Gloucestershire Safeguarding Children Board

Serious Case Review

"Lucy"

FINAL REPORT

1st June , 2016

Lead Reviewers:

Deborah Jeremiah

Joanna Nicolas

v.30 010616

Contents

1 Introduction 3
2 The Findings 15
3 Findings in Detail 22
3.1 Finding One 22
3.7 Finding Two 27
3.13 Finding Three 34
3.19 Finding Four 38
3.25 Finding Five 42
3.31 Finding Six 45

Appendices

Appendix 1 Acronyms & Glossary
Appendix 2 That Difficult Age: Developing a more effective response to risks in adolescence

1 Introduction

1.1 Why this case was chosen to be reviewed

This case was taken to the serious case review subgroup on 22nd April 2014 due to the nature of the child's death. The child, Lucy, was the subject of a serious assault by her partner, Daniel on 2nd April 2014. Lucy was pregnant. Lucy and her unborn baby, Sarah, , died as a result of the assault and her partner was found guilty of her murder on 3rd October 2014 and given a life sentence.

1.1.1 Gloucestershire Safeguarding Children Board (GSCB) Independent Chair made the decision that the circumstances of the child's death fully met the criteria for a serious case review, as set out in Chapter 4 of Working Together to Safeguard Children, 2013 on 22nd April 2014.

1.2 Succinct summary of case

Lucy had lived between her mother, father and maternal grandparents for most of her life. Prior to 2011, when she was 13, she was only known to health and education services. Between 2011 and 2013 there was some involvement with the Children and Young People's Service, which is the child and adolescent mental health service in Gloucestershire and one brief intervention by Social Care.

1.2.1 The first known physical assault by Daniel was on the 31st October 2013 which was also around the time Lucy found she was pregnant. From that time until her death, agencies, including social care, were working with Lucy and her family. This was primarily because of concerns around Lucy's housing situation; Lucy and the professionals working with her considered her to be homeless, the fact that she was at times estranged from different family members and concerns about Lucy's unborn baby, Sarah.

1.2.2 At the time of Lucy's death she had recently moved back to live with her mother, having left Daniel's home.

1.3 Family composition

Child – Lucy, aged 16 and the time of her death in 2014
Child's partner – Daniel, aged 18 at the time of Lucy's death in 2014
Mother – Heather
Father – Paul
Maternal grandmother – Hilary
Maternal grandfather – John
Lucy's unborn baby – Sarah

1.4 Timeframe

Systems reviews consider how safeguarding systems and practices within a local authority area operate and we test out how safe and effective they are. Therefore when considering where to start the review we do not go back many years because our systems will have changed. This does not mean that family history is overlooked but what is relevant is whether the professionals working with the family during the period under review know about the family history.

1.4.1 In this case it was agreed that we would start the review from 10th October 2011, which was the date that Lucy and her family first became known to social care.

1.5 Timeline of Events

Date	Event/Circumstance
10.10.11	Lucy made allegation to the police that her grandfather hit her which her grandfather denied. Lucy's account later changed and no formal complaint or charges were brought. Referral made to social care. Police describe Lucy as an out of control child. Lucy goes to stay with her father, Paul, having previously lived with her grandparents.
18.10.11	Lucy seen by the Children and Young People's Service (CYPS), the mental health service, for assessment. (She had been referred in September because of her behaviour and concerns of self-harm). CYPS concludes there is no role for them at that time and refers the family to a local charity, County Community Projects, for family mediation, which was not progressed as Lucy had moved in to live with Paul.
21.10.11	Social care complete their initial assessment and conclude there is no role for them at that time.
5.11.11	Paul reported Lucy as missing. Located at a friend's home.
18.11.11	Paul reported Lucy as missing. Located at a friend's home.
11.4.12	Lucy prescribed the contraceptive pill for period pain control. She told the GP she was not in a sexual relationship.
7.10.12 – 30.10.12	Lucy has recurrent urinary infections
7.01.13	Lucy saw GP alone and expressed insomnia, anxieties around various aspects of her life and relationships. GP referred Lucy to the Children and Young People's Service for a second time.
24.01.13	Appointment with Children and Young People's Service. Low mood, anxiety, alcohol consumption and insomnia, and planned liaison for social care and support to grandparents and Heather.
17.04.13	Heather states that Lucy is refusing to go to school and that she says no one wants her.
20.5.13	Referral received by Children and Young People's Service parenting programme office

Date	Event/Circumstance
29.4.13 – 15.7.13	On-going appointments with Children and Young People's Service
22.7.13	Lucy was at a party where she believed she had been "injected by boys because they want to have sex with me". Lucy was intoxicated, allegedly injected and possibly had been sexually assaulted. Going into the early hours of the next day Lucy was taken to Cheltenham General Hospital by Heather before being transferred to Gloucestershire Royal Hospital by ambulance. She was intoxicated. The incident at the party was reported to the police. The Hospital found evidence of alcohol misuse. Tests done. Referral to social care not accepted. Family offered support through the targeted support team, which offers support at a lower level, and an assessment under the common assessment framework was to be completed.
20.8.13	Lucy reviewed by the Children and Young People's Service, the mental health service. Referral made for cognitive behavioural therapy. Lucy placed on waiting list.
6.9.13	Heather and Hilary declined parenting programme
14.10.13	Heather reports to a nurse at the GP Practice that Lucy missed contraceptive pills that month. Advice given.
22.10.13	Pregnancy test negative – checked at school as Lucy presented herself to school nurse.
25.10.13	Lucy's care reviewed by Children and Young People's Service. Still on the waiting list for cognitive behavioural therapy. Counselling to be offered as an alternative, to be provided by Teens in Crisis, a local charity, due to the waiting time for cognitive behavioural therapy
26.10.13	Lucy believed she was having a threatened miscarriage – bleeding reported to Out of Hours GP service.
27.10.13	999 call to police from a female saying 'help me". Call cut off abruptly. Police called back and she said things were fine and that she had called by mistake and she was going home. Incident was closed. It was only after Lucy's death that it was ascertained it was Lucy who had made the call .
31.10.13 – 1.11.13	Doctor neighbour of Paul's saw Lucy distressed in the street and with visible injury and signs of self-harm. This was approx. 11.30pm. Taken in by neighbour and police called. Lucy told neighbour that she had been assaulted by Daniel and that she thought she was pregnant and that he had knocked her to the ground and then kicked her in the stomach the weekend before when she had told him she thought she was pregnant. Nine month relationship and previous aggression. Police attended but after short time and Lucy having been in constant contact with Daniel by telephone, Lucy refused to make a formal complaint. No Domestic Abuse, Stalking and Honour Based Violence (DASH) form completed that night by police but handover to the officer for the next shift at around 1am when attending officers went back to the station. Agreed that there would be full statements taken the next morning. Police looked but unable to locate Daniel.

Date	Event/Circumstance
1.11.13	Lucy seen by police officer for some time at her grandparent's house and encouraged to take matters further and make a formal complaint. Lucy unwilling. Lucy called the police that evening to say she would now make a complaint. Referral to social care had been made by the police and an initial assessment would commence.
2.11.13	Daniel arrested and states that he and Lucy have split up and that was why she was making the complaint. Released without charge. Maternal grandmother informed. DASH form completed.
11.11.13	Social worker One (SW1) tried to see Lucy at her grandparents' home but she had moved to Heather's so not seen.
13.11.13	First Counselling session at school
14.11.13	Pregnancy confirmed by nurse at the GP Practice. Lucy 15. Boyfriend noted to be two years older. Lucy referred to the GP.
16.11.13	Daniel had an altercation with someone and head-butted their car windscreen causing it to crack.
19.11.13	Further pregnancy test at school – positive and Heather noted to be supportive. School nurse referred Lucy to the teenage pregnancy midwife. Shortly afterwards the pregnancy was announced on Facebook
26.11.13	Mental health worker records that Heather has told her that Lucy is now living with her due to extreme difficulties in the relationship with her grandparents.
28.11.13	999 call by anonymous caller to the police to report an on-going domestic at the "Rec", a park in Cheltenham The caller heard Lucy saying she could not breathe. The caller's neighbour then joined the caller and the police were told that it sounded as if the "lady may be in labour and her partner is not allowing her to call her mother". The police attended. Lucy denied domestic abuse. Ambulance not needed but when Heather arrived to collect Lucy, was advised to take Lucy to the Emergency Department.
10.12.13	Initial pregnancy booking appointment with midwife and midwife makes referral to the teenage pregnancy midwife. This was the second referral to the teenage pregnancy midwife. Intermittent bleeding noted and urinary symptoms. On-going counselling at school. Initial assessment not yet completed by social care.
11.01.14	Lucy attended the Emergency Department. She had been hit to the ground by a male she would not name. She had been punched in the face and had a bleeding nose. After treatment Lucy was discharged to Heather's home. Doctor and mother believed assault to be from Daniel and Heather reported they argue a lot. Duty social worker informed of assault. Police not involved. GP informed of attendance by letter.
14.01.14	Meeting arranged by the school because Lucy's attendance was dropping off. Purpose of the meeting was to look at how professionals could support Lucy in attending school during her pregnancy. Lucy and Heather attended. Midwife, counsellor and pastoral head attended meeting. Concerns about housing for Lucy. Sickness in pregnancy a problem. Counsellor was asked to follow up with social care. On doing so counsellor was advised of concerns around domestic

Date	Event/Circumstance
	abuse toward Lucy from Daniel.
21.01.14	Lucy failed to attend appointment with Sexual Health.
22.01.14	Call to school nurse from the GP. GP had concerns if enough support in place and that Lucy was considering a termination of pregnancy. This was discussed at school and CSE tool completed with high score. This form was sent to the police and risk discussed with social care. Was seen by the teenage pregnancy midwife.
28.01.14	Multi-agency meeting held by the school. After the meeting the teenage pregnancy midwife made referral to CYPS, which was accepted because of concerns about Lucy's mental health, Lucy had self-harmed at the beginning of pregnancy. After the meeting the pastoral support worker claims she told SW1 she had seen some bruising around Lucy's eye.
03.02.14	Heather reports Lucy as missing to the police. Believed to be with Daniel. Heather explained that Lucy did not have a mobile phone and that Daniel smashes Lucy's phones and forced Lucy to close down her social media communications and that Daniel was repeatedly abusing Lucy. Lucy returned home by Daniel's grandmother.
04.02.14	Social care completes Initial Assessment. Case transferred from referral and assessment team to children and families team, within social care.
05.02.14	Heather tells her mental health worker that Lucy punched her in the face and she wants her to leave.
06.02.14	Home visit by mental health workers to Heather. Lucy noted to be hostile, aggressive and abusive towards Heather.
08.02.14	Heather tells her mental health worker Lucy abused her the previous day. The worker records that Heather says Lucy is accusing her of informing social care about the abuse inflicted on Lucy by her partner. Lucy goes to stay with Paul.
10.02.14	Visit at Paul's home. SSW records that throughout Daniel was constantly calling and texting Lucy. Six calls and in the ones she answered, Daniel seemed to be very controlling and dominating
11.02.14	Adult social worker from the Crisis Team contacted SSW. Heather had shared information with her about Lucy. Heather had said that Lucy was experiencing on- going assaults from her partner and Heather would describe it as being the "tip of the iceberg". Heather also said Lucy self-harms and has lots of scars on her arms. Heather said Lucy had threatened her and had assaulted her. SSW advised that Heather should contact the police, if she was concerned. Lucy becomes homeless. She is pregnant a child and a victim of domestic abuse. When Lucy is with Daniel she cannot be reached as he will not allow her a mobile phone. Social care's Diversion and Placement Support Team are involved but unable to secure a place for Lucy with any of her family members. Lucy goes to stay with Daniel and his parents.

Date	Event/Circumstance
	Social care decide to arrange Strategy Discussion in respect of Lucy and her unborn baby, Sarah.
12.02.14	Lucy's 16th birthday. Immediate issues of where Lucy can stay overnight being managed by SSW and Lucy declines foster care.
13.02.14	SSW discusses safety plan with Lucy – ring 999 or other emergency services and Paul's house was identified as the place of safety for Lucy to go to in an emergency. SSW notes reported and unreported incidents of abuse. Lucy stays and Daniel's.
17.02.14	Lucy declines Nightstop as she was scared of meeting strangers. Safety plan was reiterated.
18.02.14	Teenage pregnancy midwife contacted CYPS
19.02.14	Heather tells her mental health worker and SSW that Lucy has a bruised eye but does not want to lose relationship with Lucy by reporting it to the police. Heather also says she is reluctant to inform the police because of their lack a response previously. Heather is encouraged to report it herself to the police. SSW advised Heather that there was to be a strategy discussion to consider all the concerns.
25.02.14	Strategy Discussion held with regard to Sarah, as decided by Social Care on 11.02.14. Decision was to undertake a child protection investigation for Sarah. Lucy now living with Daniel and his parents and sleeping on the sofa. No vacancies at the Mother and Baby unit.
05.03.14	Reports that Lucy has no money. Paul advises Social Care that Lucy was getting money from the family but it was suspected that Daniel was taking it from Lucy and that he has a gambling problem.
11.03.14	Social Care draw up a Child in Need Plan in respect of Lucy. She is referred to as a Child in Need. There is a clear plan of action and reference to the plan being reviewed on 15th April 2014.
17.03.14	Initial Child Protection Conference held in respect of Sarah. Sarah made subject of a Child Protection Plan under the category of at risk of physical and emotional abuse. Social Care advise Lucy that she will not be able to keep Sarah if she remains with Daniel, given the domestic abuse.
21.03.14	Lucy moves back with Heather in an attempt to separate from Daniel. She meets the SSW and says she wants to make changes to reduce the risk to the baby.
25.03.14	Decision to close Lucy's Social Care case as her needs can be met through Sarah's Social Care case.
26.03.14	Core Group meeting
27.03.14	Daniel is declined seeing Lucy at school. Lucy is in agreement for a Mother and Baby placement.
02.04.14	Serious assault upon Lucy by Daniel and she and Sarah subsequently died a few days later.

1.6 Organisational Learning and Improvement

Statutory guidance on the conduct of learning and improvement activities to safeguard and protect children, including serious case reviews states that:

1.6.1 Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. Local Safeguarding Children Boards (LSCBs) and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children (Working Together 2013).

1.6.2 Gloucestershire Safeguarding Children Board identified that this serious case review held the potential to shed light on particular areas of practice.

1.6.3 Working with teenagers has it own set of challenges. The Home Office has highlighted the complexities of abusive relationships between young people. Gloucestershire agencies are currently working together to highlight and scope how we should respond to cases of this type of domestic abuse. GSCB wishes to consider how we can work more effectively with this age group. It was identified that this case review had potential to shed light on how agencies in Gloucestershire are responding to some of the challenges which arise, including:

- Engaging with teenagers
- Understanding teenagers at risk
- Teenagers in unhealthy relationships
- Engaging teenagers effectively in child protection and safeguarding systems

1.6.4 In summary, GSCB wants to gain a greater understanding of the systems currently in place to work with teenagers. In addition to this, GSCB wants to develop a greater understanding of and work more effectively with teenagers given the particular set of challenges they present with.

1.7 Methodology

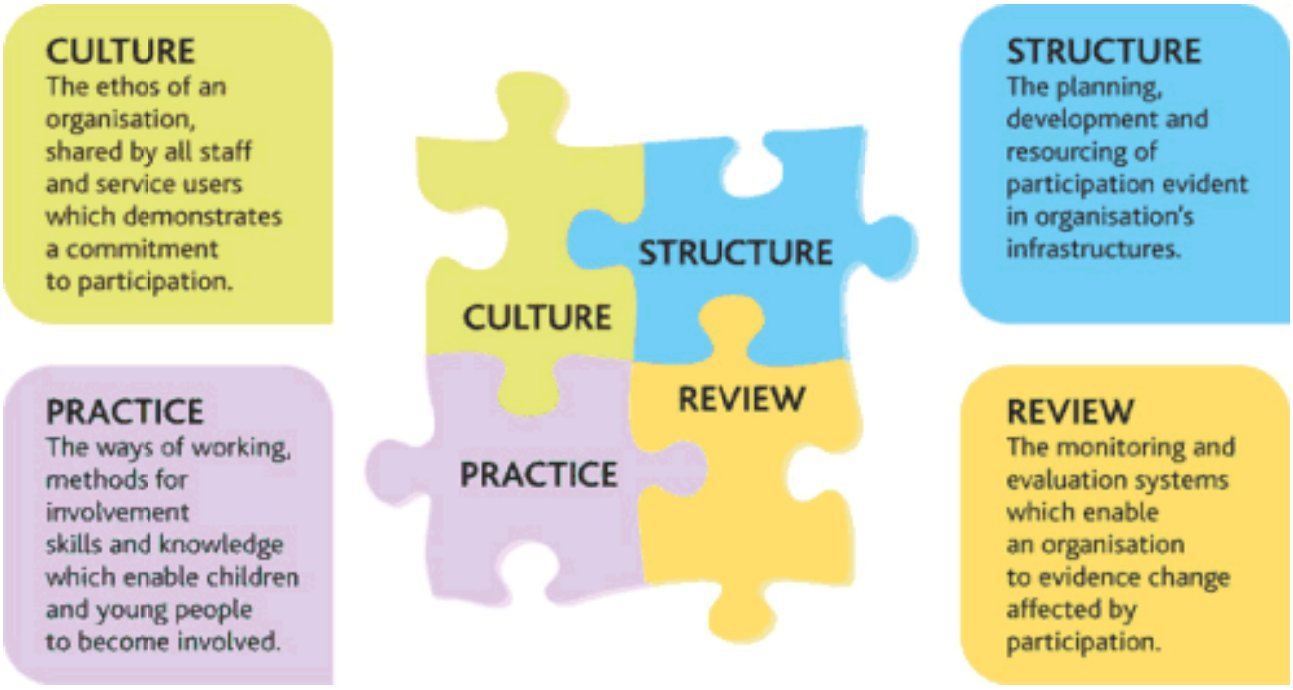
Statutory guidance requires serious case reviews to be conducted in such a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individual and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

1.7.1 It is also required that the following principles should be applied by LSCBs and their partner organisations to all reviews:

- There should be a culture of continuous learning and improvements across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- The approach taken to review should be proportionate according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process.

1.7.2 In order to comply with these requirements Gloucestershire Safeguarding Children Board has used the Social Care Institute for Excellence (SCIE) Learning Together systems model (Fish, Munro & Bairstow 2010). In the words of Wright and colleagues (2006) different elements of participation can be brought together in a single framework, like a jigsaw puzzle[1].



[1] http://www.scie.org.uk/publications/guides/guide17/wholesystems.asp

1.8 Reviewing expertise and independence

The serious case review has been led by two people independent of the case under review and of the organisations whose actions are being reviewed. Deborah Jeremiah and Joanna Nicolas are both accredited to carry out SCIE Learning Together Reviews, and have extensive experience in serious case reviews. Neither have any previous involvement with this case, and both work independently of Gloucestershire County Council and its partner agencies.

1.8.1 The lead reviewers have received supervision from SCIE as is standard for Learning Together accredited lead reviewers. This supports the rigour of the analytical process and reliability of the findings as rooted in the evidence.

1.8.2 Statutory guidance requires that serious case review reports be written in plain English and in a way that can be easily understood by professionals and the public alike. Writing for multiple audiences is always challenging. In the Appendix we provide a section on terminology. Our aim is to support readers who are not familiar with the processes and language of safeguarding and child protection work.

1.8.3 LSCBs and SCIE are both keen to improve the accessibility of serious case review reports and welcome feedback and suggestions for how this might be improved.

1.9 Participation of Professionals

The review consisted of two groups of professionals. The Review Team which consisted of a senior manager from each of the agencies involved during the period under review, none of whom had had line management of the case, and the two independent lead reviewers.

1.10 Review Team

Deborah Jeremiah	Independent Lead Reviewer
Joanna Nicolas	Independent Lead Reviewer
Business Manager	GSCB
Service Leader Safeguarding	Children and Young People's Operational Delivery
Detective Sergeant	Gloucestershire Public Protection Bureau
Operations Manager	Gloucestershire Youth Support
Strategic County Domestic and Sexual Violence Coordinator	Gloucestershire Public Protection Bureau
Safeguarding Lead/Named Nurse Safeguarding Children	2gether NHS Foundation Trust
Named Nurse Safeguarding Children	Gloucestershire Care Services NHS Trust
Divisional Nursing and Midwifery Director Women and Children, Named Nurse/Midwife Safeguarding Children	Gloucestershire Hospitals NHS Foundation Trust
Safeguarding Children Development Officer (education)	Education
Strategy and Engagement Manager	Cheltenham Borough Council (Community Safety Partnership)
Deputy Director Nursing, Designated Nurse	CCG
Business Contracts Manager	Independent housing provider

1.11 The Case Group

The case group was made up of the key frontline professionals who had been working with the family during the period under review.

Support co-ordinator	Independent housing provider
Support co-ordinator	Independent housing provider
Social worker 1 (SW1)	Children's social care referral and assessment team
Team manager	Children's social care referral and assessment team
Social worker 2 (SW2)	Children's social care children and families team
Student social worker (SSW)	Children's social care children and families team
Team manager	Children's social care children and families team
Family support worker	Children's social care diversion and placement support team
Family support worker	Children's social care diversion and placement support team
Chair	Children's social care child protection conference chairs team
Community midwife	Gloucestershire Hospitals NHS Foundation Trust
Teenage pregnancy midwife 1	Gloucestershire Hospitals NHS Foundation Trust
Teenage pregnancy midwife 2	Gloucestershire Hospitals NHS Foundation Trust
School nurse	Gloucestershire Care Services NHS Trust
Sexual health nurse advisor	Gloucestershire Care services
Counsellor	Teens in Crisis +
GP1	GP Practice
GP2	GP Practice
Case responsible officer, Not in employment, education, or training (NEET)	Gloucestershire Youth Support
Case responsible officer, Housing	Gloucestershire Youth Support
Team manager	Children's social care 16+ team
Social worker	Children's social care 16+ team
Police Constable (PC1)	Gloucestershire Constabulary
Police Constable (PC2)	Gloucestershire Constabulary
Detective Sergeant	Gloucestershire Constabulary
Pastoral support worker	School
Designated safeguarding lead	School
Mental health support worker	2gether NHS Foundation Trust
Care co-ordinator	2gether NHS Foundation Trust

1.11.1 There was on-going interaction between the two groups to test out accuracy, developing analysis and findings

1.12 Perspectives of the family

In this case Heather met with two members of the review team and Paul and the maternal grandparents met with the two lead reviewers. Their views are woven throughout the report. Daniel and his parents were given an opportunity to engage with the review team, so we could hear their views, but they declined to be part of the serious case review.

1.13 Methodological comment and limitations

It was Daniel and his parents' choice whether they contributed to the serious case review. Efforts were made to engage with them because their contribution would have enhanced the review, particularly in view of the fact that Lucy stayed with Daniel's parents for several weeks before her death and Daniel was present at many of Lucy's appointments and for the meetings held for Sarah. They did not participate in this review but did feel able to helpfully contribute to the Domestic Homicide Review being undertaken alongside this serious case review. Consequently their perspectives are reflected in the Domestic Homicide Review report.

1.13.1 The Review Team acknowledges that we have not been able to gain an understanding of what happened, from Daniel and his parents' perspective because they were unwilling to contribute to the review. We are also unable to know whether their input would have changed the understanding we have developed of what happened in this case and why, and what the implications are for future service improvement.

1.14 Parallel procedures

Daniel was charged with the murder of Lucy and found guilty of her murder on 3.10.14. There is a concurrent domestic homicide review. "When the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
b) a member of the same household as himself2 a domestic homicide review must be held with a view to identifying the lessons to be learnt from the death. This is statutory.

