Wallace Unit

Relevant Standard(s):

STANDARD 40 - My plans for moving on meet all my needs. They involve everyone who has responsibility to care for and support me.

STANDARD 41 - I am fully prepared for making the transition from the service and this is taken at a pace which means I am completely ready.

STANDARD 42 - I am confident that people I know well and have trust in will continue to be involved in supporting me after I leave the service.

What activity have you undertaken to support the implementation of this Standard?

Through the pre-referral, referral acceptance and post-admission processes and discussion with the young person, it was identified that his pre-secure care was a nurturing and supportive children's home where significant relationships and comprehensive understanding had been developed over a period of time.

It was agreed that the primary aim of secure care would be for the young person to safely return to their pre-secure children's home following a period of safety and stabilisation with an improved care/support plan informed by an advanced assessment of risk, need and vulnerability.

Removing the uncertainty of the next step and the child knowing his team remained committed to him, leading his plan from admission to liberation and that he would be returning home, mitigated against rejection and maintained the child's trust, giving him the confidence to develop new relationships and engage with support. Knowing he was returning home at the point of admission to secure care was reassuring and motivational.

The multi-disciplinary team structure and participants remained the same throughout the child's stay: the social worker, pre-secure care placement key team, education psychologist, house unit key team (SMK), specialist intervention social worker (SMK), education (SMK) and transitions staff (SMK). This ensured continuity of care, shared understanding of the child and their story and maintained the trust and confidence of the child.

The child moved back home after a period in secure care, once the child and team agreed the aims of secure care had been achieved and could be sustained. The transition was planned and reviewed, progressing at an agreed pace to ensure a rhythm, predictability and to allow for setbacks and challenges to be overcome. The child was supported by his team (SMK and SW/Residential) to attend an external training and work experience course. This offered practical support and evidenced to the child that his team were working together for him, sharing responsibilities beyond group discussions and procedural forums. Furthermore, it allowed the secure and residential teams to speak in first-hand terms with the child and share in the experience, rather than the child having to retell, repeat or feel the pressure of

articulating his experiences. This approach became particularly useful when the child experienced some difficulties.

The formulation meeting /assessment agreed a model and program of intervention to be delivered during the YP's secure journey. The young person had worked closely with our Specialist Intervention Team and the identified SIT worker was an integral part of the assessment, intervention, and transition. The intervention plan ran beyond the transition with therapeutic work continuing following his return home. The SIT worker supported the residential key team and educational psychologist to understand and then contribute to the intervention plan. This progressed to co-delivery and then to the non-secure support leading on the intervention. This ensured continuity in the delivery and maintained the child's confidence, reducing the impact of wash-out, avoiding drift, preserving rhythm and routine, and predictability.

What have been the benefits and impact on children and young people and their outcomes? How are you monitoring or measuring these?

Young people are experiencing more tailored transitions that promote shared responsibility and agreed commitment from the whole team supporting them. They receive support from those who have been supporting them through their placement in secure care and this helps settle them back into life in the community. Transitions are discussed and planned at admission, it is integral to the care plan and not an add on or tailing off.

In general, young people are supported on a final mobility/community outing by a manager and given the opportunity to feedback on their experience and asked for their suggestions on how SMK can improve.

Young people, if they agree, take part in a survey three-months post transition.

In this case, the continuation of intervention into the community and handover of supporting roles, provided a much richer understanding of the young person's experience.

What makes this work?

The success of this transition relied on the young person returning to the residential house he knew as his home and to the team and carers he trusted and who loved him. His post secure destination had been explicitly agreed prior to his admission into secure care. Mitigating against feelings of rejection and uncertainty, this allowed for clear and realistic planning, avoiding hypothetical thinking and reactive responses. Furthermore, the multiagency formulation in the first couple of weeks of the young person's admission helped to develop a shared understanding, comprehensive assessment, and planned intervention approach. All agencies and the young person contributed to this at varying stages. Working in partnership with the young person, local authority social worker, and their next destination was effective. Ensuring agreed aims of secure care, that these are shared and committed to, and used to review the period in secure care is necessary.

