Think Family

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Barnet Safeguarding Children Partnership

Barnet Safeguarding Adults Board

Welcome to our monthly Lunch and Learn session

- Webinar house keeping:
- Please put all microphones on **MUTE**
- If you would like to ask a question, please use the **CHAT** function
  RESPECT the stories you hear and protect the identity of adults at risk through **CONFIDENTIALITY**
- Take care of your own **WELLBEING** throughout this session

How to report concerns in Barnet: Adults at risk

Social care direct at Barnet council are the point of first contact

- **Tel 020 8359 5000 text (SMS) 07506 693707**
  email socialcaredirect@barnet.Gov.Uk

Police community safety unit in an **emergency 999**

- **Tel 020 8200 1212 email** sxmailbox-tib@met.Pnn.Police.Uk
- What happens after you report abuse: https://www.Barnet.Gov.Uk/sites/default/files/assets/citizenportal/documents/adultsocialcare/whathappensafteryoureportabusebookletmay12.Pdf
- Your concern should always be taken seriously and acknowledged. Usually, the adult at risk will be consulted and you should always be told if the concern will be investigated.
- Barnet MASH : mash@barnet.gov.uk / 0208 359 4066 / www.thebarnetscp.org.uk
- If you hadn't had this it is ok to ask again!

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Common pitfalls in complex safeguarding cases

Crucial to effective safeguarding practice is the organisational support around the team providing direct work, but too frequently practice reviews report insufficient support/supervision to enable practitioners to work effectively with family members who are uncooperative**,** ambivalent, confrontational, avoidant or aggressive. There are policies (e.g. BSAB self-neglect policy) and courses available to develop these skills, but remember also to speak to your line manager, Designated Safeguarding Leads/ Champions and legal departments for ongoing support.

Another common pitfall occurs if, during the initial assessment/enquiry process, practitioners do not clearly check that others have understood their communication. There is an assumption that information shared is information understood. This can be amplified if there is overreliance on IT systems across multi-agency practice. Do not assume case information recorded on one system is accessible, ensure care or treatment providers, other professionals and familial carers understand what is expected to reduce risk and what they should do if risk remains. This should be recorded in the care or protection plan!

We know that all too often case responsibility is diluted in the context of multi-agency working, impacting both on referrals and response. Too often adults at risk involved in SARs were signposted to other agencies, with no follow up and insufficient checks to ensure those agencies could meet the needs/ risks identified. A key theme in the 2020 SAR analysis was lack of management oversight of key decisions [7.3.4] *'Only by using an approach of active leadership, supported by internal audit and responsive escalation routes, can an organisation ensure the needs of adults at risk can be responded to with timely approaches consistent with agreed polices and procedures.'*

Think Family: Local Context

The Right to respect for family life is enshrined in the Human Rights Act, but we know from local safeguarding practice reviews that interpreting these duties alongside obligations to safeguard adults at risk and children can be complex.

BSAB Safeguarding Adults reviews:

- Gabrielle- harm caused by family members refusing pressure ulcer care for their loved one during the Covid-19 lock down. This highlighted the importance for professionals to understand the issues of the whole unit using a multi-disciplinary/multi-agency approach, including psychology, in order to develop whole family plans.
- Thematic SLIP review- harm caused by family members refusing health and social care support for their adult child with learning disabilities. Whilst professionals recognised the risk of harm, failures to pass relevant information to legal advisors hindered escalation, leaving practitioners feeling powerless to intervene and support the adult at risk and her family.

LSCP thematic and practice reviews:

- Transitional safeguarding- importance of understanding the whole picture around young people, including their relationships with siblings and parents, who often have their own support needs. It is crucial that practitioners are aware of the support/interventions going on with other family members and consider how this interacts with their work with the individual young person. The wider context of the young person's life, including cultural heritage and any protected characteristics that may make them more vulnerable or in need of a more bespoke approach to safeguard them through their transition.
- CSPR Child L – due for publish early 2022.

Local and national data reported domestic abuse concerns rose during Covid-19 lockdowns, incl. a significant rise in concerns of adult children abusing elderly parents.

- National research identified confusion among agencies as to what constitutes elder abuse versus domestic abuse in later life (McGarry et al. 2014).

- Professionals working with older people may miss signs of abuse due to their own assumptions and perceptions of domestic abuse and ageism (Brossoie and Roberto 2015) or mistake abuse for carer stress (Carthy and Holt 2016) or medical symptoms associated with old age (Yechezkel and Ayalon 2013).

- A failure to recognise and effectively respond to domestic abuse in an older person may lead to inappropriate referrals and potentially unsafe outcomes (Welsh Government 2017). In addition, very limited options for onwards referral after identification is likely to negatively impact on older people seeking support or following through on referrals to domestic violence support services (Knight and Hester 2016).

