Transitional Safeguarding and Homelessness Webinar

Monday 26 September
2:00 – 4:00pm

Care and Health Improvement Programme

Agenda

2:00-2:05PM	**Introduction**	**Dr Adi Cooper - Care & Improvement Advisor London, LGA & ADASS**
2:05 -2:30PM	**Transitional Safeguarding, Homelessness and Care- experienced Young People: Learning from case reviews in England.**	**Professor Christine Cocker - University of East Anglia**
2:30 – 2:55PM	**Transitional Safeguarding and Homelessness- Emerging themes from SARs**	**Sarah Williams and Fiona Bateman - Safeguarding Circle**
2:55 – 3:20PM	**Using an evidence-base in SARs to promote best practice**	**Professor Michael Preston-Shoot**
3:20 – 3:55PM	**Q&A Session**	**Panel: Christine Cocker, Sarah Williams, Fiona Bateman and Michael Preston-Shoot**
3:55-4:00PM	**Chairs Closing remarks and close**	**Adi Cooper Care & Improvement Advisor London, LGA & ADASS**

Transitional Safeguarding, Homelessness and Care-experienced Young People: Learning from case reviews in England.

Professor Christine Cocker

University of East Anglia

There’s a ‘cliff-edge’ at 18 years…

Concerns about the State's failure to support care experienced young adults are not new

- Local Government Ombudsman finding against Kent County Council and Dover District Council (2012) - continual failure to assess a young person's housing and support needs. The young person had to live in a tent and experienced physical and mental ill-health as a result.
- Local Government and Social Care Ombudsman and Cornwall Council (2018). Young person left in a tent and static caravan contrary to statutory guidance on accommodating homeless young people. The Council failed to work with agencies regarding the young person's mental health and substance misuse needs, declined to offer accommodation under section 20 Children Act 1989 and failed to include the young person's mother in assessments.

- (credit – Michael Preston-Shoot)

There is existing law and guidance in England relevant to care leavers and homelessness

- Children Act 1989, s24: All young people qualify for advice and assistance from the local authority to promote their welfare when they cease to be looked after.
- Children Leaving Care Act (CLCA) 2000: creates a duty to assess and meet the care and support needs of eligible, relevant and former relevant young people. They must have a pathway plan, until they are at least 21, covering education, training, career plans and support
- Children and Social Work Act 2017 - personal adviser support can continue to 25 for all care experienced young people, not just those in education and employment.
- The Homelessness Act 2002 requires that all young people aged 16 and 17, and those between 18 and 21 when leaving care, are regarded as vulnerable and in priority need for housing. The Act also advises that young people aged 16 and 17 should not be placed in bed and breakfast accommodation.
- The duties on agencies to co-operate to improve young people's wellbeing, and to safeguard and promote their welfare (ss.10 and 11, Children Act 2004), apply to young people aged 18 and 19 receiving leaving care services.
- Local authorities should have sufficient accommodation for looked after children in their area (Children and Young Persons Act 2008). Care plans should cover arrangements for their health, education, emotional and behavioural development, family and social relationships, and self-care skills. Due regard should be paid to their wishes and feelings. The Independent Reviewing Officer should adhere to the timeframe for reviews and ensure that young people are adequately safeguarded in suitable accommodation.

- (credit – Michael Preston-Shoot)

Transitional Safeguarding - A thematic review of case reviews: Safeguarding Adults Reviews, Serious Case Reviews/Child Safeguarding Practice Reviews that involve care-experienced children aged 15-25

- Work being undertaken by University of East Anglia and Research in Practice
- We have gathered SARs and SCRs/CSPRs involving care experienced young people aged between 15-25 (UN definition of young person) from 2014 – 2021
- n=24 SARs and n=35 SCR/CSPRs
- Total n=59
- We are analysing these data during 2022

Descriptive data

- Majority of reviews occurred since 2018 (64%)

- Mean (average) age = 16.9
- Median (middle) = 17
- Mode (most common) = 17
- Range = 15-25 yrs

- 59% male
- Very little data clarifying ethnicity
- Very little data clarifying religion or sexuality

Current themes arising

- Lack of grounding in professional practice of the young person's context and history.
- Weak acknowledgement of the complexity of lived experience
- Poor legal literacy across the system
- Failure of multi-agency communication, weak links with police, youth justice, probation, housing and homelessness services
- Very poor links between Child and Adolescent Mental Health and adult mental health services
- Poor commissioning of appropriate placements for young people with complex needs

Multiple-exclusion homelessness

- People have experienced MEH if they have been 'homeless' (including experience of temporary/unsuitable accommodation as well as sleeping rough) and have also experienced one or more of the following other domains of 'deep social exclusion':
- 'institutional care' (prison, local authority care, mental health hospitals or wards);
- 'substance misuse' (drug, alcohol, solvent or gas misuse);
- participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work).
- (Fitzpatrick et al., 2011)

Housing situation of young people

Housing options for entire sample included in study were:

- Supported accommodation (n=10) 18%
- Family and friends (n=8) 14%
- Foster home (including staying put arrangements) (n=5) 9%
- Emergency/temporary accommodation (n=5) 9%
- Residential care (n=5) 9%
- Independent flat (n=4) 7%
- Youth offending institution (n=4) 7%
- Semi-independent unit (n=3) 5%
- unknown (n=14)
- TOTAL (n=58)

  (missing case is multi-subject)

Accommodation of former care leavers (DfE data 2020-2021)

- For 17-year-old care leavers
  - 49% were living with parents,
  - 6% were in semi-independent transitional accommodation and
  - 5% were in custody
  - (however, for 24% the information was not known).
- For 18-year-old care leavers
  - 32% were in semi-independent transitional accommodation,
  - 19% were with former foster carers,
  - 12% were living with parents or relatives and
  - 11% were in independent living .
  - Information was not known for 4% of young people.
- For 19- to 21-year-old care leavers
  - 36% were living independently,
  - 17% were living in semi-independent transitional accommodation,
  - 11% were living with parents or relatives and
  - 8% were living with former foster carers.
  - Information was not known for 7% of young people.

