**** **Criteria for referrals to**

**Adolescent Support Teams (AST) and**

**Adolescent Early Help Units (AEH)**

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**1. Introduction**

Integrated Adolescent Services currently include Youth Justice (YJ); Adolescent Social Work Support Teams (ASWT) and Adolescent Early Help (AEH). ASWT and AEH mirror Support Levels for Children’s Social Work (CSWS) and Early Help (EH) with a specific focus on adolescents being the *primary* beneficiary of support, and needing to make the most significant change, rather than the parents (although a whole family approach is expected).

**2. Referral processes**

In most districts and areas, referrals:

1. to AEH are via the front door, or, where agreed between managers, via a step down or step-across process from CSWS, ASWT, EH or YJ
2. to ASWT are via the Front Door for Joint Housing Assessment (JHA) requests, or for C&F assessments. Occasionally there will be transfers between ASWT and CSWS (in either direction) as agreed between Team Managers.
3. For statutory Youth Justice assessment, planning and intervention are via E-YOTs and Out of Court Disposal report requests, via the Front Door (including Youth Conditional Cautions and step-ups from AEH); by transfer from other Local Authorities; via the Occasional and Youth Courts.
4. For voluntary Youth Justice support, as agreed with Team Managers.
5. Referrals stemming from Missing episodes will be sent from the Front Door to the allocated practitioner for those young people who are open to a service. Section 5.2 of this protocol refers to Mispers who are not currently open.

**2.1 Transfers**

* No transfer should be made directly into Liberi/EHM worktrays, without agreement between Team Managers/Unit Leads. Any disagreement about transfer should be escalated for peer-to-peer resolution, initially between Service Managers, and if necessary, with Assistant Directors for agreement.
* Capacity is not an acceptable reason for refusing a transfer which meets agreed eligibility criteria.
* Transfer, once agreed, should be timely. Any delay must be defensible and recorded on the relevant system as a management entry (such as requiring assessment, review, joint visit, or other relevant process to be completed).

**2.2 Contextual Safeguarding**
Adolescent services have led on the creation of a multi-agency contextual safeguarding framework. Regardless of which team has case holding responsibility, the framework is available to all services to support the identification, assessment and response to contextual risks, and to manage the serious risk of harm that some children pose to others.

**3. Eligibility Criteria for Adolescent Services**The premise for referral in to AEH or ASWT is that an adolescent practitioner is needed because the referred child presents with high-risk contextual factors and/or adolescent behaviours which are not the result of a neurodevelopmental issue or disability (such as ASC) needing specialist intervention, and pose a significant risk of family breakdown:

* adolescent to parent violence where there is a pattern of aggression towards parent/s which is not associated with historic or current parental abuse or neglect;
* parents are trying to impose boundaries, and want their child to be within the home, but are unable to keep the adolescent safe from significant risk of harm outside of the home (for example a child has been trafficked or exploited);

AND

* a flexible, strength-based approach which focusses on building a trusting relationship with the adolescent, is required to effect the required changes to keep them safe.

The age range for Adolescent services is expected to be 13+ years.

Contextual and familial risks are often present at the same time and the issues which make families appropriate for a referral to adolescent services are when the focus of intervention, or the predominant need for change, are the adolescents’ thinking and behaviour, rather than parenting needs/capacity.

Where there are issues of parenting capacity and those parents are unwilling to make changes to safeguard their child, even when those risks are extra familial, and the child is unlikely to remain or return home, the family should be supported by Children’s Services. Adolescent services may support the direct work with the adolescent, if there is capacity to do so. Services should access the multi-agency contextual framework to support the identification and multi-agency responses to contextual concerns.

The difference between ASWT and AEH is that ASWT operates at CIN level and above, and AEH are a preventative service that operates below the threshold for social work. ASWT will therefore work with more critical cases where risk is complex and high, requiring flexible and intensive intervention. AEH will work with cases where risk is emerging and increasing, and where a preventative and flexible approach is required to avoid escalation.
 **4. Adolescent Social Work Teams (ASWT)**

**4.1 REMIT**
ASWTs operate at support levels 3 and 4: CIN and upwards, offering intensive support at critical times of high risk to prevent children from coming into care, or to reunite them with their family. This might typically require multiple contacts each week with the adolescent and their family, where most contacts are expected to be, although not exclusively, with the adolescent.