- See Hannah Bows' report, '*Practitioners' views on the impacts, challenges and barriers in supporting older survivors of sexual violence':* https://journals.sagepub.com/doi/10.1177/1077801217732348

Domestic abuse: Challenges for older victims

Prevention and effective multi-agency responses to safeguarding risks

- Covid-19 lockdown put into sharp focus how important it is to work collaboratively to anticipate risk and adapt to respond effectively to this.
- The BSAB understands we have a dual responsibility both to protect adults at risk and to ensure those caring for them have access to the help and guidance they need to provide safe care, maintain their own wellbeing and understand how to report concerns.
- Adults have the right for their decisions to be respected, but practitioners and carers must actively consider if they have capacity to know the risks and protect themselves.
- Preventative advice and support should form part of any health intervention or social care assessment. Practitioners, incl housing officers, district nurse, OTs, must be aware of risks to children and any adult with care and support need within the household. It is important to build confidence to recognise and report so that you can involve police, Office of the Public Guardian and all relevant partners: *Southend on Sea Council v Meyers* [2019]

MAKE EVERY CONTACT COUNT!

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5 key themes from learning review:

Understanding the whole family picture

- Barnet LSCP and SAB's transitional safeguarding deep dive highlighted the importance of understanding the whole family picture. **It is crucial that professionals are aware of the support/interventions going on with other family members and consider how this interacts with their work with the individual young person. The wider context of the young person's life, including cultural heritage and any protected characteristics that may make them more vulnerable or in need of a more bespoke approach to safeguard them through their transition.**
- Gaps in the housing offer for young people was also identified, with the youth homelessness policy only applicable to 16- and 17-year olds therefore young people 18 and over lack this statutory support. Furthermore, certain groups of young people, particularly those identifying as LGBTQ+ have had little bespoke support for example when being made homeless when coming out as LGBTQ+ in their homes. Many come from homes where it is culturally not accepted to identify this way.

Missed diagnosis:

- For some young people/adults, concerns were raised about undiagnosed learning disabilities, possible autism spectrum disorder, or issues around emotional regulation. **Particularly where the young person had other more severe/apparent support needs (eg physical health) professionals felt that their other conditions were not always given sufficient thought.** There were mentions in records of historic diagnoses, but these were not always shared with all professionals involved, leading to confusion and possible issues with eligibility for services.

- The case review group highlighted how retrospective diagnosis and knowledge and understanding around conditions such as ADHD are more attuned now than they were a few years ago. Mental health professionals in the case review understood how a lack of diagnosis may make it more difficult for the young person as other services won't necessarily understand how they need to adjust their offer of support to take into account the young person's mental health needs. The contextual and cultural background of the young person also comes into play with different cultural understandings and acceptances of mental health conditions and the stigmas that surround this. It is important to champion and advocate for diagnosis and normalise mental health conditions in a pragmatic manner.

Working together:

- The learning review discussed how some young adults had fallen through gaps, for example an individual with SEN who went to a mainstream school out of borough, or by accessing care and support from private or voluntary, community and faith sector providers**. These different ways of accessing support meant that statutory services did not pick up on the individuals until later down the line, and families were not aware of all the support available to them**. It is also important that we work with families to understand what is important to them, their religious/cultural identity, and how this may affect the services they want to access. **All services working with the young person should be involved in transition planning and sharing information to coordinate support.**

- The learning review noted that care leavers have health passports that track their health needs, but other needs and support are not well tracked across other services. Consideration about how to build in 'trauma-informed practice' to health, social care, housing and other services is needed. It is important that all services that need to are aware of those at high risk of exploitation and abuse during adolescence. SEAM tool as an example.

- Definitions of vulnerability can be different for different services and organisations and this can mean eligibility for services and understanding services can be difficult for professionals as well as for the young person.

Building trusted relationships:

- With a consistent and well-developed relationship with a particular practitioner, the young person and their family are able to establish trust and work together better. Several of the families within the learning review had raised frustrations about having to repeat their story multiple times and trust in statutory services subsequently deteriorated. These trusted relationships or a 'key worker' style approach is particularly helpful for planning and coordinating transitions.