Numbers of young people in our study facing multiple-exclusion homelessness

- 27 young people (47%) faced multiple exclusion homelessness
- Of this number:
  - 52% female
  - 93% had mental health problems
  - 40% of that number had diagnosable mental disorders
  - 67% had a drug or alcohol problem
  - 59% had a history of youth justice involvement
  - 52% had a Learning disability
  - 37% Child Sexual Exploitation concerns

- Of these 27 young people
  - 1 had 1 factor
  - 8 had 2 factors
  - 7 had 3 factors
  - 10 had 4 factors
  - 1 had 5 factors

Homelessness amongst this group of young people

- Homelessness is more than street-based homelessness
- There were multiple routes into homelessness, with the most common being a breakdown in families.
- Many young people were in some sort of temporary accommodation when they died, with no clear plan for their future
- Domestic abuse, cuckooing and exploitation were also issues causing homelessness for these young people and affected how they were treated.

Homelessness amongst this group of young people – issues for practitioners

- Practitioners seeing homelessness as a 'lifestyle choice'.
- Practitioners knowing the risks and concerns about the young person, but lacking curiosity about changing dominant narratives about the young person and the agencies' responses to them.

Homelessness amongst this group of young people – issues for agencies

- There was a lack of leadership in supporting young people with significant and complex issues. Some agencies did not know how to raise their concerns across the network of other agencies supporting the young person. Consequently individual agencies didn't come together to share information. Instead each had their own view.
- The lack of commissioning of appropriate services.

Our role is more than the provision of a flat or other accommodation

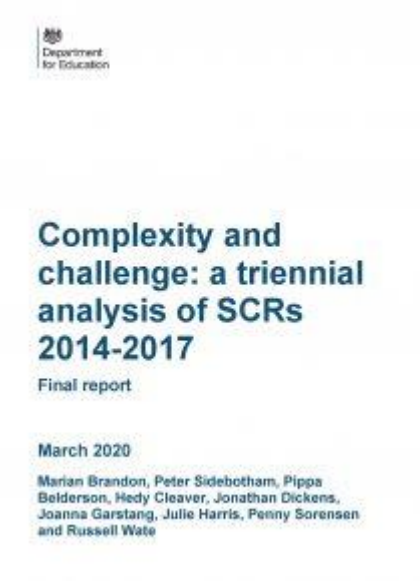
- Loneliness – often identified as something that predominantly affects older adults.
- We have responsibilities to consider this for anyone with care and support needs, as part of the wellbeing principle areas in the Care Act 2014 guidance (1.5).
- Why don't we think about the 'loneliness' of young people, particularly those who are care-experienced?

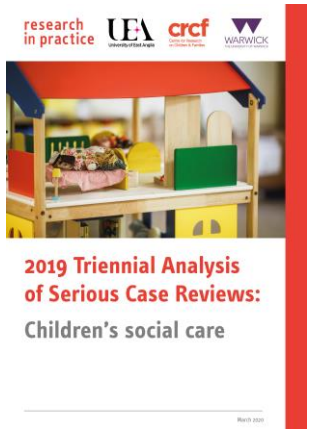
Mental health issues amongst this group of young people

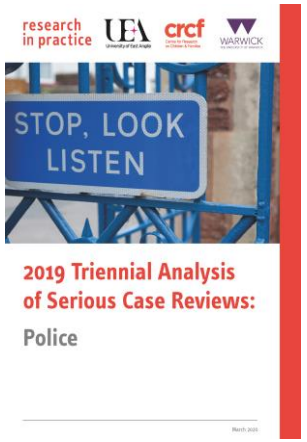
- Most young people had experienced lives that were full of loss and trauma, and experienced mental health problems and substance misuse issues as a result of this.
- Over three quarters of the entire sample had mental health problems or a diagnosable disorder (at least one, sometimes more than one)
- Some issues of neurological divergence – autism, learning disability for nearly 40% of sample.
- Too often the whole of a young person's story wasn't taken into account by those supporting them, with 'user did not engage – case closed' summarising the way in which some individuals discharged their responsibilities.
- The transition point from CAMHs to adult mental health services was particularly difficult – this is not a new problem

Role of biennial reviews of CSPRs and national review of SARs

- Identify key themes and lessons for practice BUT how do we create sustainable change?
- Often the same issues arise, which indicates the complexity of the problems we are dealing with at a practice, organisational, multi-agency and strategic level







Literature – broader context

- one third of care leavers become homeless in the first two years immediately after they leave care (Stein and Morris 2010)
- 25% of all homeless people have been in care at some point in their lives (Mackie and Thomas (2014)
- *We are concerned that despite 605 care leavers aged 18-20 being accepted as statutorily homeless in England in 2015/16, there is still no requirement to record the number of care leavers who are denied an offer of settled accommodation because they are deemed to have made themselves homeless…We are concerned that the Department for Education (DfE) does not collect data on care leavers after 21, or the number of young people housed in B&B accommodation, therefore we do not know the numbers of care leavers living in unsuitable or unsafe accommodation.* (APPG 2017, p5)

- Simon (2008) found that care leavers had fewer crisis transitions and less experience of homelessness, together with a much higher level of autonomy and support in their first accommodation, relative to other young people in difficulty. Several factors contributed to their better access and use of housing services, including:
  - having family and friends to turn to
  - leaving care teams that negotiated on their behalf with housing services.

All Party Parliamentary Group (2017) recommendations

- 1. National Government should exempt all care leavers from the Shared Accommodation Rate up to the age of 25
- 2. Local authorities should use their existing powers to exempt care leavers from council tax until the age of 25.
- 3. The DfE should make homelessness prevention one of the criteria for achievement of the Staying Close pilots.
- 4. National Government should abolish intentionality for care leavers aged 18-25.
- 5. The Department of Communities and Local Government (DCLG) should conduct a review of the 2013 allocation guidance

Discussion

- This is a 'wicked' problem, so no easy answers. Keeping on doing the same thing is not going to address this issue

- *Wicked problems often crop up when organizations have to face constant change or unprecedented challenges. They occur in a social context; the greater the disagreement among stakeholders, the more wicked the problem. In fact, it's the social complexity of wicked problems as much as their technical difficulties that make them tough to manage. Not all problems are wicked; confusion, discord, and lack of progress are tell-tale signs that an issue might be wicked.*
  - (Camillus, 2008)

Conclusion

Seen in this light, SARs [SCRs and CSPRs] are human stories, rooted in an understanding of what matters deeply for service users and those working with them (Preston-Shoot, 2003), that aim for a system turn, the development of understanding that takes practitioners, managers and policymakers beyond incremental tinkering with present practice and its context, to an envisioned future.

