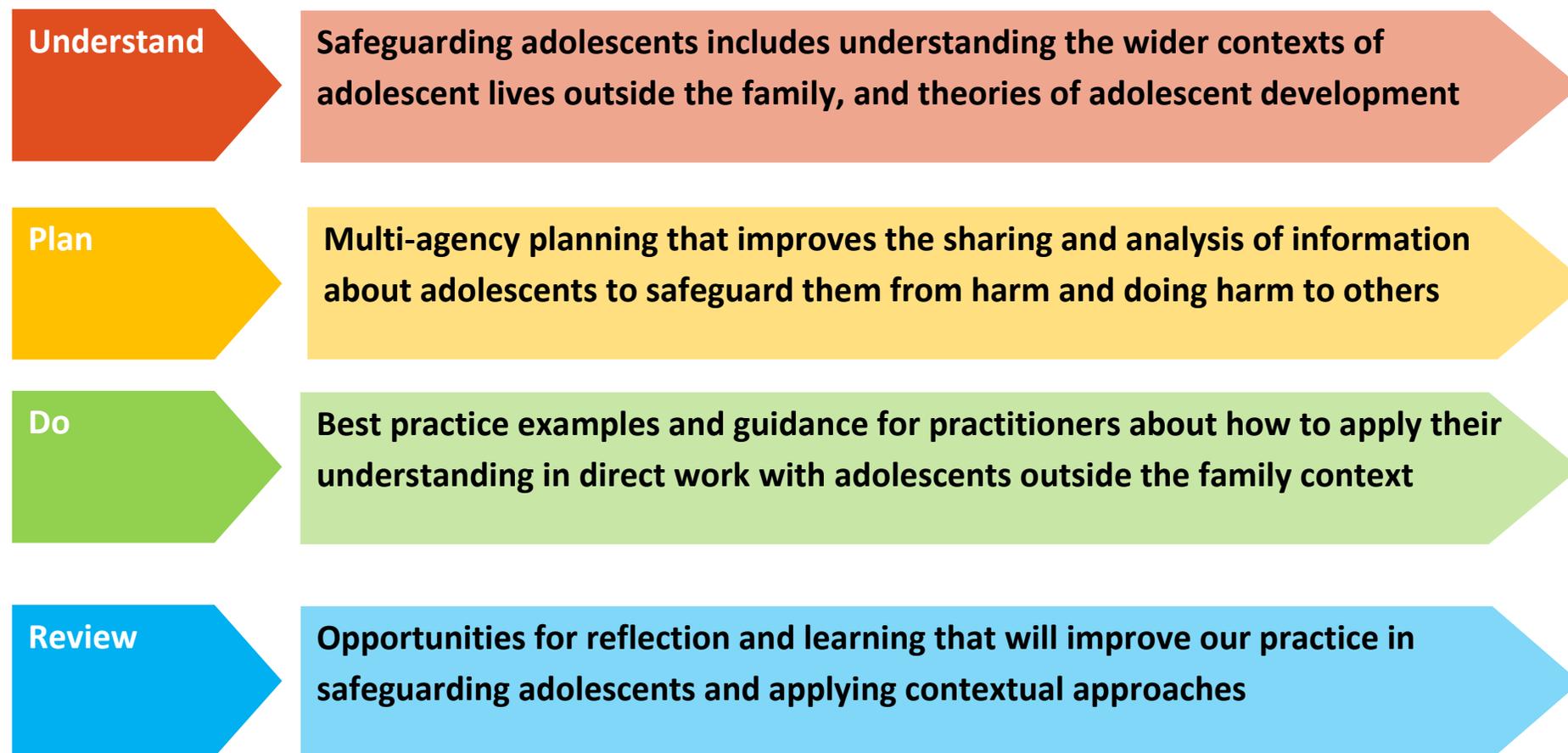




Practice framework

This practice guide is organised into four themes to help practitioners in any context to apply these frameworks in their own practice.

There are elements of each theme in each section, and the arrows at the top of the page highlight the theme of the guidance contained on that page.



PART 2: Understand adolescent risk and development

Levels of need in Waltham Forest

The approach to levels of need used in Waltham Forest is drawn from the pan-London Threshold Document: Continuum of Help and Support.

Tier 1: adolescents with no additional needs = Good Outcomes

Adolescents with no additional needs; health and developmental needs are met by universal services. These adolescents consistently receive support from their parents and the community. Most of these adolescents require support from universal services alone.

Level 1 Emerging needs

We make a distinction between **Good Outcomes** - no additional needs - and **Emerging needs** to reflect those adolescents who have low level risks, including risks outside the family context and low level SEND, whose additional needs can be met by a single agency in universal services.

Tier 2: Early Help = Level 2 Multiple needs

Adolescents with additional needs may be showing early signs of abuse, neglect or risk of harm outside the family. Adolescents may have SEND. Their needs may be not clear, known, diagnosed, and/or not being met. This is the threshold for a multi-agency assessment. These adolescents require a lead professional for a co-ordinated approach to the provision of services. These will be provided within universal or targeted provision and do not include services from Children's Social Care.

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Tier 3: Adolescents with complex needs = Level 3 Complex needs

Adolescents require specialist services to achieve or maintain a satisfactory level of health or development or to prevent significant impairment of their health and development and/or who have SEND. They may require longer term intervention from intensive or specialist services. This is the threshold for an assessment led by Children's Social Care under Section 17, Children Act 1989 although the assessments and services required may come from provision outside of Children's Social Care, such as the Youth Offending Team or another targeted service.

Tier 4: Adolescents in acute need = Level 4 Acute needs

Adolescents who are suffering or who are likely to suffer significant harm. A statutory assessment is required. Adolescents are likely to have already experienced adverse effects and to be suffering poor outcomes. This tier also includes Tier 4 health services which are very specialised services in residential, day patient or outpatient settings for children and adolescents with severe and/or complex health problems. This is likely to mean they are referred to Children's Social Care under section 20, 47 or 31 of the Children Act 1989¹. This would also include those adolescents remanded into custody and statutory youth offending services.

¹ Information on Children's Act 1989/2004 can be found at [this link](#)

Understanding 'Contextual Safeguarding'

In response to the demand for a better framework for adolescent risk, research conducted at Bedfordshire University has produced a new model known as 'Contextual Safeguarding', which has shaped the information and tools provided in this practice guide.

In brief, the 'Contextual Safeguarding' framework:

- Recognises the weight of peer influence on adolescents's decisions
- Extends the notion of 'capacity to safeguard' beyond the family
- Provides a framework for referrals for contextual interventions to complement work with individuals and families (Firmin, 2014)

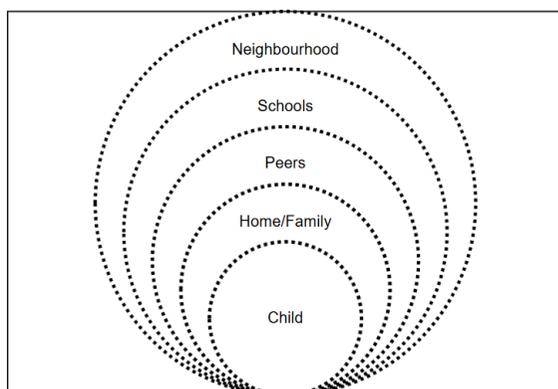


Figure 1: Contexts of Adolescent Safety and Vulnerability(Firmin 2013:47)

For examples of safeguarding practice in context, see p14, p19 and p26

What does the new DfE guidance say about 'Contextual Safeguarding'?

“As well as threats to the welfare of children from within their families, children may be vulnerable to abuse or exploitation from outside their families. These extra-familial threats might arise at school, from within peer groups, or more widely from within the local community. These threats can take a variety of different forms from online safety, exploitation, sexual, by criminal gangs and organised crime groups to the influences of extremism leading to radicalisation and trafficking.

Assessments of children in such cases should consider whether wider environmental factors are present in a child's life and are a threat to their safety and/or welfare. Interventions should focus on addressing these wider environmental factors, which are likely to be a threat to the safety and/or welfare of a number of different children and adolescents who may or may not be known to local authority children's social care.

For example, Channel panels, established under the Counter-Terrorism and Security Act 2015, assess the extent to which identified individuals are vulnerable to being drawn into terrorism, and, where appropriate, arrange for support to be provided. When assessing Channel referrals, local authorities and their partners should consider how best to align these with assessments undertaken under the Children Act 1989..”

