Key Definitions

Harm:

- Ill treatment
- The impairment of health and development

Ill Treatment: physical, emotional, sexual abuse and neglect

Health: physical and mental

Development: emotional, social, behavioural, physical, intellectual

Children Act 1989 (s.31)

Risk: The likelihood of a future event the outcome of which may lead to loss, harm or damage

Risk Assessment: The collection of information (by clinical / actuarial means) about children and their families through the process of enquiry, observation and communication with others.

Risk Analysis: Making sense of the data. The process of evaluating the impact of the child’s exposure to the risk of harm and taking account of individual / family strengths and agency services that could reduce the likelihood of future harm.

Risk Management: The statement of plans and the allocation of responsibilities for translating the outcomes of risk assessments and analysis into practical measures to reduce risk.
How the Model Works

What has happened to this child? (presenting information)

What kind of parenting produced this outcome? (working hypothesis – because of dv / alcohol / mental health / toxic care giving / other stressors. Consider HRI’s, URF’s and attachment)

Check out hypothesis against known information
Talk to child / parent (clinical assessment)

Look at histories. Talk to other agencies about parents current and past functioning (actuarial assessments)

Analyse this information (make sense of the data – does this care giving promote or impair the child’s safety and welfare?) Include the child’s voice
Answer assessment into analysis questions
What is the impact on the child – the so what question?
What is the child’s resilience?
Risk statement

Ability to change (Where are the carers in the continuum of change? Do they have the motivation and the capacity to change?)

Risk management (The development of SMART, outcome focussed plans)
Underlying Risk Factors

Those elements that are often present in risk situations but which do not, of themselves, constitute a risk:

- Poverty
- Poor housing
- Lack of support network/isolation
- Experiences of poor parenting
- Low educational attainment
- Physical/learning disability (adult / child)
- Mental health difficulties (adult / child)
- Drug and alcohol use/misuse
- Victimisation from abuse/neglect
- Disordered/discordant relationships
- Previous history of offending
- Rejecting/antagonistic to professional support
- Behavioural/emotional difficulties in parent
- Behaviour/emotional difficulties in child
- Young, inexperienced parent
- Physical ill health (adult / child)
- Unresolved loss or grief
High Risk Indicators

Those elements which, by their presence, do constitute a risk

» Previous involvement in child physical and sexual abuse/neglect

» History of being significantly harmed through neglect as a child

» Seriousness of abuse (and impact on the child)

» Age of the child (particularly if less than three years old)

» Incidence of abuse (how much abuse over how long a period of time)

» Record of previous violent/sexual offending (against both children and adults)

» Evidence of disorganised attachment in the adult

» Older child removed or relinquished

» Unexplained bruising (particularly in pre mobile children)

» Uncontrolled mental health difficulties (including periods of hospitalisation)

» Personality disorders

» Chaotic drug/alcohol misuse

» Denial/failure to accept responsibility for abuse/neglect

» Unwillingness/inability to put child’s needs first and take protective action

» Cognitive distortions about the use of violence and appropriate sexual behaviour

» Inability to keep self safe

» Unrealistic, age inappropriate expectations of the child

This list is extensive but not exhaustive.

From the work of Dalgleish and Drew
Framework for Analysis

The key questions to be answered in the analysis of the information obtained through the process of risk assessment are...

» To what extent is the parent able to meet the child’s needs and the nature and extent of the child’s unmet needs (Triangle … Parenting Capacity)

» What is the nature of the child’s attachment to the parent and what is the parent’s early life experience of attachment (how well was the parent parented?)

» What is the adult state of mind – are they physically and emotionally available for their child?

» What is the meaning of the child in the adult’s life and what does the adult mean to the child?

» How far does the adult recognise and share the causes for concern and are they able and willing to put the child’s needs first?

» What stressors are experienced in the adult’s life and what is their ability to regulate and manage these (adult resilience)? Is the adult able to keep him or her self safe (dv / substance abuse / mental health?)

