“The Right Help at the Right Time” For Children, Young People and their Families

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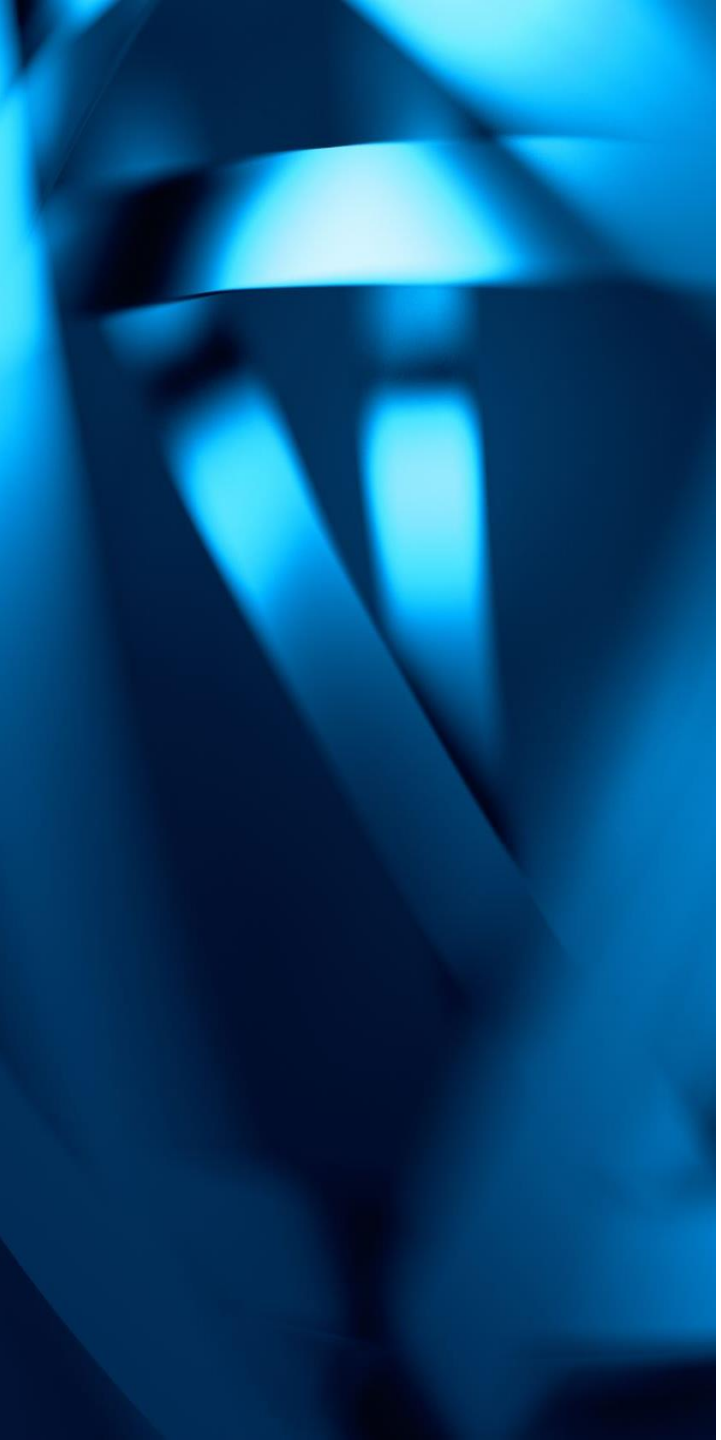


An information sharing session to introduce
CYSUR Threshold and Eligibility Support Document;
The next phase of Multi-agency Safeguarding Training

Session Aims

- Consideration of emerging themes from the recent Professional Curiosity Training
- Making a connections between thresholds and recurring themes from child practice reviews (CPR)
- Developing a future approach and introduce the next phase
- Introduction to the new threshold document and training.

Professional Curiosity Training - Emerging Themes

Background to Professional Curiosity

The Inquiry into the death of Victoria Climbié, the Laming Report (2003) first introduces the concept of professional curiosity.

It talks of “respectful uncertainty” which the report says should lie at the heart of the relationship between the social worker and the family.