Working Together to Safeguard Children, draft for Consultation 2018

Understand

Understanding the risks outside the family context: adolescent peer groups and environments

The child protection system was designed to protect children from risks posed by their families and/or situations where family members do not have the capacity to safeguard children. Risks outside of the family – from peers and wider social groups – can reduce the capacity of families to safeguard adolescents, and in this sense these risks are not addressed by our existing child protection system (Fermin 2017, p6).

“As individuals move from early childhood and into adolescence they spend increasing amounts of time socialising independently of their families.

During this time the nature of adolescent’s schools and neighbourhoods, and the relationships that they form in these settings, inform the extent to which they encounter protection or abuse [...]

Peer relationships are increasingly influential during adolescence, setting social norms which inform adolescents’ experiences, behaviours and choices and determine peer status. These relationships are, in turn, shaped by, and shape, the school, neighbourhood and online contexts in which they develop” (Ibid, p3)

An alternative approach to dealing with risks outside the family is for practitioners to support change within the contexts of peer groups, schools and neighbourhoods. Often, parents cannot influence what happens in these contexts, but agencies and practitioners who deliver services in these contexts may have more capacity to change things. Working within these contexts is critical to safeguarding adolescents. This alternative approach extends what we mean by ‘capacity to safeguard’ beyond families and includes individuals and agencies who manage settings outside the family in which adolescents encounter risks (Ibid, p6).

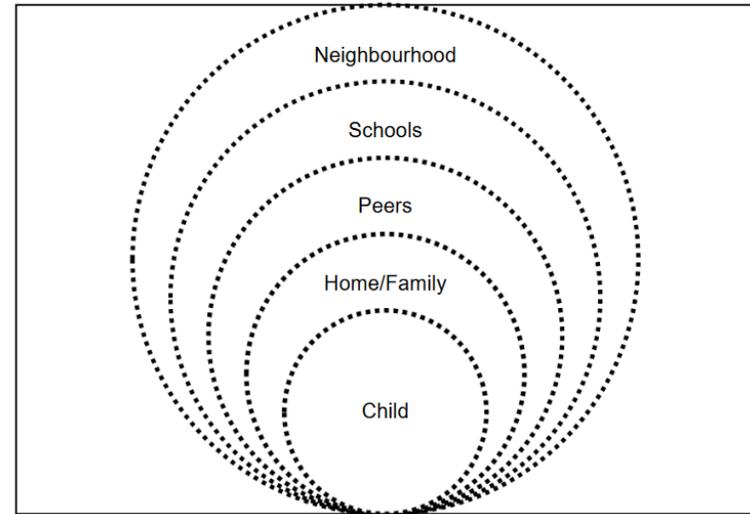


Figure 1: Contexts of Adolescent Safety and Vulnerability(Firmin 2013:47)

Understand: what does this mean for practitioners?

As practitioners, this means that to undertake effective safeguarding with adolescents, we must extend our knowledge and analysis of the risks and dynamics within the family home and begin to include the risks and dynamics within peer groups, schools, neighbourhoods and communities. Adolescents experiencing harm from CSE, gangs, HSB, and missing episodes are mostly likely to be at risk in within these wider

While extending the approach to include an understanding of these contexts, we need to *continue to work with families* to understand the push and pull factors in adolescent lives.


 Understand

Contextual Safeguarding in every day practice

All practitioners have opportunities in every day work with adolescents to identify risks outside the family home:



The role of trusted adult is to build a relationship so that adolescents feel able to talk. This approach should not be used to pry into adolescents' personal lives. Many adolescents go through a period where they need independence and personal space and may seem to communicate less. They may be reluctant to provide details about their friends or about places where they are spending time, they should not be pushed by intrusive questions. Instead, this approach should be used to **safeguard adolescents** who are already identified as vulnerable or at risk of harm.

Understand: Safeguarding adolescents with SEND

Some adolescents with SEND may be at additional risk out of the family home or professional setting due to their specific needs and abilities.

Practitioners must be willing to hear the concerns of these adolescents. For those who are at an earlier developmental stage than their chronological age, the safeguarding concerns may be equivalent to those of younger children.

Adolescents with SEND are less likely than others to move their social circle beyond the home. In some senses, this keeps them safe, but practitioners need to be aware of the risks that arise for adolescents within a relatively closed circle where outside scrutiny is limited.

The dynamics within some peer groups may increase the risk that an adolescent with SEND will be marginalised or be the focus of peer-on-peer abuse. This can include peers who take advantage of adolescents with SEND, asking them to carry out unsafe or criminal activities where they may not fully understand the risk of consequences. This form of abuse may be carried out by gang-affected adolescents.

Some adolescents with SEND may also be at risk of overprotection, which may lead to a adolescent not fulfilling their potential as an adult, including a lack of awareness and understanding of wider contexts.

How do you consider the risks for adolescents with SEND in your agency?

Understanding adolescent development: attachment

Attachment refers to a child or adolescent’s relationship with their primary caregiver. This relationship has a significant impact on behaviour, resilience, and the ability to form relationships with others.

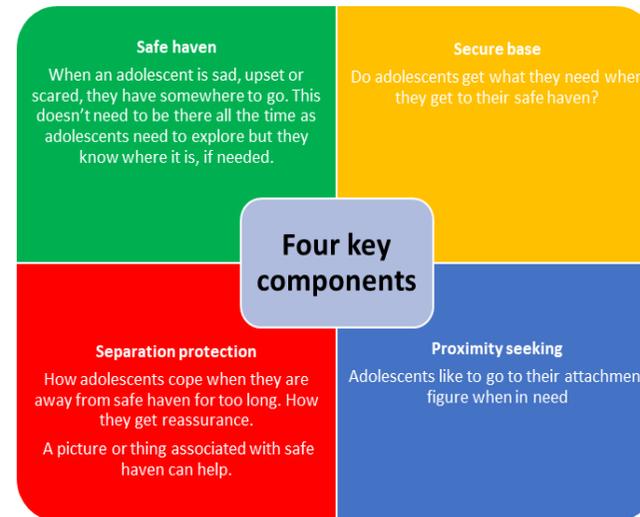
There are four types of attachment style:



Attachment is considered significant for work with babies and young children however research has demonstrated that attachment security in adolescence has precisely the same effect on development as it does in early childhood. A secure base supports adolescents to explore and to develop thinking, social and emotional skills (Moretti and Peled, 2004)

What does attachment mean for adolescents?

Practitioners should be aware that the behaviour, relationships and resilience of adolescents is informed by four key components that support feelings of security:



Understand: what does this mean for practitioners?

Practitioners need to develop an understanding of these four components in the lives of adolescents they work with. Do these adolescents have specific needs that interact with their attachments? For example, adolescents may establish new places and people outside of the family home where they feel safe, but where they may also be at risk.

Adolescents with SEND may have difficulties in establishing safe havens and safe people. Practitioners such as key workers or mentors have a role in helping them to do so.

Safeguarding adolescents is everyone's business

It is essential for all practitioners working with adolescents to understand the influence of wider contexts and contribute to sharing information.

This includes practitioners working in all disciplines: health, including mental health, education, youth work and youth justice, family support and parenting, police, probation, housing, social care, voluntary, community and faith organisations, and so on.

It also applies to practitioners working at every level of need from universal and targeted services, to specialist and statutory.

Sharing information about adolescent risk and harm

Adolescents, especially those who are experiencing CSE or CCE, may not want to share information about their friends, associates or places they have been because it would put them at risk to do so. The adolescent will therefore need time and to build trust with you to share such details.

Adolescents with SEND may not be able to give or withhold consent for information sharing and this presents an ethical issue where there are concerns as to whether it is right to seek consent from parents.

If you're unclear about the purpose of gathering information about a child or adolescent, then you should consider whether the information will be used to safeguard them from harm.

If you have any doubts about when and how to share information, you should always discuss these doubts with your line manager and/or your Designated Safeguarding Lead.