(Preston-Shoot, Cocker and Cooper, 2022, p98)

Further Reading

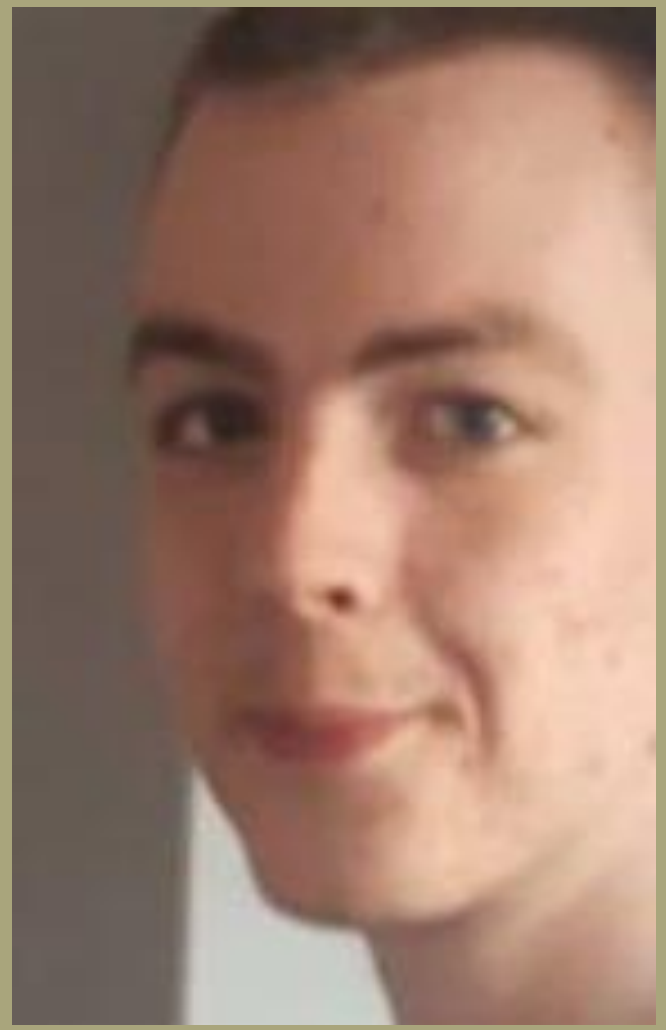
- All Party Parliamentary Group (2017) APPG Group for Ending Homelessness : Homelessness prevention for care leavers, prison leavers and survivors of domestic violence. Available at: https://www.crisis.org.uk/media/237534/appg_for_ending_homelessness_report_2017_pdf.pdf
- Cocker, C., Cooper, A., and Holmes, D. (2021) Transitional safeguarding: Transforming how adolescents and young adults are safeguarded. *British Journal of Social Work*. Available at: https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcaa238/6102523?guestAccessKey=78b38361-28be-48b8-b591-9f2edff7fff4
- Cocker, C., Cooper, A, Holmes D, and Bateman F. (2021) Transitional Safeguarding: Presenting the case for developing Making Safeguarding Personal for Young People. *Journal of Adult Protection* 23(3), pp. 144-157 https://doi.org/10.1108/JAP-09-2020-0043
- Holmes, D. and Smale, E. (2018) *Mind the Gap: Transitional Safeguarding – Adolescence to Adulthood.* Dartington, Research in Practice
- Holmes, D. (2021) *Bridging the Gap*: *Transitional Safeguarding and the role of social work with adults.* London, Chief Social Work Office for Adults/DHSC. Available at: *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/990426/dhsc_transitional_safeguarding_report_bridging_the_gap_web.pdf*
- Holmes, D. (2022) Transitional Safeguarding: the case for change, *Practice*, Vol. 34 No. 1, pp. 7-23, https://www.tandfonline.com/doi/full/10.1080/09503153.2021.1956449
- Mackie P and Thomas, I (2014) Nations Apart? Experiences of single homeless people across Great Britain, London, 2014, Crisis. https://www.crisis.org.uk/media/20608/crisis_nations_apart_2014.pdf.
- Preston-Shoot, M. Cocker, C. and Cooper A. (2022) Learning from Safeguarding Adult Reviews about Transitional Safeguarding: Building an evidence base. *Journal of Adult Protection* Vol. 24 No. 2, pp. 90-101. https://doi.org/10.1108/JAP-01-2022-0001
- Simon, A. (2008) 'Early Access and use of housing: care leavers and other young people in difficulty', Child and Family Social Work Volume 13, pp.91- 100.
- Stein M and Morris, M (2010) Increasing the Number of Care Leavers in 'Settled, Safe Accommodation, London, C4EO,

Transitional safeguarding and homelessness- emerging themes from SARs

Sarah Williams and Fiona Bateman

Adult Safeguarding and Homelessness Webinar series 26th September 2022

Safeguarding Circle



Joe Pooley was a 22-year-old care-leaver who received support from Suffolk County Council adult services as he had a learning disability. Joe was described as lovable, impulsive, confident yet vulnerable, very trusting and eager to make friends, but he had difficulty maintaining relationships.

As an adult, Joe struggled to sustain stable accommodation, being evicted or moving repeatedly. His cannabis use led to drug debts and Joe was subjected to threats, assaults and financial exploitation, but Joe was not willing, or due to coercion was unable to give information to the police to prosecute those responsible. Although practitioners working with Joe worked hard to support him, there was a limited strategic approach to mitigate these emerging risks.

Findings from Joe's case

- Limited understanding of executive capacity resulted in practitioners taking a dogged approach to providing Joe with accommodation and support which prevented resolution of these issues.
- Trauma-informed care was not embedded in commissioned services, in particular accommodation-based services
- A lack of clear escalation procedures and siloised approach by services resulted in practitioners becoming 'stuck' in terms of meeting Joe's accommodation needs for several years.
- There is a gap in the availability of commissioned services able to offer bespoke placements for individuals with complex needs, both locally and nationally.
- There is a clear need for specialist placements or, in the interim, greater flexibility from commissioners locally to use wider powers under National Health Service Act 2006, Mental Health Act 1983 and Care Act 2014 to provide accommodation based, trauma-informed holistic support so as to not over rely on accommodation provided via Housing Act 1996 duties that is designed to provide life skills support.

‘Madeleine’

This was a young person well-known to many services. She had a considerable history with CAMHS from a very young age, including as an inpatient when she was 9 years of age. Madeleine had a diagnosis of Autistic Spectrum Disorder [‘ASD’] and presentations of emotional dysregulation and OCD. She had an EHC plan, but experienced numerous exclusions because of challenging behaviour.

