Risk Sensible Framework

For Multi Agency partners

comms: 5007

Based on Lancashire's Risk Sensible Model used within Children's Social Care

This toolkit has been designed to help you think about risk and need when undertaking a referral or work with a family

Please read in conjunction with *Lancashire's Continuum of Need*

Lancashire Safeguarding Children Board

Contents

Purpose of this Framework

Although there is a national assessment framework (see next page) in place this does not explicitly draw out what is meant by risk, and what constitutes significant harm. The risk sensible framework will help support you in understanding how underlying and high risk factors may be identified, and support practitioners to target referrals appropriately.

It aims to assist multi agency partners in thinking about the needs and risks present for a child or young person within their family or a care setting.

When read in conjunction with *Lancashire's Continuum of Need* it aims to support you in understanding thresholds of intervention.

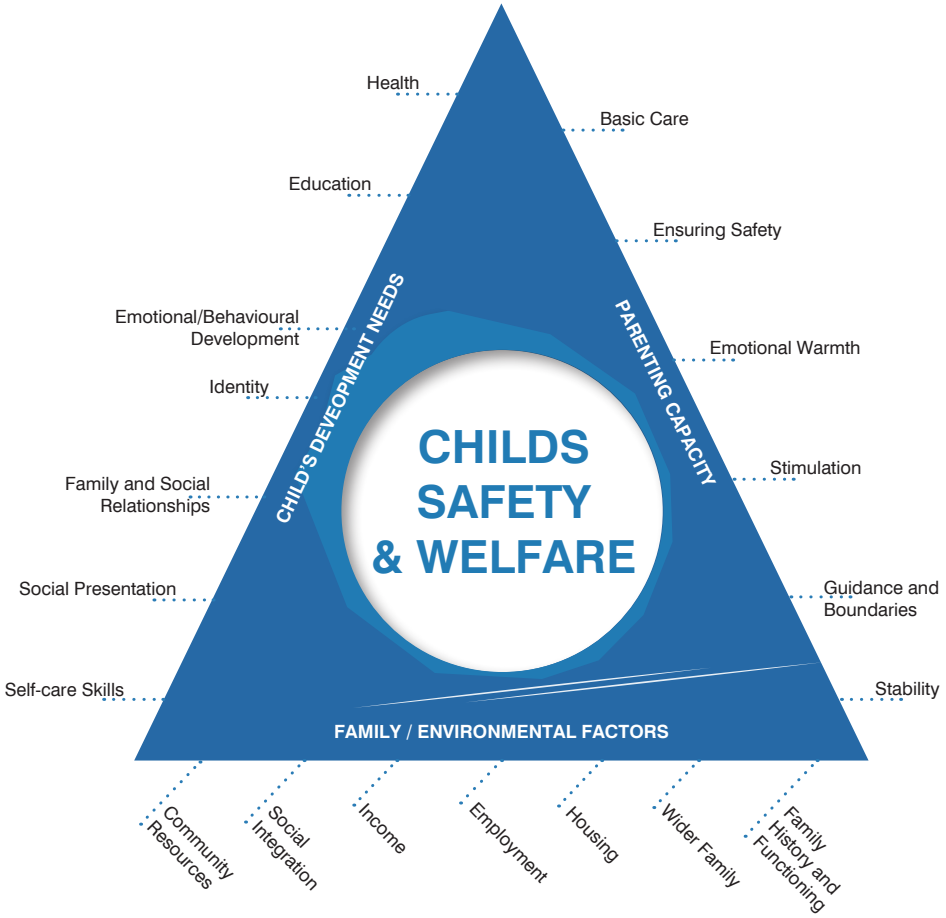
The framework can also support decisions around when to make a referral to Children's Social Care and when to start or continue to support a family via the Common Assessment Framework (CAF) and Team Around the Family (TAF) process.

Professionals should use this guidance in order to avoid identifying or weighting families at the statutory level of 3 or 4 "just in case". This is in order to move away from a risk averse approach to one that is "risk sensible" where decisions are evidenced and balanced.

Engagement with families is important and will help towards successful outcomes.

For the purpose of this framework 'parent/s' refers to parents or carers.