1.14.1 Gloucestershire Safeguarding Children Board, who undertake the serious case review, and Cheltenham Community Safety Partnership, who undertake the domestic homicide review,

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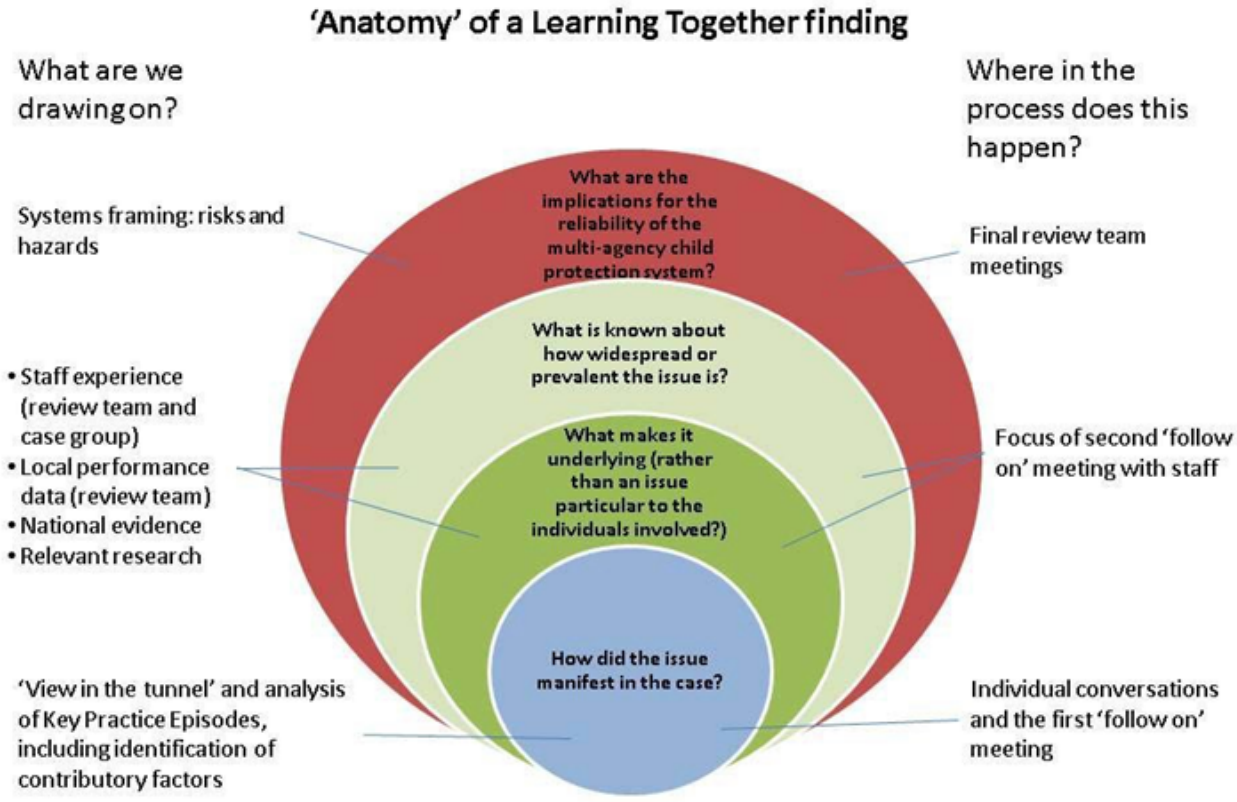
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209020/DHR_Guidance_refresh_HO_final_WEB.pdf

have agreed that the two reviews will be as aligned as closely as possible. To this end both reviews will follow a similar timescale and be guided by the same panel of professionals. Deborah Jeremiah has been appointed to be one of the two serious case review lead reviewers and to also chair the domestic homicide review panel.

2 The Findings



2.1 Introduction

Statutory guidance requires that serious case reviews provide a sound analysis of what happened in the case and why, and what needs to happen in order to reduce the risk of recurrence. These processes should be transparent, with findings of reviews shared publicly. The findings are not only important for the professionals involved locally in cases. Everyone across the country has an interest in understanding both what works well and also why things can go wrong.

2.1.1 This section contains six priority findings that have emerged from the SCR. The findings explain why professional practice was not more effective in protecting Lucy and Sarah in this case. Each finding also lays out the evidence identified by the review team that indicates that these are not one-off issues. Evidence is provided to show how each finding creates risks to other children and families in the future cases, because they undermine the reliability with which professionals can do their jobs.

2.1.2 First, an overview is provided of what happened in this case. This clarifies the view of the review team about how timely and effective the help that was given to Lucy and her family was, including where practice was below expected standards.

2.1.3 A transition section reiterates the ways in which features of the particular case are common

to the work that professionals conduct with other families and therefore provides useful organisational learning to underpin improvement.

2.2 Appraisal of professional practice in this case: a synopsis

This review considers the multi-agency response to a teenager (Lucy) who presented with multiple risks; perceiving herself to be homeless, pregnant, estranged at different times from different members of her family and who was in an abusive and violent relationship. Lucy had experienced periods of instability in her family life and in her education. In her early teens she became difficult to manage due to her behaviour and was moving around numerous relatives. At age 14, Lucy was described by police to be outside parental control. She had, by then, a history of emotional difficulties with self harming, challenging and risky behaviour and her relationships with her immediate family were starting to falter.

2.2.1 Lucy first came to the attention of child and adolescent mental health services (now called Children and Young People's Service, CYPS) at the age of 13. This service also received two further referrals concerning Lucy when she was 15. However, faced with lengthy waiting times for Lucy to proceed with Cognitive Behavioural Therapy (CBT) Lucy was passed to a counselling service, Teens in Crisis+, and was seen on a number of occasions by the counsellor at school.

2.2.2 At the age of 15 Lucy's relationships with her family deteriorated to the point that she could not be accommodated by any of them, even when pregnant and in an abusive relationship. Lucy effectively became homeless despite efforts by social care to negotiate with individual family members to try and avoid that. At no time were all the family members brought together to discuss the reasons for this or share their individual perspectives and concerns to work towards a solution, as would have been good practice, though we cannot say for sure what the outcome of this would have been. The professionals state that to have done so would have been against Lucy's wishes. They perceived that without Lucy's engagement a family group conference or similar could not take place. This meant that at no time were the family members brought together to discuss a solution facilitated by professional support. There is a balance to strike when practitioners work with teenagers, between respecting and supporting their autonomy and their need to be protected as children and this is challenging to get right[3]. This preference was even more apparent later on when professionals assumed that Lucy was making a conscious decision not to engage and yet she was in an abusive and controlling relationship with Daniel.

2.2.3 Before her family decided that they could not accommodate Lucy, a key event had occurred. On 31st October 2013 Daniel had assaulted Lucy and there was also reference to him kicking her in the stomach two weeks previously when she had told him she thought she was pregnant. The professional response to this was led by the police who were called to attend

[3] This challenge is explored further in **Finding One**

by a member of the public who had been out and Lucy had approached her in the street in a distressed state. The attending officers spent some time ascertaining what had happened. During this time Lucy was known to be in contact with Daniel and as Lucy started to calm down she started to minimise the incident. After the police officers left Lucy there were attempts made to find and arrest Daniel. Lucy was taken home by family members and then seen again by the police the next day and a Domestic Abuse, Stalking, Harassment and Honour based Violence (DASH) form was completed. This form was originally created for adult victims of domestic abuse. Since April 2013, the definition of domestic abuse under the law was extended to those aged 16 and 17. The DASH is therefore used for this age group as well as adults. At the time the DASH was completed for Lucy she was 15 years and the review team consider it was good practice the DASH was completed, even though a 15 year old sits outside what is legally defined as domestic abuse. At that time this was the only tool available to the police but since then other tools have been developed aimed more at the young person such as young person's DASH. The DASH used in this case was completed in Lucy's presence, as is also good practice. However essential information known to the police was not captured in the DASH; specifically that Lucy was alleging Daniel had punched her to the floor and kicked her in the stomach when she told him she thought might be pregnant[4].

2.2.4 Lucy expressed at the time of being seen that she did not wish to press charges, nevertheless Daniel was arrested but later released without charge. As part of the process the police should have completed a Youth Process form prior to Daniel's release as he was under 18. This was not done at the time, but completed retrospectively. There was, therefore, a missed opportunity for a further review of the investigation with the duty inspector before release. The form was shared with the Youth Offending Service but as no further action was being taken by the police, it is not routine practice to attempt to engage young people into the service. Heather's perception thereafter was that the police were unlikely to assist if there were further incidents of domestic abuse between Daniel and Lucy, which then went unreported (see para 2.2.7 for further description). There are evidential challenges to prosecution in a situation where the victim of domestic abuse does not press charges and does not separate from the perpetrator. Nonetheless, the review team find the police response to Daniel in this case was limited and there was a lost opportunity to engage with Daniel around his behaviour.

2.2.5 Initially Lucy was not prepared to support a prosecution against Daniel but later she telephoned the police station to say that she had changed her mind and now she wanted to. This change of view was not picked up due to human error. Lucy was in a place of safety with her grandparents and had expressed that she was prepared to support a prosecution so risks related to possible repercussions for her were limited and this was a missed opportunity.

[4] The use of the DASH and its effectiveness as a tool for domestic abuse for 16 and 17 year old victims is considered at **Finding Two.**

2.2.6 The immediate and longer-term response by social care following this incident did not reflect the urgency or complexity of the case. An assessment was commenced as expected, but there was considerable delay to it being completed. This was because SW1 was absent from work, unwell, and the case was not reallocated as those managing the service did not appreciate the risks posed to Lucy. Another contributory factor was that it also took some time to engage with Lucy as she was moving around between relatives and her attendance at school had started to drop. Lucy was eventually referred to the Children and Families Team for longer-term work on 12th February 2014. By now, Lucy and the professionals working with her considered her to be homeless, she was pregnant, and there was evidence of further assaults and coercive control from Daniel. Day to day casework was undertaken by a student social worker (SSW) supervised by an experienced social worker, SW2. Student social workers have to gain experience through casework but the review team's view is that this was too complex a case for a student social worker to manage, even with supervision as Lucy was presenting with a complex dynamic of multiple risks and was also saying she was going to move in with Daniel and his parents. The student social worker only focussed on the risk he considered most imminent – Lucy being homeless.

2.2.7 During this time there was information coming forward from Heather of two separate assaults and coercive control and there was confusion as to who should be holding this information and acting upon it. Heather was being told to inform the police though she had a mental illness and was unwell at that time, and the SSW, while putting a great deal of time into the case should not have been expected to manage the competing risks being presented. The SSW worked very hard on seeking to support Lucy and certainly sought to utilise all the skills he had at that time to take the case forward

2.2.8 There was a lack of understanding of the components and complexities of domestic abuse between teenagers, in that it can be multifactorial and present as physical abuse but also as coercive control and there was clear evidence of both. The element of coercive control is a very serious indicator and in March 2015 has become a criminal offence[5].

2.2.9 Lucy moved to Daniel's home against the SSW's advice and with no realistic safety plan in place; the plan was to telephone 999 in an emergency and go to Paul's house. It was known by social care that Daniel was controlling Lucy's communications, smashing her phones and Paul lived several miles from Daniel's parents' home and it was known that Lucy often had no money. It was noted that when Lucy was in the presence of the SSW that Daniel was in constant contact with her. Heather told the review that Daniel took money from Lucy and would not let her wear make up, see her friends or dress as she would choose to. There had been no discussion with Lucy as how she could safely separate from Daniel. This indicates a disparity with how professionals work with adult victims of domestic abuse, where this issue is discussed. There is a framework of support for known adult victims. This framework does not

[5] The lack of understanding of domestic abuse in teenage relationships is fully explored in **Finding Three.**

fit neatly into a child protection system and does not easily apply to those below 18[6]. This does depend on the young person engaging with any support service for domestic abuse as it would of course in adult services.

2.2.10 It is clear from research[7] that physical violence is likely to commence or increase when a woman becomes pregnant, if she is in an abusive relationship. The fact that Lucy was pregnant was therefore a major risk factor for an escalation of domestic abuse but one that was not recognised by social care, as their response demonstrated. It is likely that it was the news of the possible pregnancy that was the trigger point for the physical abuse of Lucy by Daniel. It is concerning that the social care workers involved in this case do not seem to recognise risk factors around the particular vulnerability of a child who is a victim of domestic abuse. The review team would expect all social workers, particularly those in decision-making roles, to have an in depth understanding of domestic abuse, regardless of whether the victim is an adult or a child and the risk factors in both set of circumstances.

2.2.11 Once Lucy became pregnant SW2 focussed on Sarah, the unborn child, in child protection terms though Lucy was still a child herself and very vulnerable. Professionals should have seen Lucy as a child in need of protection in her own right. There is always a risk when a child becomes pregnant that the direct risks to her as a child in her own right are diverted away toward the consideration of the unborn child. It was also noted by the review team that Lucy had at times been a perpetrator herself, in that she had been physically abusive toward Heather and that seemingly conflicted with the picture of vulnerability though no work had been done with Lucy as to what triggered that behaviour. Lucy did stay in touch with Heather throughout though she could only see Heather without Daniel's knowledge until she moved back in with Heather for what was the last time.

2.2.12 Lucy's last school developed a good rapport with her and a number of professionals there increased their support towards her to keep her attending regularly. There was one professional in the school in particular who went beyond what would have been expected to support Lucy. Interestingly, Lucy did not share any of the incidents of domestic abuse with the school professional she was closest to, who it was believed Lucy highly respected as a significant adult in her life. The school was not informed of the domestic abuse for some time by social care and therefore were not aware of the gravity of Lucy's situation. They were however concerned around Lucy's mental health and had referred Lucy to CYPS. CYPS had yet to assess at the time of Lucy's death.

2.2.13 Following becoming pregnant, Lucy was subjected to further acts of physical abuse as reported by Heather to her mental health worker. These injuries were hidden, according to Heather, although the pastoral support worker at school noticed that Lucy had bruising

[6] This issue is explored fully in **Finding Three**.
[7] http://www.refuge.org.uk/get-help-now/what-is-domestic-violence/domestic-violence-and-pregnancy/

around her eye and claims she did inform SW1 after the meeting at the school on 28th January 2014. The school remained concerned about Lucy's vulnerability and felt strongly that she should be subject to a child protection plan in her own right. The escalation policy is there for use by agencies when there is a difference of professional opinion on the risks, thresholds and responses. However across agencies in Gloucestershire there is some uncertainty as to how the policy should be used and some agencies report that there is a tendency to defer to social care's experience and knowledge around child protection and rely on it.

2.2.14 Another finding that has also been noted in previous serious case reviews nationally is the significant challenge in a complex case as this, for one lead professional or agency to have the whole picture of what was happening in the child's world. After the first known incident, Lucy denied that Daniel perpetrated all subsequent injuries. Lucy was receiving care from a number of health agencies; her GP, a number of midwives, a school nurse, a counsellor, and she also attended the Emergency Department after an assault, having been brought in by two members of the public. The different services and agencies struggled to share information together with no one person having the overview of everything that was happening to Lucy in her world[8].

2.2.15 At no time did any agency actively work with Daniel around his violent or controlling behaviour or explore the reasons behind this, as would have been good practice. There was an acknowledgment that there was domestic abuse in the relationship. At the initial child protection conference Daniel said he would be willing to attend anger management classes but the chair advised that it was specialist domestic abuse services he would need to attend. At the same meeting Daniel was commended for his behaviour at the meeting and for engaging with the child protection process and this must have sent out a very mixed message, particularly as we will never know whether Daniel was attending for those reasons, or as part of his control of Lucy. Heather was not invited to this child protection conference as the subject of the conference was Sarah rather than Lucy but had told SW1 and the SSW of the on-going abuse against Lucy from Daniel. This clearly demonstrated that Daniel's behaviour as a perpetrator of domestic abuse was not diminishing[9].

2.2.16 Heather told the review that on one occasion Daniel had locked Lucy in his home and it was after this that Lucy decided to move back with Heather. Neither Heather, nor Lucy told professionals about this at the time. Heather reported that Lucy told her that she was seeking to break away, in the best interests of her baby. She was making good progress and had told her mother that she was going to start wearing make-up, replace her hair extensions and start dressing how she wanted to again, when Daniel intercepted her on her way to school and fatally assaulted her and Sarah. It is well known that when a victim is planning to, or leaves, their partner, that is a time of heightened risk of homicide. Lucy's separation from Daniel was

[8] This is considered in **Finding Five.**
[9] Working with perpetrators outside the youth justice system is a developing area and is looked at in **Finding Six**.

known, even though Lucy spoke of it in ambiguous terms but was not explored or understood by professionals. This is in large part because, as we noted above, there was a lack of orientation as to how to respond to a child who is a victim of domestic abuse.

2.3 In what way does this case provide a useful window on our systems

When considering this question we consider six lines of enquiry that reflect the category scheme to distinguish different types of finding. These are:-

1 **Tools** – what have we learnt about tools and their use by professionals?
2 **Responses to incidents/Crises** – are there particular patterns we have identified about how professionals respond to incidents
3 **Longer term work** – are there particular patterns we have identified about ways of working over a longer period with children and families
4 **Management Systems** - are any elements of management systems a routine cause for concern in a particular ways?
5 **Family-professional interaction** – what patterns of ways that professionals are interacting with different family members are discernible, and do they introduce risk into our systems?
6 **Innate Human biases** – are there common errors of human reasoning and judgement evident that are not being picked up through current set ups?

Our findings in this case fit into five of our categories of the typology.

2.4 Summary of findings

The review team have prioritised six findings for GSCB to consider. These are:

FINDING	CATEGORY
FINDING ONE: In Gloucestershire safeguarding teenagers at risk can lead to challenges between the young person's autonomy and the duty of professionals to keep them safe.	**Family/professional interaction**
FINDING TWO: The design of the Domestic Abuse, Stalking, Harassment and Honour Based Violence (DASH) form makes it highly likely that critical information will be missed if used for people under 18.	**Tools**
FINDING THREE: This review indicates a general lack of understanding of how to recognise key features of domestic abuse between young people, leaving child victims and perpetrators without the necessary support and protection	**Communication & collaboration in longer-term work**
FINDING FOUR: A healthy culture of challenge and response is not fully embedded in Gloucestershire. This may leave children more vulnerable.	**Management system issues**
FINDING FIVE: In Gloucestershire there is a lack of established practice and process to support a full multi- agency understanding of the child's experience and this inhibits a comprehensive assessment of risk.	**Management system issues**

FINDING SIX: In Gloucestershire understanding how to work effectively and safely with young males who are perpetrators of domestic abuse, requires further development.	**Management system issues**

3 Findings in Detail

3.1 Finding One: In Gloucestershire safeguarding teenagers at risk can lead to challenges between the young person's autonomy and the duty of professionals to keep them safe.

Typology: Family-professional interaction – what patterns or ways that professionals are interacting with different family members are discernible, and do they introduce risk into our systems?

3.1.1 By law a child is up to the age of 18. When social care accept a referral and work with a child and their family they will be doing so either under s.17 of the Children Act, 1989, a child in need, or s.47 of the Children Act, 1989, a child in need of protection. (See glossary for descriptions).

3.1.2 Following their assessment if a child is identified by social care as a child in need then there should be a multi-agency meeting and a child in need plan should be drawn up and then reviewed in a timely fashion. The timescales for review are not prescribed in statutory guidance but Gloucestershire has set timescales of six-week reviews.

3.1.3 A child in need of protection is a child considered to be suffering, or likely to be suffering, significant harm, as defined in the Children Act, 1989. This is defined as any physical, sexual, or emotional abuse, neglect, accident or injury that is sufficiently serious to adversely affect progress and enjoyment of life. Harm is defined as the ill treatment or impairment of health and development. This definition was clarified in section 120 of the Adoption and Children Act 2002 (implemented on 31 January 2005) so that it may include, "for example, impairment suffered from seeing or hearing the ill treatment of another".

3.1.4 In the first instance, if a child is thought to be suffering significant harm, the local authority children's social care must initiate enquiries to find out what is happening to the child and whether protective action is required. Local authorities, with the help of other organisations as appropriate, also have a duty to make enquiries under section 47 of the Children Act 1989 if they have reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, to enable them to decide whether they should take any action to safeguard and promote the child's welfare. Initially there will be a strategy discussion, which is a multi-agency discussion, chaired by social care. The purpose of the strategy discussion is to determine the child's welfare and plan rapid future action if there is reasonable cause to

suspect the child is suffering, or is likely to suffer, significant harm[10].

3.2 How did these issues manifest in this case?

There was a perception by some professionals that Lucy was resistant to a family group conference (see glossary). This is stated as the rationale for the process not taking place because at that time in Gloucestershire it was considered preferable if the young person was consenting to the conference. Essentially the family group conference is stated to be a restorative process and if all parties do not consent the process is considered as futile. Gloucestershire's Family Group Conference Policy, which is currently in draft states that the young person has to be in agreement for the conference to take place, if they are considered to have the maturity to make the decision for themselves, independent of those with parental responsibility. Throughout Lucy's life she had lived between her mother, her maternal grandparents and her father, each caring for her in different periods of her life.

3.2.1 Lucy exposed herself to a greater level of risk when she moved to live with Daniel and professionals considered she had the autonomy to take this step despite the increased risk to herself and Sarah. Working with teenagers is inherently difficult and timing is important to provide the services quickly when the teenager's issues first become known because evidence shows us that that is the optimum time to engage with the teenager. The approach to working with teenagers around healthy relationships and risks of domestic abuse and their increased vulnerability in relation to pregnancy requires a sophisticated and coordinated approach. It requires experienced professionals to positively influence the young person's understanding of the risk to which they are exposed. This manifested in this case by Lucy ignoring the advice of the SSW and going to live with Daniel despite the concerns being expressed.

3.2.2 Lucy was considered to be resilient by some professionals but this was not tested in the context of her maturity and the potential impact of coercive control on her self-determination and capacity to make informed conditions.

3.3 How do we know it is an underlying issue and not something unique to this case?

The review team and the case group are clear that there would be an assumption that a teenager will be competent to make informed decisions, in most cases, in accordance with and with the application of the Fraser Guidelines (See glossary).

3.3.1 The review team tell us that social care often puts forward an argument as to what the benefit would be of a child becoming the subject of a child in need, or child protection plan however this is not the argument for whether a child becomes the subject of a plan of any sort. The argument is does it meet the threshold? So with a child protection plan the decision has to be

10 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf

"Do we think this child is suffering, or likely to suffer, significant harm?" and if the answer to this is "yes" then the threshold has been met for a child protection conference. This is a professional judgement underpinned by law to be made based on multi-agency information. This information should represent direct and objective evidence of the risks to and posed by the child. When making these judgements professionals are required to act within the formal safeguarding framework and the autonomy of the child is a consideration rather than an overriding factor.

3.3.2 Family group conferences do not happen in Gloucestershire unless the young person is in agreement, if they are deemed to have the maturity to make decisions independent of those with parental responsibility.

3.3.3 All of the agencies involved in this serious case review conveyed that working with teenagers is very challenging. It is also not always apparent who has the greatest rapport with the young person and therefore has the greatest chance of positively influencing engagement.

3.4 How prevalent is this issue?

In Gloucestershire at 1st May, 2015 there were 440 children subject to child protection plans. Of those 33% were aged four and under, 10% were 15, or over.

3.4.1 In Gloucestershire at 1st May, 2015 there were 1,710 children subject to child in need plans. Of those 39% were four and under and 14% were 15, or over.

3.4.2 Between April 2014-15 the Diversion and Placement Support Team received 148 referrals for diversion work where it had been assessed that the young person was at the 'cusp of care' or at a point of family breakdown where accommodation was being considered by the case holding social worker, or the team. In 91% of these cases, by working with the DPST the young person avoided being placed outside of the family home.

3.5 How prevalent is this issue?

All of the agencies who work with teenagers appear to experience similar challenges around the balance between the young person's autonomy and protection because we have to respect their autonomy and listen to their wishes. There is also the challenge of maintaining engagement of the young person.

3.6 Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

There can be a risk if you let the young person be the decision-maker because that is based on an assumption that the young person is able to keep themselves safe. This decision should be based on hard evidence with a realisation that a child who is in a relationship involving domestic abuse will often seek to minimise violence and coercion and protect the perpetrator. This can be as a result of the hold that the perpetrator has over the victim, at

times underpinned by the child's inability to identify the relationship as risk-laden and abusive. Decisions should not be based on the reassurance of a young person, who is a victim themselves, for whom there may well be significant negative consequences if the investigation continues. The challenge for professional is how to safeguard a teenager who is making choices that put themselves at risk. There must be a point in safeguarding systems when the child's vulnerability outweighs their ascertainable wishes.

3.6.1 In 2014 Research in Practice published a paper entitled "That Difficult Age: Developing a more effective response to risks in adolescence"[11]. The Association of Directors of Children's Services and the Families, Children and Young People Committee instigated this piece of work, exploring the research and practice evidence around adolescence and risk, in the spring of 2014. The paper should be read in its entirety and in conjunction with this serious case review because it resonates with the findings of this review and is attached as Appendix One. The paper reflects a growing sense from the sector that the current child protection system is not working effectively enough for many adolescents.