» What environmental factors are helpful to the adult and protective of the child, and which are unhelpful and potentially harmful (additional stressors)?

» Does the adult have the ability and motivation to make and sustain the changes needed to safeguard and promote the child’s welfare within the child’s timescales?

» The impact of all of the above on the child and the child’s resilience

The outcome of this process should be the explicit identification of the child’s unmet needs and explicit identification of those issues that need to be addressed to improve parenting capacity.
Assessing Capacity to Change

The process of change follows a predictable pathway *

The following framework can be used to assess where the client stands in relation to the causes for concern and their capacity to change:

» Client accepts there is a problem
» Client accepts some responsibility for the situation
» Client has some discomfort over the problem
» Client believed things must change
» Client sees self as part of the situation
» Client sees that choices are possible
» Client identified next step towards change

Each heading can be used as a prompt for further exploration. The client has to respond positively to each step for any realistic prospect of change,

* Prochaska and Diclemente (1992)
SMART Plans

All plans (CP / CiN / Pathway / Care) should be developed using SMART principles and should be recorded on the Blackburn with Darwen approved template which clearly identifies desired outcomes from professional interventions and the evidence needed to demonstrate the outcome has been achieved.

For Child Protection Plans

S - Specific: every risk (HRI and relevant URF) identified in the risk assessment / analysis needs to be reflected in the risk management plan.

M - Measurable: things can be measured in two ways, inputs or outcomes. Inputs are usually measured in terms of services offered. Outcomes are measured in terms of impact of intervention (improvements) Inputs are usually counted. Outcomes need to be assessed.

A - Achievable: Plans should be aimed at risk reduction not risk removal. There should be explicit statements about degree of improvement required (i.e. acceptable level of residual risk).

R - Realistic: This will depend on how intractable the problem is (how long / how severe) and the client’s motivation and capacity to change.

T - Timely: Changes need to be made within the child’s timescale to promote safety and welfare, not the adult’s timescale.
Support with the Risk Model

• The Advanced Practitioners hold regular consultations regarding the implementation of this model. Speak to admin in order to book on for discussion.

• Why not take a copy of this toolkit to your supervision with a view to working through specific cases with your manager?

• Prior to Child Protection Conferences have a read through the toolkit and familiarise yourself with the issues within the case using this framework.

• Risk assessments are not separate to Child and Family Assessments – they are integral to them. Speak to your manager or AP for further support on how to integrate analysis of risk to the assessment.

Useful websites
Analysis into Assessment

Additional Guidance
The purpose of this guidance is to offer further clarification on the relationship between the BwD risk assessment model (and the analytical framework it contains), the use of the NAF (the Purple Book) and the Single Assessment process.

The assessment process is the collection of data through observation, conversation and consultation with others. From this the assessor will understand *what* is happening (how well the child’s needs are being met and the extent of the parent’s capacity to meet the child’s needs). Using the analytical framework contained in the toolkit the assessor should be able to provide an explanation for *why* things are as they are.

Assessment of need and risk are not the same thing. The assessment of risk is relatively easy. By collecting data about what has happened to the child (the abuse/neglect to which he/she has been exposed), seeing this in the context of the HRI’s that are present and any relevant historical data and asking questions about

- How the abuse/neglect occurred (explanation)
- Whether the adult shares the professionals concerns about what has happened
- Whether the adult is able to put the child’s needs before their own
- Whether the adult is able to keep themselves safe

the assessor should be able to conclude whether the child (on the balance of probability) has suffered or is likely to suffer significant harm.

Further assessment of the adult and child’s resilience and any strengths or protective factors will give an indication of how and where (at home or through removal) the identified risks can be managed.

The outcome of the risk assessment is captured initially in the record of S.47 enquiry which then informs the development of a report for an ICPC in which the HRI’s and relevant URF’s constitute the outline protection plan.