National Assessment Framework
(Working Together 2015)



Risk Sensible Thinking

Key Definitions and what they mean:

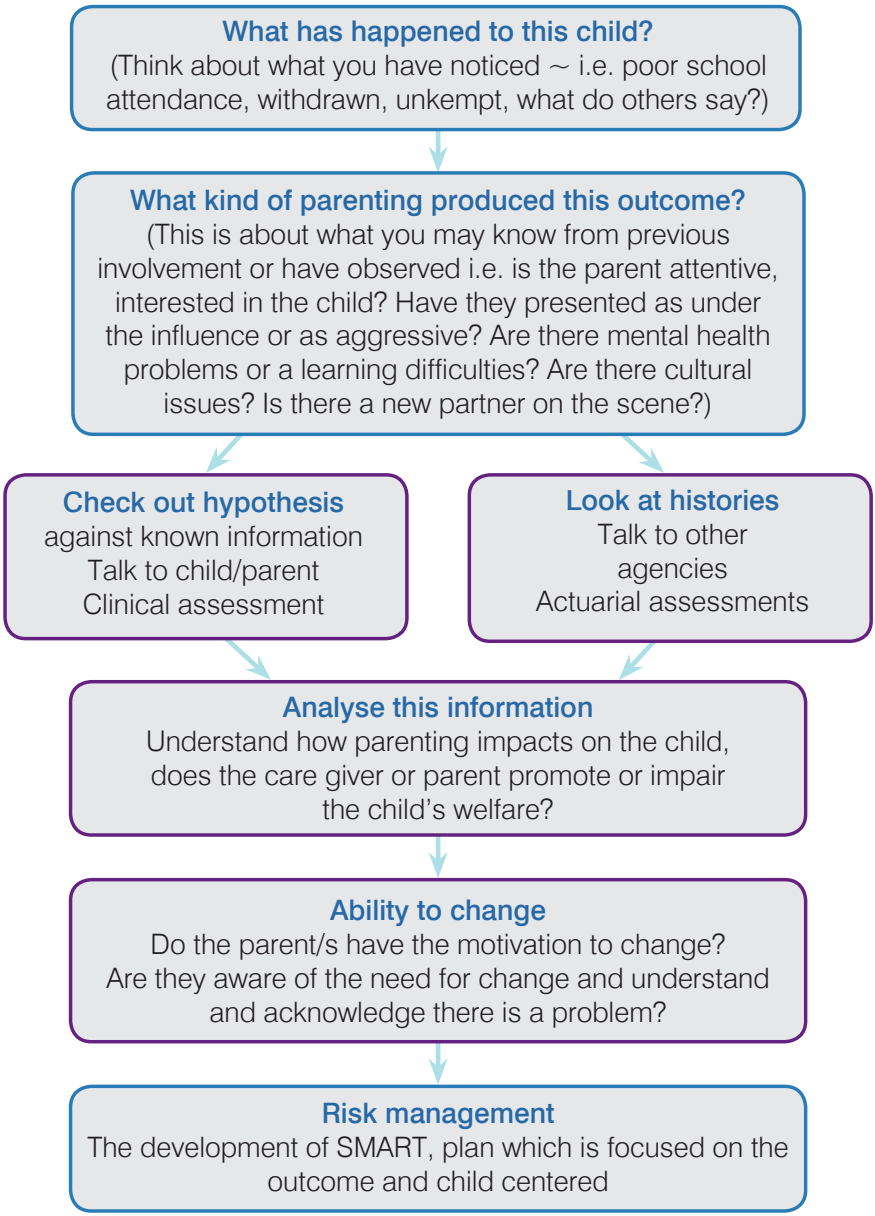
When making a referral or developing a plan for children, think about where you may be obtaining information from and the process you go through to come to a decision. This could be seen as undertaking the following:

Risk Assessment: This is the collection of information about children and families by clinical and actuarial means. This is completed through the process of enquiry, observation and communication with the child, family and partner agencies.

Risk Analysis: This is about making sense of the information above, by evaluating the impact of the child's exposure to the risk of harm and taking account of individual/family strengths and agency services that could reduce the likelihood of future harm.

Risk Management: This is the formation of a plan and allocation of responsibilities for implementing the outcomes of risk assessments and analysis into practical measures to reduce risk (i.e. a team around the family or child protection plan).