3.6.2 The paper concludes "A paradigm shift is now needed in how we understand and respond to risk in adolescence" because "A child protection system that is conceptualised primarily around preventing harm and maltreatment among younger children, who may be most at risk within their own family, is not well placed to serve the needs of adolescents". Two of the greatest challenges in working with teenagers are that a teenager may be exposing themselves risk through their behaviours, relationships and decisions they make and as professionals we cannot impose on teenagers as we can with younger children. Compliance with young children is not issue but with teenagers one has to secure engagement and compliance. This calls for a sophisticated and collaborative way of working.

3.6.3 If professionals lose sight that a teenager is a child, with all the inherent vulnerabilities that being a child brings, they fall out of being afforded adequate protection, as younger children are, because they are seen ultimately as autonomous.

3.6.4 When a teenager is involved in an intimate abusive relationship there is a pattern that professionals do not always seek to test out whether the young person does truly have rights of self-determination, such rights of self-determination can be impaired by elements of the abusive relationship, such as coercive control. This increases the likelihood that the teenager will be left at risk.

3.6.5 Teenagers are inherently vulnerable, as is being increasingly recognised through child sexual exploitation serious case reviews nationally. For a pregnant teenager if the focus is primarily upon the unborn baby this distracts from the fullest assessment of risk to the child, as an

[11] https://www.rip.org.uk/news-and-views/latest-news/evidence-scope-risks-in-adolescence/

individual in her own right and overlooks their vulnerability. The consequence of this is that it is more likely that there will be an incomplete assessment of the risks posed to the child.

FINDING 1: In Gloucestershire safeguarding teenagers at risk can lead to challenges between the young person's autonomy and the duty of professionals to keep them safe.

If the alleged victim is a young person, as opposed to a younger child there will be additional complexities. On the face of it the child may be seen to be able to make decisions and exercise their free will but this is not always the case, particularly when the young person is in an abusive relationship. If this is not recognised the child is seen as being non-engaging, or belligerent, rather than not having the skills, or maturity to manage their life if they do not concur with the professionals' plan for them. This works against positive and progressive work with teenagers and leaves professionals feeling impotent.

Considerations for the Board and member agencies

- How will the Board address the balance within a safeguarding system that is geared towards protecting younger children but is having to work increasingly with young people, as we learn more and more about their vulnerability?

- How can the Board be confident that they fully appreciate and understand the challenges faced by professionals working with this older but equally vulnerable group?

- How will the Board seek assurance that the right people, with the right skill sets, are being deployed to work with this age group?

- How can the Board assure itself that when a child becomes pregnant the focus remains equally on the child and the unborn baby?

3.7 Finding Two: The design of the Domestic Abuse, Stalking, Harassment and Honour Based Violence (DASH) form makes it highly likely that critical information will be missed if used for people under 18.

Typology: Tools - what have we learnt about the tools and their use by professionals?

3.7.1 DASH forms are intended to be used in situations of domestic abuse, to support an assessment of the risk to which the victim stands vulnerable. They are predominantly used by the police but can be used by any agency. While there is a national template local areas can modify the form. In Gloucestershire there are two versions of the DASH, a police one and a partner agency one. The differences are however negligible. There is no difference in the questions asked. With the partner agency form the details are sent to GDASS if standard or medium and MARAC if high. For the police all go to the central referral unit (as in this case) with the expectation that the police officer will explain what they have done to mitigate any risk and details of supervisory oversight. We would therefore have expected the form to have played a key part in professional activity in this case concerning Lucy, working to support professionals to realise her vulnerability and the high level of risk she was facing. In fact this

was far from the case. The review has identified that both the design of the form itself and the way that professionals are using it for under 18s in Gloucestershire mean that the tool is far from fulfilling its potential of supporting effective interventions in these circumstances.

3.7.2 It is helpful to recall here the Government definition of domestic abuse and how this was widened to include 16-17 year olds, in April 2013. The legal definition of domestic abuse does not apply to anyone under the age of 16 however the recent legislation enacting the offence of coercive control into law denotes that the offence of coercive control applies to those over the age of criminal culpability. The age of criminal culpability is currently ten. Although not relevant in this case the concern is that this disparity in the age of culpability in these different elements of domestic abuse will confuse professionals. By law anyone under the age of 18 who is in an abusive relationship should be considered and managed under child protection legislation and guidance, as well as domestic abuse legislation, because legally they are a child. The police will capture data and provide data returns nationally based purely on the government definition which is set out below.

3.7.3 The Government definition of domestic abuse is:
"Any incident or pattern of incidents of controlling coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but not limited to, the following types of abuse:

- *Psychological*
- *Physical*
- *Sexual*
- *Financial*
- *Emotional"*

3.7.4 Controlling behaviour is:
"A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of means needed for independence resistance and escape and regulating their everyday behaviour"

3.7.5 The core elements of 'power and coercive control' have long been recognised by those working in the domestic abuse field.

3.7.6 Warning signs and behavioural techniques of abuse include:-

- Unpredictable mood swings- switching from charm to rage
- Excessive jealousy and possessiveness
- Isolation-preventing partner from seeing family or friends
- Constant criticism including putting the partner down in public
- Control of the partner's money

- Control over what the partner wears, who they see, where they go, what they think
- Exerting pressure on the partner to have sex against their will
- Use of threats of physical violence to punish partner if partner is considered to have disobeyed
- Random and unexpected use of violence to frighten and subdue partner

3.7.7 The DASH form is a nationwide tool created in 2009. The DASH checklist was created by Laura Richards, BSc, MSc, FRSA on behalf of the Association of Chief Police Officers and in partnership with Safe Lives, a national charity dedicated to ending domestic abuse. Its purpose is to capture information and to assess level of risk around incidents of domestic abuse, stalking, harassment and honour based violence. The form does not specify if the victim is an adult or a child, it only requests date of birth. The only reference to children in the form is as dependents of the victim. The form is designed to see children as dependents of the victim of abuse, rather than a child being the victim.

3.7.8 There is no central collation of DASH forms completed for all levels of risk in Gloucestershire, or other areas however all high risk DASH forms will be sent into the Multi-agency Risk Assessment Conference (MARAC) Administrator for processing; sharing information, referring to the independent domestic abuse advisory service, safety planning and arranging multi-agency meetings where necessary to discuss interventions. Medium or standard risk DASH forms cannot be shared, without the victim's consent.

3.7.9 The DASH form can be completed by any professional who believes their service user is a victim of one of these forms of abuse. It is best practice that a professional completes a DASH if someone is believed to be a victim of domestic abuse. There are two enhanced sections of the form which must be completed if there is a positive answer to the question "Is there any other person that has threatened you or that you are afraid of?" This enhanced section has a further ten questions and goes into much greater detail of the victim's circumstances. The other enhanced section is with reference to stalking and honour-based crimes.

3.7.10 The form asks closed questions that only require a yes, or no response, however there is additional space under each question to explain in detail the victim's response capturing their voice. Training on completion of DASH forms emphasises this point. The quality of the risk assessment is determined by the comprehensive collection of information attached to each question and on the summary page at the rear of the form.

3.7.11 The risk management framework of the DASH is based on there being three levels of risk to the victim.

1 **Standard** – current evidence does not indicate likelihood of causing serious harm

2 **Medium** – There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change of circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse.

3 **High** – There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be risk of serious harm (Home Office 2002 and Offender Assessment System 2006): "A risk which is life threatening and/or traumatic and from which recovery, whether physical or psychological, can be expected to be difficult or impossible".

3.8 How did these issues manifest in this case?

The DASH form was only completed on one occasion in this case but this presents a striking example of critical information being missing from it. Lucy told the police officers who attended the incident and the police officer who attended the following day that, when she told Daniel the previous week that she thought she was pregnant, he had knocked her to the floor and kicked her in the stomach. However, the form did not include this information. It did not highlight the fact that Lucy was a child who was a victim of domestic abuse or that she thought she was pregnant.

3.9 How do we know it is an underlying issue and not something unique to this case?

The review team looked more closely at the DASH form itself as part of this review and this revealed that it does not lend itself to capturing all the salient information from the victim for a risk assessment, particularly for under 18 year olds.

3.9.1 Firstly, the main body of the form asks very little about the victim's circumstances. It is only if they give a positive answer to the question "Is there any other person that has threatened you or that you are afraid of?" that the professional is directed to complete an additional section. This enhanced section has a further ten questions and goes into much greater detail of the victim's circumstances. However, because the form asks closed questions that only require a yes, or no response, it is very likely that the phrasing of the question will get a false negative answer, as happened in this case.

3.9.2 Secondly, the form assumes that children are the dependents of the victim of abuse and the design of it makes it almost impossible to draw attention to the fact of a child being the victim. For example, the form does not require that the professional specify if the victim is an adult or a child. Instead, it only requests date of birth.

3.9.3 This suggests that the design of the form itself works against the comprehensive collection information and therefore good quality assessment. If another professional were in a similar position as the Officer in this case, the review team did not think it likely they would complete the form any differently suggesting it was not an issue unique to this case or to the professional who is completing the form.

3.9.4 There is no evidence that education or health professionals would consider completing a DASH for the 16-17 year olds where there is actual knowledge, or suspicion of, domestic abuse as a matter of course. This would be seen as purely a child protection matter and therefore the process followed is the child protection pathway - to contact social care, rather than complete a DASH, or involve the police. Mental health professionals for adult victims of domestic abuse sometimes complete the DASH form. GPs are not aware of the DASH form despite training around domestic abuse. Professionals in CYPS (mental health for children and young people) do not use the DASH form for young people. School nurses in Gloucestershire are familiar with the DASH but there is confusion as to who is permitted or authorised to use it. The DASH is available for all professionals to use.

3.9.5 The majority of DASH forms are completed by frontline police officers. Between 2010 – 2013 Gloucestershire Constabulary ran a series of one-day workshops for frontline police officers on completing the DASH form. These workshops were attended by a total of 641 frontline police officers and 488 police community support officers. 329 members of staff were unable to attend the training.

3.9.6 Since only the high-risk information is collated, it is only possible to know the breakdown of professionals completing those DASH forms. From November, 2014 – April, 2015 72% of DASH forms were completed by the police, 15% by health professionals, predominantly in the Emergency Department, 11% by Gloucestershire Domestic Abuse Support Service (GDASS) and the remaining 2% is made up of referrals from Probation, Local Authority and Social Care. These agencies will all be working with a significant number of domestic abuse cases and yet there is minimal evidence they are completing DASH forms as part of their role.

3.9.7 Safe Lives (previously known as CAADA) developed a young person's DASH form in 2013. Each local authority was asked to nominate an individual/practitioner to attend some free training provided by CAADA to become an accredited young person's violence advisor. Gloucestershire nominated a practitioner from Prospects who works part time. Another practitioner has also undertaken this training and is part of the GDASS team. Both of these individuals are trained to use the young person's DASH and to utilise the tool.

3.10 How prevalent is this issue?

It is not possible to ascertain the prevalence of DASH forms completed for teenagers because this data is not captured by any agency other than the police and Gloucestershire Hospitals NHS Foundation Trust, unless the victim is deemed to be at high risk.

3.10.1 Since Lucy's death there has been a significant increase in domestic abuse training for frontline police officers. The training covers the fact that the age has reduced to 16 and makes specific reference to teenagers who are victims of abuse. In the early part of 2014, five distance learning packages were introduced by the Force and were mandatory for officers; these did not consider domestic abuse where the victim is a child specifically. These were national resources and what was provided by the College of Policing. The completion rate of these packages was between 90 - 95% so the police say there has been an increase in understanding of domestic abuse through training. The police also commissioned an expert in the field to develop and deliver domestic abuse master classes.

3.10.2 GSCB provides multi-agency domestic abuse training. This training makes reference to domestic abuse where the victim is a teenager. 10 courses were run during 2014/15. 165 delegates attended this training. In the previous year 2013/14 72 delegates attended day one of the two-day training and 87 attended day two.

3.10.3 Between January – December, 2014 Gloucestershire Constabulary completed 5,909 DASH forms. Of those 719 were deemed to be high risk, 1208 medium risk and 3,982 standard risk. In the last year seven young people aged 16 and 17 have been the subject of MARAC meetings.

3.10.4 Gloucestershire Hospitals NHS Foundation Trust has been using DASH forms since 2010. Initially a member of staff was seconded to process DASH forms and information sharing requests but that secondment was halted at the end of 2011. The post was not refilled until February, 2014. General staff covered the domestic abuse work in the absence of someone with time allocated specifically for this but there was not the capacity to collect and collate data. Therefore the figures they have are from 2014 onwards. In the year 2014-2015 Gloucestershire Hospitals NHS Foundation Trust completed 154 DASH forms that were deemed to be high risk

3.11 How widespread is the issue?

Towards the end of 2013 Gloucestershire Constabulary had been subject to a Her Majesty's Inspectorate of Constabulary report that highlighted flaws in the response to domestic abuse and areas for improvement. There is no audit or data analysis done by any of the agencies around the profiling of the victim's age.

3.11.1 The young person's DASH form is not being used by staff as this is currently at the early development stage in terms of making professionals aware of this resource and also the training required to use it effectively. The police state that all their frontline staff would need to be trained to use the young person's DASH.

3.11.2 GSCB does not offer guidance on their website as to when professionals should complete a DASH form although the form itself is on the GSCB website.

3.12 Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

Both professionals and the various tools they are given to use play key roles in keeping children safe. Research has demonstrated the importance of involving people who have an intimate knowledge of how they will be used in the design of the tools, to make sure they are fit for purpose. This finding indicates that the DASH form works poorly in practice when the victim is a child. The form does not support practitioners gaining a full appreciation of a child victim's particular circumstances in the context of the common features of domestic abuse, and reflecting any additional vulnerability that a child victim may bring. As such, the tool currently makes it more rather than less likely that critical information will be missed for under 18 year olds. In addition to this, the majority of DASH forms are completed by the police but they do not have anyone trained in the Young Person's DASH form, so they are using the adult form.

FINDING 2: The design of the Domestic Abuse, Stalking, Harassment and Honour Based Violence (DASH) form makes it highly likely that critical information will be missed if used for people under 18.

For tools to be part of a safe system they need to be designed and used in such a way to enable professionals to gain a full appreciation of a victim's particular circumstances in the context of the common features of domestic abuse. The fact that a victim is a child should not be lost and the tool used should reflect the additional vulnerability that being a child will bring.

Considerations for the Board and member agencies

- How the Board is confident there is a satisfactory risk assessment tool for young people who are victims of domestic abuse? Safe Lives developed a young person's DASH form in 2013.
- How is the Board confident the suite of tools they have to assess risk all work together effectively and are clearly understood by frontline professionals?
- How does the Board consider the MARAC framework and/or the child protection process, as part of the suite of tools available, could be more effectively used to support multi-agency working around domestic abuse for 16-17 year olds?
- In what way would the Board consider it to be appropriate for data from completed DASH forms to be collated?
- Is the Board confident that the wider implementation of the Young Person's DASH form is the best way to safeguard teenagers who are subjected to domestic abuse, or whether other processes should be better utilised?

3.13 Finding Three: This review indicates a general lack of understanding of how to recognise key features of domestic abuse between young people, leaving child victims and perpetrators without the necessary support and protection

3.13.1 There is no national or local guidance on involving any parent or carer who is a perpetrator of domestic abuse in maternal and child services. In Gloucestershire there are no policies or procedures in place for staff working across the statutory agencies to guide them in their practice. There are particular vulnerabilities with the below 18 group given they are still children and this will bring further complexities (Sharpen, J 2012). Further, simply because of their age, ironically many children subjected to domestic abuse may be unable to access the same levels of support as over 18's. Yet in this case we saw strikingly little cognisance of, or recognition of the fact that Lucy was a child in her own right.

3.14 How did these issues manifest in this case?

3.14.1 Daniel was encouraged to attend meetings and health appointments. The review team agreed that domestic abuse, where the victim is a child, is not well recognised across the agencies. Children's exposure to domestic abuse is historically seen more in the context of the child witnessing this between adults in the family.

3.14.2 The police responded to the first confirmed incident on 31st October, 2013. The information Lucy shared with the officers attending on the night and the officer the following day about the alleged previous incident of abuse was not included in the DASH. Research tells us that nearly one in three women who suffer from domestic abuse during their lifetime report that the first incidence of physical violence happened while they were pregnant[12]. In legal terms Lucy was not a victim of domestic abuse at this stage because she was under 16 and the legal definition of domestic abuse is for those over the age of 16.

3.14.3 In the DASH it is written that Lucy was feeling low because she and Daniel had separated. She also said that the abuse had started with shouting and Daniel had now become physically violent when he got jealous. Lucy described Daniel as a very jealous person. In the DASH it is recorded that "He thinks I am looking at other boys. He displays paranoid behaviour".

3.14.4 Lucy told both police officers that when she told Daniel she thought she was pregnant the week before, he had knocked her to the floor and kicked her in the stomach but the DASH makes no reference to this.

[12] http://www.hqip.org.uk/national-programmes/a-z-of-clinical-outcome-review-programmes/cmace-reports/

3.14.5 The DASH completed on 2nd November, 2013 concluded that the level of risk to Lucy should be standard. (See para 3.7.11 for description)

3.14.6 Social care knew that Daniel had allegedly punched Lucy to the floor and kicked her in the stomach when she told him she thought she was pregnant on 31st October, 2013 but despite the severity of that incident the initial assessment was not completed for three months.

3.14.7 Different agencies had different pieces of information about what was happening including that Daniel was destroying Lucy's mobiles, that he was gambling, that Lucy was frequently given money by her family but never seemed to have any, that he had stopped Lucy's use of social media, that he was isolating Lucy from her family, that he was controlling how and where she met with her family and professionals, that he got drunk twice a week, according to Lucy. They also knew that Daniel was physically abusive, that when Lucy was with professionals, if she did have a mobile, Daniel would often be texting and calling her repeatedly. The SSW noted during one meeting "I counted six calls and the ones she answered he seemed very controlling and dominating towards Lucy". For all of this Lucy was never formally recognised as a child at risk of, or suffering from, significant harm.

3.14.8 The SSW devised a safety plan for Lucy when she went to stay with Daniel. The safety plan consisted of ringing 999 but it was well known that Lucy often did not have a mobile because Daniel destroyed them. The second part of the plan was for her to go to her father's house but he lived over four miles away and she had no means of transport. There was nothing else in the plan.

3.15 How do we know it is an underlying issue and not something unique to this case?

The review team and the case group recognise that supporting teenagers who find themselves in unhealthy relationships with features of domestic abuse is complex and that this is a relatively newly developing area of practice. This is in the context of a growing realisation of the challenges of working with the teenage group, who are more likely to have a propensity to risk-taking behaviours than other age groups[13]. There is no focused training in Gloucestershire on this issue.

3.15.1 There is a concern that incidents of domestic abuse between teenagers are increasing but currently there is little specific and accurate data on which to improve service provision. This combined with the perception of autonomy that teenagers can project does present a difficult balance for all professionals, particularly because if the risk materialises of domestic relationship abuse the results can be devastating.

[13] https://www.ucl.ac.uk/news/news-articles/1003/10032503

3.15.2 Consideration of domestic abuse between teenagers is a relatively new area, which is continuing to devolve and develop. There is a relatively new term being used, which is "teenage relationship abuse" however there is no legal definition as to what constitutes teenage relationship abuse, other than a teenager is aged between 13-19. Across agencies there are differing levels of understanding and this impacts greatly on the risk assessment of the young person. In legal terms a child under the age of 16 cannot be a victim of domestic abuse.

3.15.3 There is also a lack of clarity as to which process to use when a teenager is a victim of domestic abuse and professionals acknowledge that when dealing with a teenager with multiple risks and vulnerabilities it can be difficult to assess the single risk of domestic abuse, particularly in the context of other seemingly more immediate issues such as homelessness from which there are more tangible outcomes. It is clear from discussions with the case group and the review team that professionals are challenged by the complexity that the risks associated with teenage victims of domestic abuse bring and revert to managing a single risk factor, which at the time appears more imperative. In reality the child will present with multiple risks, all of which could potentially have a major impact on the safety of the child. The management of risk should not be predicated on an ethos of "either/or" but the ethos of multi-agency work around the child should be around managing all the risks concurrently. This does present a challenge to the system where it is working with teenagers who are subjected to domestic abuse because the nature of such relationships are complex and require a highly coordinated and skilful approach and specialist service.

3.15.4 This lack of clarity around systems and processes means that there is no effective framework that professionals cross-agencies can use to manage, support and protect children of any age subjected to domestic abuse, despite domestic abuse being put on a statutory platform for 16 and 17 year olds since April 2013. That is not to say that this age group requires a duplication of what is on offer for adults but a service provision designed for this younger age group.

3.16 How prevalent is this issue?

The 2011/2012 British Crime Survey found that young people are more likely to suffer partner abuse than any other age group, with 12.7% of women and 6.2% of men aged 16-19 having experienced some kind of domestic abuse in the previous year.

3.16.1 A recent report by the charity Against Violence and Abuse indicates that "research has shown that some teenagers have worryingly high levels of acceptance of abuse within relationships and often justify the abuse with the actions of the victim, e.g. because they were unfaithful. A study by the NSPCC and the University of Bristol questioned 1,353 young people (aged between 13 and 17 years old, from eight UK schools) violence in their intimate relationships. Key points from the research include the following:

- 33% of girls and 16% of boys reported some form of sexual abuse.

- 25% of girls (the same proportion as adult women) and 18% of boys reported some form of physical relationship abuse.
- Around 75% of girls and 50% of boys reported some form of emotional relationship abuse.
- Most commonly reported forms of emotional abuse, irrespective of gender, were 'being made fun of' and 'constantly being checked up on by partner'.
- Girls were more likely than boys to say that the abuse was repeated and that it either remained at the same level of severity, or worsened, especially after the end of the relationship.
- Younger participants (aged 13 to 15 years old were as likely as older adolescents (aged 16 and over) to experience some forms of relationship abuse.

3.17 How widespread is the issue?

The review team is clear that the issue of how professionals work with child victims of domestic abuse is not unique to Gloucestershire but is a national issue. Working effectively with child victims of domestic abuse is a national issue. A recent serious case review published by Liverpool Safeguarding Children Board "Child D"[14], a child who was a victim of domestic abuse who was murdered by her partner, concluded that agencies did not know how to respond appropriately because models for dealing with domestic abuse are adult based and the professionals did not see the child victim as requiring protection under the safeguarding system. The report went on to say that many of the professionals did not treat Child D as a child and if they had done so they would have been more likely to have adopted a safeguarding response.

3.18 Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

There is a concern that domestic abuse between those under the age of 18 is on the increase but this age group may not be afforded the protection of child safeguarding systems and at the same time are unable to access the same support and resources that would be available for an adult victim.

3.18.1 Because of a lack of experience in constructing respectful relationships and because of their peer group norms it can be difficult for teenagers to judge their partner's behaviour as being abusive

14

http://www.liverpoolscb.org/user_controlled_lcms_area_scr/uploaded_files/LSCB%20SCR%20Overview%20Report%20Child%20D.pdf

FINDING 3: This review indicates a general lack of understanding of how to recognise key features of domestic abuse between young people, leaving child victims and perpetrators without the necessary support and protection

Child protection systems need to be able to respond to a diverse range of scenarios that differ depending on the interface of the child's age and the type of risk to which they are exposed. This finding has identified a gap in relation to child victims of domestic abuse. Without a routine recognition of and understanding of this scenario the victim will be left at risk.

Considerations for the Board and member agencies

- Does the Board accept that system improvements are required to better protect children who are victims of domestic abuse?

- How will the Board work with strategic partners to secure future sustainable action for interventions and services for this age group, which are responsive and reflective of local need?

- Do all Board members think it would be fitting to challenge the disparity of the response cross-agency given to adult victims and child victims of domestic abuse and if so how could this be achieved?

- What can the Board do to promote agencies developing appropriate mechanisms to record child victims of domestic abuse data and intelligence, to inform future strategic need assessments and evidence based responses?

- Does the Board consider the multi-agency systems and processes currently in place to manage risk consist of adequate skills, capacity and access to safe places to engage with under 18s?

- How does the Board intend to embed an understanding of the new offence of coercive control, in as far as this applies to those aged 10 and over and its interface with the wider offence of domestic abuse which legally only applies to those aged 16 and over?

3.19 Finding Four: A healthy culture of challenge and response is not fully embedded in Gloucestershire. This may leave children more vulnerable.