The assessment of need and in particular *unmet need* is slightly more complicated. It begins with a clear understanding of the causes for concern or issues identified in the referral information and a review (and understanding) of...
any historical involvement (what were the issues, what were the interventions and what were the outcomes). It is also helpful to identify which other agencies are/were involved with the family.

The assessment is conducted using the NAF and begins with an assessment of the child’s **unmet needs**. (In reality the assessment of unmet needs, parenting capacity and family and environmental factors go on simultaneously, but for simplicity’s sake they will be considered in linear fashion).

The process of assessing unmet needs is one of comparing where the child actually is in terms of their health, education, emotional and behavioural presentation etc with where they should be given their age and stage of development. The gap between what the assessor observes in the child and the stage or level they should be at is the child’s unmet need (this obviously presupposes the assessor has a working knowledge of normal child development at each stage). Closing the gap between where the child is and where they should be then becomes the intervention objective (i.e. what needs to be done to improve this child’s health, education, sense of identity etc).

In order to aid the assessor in this process, each ATM has a copy of “Safeguarding Children: Assessment and Analysis Framework” (SAAF). This provides detailed advice for the assessor in relation to what could constitute evidence of the child’s needs being met and what would constitute evidence of the child’s needs being significantly unmet (to the point at which it could be considered that the child was being abused). The assessor is then invited to locate the child’s level of that particular need between level 5 (considerable strengths with no unmet needs) and level 1 (considerable difficulties, extensive unmet needs with possible evidence of abuse).

When writing up this section of the assessment the assessor must state **explicitly** under each domain the extent of the child’s unmet need (largely met, partly met, largely unmet). The self-reported information by the parent about the child or from the child himself should be considered alongside the assessors observations and checked through consultation with professionals from other agencies (HV’s, GP’s Teachers etc).

One of the criticisms that is levelled at assessments is that they do not capture the child’s personality and they do not suggest that the assessor has taken time to really get to know the child. This can be remedied by the assessor providing a rich description of the child’s personality, presentation, demeanour and resilience (or otherwise) in the “identity” and “social presentation” domains of the assessment framework. The write up of each domain under “Child’s
Developmental Needs” should be concise and succinct and get to the heart of the issues (including as already mentioned the explicit identification of the child’s unmet needs). It is not necessary to provide an extensive narrative. The assessor should seek to provide enough information to support the conclusion rather than everything that they know.

A similar method is used when assessing “Parenting Capacity”. The assessor compares the level of care actually provided under each domain with what would be expected from a responsible parent in similar circumstances. The gap between the care that is offered and what could be expected is the parenting capacity deficit. It is largely because of these deficits that the child’s identified unmet needs are as they are. Again, the SAAF provides helpful guidance for the assessor in identifying the gap between satisfactory and problematic parenting. In relation to assessing parenting capacity in the “basic care” domain, additional guidance is available in the Action for Children “Working with Neglect” toolkit, a copy of which is held by each ATM.

It is in the assessment of parenting capacity that the connection between the single assessment process and the risk assessment model is most clear. It is in this section also that the bulk of the analysis (explaining why things are as they are) takes place.

So, for example it may be that there are significant deficits in providing basic care. This needs to be explained not just described and may be because the parent themselves was neglected as a child (HRI) and as a consequence has no “mental model” of what “good enough” care looks like or it might be that the parent is a chaotic drug user (a different HRI) and is preoccupied with their addiction at the expense of the child’s care.

Or, if the deficit is in relation to ensuring safety this too needs to be explained and it maybe that because the parents’ own childhood was so poor and they themselves are so emotionally needy that they are willing to prioritise their relationship with a violent partner (HRI – inability to keep self safe) over the needs of their child.

Using these examples the structure for this part of the assessment then is clear... the assessor identifies the level of parenting capacity under each domain and explains the deficit by reference to the impact of HRI’s (and relevant URF’s) on the parents’ ability to provide adequate care.