How the model works:



Risk Factors

There are different types of risk factors. Look at the following, which will guide you in relation to what sort of risks are present:

1) Underlying Risk Factors

Those elements that are often present in risk situations but which do not, of themselves, constitute a risk:

- Poverty;
- Poor housing;
- Lack of support network/isolation (e.g. previous LAC, Care Leaver);
- Experiences of poor parenting (e.g. Adverse Childhood Experiencies);
- Low educational disability (adult/child);
- Physical/learning disability (adult/child);
- Mental health difficulties (adult/child);
- Drug and alcohol use/misuse;
- Victimisation from abuse/neglect;
- Disordered/discordant relationships (e.g. domestic abuse, attachment issues);
- Previous history of offending;
- Rejecting/antagonistic to professional support;
- Behavioural/emotional difficulties in child;
- Young, inexperienced parent (e.g. teenage pregnancy);
- Physical ill health (adult/child);
- Unresolved loss or grief.

2) High Risk Indicators

Those elements which, by their presence, do constitute a risk, therefore consideration must be given to undertaking a section 47 referral to Childrens Social Care:

- Previous involvement in child physical and sexual abuse/ neglect;
- History of being significantly harmed through neglect as a child;
- Seriousness of abuse (and impact on the child);
- Age of the child (particularly if less than three years old);
- Incidence of abuse (how much and over how long a period of time);
- Record of previous violent/sexual offending (against both children and adults);
- Evidence of disorganised attachment in the adult;
- Older child removed or relinquished;
- Unexplained bruising (particularly in pre mobile children);
- Uncontrolled mental health difficulties (including periods of hospitalisation);
- Personality disorders;
- Chaotic drug/alcohol misuse;
- Denial/failure to accept responsibility for abuse/neglect;
- Unwillingness/inability to put child's needs first and take protective action;
- Cognitive distortions about the use of violence and appropriate sexual behaviour;
- Inability to keep self-safe;
- Unrealistic, age inappropriate expectations of the child;
- Evidence of Domestic Abuse, so called Honour Based Violence, Female Genital Mutilation and Forced Marriage.

In looking at the risk factors you may have identified, here is some guidance around what environment or context these risk factors sit within. Some of these questions you may not know the answer to, however, this provides a guide:

Framework for Analysis

The key questions to be answered in the analysis of the information obtained through the process of risk assessment are…

- To what extent is the parent able to meet the child's needs? What is the nature and extent of the child's unmet needs?

- What is the nature of the child's attachment to the parent and has the parent experienced any early childhood trauma or adversity? (based on observations you have made)?

- What is the adult state of mind – are they physically and emotionally available for their child? (for example are they focused, and are they able to focus on the child's needs in conversation?)

- What is the meaning of the child in the adult's life and what does the adult mean to the child?

- How far does the adult recognise and share the causes for concern and are they able and willing to put the child's needs first?

- What stressors are experienced in the adult's life and what is their ability to regulate and manage these (adult resilience)? Is the adult able to keep him or herself safe (i.e. domestic abuse/ substance abuse/mental health)

- Which environmental factors are helpful to the adult and protective of the child, and which are unhelpful and potentially harmful (additional stressors)?

- Does the adult have the ability and motivation to make and sustain the changes needed to safeguard and promote the child's welfare within the child's timescales?

- The impact of all of the above on the child and the child's resilience

The outcome of this process should be the explicit identification of the child's **unmet** needs and explicit identification of those issues that need to be addressed to improve **parenting capacity.**

Parents' motivation and the ability to change

As a guide when you are working with the child or family think about parent/s ability to change.

The following prompts can be used to assess where the parent/s stand in relation to the causes for concern/presenting need and capacity to change, and the impact on the child:

The family/parent:

- accept there is a problem;
- accepts some responsibility for the situation;
- has some discomfort over the problem;
- believes things must change and is motivated to take action with support;
- sees self as part of the situation;
- sees that choices are possible;
- identified next step towards change.

Each heading can be used as a prompt for further exploration.

The parent/s has to respond positively to each step for any realistic prospect of change.

Reference: Howarth, J and Morrison, T (2001) The Children's World. London: Kingsley, J.