Typology: Management systems - are any elements of management systems a routine cause for concern in any particular ways?

3.19.1 An escalation policy is a key mechanism that facilitates professionals being able to challenge decision-making around safeguarding the child. It is a formal framework by which professionals can resolve any differences in opinion, if those differences cannot be resolved at an earlier stage.

3.19.2 Gloucestershire has in place an escalation policy[15]. The escalation policy is an intra and inter-agency policy that has been developed to ensure there is resolution of professional disagreements in respect of the safeguarding of children and young people.

3.19.3 The escalation policy has been in place in Gloucestershire since 2009 and was last updated in May, 2014. The policy sets out the process of what to do if workers within one agency feel that the decision made by a worker from another agency on a child protection or child in need case is not a safe or appropriate decision.

The process has four stages:

Stage One

Any worker who feels that a decision is not safe or is inappropriate should initially consult a supervisor/manager to clarify their thinking in order to identify the problem, and be specific as to what the disagreement is about and what they aim to achieve. Initial attempts should be taken to resolve the problem at the lowest possible level. This would normally be between the people who disagree. It should be recognised that differences in status and/or experience may affect the confidence of some workers to pursue this unsupported.

Stage Two

If the problem is not resolved at stage one the concerned worker should contact their supervisor/manager within their own agency who should raise the concerns with the equivalent supervisor/manager in the other agency. The manager should also notify the GSCB Business Manager, who will keep a record of all on-going disagreements.

Stage Three

If the problem is not resolved at stage two the supervisor/manager reports to their respective operations manager or named/designated safeguarding representative. These two managers must attempt to resolve the professional differences through discussion. The GSCB Business Manager should be advised of any outcome.

Stage Four

If it is not possible to resolve the professional differences within the agencies concerned the matter should be referred to the Chair of the GSCB, who may either seek to resolve

[15] http://www.gscb.org.uk/CHttpHandler.ashx?id=60436&p=0

the issue direct, or to convene a Resolution Panel. The panel must consist of GSCB representatives from three agencies (including the agencies concerned in the professional differences, where possible).

3.19.4 Awareness of the escalation policy is done through all single and multi-agency training. The escalation policy was also covered at recent GSCB roadshows, learning events for practitioners; it was included through Designated Safeguarding Leads Forum for educational settings and has recently been shared with Early Years Designated Safeguarding Leads through their safeguarding forum.

3.20 How did these issues manifest in this case?

The school first became concerned about Lucy in the middle of January, 2014. From the middle of February, when Lucy became homeless, until the time of her death, they became increasingly concerned and were in frequent contact with social care, expressing those concerns. Later on they were given reassurance by social care that Lucy's needs would be met through the child protection plan for Sarah but they remained extremely concerned about Lucy, as a vulnerable child in her own right. Although they expressed their concerns to social care they did not utilise the escalation policy. The school considered they were being reassured that the needs and risks for Lucy were being managed. The notes of the strategy meeting were not circulated until after Lucy's death and so the school were unable to challenge.

3.21 How do we know it is an underlying issue and not something unique to this case?

The GSCB monitors usage of the Escalation Policy in a number of ways. The policy itself states that the GSCB Business Manager should be notified at stage three, the Business Manager states that this does not always happen in practice. It is more usual for the GSCB Business Manager to be notified on the outcome of an issue that has escalated to stage three. A question on the use of the escalation policy is included in all multi-agency audits that are undertaken by the Quality Assurance Sub-Group of the GSCB and through the Section 11 audit process. In addition, all multi-agency training evaluation includes a question relating to confidence in knowing what action to take if you are not happy with an agency response. This question is asked again at the three-month post course phase, which will enable the GSCB to monitor if improved understanding and confidence is embedded in professional practice.

3.21.1 The GSCB Business Manager is rarely informed that the escalation policy has been invoked, at stage two, which is a requirement. The GSCB Business Manager tells us that at stage three differences are resolved speedily but it is not known how effective it is at stages one and two.

3.21.2 It is apparent from the GSCB training programme that although the escalation policy is highlighted in every training course, there remains a lack of knowledge about what the policy is, how to implement it and how effective it is. Some professionals report it is highly effective, whilst others report that they go back and forth between themselves and the other agency. That other agency is most likely to be social care. This, as a system, is not consistently effective.

3.22 How prevalent is this issue?

During 2014/15 the GSCB Business Manager was notified on ten occasions that the escalation policy had been implemented. There is greater awareness now of the escalation policy than there has been in previous times. There is also evidence from the review team and case group that the policy is used informally on a regular basis, especially at stages one and two however there remains a culture of the escalation policy not being embedded in day to day practice.

3.23 How widespread is the issue?

The lack of healthy challenge in this case is not unique. The review team reports that there is a pattern of agencies, outside of social care, not always owning their safeguarding concerns. There can be a lack of confidence and /or ownership by professionals outside of social care to drive forward actions to safeguard the child and reticence to challenge social care as they are seen as the final decision-maker.

3.24 Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

It is entirely natural that there will occasionally be different views between professionals and agencies as to the level of risk a child faces and how safe they are. As the escalation policy states, disagreement will usually be around levels of need, roles and responsibilities, the need for action or communication. It is the welfare and safety of the child that is paramount and therefore it is vital that any differences of opinion are discussed and resolved, in a timely fashion. If this is not happening children may be left at risk because either professionals are not escalating their concerns, or the response is delayed.

3.24.1 If the mechanisms for resolving differences are not effectively used the risk is a culture of resentment and defensiveness builds up between agencies, which will impact negatively on effective multi-agency working.

FINDING 4: A healthy culture of challenge and response is not fully embedded in Gloucestershire. This may leave children more vulnerable.

A safe system is predicated on each agency taking responsibility to formally escalate a case where it has not been possible to resolve differing views. Without this children may be left at risk and multi-agency working around the child may not be as effective

Considerations for the Board and member agencies

- How can the Board capture the extent to which agencies are able and willing to challenge other professionals when an apparent difference of opinion arises around a child and their family?

- How can the Board support agencies create a culture in which healthy challenge is the norm?

- Does the Board share the view that the escalation policy is not sufficiently embedded across its partner agencies and if so how can the board fully embed the policy into practice?

- How can the Board empower agencies to use the escalation policy with confidence and in a timely manner?

- Is the Board confident that the escalation policy gives sufficient guidance as to within what timescales one should implement the policy and resolution be achieved?

3.25 Finding Five: In Gloucestershire there is a lack of established practice and process to support a full multi-agency understanding of the child's experience and this inhibits a comprehensive assessment of risk.

Typology: Management systems

3.26 How did these issues manifest in this case?

What has come from this review and has been confirmed by the case group, the frontline professionals, is that not one professional, or one agency, had all the information about what was happening in Lucy's life. In addition to this the police dealt with each contact in isolation and there was no overview, this was replicated across health agencies. There were also a number of times when Heather and her mental health professionals struggled to pass information to SW2 direct. While the SSW was stated to be working on the case on a task basis, all other professionals saw that professional as leading and was the main recipient of information from other professionals and Lucy.

3.26.1 The information that Lucy had given the police who attended the domestic abuse incident on 31st October, 2013 about what Daniel had allegedly done when she told him she thought she was pregnant was lost along the way, as by the time of the strategy discussion, four months later, what was shared was that Lucy said she had been kicked in the stomach but would not say who the perpetrator was.

3.26.2 On 3rd February 2014 Heather reported Lucy as missing to the police. Heather told the police that Daniel had smashed Lucy's mobile, as he had done numerous times previously, and Heather could not reach her. Heather also told the police that Daniel had forced Lucy to close down her Facebook and Twitter accounts and she said that Daniel was repeatedly abusing Lucy. This information was never shared with social care, either at the time or at the strategy discussion three weeks later, or the initial child protection conference.

3.26.3 On 11th February Heather's mental health worker contacted SW2 because Heather had shared information with her about Lucy. She told SW2 that Heather had said that Lucy was experiencing on-going assaults from her partner and Heather would describe it as being the "tip of the iceberg". She also said Lucy self-harms and has lots of scars on her arms. Heather said Lucy had threatened her and had assaulted her. This information was not shared at the strategy discussion.

3.26.4 At the strategy discussion on 25th February, 2014 there was also reference to another incident where Lucy said Daniel had punched her in the face because he did not like the way she looked at another boy/man. What was not shared and therefore known by all agencies were the incidents on 27th October, 28th November and 11th January.

3.26.5 A number of agencies were giving social care significant information about what was happening in Lucy's life, for example Heather's mental health workers told social care on a number of occasions that there were significant risks to both Lucy and Sarah based on the information Heather was giving her mental health workers. Information was not effectively considered and therefore did not inform the risk assessment.

3.27 How do we know it is an underlying issue and not something unique to this case?

The review team and the case group have both confirmed that it is common for not all of the professionals working with a family to have all the relevant information. Despite it being an action from a previous review in 2012 that multi-agency chronologies should be used when a child is made the subject of a child protection plan, this is not happening routinely. One of the reasons for this is because there is a lack of clarity about what information is required by agencies. There are also issues around professionals knowing what is relevant, without necessarily knowing the context. Each piece of information may be a worry but we only know how significant the information is when all the worries are put together.

3.28 How prevalent is this issue?

Gloucestershire has undertaken four case reviews in the last four years. In all of them it has been an issue that not all the frontline professionals had all the information.

3.29 How widespread is the issue?

The review team tells us that lack of information sharing is an issue across all agencies but it is not just about information it is also about understanding each other's language, systems and processes.

3.29.1 It is a common theme of serious case reviews nationally that information has not been shared between agencies. A recent Department for Education report[16] stated "All biennial reviews (of serious case reviews) refer to the perceived problem of serious case reviews repeatedly identifying the same problems in relation to interagency working, particularly around information sharing and the quality of recording and analysis of information"**.**

3.30 Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

Within the various components of the single agencies there is also the challenge of pulling together the various strands of information that the single agency holds. Without the single agency having the fullest picture of all the information held for the child, the quality of what is then shared multi-agency is impaired.

3.30.1 Information sharing is a cornerstone of protecting a child. Inadequate information sharing systems will impact on the effectiveness of any risk assessment and therefore planning around the child. Agencies must act as recipients of information. That information needs to be fully considered to inform the profile of what is happening in the child's world, real terms, in what is always a dynamic situation where risk can fluctuate. Information must then be proactively disseminated to their partner agencies. Only then can a multi-agency child protection system be reliable.

[16] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181618/DFE-RR037.pdf

FINDING 5: In Gloucestershire there is a lack of established practice and process to support a full multi-agency understanding of the child's experience and this inhibits a comprehensive assessment of risk.

In this case information was not joined up until after Lucy's death and it is apparent that there is a large body of information that was held by single agencies and family members but not shared at the time. Without the benefit of all known information being shared across agency any risk assessment around the child will be compromised and ineffectual.

Considerations for the Board and member agencies

- What would the Board consider to be an effective way of bringing all the information together?

- What does the Board consider are the barriers to the use of multi-agency chronologies?

3.31 Finding Six: In Gloucestershire understanding how to work effectively and safely with young males who are perpetrators of domestic abuse, requires further development.

3.31.1 There is no national or local guidance on involving any parent or carer who is a perpertrator of domestic abuse in maternal and child services.

3.31.2 If a perpetrator comes into the criminal justice system they may or may not have to attend a perpetrator programme. If a perpetrator is not prosecuted there is no specific service provision to work with that perpetrator, even though it may be apparent that they are a perpetrator of domestic abuse.

3.31.3 In Gloucestershire there has been a community voluntary perpetrator programme in place since 2013 but this is for perpetrators over the age of 18.

3.31.4 In Gloucestershire decisions about whether to involve fathers who are perpetrators of domestic abuse are made on a case-by-case basis. There is no clear national guidance as to the most effective way to involve perpetrators in the child protection process. Consideration of how to involve the perpetrator in the process must be balanced with consideration of the risk to the victim and the unborn baby/child.

3.32 How did these issues manifest in this case?

Because of the lack of national and local guidance, policies, or procedures about involving parents or carers who are perpetrators of domestic abuse in maternal or child services the review team and case group tell us there is inconsistency in practice. Perpetrators may be

praised for attending ante-natal and subsequent services without questioning whether the motivation for engagement or attendance maybe controlling in its nature .

3.32.1 Daniel gave a "no comment" interview to the police following the incident on 31st October, 2013 and no other professionals explored with Daniel whether, or why, he allegedly punched Lucy to the floor and then kicked her in the stomach when she told him she thought she was pregnant

3.32.2 There was a failure to understand that the pregnancy increased the risks to Lucy.

3.32.3 Prior to Lucy's pregnancy there was very little engagement with Daniel and once Lucy became pregnant Daniel was praised for attending appointments; his attendance was seen as positive engagement, as opposed to coercive control. Although we cannot conclude that Daniel's attendance at appointments was more about control than support it is a well known factor of domestic abuse that the perpetrator may attend appointments with the victim to ensure control and restrict disclosure.

3.32.4 Professionals did not test out Daniel's history, or family background, even at the point when Lucy went to live with Daniel and his family. The SSW did one visit to their family home following the initial child protection conference. The police had offered to check Daniel's family background at the strategy discussion but this did not happen because it was not an agreed action from the discussion. We cannot say if this would have changed the consideration of risk.

3.32.5 The review team and case group have told us of the inconsistencies of how we work with young males who are perpetrators of domestic abuse; unless they are under the criminal justice system, when there will then be clearer pathways.

3.32.6 Not all perpetrators of domestic abuse are prosecuted and there is inconsistency nationally around pursuing prosecution in the absence of the victim agreeing to press charges. The review team have told us that one of the inhibitors of prosecuting is the possible implications and repercussions on the victim, from the perpetrator while others have a zero tolerance approach. In all cases it must be recognised that there are real evidential challenges when the victim is not prepared or able to give evidence and take complaints forward assertively.

3.32.7 The case group have told us of the dilemma of wanting to encourage fathers to engage but not being sure if that is the right thing to do if they are perpetrators of abuse. This is particularly significant in the child protection arena.

3.33 How prevalent is this issue?

It is not possible to ascertain the approach taken with parents or carers who are perpetrators of domestic abuse because it is not something that is currently quantifiable.

3.34 Between 1st April 2014 and 31st March 2015 there were 269 children made subject of a child protection plan in Gloucestershire where domestic abuse was recorded as a factor in the Initial Assessment. Statistics around the age of the victim of domestic abuse are not recorded. It is not known how many of these cases involve parents who are children who are victims of domestic abuse

3.34.1 Nationally, domestic abuse is a known risk factor for unborn babies and children. The charity Women's Aid reports that "The link between child physical abuse and domestic abuse is high, with estimates ranging between 30% to 66% depending upon the study. (Hester et al, 2000; Edleson, 1999; Humphreys & Thiara, 2002; Mullender and Morley, 1994; Radford and Hester, 2007.)"[17]

3.34.2 No agency in Gloucestershire collects data specifically around child victims of domestic abuse for reasons set out above.

3.35 How widespread is the issue?

The issues as described here are not unique to Gloucestershire. How to work effectively and safely with perpetrators is a national dilemma.

The review team and case group have informed the review that there is inconsistency of practice when it comes to involving parents or carers who are perpetrators of domestic abuse in child and family services because of a lack of guidance or professional expectation.

3.36 Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

Decisions should be made about the level of involvement of the perpetrator of domestic abuse in each individual cases using an evidence-based approach.

Domestic abuse is extremely prevalent in England and Wales. It cuts across all social, geographic and cultural groups and has potentially devastating impact on those affected by it. The impact extends to their families and includes children and young people. Domestic abuse between teenagers is thought to be on the increase. This is being reported in commentary from the national charities that support and provide helplines to young people below and above 16 and anecdotally by agencies working with children. This area merits more formal research.

[17] http://www.womensaid.org.uk/domestic-violence-articles.asp?section=00010001002200020001&itemid=1262

3.36.1 It is vital to actively recognise and reduce the prevalence and impact of domestic abuse between teenagers. In order to do this Gloucestershire needs to develop a co-ordinated multi-agency response to working with young males who are perpetrators of domestic abuse, which takes into consideration the increased vulnerability of the victim from the moment she thinks she may be pregnant. This is necessary in order to reduce criminality but also to protect child victims of domestic abuse. It should be acknowledged that there are pockets of work on-going in Gloucestershire but this is in very early development.

FINDING 6: In Gloucestershire understanding how to work effectively and safely with young males who are perpetrators of domestic abuse requires further development.

The lack of a defined strategy in working with young males who are perpetrators of Domestic abuse is impairing the wider response to the protection of those affected by it.

Considerations for the Board and member agencies

- How will the Board maximise the opportunities to work with young males who are perpetrators of domestic abuse, including in the child protection arena?

- Does the Board consider the specialist support services currently in place to encourage engagement of teenage victims and perpetrators of domestic abuse in criminal and civil justice processes to challenge perpetrator behaviour are sufficient?

- How can the Board support agencies to develop and maintain programmes for early identification of children at risk of developing abusive or unhealthy behaviours?

3.37 What happens next?

GSCB now has a responsibility to consider these 6 findings and their response will be published in due course.

Appendix 1: Acronyms and Glossary

SW1	Social Worker One
SW2	Social Worker Two
SSW	Student Social Worker
PC1	Police Constable 1
PC2	Police Constable 2
CAADA	Co-ordinated Action Against Domestic Abuse. A national domestic abuse charity that has now been renamed Safe Lives.
Child in Need	Under Section 17 (10) of the Children Act 1989, a child is a Child in Need if: • He/she is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority; • His/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services; or • He/she is a Disabled Child
Child Protection	Section 47(1) of the Children Act 1989 states that: Where a local authority have reasonable cause to suspect that a child who lives, or is found, in the area and is suffering, or is likely to suffer, significant harm, the authority shall make such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.
Child Protection Procedures	The system in place to protect children, which include policies, procedures, training and resources.
Coercive Control	"A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of means needed for independence resistance and escape and regulating their everyday behavior"
DASH	Domestic Abuse, Stalking and Honour Based Violence

Domestic Abuse	Any incident or pattern of incidents of controlling coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: • Psychological • Physical • Sexual • Financial • Emotional
Family Group Conference	A family group conference is a process led by family members to plan and make decisions for a child who is at risk. It is a voluntary process and families cannot be forced to have a family group conference
Fraser Guidelines	When deciding whether a child is mature enough to make decisions, people often talk about whether a child is 'Gillick competent' or whether they meet the 'Fraser guidelines'. Gillick competency and Fraser guidelines refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year olds without parental consent. But since then, they have been more widely used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. In 1982 Mrs Victoria Gillick took her local health authority (West Norfolk and Wisbech Area Health Authority) and the Department of Health and Social Security to court in an attempt to stop doctors from giving contraceptive advice or treatment to under 16-year-olds without parental consent. The case went to the High Court where Mr. Justice Woolf dismissed Mrs Gillick's claims. The Court of Appeal reversed this decision, but in 1985 it went to the House of Lords and the Law Lords (Lord Scarman, Lord Fraser and Lord Bridge) ruled in favour of the original judgment delivered by Mr. Justice Woolf: "...whether or not a child is capable of giving the necessary consent will depend on the child's maturity and understanding and the nature of the consent required. The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent."
GDASS	Gloucestershire Domestic Abuse Support Service: Countywide service to reduce the level of domestic abuse and improve safety

	of victims 16 and over and their families.
GSCB	Gloucestershire Safeguarding Children Board
LSCB	Local Safeguarding Children Board
MARAC	Multi-agency risk assessment conference. A MARAC is a regular local meeting to discuss how to help victims at high risk of murder or serious harm. A domestic abuse specialist (IDVA), police, children's social services, health and other relevant agencies all sit around the same table. They talk about the victim, the family and perpetrator, and share information. The meeting is confidential[18]
Nightstop	Charity that works directly with single young homeless people aged 16-25 across the county of Gloucestershire.
Safe Lives	National domestic abuse charity
SCIE	Social Care Institute for Excellence
SCR	Serious Case Review
Section 11 audit	s.11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions and any services that they contract out to others are discharged having regard to the need to safeguard and promote the welfare of children.
Working Together to Safeguard Children, 2013	The statutory guidance for inter-agency working to safeguard and promote the welfare of children. This guidance was updated in 2015

[18] http://www.safelives.org.uk/practice-support/resources-marac-meetings

research in practice

ADCS
Leading Children's Services

That Difficult Age: Developing a more effective response to risks in adolescence

Dr Elly Hanson and Dez Holmes

Dartington

www.rip.org.uk

Foreword

This piece of work, exploring the research and practice evidence around adolescence and risk, was instigated by the Association of Directors of Children's Services (ADCS) Families, Children and Young People Committee in the spring of 2014. It reflects a growing sense from the sector that the current child protection system is not working effectively enough for many adolescents. As with the work undertaken by ADCS in 2013, 'What is Care For?', this work aims to challenge our thinking and encourage us to focus on *what we know* rather than continue to be constrained by the systems we have.

The evidence scope draws on research evidence relating to adolescent risk, the causes and impacts of these risks, what is known to be effective in addressing these risks, and adolescent development. It also draws on knowledge from the sector, using practice examples to illustrate how the research can be implemented. This work is timely in that it reflects the increase in policy attention on the risks facing young people and resonates with the aims of the Department for Education's innovation fund. It also chimes with the recent Health Select Committee's report on mental health provision for children and young people, the forthcoming framework from Public Health England and the recent reviews of the sector's response to child sexual exploitation.

It is right we acknowledge that there are far too many young people who are not having their needs met by services and far too many examples of young people not being supported to avoid, reduce and recover from risks they face. Nonetheless, a more complex narrative is presented here than simply asserting that services are failing young people; the response to our call for practice demonstrates that a range of excellent, bold and creative service provision exists at a local level. However, this evidence scope argues that these services and the pockets of excellent practice exist *in spite* of the system rather than being enabled by it.

There is a wealth of talent and knowledge across partner agencies, and within young people and their families, that must be galvanised and used to create a more sophisticated model of risk prevention and protection. This paper offers seven principles that can be used to underpin service-level and system-wide approaches, which are inter-connected and build upon existing principles of effective practice.

There are, of course, limitations to this scope. It is not a systematic review of all relevant research, nor does it offer an exhaustive list of recommendations and, as with any effort to synthesise a large body of knowledge, there is the risk that some of the subtleties may be lost in translation.

Lastly, we wish to extend our profound gratitude to those local areas who submitted practice examples and the numerous colleagues who helped to refine the scope by reviewing early drafts and participating in feedback workshops. This support has been invaluable and demonstrates that the sector is absolutely committed to continuously improving the way in which we protect young people and improve their lives

Dez Holmes

Director, Research in Practice

Jenny Coles

Director of Children's Services,
Hertfordshire County Council and
Chair of the ADCS FCYP Committee

Contents

1 Introduction 4

2 The key significant risks adolescents face 6

3 Making sense of adolescent risks 14

4 Promoting resilience 21

5 The interplay between choice and risk in adolescence 24

6 Overcoming challenges to engagement 26

7 The case for change 29

8 Emerging principles for addressing adolescent risk 31

9 Explicated examples – the principles in practice 33

10 Conclusion 40

Note: The references are collated on a separate document and can be found **here**.

1 Introduction

Background and context

It is now widely acknowledged that, as a nation, we do not adequately understand, identify, prevent or effectively reduce the significant risks that some adolescents experience (ADCS, 2013). Yet this is despite the many promising practices that are making a difference in local areas around the country, examples of which are drawn upon in this scope.

Several criticisms of the current system have been made, and often by those working directly within it.

> ***When resources are strained, adolescents' needs are frequently deprioritised in favour of those of younger children.***
>
> (Gorin and Jobe, 2013)

In part, this may reflect faulty assumptions that adolescents, because of their age, are more 'resilient' than younger children (despite having experienced more cumulative harm – see for example Stanley, 2011, in relation to domestic abuse), and that some of the risks they encounter are the result of their own choices – choices that are assumed to be freely made, informed and adult-equivalent. Adolescent agency in relation to risks makes adolescents 'imperfect victims' (Rees and Stein, 1999) and makes addressing those risks (and their impact) a complex business. This is made more difficult still by working within a child protection system that is designed primarily to meet the needs of younger children maltreated within the family (Bilston, 2006).