Support for her mental health was fragmented from a young age. Health partners were not adequately engaged with multi-agency assessment processes (for SEND or transitions assessments) so gaps in therapeutic services to meet her identified behavioural needs were not met or reported to commissioners. By 16 her parents were told CAMHS had ‘tried everything’ so they should ask for help from social care.

She was 16 when taken into care and, following 8 placements in 5 months, was placed in secure accom. in Scotland. Days before her 18th birthday she moved (with short notice and against her wishes) from secure accommodation to supported living, commissioned by the leaving care service with no agreement on who would lead on meeting her complex needs or longer-term accommodation options.

Poor understanding of the legal framework to support transition and young people with autism, together with poor multi-agency communication created unrealistic expectations that social care would manage her needs independently of health input. This, in turn, resulted in an overreliance for supported housing workers to lead on coordinating care for her complex conditions and police to respond when Madeleine was in crisis.

"The risks for young people go through the roof if you place them with adults with entrenched drug problems, it normalises it. It's just so dangerous"

"...it was the worst street in [town], everyone knows it"

"I wouldn't walk alone at night in that area, how could they place someone so vulnerable there?"

"It's so unfair. The conditions they put on accommodation for young people are so much stricter than any normal tenancy. So they kick-off, then they're kicked out."

"That hotel was notorious, it was full of drug addicts and people with serious mental health conditions"

Common barriers to effective interventions:

- **Co-operation and continuity of care**: specific duties within welfare legislation of cooperation between Local Authorities (social care and housing), NHS and 'relevant partners' to ensure continuity of care are not well understood or embedded across mainstream services. This results in missed opportunities to identify and respond effectively to obvious risks or escalating care and health needs.
- **Capacity to stay safe**: Understanding the impact of trauma, institutionalised backgrounds (esp. LAC status) or complex conditions can have on a young person's capacity to make decisions regarding their residence.
- **Lack of suitable provision**: The impact of austerity and fragmented commissioning has resulted in a UK wide chronic shortage of suitable accommodation options for young people at risk, resulting in an overdependency on supported living placements designed to support the development of 'life skills'. Often such placements have unrealistic (& arguably discriminatory) rules prohibiting 'quiet enjoyment'.
- **Poor contingency planning to prevent escalation of needs**: especially where there are risks associated with substance misuse, self-harm and/or exploitation of young adults

Decision making in respect of young people

Parental responsibility: s3(1) Children Act 1989 '*all the rights, duties, powers, responsibilities and authority which by law a parent has in relation to the child and his property*'. This permits parents to make decisions on behalf of a child provided it is within the 'zone of parental control', i.e, determining of the child's name, religion and education, appointing a guardian, consenting to medical treatment or adoption, representing them in legal proceedings, lawfully correcting the child, maintaining the child and having physical possession of the child. There are restrictions on the exercise of PR:

- The Mental Capacity Act 2005 applies to everyone 16 or over, so whilst a parent can authorise a placement, they can't deprive their child of liberty: *D (a Child)* [2019]. So, if restrictive arrangements are necessary and proportionate to keep a young person safe, authorisation under the correct legal framework is needed e.g. DoLS
- Medical treatment provided in accordance with the child's wishes, even without consulting parents, lawful if the child/YP understands medical advice, cannot be persuaded to inform her parents and it is in her best interests: . *Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security* [1984]

Continuity of care legal obligations for care experienced young people:

Leaving care provisions in the Children Act 1989 places a duty on councils to act as good 'corporate parents' and provide continuous support from social care for young people who have been accommodated under the Children Act 1989, up until the age of 25. Whilst these leaving care duties are clearly important, the Supreme Court is explicit these legal powers do not supplant the legal duties owed under:

- National Framework for Continuing Healthcare and 'promoting the health and wellbeing of looked after children' [2015] requires every looked after child has an up-to-date individual health plan based on the written report of the health assessment and appropriate referrals are made so clinicians can be actively involved in transitional planning for anyone with significant health needs who may be eligible. Formal screening for CHC eligibility should occur at 16 and eligibility determined in principle when the young person is 17. Health partners should contribute to any EHC plan/review and provide guidance re transitional plans from age 14.
- Care Act to provide care and support to those reaching 18 with eligible needs.
- The Homelessness Code of Guidance 2018 requires authorities in both unitary and two-tier areas to prepare joint protocols that establish arrangements to meet the accommodation needs of care leavers, including pathway planning systems that anticipate accommodation needs. They should engage each young person, their personal advisor and housing services staff regarding suitable housing options and any additional support needed including substance misuse services, so that the necessary arrangements are in place at the point where the young person is ready to move on from their care placement, with contingency plans in place.

Continuity of care obligations for young people who will likely have care/ support needs post 18, incl. those with caring responsibilities.

When:

For those with EHC plans: year 9 (age 14) as part of the annual statutory review. Young people who do not have EHC plans have the right to request an assessment of their SEN or transitional needs at any point prior to their 25th birthday.

For those with caring responsibilities or an 'appearance of need for care and support post 18' this should start at 14. However, the need can't be linked to mere circumstantial factors. Eligibility regs require for post 18 social care support, there is '*a physical or mental impairment or illness*.' Guidance defines this as "*a condition as a result of either physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury*." The timing of assessments should be whenever it is of 'significant benefit' for the young person. [16.10 Guidance]

2016 NICE guidance advocates that when young people are open to CAMHS, transition planning should start when the young person in 14, with an updated assessment of their needs to ensure a smooth transition to adult services. This further advocates a care planning approach to transfer between services in complex case. S117 MHA sets out specific legal duties to enable continuity of care.

There are also clear legal duties to ensure continuity of care for people going into and being released from custodial settings under the Care and support guidance.

How:

s12(5) Care Act- LA can combine assessments it is carrying out (whether or not under the Care Act) provided the adults involved consent or, in the case of a child's assessment, the consent conditions are met. The Children Act, C&FA and Care Act also all require practitioners consult with carers, their families and anyone with relevant information to support effective planning.

Key learning for frontline practitioners

Ask the question 'do you understand why I am concerned about you?' to explore with the person their understanding of the risks they face, how these impact on their immediate and longer-term wellbeing and their plan/ wishes to address those risks.