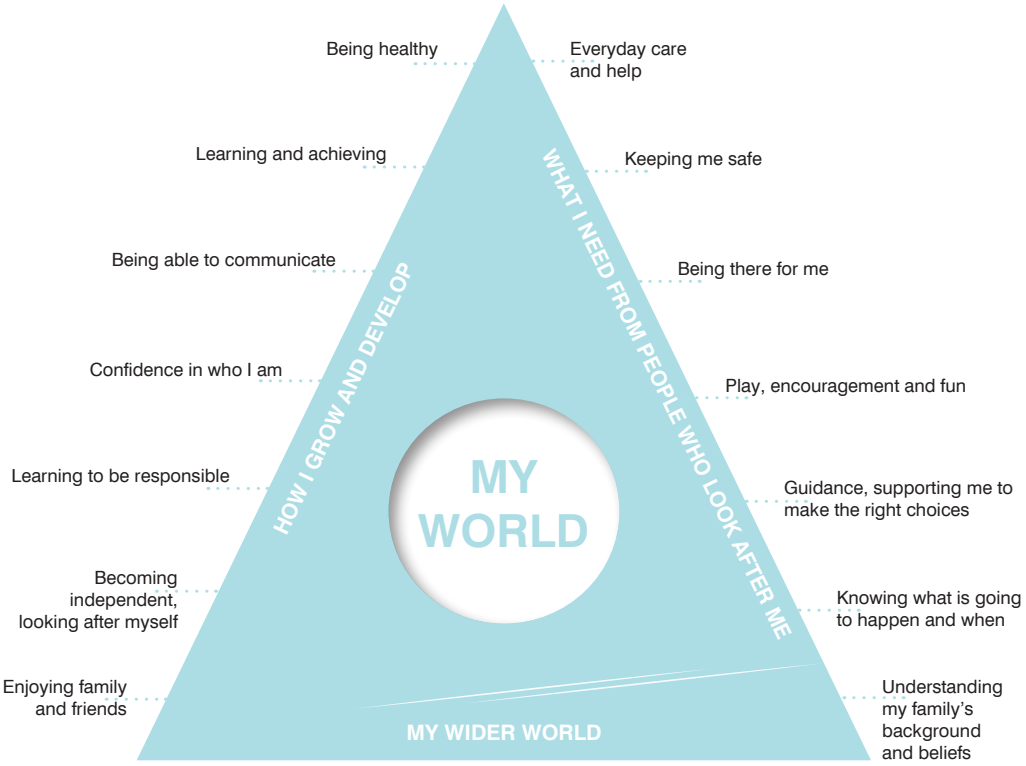
Consent

Consent to share information must be both informed and explicit. Informed means the person understands why the information in being shared, what information is being shared, with whom, and for what purpose. Explicit means the consent has been discussed and this discussion is clearly recorded on case records.

Consent can be implicit. This refers to situations where a child/parents accepts the need for a service that is recommended and in order to receive this service, information will need to be shared. As consent has been obtained to refer to the service implicit in the agreement is consent to share information. Explicit consent is best practice and ideally should be gained in writing. In the case of emergencies, what information will be shared with agencies should be explained during the process of providing the emergency service.

Remember, engagement and partnership with families is a two way relationship.

National Assessment Framework
from the child's perspective



Support from the family, friends and other people, school, enough money, work opportunities for my family, local resources, comfortable and safe housing.

Record Keeping and SMART Plans

Information must be recorded in line with your agency's policies and procedures. However when recording or undertaking a TAF or referral the following can be used as a guide:

1. Observations;
2. High risk indicators and underlying risk factors;
3. Analysis;
4. Readiness for change;
5. Clear rationale for decision making;
6. SMART action plan; NB The next visit date does not constitute a plan.

SMART Plans i.e. CAF & TAF:

SMART goals should be aimed at risk reduction for the child, outcomes are measured in terms of impact of intervention on the child.

Specific Must record the specific issue, risk or unmet need, the specific desired outcome, specific actions and specific evidence of achievement.

Measureable Things can be measured in two ways, inputs or outcomes. Inputs are usually measured in terms of services offered and are counted. Outcomes are measured in terms of impact of intervention (improvements) and need to be assessed.

Achievable There should be explicit statements about degree of improvement required (i.e. acceptable level of residual risk). Plans should be aimed at risk reduction not risk removal.

Realistic This will depend on how intractable the problem is (how long/how severe) and the parent/s motivation and capacity to change.

Timely Changes need to be made within the child's timescale to promote safety and welfare, not the adult's timescale.