Local authority spending to protect adolescents from serious risks is also skewed towards solutions that involve the care system. Approximately 50 per cent of children's services spending goes on care placements (Audit Commission, 2014). Care placements for adolescents are the most expensive and make up 30 per cent of the care budget (DfE, 2013a). Trends indicate that the number of young people in care (especially welfare secure and specialist residential care) is increasing, with some local areas reporting an increase in 16 and 17-year-olds becoming looked after (Brooks and Brocklehurst, 2014). Although many placements are effective at reducing risk, the finding that looked after children are disproportionately caught up in the most serious risks – for example, sexual exploitation, violence and running away (eg DfE, 2013b) – suggest that care solutions are not sufficiently effective on a national level. In a recent discussion paper on the use of care with adolescents ADCS (2013, p8) conclude that '*a significant amount of residential care would be de-commissioned if it were judged more carefully on outcomes.*'

This growing sense that the current system of protection and risk reduction is not effective enough for many young people is accompanied by an increase in our knowledge and understanding about adolescent development and the specific risks they face. Research offers insights on physiological development, with adolescence now recognised as the fastest changing period of development aside from infancy (Coleman, 2011). Research also provides clear evidence of the powerful and central role that relationships play in adolescent well-being (WHO, 2014). This evidence converges with key policy drivers, such as foregrounding the young person's perspective and experience of service intervention (for example, Munro 2011), and working preventatively with young people in order to support well-being (PHE, in press).

If this understanding about adolescent development and the distinctive risks that young people face is not applied consistently across policy and practice, a range of consequences is likely:

- missed opportunities to work as a team *with the adolescent* and often *their family* in combatting risk
- misunderstandings about the fundamental drivers and contexts of risk, with the result that resources are channeled to the wrong places (eg risk is assumed to be within the adult world rather than the peer group) (Firmin, 2013)
- harmful assumptions made about adolescent choice (on the one hand choices are minimised, and on the other they are perceived as adult 'lifestyle choices')
- a failure to recognise (and therefore address) the challenges involved in preventing and reducing adolescent risk (eg the frequent challenge to engage young people in interventions).

The result is that young people can be left to experience harmful risks without adequate help or are offered help that is too heavy-handed or comes too late. This not only fails young people but also racks up costs for society over both the short and longer term. In their review of a sample of local approaches to diverting young people from care, Ofsted (2011) found that all areas demonstrated savings arising from young people not entering care. These ranged from £93,000 savings for one family alone, to £688,000 in total for a children's services budget. Similarly, an evaluation of the impact of Intensive Intervention Projects – designed to 'turn around' the lives of the most challenging and troubled young people – found that the IIPs *'generated average savings from prevented expenditure over five years with an average present value of about £280,000 per person … With a return of £8 of savings per £1 spent, these figures indicate significant quantifiable cost-benefits from the intervention'* (Flint et al, 2011).

Aims

The purpose of this paper, then, is to explore key dimensions to adolescent risk and resilience (including the ways in which choice and behaviour can play a role in both) and consider the implications of all of this for current practice and service design. The wealth of evidence we now have to draw upon arguably invites a paradigm shift in how we, as a whole society, perceive young people and the risks they face. Applying this understanding to policies and practice with at-risk young people will require innovation and leadership. In parallel, smaller and immediate changes that make day-to-day practice more 'young person friendly' can achieve lasting positive impact in the lives of young people and be the route to more fundamental change.

So this paper aims to stimulate thinking about how local practice with adolescents can be improved. Principles and examples of potentially effective practice are offered with this in mind (see, in particular, Sections 8 and 9) – not as a limiting list, but as ideas to prompt further thinking about what might work in local contexts. (This briefing is also accompanied by a separate Appendix of Practice Examples.)

Definitions and terminology

We use the following definitions of developmental periods (whilst recognising that there is no absolute consensus on age cut-offs between different life stages, and that such demarcations can be unhelpful when applied too prescriptively):

'Children' refers to individuals between 0 and 17 years of age; *'young people'* to those roughly between 11 and 20 years; and *'adolescents'* to those roughly between 10 and 18. *'Early adolescence'* is seen as the period between 10 and 13 years of age; *'mid-adolescence'* between 13 and 16 years; and *'late adolescence'* from 16 into the final teen years. *'Parents'* is used as shorthand to include also carers and parental figures.

We use the term *'risk'* to refer specifically to the experience of a significant adversity or abuse that would typically incur the attention of children's services (ie a child being at risk of significant harm) and/or would seriously threaten the adolescent's life or health (whilst recognising again that other definitions of risk exist which may be more useful in different contexts – for example, risk as the *likelihood* of experiencing such adversity, or risk as the experience of *a wider range* of adversities including such things as poor education and poverty, involvement in minor crime, and mental health problems). We also recognise that *'risk-taking'* can often serve a number of positive functions.

Mental health problems are discussed here insofar as they contribute to, or are a consequence of, the adversity or risks discussed. We have chosen our focus to ensure that the discussion does not become unwieldy and to avoid duplication with other complementary activity that focuses on this wider range of adversities and difficulties – for example, Public Health England is soon to publish a public health framework for improving young people's health and well-being (PHE, in press) which addresses several of the health-related issues.

2 The key significant risks adolescents face

From a global perspective, the UK can be seen as a relatively safe place for the average child to grow up. Indeed, some risks towards adolescents have been shown to be decreasing (eg substance misuse: HSCIC, 2013). Nonetheless, evidence suggests a high proportion of adolescents in the UK today still face one or more serious risks. A number of these are outlined in Table 1. It is worth noting that many can be a cause of further risk, as well as a response to or result of previous risks in the young person's life (we discuss this later).

The table is also designed to illustrate how, if we wanted to categorise these risks within the current child protection framework, we would have to expand the definitions of the current child protection categories *and* create new categories (we discuss this below).

Child protection category within which risks fit, or are closest to	Some of the risks adolescents face in the UK (often distinctive within adolescence, either in prevalence or impact)
Sexual abuse	Sexual exploitation by gangs or groups
	Sexual abuse by peers
	Duress / coercion to sexually exploit / abuse others
	Online sexual abuse
	Intrafamilial sexual abuse
	Sexual abuse by those in positions of trust or authority
Physical abuse	Family violence – adult(s) to adolescent
	Mutual family violence between adult(s) and adolescent(s)
	Gang-related and community violence
	Violence from relationship partner
Neglect	Neglect from family members including rejection and abandonment, and parental mental health or substance misuse problems that disrupt parenting capacity and incur caring responsibilities on part of the young person
	Overly restrictive parenting
	Neglect in custody[1]
Emotional abuse	Emotional abuse from family members towards adolescents
	Emotional abuse between family members and adolescent
	Extensive bullying by peers and/or online
	Exposure to other risks listed above and below
	Living with domestic abuse between parents
	Emotional abuse from relationship partner
None of the above	Homelessness
	Self-harm including deliberate self-harm, suicide attempts, eating disorders
	Gang involvement
	Substance misuse

Table 1 *Serious risks facing adolescents in the UK today (by closest child protection categories)*

[1] Neglect is the persistent failure to meet a child's basic physical and/or psychological needs. In young offender institutions, arguably children are not looked after by a parent or parental agent who aims to meet the child's basic psychological needs (The Howard League for Penal Reform, 2010). This is in stark contrast to homes with authoritative parenting and also to residential care homes underpinned by a caring ethos. (See section 4 for further discussion of the extent and impact of this.)

The nature and prevalence of some of these risks are explored here in order to enrich the picture – both through insights into specific risks, as well as general themes that cut across them. Vulnerabilities, causal pathways and protective factors are considered in later sections, which seek to make sense of risk and develop principles for effective prevention and response.

Neglect of adolescents by family members

Researchers have recently argued that parental neglect is particularly poorly identified and addressed when adolescents are its victims (Rees et al, 2010). This may be partly because it is more difficult to define than the neglect of younger children. Adolescence is a time of developing autonomy and there is great variability in the speed at which different individuals develop the propensities and skills involved in greater independence. This means that whether parental behaviour constitutes neglect or not will, in many cases, depend on the individual adolescent's development. So for instance, some 16-year-olds may desire and be skilled enough to live independently whereas others may not; therefore insisting that one's child lives independently may be neglectful in the second instance but not in the first.

It is also normal for developing independence in adolescence to involve some heightened conflict with parents and some rejection of parental rules and care (Collins and Laursen, 2004). In this context, non-neglectful parenting may need to be particularly resourceful and persistent (such as proactively impeding a child from running away), whilst neglectful parenting can appear to conform with the adolescent's own wishes. An additional layer of complexity comes in the form of cultural norms and expectations, which vary widely in relation to the roles of young people and their parents. What is deemed appropriate parenting in one culture may be overly restrictive in another to the point where it is neglectful of the adolescent's needs to develop social skills and greater autonomy (Rees et al, 2010).

Given that adolescents have very different parenting needs to those of younger children, some have argued that adolescent neglect requires its own definition (Rees et al, 2010). Indeed, to use a single definition that does not recognise the complexities of adolescent neglect might risk minimising both its existence and the harm it causes. Adolescents exposed to the same parenting omissions as younger children are assumed to be more resilient due to their developing skills (Rees et al, 2010), but this can prevent the distinctive features of neglectful parenting of adolescents being identified and addressed. An example is the potentially greater prevalence of acts of *commission* in adolescent neglect (versus that of younger children), such as coercing one's child to leave home. Parental unwillingness to house young people is the foremost reason for youth homelessness (Homeless Link, 2014).

So lack of clarity about adolescent neglect and assumed resilience impede its identification (in a vicious spiral), even though research suggests it may be a significant problem. Neglect is the most commonly used category on child protection plans for children aged 10 to 15 (as is also the case for younger children) (DfE, 2014). In serious case reviews (SCRs), neglect features more prominently for 11 to 15-year-olds than for any other age group (Brandon et al, 2013) and one study of seven youth suicides resulting in SCRs found that neglect and rejection were prominent in all of the young people's histories (Brandon et al, 2014). In the most recent prevalence study of child maltreatment in the UK (for the NSPCC – Radford et al, 2011) 0.4% of 11 to 17-year-olds reported experiencing neglect from their parents within the past year. This figure is likely to be an underestimate due to the methodology employed[2], but even so indicates that large numbers of adolescents experience neglect.

[2] In this study, parents were likely to be close by when adolescents completed the computerised questionnaire (and so participants may have felt constrained in what they could report).

Homelessness and running away

As highlighted above, the primary reason young people become homeless is parental unwillingness to accommodate them, which is often linked to family conflict and breakdown. Other primary reasons include escaping from abuse and domestic violence, absconding from care placements, or previous places to live no longer being available after a period in custody (Homeless Link, 2014). Encouragingly, Homeless Link has recently reported an increase in joint working between housing and children's services departments and that, potentially as a result of this and the Southwark Judgement in 2009, few 16 and 17-year-olds who sought help from their local authority had slept rough (Homeless Link, 2014).

There are more findings specific to children and young people who run away than to those who are homeless (these are two overlapping groups), and research suggests those who run away are at a significantly high risk of harm. Running away is likely to be preceded by exposure to harm, and may well involve harmful and risky experiences beyond the instability and stress inherent to running away. Most children who run away are adolescents. The Children's Society found that during their experience of running away, 26 per cent were either hurt, slept rough (or at the home of someone they have just met), or stole and/or begged in order to survive (Rees, 2011). Twelve per cent of young people seen by services supporting young runaways had experienced child sexual exploitation (Smeaton, 2013). Over 70 per cent of children who run away are not reported as missing to the police and only 5 per cent actively seek help from services while away from home (Rees, 2011). As a result, official 'missing' data only capture the 'tip of the iceberg', leaving the risks involved in running away largely hidden and unaddressed. Furthermore, recording systems between police and children's services can differ (although work is underway to address this), which makes understanding the scale of the problem even more difficult.

Sexual abuse by gangs and groups

There is growing awareness across the UK of the problem of child sexual exploitation (CSE) involving gangs and groups. CSE is a form of sexual abuse where there are particular dynamics around the exchange of sex for other things (such as money, food or affection) in the context of a power dynamic (DCSF, 2009). It is a form of sexual abuse particularly targeted towards adolescents, perhaps in part because their developing agency may make them less vulnerable to other forms of coercion and manipulation in sexual abuse, whilst at the same time making them more vulnerable to grooming processes in which abusers deceptively construct a connection between sex and sought-after love, affection or status. A variety of types of gangs and groups are involved in perpetrating CSE (and not all CSE is perpetrated by a gang or group) – for example peer-led gangs versus those led by adult males – and CSE has distinct strategies and 'functions' within each.

There are problems with developing a tight definition of CSE. It appears that the term is often used to describe sexual abuse towards adolescents generally, even when the abuse does not involve clear 'exchange' dynamics and would have been described as sexual abuse if it had involved younger victims. CSE also appears to be used often as shorthand for sexual abuse involving gangs and groups.

An inquiry by the Office of the Children's Commissioner into CSE in gangs and groups reported 2,409 confirmed victims (over a 14-month period), with additional data indicating many more at risk (Berelowitz et al, 2012). The mean age of reported victims was 15, and 28 per cent were from black and ethnic minority (BME) backgrounds. Pearce (2014, p130) notes that '*even with inadequate data-recording systems, evidence of widespread abuse through CSE* [in gangs and groups] *exists, with young people in their teens being most at risk*'.

Intrafamilial sexual abuse

In the 2011 NSPCC prevalence study (Radford et al, 2011) one per cent of 18 to 24-year-olds reported sexual abuse perpetrated by a parent or guardian in their childhood. However, we do not know what percentage of this group experienced it in adolescence, nor how many experienced other forms of intrafamilial sexual abuse. This is important because other research indicates that sibling sexual abuse may be the most common form of sexual abuse (for a research summary see Stathopoulos, 2012) and that it has high levels of associated harm (Cyr et al, 2002).

Research exploring the childhood experiences of adults with symptoms of mental ill health indicates that prolonged (often intrafamilial) sexual abuse, generally starting before adolescence and persisting into it, is experienced by a significant number of people and is associated with especially high levels of psychological difficulty across the life-course (Salter, 2008). For example, Steel et al (2004) found 32 per cent of a psychiatric inpatient adult sample reported sexual abuse lasting over 10 years, with an average age of onset of eight years old. Abuse of prolonged duration is associated with complex psychological dynamics, revictimisation by others in later life, and difficulties in identification and disclosure (Loeb et al, 2011; Salter, 2008 and 2013). Although the majority of sexual abuse towards adolescents is perpetrated by those outside the family (see for example Radford et al, 2011), it should not be assumed that intrafamilial abuse is, therefore, an insignificant problem in this group – nor should it be assumed that it affects younger children only.

Online sexual abuse

Sexual abuse that begins online can take a number of forms. Young people may share sexual images consensually with someone (eg a school peer) who then, without their consent, sends them on to others. In other instances, young people are deceived and groomed into forming an emotional bond with an adult online who then uses this attachment to perpetrate sexual abuse (for example, in offline meetings or through requests for sexual images) (Whittle et al, 2013a). A further type involves sexual blackmail: a person online obtains a sexual image of a young person (often via deception) which is then used to blackmail the young person into sending increasingly explicit or humiliating images (NCA, 2014).

Adolescents are more at risk of online sexual abuse than younger children. Reasons for this include their greater usage of the internet, and this usage being bound up with the increased risk-taking, impulsivity, sensation-seeking and sexual interest common to this life-stage (Livingstone et al, 2011; Whittle et al, 2013b). In the year 2012-13, more than 1,000 children contacted ChildLine about online sexual abuse; 15-year-olds were the group most likely to call about this (ChildLine, 2013). Qualitative research indicates that online sexual abuse may have particular harms associated with it, linked to the creation of images, their permanence and reach and who is viewing them, and the deception involved (Hanson, submitted). These aspects can heighten shame, anxiety, mistrust and feelings of ongoing trauma.

Further risks	Facts and figures
Family violence and physical abuse	2.5 per cent of 11-17-year-olds report witnessing domestic violence between adults in their home in the past year; 1.2 per cent report being physically hurt by a parent or guardian in the past year (Radford et al, 2011 – these may be under-estimates due to the methodological factors noted in the footnote earlier). Adolescents are more likely to witness domestic violence than younger children (Meltzer et al, 2009). Adolescent-to-parent violence is not uncommon; despite it being widely recognised by practitioners, it is often not adequately addressed partly due to a 'silence' at policy level (Condry and Miles, 2012 and 2014).
Bullying by peers	Bullying is an 'unprovoked, sustained campaign of aggression towards someone in order to hurt them for the sake of it' (BeatBullying website). At least 20 children commit suicide each year because of bullying; many more attempt suicide or self-harm because of it (see for example http://archive.beatbullying.org/dox/resources/statistics.html and ChildLine, 2013).
Self-harm	Self-harm, defined as the deliberate self-infliction of damage to body tissue, peaks in mid-adolescence (Hagell, 2013). About 10 per cent of adolescents report having engaged in self-harm and it is more common in girls and adolescents from lower socio-economic groups (Hawton et al, 2012). Over half of young people who self-harm do so repeatedly (Madge et al, 2008). It is estimated that each year 25,000 adolescents present to hospitals in England and Wales because of self-harm – one of the highest rates in Europe (Wood, 2009).
Substance misuse	Despite adolescent use of alcohol and some drugs decreasing over the past decade, adolescents who do drink are more likely to get drunk and binge drink than those in many other countries. Additionally, amphetamine use is on the rise. Problem drug use typically occurs in conjunction with a number of other risks, such as self-harm and offending behaviour, arising out of common vulnerabilities such as a chaotic home life. 20,032 young people received help for alcohol and drug problems in England during 2012-13. (Statistics drawn from HSCIC, 2013, and PHE, 2013)
Gang involvement	Up to 6% of 10-19-year-olds self-report belonging to a gang (Centre for Social Justice, 2009 (citing Sharp et al, 2006)) Gang membership increases the risk of offending and substance misuse even when other factors are controlled for (Medina et al, 2013) – see also the discussion in section 2 on how gangs interact with normal adolescent development to increase risk.
Eating disorders	The onset of anorexia nervosa or bulimia nervosa typically occurs during adolescence. One in 250 females develops anorexia, and five times as many develop bulimia. Anorexia has the highest mortality rate of any mental health problem in adolescence (statistics collated by NICE, 2004).

Table 2 *Key statistics on some further serious risks encountered by adolescents*

Multiple risks

A significant minority of young people experience multiple risks, which can make it more difficult to identify causal risks and resultant risks, and can segment or silo the service response – further challenging those working with young people. For example, Radford et al (2011) found that 10 per cent of 11 to 17-year-olds had experienced 12 or more forms of maltreatment during their lifetime (we do not know adolescent-only rates). Evidence of coalescing risks also exists in the research on vulnerability for any one risk – so for example, an adolescent is more likely to run away and experience associated harms if they are running to escape abuse; substance misuse and self-harm are often strategies used to quell distressing emotions and memories associated with previous trauma; and gang involvement may be sought to reduce the threats inherent in neighbourhood violence (Gilman et al, 2014; Tarter, 2002; Tyler and Johnson, 2006).

At both age seven and 14, children are disproportionately at risk of entering the realm of 'polyvictimisation' (i.e. experiencing very high levels of victimisation of different types). Adolescents who experience polyvictimisation tend to be living in (at least) one of three vulnerable contexts: a dangerous community, a dangerous family (with high levels of violence and criminality), and/or a stressed or disrupted family (due to unemployment or substance misuse, for example) (Finkelhor et al, 2009). Poverty is a salient contributor to these vulnerable contexts.

Impact of risks on adolescents, and unintended consequences of policy

Over the past decade or more, there has been a focus on the impact of maltreatment experienced in the early years. One inadvertent consequence of this may have been a growing assumption that adolescence is a period of greater resilience to the impact of abuse (Gorin and Jobe, 2013). There has also been a separate (but related) move towards early intervention, based on the principle that intervening early in the life of a problem increases an intervention's chance of success. This is a useful principle for addressing risks facing adolescents also. However, prioritising early intervention has, at times, arguably translated into prioritising 'early years intervention' (Plimmer and van Poortvliet, 2012), accompanied by a related assumption that intervening at other points offers less promise.

In contrast to these assumptions, research indicates that risks experienced in adolescence may be particularly harmful and that adolescent-focused interventions can be very effective. Indeed, **adolescent maltreatment has a more global negative impact into adulthood than childhood-limited maltreatment**. A large longitudinal and controlled study by Thornberry et al (2010) found that adolescent maltreatment had a more pervasive negative impact than childhood-limited maltreatment on early adulthood outcomes (measured up to age 31). Furthermore, only adolescent (and not childhood-limited) maltreatment was significantly associated with early adulthood offending, problem alcohol use and risky sex. It also had a greater influence (than childhood-limited maltreatment) on early adulthood suicidal thinking and problem drug use. Radford et al (2011) found that polyvictimisation was associated with higher levels of trauma symptoms in 11 to 17-year-olds compared to younger age ranges.[3]

Other research has found *qualitative* differences in how adolescents are affected by experiencing risks when compared to younger children – in other words, the impact in many cases is not clearly lesser or greater, but *different*. For example, sexual abuse at a younger age at onset is more likely to lead to sexualised behaviour, anxiety and hyper-arousal in children (Kaplow et al, 2005; McClellan et al, 1996), whereas sexual abuse in adolescence is associated with higher rates of post-traumatic stress disorder (PTSD) and lower general psychological functioning (Ruggiero et al, 2000); this may be linked to the lower levels of support they are generally offered (Feiring et al, 1998).

Lastly, adolescents are exposed to a greater range of risks than younger children by virtue of their expanding social worlds (Rees et al, 2011) and increasing agency (discussed in next section). Risks such as gang involvement and abuse within intimate partner relationships tend to cluster within this age range.

[3] Polyvictimisation was defined differently according to age ranges to take account of the fact that older ages were more likely to be polyvictimised simply by virtue of their age.

Challenges of the current system

The risks that adolescents face are particularly complex and wide-ranging (this complexity is explored further in section 3). There is also no reason to believe that they are any less harmful, on the whole, than those experienced by younger children – indeed, as we have seen, some may be more so. Yet researchers have identified a reluctance to intervene with adolescents experiencing serious risks before they reach the threshold for care. And when resources are sparse, adolescents are the first age group to be deprioritised.

Interviewer: OK what do you see as the biggest challenges you face in terms of providing protective services for older children?

Social worker: Prioritising them ... we can't rush out to a sixteen year old who's perhaps sofa-surfing and perhaps experimenting with drugs and getting into crime ... we can't prioritise that when we're working with 0 to 5 year olds in, you know, some pretty dire situations.' Gorin and Jobe (2013: p1337)

In many circumstances, the current system of services and support does not adequately recognise the range and seriousness of the risks that adolescents face. Responses are often insufficient or too heavy-handed. Some responses, such as custodial sentences, simply expose adolescents to further risk and harm (see the discussion under 'The adaptive nature of adolescent development and the risk of ensnaring' in Section 3).

One option would be to expand the definitions of existing child protection categories and/or add new categories, in order to better capture adolescent risk. However, this relatively simple response is unlikely to enhance effective prevention and intervention for a number of reasons:

- Adding categories and dimensions while retaining the response framework creates further challenge for an already strained sector; it will not by itself increase resources and effectiveness.
- In the context of resource pressures, this could in fact lead to negative unintended consequences – for example, prioritising adolescents at the expense of 5 to 10-year-olds.
- Extending the child protection categories would reinforce child protection as the dominant framework for addressing risks to adolescents, yet that framework was designed primarily in response to the needs of younger children facing risks from their family. In a number of ways this makes it difficult to apply effective principles for reducing adolescent risks and harms (emerging principles for addressing adolescent risk are discussed in Section 8).
- The child protection system typically relies on mechanisms which can alienate young people – for instance, routes to participation, such as attending child protection meetings, are intimidating (Gorin and Jobe, 2013) and may inadvertently lead to young people feeling stigmatised by their risks and problems.

Interviewer: Do you see child protection as always the most appropriate response for eleven to seventeen-year-old age group?

Social worker: No, absolutely not...because you know, teenagers will very rarely attend their own meetings, it's too intimidating for them. I mean it's horrendous to sit with your teacher and family together in a room, discussing your misdemeanours, it's not something teenagers are really interested in.

Social worker: I think child protection tends to be about putting controls around parents whereas when youngsters are at that sort of age they've got much more of a personal input to situations which needs to be reflected

(Gorin and Jobe, 2013: p1338)

What is clear, then, is the need for a distinct focus on adolescent risks and the resources, principles and approaches that most effectively address them. Adolescence is a time of vulnerability to particular risks (see Table 1 for examples) and adolescents have particular developing skills, propensities, adaptations, social contexts and social relationships that can feed into risks but can also provide unique opportunities to build resilience in the face of them.