Fundamental to assessing parenting capacity (for all domains, but particularly in relation to emotional warmth, stimulation and guidance and boundaries) is an assessment/understanding of the attachment bond between child and parent.
In the course of the assessment the assessor should seek to understand the experiences of being parented of the parent who is being assessed (how they themselves were parented has a powerful influence of how they parent). Apart from asking general questions about their childhood the following questions are helpful

» Who did you like to spend most time with?
» Who did you miss most when you were separated from them?
» Who did you feel you could always count on when you needed help?
» Who did you turn to for comfort when you were feeling low?

Information from this line of enquiry will provide the assessor with an insight into the physical and emotional care experienced by the parent who is being assessed and may explain some of the findings from the assessment of their own child’s unmet needs.

In assessing attachment it is important that the assessor spends sufficient time with the child and parent(s) together to observe the nature of the attachment as well as obtaining information from conversations with both parent and child. Data from these sources will give an insight into the adults’ emotional availability to the child and the meaning of the child to the adult and the adult to the child. This information will be useful in explaining any parenting deficits in relation to providing emotional warmth, stimulation and guidance and boundaries.

To aid the assessor complete this part of the assessment there is a list of helpful questions in the Risk Assessment Toolkit. In addition the ATM’s have a brief up to date guide to using attachment theory to inform improved practice.

As with the write up of the “Child’s Development Needs” domains, the write up of the parenting capacity needs to be succinct and explicit (i.e. clearly state the extent of the parenting deficit) with some analysis and explanation (making reference to attachment assessment, HRI’s and URF’s) as to why the situation is as it is. The write up should not simply be a description of the parenting behaviour that has been observed in the course of the assessment.

The procedure for assessing “Family and Environmental Factors” domains is exactly the same and again guidance is available in the SAAF. The domains of “family history and functioning” and “family’s social integration” are probably the most important aspects of this element of the assessment.
The final part of the process is to bring all this data together in the analysis section of the Single Assessment record. The analysis provides an explanation for why the situation is as it is and connects the outcomes for the child (the degree to which their needs are met or otherwise) with the parenting capacity strengths or deficits that have been identified in the assessment.

**Suggested Model for Analysis**

1. Begin with rich description of what the child is like. How do they present, what kind of personality, degree of resilience, what are they good at, what do they like, what do they say, what do they want now and in future.

2. Comment on the degree to which the child’s needs are unmet in relation to each domain and relate this to parenting capacity deficits (including explanations). This need not be an extensive narrative as the bulk of the analytical work will have been done in the earlier sections of the assessment e.g…

Because of her own neglectful upbringing M/S Smith has no mental model of what good enough care is like and has no experience of providing this. As a consequence Jimmy has significant unmet needs in relation to his health including poor nutrition leading to inadequate weight gain, outstanding immunisations, untreated squint and poor dental hygiene. There are similar concerns in relation to Jimmy’s education. His attendance is poor and as a consequence his educational development is delayed. There are concerns also that he may have a learning disability, but this has not been assessed due to his poor attendance and his Mother’s unwillingness to consent to an assessment. The explanation for this situation lies largely in the fact that Ms Smith had a difficult time at school and she does not value or prioritise Jimmy’s education. It is also a fact that because of her own lack of self-worth and perceived lack of intelligence that she finds schools intimidating and is reluctant to speak to teachers.

Jimmy presents as a shy, lonely, anxious and introverted boy. He lacks confidence and has low self-esteem. This impacts significantly on his ability to make friends and participate with other children in games and activities. Jimmy’s presentation can be ascribed in part to the poor attachment relationship he has with his Mother. Jimmy was an unwanted pregnancy and it was only with some reluctance M/S Smith was persuaded (by her family) to full term and to keep him. She was never warmly disposed to Jimmy and has been a remote and distant figure throughout his childhood.
She is generally emotionally unavailable to Jimmy and he has little value to her. As a consequence Jimmy is an extremely emotionally needy child who would be vulnerable to abuse and exploitation in future. This vulnerability would be exacerbated by the lack of interest M/S Smith exhibits towards her son and the lack of supervision she provides him. (for a further examples of this kind of write up see “Analysis into Assessment” training handbooks and further prompts within the Toolkit).