A more recent definition:

Professional Curiosity is the capacity and communication skill to explore and understand what is happening to a child or within a family, rather than making assumptions.

“Checking and reflecting” on information received to ensure practitioners do not accept information at face value.

Child Protection Committee, 2019

Professional Curiosity Training

Professional Curiosity Training has been successfully delivered across the CYSUR Mid and West Wales Safeguarding Board to a large number of practitioners from many different disciplines.

A number of themes have emerged over the course of this training in relation to the challenges practitioners face when assessing and working with risk.

Professional Curiosity
Key Principles and Themes Explored

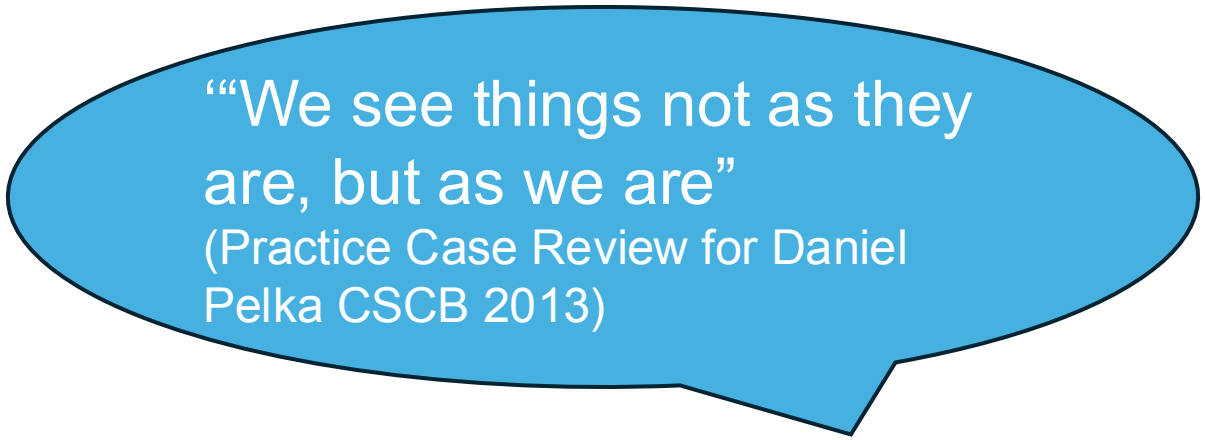
- We need to be much more sceptical and mistrustful about what might really be happening behind closed doors.
- We need to be humane but at the same time avoid being overly optimistic.
- The single most important factor in minimising errors is being able to admit that we might be wrong.
- We tend to persist in initial judgements and assessments (confirmation bias) and therefore minimise or dismiss conflicting new evidence or risks.
- Compassion however is key as those living compromised lives will often struggle to make their voices heard.

Professional Curiosity and Assessing Risk

The practice case review of Baby P highlighted:

There was a consistent lack of professional curiosity and challenge to both parents and other professionals, this contributed to poor assessment, lack of recognition of risk/vulnerability and subsequently poor ineffective management.'

(Windibank 2014)



Challenges to Embedding Professional Curiosity Within Practice

- Confidence of workers in challenging other professional especially those in higher positions or positions of (perceived) power
- Lack of experience and confidence in asking difficult question and challenging families/individuals
- Desensitisation was also a common theme for the more experienced practitioners
- Maintaining professional boundaries (particularly being overfriendly or dislike of someone)
- Fear of confrontation/aggression
- Lack of clarity regarding thresholds and roles and responsibilities.

Challenges to Collaborative Working in Safeguarding Children

Differences of roles and responsibilities of workers/agencies – different understandings of this

Lack of service provision/resources – when resources are scarce this can cause conflict or competing interests

Poor information sharing and communication – different systems – different understanding of GDPR/data protection and information sharing and seeking

Practice case/management issues – lack of clarity over roles and responsibilities

Timeliness of intervention – different priorities for different agencies or even of different teams/workers

Thresholds – lack of understanding of what these are and what they mean

Values/required objectives – can differ hugely between individuals, workers, managers, team, agencies etc.