Despite there being a diversity of excellent local examples of young person centred practice which actively draw on the evidence of what works when supporting young people (see Realising Ambition as an example of a programme of work that embodies this), it remains the case that *'many adolescent interventions are either downward extensions of adult programs or upward extensions of child programs'* (Thornberry et al, 2010). In terms of whole system approaches, it could be argued that the child protection system is an example of a 'upward extension' and the youth justice system still too much of an 'downward extension' (see APPGC, 2014).

Realising Ambition

Realising Ambition is a Big Lottery Fund programme led by Catch 22 (with the Social Research Unit, Substance, and the Young Foundation as consortium partners) that aims to reduce the involvement of young people in the criminal justice system. It does this by supporting a) the replication of evidence-based interventions with young people and their families, and b) the development of evidence for promising interventions. Interventions are delivered by local organisations across the UK, and include the Strengthening Families Programme delivered by Oxford Brookes University, Roots of Empathy delivered by Action for Children, and Lions Quest Skills for Adolescents delivered by Ambition (Clubs for Young People). For more information about the programme and the interventions, as well as learning points for commissioners, see the mid-term report and its summary available here: www.catch-22.org.uk/programmes-services/realising-ambition/

3 Making sense of adolescent risks

Approaches that effectively address adolescent risks are well served by a solid understanding of the key factors underpinning those risks, as well as those that prevent risks and reduce their impact. This section argues that:

risks towards adolescents may often have more complex pathways than those facing younger children.

It explores the ways in which some risks are not simply present in the child's environment, but are created by interactions between that environment and adolescent developmental changes and tasks. It also considers how adolescent behaviour that heightens risk is often part of an adaptive response to maltreatment and adversity in earlier childhood. Based on this understanding, together with an appreciation of resilience, the section concludes by discussing some promising ways forward.

Understanding neuropsychological development: a note of caution

An understanding of adolescent neuropsychological development adds depth to our appreciation of how adolescents differ from children and young people in earlier and later life stages, and the distinctive pathways into the risks they face. Such an understanding also invites consideration of how adolescent behaviour serves important adaptive functions. However, in utilising neuroscience generally, it is important to avoid and challenge its misinterpretation (eg that people are 'damaged') and misuse in policy development (eg to support medical over social interventions) (see Wastell and White, 2012). The adolescent brain goes through a rapid process of developing new neural connections and this process is fundamentally shaped by social interactions and relationships – thus contributing to this life stage as one that offers a significant window of opportunity.

Risk and adolescent development

Adolescence is one of the most dramatic stages of life development. With the onset of puberty come bodily changes such as spurts in growth and the development of the sexual organs, as well as changes in the neurobiological system focused on emotions and social interaction. These latter changes underpin mid-adolescents' sensitivity to emotional cues (such as rewards and threats) in comparison to older and younger age ranges (Steinberg, 2010; Dreyfuss et al, 2014). In contrast, the neural systems that underlie the complex cognitive abilities involved in control and regulation develop very differently, maturing gradually over the course of adolescence and into young adulthood. This accounts for the gradual gains over these life stages in the skills comprising 'executive functioning', the control and co-ordination of thoughts and behaviours (Anderson et al, 2001; Blakemore and Choudry, 2006). Skills in this repertoire include working memory (the ability to hold information in mind and apply it to current tasks), impulse control, selective attention and planning ahead.

One consequence of the differential development of these two subsystems (early adolescent arousal of the socio-emotional system, paired with late maturation of cognitive control systems) is a period of vulnerability to risk-taking in mid-adolescence (Steinberg, 2010; Van Leijenhorst et al, 2010). This may also account for the increased emotional highs and lows that are characteristic of this period. (For further detail of the neurobiological development in adolescence see Casey et al, 2008.)

The risk-taking might involve riskily seeking rewards (for example, joy-riding or use of illegal recreational drugs) as well as riskily responding to threats (for example, responding to a verbal slur with physical violence rather than walking away). Some of the risks involved (such as those associated with physical violence) increase with the growth in physical size and strength over this period.

Risk and adolescent relationships

Adolescence is also a time of changing social relationships. And as those working with young people know all too well, relationships are at the centre of young people's health and well-being (WHO, 2014).

Peers become increasingly important in a number of ways – as friends, sometimes as intimate partners, and as prominent social groups in which one's identity and status are constructed and worked out. Risk-taking and the salience of the peer group interact – for example, adolescents are more likely to take risks when they are observed or interacting with peers, in a way that is not true for adults (Gardner and Steinberg, 2005). In other words, the peer group can heighten vulnerability to risk. Sensation-seeking and peer pressure influence adolescent criminal behaviour, for example, but not that of adults (Modecki, 2009), and peer-group popularity is a predictor of drug and alcohol use as well as minor offending behaviour (Allen et al, 2005).

The flipside to this is that young people may be particularly receptive to support and positive guidance from their peer group – relationships are noted as both a risk factor and a protective factor in public health discourse (see PHE, in press). The online world, too, can enhance peer influence in both directions. Moderated peer-to-peer youth forums are a good example of how the strength of peer influence can be positively harnessed (Webb et al, 2008).

Examples of safe spaces for young people to receive and give support to their peers

> **The ChildLine Message Boards:**
www.childline.org.uk/Talk/Boards/Pages/Messageboards.aspx

> **The Site discussion boards:**
http://vbulletin.thesite.org

> **The Reach Out! Online Community Forum:**
http://forums.au.reachout.com

All of these sites are moderated by trained facilitators in order to make space for positive peer support while minimising negative influence.

During adolescence, friendships typically become closer, more disclosing and more supportive, and they are critical contexts for the development of identity and social skills, which are also central features of this life-stage (Meeus, 2011; Smetana et al, 2006). Peer friendships can fulfil important attachment functions (such as providing a 'safe haven') especially when relationships with parents are less secure (Nickerson and Nagle, 2005). However, despite largely providing resilience in the face of risk, friendships can at times also increase risk – for example, by obsessively going over problems together (termed 'co-rumination'). This is a process whereby friends amplify one another's negative feelings through circular, negative discussion. Co-rumination in adolescence predicts the development of depression (Stone et al, 2011). More generally, negativity and impulsivity in friends can increase the risk of self-harm (Giletta et al, 2013).

Intimate or romantic relationships are a normative part of adolescence, their salience developing in concert with sexual interest and peer relationships more generally. By late adolescence, romantic attachments, when they are present, offer a central source of support (Smetana et al, 2006). However, earlier engagement in such relationships tends to be associated with negative factors, such as low self-esteem and substance misuse, although whether the romantic relationship is a key contributing influence is not clear (Collins, 2003). As with friendships, attachment patterns in girl-/boyfriend relationships are likely to be influenced by a child's attachment to their caregivers; however, this relationship is not straightforward (Furman et al, 2002) and adolescence is a period ripe for the development of new ways of relating to others.

Older adolescents place greater emphasis on intimacy and compatibility when choosing a partner, in comparison to early adolescents who tend to place more emphasis on partner qualities that will increase their status within their peer group. So they may be more likely to choose a partner based on their appearance, fashion style and popularity (Collins, 2003). Early adolescents are also more likely to have idealised notions of romance (Smetana et al, 2006). Perpetrators of sexual exploitation are acutely attuned into these developmental propensities, which they manipulate in order to execute abuse.

Interacting with the growing importance of peer relationships are changes in the parent-child relationship.

Parents and their parenting remain of critical importance to children's well-being and resilience during adolescence. However, parent-child conflict typically increases and cohesion, warmth and support typically decrease (Collins and Laursen, 2004). Conflict arises in part as a result of adolescents' increasing sense of agency and drive for independence.

Developing autonomy also affects the influence of parenting practices – for example, it is adolescents' willingness to disclose to their parents (enhancing parental monitoring), rather than parental attempts at monitoring alone, that reduce engagement in risky behaviours (Kerr et al, 2010). Similarly, recent research has found that young people use the internet and social media in a more useful and self-regulated fashion when their parents support their autonomy, are involved in their lives and give them unconditional positive regard, whereas monitoring and restricting their online activity appear to have converse effects (Przybylski et al, 2014). These findings are reflective more widely of the growing role of children's choice and agency during the adolescent period, and suggest different routes to managing risk than standard protection measures within the current system.

Young people's expanding social world and their developing independence both help them to build their identity, one of the central tasks of this life stage (Meeus, 2011). The construction of a coherent identity is connected to greater adolescent well-being and the development of positive personality traits, such as agreeableness. However, taking on certain identities may heighten an adolescent's experience of risk; for example, identifying with a 'troublemaker' identity contributes to sexual risk-taking, aggression and substance use (Longmore et al, 2006; Seffrin et al, 2009). As discussed further in the following paragraphs, the implication here is that services need to ensure they are supporting adolescent resilience by promoting the development of positive identities and avoiding practices and policies that support negative ones (for example, those that label young people according to risks or risky behaviour).

The adaptive nature of adolescent development and the risk of 'ensnaring'

Some features of adolescence are generally perceived by society as unfortunate, such as risk-taking and emotional reactivity. From an evolutionary perspective, however, the behaviours and proclivities of this life stage usefully work together to fulfil critical functions, most fundamentally the separation of an individual from her or his family of origin and the formation of new family ties. Risk-taking, novelty-seeking and sexual interest (often presenting as problematic) actually serve an important evolutionary function – that is, to propel adolescents away from the family circle into new social worlds wherein they seek to find a partner. During the process of transitioning from a safe environment to a novel one, the ability to detect threat (especially within social relationships) is critical and this is assisted by heightened emotional reactivity (Casey et al, 2008).

Healthy adolescent development, then, does by its very nature invite some risks. Indeed, development may be enhanced by experiencing some risks in moderation;

for example, day-to-day arguments with parents can help young people develop conflict-resolution skills and the tolerance of difference (Smetana et al, 2006).

This understanding cautions against pathologising or 'problematising' normal adolescent behavioural and emotional tendencies. Rather, in the right context, they can be harnessed to serve young people and those around them well – for example, developing their creativity, community participation, and connection to others.

Social pedagogy is an increasingly influential model of working with at-risk young people. It argues that ***'learning from mistakes through engaging with risks is a necessary process for children and young people and that to do so is actually a way of safeguarding'*** (Research in Practice, 2014).

However, in other contexts that are less benign these same propensities and behaviours can interact in ways that lead to hurt, harm and limiting life trajectories. But if these propensities are 'normal' (as research would seem to suggest they are), then attention now needs to focus instead on changing those less benign contexts – that is, on making significant changes in certain societal policies that may interact with normal adolescent development to ensnare young people in more significant risks and harm. This counter-productive pattern is of particular concern where the very 'system' that seeks to protect is, in fact, interacting with evolutionary propensities to increase some risk. Examples are explored below.

1. ***Punitive and custodial responses to youth offending.*** The Ministry of Justice argues that one of the goals of the criminal justice system (CJS[4]) is safeguarding (MoJ, 2010). However, when adolescents are placed in custody, they do not necessarily receive adequate education or care (Howard League, 2010) and this constitutes a form of neglect that causes high levels of distress and mental health difficulty (Cesaroni and Peterson-Badali, 2005). This is likely to constrain adolescent skill acquisition, for example in the domains of executive functioning and social cognition (Farmer, 2011), and therefore is at odds with adolescent development. Young people may adapt to the hostility within some custodial settings by isolating themselves, becoming hyper-vigilant and using pre-emptive aggression (Gilligan, 1996; Lindquist, 2000) – strategies which, despite being adaptive in the short term, place adolescents at risk of social exclusion and further offending over the longer term.

At times, simply being caught up in the CJS may increase re-offending (McAra and McVie, 2007; Little and Sodha, 2012; Petrosino et al, 2010) by interacting with powerful developmental drivers around identity and encouraging young people to develop self-constraining identities (such as 'bad boy'), while simultaneously inviting others to treat them as such, for example by reducing employment opportunities (labelling). However, youth offending teams are likely to be able to counteract this risk when they take a truly restorative and strengths/relationships-based approach (Byrne and Brooks, 2014).

2. ***Heavy-handed responses to aggression by looked after young people.*** Problematic behaviours by looked after young people disproportionately trigger responses that label, stigmatise and destabilise them, and this further compromises their life chances and well-being. Such actions include placement changes (see The Care Inquiry, 2013, for a fuller discussion about the importance of nurturing relationships in order to avoid unnecessary placement moves for looked after children and young people), forceful restraints and police involvement, all of which would be far less likely in response to the same behaviours by young people not in the care system (young people in residential care are particularly at risk – see APPGC, 2014). These responses may compound difficulties, and are in contrast to other approaches that can deal appropriately with the behaviour without inviting such risks – such as informal restorative and authoritative parenting practices.

3. ***Exploitative people.*** Individuals who sexually exploit young people often do so a) by taking advantage of young people's limited knowledge of their rights and the adult world, and b) by manipulating the natural proclivities of this life stage. For example, displays of 'worldliness' or wealth, and dramatic promises of ideal romances, are often successful in luring adolescent girls into exploitation (eg Gohir, 2013).

Societal and cultural narratives that minimise female sexual agency at the expense of males' are likely to make it harder to recognise and resist abuse. This means that work to tackle CSE, for example, must be underpinned by wider population-level education rather than expecting police and social care to address it alone.

This need for education-led preventative approaches is supported by findings from a survey of parents and professionals, in which 89 per cent of parents and 88 per cent of professionals agreed that secondary schools should be educating children about CSE (Pace, 2013); this throws a concerning light on the finding from the same survey that 43 per cent of teachers are not confident they could identify signs of CSE.

[4] This term is used to include the youth justice system (YJS).

Emerging romantic and sexual interest, risk-taking and/or the motivation to be respected by peers make some adolescent boys and girls susceptible to sharing images with strangers online, who then use these as leverage in blackmail and abuse. These same developmental drivers (as discussed above) make some adolescents more susceptible to grooming. Despite the clear protective value of parents in addressing the risk and impact of CSE, the aforementioned survey by PACE found that:

> '*... parents are still being held responsible in part for the crimes committed against their child. Over two-fifths of professionals (44%) and parents (41%) agreed in most cases parents are in part responsible for the sexual exploitation of their child.*' (PACE, 2013: p43)

Another concern is the finding that two-fifths of teachers would not, as a matter of urgency, inform the parent of a child they thought at risk of sexual exploitation; furthermore, seven out of ten professionals and parents think that parents feel disempowered by agency involvement in the family. These findings should lead local areas to consider whether parents are being effectively engaged in identifying, preventing and addressing trauma related to CSE (for an example of service response that aims to do just that see the description of PACE's 'relational safeguarding model' and the use of family support workers in Section 9).

4. ***Gangs***. Because young people are particularly sensitive to social threat, social status and their identity (compared to those older or younger than them), they may be at risk of gang involvement if they live in a neighbourhood where gangs operate and they have few other means to feel safe, develop their sense of self, and connect to peers. The (often gradual) choice to join a gang can be adaptive, but over time, gang culture, demands and warfare drive young people into blind alleys of risk (Palmer, 2009). Risks include offending and related CJS sanctions, violent victimisation including homicide, sexual abuse (perpetrators are often simultaneously victims of gang demands around hyper-masculinity – Firmin, 2013a), and longer-term consequences in adulthood such as economic hardship, poor health and family dysfunction (Augustyn et al, 2014; Gilman et al, 2013).

Responses that focus only on criminality, rather than addressing the underlying causes of gang involvement, do little to break this cycle – and may in fact serve to label young people and reinforce negative identities. These findings endorse the approach and endeavours of those local areas that are providing integrated and holistic interventions to young people at risk from gang-related activity.

Concluding thoughts. What we now know about adolescent development requires us, as a society, to: a) work to reduce adolescents' exposure to those risks to which they are particularly vulnerable; b) develop adolescents' resilience in the face of those risks; and c) avoid responses that are disproportionately blaming if adolescents do become entangled.

We have a responsibility to *work in partnership with young people* to create a society that offers them a 'safe course' through adolescence, rather than ensnaring them – albeit inadvertently through inappropriate service responses – in risks and harms that can have lifelong consequences.

Risk and adaptation to earlier maltreatment or adversity

The impact of prior maltreatment can lead to adolescents acting in ways that inadvertently increase risk to themselves (and in vicious spirals).

It is often the case that adaptations made in a context of maltreatment can prove maladaptive in subsequent and wider contexts. The example of CSE is used below to illustrate this principle, although it can be seen at work in numerous other adolescent risks, including gang involvement, family violence, abuse in teenage partner relationships and homelessness.

Young people who have experienced prior or current familial abuse are more at risk of sexual exploitation (Kaestle, 2012); the argument advanced here is that in some cases children's adaptations to the initial abuse may play a part in this. This does not conflict with the knowledge that young people living within stable and caring families can also become victims of sexual exploitation, often as a result of perpetrators attuning to and adapting manipulating aspects of normal adolescent development, as discussed above.

There is now a body of literature to support the main premise of betrayal trauma theory: that when a child experiences gross betrayal by someone they depend on to meet critical needs (eg caregiving, protection), they may reduce their awareness of this betrayal as a way of coping with the overwhelming feelings of threat and confusion it induces (for a review see DePrince et al, 2012). For example, a child who is sexually abused by her parent may engage in strategies that enable her to hold on to the belief that he is a caring father figure. One such strategy is to reduce her sensitivity to social rules and boundaries (termed a deficit in 'social cognition'). Adaptive (that is, self-preserving) in the abusive situation, this unfortunately leaves her at risk in adolescence (and later adulthood) of missing early indicators that a person is intent on exploiting her and therefore increases her risk of abuse (DePrince, 2005). Furthermore, even if there is some awareness that a person is acting exploitatively, young people often remain in the relationship because they crave the fulfilment of fundamental human needs that were and remain unmet – for love, protection, emotional connection and belief from others. This may be accompanied by a sense (again developed in the context of prior maltreatment or neglect) that the exploitative relationship is the best hope of having those needs met, and/or that they do not deserve any better (Reid, 2011). A further element to this vicious spiral is that the capacity to dissociate from pain or negative feelings (also developed in response to earlier abuse) can compromise a young person's ability to recognise and adaptively respond to their own distress. It also appears that adolescents (and adults) can sometimes be motivated to return to abusive situations similar to those they experienced in the past (but now with greater perceived control) as an attempt to master the difficult feelings of helplessness that the earlier experiences elicited (a psychological process termed 're-enactment' – see Van der Kolk, 1989).

Faced with consequences of maltreatment that are likely to have begun prior to adolescence, adolescence brings the increased capacity and propensity to act on them, and the increased number of social worlds in which young people can do so. Once an abusive relationship has begun (albeit this is not always present in CSE), as in domestic abuse, attachment processes can kick in which paradoxically strengthen the abuser's psychological hold on a victim the more erratically and cruelly the abuser behaves (Dutton and Painter, 1993).

Another example of adaptations to prior adversity leading to increased risks are the socio-psychological pathways underpinning the offending of some young people (Lee and Hoaken, 2007). For example, maltreatment in earlier childhood can lead to children becoming hyper-vigilant to signs of threat, including potential shame, which they may then seek to protect themselves from with defensive aggression, often learnt through modelling and reinforcement (Farmer, 2011). Programmes that seek to build young people's resilience and minimise offending are therefore likely to be more effective in reducing this risk than those that only address offending behaviour (see Realising Ambition).

Recognising risk as being compounded by adaptive responses to earlier trauma can help local areas to develop service and practice responses that tackle underlying causes, and are therefore more effective in achieving sustainable positive change and avoid victim-blaming.

Figure 1 below illustrates the complex causal pathways to CSE; based on work by Reid (2011); DePrince (2005) and Kaestle (2012).

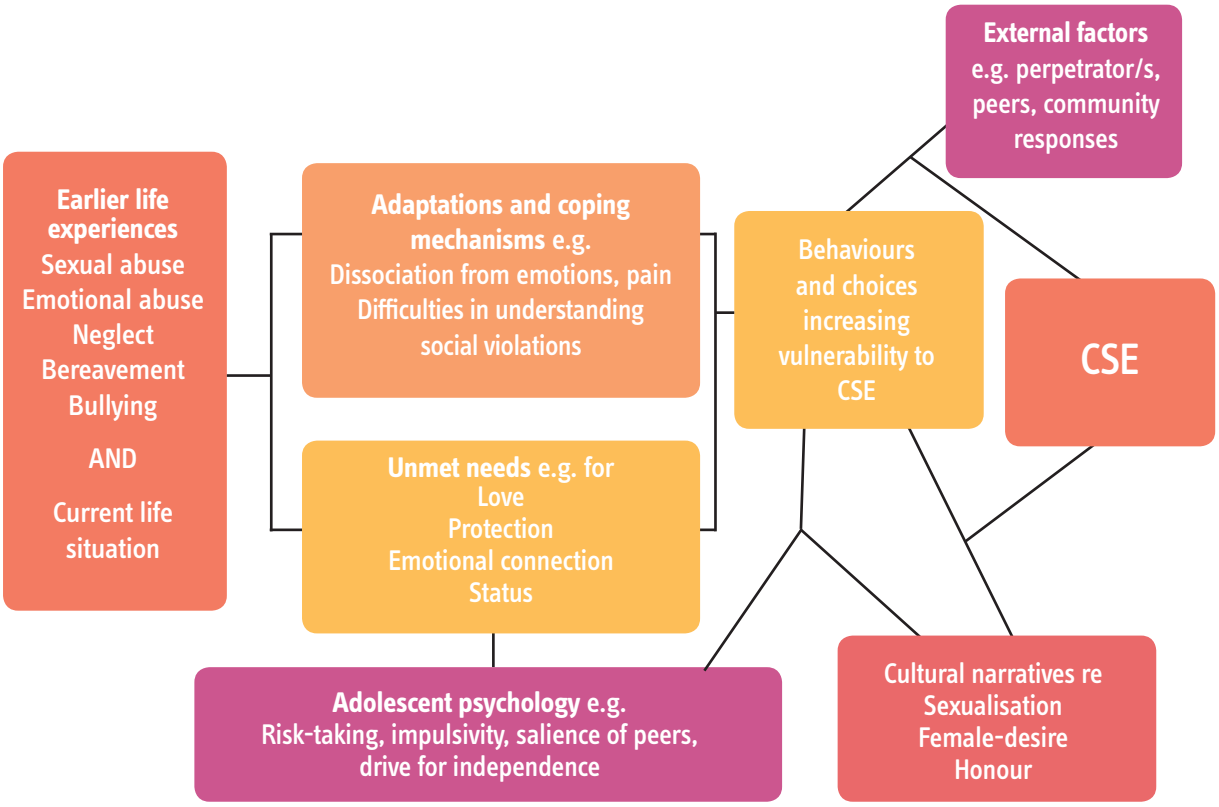


Figure 1 *An illustration of the presenting and underlying causes for CSE*

Local and national strategies to address CSE may overlook some of the underlying causal pathways to risk, focusing instead on adolescent 'behaviour and choices' and 'external factors' such as disrupting perpetrator activity. Whilst understandable, this approach translates into practice whereby symptoms are managed rather than individual causes addressed. Recognising these underlying causes should not, of course, detract from the clear responsibility held by perpetrators.

4 Promoting resilience

What is resilience in adolescence?

Resilience is the process by which an individual avoids or overcomes the negative effects of risk exposure (Fergus and Zimmerman, 2005). Arguably, several types of resilience are evident during adolescence:

- avoiding risks that adolescents are predisposed to following earlier adversity or maltreatment in childhood – for example, avoiding sexual re-victimisation
- avoiding serious risks (such as substance misuse) that adolescents may be predisposed to by virtue of their developmental stage (these overlap with the category above)
- avoiding significant risks in the environment – for example, avoiding victimisation in a violent neighbourhood
- avoiding longer-term harm associated with any of the above sets of risks – for example, avoiding addiction following substance misuse, or finding well-being and stability after an episode of running away.

It is important to have a clear understanding of what kind of resilience a service or a practitioner is seeking to support when directing resources and defining purpose.

Resilience is promoted by assets that reside within the individual, such as self-efficacy (the belief that one's own efforts can make a difference), social skills, reflectiveness, and a willingness to try new things. Typically, these are 'assets' that can be taught (see Reivich and Shatte, 2002). Resilience is also promoted by resources that exist within the social systems around the young person (also termed family and community assets); examples are authoritative parenting, having a trusted adult to turn to, and a positive school culture. (Demarcation between assets that reside *within* the young person and those that exist within the systems *around* the young person are not always clear, however.) Most resilience occurs when promotive factors feed into and enhance one another, setting up positive spirals and pathways. So for example, a willingness to try new things might enable a young person to try mentoring, which then builds their self-confidence and enables them to apply successfully for a work placement (and so on).