Remember the seven golden rules for sharing information

1. The General Data Protection Regulation (GDPR) is not a barrier to sharing information, but provides a framework to ensure that personal information about individuals is stored and shared appropriately.
2. Be open and honest with the affected individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared. Seek their agreement unless it is unsafe or inappropriate to do so.
3. Seek advice if you are in doubt, without disclosing the identity of the person where possible.
4. Share information with consent where appropriate and where possible respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, lack of consent can be overridden by the need to protect the child. Judgement should be based on the facts of the case.
5. Consider safety and wellbeing by basing your information sharing decision on considerations of the safety and wellbeing of the person and others who may be affected by their actions.
6. Necessary, proportionate, relevant, accurate, timely and secure. Ensure the information you share is necessary for the purpose for which you are sharing it. Ensure it is shared only with those people who need to have it, is accurate and up to date and is shared in a timely and secure fashion.
7. Keep a record of your decision and the reasons for it. If you decide to share information a record of what you have shared, with whom and for what purpose, should be kept.

For more advice about sharing information, you can refer to the Government guidance

<https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice>

REMEMBER:

If you think a child is at immediate risk of harm, or you think a conversation will put a child at risk of harm, then you should contact the Police on 999

Quick Check: in your organisation...

- How is information gathered about the networks, places and trends influencing the lives of adolescents?
- Do you consider the needs of adolescents who experience social exclusion or who have SEND?
- How is this information gathered and stored?
- How is this information shared with other agencies?
- Do you contribute to meetings such as Strategy Discussions?

*The purpose of a **Strategy Discussion** is to decide whether the threshold has been met for a single or joint agency (Children's Social Care and Police) child protection investigation, and to plan that investigation. They happen when it is believed a child has suffered, or is likely to suffer, serious harm.*

Understanding Strategy Meetings/Discussions

Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, there should be a strategy meeting / discussion.

A Strategy Meeting/Discussion is used to:

- Share available information;
- Agree the conduct and timing of any criminal investigation;
- Decide whether an assessment under [s47 of the Children Act 1989](#) should be initiated, or continued if it has already begun;
- Consider the assessment and the action points, if already in place;
- Plan how the s47 enquiry should be undertaken (if one is to be initiated), including the need for medical treatment, and who will carry out what actions, by when and for what purpose;
- Agree what action is required immediately to safeguard and promote the welfare of the child, and / or provide interim services and support. If the child is in hospital, decisions should also be made about how to secure the safe discharge of the child;
- Determine what information from the strategy meeting / discussion will be shared with the family, unless such information sharing may place a child at increased risk of significant harm or jeopardise police investigations into any alleged offence/s;
- Determine if legal action is required.

Strategy Meetings/Discussions are relevant to all agencies that work with children and young people in each discipline and working at each level of need. Discuss the role of your agency in strategy meetings with your Designated Safeguarding Lead.

What is MAPPA?

MAPPA stands for **Multi-Agency Public Protection Arrangements** and used by agencies such as the police, the Prison Service and Probation to work together to protect the public by managing the risks posed by violent and sexual offenders living in the community.

What is the aim of MAPPA?

MAPPA aims to manage the risks that violent and sexual offenders pose to the public by managing the risks associated with these categories of offenders. The various agencies share information about offenders under MAPPA to assess the level of risk they pose to the public.

Who is placed under MAPPA?

There are three categories of MAPPA offenders:

Category 1: All registered sexual offenders are required to notify the police of their name, address and personal details under the terms of the Sexual Offences Act 2003.

Category 2: Violent or other sex offenders not subject to notification requirements, including violent offenders who have been sentenced to 12 months or more, or to detention in hospital, and who are now living in the community subject to Probation supervision.

Category 3: Other dangerous offenders who have committed an offence in the past and are considered to pose a risk of serious harm to the public.

How does MAPPA work?

All relevant offenders are assessed to establish the level of risk of harm they pose to the public. Risk management plans are then worked out to manage those risks. MAPPA allows agencies to assess and manage offenders on a multi-agency basis by working together, sharing information and meeting as necessary to ensure that effective plans are put in place. There are three levels of response available to the MAPPA:

Level 1: Ordinary agency management is for offenders who can be managed by one or two agencies, such as the police and Probation;

Level 2: Local multi-agency management for offenders where the ongoing involvement of several agencies is needed to manage the offender;

Level 3: Multi-Agency Protection Panels are aimed at those who are deemed to pose the highest risk of causing serious harm, or whose management is particularly problematic.

I don't work for the Police or Prison or Probation service...

Practitioners in universal services such as schools and health services provide children, adolescents, families and staff with increased awareness around safeguarding issues, including adolescents and/or adults who pose a risk of harm to others.

- For example, practitioners in schools are well-placed to be alert to and aware of local activities that could provide a threat to adolescents. With the authorisation of the police, schools may be able to warn individuals or groups regarding possible dangers.
- Universal services can provide a safe environment during the daytime for children and adolescents.
- The local school is often the first port of call for parents who want to voice their concern regarding worrying activities in the area.



Best Practice examples of Contextual Safeguarding in Waltham Forest

<p>Understand:</p> <p>Using i2 charts to identify risks outside the family</p> <p>The Community Safety team produce i2 charts for multi-agency panels. These charts are a visual representation of an adult or adolescent’s network of associations and the locations where they frequently spend time.</p> <p>The charts have been pivotal in helping practitioners to identify the wider risks to and from a adolescent. The i2 charts can be used to plan interventions around groups of adolescents by identifying leaders and followers.</p> <p>See appendix for an example i2 chart.</p>	<p>Plan:</p> <p>Multi-agency risk assessment in the MASH</p> <p>The MASH (multi agency safeguarding hub), now has the local CSE police unit co-located with the team.</p> <p>The MASH has also rolled out daily risk management meetings which provide an immediate care plan to adolescents where there are concerns about CSE, gangs, county lines, HSB and missing episodes.</p> <p>The aim is for an immediate response to prevent risks from escalating over weeks while a strategy meeting is convened.</p>	<p>Do:</p> <p>Sharing information to target neighbourhoods</p> <p>The Multi Agency Sexual Exploitation (MASE) meeting is co-chaired by Police and Children’s Social Care. MASE discussed locations of interest where there have been concerns about child sexual exploitation and/or peer-on-peer abuse.</p> <p>Agencies like the Neighbourhood Team and the CSE Police Unit have been able to focus on locations of interest to address concerns e.g. when concerns were raised about a children’s unit, neighbourhood officers conducted a fire safety check, which allowed them to investigate concerns about the treatment of residents.</p>
<p>Do:</p> <p>Addressing Harmful Sexual Behaviour in Schools</p> <p>Waltham Forest has a comprehensive harmful sexual behaviour (HSB) strategy and service for children and adolescents. This innovative work provides specialist one to one and group interventions to children who are exhibiting HSB as well as providing early intervention in schools through policy consultation and teacher training.</p> <p>This work supports schools to respond when harmful sexual behaviour has occurred on school premises as well as helping schools to challenge cultures amongst pupils which endorse sexual harassment and bullying.</p>	<p>Review:</p> <p>Multi-disciplinary panels to understand trauma and risks</p> <p>The Youth Offending Service High Risk Panel regularly provides quality assurance on adolescents who are considered “high risk” due to their vulnerability and/or offending.</p> <p>Part of the success of this meeting comes from specialist CAMHS clinical input, which helps to frame adolescent behaviours within the context of previous or current experiences of trauma.</p> <p>The youth offending service (YOS) is also fortunate to have a specialist trauma informed service called ICON available to adolescents accessing the YOS.</p>	



PART 3: Working with adolescents at risk

Relationship based practice (RBP)

When working with adolescents, especially those who have experienced adversity or are at risk, practitioners must establish meaningful professional relationships. Relationship-based practice (RBP) describes a way of working with children and adolescents that recognises the vital importance of building meaningful relationships.

Many adolescents experience anxiety as a natural response to distress and uncertainty (Munro 2011; Ruch, 2005). It is essential for practitioners to develop an understanding of the adolescent’s situation and state of mind. Adolescents experiencing anxiety may have very self-critical thoughts and may be more likely to reject practitioner support.

Practitioners working with adolescents should appear:

- Available*
- Caring*
- Interested*
- Responsive*
- Sensitive*
- Accessible*
- Co-operative*
- Trustworthy*

Practitioners should avoid appearing:

- Unavailable*
- Uninterested*
- Unresponsive*
- Neglectful*
- Hostile*
- Rejecting*
- Inaccessible*
- Ignoring*
- Untrustworthy*

For adolescents with SEND, the key factors in RBP can be established through non-verbal means, such as visual communication, or through adapted language.

