KBSP Multi-Agency

Good Practice Guide

SAFEGUARDING OLDER ADOLESCENTS AND YOUNG ADULTS (16-25) THROUGH THEIR TRANSITION YEARS

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Safeguarding Older Adolescents and Young Adults (16-25) through their transition years

Older Adolescence and Young Adulthood are important developmental periods that we all go through. Often the needs of these age groups are only understood through the experience of 'Transitions' as children move into adult services. Transition is defined as;

'A purposeful and planned process of supporting young people to move from children's to adults' services.'

(Transition: getting it right for young people Department of Health and Department for Education and Skills).

In Bristol we know that we need to look beyond the Transition experience, which is one established by the service structure and legislation framework rather than determined by individual need, to understand the specific risks, vulnerabilities and strengths of this cohort.

This period of life is one in which young people experience increased independence. This comes with responsibilities for managing personal finances, having greater choice in accommodation options, seeking employment or further education, or becoming parents. These changes happen while the brain continues to grow and develop. Adolescent traits of impulsivity and risk taking have not fully reduced, and individuals' social support systems may not yet be fully developed within their communities as they seek to establish their personal independent identities.

With this in mind, personal independence can bring greater vulnerabilities: as younger adults have access to funds and accommodation and may risk being targeted by cuckoo-ing, exploitation or financial abuse. It is a period of time that heightens the risk of involvement with the criminal justice system, homelessness or unstable housing and mental health problems. They may not be known to adult services and so assessments of need can be inaccurate if reliant on the young adult to disclose. Young adults age 20-24 are the highest prevalence group for being a victim of homicide, and suicide is the second leading cause of death for males under the age of 25.

In addition, services approach can differ significantly pre and post 18 particularly in relation to how proactively they seek to engage the young person. This period can be difficult for a young person to navigate who has previously accessed children services. For those with multiple needs, these transitions may be complicated by mental health problems, becoming a parent, substance misuse or involvement in the

criminal justice system. They also make transitions across a range of services and may be ‘transferred’ from children’s health, social care and/or criminal justice services to adult equivalent. These transitions are complex and inconsistent and expectations can be unclear.
Working Together to Safeguard Children (HM Govt. 2015) states;

‘For services to be effective they should be based on a clear understanding of the needs and views of children’ (Pg 9)

Working Together gives a list of what children say they need to feel effectively safeguarded.

Furthermore, children have said that they need:

- **Vigilance: to have adults notice when things are troubling them;**
- **Understanding and action: to understand what is happening; to be heard and understood; and to have that understanding acted upon;**
- **Stability: to be able to develop an on-going stable relationship of trust with those helping them;**
- **Respect: to be treated with the expectation that they are competent rather than not**
- **Information and engagement: to be informed about and involved in procedures, decisions, concerns and plans;**
- **Explanation: to be informed of the outcome of assessments and decisions and reasons when their views have not met with a positive response;**
- **Support: to be provided with support in their own right as well as a member of their family;**
- **Advocacy: to be provided with advocacy to assist them in putting forward their views.**

Working Together to Safeguard Children (HM Govt. 2015 p.11)

These principles provide a useful guide to all services working with children and are relevant to considering their needs when transitioning.

NICE have produced a quality standard (published Dec 2016) which describes the high priority areas for quality improvement for Transition from Children to Adult’s services with 5 quality statements that should be addressed by agencies:

Statement 1 Young people who will move from children's to adults' services start planning their transition with health and social care practitioners by school year 9 (aged 13 to 14 years), or immediately if they enter children's services after school year 9;

Statement 2 Young people who will move from children's to adults' services have an annual meeting to review transition planning;

Statement 3 Young people who are moving from children's to adults' services have a named worker to coordinate care and support before, during and after transfer;

Statement 4 Young people who will move from children's to adults' services meet a practitioner from each adults' service they will move to before they transfer;

Statement 5 Young people who have moved from children's to adults' services but do not attend their first meeting or appointment are contacted by adults' services and given further opportunities to engage.