Pitfalls when thinking about resilience

There are a number of pitfalls to be avoided when thinking about 'resilience'. One is that the term is sometimes used in a way that implies resilience is a static individual trait residing within a person (*'he's a resilient boy'*). This can be unhelpful as it detracts attention from promotive factors in the child's social spheres (and thus opportunities to build resilience may be missed) and places too much responsibility on the child for their response to adversity.

Furthermore, although there are some general themes (reviewed below), there is no single set of factors that promote resilience in the face of all risks. What enables adolescents to avoid offending when they grow up in a deprived neighbourhood may well differ from what helps them overcome the negative consequences of bullying.

And paradoxically, as discussed earlier,

rather like an inoculation, at times what promotes resilience in the face of risk is some degree of risk itself.

This can be a particular challenge for services and practitioners who might feel anxious about allowing or accepting risk as part of their professional role.

Lastly, resilience has its limits and efforts to promote resilience in the face of risk should never be at the expense of action to reduce significant risks. While overcoming the impact of maltreatment is a desirable outcome, it would have been far better not to have experienced maltreatment in the first place. And in the face of certain forms of adversity, it is likely that some negative impact will always remain.

Factors that help adolescents overcome or avoid the negative impact of risks

Earlier in the paper, we explored the ways in which adolescent development creates vulnerability to certain risks; in parallel, there are many aspects of adolescence that make it a fertile period in which to grow resilience. For example, as social circles widen and diversify, new friendships and relationships bring opportunities to build self-esteem and trust. With the right support, adolescents' increasing agency and knowledge can help them seek help for difficulties and escape negative trajectories. And in certain contexts, even risky decisions made by adolescents can promote resilience; for example, when a young person is exposed to the world of sex work in their home environment, running away can in fact reduce the likelihood that they will be sexually exploited (Klatt et al, 2014).

Resilience is most likely when a child's assets, including those afforded by adolescent development, are met with support, experiences and opportunities.

When a young person's increasing agency is matched with engaging and feasible opportunities to learn and train, to help others, or to participate in decisions that affect them, then key skills and resilience-promoting beliefs develop. This can create a virtuous cycle – for example, through supporting others a young person may come to believe more in their own self-worth and self-efficacy and to develop aspects of their own identity, all of which in turn promote their take-up and indeed creation of further opportunities.

Teens and Toddlers

Teens and Toddlers is an early intervention programme that targets two sets of vulnerable children simultaneously, by pairing young people aged 13 to 16 from disadvantaged areas with children at local nurseries who are in need of extra support. The 18-week programme is run as a partnership between the voluntary sector, the local authority, schools and nurseries, and is currently offered in 17 London boroughs, eight local authorities in the north-west and a small number of others. Each young person spends time every week at nursery with their paired toddler, playing with and supporting them. Young people also attend classroom sessions aimed at developing relationship skills, aspirations, awareness of strengths and useful knowledge for navigating risks and life ahead. Through the programme, 92 per cent of graduates achieve an NCFE Level 1 QCF qualification in interpersonal skills. Research indicates that the programme heightens young people's self-confidence, positive decision-making and behaviours, relationships, and their further engagement and achievement in education, employment or training (Humphrey and Olivier, 2014). See www.teensandtoddlers.org

At all ages of childhood, authoritative parenting protects against the experience and impact of risks. This parenting style is characterised by love and warmth paired with actively communicated boundaries and high expectations. It helps young people to avoid substantive risks associated with adolescence, such as substance misuse or disengagement from education (Chan and Koo, 2011). On the other hand, achieving or sustaining this form of parenting can be particularly challenging when children reach the adolescent stage (to some degree it will depend on the adolescent's 'willingness to be socialised' – Smetana et al, 2006); and if children do get caught up in risks, parenting can be further compromised. (Re-)establishing authoritative parenting in these situations is one of the most promising routes to reducing harm – for example, via intensive family interventions, the relational safeguarding model (described in Section 9), or support utilising the care system.

More generally, relationships with trusted adults promote resilience in a number of inter-related ways – for example, by:

- developing young people's self-esteem, trust, hope and sense of belonging
- helping them to find and make the most of opportunities
- enabling them to recognise and safely disclose maltreatment or difficulties
- developing their abilities to act self-protectively and to apply their interests, values and aspirations effectively
- helping them tackle difficulties (logistical, psychological or other) that contribute to risks (Adamson and Poultney, 2010; Allnock and Miller, 2013; Cossar et al, 2013; Dooley and Fitzgerald, 2012; Rees et al, 2010).

Perhaps most fundamentally for vulnerable young people, the ongoing words and actions of such an adult demonstrate that the young person is someone to be valued and that other people can have positive intentions and be trustworthy. These fundamental messages counter those from other times or spheres in the young person's life and help create a springboard for broader engagement in life.

The powerful influence of having a positive relationship with a trusted adult is critical to addressing risks and promoting resilience in young people.

Research has consistently documented the risks to young people when such relationships are absent – for example, depression, suicidality, self-harm and the continuation of abuse (Allnock and Miller, 2013; Dooley and Fitzgerald, 2012).

A specific example of a positive and resilience-promoting relationship is the mentoring of at-risk young people (DuBois et al, 2011). At its heart, this involves a strong and meaningful personal connection between a young person and their (voluntary) mentor. The successes of mentoring depend on it following certain principles and are likely to lie in the scaffolding it provides for the development of the adolescent's skills and positive identity (Rhodes, 2005).

Successful mentoring can involve adults or peers as mentors (DuBois et al, 2011). Peer support or mentoring has the additional benefit of promoting resilience for both parties. Vulnerable young people appear to particularly value receiving support from those who are 'close' to the difficulties they face or who have had similar experiences themselves (for example, see Coffey, 2014).

Finally, as a developmental stage that inevitably involves certain risks, adolescence should perhaps be re-conceptualised as something for which we, as a society, need to build resilience (that is, beyond resilience in the face of particular individual adversities). In other words, policy, practice and daily interactions should all employ and reflect the principle of 'helping to keep adolescents safe and well' through this life stage.

5 The interplay between choice and risk in adolescence

Choice is an aspect of risk that is rarely explored explicitly. Yet arguably:

many adults and professionals have opinions on choice that are implicit and which guide their approach to adolescents, often in counter-productive ways.

Some appear to view many of the harms that young people experience as having been freely 'chosen' in a way that is comparable to an adult choosing to engage in an activity – hence the use of terms such as 'lifestyle choice' applied to risks such as sexual exploitation. Others appear to take the opposite view, perceiving those same adolescents as straightforward victims of their circumstances, similar perhaps to younger children; from this perspective, the role of the adolescent's emerging agency in risks and resilience is minimised. (See media articles on the Rochdale sexual exploitation scandal from 2012 onwards for examples of professional perceptions of both types of misconception).

We need then to unpick these suppositions in order to formulate a more accurate, nuanced and ethical perspective that can usefully develop the principles behind practice. By considering the ways in which adolescent choices and behaviours are affected by development and prior adversity, as well as the ways in which they can feed into resilience (all explored above), we can reach some related conclusions:

- Adolescents' choices and behaviours increase the likelihood that they will experience some risks (such as gang-involvement and some types of sexual exploitation, to name just a couple) and the harms associated with such risks.
- However, these behaviours and choices are a part of a complex aetiological jigsaw and cannot be seen in isolation as leading to harm.
- Where choice and behaviour are playing a part, this is typically because one or more of the following factors or processes are at work (and often interacting):
  - normative adolescent developmental processes (eg risk-taking, peer-influence, the desire for 'high-status' relationships)
  - adaptations to previous maltreatment and adversity (eg emotional numbing, difficulties detecting violations in social relationships, hyper-vigilance)
  - societal attitudes, policies and practices that interact with adolescent choice and behaviour to increase risk or harm (for example, responding to youth offending in ways that inadvertently reinforce criminal identity).
- In other words, adolescent choice and behaviour in risk is constrained by developmental processes and the actions of others in their past and present, including choices that are in fact adaptive responses to previous harm.
- These constraints can mean that an adolescent's choices and behaviours are, at times, not in their longer-term best interests. Like all of us, however, young people will also always have goals, aspirations and values that are consistent with their longer-term well-being (eg Opinion Research Business, 2000). These may be relatively hidden (and as discussed, may indeed be underpinning risky behaviours – see Pitts, 2013, for a discussion of this in relation to gangs), but young people can be supported to apply them in different ways that have longer-term benefit.
- Constraints on choice and behaviour mean that adolescents are less responsible for their actions than adults making 'lifestyle choices'. And of course, in any scenario where a person is acting to harm a young person, the responsibility for the maltreatment rests with that perpetrator, whatever the contribution of the victim's choices to their own vulnerability.

This understanding leads to crucial implications for practice:

- When adolescent choices and behaviours are seen to be playing a part in the risks that adolescents are experiencing, it would be erroneous (as well as harmful) to conclude that those choices are 'informed' and that adolescents are acting with complete 'free will' and have full responsibility for their actions.
- In parallel, it would also be inaccurate in these situations to minimise or ignore the decisions and actions of adolescents and the part they are playing.

If we do not recognise and work with adolescent agency and choice, it will remain a potent force in their various vulnerabilities.

- Reducing risk therefore involves working with young people (and key people in their worlds) to help them free themselves from unhelpful constraining forces (such as low self-esteem) and to channel their skills and developmental propensities (such as risk-taking, developing independence) towards acting in line with their aspirations and best interests. This is about empowering young people and is a key mechanism in promoting resilience.
- Such an approach is likely to be most effective (and most ethical) when it is part of a broader package that also includes: a) working with any perpetrators and groups likely to inflict harm on young people, and b) a shift in any policy and practice that 'ensnares' young people by interacting with adolescent choices to increase the likelihood of risk and harm, often for the long term.

Discussion in this section has so far been concerned only with risks where adolescent choice and actions are playing a part. There are of course risks where this is not apparent, such as parental neglect driven by parental substance misuse. In these situations, working with adolescent agency may not be as critical to reducing immediate risk; it is likely to be just as important in building longer-term resilience, however.

The recent report examining the failures to recognise and respond effectively to endemic sexual exploitation in Rotherham (Jay, 2014) is not the only analysis to have found evidence of professionals minimising the abuse of adolescents, in part because they had come to erroneous conclusions about the nature and role of adolescent agency in the abuse ('lifestyle choice' narratives). Outrage at this stance and the role it played in perpetuating abuse is not misplaced. However, offering instead a simplistic narrative of adolescent passivity is unhelpful. What we are arguing here is that a nuanced perspective of adolescent choice and behaviour in risk represents a useful 'third way'. This always places responsibility for any abuse with the person perpetrating the abuse, whilst recognising that constrained choices and actions on the part of young people can increase their vulnerability to some risks. Harnessing and channelling their agency is key to young people escaping these risks and building resilience.

This principle might be summed up with the phrase that is used to describe patient experience in the promotion of health reforms – 'nothing about you without you.' The reality of engaging with adolescent choices effectively is challenging, especially where adolescents are caught up in serious risk. In the next section we consider some of the issues around engagement and their implications for improving practice.

6 Overcoming challenges to engagement

We define engagement here as the process by which a practitioner and a young person and/or their family connect in an authentic relationship, committed to achieving certain goals together. Such relationships can be considered the bedrock to effective practice, but they often appear to be missing when we review how young people have been supported. It is worth unpicking some of the reasons why engagement is challenging.

Challenges to engagement

Some risks that adolescents experience are what has been termed 'ego-syntonic', which means that to a greater or lesser degree individuals are attached, committed or 'pulled' to those risks. Self-harm, eating disorders, drug misuse, running away are all clear examples; sexual exploitation, gang involvement, and partner abuse may also fall into this category ('pull factors' for some of these risks are explored above).

If risks are meeting some of the young person's needs in the short term, then the young person may be resistant to engaging with people or processes intent on removing those risks. This compels practitioners to understand the underlying drivers for risky behaviours, rather than treating the symptoms of it.

Many interventions also 'go against the grain' of the forces driving adolescent development. For example, interventions that are perceived to be about adult control conflict with the adolescent desire to grow in independence; interventions that force young people to 'stand out from the crowd' conflict with the importance of status and conformity among the peer group (ie risking the loss of social capital); and those that require a focus on distant goals or sanctions conflict with the propensity to focus on shorter-term horizons.

Overcoming challenges to and securing engagement

Interventions are most effective when they do not just *avoid* conflicts with adolescent development, but in fact take account of them and utilise them as a strength. For example, interest in risk-taking may encourage young people to participate in interventions that aim to develop such things as social skills, family relationships and self-belief through experiencing adventure in the natural world (for a description of Capable Families, see the box below and also the Appendix of Practice Examples that accompanies this briefing).

Capable Families

Capable Families is a set of family activity programmes based on systemic therapeutic practice run by Families Forward, a non-statutory team within children's services at the Royal Borough of Kensington and Chelsea (RBKC). Referrals are received from social workers and cases remain open to a social worker throughout the programmes' duration. Referral criteria include a young person being on the edge of care (linked to imminent risk of family breakdown) and a history of poor engagement with other services. Referred young people are often caught up in complex difficulties such as substance misuse, gang involvement, offending and exploitation.

Activity programmes include kayaking, climbing and survival, film, and gym and sports. Each involves a set number of sessions and outings in which coaches teach family members the skills involved in the activity, while systemic practitioners use the opportunities that arise from learning, facing challenges and doing something new to help families develop more positive narratives about strength and connection and to challenge negative views.

Exercises and games that strengthen communication, increase personal risk management and challenge power dynamics are integral to the programmes. Many of the programmes involve learning to handle and manage risk as a family – for example, the River Thames can be a dangerous environment in which to navigate a kayak. And when activities are more relaxing, opportunities also arise to talk about life, hopes and relationships in a natural and useful way.

These are some quotes from those who have taken part:

'Gave us time and helped our relationship.'

'We felt really good about ourselves.'

'We learned something about camping but also about what matters in life.'

Similarly, 'irreverent' interventions such as Dialectical Behaviour Therapy (see box below) may appeal to young people's desire to step away from conformity to authoritative rules and restrictions.

Dialectical Behaviour Therapy (DBT)

DBT is a therapeutic approach originally designed to help adults who suffer from a constellation of difficulties such as chronic self-harm, high risk-taking and relational victimisation, underpinned by insecure attachment patterns (Linehan, 1993). However, it has since also been applied to adolescents to good effect (Fleischhaker et al, 2011). DBT involves weekly individual and group sessions (supplemented by telephone support when necessary) focused on teaching four skill sets: mindfulness, emotional regulation, distress tolerance, and interpersonal effectiveness.

Part of DBT's general success – and its specific appeal with adolescents – may be its irreverent and paradoxical dimensions. For example, DBT eschews 'good advice', encouraging people to focus on doing what works for them and building a life worth living (appealing to adolescent drives towards independence and helping them connect to their goals and values). It also faces problems full on through 'radical acceptance', thereby embracing young people's often intense emotions, while at the same time inviting and empowering them to make the changes that work for them.

A DBT service specifically adapted for looked after adolescents is delivered in Oxfordshire. The service (which is funded by pooling money from health and local authority children's services) includes engagement sessions, weekends away, and consultation to carers and professionals to help create a validating and DBT-supportive environment outside of sessions. An evaluation has shown significant reductions in young people's depression, hopelessness and self-harm (James et al, 2011); and initial cost saving estimates suggest savings in the region of £150,000 per year (in which 37 referrals were received) (Alfoadari and Anderson, undated).

On a related note, it can also be a struggle to engage young people if they sense that the support or intervention might destabilise fragile approaches they have developed themselves to cope with their problems. For example, there might be a fear that talking about difficulties will unleash overwhelming emotions, which have otherwise been blocked through alcohol misuse. Adolescents may also fear that engagement might lead to them feeling worse about themselves, for example through feeling stigmatised, blamed or 'problem-saturated'. Conversations that start with the problem and then stay focused on the problem can unwittingly convey all these things to a young person. In contrast, strengths-based, resilience-oriented and solution-focussed conversations can surprise young people with their positive assumptions and invite the development of wanted and empowering identities – this yields multiple benefits, including being inherently engaging. (For examples of this type of approach in practice see Clark, 1998; and Djukic, 2007).

Engagement can also be difficult when a young person's ability to trust others, in particular adults, has been significantly compromised by, for example, maltreatment within the family, and/or fleeting relationships with multiple professionals, the latter often driven by organisational constraints and practices (The Care Inquiry, 2013). Because of these past experiences, adolescents may struggle to believe that others will keep their commitments, have the right intentions, and/or, most fundamentally, be able to help them in any meaningful way (see Coffey, 2014, for some examples).

When a young person feels this way, they may adopt a (protective) disengaged and resistant stance, which further hinders the formation of such relationships – even though they often want to be proved wrong and to have a reason to shift their beliefs. What is often effective in this situation is to develop, through persistence and outreach, a relationship with that young person in which the adult consistently delivers on their commitments. Advocacy and practical help may be useful, both in and of themselves and via the impact they have on developing a young person's belief in their own worth and the efficacy of others.

There are a number of examples of this type of approach in the voluntary sector; one is the Barnardo's BASE team in Bristol which supports young people caught up in sexual exploitation and related difficulties. For more information go to: www.barnardos.org.uk/basebristol/base_what_we_do.htm

Supporting those who work with adolescents

Lastly, if workers are not effectively supported in the complex task of engaging and understanding adolescents facing risk, then disengagement by young people can prompt practice that exacerbates it further. Many of those who work in this challenging field are employed in non-professionally accredited roles (for example, residential children's home staff, mentors, or schools support workers) where clinical case supervision is not provided and/or expected. For those who work with them, adolescents' choices in the risks they face can feel confusing.

Without support to help them understand adolescent choices, harness adolescent agency and build engagement, workers can be left feeling demoralised and disempowered. They may also have little support to deal with the emotional impact of working with high levels of risk and frequent rejection, and can feel isolated and without the necessary levers to achieve change.

When adolescents prove hard to engage, the isolation and lack of support experienced by many practitioners can convey 'permission to give up'. This message is often implicitly also communicated via organisational policies – for example, in relation to termination of services following non-attendance. Young people, especially those who have experienced rejection or maltreatment in the past, are often attuned to signs of rejection, including 'giving up', and may respond with further disengagement. (For research exploring the links between maltreatment, rejection sensitivity and avoidant attachment, see, for example, Feldman and Downey, 1994.)

Table 3 summarises the factors that can hinder engagement and suggests initial strategies for overcoming or avoiding them.

Driver of engagement challenge	Suggested initial strategy
Ego-syntonic risk ('*a part of me wants to keep this problem*').	Explore what needs the risk is meeting and aim to meet them in other ways. Consider Motivational Interviewing to help a young person connect with what they most want in the longer term and to develop their belief in their ability to change (Barnett et al, 2012; Feldstein and Ginsburg, 2006).
Interventions 'go against the grain' of adolescent developmental drivers.	Restructure interventions to 'go with the grain' – eg involve high levels of adolescent participation, build social capital, include some risk-taking.
Adolescent fears that fragile coping mechanisms will be destabilised.	Identify and discuss the fears; in collaboration, formulate a plan to avoid destabilisation.
Adolescent fears feeling worse about her/himself.	Use strengths/resilience/solution-focused strategies.
Adolescent has low trust or belief in adults' ability to help.	Develop a persistent, outreaching relationship that helps to meet the young person's immediate needs, for example involving advocacy or practical help.
Professionals demoralisation; spirals in operation that give implicit 'permission to give up'.	Ensure supportive supervision focused on complex issues, such as choice and engagement, in parallel with being part of a supportive network of workers and agencies.

Table 3 *Some factors behind engagement difficulties and how they might be addressed*

7 The case for change

By drawing on research to understand risk and resilience in adolescence, and exploring evidence of effective services and approaches from existing practice, the case for system-wide change becomes compelling.

Although a good deal of strong practice does exist, all too often services do not recognise or respond to underlying causes of risks, do not adequately 'work with the grain' of adolescent development, do not consistently draw on the strengths of young people, their families and peers, and do not support practitioners sufficiently to manage the complexity involved in working with adolescent risk.

Researchers, commentators, those working within relevant services and young people themselves have observed that, too often, the response of the system is unacceptably ineffective. For example:

- Many young people still find it hard to disclose risks they are experiencing (eg Allnock and Miller, 2013; Cossar et al, 2013).
- Authentic and sufficiently intensive long-term relationships are often not part of the service response (eg Coffey, 2014).
- In comparison to those facing younger children, for example, the risks young people face (and their impact) are often minimised (Gorin and Jobe, 2013).
- Risks that differ most significantly from those faced by younger children are often ignored by existing systems or inappropriate responses are applied, such as dislocating young people from their peers and school communities (eg Firmin, 2013a and 2013b).
- Interventions are often used which 'go against the grain' of young people's agency and development; disengagement can promote further exposure to risk (for example, at the extreme end, running away from care placements).
- Care placements too often place young people at risk and break resilience-promoting factors (DfE, 2013b; The Care Inquiry, 2013; Jay, 2014).
- Too few young people are offered effective support to recover from the impact of harm and to prevent revictimisation (eg Jay, 2014; Allnock et al, 2009).
- System structures can result in young people feeling stigmatised and labelled (Byrne and Brooks, 2014; O'Mara et al, 2011).

The cumulative affect of all this – and therefore the most obvious risk of all of – is greater levels of abuse, harm and suffering experienced by young people, and the often highly negative impact this has on their childhood and on into their adult lives.

The system continues to expend scarce resources in ways that are not only ineffective but also incur further costs at later stages – for example, via mental health interventions and custody in later adolescence and adulthood
(House of Commons Health Committee, 2014).

So what might systems and practices that are effective at reducing risks for adolescents, and at fostering resilience in the face of them, actually look like?

Arguably they would:

- be proactive in building a picture of the distinctive risks that adolescents face, recognising contributors, their inter-dependency and their impact
- plan approaches that address these risks as well as their antecedents and their consequences (often across a range of social spheres)
- prioritise authentic relationships and broader resilience-promoting factors in this process
- work in partnership with the young person and their families (where possible)
- support the workforce to understand the evidence, and manage the challenge and complexity that this work involves
- avoid harmful practices such as labelling young people according to their risks or behaviours, or maximising or minimising their agency in risks.

All of this would, of course, rest on standard good practices, such as embedding and applying evaluation and involving young people in service design and delivery.

All this is convergent with the many creative, engaging, and likely effective, adolescent-friendly approaches and services being developed and delivered locally across the UK. However, more widespread reform would be further enabled by:

- appreciation of the cost-savings involved: although there are up-front costs involved in delivering the shift discussed above, there are far more substantial costs involved in maintaining the status quo (see for example Godar, 2014).
- understanding and applying the now rich understanding we have of adolescent development, risk and resilience to shape practice
- a willingness to put aside archaic system responses that were not designed to tackle the risks adolescents face in the UK today
- joining the growing movement towards appreciating children's rights, in particular for meaningful participation
- making the most of the opportunities afforded by digital technology, the drive towards localism, and the austerity-drive push to 'do something more with less' (Byrne and Brooks, 2014)
- developing a spirit of creativity in partnership: for example, leaders applying this evidence to innovate in their local areas, with the involvement of young people, families and the workforce.

As part of this 'enabling' process, the remainder of this paper explores how our increased understanding of adolescence, risk and resilience could be applied to practice.

8 Emerging principles for effectively addressing adolescent risk

What we now know about adolescent risk and resilience, development and adaptation has key implications for improving practice, which dovetail with those arising from effective and promising interventions with young people. We have attempted to articulate these implications in the form of seven principles that appear to be *particularly important for effective practice with adolescents*. These are outlined in Table 4, which also provides a brief rationale for each principle, and – in the extended stand-alone version of the table - examples of their application in practice.

Our seven principles align well with others designed for inter-related areas of practice with adolescents. For example, in their six principles 'to shape thinking about young people's health', Public Health England include: putting relationships at the centre, focusing on what helps young people feel well and able to cope, and championing integrated and accessible services (PHE, in press).