Child Practice Reviews identified the following inhibitors to Professional Curiosity

- Making assumptions
- Fitting information to early hypothesis
- Lack of understanding about specific issue

- Lack of knowledge of legislation, policy and procedure (including thresholds)

- Pressures of work
- Stress
- Reluctant clients

Reoccurring Themes in Practice Case Reviews Star Hubson and Arthur Labinjo-Hughes (2022)

- Professionals failed to “unpack biases and assumptions”, which affected their assessment of the risk to child
- Too often inexperienced professionals – social workers in particular – are asked to undertake this work without sufficient supervision and support.

“This is not fair to the social workers or the children they serve.”

Annie Hudson the Chair of the Child Safeguarding Practice Review Panel:

- Our annual report shows that while many professionals work hard to protect children, there are fault lines in the system that inhibit good information-sharing, risk assessment and critical analysis and challenge.

Missed Opportunities - Practice Case Review Star Hubson and Arthur Labinjo-Hughes (2022)

- Weaknesses in information sharing and seeking within and between agencies was a common theme.
- Social workers, police and other professionals missed opportunities to intervene, failing to develop a proper understanding of what daily life was like for Arthur and Star, or robustly share or interrogate and assess new information that came to light about them.
- A lack of robust critical thinking and challenge within and between agencies, compounded by a failure to trigger statutory multi-agency child protection processes at a number of key moments.

Recommendations:

- We need sharper specialist child protection skills and expertise, especially in relation to complex risk assessment and decision making, engaging reluctant parents, understanding the daily life of children and domestic abuse.

Logan Mwangi Child Practice Review, 2022

The report found:

- Significant failings in relation to interagency working and risk assessment with “gaps in risk assessments and specialist skills around interrogating and analysing evidence”
- Practice failings occurred against a backdrop of “working environments under pressure that [did] not enable and create organisational conditions that support such complex work”, with limited opportunity for practitioners to reflect on the case.

Recommendations:

- To ensure high quality supervision, guidance and oversight of practice to tackle the inconsistencies it identified.
- Improve approaches to assessing and managing risk through a clear practice model, including “a clear framework for management oversight of safeguarding decisions and risk management plans”.
- Ensure all safeguarding staff are clear on the rights of all those with parental responsibility for a child to be informed of safeguarding concerns.

Recurring themes
Lola James (CPR, 2021)

In the recent CPR of into the death of 2-year-old Lola James

- There were many missed opportunities when agencies were in receipt of relevant information, but the “dots” were not joined.
- There was a lack of clarity of how to share information, what information could and should have been shared, when and by whom.
- The report highlighted the lack of professional curiosity with many difficult questions not being asked that may have led to different decisions being made in the assessment of Lola had they been explored.

What Challenges You?

What for you can stop you being professionally curious in your role and/or asking difficult questions?

Why is it so difficult?

- Resource rationing in austerity
- It is paradoxical to expect professionals to build trust with families whilst exercising mistrust
- Human Rights Act Article 8: intrusion of the public servant into the private domain
- Politicisation of public protection has led to a focus shift: from need to risk
- Fear of being labelled ‘risk averse’
- Pushing is uncomfortable: anxiety about this diminishes curiosity, and encourages a blame culture
- Hunches/intuition can be hard to evidence: ‘the dynamics of knowing but not knowing’
- The danger of ‘bureaucratic preoccupation’: focusing on the wrong things

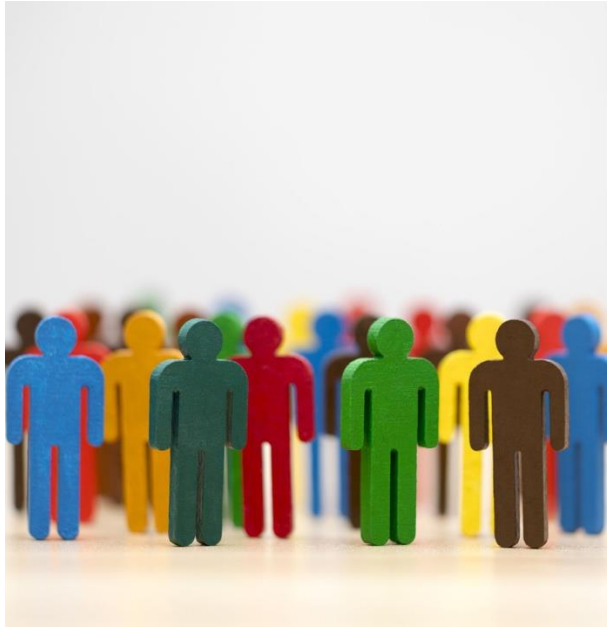
(Akister, 2011, Kashdan, 2007, Cohen, 2001, Ferguson, 2016)