Make reference to parental and child resilience and any strengths, positives or mitigating factors in the situation

3. Motivation and capacity to change
   Once the social worker has a full and proper understanding of the child’s unmet needs and parenting capacity it is necessary to complete an assessment of parental motivation and capacity to change using the model provided within this toolkit.

4. Summarise and conclude
   This level of analysis in the earlier part of the assessment then makes the construction of the CP or CiN plan quite simple.

   From the evidence available Jimmy is a child with significant unmet needs who would benefit from a period of CiN planning.

   In this case the plan needs to focus on improving Jimmy’s basic care (under each element explicitly state the desired outcome and what the evidence for this would look like). There needs to be a strategy to improve his school attendance and to have his ? LD assessed. There needs to be work on his self confidence and self-esteem and the attachment bond difficulties need to be addressed either through a “repair strategy” (working with Jimmy and his mother together) or a “replacement strategy” (who else in the family can offer Jimmy emotional warmth… the role of the Family Group Conference?) The plan would also need to address Jimmy’s possible vulnerability to abuse/exploitation.
Children with Disability

Additional Guidance

The Children Act 1989 at S.17 (10) (c) states “a child shall be taken to be in need if he is disabled”. This means that all children with disability (CwD) are by definition “in need” and therefore eligible for a single assessment. It also means that a disabled child can be “in need” without evidence of deficit or compromised parenting. This guidance is applicable to all disabled children including both physical and learning disabilities.

An underlying principle of the 1989 Act is “children first”. For the purpose of this guidance this is to be taken to mean the subjects of CwD assessment are to be regarded primarily as children who have a disability rather than disabled people who happen to be young. The assessment of the child’s disability is usually a medical matter (involving paediatricians, psychologists, etc). The purpose of the assessments undertaken by CSC are to understand the whole child and to ensure that as well as putting in place measures to counter the impact of disability, the child’s talents and abilities are also recognised and promoted. All workers need to be aware that many disabled children are assessed in relation to what they can’t do rather than what they can and should actively avoid a similar model of practice.

It is important when undertaking assessments of CwD that the same principles of inclusion and engagement apply as when assessing non-disabled children. In order to ensure that the voice of the disabled child is heard workers should make every effort to communicate with CwD at a level which is commensurate with their age, stage of development and level of understanding. Workers should expect that such assessments may take more time than is usual and should not be deterred from going at the child’s pace simply to meet deadline targets.

It is a fact that the safety and welfare of all children is best promoted when they have strong attachments and their parents are emotionally available and display warmth towards them. This is an issue that needs to be fully explored in assessments of all CwD. In the course of the assessment workers must explore the meaning of the child to the parent.
S.17/CAF Assessments

It is usual for CwD to have been the subject of many assessments and information already gathered should be accessed in the course of the single/CAF assessment. It is also important to involve other agencies in the assessment process to obtain both a holistic understanding of the child’s needs as well as an insight into the services and resources available to support the child and family going forward.

When undertaking assessments on CwD, workers who lack expertise should have access to informed advice on the nature of the child’s disability and it’s likely impact on functioning, though this will vary from child to child and will need to be checked out with the family as the assessment progresses.

In the course of the assessment the worker should consider:

» the impact of the disability on the child’s health, welfare and development
» any disabling barriers (stereotypical thinking, disabilism, etc). that the child faces
» strategies to mitigate the impact and overcome the barriers
» the additional demands on parenting capacity as a consequence of the child’s disability

The outcome of the single/CAF assessment for CwD should be the same as for non-disabled children viz:

» explicit statements about the nature and extent of the child’s unmet needs
» proportionate intervention strategies
» explicit desired outcomes with evidence of achievement
S.47 Enquiries
While being disabled is not of itself a risk indicator, it is important to recognise the increased vulnerability (of CwD) to abuse and neglect. There is a considerable body of research to support this view. It is also well known that CwD are significantly under-represented in the child protection planning process.