Prepare for the conversation by:

- Reviewing any case history held by services or partner agencies;
- Look for any indicators that the person's decision making might be impaired, including as a result of trauma, delayed brain development or external coercion
- Consider any necessary reasonable adjustments to ensure the person is best placed to participate in assessment and protection planning (s1(3) Mental Capacity Act 2005);
- Identifying the risks and how likely those risks are to impact on their wellbeing;
- Map what is know against possible assessment duties, including statutory housing duties, health and social care needs;
- Think about the role that informal carers or the person's support network plays, can this be harnessed to mitigate some risks?
- Avoid overly paternalistic, or organisational risk averse practices.

Key learning for senior leaders providing organisation support

High levels of supervision in children's placements can mask the extent to which a young person could struggle with independent accommodation. Careful assessment of capacity to manage risk in the community must occur before their 18th birthday, to enable robust care planning to take place.

Empower practitioners to respond to transitional safeguarding issues- this often involves complex, multi-agency responsibilities. Build confidence- ask '*what do we want for this young person; how do we use collective legal powers to get there?'* s.42(2) Care Act 2014 provides a legal mechanism to work collaboratively, across disciplines (to avoid professional conflict or error) and with the young person.

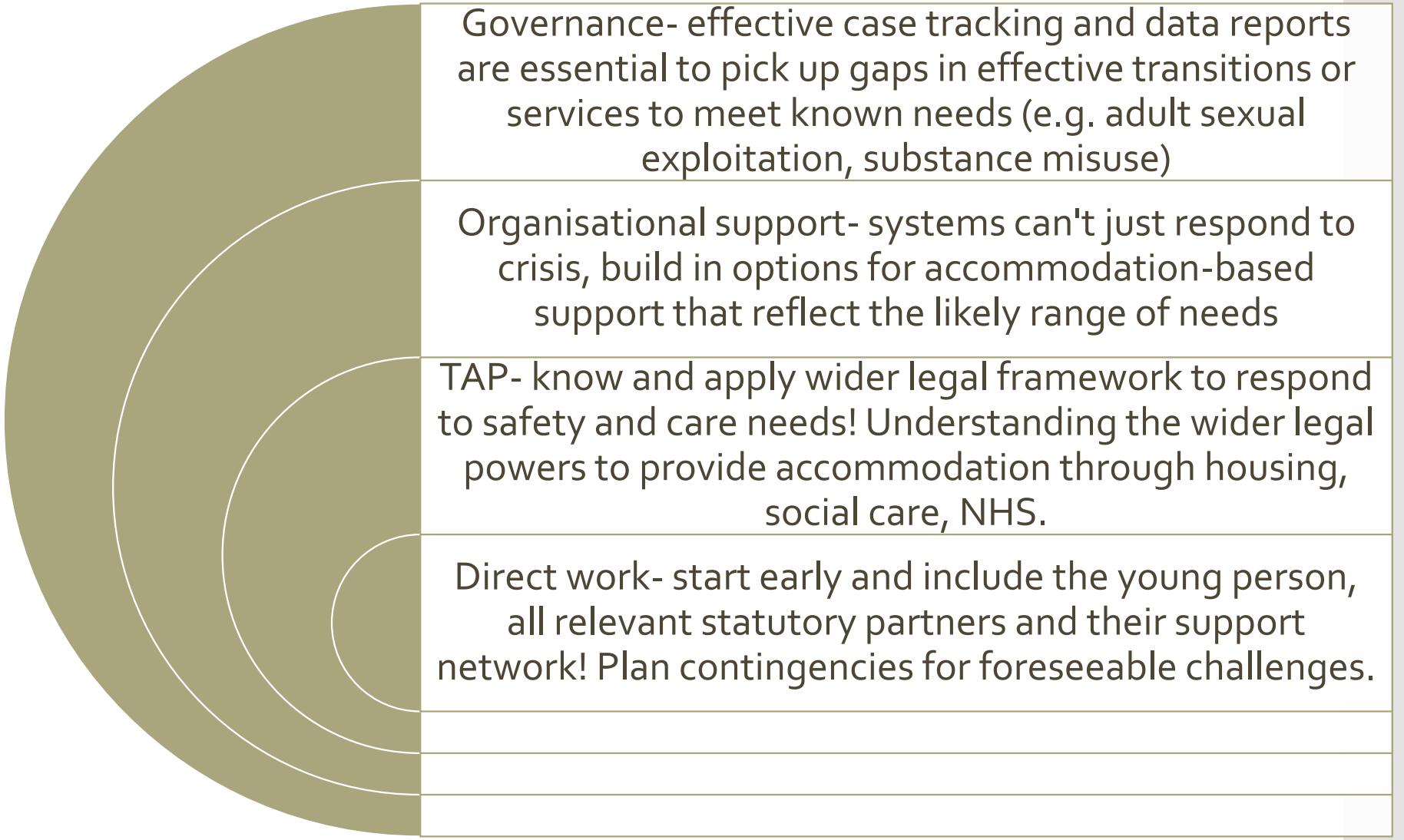
Remember, many statutory bodies have powers to provide accommodation-based support. Where there is a risk of eviction, multi-agency meetings should be convened by the lead agency (Health, CSC or ASC if they commissioned the placement) or Housing to prevent a cycle of homelessness. If there's no choice but to place a young person where they may be at risk, e.g. hotels with older substance users, multi-agency risk management should take place and the resulting protection plan be frequently reviewed.

Importantly, practitioners must be satisfied offers of accommodation are suitable. Ask 'will it obviate the person's vulnerability; can they access necessary support from the new location'? Sharing safeguarding information with supported housing providers/ landlords to ensure they can work with the person to reduce risk is not only permitted, often is it a requirement of safe care planning (s25(3) Care Act 2014). Safeguarding reviews identify that risks associated with fire safety, cuckooing, suicidal ideation or self-neglect can be overlooked leading to foreseeable harm.

Key learning for Commissioners

- Accommodation options are very limited for the highest level of need, especially care leavers with mental health conditions, personality disorders or neurodiversity, with prejudicial tenancy terms that place them at increased risk of a cycle of eviction and homelessness. A trauma-informed housing model is needed, that prioritises the need to provide a secure base for personalised support but does not make the tenancy conditional upon the individual engaging with that support. Where existing accommodation options cannot meet needs of a young person with co-existing conditions, health and social care partners need to work together to develop cohesive care plans to meet those needs in the available accommodation
- Explore opportunities for developing peer support programmes for those at risk of adult exploitation and more flexible commissioning strategies (including through regional alliances across ICB footprint) to reduce the dependency on criminal sanctions, public protection powers and services designed to deliver 'life skills' rather than rehabilitative, safe nurturing environments.
- The disruption to services caused by an out of area placement must be mitigated by careful cross-border negotiation with agencies. If out of borough placements are necessary to disrupt exploitation, plans need to ensure the necessary supports are robust and immediately available on arrival at the placement and contingency plans kept up to date to anticipate the likelihood of individuals gravitating home.