RBP has been shown to improve the outcomes of adolescents affected by Child Sexual Exploitation: “Relationship-based practice created a context for developing self-efficacy and this, in turn, helped children and adolescents to disclose abuse, be supported to leave unsafe ‘relationships’ and begin to recover from CSE.” (Alexi project evaluation, Nov 2017).

What is self-efficacy?

Adolescents who believe in their own ability to succeed in specific situations or accomplish a task. A sense of **self-efficacy** can play a major role in how adolescents approach goals, tasks, and challenges.

Meaningful relationships form a positive basis for adolescents who experience anxiety to develop their sense of self-efficacy.

How can practitioners support self-efficacy in work with adolescents?

1. Make use of adolescents' interests
2. Allow adolescents to make their own choices
3. Set moderately difficult challenges
4. Encourage adolescents to try
5. Give frequent, focused, balanced feedback
6. Encourage accurate self-praise
7. Provide specific coping strategies for stress
8. Use positive peer models such as peer mentoring



Listening to the voice of adolescents with SEND

All adolescents have a voice which deserves to be heard. Adolescents with SEND may face additional barriers to communicating and influencing decisions made about their lives. This may include adolescents:

- with speech, language and communication needs;
- with communication and interaction difficulties associated with severe and profound learning difficulties;
- with Autistic Spectrum Disorders (ASD).

Working effectively with adolescents with SEND may include using different strategies that enable them to express themselves and understand others:

Visual communication including signs, symbols, photographs, objects can assist some adolescents to express themselves and understand others

Adapting speech to individual needs may be useful, such as simplifying grammar, using concrete terms instead of abstract or figurative language, and using short, clear phrases instead of longer sentences.

An advocate supports adolescents without formal language to have their voices heard. An advocate who knows them well will be able to interpret body language and other forms of potentially communicative behaviour.

Review: engaging adolescents with SEND

- Find your agency policy on SEND, which will refer to the SEND Code of Practice 2015.
- Reflect: how can you adopt effective communication strategies to ensure the voices of adolescents with SEND are heard?

Do

Understanding trauma

Research has shown that trauma has a significant impact on adolescent brain development (see appendix). In general, trauma can be defined as a psychological, emotional response to an event or an experience that is deeply distressing or disturbing. Some adolescents will have a traumatic response to risk and/or harm that they have experienced.

Constrained choice

An understanding of trauma helps practitioners to recognise that rather than being completely in control of decision-making, adolescents often make **constrained choices** compared to developed adults who can make choices, over which they have full control.

Experiences of trauma and other factors such as grooming can significantly impact on brain development. The choices of an adolescent that adolescents who have experienced these factors are highly likely to be constrained. In some cases, due to the impact of trauma, an adolescent may not be in a position to make any choice at all.

Practitioners need to be aware that adolescents may have experienced trauma related to their SEND e.g. through medical episodes and procedures, through prejudice from others, through failed educational placements. Adolescents with SEND may not be able to identify or communicate their traumatic experiences. Where communication is not effective, choices may be constrained e.g. the adolescent cannot express a wish not to take part in an activity or to associate with a peer.

Where a female adolescent is experiencing sexual exploitation by a male, a professional might ask why the female returns to the harming male and puts herself at risk. This view ignores the impact that trauma can have on the adolescent brain, and the harm the adolescent believes they would experience if they tried to escape the harmer.

Using positive language and avoiding stigma

It is vital that practitioners choose accurate and neutral language to describe children and adolescents that demonstrates an understanding of constrained choice. Language choices must also reinforce self-efficacy, emphasise adolescent agency and the ability to make decisions about themselves and their care. There is growing national consensus through consultation with adolescents (e.g. Young Minds, The Children’s Society) that regularly describing them as “vulnerable” is patronising and diminishes the sense of adolescent agency or power.

There are a range of stigmatising words and phrases that reinforce the myth that adolescents are completely in control of their choices. For example the phrase “lifestyle choices” does not describe the constrained choice of gang affected adolescents. These phrases fail to recognise the factors that have prevented adolescents from being safe:

Inappropriate term or stigma	Suggested alternatives
Putting themselves at risk	<ul style="list-style-type: none"> • Child may have been groomed. • The child is at an increased vulnerability to being abused/exploited. • A Perpetrator may exploit the child’s increased Vulnerability • Situation could reduce the child’s safety • Location/situation could increase a perpetrators opportunity to abuse them. • Child in not in a protective environment • The location is dangerous to children • Not clear if the child is under duress to go missing • Concerns are that the child may be being sexually abused • It is unclear why the child is getting in to cars. • Concern that there is a power imbalance forcing the child to act in this way. • Concerns regarding others Influences on the child.
Sexual activity with...	<ul style="list-style-type: none"> • They have been sexually abused • They have been raped • Allegation of sexual abuse • Child has described sexual activity, but concerns exist that the child may have been groomed or coerced.

Do

Sexually active since (Age under 13)	<ul style="list-style-type: none"> Concerns exist that child may have been coerced, exploited or sexually abused. Child may have been sexually abused or raped
Have been contacting adult Males/females via phone or internet	<ul style="list-style-type: none"> Adult males/females have been contacting the child. Child may have been groomed. Concerns that the adult is facilitating communication with a child. Child is vulnerable to online perpetrators. Concerns that others may be using online technology to access or abuse the child. Adults appear to be using a range of methods to communicate with the child
Offering her drugs in return for sex	<ul style="list-style-type: none"> Child is being sexually exploited Concerns that the child has been raped Perpetrators are sexually abusing the child The child is being sexually abused The child's vulnerability regarding drug use is being used by others to abuse them. The perpetrators have a hold over the child by the fact that they have a drug dependency.
Involved in CSE	<p>The child is vulnerable to being sexually exploited or they are being sexually exploited.</p> <p>A 5-year old would never be referred to as being involved in sexual abuse for the same reasons.</p>
Promiscuous	<p>Young women who have been raped or who have experienced CSE</p> <p>This puts the blame on the child, implies they know what may be happening, and is not seen as exploitative or abusive.</p> <p>Often used to describe female behaviour.</p>
Prostituting themselves	<p>This completely misses that the child is being controlled/manipulated.</p> <p>Changes in legislation have meant that child prostitution is no longer an acceptable term and should never be used.</p>
Boyfriend/girlfriend	<p>Children have been challenged in court with practitioner's recordings where their practitioner has referred to the perpetrator as the child's boyfriend or girlfriend.</p>

Enforcement responses to adolescents who cause harm to others

When adolescents cause distress, alarm or threaten harm to others, some actions can be taken by the Police, the Council, Anti-Social Behaviour team, youth or county court. Practitioners must understand these consequences and consider how they can continue to work according to the principles set out in Parts 1 and 2 of this guide.

Sharing information about adolescents who cause harm

When the Police or Court respond to adolescent behaviour that may cause distress, alarm of harm to others, agencies are often called on share information.

Sharing information about known risks is a vital aspect of safeguarding adolescents at risk, both for those who are at risk or harm, and for those who do harm to others. This information includes the people adolescents are associating with and places where they go.

These meetings include any agencies who work with adolescents such as schools and colleges, community organisations and health services, and are not restricted to high risk services such as the Police, Youth Offending (YOT) Team and Children's Social Care.

The Scaled Approach to sentencing adolescents

When an adolescent has committed an offense and appears before the the court for sentence, they are assessed for the likelihood of reoffending and the risk of serious harm. Courts use a Scaled Approach to identify both problems and positive factors, so an intervention programme can be devised to be delivered by the YOT. This programme aims to address the needs of the adolescent, prevent further offending and address the key areas of concern in the young person's life.

Do

The Scaled Approach aims to ensure that interventions are tailored to the individual and based on valid assessment of their strengths, needs and risks. The intended outcomes are to reduce the likelihood of reoffending for each adolescent by:

- tailoring the intensity of intervention to the assessment
- more effectively managing risk of serious harm to others.

This approach is used to determine the level of intervention required by YOT following a referral order, a Youth Rehabilitation Order (YRO) or during the community element of a custodial sentence.