These statements should be supported by having an infrastructure that supports the transition process such as management oversight of the preparation and implementation of policies and strategies with their effectiveness audited and reviewed.

Purpose of Guide

This guide seeks to draw on the feedback that we have collected from Bristol adolescents and young adults who are in their transition years and from the expertise of specialist Transitions workers to identify best practice when working with this cohort. It promotes our best practice principle where we want to ensure that;

‘Person Centred Planning acts on what is important to a person and is a process for continual listening and learning, focusing on what is important to someone now and in the future.’

This guide is also in line with NICE guidelines and outlines ways of working which have been found to be effective at balancing the competing needs and rights of the older adolescent or young adult in order to provide meaningful interventions. Its aim is to ensure that commissioners, services and practitioners will ensure that young people are comprehensively prepared for transition through the adequate provision of information, the service is person centred and that adequately trained professionals in both children’s and adult’s services are effectively supporting these young adults and their families.

"To me, best practice is when ALL workers talk to each other and have proper endings not just feeling as if I am left with no support and telling me what the plan is."

Young person working with Golden Key, Bristol

Comprehensive multi agency engagement and joint working

A mutual clear understanding of referral agencies and the practice within each agency is needed to ensure consistently we are meeting the needs of these older adolescents and young adults. Consultations have highlighted that whilst there is evidence across the partnership that there is good working practice and lots of positive experiences of transitions for young people that this in somewhat inconsistent. Some are receiving good levels of support through their transition years but some are having confusing and less positive experiences. Agencies in Bristol both statutory and voluntary such as health and social care, youth services, charities, housing, education, benefits and employment agencies must meet the challenge to map their work with others, and, develop cooperation among each other whilst involving the young person and their families.

Good practice for effective transitions has occurred and will continue if;

- Transition is not seen as the core responsibility of one agency, and that all agencies work closely together;
- Where a referral is taking place to another setting, a joint meeting between a relevant clinician/professional and the young person should be offered and carried out, if agreed by the young person;
- Care plans should outline a personalised agreement of information that can be shared with the new service;
- Adult services should be aware of the different pathways and associated times lines and support that needs to be achieved;
- Clear Information about time scales for referral to a new service is provided to the young person. This should include where there are gaps in the service provisions due to waiting lists and where young people can seek interim support if anticipated;

Effective Transition Planning

A Baseline Assessment Tool **(NICE clinical guideline NG43)** could be used to evaluate whether practice is in line with the recommendations for Transition from

children’s to adults' services for young people using health or social care services. It can also help to plan activity.

Reducing the risk of young people falling between services and needing care, or treatment, for crisis can be avoided if there is effective transition planning.

Good practice that has taken place and will continue if professionals;

- Ensure that young people know how to independently (if possible) navigate health and social care, particularly adult services. For example, young people with long term conditions such as diabetes may be able to avoid emergency admission if they have clarity on how to access adult services;
- Effectively signpost to alternative non-statutory services where statutory services are not available for adults;
- Actively involve primary care in the transition process to provide another level of continuity for young people and their carers;
- Adopt at the very least a 6 month transition period to all young people. Young people being discharged from services at 18 years old should start before 17 and a half years of age;
- Ensure that whilst discharge is ideal, young people are all made aware of the other potential avenues (to avoid feeling unprepared for leaving the service) and that they have the option to self refer if necessary;
- Explore using an expected timeline that could be made available to young people marking their transition out of a service;
- Ensure that all children and young people and parents should be told the upper age limit for the service they are in and encourage questions and discussion to support this understanding. The age limit should be reflected in website and leaflet based information;
- Consistently implement pathways that apply to all staff working with this age group and their effectiveness audited by a lead. The benefits of this audit reported within documents and in the wider literature so improvements are made where needed and good practice highlighted;
- All young people should have a care plan which promotes greater shared decision making, planning which includes transition and the young person’s feedback in line with the outcomes measured;
- Ensure that changes to agreed plans are communicated to the young person in a timely way including when they are confirmed staff or organisational changes.