- Discussions in the learning review were had about training across the board and group family conferences. Art Against Knives provide trusted relationship training using the AMBIT framework, which is around building services around a trusted relationship rather than young people having interactions with several different professionals. **Develops their relationship to help**. Furthermore, it was suggested that using the family group conference model in a way that young people choose which adults are important to support them with a successful transition. It would be important to include those they trust in their community. **Finally, it was noted the importance of understanding and utilising the Making Safeguarding Personal approaches to service provision when looking at transitions.**

- https://www.scie.org.uk/care-act-2014/safeguarding-adults/safeguarding-adults-boards-checklist-and-resources/making-safeguarding-personal.asp

Navigating service criteria :

- Strict service criteria or thresholds can generate confusion for families as the system is complex and it can be difficult for them to work out what support they are able to access. Young people/adults can be caught in the gap between service eligibility and there are different age cut-offs for different services. Particular issues were raised in these cases in relation to progressive conditions, where the young person's eligibility changed quickly and forward planning was necessary. **For some of the vulnerable adolescent cases, historic information created a risk profile (eg criminal history) that made many services refuse to offer support and created challenges in finding a suitable placement.**

- Adult Social Care are taking a unique approach to high-risk cases, which includes making teams aware of the preventative and wellbeing offer from voluntary and community care, meeting with key partners in education and health, and encouraging teams to work cross-disciplinarily to discuss case complexity and plan swift transfer to minimise case slipping through the net.

- **The learning review group underlined the importance of having joint risk management planning between services to ensure all organisations are being risk averse and planning well for transitions around the young person's network and trusted relationships.** As well as championing prevention and a focus on wellbeing to prevent harm and allowing for flexibility in providing support to young people.

Discussion:

- How frequently do you discuss policy developments in team meetings, is time taken to explain how they relate to supporting you to make the right decision in difficult cases?
- What mechanisms do you have to get support if risk remains despite protective interventions?
- Are you more confident now to ‘think family’?

Further reading

- ‘Safeguarding Adults under the Care Act 2014’, Jessica Kingsley Publishers, 2017
- https://www.local.gov.uk/sites/default/files/documents/25.130%20Making%20Decisions%20on%20the%20duty_06%20WEB.pdf: LGA and ADASS guidance on decision making re s42 enquiries
- https://www.local.gov.uk/sites/default/files/documents/25.143%20Making%20Safeguarding%20Personal_04%20WEB_0.pdf: Case studies for discussion at team meetings
- https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice: MCA Code of Practice
- https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance: Care Act statutory guidance
- https://www.scie.org.uk/care-act-2014/safeguarding-adults/adult-safeguarding-practice-questions/: SCIE guidance and https://www.scie.org.uk/care-act-2014/safeguarding-adults/adult-suspected-at-risk-of-neglect-abuse/ on gaining access to an adult at risk
- http://www.cps.gov.uk/legal/p_to_r/prosecuting_crimes_against_older_people/#mental: Guidance on prosecuting crimes against adults at risk
- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf: Advice for social care practitioners on duties regarding information sharing and safeguarding

Further reading

- https://thebarnetscp.org.uk/bscp/news/bscp-publishes-report-into-transitional-safeguarding
- ADASS (2020) Transition Good Practice Principles. https://londonadass.org.uk/wp-content/uploads/2020/10/Transition-Good-Practice-Principles.pdf
- Association for Young People's Health (2019) https://www.youngpeopleshealth.org.uk/wp-content/uploads/2019/09/AYPH_KDYP2019_FullVersion.pdf
- Care Quality Commission (2014) From the pond into the sea: Children's transition to adult health services. https://www.cqc.org.uk/sites/default/files/CQC_Transition%20Report.pdf
- Cocker (2020) Transitional Safeguarding: Transforming How Adolescents and Young People Are Safeguarded. https://www.tandfonline.com/doi/full/10.1080/09503153.2020.1733826
- Cocker, Cooper, Holmes, Bateman (2021) Transitional Safeguarding: presenting the case for developing Making Safeguarding Personal for young people in England. https://www.emerald.com/insight/content/doi/10.1108/JAP-09-2020-0043/full/html
- Engage Barnet (2018) Transitions from paediatric (children's) to adult health services. https://engage.barnet.gov.uk/transitions-childrens-to-adult-health-services
- Holmes (2021). Bridging the gap: transitional safeguarding. Chief Social Worker Knowledge Briefing. https://socialworkwithadults.blog.gov.uk/2021/06/03/bridging-the-gap-transitional-safeguarding/
- Holmes (2018) Transitional safeguarding from adolescence to adulthood. https://www.researchinpractice.org.uk/all/news-views/2018/august/transitional-safeguarding-from-adolescence-to-adulthood/
- Holmes and Cooper (presentation) Transitional Safeguarding: adolescence to adulthood. https://adcs.org.uk/assets/documentation/AC19_TSafeguarding.pdf
- NICE (2013) Transition from children's to adults' services for young people using health or social care services. https://www.nice.org.uk/guidance/ng43
- Transitional Safeguarding Learning Hub Newsletter: January 2020. https://www.hertfordshire.gov.uk/media-library/documents/childrens-services/hscb/learning-hub/transitional-safeguarding-newsletter-final.pdf