Interventions to disrupt the contexts where adolescents cause harm ***Referral Order (RO)***

An adolescent will be referred to a youth offender panel, which investigates the causes of the offending and its consequences with the child or young person and their family and community. The panel is made up of an adviser from the YOT and trained community volunteers. A contract is agreed between the panel and the adolescent, which includes a programme that aims to prevent reoffending.

Youth Rehabilitation Orders (YROs)

An adolescent receiving a YRO is required to take part in activities set by the Youth Offending Team, which could include repaying the community for the offence committed. A YRO can last up to three years. YRO have a range of conditions that can assist in managing risks, for example:

Non-association: forbids contact with one or more persons for a set time;

Exclusion zones: an adolescent is forbidden from entering a defined area;

Curfew notice: forbids entry to an area, usually after a defined time in the evening. Police may stop and question an adolescent under curfew.

Criminal behaviour order

The CBO is used for seriously antisocial behaviour and can be applied or either on conviction for any criminal offence in any criminal court post-conviction or as a stand-alone injunction in a County Court. The post-conviction orders can only be made through an application by the Crown Prosecution Service. If the court is satisfied that the alleged offender has committed behaviour causing harassment, alarm and distress, a CBO is granted.

For stand-alone orders, the Court will consider the evidence of Anti Social Behaviour from the previous 6 months and consider, on the balance of probabilities, the CBO is necessary and proportionate to address the ASB.

Principled practice: maintaining focus on adolescent safeguarding

Enforcement decisions provide practitioners with an opportunity to understand adolescent behaviour and recognise the significance of boundaries in adolescent development.

Every organisation that works with adolescents needs to establish and maintain clear and consistency policy and practice for behaviour that includes limits and sanctions. This includes schools, voluntary sector organisations and statutory services like the police and social care.

Supporting adolescents who cause distress means understanding the contexts influencing their lives. The language of criminal prosecution can reinforce adult roles with phrases like “perpetrator” and “offender”, which do not reflect the reality of adolescent circumstances.

The principles set out in this guide ask practitioners to consider adolescents as children first. It remains important that we understand trauma when we describe and respond to harmful and criminal adolescent behaviours. At the same time, boundaries and sanctions are a necessary part of development.

Restorative Practice

A restorative approach is a way of working with conflict that puts the focus on repairing the harm that has been done. It is an approach to conflict resolution that includes all the parties involved.

Restorative practice in early intervention aims to keep adolescents out of the criminal justice system. This can include the use of restorative practice in schools, care homes and the community, as well as in crime prevention activity. By supporting and challenging adolescents to deal with conflict in a constructive way, restorative approaches can help them to avoid contact with the criminal justice system. This both improves their life chances and reduces demands on the police.

The use of restorative practice with adolescents is increasingly prevalent in care homes, where its benefits can be particularly clear. Adolescents in residential care are disproportionately represented in the criminal justice system, with incidents that take place in this setting more likely to be reported to the police. A restorative approach can deal with incidents in a way that resolves the situation positively without recourse to the police.

Restorative approaches teach an understanding of others' feelings and the ability to connect and communicate successfully. They enable adolescents to think about how to respond to challenging situations and enable adolescents to build trust and develop more mature responses to a difficult situation. Children can take these skills into adult life ([Restorative Justice Council, 2018](#))

Contextual responses to adolescents at risk

Research in practice in local areas has provided further examples of how agencies can respond to the wider contextual risks faced by adolescents:

Reclaiming vulnerable contexts

- Use to identify environments where adolescents are being groomed
- Specialist workers, social workers and police visit those environments on a regular basis
- Adolescents expect to see them there and begin to talk to them
- Slowly this becomes a space where exploitation can't occur

Protecting vulnerable homes

- Identify homes where peer-on-peer abuse occurring
- Identify family members with physical and learning disability, including adolescents with SEND
- Improve Lighting and CCTV
- Engagement with Safer Schools officer
- Engage peer group through combination of support and enforcement
- Home no longer used for abuse

Peer Group Mapping, assessment and intervention

- Practitioners identify links between the social care and youth offending cases
- Meet to map and refine assessment
- Design complementary interventions (Fermin 2018)

Interventions to address the impact of peer-on-peer abuse***Children and families affected by peer-on-peer abuse***

- Emotional, physical and mental well-being affected
- Involvement in offending, going missing, use of alcohol, drugs, etc.
- Family relationships affected
- Ability to access education and other services affected

Interventions to create favourable social conditions for 1:1 delivery

- Build supportive and pro-social peer networks
- Ensure safe and nurturing educational environments
- Reduce exposure to street-based and online crime and victimisation
- Provide safe sites of adolescent socialisation

1:1 and familial interventions

- Recognise/recover from trauma
- Re-build family relationships
- Re-engage in education and other activities
- Reduce incidences of offending, going missing etc.

(Fermin, 2016)

Effective engagement with adolescents

Practitioners often fall into the habit of *doing an assessment to a adolescent* rather than **with** a adolescent. The following guidelines support effective engagement with adolescents:

Listen, listen, listen: the single most important principle is to listen to what the adolescent has to say

Acknowledge: thank adolescents for being able to talk to you. what they have to say, and later support them

Stay alert: keep your eyes, ears and body language open to what the adolescent has to say, without judging, being shocked, commenting or advising (in the first instance)

Start neutral: do not discuss the consequences of their behaviour during early stages of engagement, unless there are clear and immediate child protection concerns

What's in it for me? Listen out for motivation and to gain an understanding of what the adolescent wants.

Solution-focused: ask questions that lead to solutions, rather than remaining on problems, issues, and mistakes

Be sensitive: describe behaviours of concern sensitively with adolescents considering the pace and number of questions

Adapt communication to needs of adolescents with SEND or work with an advocate who knows them well

Prepare for challenge: lead adolescents carefully towards for intrusive, probing or challenging questions

Offer a way out: explain to adolescents that they can end a discussion or engagement

Ready for change? Approach early engagements with curiosity and look for the signs of readiness to change...

Feedback: give feedback that is specific and focused on desired behaviours

What's your view? Seek their perception of their behaviour rather than talking about your perceptions.

The behaviour *not* the person: there is much more to an adolescent than their behaviour. Be aware of your own emotional responses.

Cut the judgemental phrases: ~~I am disappointed by you~~

Avoid correction: instead of questioning the decision, question how they arrived at their thinking (Elicit-Provide-Elicit Model)

Follow up! Make sure that the plans you put in place actually happen through regular communication.

Quality conversations

The starting point for all practitioners if they are concerned about an adolescent should be a **quality conversation**.

We use this term to describe the phone calls and meetings that take place between practitioners working at every level of need in Universal, Targeted, Statutory and Specialist Services and with children, adolescents, families and within the community.

A quality conversation can take into consideration the complexity of adolescent situations and can place more emphasis on **strengths and assets** as well as on the risks outside of the family.

When an adolescent's needs cannot be met by family, community and universal services alone, quality conversations will strengthen and improve joint planning, decision making, collaborative working and a partnership approach to taking the right action, at the right level, at the right time.

If we don't develop sufficient understanding of strengths, needs and risks through quality conversations with families and colleagues, we can miss both the risks and the opportunities to address them. That's why this part of the guidance is critical.



The ingredients of quality conversations

- 1. Active Listening:** giving time and space, picking the right environment, really listening and not just waiting to speak
- 2. Identifying Assets and Strengths:** finding out what matters to the other person, what their hopes and dreams are, their personal strengths and the assets around them which may include peers, family members, friends, activities they enjoy or networks they are part of.
- 3. Enabling the adolescent to take the lead:** practitioners have to resist the urge to "solve the problem" for adolescents but rather enable them to reflect and set goals to which they are more likely to be committed. Keeping in mind the possibility of constrained choice.

Affirming through reflective listening

A fundamental aspect of a quality conversation is affirming adolescent worth and capacity for change. When reflecting back what has been said, heard, practitioners can:

- Reframe and accentuate the positive and the strengths
- Allow adolescents to hear again their thoughts and feelings
- Choose carefully what to reflect
- Deepen your understanding of their situation

Strength-based practice

Every practitioner's role is to be a change agent in the lives of adolescents, using professional practice to build on the existing skills, including their relationships with their community and networks.

There is a balance to be struck between understanding the strengths and goals of adolescents and establishing a consistent approach to good behaviour and clear boundaries.