SMART Plan Template:

	Input	Outcome
Issue and Desired Outcome	**Action – by who and by when**	**How will we know the plan has worked**
Issue What are you concerned about (either HRI's for CP or unmet needs for CiN/LAC/CAF)? **Desired Outcome** What you want to achieve?	What are you going to do to address the concerns (risks/unmet needs), who is going to do it and when will it be completed?	What you will actually see and hear when you have achieved the desired outcome NOT who will provide the evidence against the plan so far.

SMART Plan Example:

Issues and Desired Outcome	Action – by who and when	How will we know the plan has worked
Issue Poor home conditions impact upon Jane's health. **Desired Outcomes** Home conditions will no longer make Jane's condition worse.	• Hire a skip – Jimmy Jones by 16/10/15 • Provide cleaning materials and equipment – SW by 20/10/15 • Clear the kitchen, bathroom, Jane's bedroom and main living areas – Jimmy Jones and Julie Jones by 23/10/15	Full skip removed from property Clean and tidy living areas observed in home visits Improved lung function (higher spirometer readings) Jane more mobile and active at school Jane says she feels better during 1:1s
Issue Lack of care routines effect Jane's health, welfare and development. **Desired Outcome** Improved routines around feeding, personal hygiene and presentation for Jane	• Family Support Worker to be allocated – SW Mary Martin by 16/10/15 • Positive Parenting course to be applied for – SW Mary Martin by 16/10/15 • Parents to attend sessions and develop routine care strategies with Jane with support from FSW – Jimmy and Julie Jones by 30/10/15	Hygienic home conditions maintained Regular meal times with evidence of 'home cooking' Clean bedding and clothes for Jane Positive reports from school on Jane's presentation and performance Jane talks positively about how she is cared for Jane has gained weight Jane says she is sleeping better and looks well rested

Defensible Multi Agency Decision Making

Practitioners must avoid weighting families at level 3 and level 4 'just in case'.

No matter how much effort goes into risk assessment and management strategies – inevitably some risk decisions will go wrong. It is impossible to eliminate all risk.

It is important both individually and organisationally that decisions that are made will be able to bear scrutiny in hindsight.

The decisions that have been made need to be defensible, i.e. acceptable even if harm has subsequently occurred. A decision is deemed defensible if the following can be demonstrated:

- Reliable assessment methods were used (i.e. views of others (i.e. other agencies), history of the family, observations as a professional, previous interventions, views of family).
- All the information available was collected and evaluated, and every effort was made to obtain information not currently available.
- All reasonable steps were taken to manage the risks identified, i.e. the risk management strategy was SMART (see page 13).
- There was a record and account for the decisions which were made.
- The risk decision was within agency policy and procedures.
- All relevant people were consulted and informed.
- Multi-agency decision making was evidenced as appropriate.

Support with the Risk Sensible Model

- If you have safeguarding leads within your organisation, they will be available to support you.
- Think about this model and the Continuum of Need when undertaking a referral to Childrens Social Care. Think about whether the family is at the stage of statutory intervention i.e. level 3 and 4.
  See *Continuum of Need* and *Thresholds Guidance*
- Take a copy of this framework to your management or safeguarding supervision/meetings with a view to working through specific cases.
- Prior to Child Protection Conferences or other multi agency meetings such as TAF read through the framework and familiarise yourself with the issues within the case using this framework. This framework can also be used whilst completing a CAF.
- If you have been delegated a piece of work with a family where there are unmet needs but no risk of significant harm and the family are not ready for change – use this model to have a conversation/discussion about where to go next.
- If you are working with a resistant and challenging family discuss in supervision what the risk factors are within this situation and what the risk defensible decision is? (see previous page).
- Clear documentation of multi-agency and other discussions in relation to the outline plan and next steps should be evident.

