Transitional Safeguarding with care-experienced young people: Learning from Safeguarding Adult Reviews and Serious Case Reviews / Child Safeguarding Practice Reviews in England.

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There’s a ‘cliff-edge’ at 18 years…

Care-experienced young people

- We have duties toward any young person leaving care.
- There are three categories of those leaving care. All are entitled to some support after their 16th birthday. The categories are **Eligible**, **Relevant**, and **Former Relevant .**
- (isn't the language used here lovely? 😐)
- All care leavers are entitled to Personal Adviser support at any time up to age 25.

KEEP CARE LEAVERS CONNECTED

The evolution of law and guidance in England for Transitional Safeguarding

- All young people qualify for advice and assistance from the local authority (s.24, CA 1989) to promote their welfare when they cease to be looked after.
- The Children Leaving Care Act (CLCA) 2000 strengthens this with respect to eligible children: those in care aged 16 and 17 who have been looked after for more than 13 weeks since the age of 14.
- The 2000 Act 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.
- Care Leavers (England) Regulations 2010 require review at least every six months, and itemize the principles that should underpin pathway plan provision and the roles of key agencies.

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Leaving care

- Is a major point of transition for young people
- Historically we haven't done a very good job of discharging our duties toward care experienced young people

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

- Stein, M. (2004) *What Works for Young People Leaving Care?* London: Jessica Kingsley Publishers.
- Stein, M. (2006) 'Research review: young people leaving care.' *Child and Family Social Work*, 11(3), 273-279.

- Local Government Ombudsman and Kent CC and Dover DC (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. Council failed to work with agencies regarding the young person's mental health and substance misuse, declined to offer accommodation under section 20 Children Act 1989 and failed to include the young person's mother in assessments.

Slide courtesy of Professor Michael Preston Shoot

Transitional Safeguarding - A thematic review of SARs, SCRs/CSPRs that involve care-experienced children aged 15-25

- Work being undertaken by UEA 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 analysed these data during the summer of 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

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

Legal literacy

- Knowledge of mental capacity and Mental Capacity Act 2005 poor
- Knowledge of Mental health Act 1983/2007 poor, especially where young people were being discharged from Tier 4 services and s117 duties applied
- Children's services - knowledge about adult safeguarding was poor
- Adult safeguarding – not much is known about the needs of young people in this space, apart from those with SEND.

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)

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

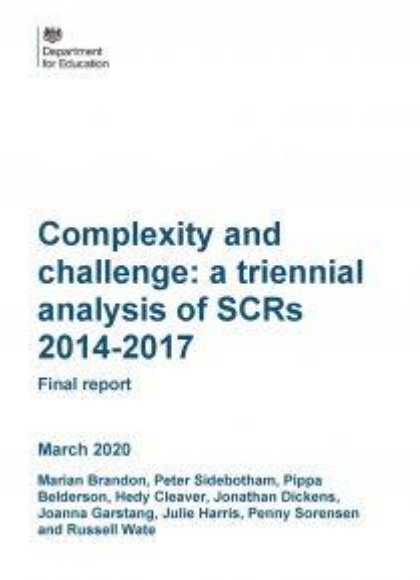
- There was a lack of leadership in supporting young people with significant and complex issues. Some agencies did not know how to raise their concerns across the network of other agencies supporting the young person. Consequently individual agencies didn't come together to share information. Instead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

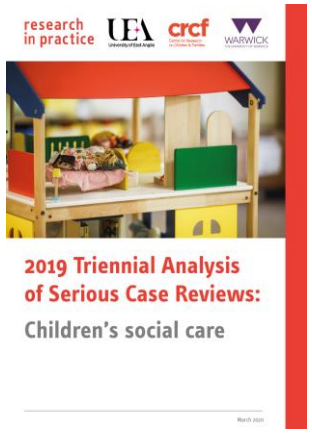
Our role is more than the provision of a flat or other accommodation

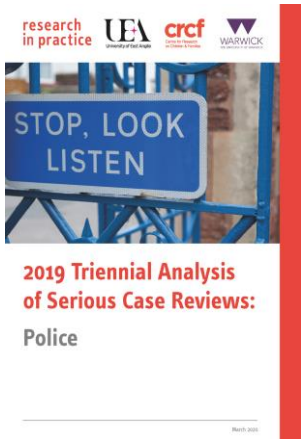
- Loneliness – often identified as something that predominantly affects older adults.
- We have responsibilities to consider this for anyone with care and support needs, as part of the wellbeing principle areas in the Care Act 2014 guidance (1.5).
- Why don't we think about the 'loneliness' of young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

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.**

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)

Madeleine

Madeleine was of mixed ethnicity (White British/Black Nigerian). She was 18 years of age when she died. At the time of her death, she was living in an unregulated placement and was 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. By 16 her parents were told CAMHS had 'tried everything' so they should ask for help from social care.