Recommendations Child Safeguarding

Practice Review 2021

To support practitioners, the panel highlighted 6 cross cutting practice themes to make a difference in reducing serious harm and preventing child deaths caused by abuse or neglect:

1. Supporting critical thinking and professional challenge through effective leadership and culture
2. The importance of a whole family approach to risk assessment and support
3. Giving central consideration to racial, ethnic and cultural identity, and impact on the lived experience of children and families
4. Recognising and responding to the vulnerability of babies
5. Domestic abuse and harm to children - working across services
6. Keeping a focus on risks outside the family.



Child Safeguarding Practice Review 2021

The Context of Threshold

(Safeguarding Network)

In an Inquiry by the National Children's Bureau (NCB) for the All-Party Parliamentary Group for children found

- "70% of … social workers [report] the threshold for helping 'children in need' had risen, … while half said the point at which a child protection plan was triggered had gone up"
- 24% increase in children with special educational needs and disabilities (2019)
- Growing budget deficit
- 28% increase in number of children going into care in the last decade
- Less preventative work is possible
- Creating a viscious cycle of escalating risk.

What this means for us

- There are significant dangers for young people which create a vicious cycle of escalating risk.
- This can create contextual risks where conscious and unconscious pressures on everyone to cause them to deviate from clear analysis or procedure and engage in defensive practice, fuelled by anxieties of “fear, blame and mistrust”. Within this the child becomes invisible.
- Highlights the importance of agencies being analytical in their approach, making fewer and more “appropriate” referrals
- Rigorous pursuit and resolution of professional differences is needed to avoid externalising risk to the child/young person and their family.

(Safeguarding Network)

CYSUR Threshold and Eligibility Support Document

Aims to:

- Provide a clear process/structure for reflection and analysis of risk which can support professional decision making
- Support agencies to develop consistent approaches to risk assessment
- Encourage interagency working and collaboration
- Threshold for action will help define the reasons to be “suspicion” of abuse or neglect rather than just relying on a “belief” e.g., on the “balance of probability”
- Help workers to better understand the difference and how we make referrals in time to “prevent” escalation.

CYSUR: THE MID & WEST WALES SAFEGUARDING CHILDREN BOARD
'The Right Help at the Right Time' for Children, Young People and their Families
Regional Thresholds & Eligibility for Support Document
A MID & WEST WALES COLLABORATION

- Developed by CYSUR: The Mid & West Wales Safeguarding Children Board in collaboration with partners across Mid & West Wales on a multi-agency basis.
- This is an updated version which was original developed in consultation with children, young people and their families in 2017.
- Designed to provide guidance to professionals to clarify in what circumstances to refer children and their families for support across the spectrum of need, building on families' strengths and personal outcomes.
- It has been updated to reflect and incorporate the ever-changing landscape of multi-agency safeguarding practice and the latest research that informs interventions known to work with children and families.

‘The Right Help at the Right Time’ for Children, Young People and their Families Regional Thresholds & Eligibility for Support Document

The document describes:

- The different levels of presenting need and strengths across the spectrum from Universal to Protective Support, providing guidance on the thresholds of need acknowledging that children and their families’ situations and circumstances can vary across the spectrum of need. It recognises that professional judgement should always be used in partnership with the family.
- The legal definition of the eligibility criteria to access Care & Support as outlined in the Social Services and Well-Being [Wales] Act 2014 and where appropriate protection under the 1989 Children Act.
- A supplementary flow chart on the process for accessing Care & Support as outlined in the Social Services and Well-Being [Wales] Act 2014
- Supplementary information and guidance in respect of the Assessment Triangle and ACEs Research (Public Health Wales)
- Appendices listing and referencing the regional safeguarding board, policies and strategies.