While risk taking and risk factors can be common in young people, a referral to ASWT becomes appropriate where the risk reaches a level that necessitates intervention to promote the safety and well-being of the child, despite efforts of the parents to safeguarding them.

ASWT provides whole family support which relates to the adolescent (such as parenting and relationship advice). Siblings requiring their own plan (including YJ, EH, CiN and CP) will be case held by CSWS, YJ or EH where these are the most relevant services: not ASWT. In these cases, the expectations of joint working and the consideration of additionality that ASWT can provide to SWs should be explored, and recorded, by the relevant Team Managers.

Family breakdown resulting from parenting challenges (including parental substance misuse and MH, abuse, and neglect) are typically appropriate for Children’s Social Work, as well as those adolescents who are expected to come into, or already are, in care, and are unlikely to return home- including where parents are refusing to have them home.

ASWT aims to work with young people in a different way to other services: particularly in intensity, flexibility and focus on relationship building with the adolescent. There may be occasions when young people open to ASWT may be at such risk that a Child Protection Plan is necessary due to contextual safeguarding issues. ASWT will continue to case hold these cases, however, should there be parenting issues identified which necessitate a Child Protection Plan there should be a consultation between ASWT and CSWT to determine whether transfer should occur between teams.

Similarly, for children in need, should AST assess that the presenting adolescent issues have been resolved, they may seek transfer to a CSWT for children in need that require longer term parenting support.

Services should consider existing relationships, and the impact of changing workers, within transfer decisions.

**4.2 JHAs**
ASWT’s priority is to meet the demand of statutory joint housing assessments (JHA) when a 16/17-year-old presents as homeless. Referrals for a JHAs come directly to ASWT via the Front Door.

ASWT will allocate a Social Work resource within their teams to undertake this within statutory timescales.

If a CSWT is holding a case where the need for a JHA arises, they can seek advice and support if needed from ASWT, to assist the allocated social worker in carrying out this task.

**4.2** **EDGE OF CARE**
ASWT will work with those families where a teenager is on the ‘edge of care’ due to a perceived high risk of family breakdown, and where parents are willing to cooperate with ASWT to prevent the adolescent from coming into care, or to facilitate their return home, in the following circumstances:

* there is evidence that the adolescent is subject to child criminal exploitation
* there is evidence the adolescent is regularly at significant risk in settings outside of the family

ASWT will work with a child and their family to sustain them at home. Where the child has entered care from CSWT, Adolescent Services will provide support to the caseholding CSWS team to explore rehabilitation options. If rehabilitation is not successful, the expectation is that the case will transfer to CiC.

If a child open to ASWT comes into care, under s.20 and expected to be short term, the ASWT will continue to work with the child, and their family, with the intention of moving them out of care.

If a child comes into care via ASWT, and a permanency planning meeting has determined that they will remain in care, the child will be transferred to the CiC team. ASWT will hold children in care until the initial Court Hearing.

**4.3 OUT OF COURT DISPOSALS**

Out of Court disposals (young people aged 10+) will be allocated to Integrated Adolescent Services (Youth Justice or AEH) according to relationship and risk. Processes already exist to inform and manage this, including the Kent screening tool.

**5. Adolescent EH Units**
AEH Units are a service at support level 3 which do not meet the threshold for CSWS, ASWT or YJ, and aim to prevent escalation to CIN, CP, CIC and statutory Youth Justice thresholds.

The age range for referrals is expected to be 13+ years. The primary consideration should be about the presenting behaviours and the benefit in having an adolescent practitioner take a flexible, relationship-based approach with the child.

Similar to the criteria for ASWT, but where the risk of homeless and family breakdown is not imminent, for example family members are perceived to be struggling but not yet expressing that the child cannot remain in their care. AEH will prioritise those families where an adolescent practitioner is required due to the specific issues which the adolescent presents with.

AEH will not prioritise cases at support level 3 simply because there are adolescents present within the family.

**5.1 Risk of re-offending/Prevention of Offending**
All Out of Court Disposals (OOCD’s), unless already open to YJ, will be sent by the Front Door to the Adolescent EH units for the screening tool to be applied. Where a YCC is appropriate or where the tool indicates specific complexities determining the need for a full ASSET plus assessment (such as a risk of serious harm to others, or an established pattern of offending), the case will be transferred to the YJ team for the assessment to be undertaken in timescales.

The AEH Unit should aim to assess all OOCDs, excluding those transferred to YJ but including Community Resolutions, and cases which are open to other services including CSWS. If the risk of offending is low and a Restorative intervention has been implemented by Police, the AEH Unit may negotiate with Youth Services to offer targeted or additional support, and to end Adolescent Service support.