Learning from Safeguarding review-What good looks like!



Further Reading:

- https://www.gov.uk/government/publications/children-act-1989-transition-to-adulthood-for-care-leavers: Children act guidance on planning transition to adulthood for care leavers
- https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance: Statutory guidance on care planning duties for adults
- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/398815/SEND_Code_of_Practice_January_2015.pdf: SEND Code of practice
- https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1087562/National-Framework-for-NHS-Continuing-Healthcare-and-NHS-funded-Nursing-Care-July-2022-revised.pdf: revised national framework for NHSCHC
- https://www.rethink.org/advice-and-information/rights-restrictions/mental-health-laws/: Information on the legal framework for mental health support
- https://pathways.nice.org.uk/pathways/transition-from-childrens-to-adults-services/transition-from-childrens-to-adults-services-overview#content=view-node%3Anodes-overarching-principles: NICE guidance on transition
- https://www.ndti.org.uk/resources/preparing-for-adulthood-all-tools-resources: Preparing for adulthood practice tools
- www.bailii.org Good search engine for UK and European case law

Using an evidence-base in SARs to promote best practice

The case of Transitional Safeguarding with care experienced young people

Adult Safeguarding and Homelessness Webinar series 26th September 2022

- Shortcomings have been consistently highlighted by safeguarding adult reviews, namely:
  - Poor planning
  - Absence of agency policies and procedures
  - Poor risk assessments
  - Failures of children's social care and adult social care to work together
  - Absence of multi-disciplinary and multi-agency meetings
  - Unclear pathways for therapeutic and other forms of support
  - Lack of legal literacy, for example about mental capacity law for 16 and 17 year olds
  - Lack of agreements regarding strategic oversight between Sabs and Safeguarding Children Partnerships

BUT … and yet

- Some SARs report good practice in terms of policies and procedures for transition planning, and evidence of pathway planning with, and support for young people.
- Some SABs report changes to practice, and the management of practice, as a direct result of SAR recommendations.

- Yet, concerns remain, for example about unregulated placements, about the lack of resources to accommodate young people with complex needs, and about the availability of services for young people/young adults with ongoing mental health needs as a result of trauma.

Background: Ms A SAR (2017)

- Ms A took her own life in December 2015 by jumping from a window of her flat. She was aged 20. She had been a looked-after child and was known to children's social care, mental health and substance misuse services, community safety, and secondary health care providers. Fabricated and induced illness was a feature.
- Recommendations focused on:
  - Management of complex cases involving young people/adults
  - Training, supervision and staff support for complex cases
  - Record keeping and information-sharing
  - Access to specialist support
  - Review of eligibility criteria and thresholds
  - How services work together operationally and strategically.

Child/Adult Q: a pen picture

He had been found unresponsive by his father in his bedroom on 29th May 2020. Paramedics had attended and pronounced life extinct. He was aged 18 years and 11 months. At a Coroner's inquest on 18th February 2021, cause of death was recorded as mixed drug overdose and a verdict of accidental death reached.

He had been known to children's services and adult services, mental health and social care. He had a history of presenting with very complex needs, including substance misuse and suicidal ideation. He had a history of adverse childhood experiences.

Child/Adult Y: a pen picture

Adult Y was born on 19th May 2000. He died on 18th June 2020 just short of his 20th birthday. He was found in a room in a semi-independent living unit to which he had very recently moved. At a Coroner's inquest on 25th November 2020, cause of death was recorded as mixed drug overdose and a verdict of suicide reached.

He had been known to children's services and adult services, mental health and social care. He had a history of presenting with very complex needs, including substance misuse and suicidal ideation. He had a history of adverse childhood experiences.

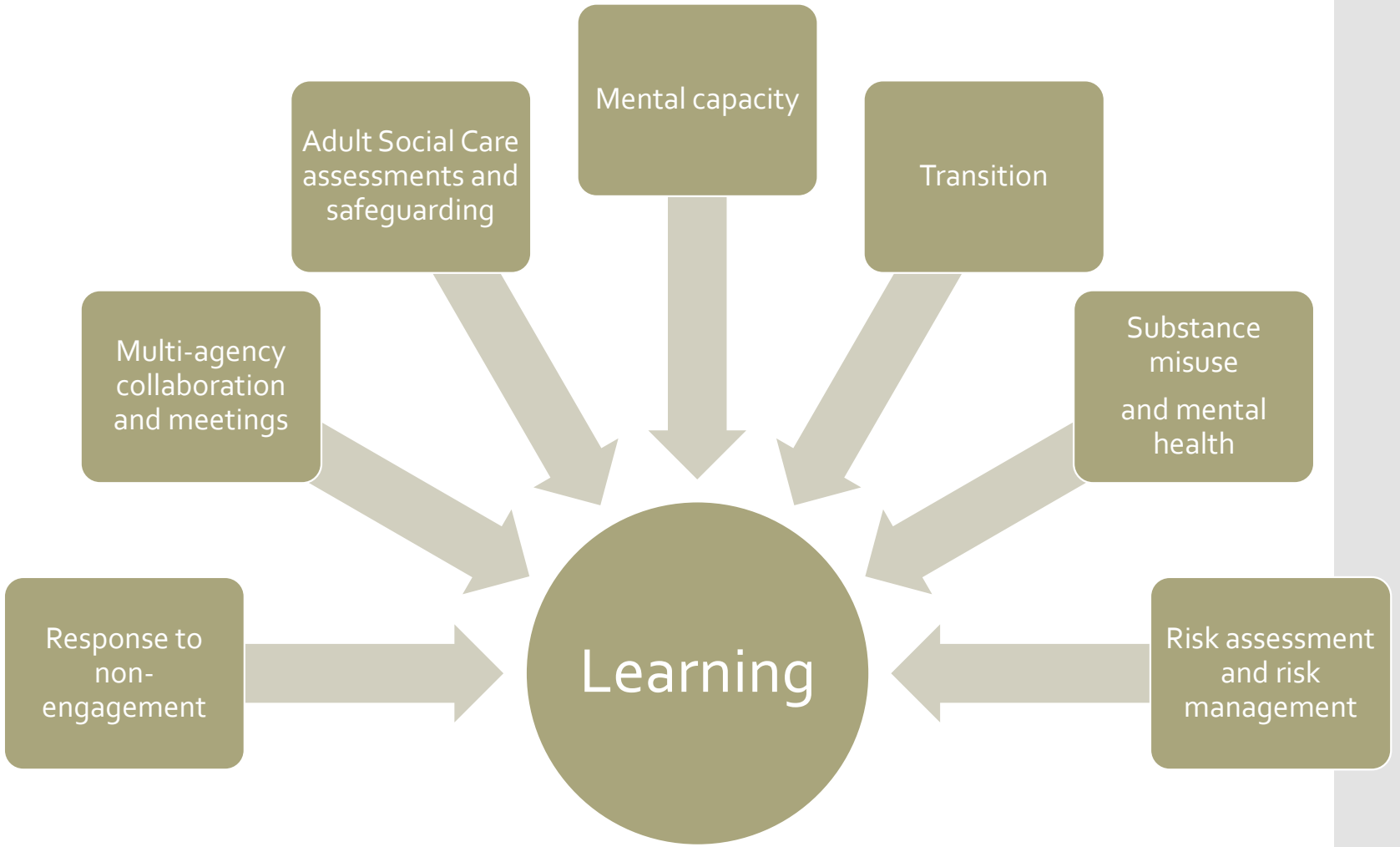
Concern in this case about fabricated and induced illness. He had been the focus of a serious case review with this theme as a central focus.