The Right Help at the Right Time Framework

Making Connections

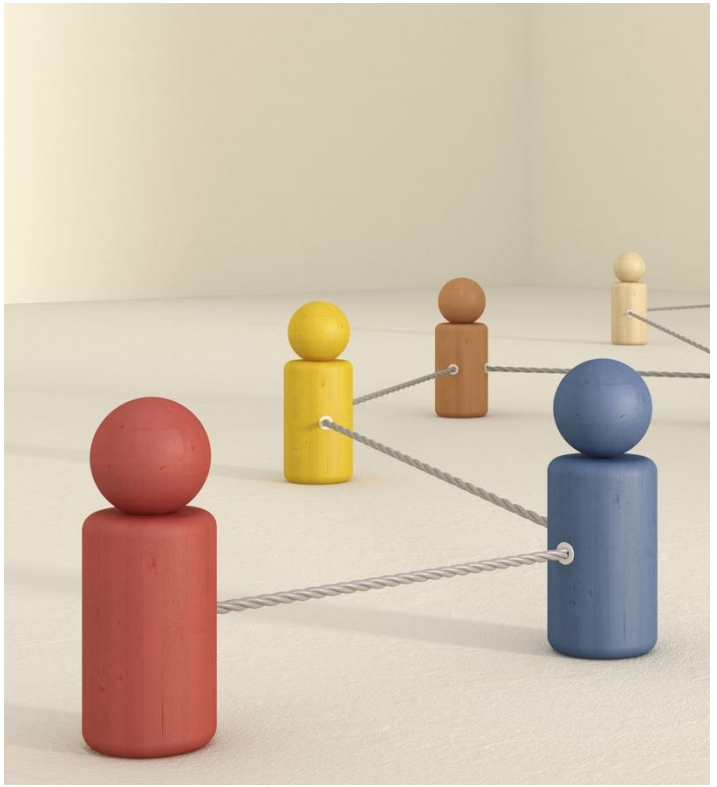
“The Right Help at the Right Time” training will aim to:

- Bring practitioners together to undertake multi-agency training allowing them to share practice wisdom and explore challenges faced
- Understand each others' roles and responsibilities better in relation to safeguarding and how this links to thresholds
- Build lasting connections between agencies
- Move away from fear of challenging and being challenged.

An introduction to
“The Right Help at the Right Time” Training

Multi-agency Safeguarding training which will aim to:

- Build skills, knowledge and understanding of thresholds and assessing risk of serious/significant harm including skills of analysis of risk.
- Develop connections for working together and best practice in information sharing.
- Supporting practitioners in wide variety of settings and roles to build confidence and competence and work together effectively to safeguard children and young people.
- Considerer challenges and obstacles to working with professional curiosity in increasing complexity and developing joint approaches.
- Develop an understanding of how the CYSUR Threshold document and “The Right Help at the Right Time” training will support multi-agency working and open a dialogue.



Why we Need Multi-agency Training on Threshold and Assessment of Risk of Significant Harm

- To help us develop a shared understanding how to assess risk
- Thresholds can be “subjective” and perspective on thresholds can differed greatly for person to person and agency to agency
- This highlights the importance of multi-agency training which allows exploration of values and encourages ethically lead decisions making
- A deficit led approach focusing on problems/issue can lead to an anxiety led approach which reduces optimism for both professionals and families
- We know from CPR’s that over optimism can be equally dangerous, so a balanced perspective become essential
- Training along with supportive supervision is needed to allow room for discussion and reflection.

Professional judgement should be combined with standardised and actuarial tools to improve accuracy (Safeguarding network).

RISK FACTORS A THEMATIC ANALYSIS OF CHILD PRACTICE REVIEWS IN WALES 2023

Analysis of children who were subject to a review (index child) and their parents/carers revealed trends which highlight the need for greater awareness and monitoring of risk factors, particularly when these co-occur or accumulate.