**5.2 Return from Missing**

1. Return from Missing Interview requests, for those young people aged 13 and over, who are not already open to another practitioner, should be allocated to the AEH Units.
2. Return from Missing Interview requests, for those children aged 12 and under, who are not already open to another practitioner, should be sent to the Early Help Units. This is based on the likely future relationship with services if ongoing intervention is required following the RI.
3. AEH Unit Leads should negotiate the completion of Misper RIs by Youth Services which are low risk and do not indicate a need for a level 3 or above Adolescent Practitioner.

The appropriate AEH Unit will undertake RI’s for those young people where the known facts of the missing episode, or the known case history, indicate a risk of CCE, CSE, extra familial risk, offending or significant ASB. Examples (but not an exhaustive list) of missing concerns include:

* Frequent missing episodes (e.g. 3 or more missing episodes over a 6-week period)
* Lengthy missing episodes (over 24 hours)
* Multiple risk factors
* Distance they were found from family – e.g., out of county
* Criminal exploitation, coercion and offending
* Health issues arising from episode (including substance misuse or injury)

Young people who are being actively exploited and who are at such high risk that they need specific intervention to keep them safe should be considered for escalation to Level 4 (CSWS or ASWT).

**5.3 Front Door and Step-Across referrals to Early Help**
Some examples (not an exhaustive list) of appropriate referrals for AEH Help include:

* Prevention of family breakdown/homelessness – where there is evidence that family relationships need to be improved and/or without a targeted intervention the child may imminently become excluded from their family network
* There is a likelihood that the child, will regularly be at contextual risk in settings outside of the family which may include being involved in a ‘group of concern’ (e.g. identified at DCSM).
* Persistent Absence/Pattern of Exclusion - Often attendance and behaviour issues are underpinned by aspects of extra-familial risk or other high risk behaviours. Liaison with Attendance & Inclusion should continue to feature for all case holders where young people have issues relating to education attendance and engagement.
* Multiple adolescent risk factors
-E.g. adolescent is NEET; substance misuser; poor relationships

-extra familial harm is evidenced over a persistent period

**TRANSFER**
Professional conversations between Unit Leads can agree transfer of cases, where appropriate, between EH and AEH Units, where adolescent service criteria are met

**STEP ACROSS and STEP DOWN**

CSWS identifying step-across (cancellation of C&F) and step-down (upon completion of C&F) cases as being appropriate for AEH should liaise with the AEH unit lead in accordance with the step-across and step-down processes. EH unit leads should not accept these cases and then transfer them to AEH.

Young people will sometimes have contact fortnightly or more than fortnightly. The expectation of intensive work is that it will respond flexibly to the needs of adolescents.
The AEH Units will hold case numbers similar to their counterparts in the generic Early Help Units.

Likewise, they will take a whole-family approach, but will focus on work with the adolescent in a flexible way.

**7. ACCESS TO OTHER SERVICES**

**Youth Services and Children’s Centre Provision**All case holders across Integrated Adolescent Services and CSWS (including CiC) should expect to access universal and, where appropriate, targeted Youth and Children’s Centre provision for their families. This includes accessing the parenting support offer. Access to Universal and Targeted Youth Provision should be considered for all adolescents who are referred in at support levels 3 and 4.

**7.1 ADDITIONAL SUPPORT IN OPEN ACCESS**
Any requests for ‘**Additional Support in Open Access’** should be discussed with the relevant Children’s Centre or Youth Service Delivery Manager. Typically, Additional Support in Open Access is a bespoke intervention for up to 6 sessions, circa 8 weeks, with an adolescent (Youth team) or a parent and/or young child (Children’s Centre team). Often, the aim of this intervention is to work towards engaging a child in universal or targeted groups.

If longer term 1:1 additional support for adolescents is required, this should be discussed between the relevant Social Work Team Manager and the Open Access Delivery Manager.

**7.2** Liaison with **Attendance & Inclusion** should continue to feature for all case holders where young people have issues relating to education attendance and engagement, including missing education and exclusion.

**7.3** Referrals should continue to be made to **TEP** for post-school aged young people who are not in employment, education or training.

**7.4** Referrals to **Emotional Well-being** including Head Start should continue to be considered for all cases where relevant and can be made directly by allocated practitioners. These referrals do not need to go via open access staff.

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