Summary of cases

The commonalities in these two cases revolved around:

- transitional safeguarding
- substance misuse
- mental health
- lack of use of adult safeguarding procedures
- shortfalls in responses to health, and care and support needs.
- concerns about the assessment of mental capacity
- the adequacy of multi-agency working particularly in terms of addressing risk.

Key emergent themes



Recommendations

- Eighteen recommendations designed to build on achievements to date and enhance Transitional Safeguarding.
- Specific recommendations that HSAB, together with HSCP, should consider:
  - Reviewing the transitions panel
  - Conducting audits of practice
  - Escalating concerns about availability of specialist placements
  - Commissioning a multi-agency training programme following a needs analysis
  - Renewing the vision and policy for Transitional Safeguarding in Havering, drawing on the experiences of young people/adults
  - Establishing a culture of seeking legal advice for complex cases

So, how can SARs influence change?

- The national analysis recommended the development of an evidence-base for best practice concerned with different types of abuse and neglect, and different fields of practice within adult safeguarding. It further recommended that building this evidence-base should maximise learning from SARs and research in order to explore what facilitated good practice and the barriers or obstacles that led to practice shortfalls.

(1) Clarity about the ambition for learning and change?

- SARs have not built on learning from previously completed reviews but have "started again." Newly commissioned reviews should compare their findings against the outcomes of previous recommendations locally and nationally.
- SARs have zoomed in on local practice, neglecting a wider angle lens. Adult safeguarding operates within, and is not independent of a legal, policy and financial context from which it derives its legitimacy and authority (Yu, 2015). Adult safeguarding can only be understood in its context, including the impact on services of austerity and emphasis on case management rather than relationship-based practice.
- SARs describe what is found but rarely penetrate beneath the surface of what has been observed (Dore, 2019) with analytic depth to answer questions "why?" The hope of transformational change rests on reviews analysing what promoted and sustained good practice and what human, organisational and legal/policy factors obstructed best practice.

(2) Extending the ambition for learning and change?

- Recommendations for change accept current organisational structures as fixed and unchallengeable (Weiss, 1993). The orientation is reformist rather than a forensic examination of what sustains the observed findings (Dore, 2019). The focus is change in a system rather than changing the system (Yu, 2015).
- SARs often eschew commentary on law, policy and the financial context, and therefore legislative and policy advocacy (Elmaliach-Mankita et al., 2019; Preston-Shoot et al., 2020).
- Consequently, SARs have limited their scope to unsettle entrenched and persistent problems, to challenge assumptions about where improvement is needed. To be transformative involves questioning and challenging, facilitating thoughtfulness, stimulating a capacity to imagine and envision. UNESCO refers to this as "futures literacy". Can SARs become a laboratory of ideas, looking forward to a desired adult safeguarding world and highlighting what is needed to get there? Otherwise, in failing to learn from history, SARs may be destined to merely repeat it.

The evidence base for direct practice (1)

- Personalised. Practice is relational and participative, tenacious and curious, needs-led, person-centred and rights-based: all aspects of that individual's situation are taken into account in the safeguarding process, including structural inequalities.
- Context and history. Practice considers the strengths and challenges in the young person's familial and social networks, working in collaboration to build circles of support.
- Developmental. Practice is not bound by age-determined boundaries. It also recognises the inconsistencies in age in the legal, policy and service frameworks and seeks to resolve tensions in these (Cocker et al., 2021a).
- Prevention, protection and recovery. Practice is trauma-informed, strengths-based and outcomes focused, aimed at promoting safety and wellbeing (Holmes and Smale, 2018). Practice offers flexible and integrated support.

The evidence base for direct practice (2)

- Whole-person. Work with young people/young adults is characterised by a holistic view of the person rather than defining their needs, vulnerabilities or strengths according to age or eligibility.
- Equalities. Practice recognises protected characteristics arising from gender, sexuality, race and disability. Practitioners acknowledge inequalities, recognising the impact on their lives, and addressing unconscious bias.
- Exploitation. Practice recognises the impact on decision-making of coercion and exploitation. It challenges any assumptions about lifestyle choice (Holmes and Smale, 2018). Practitioners explore with young people/young adults their decision-making, offering support and advocacy.
- Mental capacity. Practice is informed by a legally literate understanding of the Mental Capacity Act 2005 (Preston-Shoot et al., 2020).
- Assessment. Assessments are timely and fulfil statutory requirements. Assessments of care and support needs are incorporated into other processes, such as looked after children reviews, to minimise the need to repeat information (Holmström , 2020). Assessments of care and support focus not just on eligible needs but also on wellbeing and prevention. Assessments of risk are completed.

The evidence base for direct practice (3)

- Planning. There is evidence of early and proportionate planning (Holmström , 2020). Planning is not limited by a focus on eligibility criteria and thresholds (Preston-Shoot et al., 2020). Care plans are followed through and reviewed. Contingency planning also occurs. There is clear evidence of pathway planning, with key worker/personal adviser offering continuity and a sustained relationship that incorporates insight into the young person's feelings and experiences.