Named worker

Young people and Service Providers felt that having a named/key worker provided them with a positive experience when transitioning between services. They felt that the following helped them and suggested that it would help other young people if:

- The young person was helped to choose one practitioner (**a named worker**) from those who support them to take on a coordinating role who could act as a link to other professionals and provide advice and information. It was felt that identifying a named worker that the person trusts, would be key to a successful transition process;

- The named worker considered ways that would allow the young person to become familiar with the adult's services, such as through young adult support teams, joint or overlapping services and appointments. It was felt that visits to adult's services with someone from children's services would prove helpful;

- The named worker arranged visits to a service that the young person may potentially use so that they could make an informed choice. This would make young people feel more included;

- The named worker ensured all the relevant information was available regarding alternative support including financial support and benefits. This would prove less confusing;

- The named worker could give the young person the opportunity to test out different ways of managing their care so they could build up confidence over time and take ownership. This could be done with a stepped approach;

- A contingency plan is put in place to provide consistent support if the named worker left their position;

- A person folder was considered, made to tell other professionals and volunteers that may be involved with the young person about them which information about their skills, character, goals, hopes for the future, strengths, child treatment, health conditions, emergency care planning, preference about their parent and carer involvement and history of unplanned admissions.

Improved Information and Information sharing

The provision of high quality information is vital for Professionals, Young Adolescents and Young Adults in their Transition years. A common theme found (when talking to young people) was that they did not want to share their story with every professional they worked with.

Good practice has taken place and will continue if;

- A concise list of up to date information is created and made available to the young person and all professionals for use in their practice;
- Any pathway relating to the discharge/transition should be communicated clearly with the Young Person and any agreed family members. It should be in an accessible format, depending on the needs and preferences of the Young Person. This could be in written format, computer based methods, braille etc. It should describe the transition process, the support that is available before and after and what benefits and financial support are available;
- The Young Person is asked at the very beginning of their relationship with the service provider what information they would like shared. Young People shared that they feel more in control and included in decision making;
- Information is communicated with the young person on more than one occasion and clarification of the young person's understanding sought and evidenced in notes and care plans.

Participation and engagement

Participation and Engagement with young people using person-centred support should involve (where possible) the full participation of young people and their families. Good practice that has taken place and will continue if;

- All staff ensure that they understand what the rights of the children and young people are within their service, including the importance of the young person's right to change workers if need be and their right to be seen alone. All leadership staff should be responsible for sharing good practice and specific rights belonging to the service user;
- Young people are involved in their transition planning, through peers support, coaching or mentoring, advocacy or through contact via virtual meeting using mobile phone or webcams;
- Any means of communication is used to ensure that the young adolescent or young adult is able to communicate their views in their own way; this could be Makaton, eye gaze, picture cards or digital communication boards;
- Quick fix measures such as sending a text reminder to a young person to remind them of an appointment and making the appointment at a time and on a day that is the similar to their previous appointments so it is easy to keep track of;

- Young people are regularly asked how their parents or carer should be involved throughout their transition, including when they have moved to adults services. Help young people help their parents/carers as quite often parents/carers find it difficult to become less involved as the young person moves into adulthood.
- Ensure that service users are allowed to feedback about their experiences so that their voice is embedded in policy and procedure as well as staff recruitment;
- Young adolescents and young carers are given the opportunity to speak separately from their parents or carer to raise any concerns that they may have during this process.

MISSED APPOINTMENTS AND SUPPORTING YOUNG PEOPLE TO ENGAGE

If a young person that has moved to Adult's services does not attend a meeting or appointment or engage with services this could be an early indicator that the person is unwell, overwhelmed and/or their vulnerability has prompted/increased exploitation to criminality, sexual exploitation, substance misuse, untreated medical conditions. Contact and attempts must be made to engage with this person. Consider involving other relevant professionals such as the GP or named worker;

If a young adolescent or young adult does not engage, the named worker should review the person centred care and support plan with the young person to identify:

1. How to help them use the service, or;
2. Find an alternative way to meet their support needs;
3. Explore the option of the young adolescent or young adult seeing the same person in adults services for (at the very least) the first two occasions after transition.

Ensure young people that refuse to engage understand that they can self refer at any time.