Practitioners should start a strength-based conversation with the adolescent or their family, unless this is likely to increase the risk of harm to the adolescent. This conversation is to gain an understanding of the adolescent's experiences, wishes and feelings, the family environment, the adolescent's life outside the family, and any other agencies involved.

Conversations should be based on acknowledging what the adolescent is already doing well and building on these strengths instead of a focusing on what they are not doing or what they should be doing. Practitioners can develop techniques to identify how adolescents are doing, paying attention to the problems they face and working with them so that they can tap into resources to help themselves.

Once there is shared understanding of the issues, the practitioner should help to explore solutions. The default option should not be to suggest a source of support external to the adolescent, but to identify what the adolescent can do to address the problems and/or prevent it developing.



Motivational Interviewing

Motivational Interviewing (MI) is a collaborative conversation style that practitioners can use to strengthen an adolescents' motivation and commitment to change.

Partnership

The MI approach uses the ingredients of quality conversations and is carried out in the spirit of partnership with adolescents. This means that all conversations are held **for** and **with** the adolescent not **to** and **on**.

MI conversations are an active collaboration between experts. MI is not manipulative, or a way of tricking adolescents into changing their behaviour. There is profound respect from practitioner for their partner in the collaboration. Practitioners will always work to look at the world from the point of view of the adolescent.

Compassion

To be compassionate is to actively support the other's welfare, to give priority to the other's needs.

Acceptance

MI has Four Aspects

- **Absolute Worth:** prizing the inherent value and potential of every human being
- **Accurate Empathy:** The skill of perceiving and reflecting back another person's meaning
- **Autonomy Support:** accepting and confirming the adolescents's irrevocable right to self-determination and choice
- **Affirmation:** accentuating the positive, seeking and acknowledging an adolescent's strengths and efforts

Evocation

For Motivational Interviewing to be effective, practitioners must consider that all adolescents have what is needed within themselves.

The task of the practitioner is to evoke it, to call it forward. Adolescents who are ambivalent about change already have both arguments within them (sustaining the situation and making the change).

Miller and Rollnick (2013, Adapted for this guide), 'Motivational Interviewing Third Edition', Guilford Press.

Involving adolescents in their care

Adolescents tell us that they want to be actively involved in looking after their wellbeing and they want **more** information and support to help them take an active role in their own care (Young Minds, 2017).

Adolescents in Waltham Forest have said:

"Professionals need to listen to me and give me the time to speak"

"One: they have to listen to the adolescents because that's why they are there. Two: talk to me in a way I understand and three: treat me the same way they treat other people."

"[I appreciate it when professionals are] supporting me, doing activities that give me space and calm me down. Professionals listening to me"

Do

Adolescents who are more involved in making decisions about their care and the services supporting them are more likely to engage meaningfully, develop positive relationships with professionals and improve outcomes.

Often the adolescents we are most concerned about are those who do not have positive relationships with professionals and where practitioners have failed to effectively engage them.

Adolescents with SEND should be able to make and communicate choices with support and can take an active role in their lives. There will be valuable information about adolescents and the factors which contribute to their quality of life in EHCPs and school or college support plans.

Practice tells us that adolescents need practitioners to be:

Persistent in trying to engage them without being pushy e.g. do not automatically close a case after they do not attend three sessions but follow up if the adolescent says that they want to work with the service.

Respectful of their boundaries and choices e.g. offering adolescents a choice whether to work with you.

Creative in how they engage adolescents e.g. offer support for a challenge they face to establish an initial relationship.

Flexible in how they engage adolescents e.g. offering to meet a adolescent where they feel safe and comfortable rather than expecting them to travel to your office.

Sensitive to individual needs e.g. giving a adolescents with speech and language difficulties time to process and respond to speech.

Reflective practice: attitudes, values and beliefs

Practitioners must reflect on how their attitudes and beliefs can act as a barrier that prevents adolescents from accessing the support they need. Investigations into high-profile child sexual exploitation cases (e.g. Rotherham, Rochdale, and Oxfordshire) have highlighted how professionals' attitudes and beliefs about those who have suffered abuse contributed to systematic failings in safeguarding adolescents.

Adolescents experience different barriers to engaging with practitioners, and practitioners will not always be able to overcome these barriers. It may be that the ethnicity, gender and/or age of a practitioner lead an adolescent to feel they will not be able to identify with the practitioner. An adolescent with SEND may feel that a practitioner is not understanding of their needs or has a negative attitude to SEND.

To overcome these barriers and to maximise opportunities for adolescents to engage with services, practitioners must be aware of their own attitudes, values, beliefs, privilege and cultural positioning and the impact these factors may have on professional relationships.

Reflective supervision with managers or peers in a one-to-one or group setting can be an effective way to examine some of these factors and the effects they may be having in building relationships with adolescents.

Review: reflecting on the balance of enforcement and support

Practitioners and managers must consider what the best course of action might be to safeguard an adolescent who is at risk of harm or who has done harm to others. Reflective supervision is a safe conversation to explore thoughts and feelings about the balance between enforcement and support of adolescents.

Review: reflective practice

Reflection on actions and conversations with adolescents and other professionals can help practitioners to better understand and overcome the barriers to engagement and building relationships.

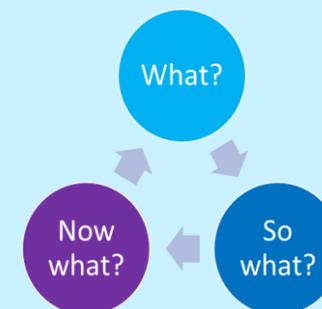
Reflective practice is a skill you can explore in line management, with your peers or with a supervisor from outside your agency.

Reflection can help you to explore an event and the thoughts and feelings you have about what happened.

You may consider your own behaviour, the response from others, and any other factors that influence an event. When you explore your behaviour and your relationships with adolescents in this way, you can begin to learn more from your experiences.

You may find that the event you explore does not match with your previous ideas or beliefs. If the outcome of an event was not expected, you can explore what might have changed the outcome if you had behaved differently.

Reflection is an ongoing process throughout your work with adolescents and can be used in any discipline and at any level of need. Reflective practice is not just for social care and mental health workers and can be applied by any practitioner in informal settings, as well as during formal supervision.



Services specific to adolescent identities: sexuality and gender

Before engaging with adolescents, practitioners must consider whether they have the relevant individual experience to meet the needs of adolescents. Some adolescents may have a diversity need e.g. an adolescent who is vulnerable and is questioning or unsure about their sexuality may benefit from a LGBTQ-specific service.

Research shows that gender-neutral provision can disadvantage some women (CEDAW, 2008) and that gender specific services can offer young women increased feelings of physical safety (e.g. not worrying about sexual harassment), a greater sense of solidarity and increased self-confidence (Dromey for the YWCA (now Platform 51) in 2005, and later the Women's Resource Centre). Offering gender specific or gender-responsive services is particularly important when working with adolescents who have experienced CSE or other forms of sexual violence.

Specialist and voluntary sector response

In all situations, adolescents should take a lead on deciding what they think will be useful to improve their wellbeing. The adolescent may have a strong relationship with a practitioner already involved in their care. Adolescents may require a specialist response due to the level of risk. Waltham Forest offers specialist services for adolescents where there are specific concerns about gangs, CSE, HSB or substance misuse.

Sometimes, a voluntary sector practitioner will be better placed than the lead professional to provide support. The Alex Project, an evaluation into the effectiveness of specialist CSE interventions, reported in 2017 that:

- Specialist voluntary sector workers are in a unique position to support adolescents at risk due to consent-based services model, giving adolescents an opportunity to take control in their lives;
- Voluntary sector services can provide adolescents with a service independent from statutory services, including advocacy and challenge to other agencies where necessary;
- Specialist CSE workers are able to improve children and adolescents' engagement with wider services which can contribute to better operational outcomes such as better prosecutions and convictions.

Adolescents with SEND who have an EHC plan

Some adolescents with SEND will have an Education Health and Care plan, which will contain useful and detailed information on the strengths and needs of the individual adolescent. If you are aware that an adolescent holds an EHC Plan, you should aim to have a conversation with the lead professional or key worker to discuss how you might best contribute to sharing information or safeguarding the health and development of the adolescents with SEND.