- Two thirds of CPRs were prompted by a child's death
- Suicide, other medical/health issues and non- fatal physical abuse were the most common incidents.
- The most common parental/carer risk factors were drugs/alcohol misuse, mental health issues and domestic abuse relationship.
- There were significant correlations across these risk factors – in particular, mental health issues, criminal history, ACEs (Adverse Childhood Experiences), domestic abuse relationship and young parents.
- Parents/carers with historical experiences of trauma, or ACEs themselves, being a looked after child or being a young parent often correlated with behavioural risk indicators
- The children's most common vulnerabilities were emotional abuse, neglect and living in poor home conditions.

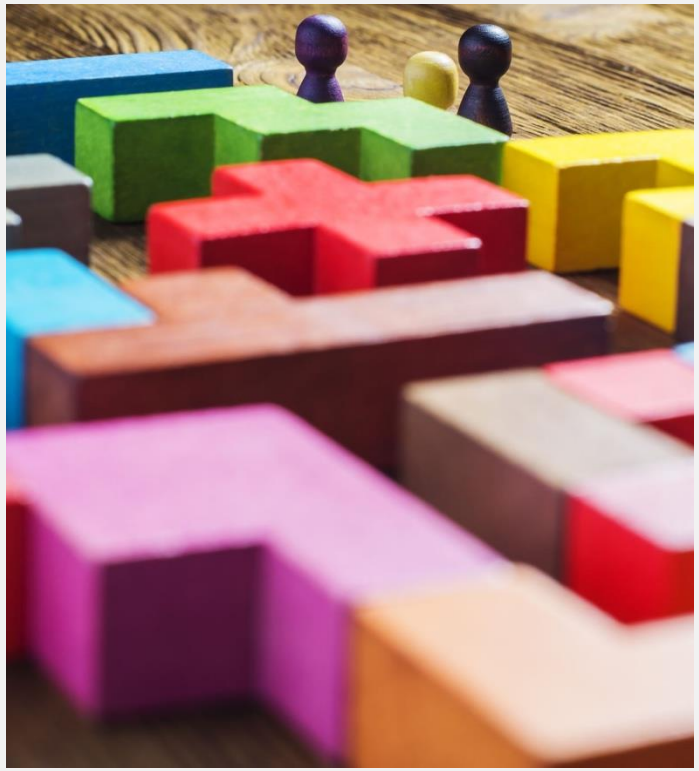
Structures and Process Barriers

A THEMATIC ANALYSIS OF CHILD PRACTICE REVIEWS IN WALES 2023

The reviews highlighted issues regarding clarity in:

- Understanding decision making and **'threshold uncertainty'** where an agency makes a safeguarding referral or report, but it does not reach the threshold for statutory intervention.
- CPRs noted that agencies should "continue to refer to Children Services should neglect concerns persist".
- There was also uncertainty around escalating and monitoring safeguarding concerns internally and a lack of confidence in challenging decisions by senior members of staff.
- Information sharing is a longstanding issue.
- The CPRs showed that the infrastructure which is in place to routinely share information is not always clear and there is confusion around coordination of ownership.
- In instances where safeguarding concerns do not reach a threshold decision that warrants statutory intervention, the pathways for coordinating safeguarding responsibilities between agencies can be unclear.
- A key barrier is the lack of logistical structures for sharing accumulative information.

Findings from the Thematic Analysis of Child Practice Reviews in Wales 2023



The training will explore these, and other themes raised in recent CPR's

The main cross cutting themes identified:

1. Greater weight is given to some professionals' and family members' knowledge.
2. This hierarchy of knowledge led to 'tunnel vision', where certain attitudes are formed and then become hard to challenge. The views of mothers tended to be privileged over both children's and fathers' (Halo effect).
3. Poor information sharing within and across agencies (missed opportunities).
4. Faulty assessment was prevalent with practitioners sometimes evaluating people as individuals not as part of the wider domestic/family context.
5. Children's voices or the perspective of the child were sometimes missing and/or not always central to practice.

Recommendation the Lola James Review, 2021

The review concluded that there is a lack of clarity over when a MARF is actually needed and what information needs to be included with "vague" professional language used.