- Meeting need. Placements and accommodation provision are suitable. The impact of transition, of moving on, on mental health is recognised (Preston-Shoot et al., 2020). Practice is characterised by wrap-around support aimed at meeting accommodation need but also enhancing physical and mental wellbeing, and supporting young adults into training and/or employment. Options are considered, with adherence to the young person's preferences unless contraindicated.

The evidence base for the team around the person

- Working together. Agencies work together across service and geographical boundaries rather than in silos to offer an integrated system of planning and support, recognising the inter-connected nature of harms and risks (Holmes and Smale, 2018). There is a clearly agreed lead agency and key worker to facilitate and coordinate planning and decision-making (Preston-Shoot et al., 2020).
- Information-sharing. There is early and proportionate sharing of information about risk and the range and level of support required (Holmström, 2020). Information is shared without consent when this is necessary to safeguard a young adult at risk.
- Legal literacy. There is less focus on eligibility and more on preventative work and wellbeing. Advice and support are sought to address the inconsistencies in age in the legal, policy and service frameworks regarding young people's transitions to adult services (Cocker et al, 2021a). Legal rules are used to prevent and to disrupt sources of harm.
- Safeguarding literacy. Adult safeguarding concerns are referred appropriately using the criteria in section 42(1) Care Act 2014, including without consent when necessary to safeguard a young adult at risk, and decision-making regarding the duty to enquire is robust and lawful (Preston-Shoot et al., 2020).
- Multi-agency meetings. Practice is characterised by the use of multi-agency, multi-disciplinary meetings to share information, identify needs and risks, and agree a coordinated plan, with a lead agency and key worker clearly identified. Pathways for convening multi-agency meetings are clearly stated and understood (Preston-Shoot et al., 2020).
- Recording. Reasons for decisions, including of mental capacity assessments and best interest decision-making, are clearly recorded (Holmström, 2020).

The evidence base for organisational support for the team members (1)

- Supervision. Practitioners are offered reflective, trauma-informed supervision, to enable them to manage the emotional impact of the work, and explore any unconscious bias. Supervision enables practitioners to maintain a person-centred approach in complex cases where a young person's engagement may be ambivalent (Preston-Shoot et al., 2020).
- Training. Practitioners and managers are offered training to develop their knowledge of and skills for transitional safeguarding. This includes understanding the developmental needs of young people, proportionate risk-taking, legal literacy, mental capacity, trauma informed practice, and development of skills of professional curiosity and enquiry into young people's lived experiences (Preston-Shoot et al., 2020).
- Specialist advice. Practitioners and managers across services have access to specialist advice and guidance, for instance from lawyers and mental capacity and mental health specialists (Holmström, 2020).
- Co-production. Commissioners and providers involve young people/young adults in co-design/co-production of services for safeguarding young people.

The evidence base for organisational support for the team members (2)

- Commissioning. Commissioners (health, housing and social care jointly), providers and young people/young adults regularly conduct needs analyses and review available services to identify any gaps in provision, ensuring that planning is responsive and evidence-informed. Commissioning recognises the importance of services that are developmental, that are not bound by rigid age-determined boundaries, and that offer flexible support. Commissioners escalate concerns about shortages of accommodation and other resources, and contribute actively to the assessment of suitability of proposed placements (Preston-Shoot et al., 2020).
- Management. Senior managers demonstrate leadership that spans boundaries, essentially embracing a life-course and contextual/ecological approach. The setting of a clear vision across different service areas and having 'a 'listening' senior management open to change' are managerial strengths and necessary enablers to facilitate improvement in transitional safeguarding approaches to working with young people (Cocker et al., 2021b).
- Policies and procedures. There are agreed multi-agency procedures and practice guidance for transitional safeguarding (Preston-Shoot et al., 2020). This includes clear pathways for victims of exploitation, including access to therapeutic and mental health support.
- Staffing. Caseloads allow for the development of relationship-based practice as transitional safeguarding cannot be time-limited work (Holmes and Smale, 2018). Staff have sufficient knowledge and experience to manage case complexity. Recruitment and retention of staff enable continuity of relationships with young people/young adults (Preston-Shoot, 2020).

The evidence base on governance

- Safeguarding Adults Board (SAB). The SAB routinely exercises its statutory mandate by seeking assurance regarding how transitional safeguarding is being developed and embedded in policy and practice locally.
- Strategic response. The SAB works closely with the Community Safety Partnership (CSP) and with the Children's Safeguarding Partnership (CSP) to ensure system-wide, coordinated oversight of transitional safeguarding locally. This might involve shared chairing arrangements, shared work groups or shared objectives between SABs, SCPs and CSPs (Walker-McAllister and Cooper, 2021). It might include a cross-age strategic group to direct activity for both children and adults, with a shared vision of purpose, clear terms of reference, multi-agency membership and clearly defined responsibilities (Preston-Shoot et al., 2020).
- Quality assurance. Regular case audits of transitional arrangements are conducted (Holmes and Smale, 2018).
- Reviews. Safeguarding Adult Reviews and Child Safeguarding Practice Reviews are used to develop arrangements for care leavers. Boards and Partnerships track the impact of reviews.

The evidence base for the fifth domain

- SAR authors highlight where the national legal, policy and financial context created barriers or obstacles for services in aligning practice with the evidence base.
- SABs regionally and nationally collate SAR findings and escalate concerns about the impact of this national context to the Department of Health and Social Care, Ministry of Justice, Home Office and DWP as appropriate.
- SABs are clear in their advocacy when and where parts of this overarching system are not working.

A final word on organisational support and on governance?

- DLUC (2022) Ending Rough Sleeping for Good
- SABs should have a named member advocating for people sleeping rough.
- SABs should ensure, in their partnerships with housing teams, clear accountability for people sleeping rough. This should include joint working between the Sab and Director of Housing.
- Support for care leavers across housing, health, social care, criminal justice, employment and welfare.
- Care leaver Covenant to improve transition, to offer care leavers employment opportunities and tailored support.
- Aim to improve quality of supported housing provision for 16/17 year olds and care leavers.
- Aim to introduce standards and registration for currently unregistered providers who accommodate 16/17 year olds and care leavers.

Conclusion

Seen in this light, SARs are human stories, rooted in an understanding of what matters deeply for service users and those working with them (Preston-Shoot, 2003), that aim for a system turn, the development of understanding that takes practitioners, managers and policymakers beyond incremental tinkering with present practice and its context, to an envisioned future.

(Preston-Shoot, Cocker and Cooper, 2022, p98)

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