The need for reflective supervision

Practitioners who support adolescents who have experienced trauma are at risk of **vicarious trauma**.

Vicarious trauma is an aspect of any profession that involves caring for others and can be more acute for professionals who work with traumatised children. Empathising with clients is vital, but can mean that practitioners take on trauma.

To remain effective and to get the best possible outcomes for traumatised children it is essential to make sure that professionals have access to the support they need to protect themselves (Vicarious trauma: the consequences of working with abuse NSPCC research briefing 2013).

Secondary Trauma or Compassion Fatigue

Refers to the presence of Post-Traumatic Stress Disorder (PTSD) symptoms caused by at least one indirect exposure to traumatic material. Compassion fatigue is a less stigmatizing way to describe secondary traumatic stress, and has been used interchangeably with the term.

Burn out

This is characterised by emotional exhaustion, depersonalisation, and reduced feelings of personal accomplishment. While it is also work-related, burn out develops because of general occupational stress; the term is not used to describe the effects of indirect trauma exposure.

Identifying signs and symptoms of vicarious trauma

One way to prevent the onset of vicarious trauma and compassion fatigue is to be able to spot the signs and symptoms in staff. Staff showing any of the following signs and symptoms (list not exhaustive) may need extra support to address the impact of their practice on their wellbeing:

Social withdrawal	Intrusive imagery
Mood swings	Cynicism (may include blaming adolescents for abuse they have experienced)
Aggression	Difficulty managing boundaries with service users
Greater sensitivity to violence/abuse	Physical health impacts e.g. frequently becoming ill
Somatic symptoms	
Sleep disturbances	

Practitioners may also experience reduced professional capacity. Performance levels may be affected, ability to relate to clients may be diminished and morale may suffer. It is therefore in managers' interests to actively prevent the onset of these states.

Supporting practitioners to prevent vicarious trauma

Good practice examples for actively supporting practitioners to prevent the onset of vicarious trauma include:

- Providing reflective supervision i.e. supervision not target or performance-driven, either on a one-to-one or peer group basis
- Providing clinical supervision from an external organisation
- Encouraging staff to consider self-care and strategies they can adopt outside of work to look after themselves. Examples of self-care can be found in the appendix.
- Encouraging staff to adopt firm work/life balance boundaries e.g. switching work mobiles off at the end of a shift, avoiding looking at emails out of work hours, etc.
- Encouraging and adopting an environment/workplace culture that is open and discusses the impact that work has on staff's wellbeing, feelings and emotions.
- Encouraging positive relationships between team members.
- Ensuring that staff take appropriate breaks to leave the office to re-energise e.g. lunch breaks.
- Ensuring that staff are taking time off in lieu (where they have worked overtime), annual leave and sick leave where required.
- Make employee assistance lines available to staff and ensuring staff know who they can access these



APPENDIX 1: Multi-agency Safeguarding Hub (MASH)

The Multi-Agency Safeguarding Hub (MASH) is the central service for all concerns relating to children’s safeguarding, and this is no different for adolescents who are at risk and require safeguarding.

Professionals who have concerns about an adolescent being at risk should make a referral to the MASH who will then make decisions on what service/s the adolescent requires.

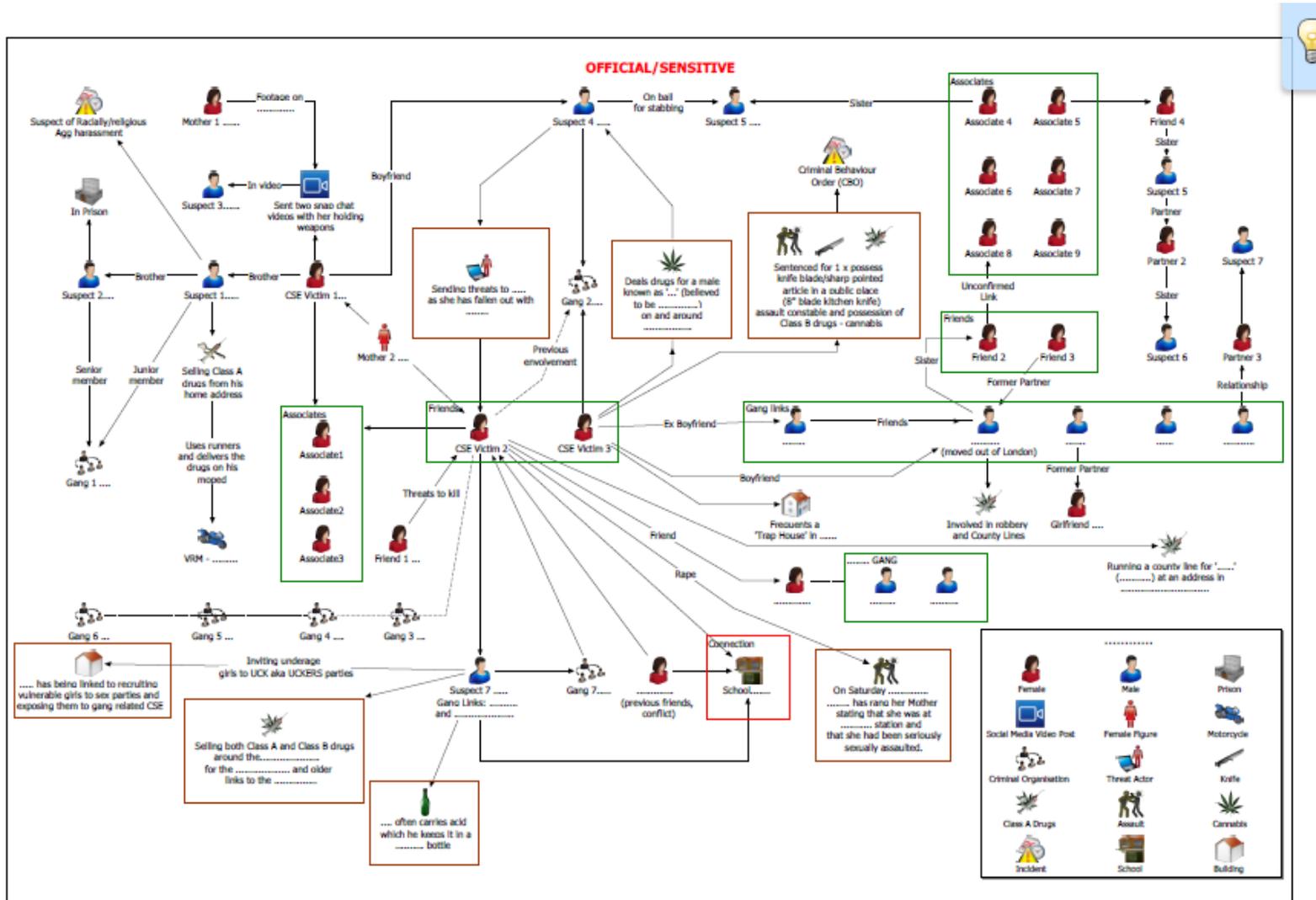
The MASH may choose to direct the referral to:

- The bronze panel if there are concerns about gangs
- Children’s social care
- Voluntary sector providers e.g. Safer London or Solace if a specialist response is required
- The Police
- Early Help
- The lead for Harmful Sexual Behaviour

[LINK TO MASH GUIDANCE](#)

[LINK TO THRESHOLDS GUIDANCE](#)

APPENDIX 2: i2 Chart:



APPENDIX 3 CSE Warning signs, taken from the OCC's report into CSE in groups and gangs (2012)

CHILD SEXUAL EXPLOITATION

WARNING SIGNS AND VULNERABILITIES CHECKLIST

The following are typical vulnerabilities in children prior to abuse:

- Living in a chaotic or dysfunctional household (including parental substance use, domestic violence, parental mental health issues, parental criminality).
- History of abuse (including familial child sexual abuse, risk of forced marriage, risk of 'honour'-based violence, physical and emotional abuse and neglect).
- Recent bereavement or loss.
- Gang association either through relatives, peers or intimate relationships (in cases of gang associated CSE only).
- Attending school with young people who are sexually exploited.
- Learning disabilities.
- Unsure about their sexual orientation or unable to disclose sexual orientation to their families.
- Friends with young people who are sexually exploited.
- Homeless.
- Lacking friends from the same age group.
- Living in a gang neighbourhood.
- Living in residential care.
- Living in hostel, bed and breakfast accommodation or a foyer.
- Low self-esteem or self-confidence.
- Young carer.