What the research suggests is:

» CwD are at a greater risk of physical, sexual and emotional abuse and neglect than non-disabled children

» CwD at greatest risk of abuse are those with behaviour/conduct disorders. Other high risk groups include children with learning difficulties/disabilities, children with speech and language difficulties, children with health-related conditions and deaf children

» CwD in residential care face particular risks

» bullying is a feature in the lives of many CwD

Factors that increase risk and lessen protection for CwD include:

» attitudes and assumptions – a reluctance to believe disabled children are abused; minimising the impact of abuse; and attributing indicators of abuse to the child’s impairment

» barriers to the disabled child and their family accessing support service

» issues related to a child’s specific impairment – e.g. dependency on a number of carers for personal or intimate care; impaired capacity to resist/avoid abuse, difficulties in communicating; and an inability to understand what is happening

» limited opportunities for disabled children to seek help from someone else

» a lack of professional skills, expertise and confidence in identifying child protection concerns and the lack of an effective child protection response
Bearing these factors in mind when making S.47 enquiries, social workers must undertake this task from a position of “sceptical disinterest”. They must use the same values and principles as they do when assessing non-disabled children. They must beware of accepting parental explanations for actions or behaviours (which they attribute to the difficulties experienced in looking after the CwD) that they would regard as questionable or unacceptable for non-disabled children (locking children in rooms or strapping them to chairs, etc).

When considering the outcome of S.47 enquiries social workers must always entertain the possibility of a “differential diagnosis” – that the satisfactory explanation for a child’s injuries or condition might be true, but also they might be the result of abusive and/or neglectful behaviours. It is important that social workers take advantage of reflective supervision and offer their analysis of the findings to the challenge of their supervising manager.

It is customary for CwD to be the subject of long term CiN or CAF plans during which time social workers (and others) develop supportive relationships with parents. It is important to recognise the inherent tensions in maintaining such relationships while recognising the need to be constantly vigilant as to possibility of safeguarding issues and the need to take action should these emerge. Staff involved in the long term support of CwD and their families should have access to workers with safeguarding experience and expertise and should receive regular reflective supervision on their case load.
Child Sexual Exploitation (CSE)

Definition:

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

(DfE CSE Guidance 2017)
High Risk Indicators

The following high risk indicators and underlying risk factors have been developed and include the vulnerabilities and indicators highlighted in the Department for Education CSE Guidance 2017.

(Those factors which by their presence constitute a risk of CSE)

» Direct disclosure of victimisation by a child or young person;
» Peer group relationship with other young people known or strongly suspected to be involved with CSE;
» Associating with adults known or strongly suspected of CSE perpetration;
» Family members or other connections involved in adult sex work (HRI);
» Being found in places where CSE or sex work is known or strongly suspected to occur;
» Gang-association and/or isolation from peers/social networks;
» Repeat sexually transmitted infections, pregnancy and terminations;
» Change in physical appearance or dressing in a more sexualised way;
» Acquisition of money, clothes, mobile phones etc. without plausible explanation/ Child has funds for drugs, alcohol, clothing, gifts and unexpected items;
» Child has two or more mobile phones that cannot be accounted for;
» Recruiting others into exploitative situations;
» Child or young person feeling forced, possibly through threats, to engage in sexting/online chat/sending receiving images / performing sexual acts online;
» Leaving home/care without explanation and persistently going missing or returning late;
» Evidence of/suspicions of physical or sexual assault;
» Relationships with controlling or significantly older individuals or groups.
Underlying Risk Factors

(Those factors often associated with CSE but which in themselves do not constitute a risk of CSE).

