Thinking Family

LEARNING FROM REVIEWS

MID AND WEST WALES SAFEGUARDING BOARD, NOVEMBER 2022

Sources of Evidence

- National Analysis of SARs April 2017 – March 2019
  - 12 SARs (n=231) focus on "think family"
  - Cases involving domestic abuse, carer/cared-for relationships, transitions
- SARs on Transitional Safeguarding – care experienced young people/young adults
- Serious Case Reviews
- Self-Neglect SAR Database
  - Contribution of informal carers, family and relationship dynamics, impact of adverse (childhood) experiences

A Human Story – Christopher (Bristol SAB)

- Christopher had lived with his father and had significant involvement with an extended family for the first 30 years of his life.
- Services had provided respite care for Christopher as a young person and young adult, and knew him well
- He moved into supported living when his father had been unwell. The family and respite care setting produced extensive information to help supported living staff meet Christopher's needs
- A philosophy of independent living, which emphasised Christopher's autonomy and self-determination, meant that family members felt that their concerns and advice were unwelcome and not fully considered once Christopher began to experience difficulties within the placement

A Human Story – Andy (Salford SAB)

- As a young adult Andy developed several potentially life-limiting illnesses.
- He lived alone in a privately-rented house that became increasingly uninhabitable
- He did not keep all the medical, mental health, housing and welfare benefit appointments
- He lived in extreme poverty and often appeared to dis-engage from healthcare services
- He had a step-father, sister and brother who kept in touch with him but did not know the extent to which Andy was not engaging with services
- They reflected that he did not intentionally self-neglect but was often unable to engage with the support being offered
- They thought that his anger was understandable, given what had happened to him
- They reflected that they had not been asked for information about Andy or whether they could be a circle of support for him

A Human Story – Honor (Swindon SAB)

- Repeated concerns about physical and financial abuse by Honor's son
- When Honor was interviewed at home, this was always in the presence of her son and she denied abuse
- When interviewed away from home, on her own, she began to disclose
- SAR found that coercive and controlling behaviour was not well understood
- Intervention was framed through a lens of a stressed carer rather than through a lens of domestic abuse

A Human Story – Mr K (Bexley SAB)

- Children's Social Care are concerned about abuse and/or neglect of children in a household
- Children's Social Care staff refer Mr K to Adult Social Care, concerned about his self-neglect and mental health
- There are also concerns about domestic abuse
- The two departments do not coordinate their assessments and intervention
- For some time Adult Social Care fails to respond to the referred concern
- Children's Social Care staff focus on the welfare of the children only

Think Family

- Derbyshire SCB (2014) Child D
  - Lack of carer assessment and of professional curiosity and risk assessment of family relationships & impact of domestic violence, mental health & self-neglect
  - Absence of supervision and management oversight
  - Impact of workloads and lack of risk assessment expertise
  - Poor information-sharing and missed opportunities for input from relatives
- Bournemouth & Poole SCB (2015) Baby N
  - Mother and baby live with mother's mother who hoards
  - No assessment of the living environment before discharge from maternity unit

More on Think Family

- Dorset SCB (2014) Family S11
  - Young person (15) self-neglects in context of neglect and vulnerability in a service resistant family
  - Parental mental health issues
  - Importance of communication between children's social care, adult social care and mental health providers
  - Lack of protocol for working with hard to engage families
  - Need to consider the impact of case closure decisions
  - Assessment family dynamics including the possible meaning of behavioural patterns
  - Support worker resilience
- A London SAB (2016) not published
  - Liaison between children's social care and adult social care essential
  - Danger of agencies working in silos and not considering the whole picture
  - Importance of information held by other family members

When Family Members Prevent Access

- Westminster (2011) BB
- Newcastle (2014) Adult D
- Surrey (2014) Mr D
- Glasgow (2015) Ellen Ash
- Kent and Medway (not published)
  - Think family – assess the relationship history & dynamics
  - Family members may hold useful information & may help to gain entry
  - Assess impact if and when they withdraw help
  - Carer assessments
  - Assess mental capacity in terms of undue influence, situational capacity and the impact of controlling behaviour
  - What might lie behind a relative's resistance and hostility?

Learning from SARs on Transitional Safeguarding – Care Experienced Young People/Young Adults

- Havering SAB – MS A; Havering SAB – Child/Adult Y and Child/Adult Q; Croydon SAB – Madeleine
- Having family and friends to turn to, and leaving care teams that negotiate on their behalf with housing services, can make a positive difference for care experienced young people.
- Support needed beyond housing need, especially for mental health and well-being, often as a result of significant trauma, family breakdown, and unsafe relationships.
- Law and statutory guidance was not complied with.
- Poor planning. Absence of multi-disciplinary and multi-agency meetings.
- Many have no control over where they live and often feel unsafe in types and location of accommodation. Many feel unprepared to manage money, which can result in debts and loss of tenancies. Many do not feel sufficiently involved in plans, do not understand the options, and do not feel listened to.
- Lack of operational and strategic agreements between SABs and Safeguarding Children Partnerships, Children's and Adult Mental Health Services, Children's Social Care and Adult Social Care