An important caveat is that the seven principles are not stand-alone. Rather, they are designed to complement long-standing principles for best practice in addressing risks across the age range (see for example Munro, 2011). A baseline framework for tackling the serious risks children face is largely embedded across the sector; it includes:

- multi-agency communication
- drawing upon resources, skills and responsibilities across agencies and services
- close attention to vulnerability at transition points
- a focus on developing resilience and strengths
- embedding ongoing evaluation and application of its results
- children's participation in service development, delivery and evaluation
- tackling the spectrum of risks in a child's life
- intervening early in the life of a problem
- being a part of a wider strategy, which includes primary and secondary prevention approaches.

Principle	Rationale and further explanation
1: *Work with adolescent development*	> If we do not recognise and work with adolescent agency and developmental drivers, they can remain a potent force in adolescent vulnerabilities. > Resilience develops when young people are given opportunities to connect with, and apply positive decision-making to, their aspirations and values. > It is vital to avoid policies and practices that respond to adolescent choices and behaviours by constraining positive development and inadvertently 'ensnaring' them (see Section 3). As such, avoid responses that 'do to' adolescents rather than 'work with' them.
2: *Work with young people as assets and resources*	> This directly builds young people's self-esteem, skills and confidence, while more generally utilising their strengths and insights to develop services and responses that are most effective. > Young people's voices are a source of important and useful information regarding practice quality, organisational performance and local needs.
3: *Promote supportive relationships between young people and their family and peers*	> Authoritative parenting is arguably the most effective means for helping most young people chart a safe course through adolescence. > Other family relationships (eg between parents, siblings, extended family) can also powerfully build resilience. > Peers are critically important to young people and peer relationships have the potential to promote specific social skills and sources of self-esteem. > Together, positive family and peer relationships enable young people to access and make the most of their opportunities, to build key skills and develop positive beliefs about themselves and others, and to recognise and disclose any risks they are facing.

4: *Prioritise supportive relationships between young people and key practitioner(s)*	> Both research and practice consistently point to the central role that supportive, committed relationships between keyworkers and young people play in successfully reducing risk and building resilience. > Barriers to a relational approach include service boundaries that are thresholds-based rather than needs-led – leading to multiple people working with a young person and frequent changes of lead worker; practitioner low self-confidence; and inspection and governance that is overly focused on processes rather than outcomes.
5: *Take a holistic approach both to young people and the risks they face*	> Working narrowly with young people around a single difficulty or risk can: a) label and so constrain young people; and b) miss the opportunity to utilise their skills, aspirations and other strengths. Young people recognise this and have concerns about overly targeted programmes (O'Mara et al, 2011). > In addition, risks often coalesce and intersect during adolescence, and come from a wider variety of contexts than those faced by younger children. They also have complex aetiological pathways that involve a combination of environmental and psychological factors – both need to be addressed to avoid risks persisting or re-appearing. > In this context, it is arguably most effective to build an approach based on a holistic assessment of the risks a young person is experiencing (and their contributors) as well as a holistic understanding of strengths (as opposed to multiple services dealing with discrete risks, often with limited attention to their contributors or intersections).
6: *Ensure services are accessible and advertised*	> Approaches are likely to be most effective if they provide support when adolescents need and want it; and when they are responsive to adolescent agency (without requiring that agency to be comparable to that of an assertive and informed adult who can navigate complex referral pathways). > In other words, for young people to be able to make positive choices, they need to know about the range of positive options. This may require advertising and outreach to articulate the benefits.
7: *Equip and support the workforce*	> Young people can be difficult to engage, due to adaptive features of adolescent development and adaptations to previous life experiences. Sometimes multiple experiences of being 'let down' by the system can contribute. > A nuanced view of the risks a young person is facing, including an understanding of any choices they are making and why, can take time to arrive at; but this is essential in order to map a way forward and avoid demoralisation and disengagement. > Working with young people experiencing high levels of serious risks can be vicariously traumatising. While such works *requires* connection with young people, connection can come at a high emotional cost for practitioners. > Young people want ongoing relationships. Obviously, these are more likely to occur if organisations are successful in retaining staff over the longer term.

Note: This is a summary version the principles and their rationale. A stand-alone version of this table, offering examples of how these principles can be applied in practice can be found **here.**

It is worth noting that these principles closely intersect, so that fulfilling one often requires attention to others. For example, working with adolescent agency and development typically requires prioritising supportive relationships, so an example of one is often also an example of others. However, they each have a distinctive message.

9 Explicated examples – the principles in practice

This section explores in more depth the seven principles set out in Table 4 (see Section 8) and considers some examples of those principles practice. (Other practice examples are highlighted in earlier sections, and see also the Appendix of Practice Examples that accompanies this briefing.) Both the principles and their exemplars are likely to be most useful when read as inspiration and ideas for ways forward, rather than as a constraining or finite list.

We are at an early stage of building a distinctive and more effective approach to tackling risk in young people. In this context, leadership and innovation accompanied by evaluation can have a big impact on driving forward positive change. At the same time, small changes to everyday practice can also make a significant difference.

Here we describe examples from across this range, drawn from the international arena and UK local areas. We focus on practice in children's services, as well as considering effective ways of working across a range of agencies.

Principle: *'Work with adolescent development – particularly perception, agency, aspiration, and skills'*

If adolescent decision-making, behaviour and aspirations are contributing to adolescents' experience of serious risk, it makes sense that those risks are likely to reduce if we engage with young people to help them instead utilise these things to fulfil goals that are in in their longer-term best interests. Young people will always have aspirations for a positive future. However, they may need support in accessing, developing and acting upon those hopes. We also need to build a system that hears and takes seriously adolescents' sense of threat (as this will often, accurately, perceive risk where systems do not – see, for example, Rees et al, 2011) and supports their attempts to protect themselves.

As with each of these principles, multiple examples of how they might be applied in practice are listed in Table 4. A few are outlined in more detail below.

Open-access emergency accommodation

In Denmark, Germany, France and the United States young people can themselves access emergency accommodation directly if, for example, they have run away from their family, foster care or residential home. This emergency accommodation is well publicised and is sometimes linked to counselling, a telephone helpline and family therapy where appropriate (Boddy et al, 2009; Slesnick, 2004).

Invitational, narrative, and appreciative inquiry 'therapeutic' approaches

These approaches converge in helping young people to separate their sense of self from their difficulties, so that the problems they face no longer act as a constraint on their developing identity and actions (see McAdam and Lang, 2009; Morgan, 2000; Slattery, 2003). Such approaches also raise young people's awareness of their own skills, strengths, values and aspirations, so that these develop and become a stronger influence in their lives. These 'therapeutic' approaches can be used in day-to-day interactions with young people, as well as formal therapy.

Principle: *'Work with young people as assets and resources'*

Although individual practitioners are usually committed to listening to young people and involving them in decisions that affect them, the 'system' often does not enable young people to actively contribute to decision-making. Barriers to participation can be found in processes that deter young people, such as child protection conferences (Gorin and Jobe, 2013), or in structural elements, such as looked after young people not being enabled to share decision-making about their care placement (The Care Inquiry, 2013).

Given the evidence discussed above regarding young people's ability to understand risk and to provide support to others facing risk, the failure to draw upon young people as assets and resources is a significant missed opportunity.

Young people also have much to offer in terms of supporting service design, though too often efforts to involve them are tokenistic (Cavet and Sloper, 2004). Schemes such as the Young Inspectors Programme[5] and youth councils can be effective. However, given the current marginalisation of some adolescents facing risk, particular attention should be paid to involving those young people in the continuous improvement of specific services designed to address risk.

Street Safe Lancashire

Street Safe Lancashire is a voluntary sector service working with children and young people at risk of CSE and other forms of harm. (The service works as part of Lancashire's four multi-agency CSE teams.) Each young person supported by Street Safe has the opportunity to contribute their views and knowledge in a variety of ways, including one-to-one, in group-work, and in writing or pictures. The 'Purple Monsters' group consists of young people who have experienced CSE coming together to share their thoughts, support others and influence services. The group has produced a booklet for professionals on 'How not to work with young people' full of personal stories, comments, poems, pictures, advice and guidance. This appears to be increasing identification and engagement of vulnerable young people. Young people also contribute to service improvement by feeding in their views through one-to-ones with an independent worker, speaking at conferences and contributing towards the development of other guidance for professionals.

For more information go to http://speakoutlancashire.org.uk/?page_id=181 and see also the Ofsted good practice example: 'Involving children and young people in developing the services they receive: Street Safe Lancashire' (2013), available from www.ofsted.gov.uk/resources/goodpractice

Principle: *'Promote supportive relationships between young people and their family and peers'*

Given that 1) risks facing young people often arise from outside their home environment, 2) authoritative and supportive parenting promotes resilience across a range of risks, and 3) this form of parenting is often compromised in situations of high risk (for example, gang members or CSE perpetrators isolating young people from familial support), it makes sense that any safeguarding strategy for young people should prioritise supporting families to support their adolescent (unless assessment reveals contraindications).

Family support workers and the *'relational safeguarding model'*

PACE (Parents against child sexual exploitation) have devised the 'relational safeguarding model' to improve the safeguarding of children in families affected by child sexual exploitation. The model has been implemented in partnership with local agencies in Oxford, Rochdale and across Lancashire. It is a flexible model of practice that both engages with parents as partners in the safeguarding process and supports them in dealing with the practical and psychological impacts of CSE upon the whole family. Practice is based on the assumptions that parents want their children to be safe and are central assets in the task of achieving this. Although the model can be implemented in a variety of ways, PACE argue that it can be most easily achieved by embedding an independent parent support worker (IPSW) within teams that work with CSE, alongside changes to organisational cultures which traditionally identify parents as a threat to safety (PACE, 2014). A recent independent evaluation in Lancashire indicates positive outcomes of this approach (Palmer and Jenkins, 2012).

For more information go to www.paceuk.info and see also The Relational Safeguarding Model: Best practice in working with families affected by child sexual exploitation (2014) www.paceuk.info/wp-content/uploads/2013/11/Relational-Safeguarding-Model-FINAL-PRINTED-May-2014.pdf

[5] More information on the Young Inspector approach can be found at http://www.participationworks.org.uk/topics/young-inspectors

Focused family interventions

There are a number of evidenced interventions that focus on improving family functioning (including parenting) in order to reduce serious risks to adolescents, such as substance misuse and homelessness (eg Slesnick et al, 2013; Waldron et al, 2007; Warwick and Kwan, 2011). For example, the Strengthening Families Programme, which aims to reduce substance misuse in particular, helps parents develop authoritative parenting, communication skills and strategies for dealing with stress. At the same time, young people develop skills to help them deal with peer pressure, cope with stress, communicate more effectively and manage their emotions. UK research suggests the programme is effective in reducing early adolescents' substance use, as well as building a range of resilience factors such as family functioning (Coombes et al, 2009).

Another example is Community Reinforcement and Family Training (CRAFT) which works with parents of substance-misusing teenagers to develop their abilities to a) communicate effectively with their child, b) help their child to engage in treatment, and c) support the child's treatment and recovery (Waldron et al, 2007). Both approaches are likely to offer promise in wider application beyond the risk of substance misuse.

Adolescent Support Unit: An alternative to care approach, Blackburn and Darwen

Blackburn with Darwen Council's Adolescent Support Unit is a successful 'alternative to care' model, which provides short breaks for young people experiencing problems within the family and who are at risk of being taken into care. The ASU has been developed over the last seven years by reinvesting funds from the closure of a residential children's home (the council still runs two residential homes). It was developed in the knowledge that some young people do not need to be in care but do need intensive support, possibly over the long term, and that some families need interventions that are available in a crisis 24/7, including 'time out'.

Residential staff are skilled workers trained in a variety of ways to enable them to work with families and young people to improve relationships and family lives on an outreach basis. For example, staff are trained to deliver specialist courses such as Strengthening Families, AIM, Team-Teach and Boys Own. The ASU provides positive opportunities and activities for young people, including canoeing, fishing, cookery and participation in the Duke of Edinburgh's Award scheme. The service has generated significant year-on-year savings, in excess of £800,000 in 2013-14 and with 28 fewer young people being brought into care than when the unit opened. For more information, see www.adass.org.uk/uploadedFiles/adass_content/events/ncasc_2014/2014_Presentations/WI2%20Alternatives%20to%20care.ppt (see also the following Guardian article, from 29 October 2014: www.theguardian.com/social-care-network/2014/oct/29/blackburn-innovative-support-unit-residential-care

Principle: *'Prioritise supportive relationships between young people and key practitioner(s)'*

The centrality of positive relationships with adults has been highlighted previously as a key protective factor for young people at risk. The forthcoming public health framework for young people states clearly that *'Recognising and supporting healthy relationships is central to improving young people's physical and mental health and wellbeing'* (PHE, in press), while young people themselves frequently highlight their frustration at being passed from one professional to another (The Care Inquiry, 2013). Recent reports exploring CSE have also identified the need for young people to have consistent and trusting relationships with adults to help keep them safe (Coffey, 2014; Berelowitz et al, 2012).

Evidence-based mentoring programmes

Evidence-based mentoring programmes (DuBois et al, 2011) develop resilience in young people by building and developing skills (such as social skills and the ability to regulate emotion), a sense of identity and belief in oneself and others. Mentoring programmes are most effective when there is a) a good 'fit' between the mentor and the young person, b) adherence to core principles (such as mentor screening, support and training), and c) a focus beyond general non-directive 'chat'. These latter points highlight the critical importance of ensuring mentoring interventions are well-resourced, and designed to include robust support for mentors. Peer mentoring is not a cheap option.

Chance UK is a model of focused mentoring (linked to other sources of support) for primary school children with behavioural difficulties, which holds promise in preventing gang involvement and sexual exploitation. For more information, go to: www.chanceuk.com

Principle: *'Take a holistic approach both to young people and the risks they face'*

One challenge of tackling the inter-related risks that young people face is that services and practice too often delineate between those risks and between causal and resultant risks. This creates spurious boundaries, and fails to recognise that an holistic approach is needed.

Regular well-being enquiries

Research has shown that a significant number of young people do not disclose maltreatment because they have few opportunities to do so (Allnock and Miller, 2013; Cossar et al, 2013). Regularly and authentically 'checking in' with young people about how they are and what is going on for them communicates that the person asking 'cares' (which is key to facilitating disclosure) *and* provides an opportunity to discuss matters that are significant.

These conversations can also develop a young person's ability to recognise abuse and take what protective action they can (Cossar et al, 2013). Practitioners can make well-being enquiries (undertaken in a natural and genuine fashion) as part of their routine practice, as well as prompt parents and carers to do so.

Generic adolescent services

Generic adolescent teams have great potential to offer relationship-centred, participatory and 'informalised' support. One example is the Surrey Youth Support Service – see box on following page.

Surrey Youth Support Service

In 2012, Surrey disbanded its youth offending team and incorporated the YOT's functions into a wider youth support service (YSS). The Surrey YSS comprises 11 local teams, and utilises a proactive keyworker approach to help and support young people experiencing one or more of a range of risks. Those risks include homelessness, disengagement from education, employment or training, mental health difficulties (where the young person is open to but not engaged with CAMHS) and offending. The team also work with adolescents categorised as 'children in need'.

A young person's caseworker will work with the young person to understand their view of the situation and to develop a holistic package of support. Support is mostly delivered by the caseworker, who brings in suitably qualified specialists for advice and co-work when required. In this way, the relationship between the young person and their keyworker is developed and harnessed as the central driver of change. Keyworkers focus on young people's strengths and work with the young person to find opportunities to develop these.

The YSS works closely with other council-led teams, such as housing, and also has developed partnerships with public, voluntary and private sector employers and local economic partnerships to provide a route to training and employment opportunities for young people.

This 'one-stop shop' approach and having one individual keyworker means young people don't have to navigate complex pathways (with the associated risks of rejection and delay) and can instead have multiple needs met through one holistic package. Labelling is also minimised when young people are supported by the generic YSS rather than a YOT. The YSS approach also has the potential for cost-savings.

For more details see Byrne and Brooks (2014), which also outlines how this model arose from opportunities within the current policy context.

Multi-agency working arrangements / multi-agency teams

These can be used to avoid multiple services duplicating work with young people (and the associated risk of disengagement) and to support 'one keyworker' and 'no wrong door' approaches. Examples include the Youth MARAC in Lewisham and the Lancashire multi-agency CSE teams. Ofsted has published good practice examples for both: 'Trailblazing a multi-agency approach to support and enable young victims of serious crime to feel safer and more secure: Lewisham' (2013), and 'Tackling child sexual exploitation: Blackburn with Darwen Borough Council' (2013), which can be found at www.ofsted.gov.uk/resources/goodpractice

Easily accessible training and apprenticeship schemes

One such scheme is the Pathways programme in Ealing. This is a six-month pre-employment programme offered to all at-risk young people. (For a full description and a personal statement about its impact, see the Appendix of Practice Examples that accompanies this briefing.) The programme includes an employment-based placement in the council for three days a week, with training. Support is also provided for health, accommodation and other needs. Reporting indicates 'an 85 per cent success rate with a very vulnerable group'; this appears to be because of the programme's ability to build self-esteem, self-efficacy and life skills, as well as creating practical opportunities through the employment experience.

Programmes that address contributors to victimisation

The Pattern Changing programme (Goodman and Fallon, 1995; McTiernan and Taragon, 2004) helps to prevent domestic abuse revictimisation by building women's self-esteem, assertiveness, reflective capacity, and their knowledge of rights and healthy relationships. Such an approach could be adapted to address young people's psychological vulnerabilities to partner abuse; this would likely be most effective in conjunction with parallel approaches that target individuals at risk of perpetrating.

Principle: *'Ensure services are both accessible and advertised'*

Currently when a young person is aware of the risk they are caught up in, it can be difficult for them to know where they should go to get the right support. And even when they do know, getting to this source of support may depend on overcoming a number of logistical and psychological barriers (for example, talking to their parents about the problem; attendance at intimidating meetings; waiting with no guarantee of the outcome).

However, adolescents' emerging agency and independence seeking are skills that they can use to escape certain risks (and their impact), if they are given effective routes and support to do so. When a young person recognises they need help to address a risk in their life, we should match this with accessible and early help.

In this spirit, and in recognition of the ways in which young people access information,

all services that aim to support at-risk young people should provide mechanisms for self-referral, employ social marketing to raise awareness of the support they offer, and adopt assertive outreach to target at risk groups (Bamberg et al, 2011; Ozechowski and Waldron, 2010).

Self-referral, social marketing and assertive outreach

The charity MAC-UK (www.mac-uk.org) provides a good example of the use of outreach to connect young people at risk of mental health difficulties and violence to effective support and resilience-building projects. It was set up directly in response to the low levels of young people accessing help in CAMHS despite evidence of high levels of need. Examples of statutory services that offer self-referral routes include Parkside CAMHS in West London, and the Youth Inclusion Support Panel (YSIP) in South Devon. Via these routes young people can act on their awareness of a problem to receive immediate responsive help and connections to other resources.

Accessible information about a service designed by young people

A general message from research is that people experiencing risks would like more information about the services available to them (Easton et al, 2013; PHE, in press). Service information that is designed by young people themselves can be particularly engaging; it communicates a sense of inclusivity and can reduce feelings of isolation or stigma. Additional benefits include developing the skills and confidence of those designing the information, and matching communication to the right developmental stage (although young people, like adults, may require support in making information accessible to those with literacy, language or learning difficulties).

Information is likely to be most accessible when delivered via a variety of media – for example, radio, magazines, social networking sites, posters, blogs, and face-to-face (EdComms, 2009; also see Stanley et al, 2009, and TNS Social, 2009, for information about effective social marketing to 'hard-to-reach' groups). Young people who have used a service will have the best sense of how to most effectively deliver information to others like themselves.

Blended universal and targeted programmes

Triple P is a highly effective approach to increasing positive parenting and reducing maltreatment (Sanders et al, 2014; and for more information see www.triplep.net), including with high-risk groups and adolescents. Its blending of a universal and targeted approach appears to be part of the reason for the programme's success (Poole et al, 2014; Fives et al, 2014). Parents can enter the universal programme and also choose more intensive intervention should they become aware of a need for it. This approach means that more people with higher levels of need access the targeted intervention, as there is less stigma attached to doing so. Also, the programme is able to reach the target population without 'over-servicing' and there is no need for comprehensive assessments to manage access and thresholds. This blended 'universal-targeted' approach could be used across a variety of areas; it rests on the assumption that people will ask for the right levels of support when that support is accessible and non-stigmatising.

Principle: *'Equip and support the workforce'*

In order to identify and respond to adolescent risk effectively, practitioners who support young people must be well supported. However,

this work is complex, emotionally demanding and often politically charged. To ask practitioners to work in such an environment without high-quality training, support and supervision undervalues them and the young people they support.

A strong and widespread understanding of adolescent risks (and their dynamics), resilience, engagement and how all this relates to adolescent development, can act as a springboard for a myriad of improvements. Training is a primary means of developing such understanding, although care must be taken to ensure that applied learning and 'training transfer' is enabled (Research in Practice, 2012).

As well as embedding understanding from research, learning and development opportunities for staff should also support practitioners to acquire and maintain an 'adolescent practice' skill set. This would involve adding some specific skills to an existing core set of skills for working with all children and young people. It would usefully build on practitioners' existing expertise, much of which may be natural and intuitive. Young people would, of course, be valuable partners in the design, delivery and impact-evaluation of such training and career pathways.

Core training for all who work with adolescents facing risk
1. Adolescent development and adaptivity
2. Adolescent risks: their nature, impact and contributors
3. Nuanced perspective of adolescent choice and behaviour in certain risks and implications for practice
4. Resilience in relation to risks in and implications for practice
5. Engagement skills for working with adolescents and their families

Table 5 *Suggested training for all practitioners who routinely work with adolescents experiencing risk*

Needless to say training is most useful when workers practise within a framework which complements learning (see Table 4).

Adolescent specialists (an example of a 'draw down' model)

The baseline level of understanding and skill introduced in the training described above could be complemented by support and input from 'adolescent experts' within an agency or within a multi-agency working arrangement. The introduction of such experts could improve practice in a variety of interlinked ways – for example, people acting on the basis of consultations with the expert, thereby avoiding the escalation of cases; retention of adolescent practice expertise through the new career pathway; and by providing a channel for innovation and the introduction of new ideas. This model is not unique: consultant social workers / social work practice leads are becoming more widely used, and principal education psychologists and some mental health clinicians operate in this 'draw down' way already.

10 Conclusion

This paper argues that a paradigm shift is now needed in how we understand and respond to risk in adolescence. Specifically, it argues that adolescence, as a discrete and critical period of child development characterised by increasing agency, a formative drive towards independence and a focus on peer relationships and social groups that extend beyond the family, requires a complex and nuanced response that reflects the realities and opportunities of this life stage. A child protection system that is conceptualised primarily around preventing harm and maltreatment among younger children, who may be most at risk within their own family, is not well placed to serve the needs of adolescents.

Currently, local authority spending on the protection of adolescents is weighted heavily towards the care system, even though research shows that outcomes for late entrants to care are often poor. Of course, many such placements do provide effective and ongoing support, but care solutions are not and cannot be an effective sole response to the distinctive risks that adolescents face. Similarly, whilst many adolescents are supported through the traditional child protection system, all too often this system is not able to meet their needs effectively. And yet, as this paper has shown in the practice it describes and in the Appendix of Practice Examples that accompanies it, there are many emerging examples of promising and innovative local practice around the country and beyond from which we can learn.

At a time of sustained austerity it becomes more important than ever that resources are allocated to optimal effect. Indeed, the challenge of constrained resources can sometimes act as a catalyst for innovation, and there is evidence to suggest that this is the case currently in relation to redesigning services for adolescents. Leaders of local children's services are uniquely placed to direct shifts in thinking and in spending so that we may more effectively reduce adolescent risk. This evidence scope argues that this can best be achieved by ensuring that strategies, services and practice all 'work with the grain' of adolescent development, recognise young people as partners in the work, and harness the distinctive strengths and opportunities that adolescence brings.

None of this is easy and much of it will require imagination, determination and innovative thinking; it may well involve the taking of some risks. But for young people, their families, and those working to improve the lives of at-risk young people, the rewards will be considerable.

research in practice

ADCS
Leading Children's Services

That Difficult Age: Developing a more effective response to risks in adolescence

Authors Dr Elly Hanson and Dez Holmes
Edited by Steve Flood
Photo Alice Carfrae
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Research in Practice
The Granary Dartington Hall
Totnes Devon TQ9 6EE

tel: 01803 867692
email: ask@rip.org.uk

www.rip.org.uk