» Lack of a safe/stable home environment, now or in the past (domestic violence or parental substance misuse, mental health issues or criminality, for example);

» Regularly coming home late / going missing;

» History of abuse (including familial child sexual abuse, risk of forced marriage, risk of honour-based violence, physical and emotional abuse and neglect);

» Bereavement or loss;

» Unsure about their sexual orientation or unable to disclose sexual orientation to their families;

» Abandoned/estranged from family and/or homeless, living in hostel, bed and breakfast accommodation;

» Child associates with older friends who engage in risk taking behaviours and appears easily influenced;

» Low self-esteem / negative sense of self;

» Emotional and/or mental health difficulties; Self-harm or significant changes in emotional well-being;

» Truanting or more regular non-school attendance/ Exclusion or unexplained absences from school, college or work;

» Secretive use of mobile phones / internet / sexting; and/or Excessive receipt of texts/phone calls;

» Sexual activity at an early age;

» Change in behaviour – could be positive or negative;

» Diversity needs unmet;

» Child engaging in sexting/online chat/sending receiving images / performing sexual acts on line;
Underlying Risk Factors

» Social isolation or social difficulties;
» Economic vulnerability;
» Having a physical or learning disability;
» Being in care (particularly those in residential care and those with interrupted care histories);
» Returning home under the influence of drugs/alcohol;
» Multiple callers (unknown adults or peers);
» Increasing secretiveness around behaviours;

N.B. While one underlying risk factor does not, in itself, constitute a risk, the greater the number of such factors that are present (particularly the more sexual ones), the greater the likelihood that CSE is a feature.
Supporting Young People at Risk of CSE

» Indicators are not evidence that sexual exploitation has taken place. All they tell you is that you need to use your professional curiosity and judgement to explore what is going on for the young person. Information sharing between agencies is a first step; the next has to be sensitive but inquisitive conversations with young people. CSE is discovered, not disclosed.

» Enabling young people to find a way out of CSE can be similar to supporting victims of domestic violence; focusing on strengths, assessing risk and widening space for action – a process called ‘sustained safeguarding’. Support needs to be a counterbalance to the ‘pull’ of exploiters. This includes being proactive and consistent even where this support is initially, or repeatedly, rejected.

» The CSE advice and associated annex document (DfE, February 2017) discuss how effective local responses to CSE require support for staff to ‘work with risk’ so that a young person becomes an active partner in their ‘recovery and reintegration’ to achieve long-term meaningful change rather than temporary ‘enforced compliance’.

» ‘Sustained Safeguarding’ is achieved through ‘relationship based practice’ where the barriers to disclose and discuss CSE are explored to their basic levels:
  - Anxiety (reprisals/fear; loyalty to exploiters; fear of being disbelieved).
  - Shame (understanding the multiple breaches of trust in family, professional and peer relationships).
  - Guilt (disbelieved and blamed).

To develop ‘relationship based practice’, the follow steps are helpful

1. Develop an open/honest relationship.
2. Consider with the young person - why CSE?
3. Consider with the young person the positive and negative impacts of CSE.
4. Consider with the young person their own and other people’s responsibilities.
5. Explore with the young person their future.
6. Consider with the young person how they can make decisions about their life and CSE.
7. Act on decisions, including agreeing how to deal with setbacks.
Guidance/procedures

» Tri-x guidance details Children’s Social Care procedures, guidance and role of Engage Team and the Police; Sharepoint has links to resources and guidance on where to find important documents on protocol.

» If you’re concerned about a case already open to you: Discuss the case with your manager. They will determine if a referral to The Engage Team is appropriate and discuss with The Engage Team Manager. If agreed the case will be allocated and an assessment will be undertaken within 10 working days. The co-working protocol between Children’s Social Care and Engage is held within Tri-X;

» The Feb 2017 definition and associated guidance can be found at the following address: www.gov.uk/government/publications/child-sexual-exploitation-definition-and-guide-for-practitioners

» Specific CSE AP support sessions and CSE/Engage workshops are available;

» CSE training is available via the LSCB.

The Engage Team is located within Greenbank Police Station:
Whitebirk Drive,
Blackburn
BB1 3HP
Tel: (01254) 353667

(if you are telephoning please mention that you are calling regarding a Blackburn with Darwen Child as Lancashire County Council are based in the same office).