Elements of the Evidence-Base for Best Transitional Safeguarding Practice (1)

- Personalised. Practice is relational and participative, tenacious and curious, needs-led, person-centred and rights-based: all aspects of that individual's situation are taken into account in the safeguarding process, including structural inequalities.
- Context and history. Practice considers the strengths and challenges in the young person's familial and social networks, working in collaboration to build circles of support.
- Developmental. Practice is not bound by age-determined boundaries. It also recognises the inconsistencies in age in the legal, policy and service frameworks and seeks to resolve tensions in these (Cocker et al., 2021a).
- Whole-person. Work with young people/young adults is characterised by a holistic view of the person rather than defining their needs, vulnerabilities or strengths according to age or eligibility.
- Equalities. Practice recognises protected characteristics arising from gender, sexuality, race and disability. Practitioners acknowledge inequalities, recognising the impact on their lives, and addressing unconscious bias.

Elements of the Evidence-Base for Best Transitional Safeguarding Practice (2)

- Assessment. Assessments are timely and fulfil statutory requirements. Assessments of care and support needs are incorporated into other processes, such as looked after children reviews, to minimise the need to repeat information (Holmström , 2020). Assessments of care and support focus not just on eligible needs but also on wellbeing and prevention. Assessments of risk are completed.
- There is evidence of early and proportionate planning (Holmström , 2020). Planning is not limited by a focus on eligibility criteria and thresholds (Preston-Shoot et al., 2020). Care plans are followed through and reviewed. Contingency planning also occurs. There is clear evidence of pathway planning, with key worker/personal adviser offering continuity and a sustained relationship that incorporates insight into the young person's feelings and experiences.
- Meeting need. Placements and accommodation provision are suitable. The impact of transition, of moving on, on mental health is recognised (Preston-Shoot et al., 2020). Practice is characterised by wrap-around support aimed at meeting accommodation need but also enhancing physical and mental wellbeing, and supporting young adults into training and/or employment. Options are considered, with adherence to the young person's preferences unless contraindicated.

Elements of the Evidence-Base for Best Transitional Safeguarding Practice (3)

- Working together. Agencies work together across service and geographical boundaries rather than in silos to offer an integrated system of planning and support, recognising the inter-connected nature of harms and risks (Holmes and Smale, 2018). There is a clearly agreed lead agency and key worker to facilitate and coordinate planning and decision-making (Preston-Shoot et al., 2020).
- Information-sharing. There is early and proportionate sharing of information about risk and the range and level of support required (Holmström , 2020). Information is shared without consent when this is necessary to safeguard a young adult at risk.
- Legal literacy. There is less focus on eligibility and more on preventative work and wellbeing. Advice and support are sought to address the inconsistencies in age in the legal, policy and service frameworks regarding young people's transitions to adult services (Cocker et al, 2021a). Legal rules are used to prevent and to disrupt sources of harm
- Multi-agency meetings. Practice is characterised by the use of multi-agency, multi-disciplinary meetings to share information, identify needs and risks, and agree a coordinated plan, with a lead agency and key worker clearly identified. Pathways for convening multi-agency meetings are clearly stated and understood (Preston-Shoot et al., 2020).

Extracts from National Analysis of SARs 2017-2019

- Good practice – working with families

- "*Adult Social Care were responsive to the needs of X's daughter aiming to provide support to her quickly and reduce the risk of a re-admission to hospital by arranging alternative respite care, which can be identified as good practice.*" Working closely with families enabled practitioners to source valuable information that contributed to work with the individual, for example in one case how to communicate.
- A holistic 'think family' approach at a safeguarding meeting where education, housing and children's services provided important input.

Extracts from National Analysis of SARs 2017-2019 (2)

- SARs sometimes referred to an absence of a 'think family' approach – a failure to consult with siblings, children, parents, even when they were providing significant levels of support and in one case a failure to consider the risks of children's exposure to alcohol misuse, mental ill-health, isolation and domestic abuse. In one case, an individual's self-discharge from hospital and subsequent refusal of services when living in conditions of severe self-neglect – a move that had serious implications for her parents and her children - did not initiate a proportionate response from services. This was compounded by poor recognition of a child carer's perspective:
- "*There was a lack of a joined or focused up approach to supporting him and understanding the impact of this role on his emotional well-being and on his day to day life. Agencies seemed to have little understanding of what he wanted or hoped for during this episode and his views about what would be best for his future were not apparently sought.*"

More Extracts from National Analysis of SARs 2017-2019

- In another case, a family's exclusion compromised the level of support an individual received when making a transition to independence: "*There is no evidence that his family were involved by professionals in any planning to support X toward independence, or indeed in any aspect of his support. As family members they may have been able to advocate for (him), as well as support him. They had been very involved with reviewing and planning his support prior (an earlier move) but after this point they were not invited to meetings or informed of any element of his progress. X continued to spend time with his family on holidays and extended visits, but they were excluded from all aspects of his interaction with services*."
- Several SARs noted a disconnect and failure of collaboration between adult social care and children's services in the local authority: "*Adults and children's social care are so institutionally and culturally separate that taking a "think family" approach is not standard, even in cases where there is a parent-carer of and adult-child living with other younger children*."
- In another case the same disconnect was noted between adolescent and adult mental health provision.