- Regular multi-agency training will assist collaborative working
- Improve understanding of threshold which must be considered when professionals are considering whether or not to submit a MARF.
- Understand what is needed to ensure that there is a consistent approach and shared vision on safeguarding procedures and that the threshold for completion, and the actual completion of the MARF thereafter, is fully understood.
- Improve future practice as fewer MARFs may result additionally; a well completed MARF will allow those picking it up to immediately understand what the issues are and triage the referral thereafter.

Phases of the Understanding Thresholds and Assessing Risk of Significant Harm Training
“The Right Help at the Right Time”

How to Complete a MARF – 1 hour presentation

- What are the key purpose and principles of a MARF
- What do you need to record?
- How to record it, including use of professional language.
- Do’s and don’ts.
- How to capture information relating to culture, race, ethnicity, language spoken etc.
- Sharing information (seven golden rules of Information Sharing).
- Consent and what this means.

This will include:

- Link to evidence, what historical information is needed, reviews – action plans.
- What a good MARF looks like.
- Hints and tips on being clear and concise.

Half Day Training Introduction to Understanding Thresholds and Assessing Risk of Significant Harm "The Right Help at the Right Time"

- Key purpose and principles of thresholds (linked to assessment of risk) including underlying values
- What are thresholds and how do we assess them? Right help right time framework.
- Develop definition and understanding of assessing risk of serious/significant harm
- Roles and responsibilities and collaborative multiagency working
- Rights versus risk, the importance of positive risk taking and preventative working
- Professional Curiosity and how to embed this within practice
- The voice of the child - lived experience.
- Exploration of cross cutting themes
- Assessing risk and working together include dealing with professional differences and sharing information
- The "Right Help at the right time" framework to summarise.

Full day Training
Understanding Thresholds and Assessing Risk of Significant Harm
"The Right Help at the Right Time"

Themes from half day course will then lead into more complex themes for a full day's training

- Exploration of underpinning values and how to question our assumptions
- Working with uncertainly/managing expectations
- Challenges to assessing risk and working together (include dealing with professional differences)
- Roles and responsibilities, understanding categories of abuse and how they link to thresholds

➢ Assessing levels of risk – preventing escalation-building on strengths

➢ Links to practice case reviews and current research/underpinning values through use of case studies

- Building a tool kit; links to models and theories; risk assessment models, strengths approach, Signs of Safety etc.
- Use of supervision, peer support and reflective practice.
- Summaries with links to RSB risk and response doc.

Recommendations from the Thematic Analysis of Child Practice Reviews in Wales 2023

Multi-Agency Partnership Training

- Regular multi-agency training ensures common understanding, facilitates regular discussions of different agency perspectives and strengthens roles and expectations in recognising and managing safeguarding concerns.
- This can help to overcome collaboration barriers and enable more proactive responses where there is uncertainty about decision-making regarding thresholds for intervention, agency expectations and individual responsibilities.

Training should specifically address:

- Understanding the child's voice as the daily lived experience of the child within their environment, how to best record, appropriately share and utilise within decision-making and interventions.
- Undertaking a 'Whole Family' approach and developing competent and confident workforce in applying
- 'Professional Curiosity'. Practitioners need to be clear on individual agency responsibilities and the processes and pathways for collating intelligence in identifying emerging risk.
- This includes co-occurring and interacting risk factors and with an understanding of the dynamic impact of past, present and potential risks in the continuing assessment of harm and risk.

Munro Report (2011)

Lessons ....

- Intuitive and analytic reasoning skills are developed in different ways, so services need to recognise the differing requirements if they are to help practitioners move from being novices to being experts on both dimensions.
- Analytical skills can be enhanced by formal teaching and reading. Intuitive skills are essentially derived from experience.
- Experience on its own, however, is not enough. It needs to be allied to reflection with time and attention given to mulling over the experience and learning from it.

Sum Up

- Remain focused on the child.
- Never be afraid to step back and reconsider a new approach. Differences in professional opinion indicate that no one agency has fully understood the child's situation.

(Nottingham City Safeguarding Board)

Any Questions or comments you would like to make?

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