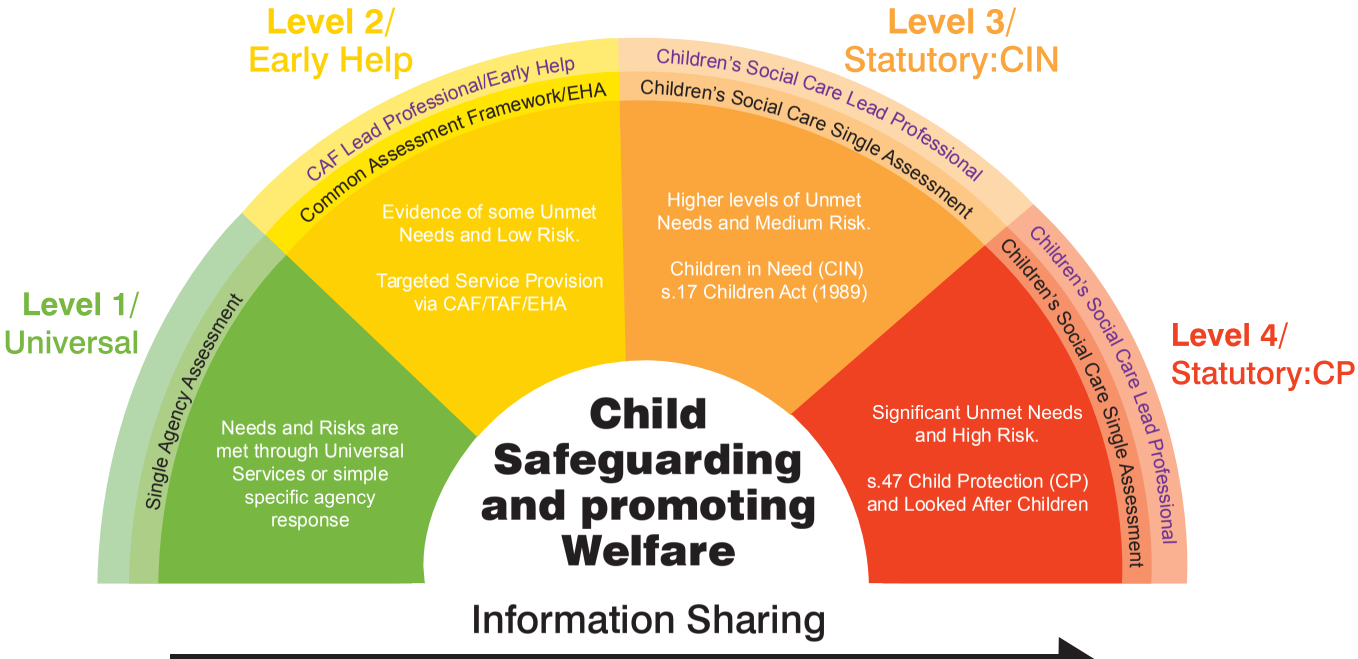
Glossary

Assessment	The process of gathering and interpreting the information needed to decide what action to take to help meet the child's (or their parent/s) needs. In many cases, it is simply a conversation with the child or young person and/or their parent/s.
CAF	Common Assessment Framework – An Assessment and Planning Tool
CLA or LAC	Children Looked After by the Local Authority
Clinical and Actuarial Assessments	Clinical Assessment is an individualistic assessment of "personality" and "situational" factors (and the interaction between them) believed to be relevant to the risky behaviour. The can be based on based on: knowledge and professional experience and expertise of the assessor, social history, Self-report of the individual being assessed and observation. Actuarial Assessment is based on based on statistical calculations and probability. Assessment is based on predicting an individual's behaviour from the behaviour of others in similar situations or with similar profiles. This can be based on research and evidence.
CON	Continuum of Need
CP	Child Protection
CYP	Children and Young People

Glossary

EHWB	Emotional Health and Well Being
FSW	Family Support Worker
GP	General Practitioner
Hypothesis	A supposition or proposed explanation made on the basis of limited evidence as a starting point for further investigation.
Lead Professional	The Lead Professional (LP) is someone who takes the lead to co-ordinate provision and be a single point of contact for a child/young person and their family, when a range of services are involved and an integrated response is required.
LSCB	Lancashire Safeguarding Children Board
MASH	Multi Agency Safeguarding Hub
MFH	Missing from Home
S47	Section 47, Children Act 1989
SEND	Special Educational Needs or Disability
SMART	Specific, Measureable, Achievable; Realistic; Timely
SW	Social Worker
TAF	Team Around the Family

Pan-Lancashire Continuum of Need



If in doubt, consult with agency safeguarding leads, or the Duty Social Worker in your area:
Lancashire 0300 123 6720; Blackpool 01253 477299; Blackburn with Darwen 01254 666400

BLACKPOOL SAFEGUARDING CHILDREN BOARD

Blackburn with Darwen

Lancashire Safeguarding Children Board

Lancashire **Safeguarding Children** Board

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