More Extracts from National Analysis of SARs 2017-2019

- A whole network or "think family" approach. This may involve the provision of information about how to raise concerns and feeding back how complaints and safeguarding alerts have been addressed. Recommendations highlight family involvement where appropriate and carer assessments but also exploration of family relationships and challenge when it seems that relatives may not be acting in a person's best interests. Recommendations focus also on information-sharing and highlight the importance of communication. Examples include:
-
- *"Health and social care to consider a whole family approach and relationship-based practice, including use of genograms/ecograms, ensuring individual voices are heard and robust support when individuals and families with significant risk are identified."*
-
- *"SAB and LSCB to ensure that CSC and ASC systems align into a whole family framework and life course approach to address risk."*
-
- *"SAB to seek assurance that carer needs are identified and offered assessment, including dependence between carer and cared-for person, and contingency arrangements."*

Child and Adult Practice Reviews (West Glamorgan Safeguarding Board)

- Transitional Safeguarding – WGA N11 2019
- Self-Neglect and financial exploitation by a family friend – WGA S13 2019
- Neglect of a mother by a son – WGA S14 2019

- Father sustains a brain injury, mother experiences depression and anxiety, risk to children – WG N60 2020
- Chaotic household, including poor home conditions; concerns about parents' behaviour towards each other and the children – WG S58 2020

Themes – Organisations around the Person

- Importance of an organisational and multi-agency partnership culture that always "thinks family"
  - Strategic cooperation between Safeguarding Adults Boards, Community Safety Partnerships and Local Children's Safeguarding Arrangements
  - Protocols on "think family", including shared records, carer assessments, domestic abuse
- Importance of close collaboration between Children's Services and Adult Services
  - Working with and focusing on the whole family
  - Joint visits
  - Participation in child protection and adult safeguarding meetings
  - Convening the whole (multi-agency) system
  - Shared records

Themes – Working with Individuals and their Families

- Information gathering from family, neighbours and friends
- Information-sharing to safeguarding and promote wellbeing/welfare
- Family involvement in assessing and care planning – circle of support?
- Recognising the contributions of carers
- Understanding (changing) family relationships and dynamics, for example between carer and cared-for person
- Considering both neglect and self-neglect, victim and perpetrator of abuse/neglect
- Family Group Conferences
- Drawing on different legal mandates to addressing need and minimise risk
- Guarding against the rule of optimism and "starting again"

Learning from Reviews (1)

- The need to improve
  - Safeguarding and legal literacy
  - Integrated whole system working
  - Recognition and assessment of care and support needs
- The need to clarify
  - Pathways into safeguarding
  - The role of different multi-agency panels
- The need to assess
  - The likelihood and significance of risks
  - Executive functioning after prolonged substance misuse
  - The impact of trauma and adverse experiences

Learning from Reviews (2)

- The need for creativity
  - Thinking collectively about ways forward
  - Avoidance of case dumping
  - Inter-agency mechanisms for responding to stuck and stalled cases
- The importance of wrap-around support
  - Not just for service users but also for staff; the work is challenging
  - The importance of time, relationships and being "held"
- The importance of candour and challenge
  - The importance of escalation of concerns
  - Ensuring all voices are listened to and included in multi-agency meetings

Important Final Word – Helen's Message

- "What hope do I have to ever recover or feel better when this keeps happening? I encourage anyone who truly cares to come and spend a day with me to see what it's like to be helpless, when days feel like weeks, weeks feel like months." (reported in a Luton SAB SAR).

- Children's Social Care did exhibit a "think family" approach and sought to involve other agencies as part of the work to support Helen and her family network with her disabled son. However, this attempt to secure a "think family" approach did not materialise. There were delays in assessments and service provision, and a failure to involve all the family when they were providing support.

Discussion

- What barriers are there to adopting a "think family" approach?
- What are the enablers that promote effective "think family" practice?
- What changes in systems, policy or practice could help to promote a "think family" approach?
- What specific recommendations would you make?
  - In relation to your own practice?
  - In relation to your own organisation?
  - In relation to interagency working?

References

- Braye, S., Preston-Shoot, M., Preston, O., Allen, K. and Spreadbury, K. (2020) *Biennial Analysis of Safeguarding Adult Reviews April 2017-March 2019: Findings for Sector-Led Improvement*. London: LGA and ADASS.
- Preston-Shoot, M. (2019) 'Self-Neglect and Safeguarding Adult Reviews: Towards a Model of Understanding Facilitators and Barriers to Best Practice.' *Journal of Adult Protection*, 21 (4), 219-234.

Professor Michael Preston-Shoot

- Independent Chair, Greenwich Safeguarding Adults Board
- Independent Chair, Lewisham Safeguarding Adults Board
- Adult Safeguarding Consultant
- SAR author
- Joint Convenor, National Network for Safeguarding Adult Board Chairs.

- michael.preston-shoot@beds.ac.uk