Madeleine had a diagnosis of Autistic Spectrum Disorder ['ASD'] and presentations of emotional dysregulation and OCD. She had an EHC plan, but despite this had experienced numerous exclusions because of her challenging behaviour.

She was first assessed by social care aged 12, but by 16 was taken into care and, following 8 placements in 5 months was placed in secure accommodation in Scotland. Shortly before her 18th birthday she moved from secure accommodation to supported living in Croydon. A neighbouring borough (L.B. Wandsworth) had legal responsibilities for her care prior to and after Madeleine turned 18.

Findings

- Madeleine's voice was not heard. Care planning was done about her- without her. This, understandably, increased her anxiety and feelings of hopelessness. Neither her or her family were supported to understand her diagnosis or offered meaningful support to address her behaviours.
- 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.
- Risk identification and multi-agency management was very poor. Very little consideration was given to indications of high risk factors for self-harm and suicide. The lack of escalation processes for partners or commissioned services meant that those working directly with her had little organisational support.
- Poor understanding of the legal and policy 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 on police to respond when Madeleine was in crisis.

Colin

Colin was a man in his early twenties who lived in supported living accommodation. He had a learning disability and some physical problems. Colin was murdered by peers in the local community. Colin had been in foster care as a child and had special educational needs.

Colin remained in his foster placement after he turned 18 in a 'staying put' arrangement. He made the decision to move to supported living accommodation to develop his independence. However, records show that Colin had less independence in the supported living environment than he did when he lived with a foster carer. With the help of his foster carer, Colin began to develop his relationship with family members, which continued until his death.

A psychologist's report for Colin gave insight into his development and recommended preparatory planning for independence. Unfortunately, no such work was undertaken with Colin until shortly before his death. Instead, the provider continued to rely on a voluntary agreement with Colin, who was deemed to have capacity to make health and welfare decisions, that he would not go out unaccompanied. Over time, Colin began to exhibit more disruptive behaviour and some violent incidents ensued, culminating in the Police being called when carers felt that they were unable to manage his behaviour.

In the weeks and months prior to Colin's death, he started asserting his right, as an adult, to go out into the community unaccompanied. Colin began to socialise with a large group of people of a similar age, and with similar vulnerabilities. Late-night incidents occurred, including in an incident where Colin was a victim of an assault, with an unsubstantiated 'throwaway' comment made that Colin was a paedophile. Colin continued to associate with the same wider group after his assault and was subsequently killed by two of his peers.

Findings

- Better legal literacy regarding Mental Capacity Assessments and Deprivation of Liberty/ Safeguards from all care and support staff in any residential accommodation about people living in their accommodation.
- Transitional planning and risk management plans are enacted. As it had been established (by the MCA assessment in Oct 2011) that Colin had capacity to make decisions about going out unaccompanied, there should have been greater emphasis on preparatory work to develop his independence in the community and effectively manage risks. This work should have commenced from early in his placement with the Supported Living Provider, rather than waiting until very shortly before Colin (not unpredictably) started asserting his right as an adult, to go into the community without supervision.
- Better multi-agency communication. Where there are safeguarding concerns, effective and timely communication, care planning and risk assessment processes are of paramount importance. These are matters which should be recognised as having joint ownership, rather than 'tasks' to be passed from one agency to the other. If one of the agencies does not carry out agreed actions, professional challenge should be applied by the partner agency.
- Better communication and involvement of birth family members. The value of engaging supportive family members in support planning and risk management processes should not be under-estimated. With the consent of the adult in question, consideration should always be given to inviting family members to attend review and planning meetings and generally to have an active input into these processes. Decisions not to involve family members in this way should be recorded, along with a clear rationale for the decision.
- Violent incidents in care and support settings. If there is evidence of a pattern of violent incidents involving people with care and support needs (as perpetrators and / or victims) in a supported living or care home environment, this should be considered as a potential safeguarding issue.

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)

Transitional Safeguarding guidance for social work with adults

- Available here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/990426/dhsc_transitional_safeguarding_report_bridging_the_gap_web.pdf

Further Reading

- Bateman, F. and Cocker, C. (2021) *Safeguarding Adults Review: Madeleine.* Croydon Safeguarding Adults Board, London. Available at: *https://www.croydonsab.co.uk/wp-content/uploads/2022/03/PDF-Madeleine-SAR-Final-Report.pdf*
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