Ensuring the young person experienced consistency and continuity in their care was key.

What challenges or barriers have been faced? How have these been addressed?

The primary barrier to positive transitions and meeting the Standards specifically 40, 41 and 42 is having a suitable destination and support team in place contributing to the young person's plan in a timely manner and not when the secure care order is coming to an end.

On a practical level, freeing up staff to visit the young person in the community can quickly stop being a priority against the competing demands of the service, particularly in a

pandemic. SMK now have dedicated transitions workers though they are still subject to competing demands.

With respect to this good practice example, the young person resides in and is the responsibility of a neighbouring local authority. Challenges across all plans with respect to transitions and Standards 40-42 increase with geographical distance.

In this example, SMK management and the local authority social work team had an established and trusting professional relationship enabling effective communication, and promoting professional confidence. This is not always the case.

How do you plan to continue and develop further this work?

There are many lessons and aspects of good practice within this case study, the most significant factor being that the child returned home. He did not feel rejected and believed he was valued and cared for.

There is a continuum of failure in many care journeys – removed from home – foster care – residential care – multiple placements – secure care …. Effective safety and stabilisation should present the opportunity to stop or prevent this. If a child cannot return to their pre-secure care, they should know at the earliest point where next and what are they working towards.

The developing post admission and formulation processes at SMK now apply greater emphasis on the ending and this will be maintained throughout the looked after and accommodated and court proceedings going forward.

SMK are working towards improved participation from children, young people, staff and external agencies. This combined with the final community outing feedback, will be used to develop the model that best supports children and young people transitioning from SMK in accordance with Standards 40, 41 and 42.

Iona Unit

Relevant Standards

STANDARD 34 - I benefit from a wide range of high quality educational, vocational and community-based experiences and qualifications.

STANDARD 40 - My plans for moving on meet all my needs. They involve everyone who has responsibility to care for and support me.

STANDARD 41 - I am fully prepared for making the transition from the service and this is taken at a pace, which means I am completely ready.

What activity have you undertaken to support implementation of this Standard?

Through assessment and discussion with the young person, it was identified that they can struggle with the regimented structures of ‘mainstream’ schooling and the formality of a classroom environment. This was reinforced with feedback from the education department within St Mary’s who noted that this young person tends to do well in practical classes as opposed to theory-based classes. Instead, this young person sought to widen their educational capacities in a practical way and equip himself with skills/knowledge that would allow him to live more independently after secure care.

In collaboration with the young person's social worker, an educational placement was sourced for this young person to attend an external mechanics' course once a week. Additionally, they enrolled into a community run course, which focuses on improving young people's mental and physical health, as well as providing them the opportunity to gain formal awards, vocational work experience and develop core skills. These external courses are being used to form a transition plan aimed to equip this young person for leaving secure care.

A crucial part of this transition plan has been that the young person has been able to visit a new placement with their social worker and family and decide if they like the area/property beforehand. The staff of St Mary's as well as the staff from the new placement have facilitated this. In addition to this, the young person has had regular contact and face-to-face meetings with staff from their new placement and there are plans in place for them to have overnight visits prior to leaving secure care.

While this may seem a lot for a young person to take on at one time, they are working closely with an allocated worker from the Specialist Interventions Team (SIT). This has been integral to the implementation of the above standards. Prior to starting a transition plan, SIT have worked with this young person to develop a full psychological assessment with recommendations for care, further assessment and intervention. Work with SIT focused on the 'zones of regulation' programme developing strategies to regulate their emotions appropriately and on understanding their own journey using a formulation based approach which aimed to support the young person to become ready for transitioning from secure care back into the local community. Some work has also been carried out to make this young person aware of what to expect after secure care in relation to any legal proceedings and the difference that being on, or off a CSO could mean. It was important to help this young person understand that they are subject to two systems yet (being a child within an adult justice system) and what this means for them during and beyond their transition. SIT have also assisted in creating a realistic mobility and transition plan and share information and assessments via a range of statutory processes including but not limited to LAC reviews, secure screening processes and Care and Risk Management protocol. The young person has been supported to engage in scenario planning and consider the risks that are relevant to them and it provided an opportunity to discuss how they would respond to this.