The following signs and behaviour are generally seen in children who are already being sexually exploited:

- Missing from home or care.
- Physical injuries.
- Drug or alcohol misuse.
- Involvement in offending.
- Repeat sexually-transmitted infections, pregnancy and terminations.
- Absent from school.
- Change in physical appearance.
- Evidence of sexual bullying and/or vulnerability through the internet and/or social networking sites.
- Estranged from their family.
- Receipt of gifts from unknown sources.
- Recruiting others into exploitative situations.
- Poor mental health.
- Self-harm.
- Thoughts of or attempts at suicide.

APPENDIX 4 The biology of trauma

Trauma is defined as a psychological, physical threat or assault to a child or adolescent; physical integrity, sense of self, safety, and survival. Children/adolescents may experience trauma as a result of a number of different circumstances such as:

- Sexual, physical emotional abuse
- Chronic neglect
- Disorganised insecure parent –child attachment relationship
- Exposure to domestic violence
- Abandonment
- Direct experiences of interpersonal violence i.e. domestic violence
- Gang related violence
- Sexual exploitation
- Rape and sexual assault
- Severe bullying
- Exposure to wars and conflict zones
- Household substance misuse
- Household mental illness
- Significant bereavement

Additionally, environmental stressors can add to children and adolescents' adverse experience.

- Inadequate social support
- Stigmatisation i.e. held responsible and to blame for abuse
- Social marginalisation and oppression are likely to exacerbate psychological symptoms

The adolescent's exposure to adverse conditions produces a range of symptoms that have a profound impact on the cognitive, emotional, physical, and social development of the individual. "Trauma-specific" services are designed to treat the actual consequences of trauma.

We know that brain development continues throughout childhood and adolescence becoming finalised during mid-twenties. Adolescence is a period of accelerated brain development characterised by the maturing of the prefrontal cortex which is linked to executive brain functions such as controlling impulses, multi-tasking, organisation skills, planning and making decisions.

Understand

The impact of trauma and the activation of the survival response i.e. fight, flight, freeze leaves an indelible imprint on brain functioning. These responses release stress hormones such as cortisol which at extreme levels can cause alterations in brain development and functionality.

- Cortisol inhibits the production of two critical neuro-transmitters dopamine (involved in judgement and impulse control) and serotonin (self-soothing and calming abilities)
- Sustained high levels of cortisol can damage the hippocampus an area of the brain responsible for learning and memory
- Excessive cortisol can suppress the body's immune response. This can lead to vulnerability to a variety of infections and chronic health problems
- A survival brain develops which constantly scans for threats and responds to fear at the expense of development of the learning brain which is able to process novelty, has the ability to self sooth, can facilitate healing / growth / rejuvenation / learning and self-development
- Chronic stress results in the under development of the frontal lobe (key to learning decision making and planning)

Trauma becomes grooved and etched into the brain by neural pathway. Normal responses are predictable, formed from the firing and wiring together of neurones. This is a vital function of the brain and without this ability we would need to relearn how to walk every day, a similar process occurs with trauma which becomes encoded in the brain. The activation of the trauma response ensures the frontal lobes disappear and the individual becomes hard wired to the trauma response and danger.

Martin Teicher's (2007) research into teenage girls who had experienced abuse found a significant reduction in an area of the brain associated with speech, language and communication. Techier concluded that listening to verbal aggression creates a defensive response in which key areas of the brain are shut down and development is reduced. Alan Shore suggest that children who are abused and neglected the areas of the brain connected to self-hood and relating to others are compromised and do not develop to their full potential. Shore suggests this can manifest in the following ways:

- Trauma creates and effects internal rhythms whilst externally attachments, between other people are disrupted. Communication with others and the developmental of empathy is aided by mirror neurones which enables connection and attunement with others. Due to trauma this process is severely compromised, resulting in a diminished ability to interact with people
- A lack of understanding of their internal emotional world
- An inability to manage internal states
- The parts of the brain responsible for memory, reward and evaluation of punishment is impaired resulting in individuals who are dis-inhibited, show anti-social behaviour and do not respond to discipline



LONG TERM MENTAL HEALTH CONSEQUENCES

Trauma clinician Bessel van der Kolk (1996) has written that “traumatised people lead traumatic and traumatising lives.” Early childhood trauma contributes to negative outcomes in adolescence, which can impact through to adulthood. A history of childhood / adolescent interpersonal violence can give rise to a host of additional, mental health conditions that co-exist alongside PTSD with a range of effects that persists throughout adolescence and into adulthood including:

- Major depressive illness
- Problematic substance use
- Borderline and anti-social personality
- PTSD
- Phobia
- Attention- deficit hyperactivity disorder ADHD
- Oppositional defiant disorder
- Anxiety disorders
- Social anxiety
- Obsessive compulsive disorder
- Psychotic Disorders
- Sleep disorders
- Somatization disorder
- Hyper activity disorder
- Disorders of attachment
- Conduct disorder
- Dissociative reactions
- Eating disturbances

Early trauma during childhood and adolescence seems to set in motion a chain of events that stretch into adulthood. This potential negative trajectory places those individuals with the greatest exposure and the fewest positive mediating or ameliorating factors at greatest risk of significant and debilitating effects on all aspects of their development. This spiral of factors is known to increase the occurrence of adult psychopathology.

LONG TERM IMPACT OF TRAUMA

The legacy of trauma casts a long shadow into the future well-being of individuals. The following are intended to provide an indication of the adult repercussions of early trauma:

- The consequences of early trauma on adult functioning has been shown to expose the body to chronic stress which lowers the immune system and increases vulnerability to autoimmune diseases
- The neurophysiology imprinting of trauma response such as dissociation, hyper arousal freezing and so on compromise brain function which in turn impact on learning, character development and self esteem
- Health risks associated with depression
- Increased suicide rate
- Increased health vulnerabilities due to risky coping strategies such as: problematic substance use, cigarette smoking and obesity
- Earlier deaths from a wide range of disease such as:
 - Cancers
 - Coronary disease
 - Early onset dementia
 - Liver kidney / disease
 - Autoimmune disease
 - Chronic lung disease
 - Skeletal fractures

Traumatic events may contribute to other negative outcomes, both in adolescence and in adulthood:

- Truancy and dropping out of school
- Problematic substance use
- STI's
- Unintended pregnancies
- Decreased educational/occupational attainment
- Homelessness
- Criminal justice system involvement
- Being put into care

Understand

For young women, the effect of early trauma can leave them vulnerable to further sexual exploitation and creates a direct path into prostitution. The Home Office study *Paying the Price* (2004) found that 57% of women involved in prostitution have childhood experiences of abuse. The reasons for this are multi-dimensional and may involve contributory factors such as:

- A normal response to trauma is internalisation and re-enactment of experiences as a means to normalise the trauma which can manifest in sexualised behaviour, this is exploited by pimps
- PTSD characterised by patterns of dissociation can lead to risky and self-harming behaviour
- Lack of interpersonal communication skills and confidence in asserting boundaries
- Substance misuse lowers resistance
- Efforts to escape familial abuse by running away and becoming homeless
- There is a strong relationship between being in care and childhood sexual exploitation

Legacy and Impact

- Early trauma in childhood referred to as Developmental Trauma the impact occurring at critical windows of development and influencing brain response and function. During normal development the brain is engaged in exploration and learning, novelty is experienced as exciting and new. However, the influence of development trauma the brain switches to the survival brain in a defensive and vigilant mode intent on detecting for threats and anticipating danger.
- The activation of the stress response system of the survival brain compromise's the body's reward system and balance of neurotransmitters such as dopamine that manages distress and serotonin linked to wellbeing and happiness. The dominance of the survival brain inhibits higher brain functionality with a reduction in hippocampal volume and lack of engagement of cerebral cortex the ability to make complex conscious judgements and plans is compromised. The capacity for healing, growth, rejuvenation, learning, self-soothing and self-development are lost. The individual retreats to a detached state and is trapped by a disorganised attachment system with a chaotic mix of excessive help seeking, dependency, social isolation, disengagement, impulsiveness, inhibition, submissiveness and aggression.