In terms of Standard 41, it was important to develop a transition plan at the correct time for that young person. Within the context of secure screening meetings, there were discussions about changes in risk and behaviours displayed by the young person. These discussions allowed professionals to consider changes in behaviour and allowed decisions to delay the development of transition planning to a time in which the young person was able to stabilise some of their behaviours. This allowed for consideration of future journey to take place at a time in which they are ready to move on.

As part of this young person's transition, the placing local authority have oversight via the use of Care and Risk Management meetings. This has allowed for oversight of the planning at an operational level and allows for the development of a community-based plan that aims to reduce risk and ensure the safety of the young person and others. This process has ensured responsibilities for community partner agencies in terms of supervision, monitoring, intervention and victim safety planning. Maintaining links with community partners has also been highly beneficial for this young person as it ensures consistency in terms of relationships and the type of support that can be offered.

It has been extremely important to engage with the community-based agencies, specifically social work and care providers that have been identified. Transition planning meetings have

been undertaken where SIT share their psychological formulation within the framework of the ABC's of understanding me. Contained within is guidance for care staff, as well as identification of future risk and guidance on how to support that young person to have their needs met in the most appropriate way. The transition-planning process also allows for discussion around what has worked in terms of the care provided and creates a forum for the sharing of social stories, visual planners and other aids that have assisted the young person to develop routines, beliefs and attitudes within the secure care environment.

What have been the benefits and impact on children and young people and their outcomes? How are you monitoring or measuring these?

Young people are able to take part in learning that is best suited to them and equips them with vital skills that will be useful when they leave secure. They also have an aspect of agency over their immediate future and experience a person-centered transition plan created to move at a pace comfortable to them. Throughout their transition, they receive support and guidance from internal and external people involved in their care. This can help them integrate and adjust to life in the community.

Three months post transition; young people are provided with an opportunity to take part in a survey, which considers their views of their progress and current situation. This allows the transition outcomes to be monitored and measured.

What makes this work?

Collaborative work between local authorities, existing and new placements and young people's families whilst keeping the young person's thoughts, feelings and wants at the forefront of decision-making contributes to making this work. This joined up working ensures a smooth transition where the young person is being appropriately advocated for by all those responsible for their care. Sharing of information and regular contact and liaison with community based supports and family members has been crucial in this instance and contributed to a greater understanding of the needs of the young person has allowed a shared approach to be adopted when supporting them.

What challenges or barriers have been faced? How have these been addressed?

The COVID-19 pandemic has been a significant barrier in the transition of this young person. At times, there have been people associated with this young person who have tested positive, which placed a delay on them starting the external courses and visiting the new placement. Additionally, there have been organisational barriers in relation to having enough staff to facilitate transport and visits.

To address these barriers, St Mary's have worked with the social work department and the new placement to co-ordinate visits while the young person was already out at their external course. Additionally, no plans were confirmed or relayed to the young person until it was confirmed that transportation was available again contributing to a smooth transition. Remote sessions were offered to support the young person using Microsoft teams during times of restricted access, which allowed for continued support and intervention.

How do you plan to continue and develop further this work?

Intense work with the Specialist Interventions Team should continue to ensure young people are aware of how to express and advocate for themselves and to have a realistic picture of what leaving secure care will be like. Further work is also required to ensure that a formulation based approach is adhered to at all times by all staff to ensure consistency of care within St Mary's and to ensure that the young person consistently has their needs met

in a way that is appropriate and individualised for them. There may also be scope for the contents of the formulation to be explained to staff within identified future destinations. This would allow for a continuation of care and would contribute to ensuring that the young person's needs are met and that any plans are developed with an awareness of the approaches that have worked for that young person.

With transitional work, it is imperative that the young person's needs and feelings are at the forefront of decision making and the young person themselves should play an integral part of what their transition will include, and how long it will take. Collaborative working throughout the transition plan should continue as this enables the young person to develop relationships within the new placement and may alleviate any concerns. Follow up sessions with the young person and the new staff team to support this transition is imperative and something which should be part of all transition plans.