Purpose and context

In the English system, the purpose and structures for multi-agency working to keep children safe and to provide for their well-being comes from The Children Act 2004.

These are developed in regularly reviewed guidance the most recent at time of writing being Working Together to Safeguard Children 2020. The basis for this guidance comes from past Child Safeguarding Practice Reviews (formerly known as serious case reviews) which consider the impact of inadequate multi-agency working.

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Activity One

Please consider and discuss the following questions:

1. What are the legal structures for safeguarding and ensuring the well-being of children which apply in participants' area?

2. To what extent is effective inter-professional working required and/or encouraged in the guidance given?

3. What do Child Safeguarding Practice Reviews report on inter-professional working in the participants' area?

Context:
A key feature of guidance in England is that all professions understand the role they should play and how that inter-relates with the roles of other practitioners. Three professions are defined as having a key role: local authorities (including social services and education), police and health authorities. Other professions are noted but the list is not intended to be an exhaustive one.

Activity Two

Please discuss the following question together:

1. Which professions/organisations/agencies have a stated responsibility for safeguarding and well-being of children in the participants' area? Which have no stated responsibility but could make a useful contribution?

Activity Three

Please discuss the following question together:

It is important to be aware of the effect of using acronyms, especially when talking to children, young people and their families.

Who's who?

Depending on the situation, there are a variety of professionals and organisations that could be involved in supporting individual children and young people. This support may be given within an educational setting or separate from it. There is often a tendency to use acronyms (abbreviations formed from the initial letters of other words) to describe these.

These are some acronyms used in the children's services in England:

1. SW	2. EWO	3. CAMHS
4. SALT	5. OT	6. VS
7. CWP	8. YOT	9. Ed Psych

This is a brief description of each of the roles. Can you match the role with the acronym?

a. A specialist NHS service offering assessment and treatment when children and young people have emotional, behavioural or mental health difficulties.

b. Works with young people whose education is being affected by irregular attendance or absence from school.

c. Offers short targeted and specific interventions for children with mild to moderate mental health difficulties. Usually employed by CAMHS.

d. Specialises in assessment and specialist support for speech and language needs.

e. Supports children/young people and their families at difficult times focusing particularly on the safety of the child.

f. Promotes the progress and educational attainment of children and young people who are or who have been in care

g. Assesses and supports children and young people who are experiencing difficulties that hinder their successful learning and participation in school and other activities. These difficulties can include a range of learning difficulties including those related to social, emotional and mental health.

h. Works with children or young people who are at risk of or who have committed a crime, to prevent them from reoffending.

i. Provides intervention, support and/or advice to children and young people and their families, where there is disability or impairment which impacts on their performance and participation in everyday activities of life.

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UK Child timeline

	Before conception	Conception to birth	0-2 years	2-5 years	5-11 years	11-16 years	16-18 years	18-25 years	25 years +
Health services		If known to the state							
Education									
Police									
Social Services									
Other					10 yrs = criminal responsibility		16 yrs = sexual activity. Marriage with parental consent 17 yrs = driving licence	18 yrs = alcohol , smoking, voting 18 yrs = marriage without parental consent	25 yrs = vulnerable young person

Mandatory action

Action by need

HANDOUT 3

Gender Identity Development Service

Multi-Agency Working as Best Practice

Multi-agency working is firmly advocated in government agendas such as The Children's National Service Framework (2004) which encourages services to be designed around the needs of the child, not individual problems. The children's commissioner, Professor Aynsley-Green summarised this vision by stating that "the practical challenge is ensuring that children's services locally are coherent in design and delivery, with good coordination, effective joint working between and across sectors and agencies, with smooth transitions and in partnership with children, young people and families" (Executive Summary, Department of Health, 2004).

In Every Child Matters (2003) emphasis is on empowering the young person to make a positive contribution, facilitating communication across services and reducing stigma through acceptance and understanding, modelling and consultation. The Children's Plan (2007) asserts that services need to be shaped by and responsive to young people and families, not designed around professional boundaries. This Plan espouses working in teams made up of professionals from different backgrounds, and is supported by the Children's Workforce Network, which aims to "encourage the shared values of practitioners with distinct expertise and roles and value their contributions" (Children's Workforce Network, 2008).

GIDS and multi-agency working

Multiple agency working is an essential part of the work of the GIDS which is a Tier 4, multi-national service. The GIDS is part of the Adolescent Department at the Tavistock & Portman Foundation NHS Trust, in London. Referrals of young people (up to the age of eighteen) are accepted from health and social care professionals from tier three services. The young persons present as feeling unhappy and at odds with their biological sex and often want to be the other sex. Gender identity difficulties are rare and complex and can be associated with psychological difficulties linked to all aspects of development, including cognitive, physical and social (DeCeglie, 2000). Gender identity difficulties can be seen on a continuum with Gender Identity Disorder at the extreme where individuals display a strong and persistent desire to be, or insistence that they are the other sex. These individuals may dress and take on the role of the other sex and feel distressed and uncomfortable with their biological sex (i.e. APA, DSM-IV, 2004). There are many potential outcomes and etiology remains inconclusive and is likely to be

multi-faceted (Cohen-Kettenis, 2003).
At the GIDS the young people are seen individually and with their families for assessment and psychosocial intervention by members of the multi-disciplinary team which includes psychiatry, psychology, psychotherapy and social work. The GIDS also works closely with two consultant paediatric endocrinologists who run a regular liaison clinic where all members of the team attend. Discussions take place during the weekly team meetings providing a space where shared formulations can be derived at drawing on the experiences and skills of the whole multi-disciplinary team.

Due to the wide geographic area from which referrals are accepted and the complexity of the presentations, outreach is always conducted. 'Network meetings' (DiCeglie, 2005) between the professionals involved in the young persons care, including the GIDS clinicians are usually held in the young person's local service. This is most often at the young person's local Child and Adolescent Mental Health Service (CAMHS) or school. The meetings aim to offer an opportunity to co-ordinate care and offer consultation and guidance with the network of professionals involved. The professionals meet in the first hour and are joined by the family in the second hour. In the second hour feedback is given to the family about what has been discussed and they are asked for their views and questions. An action plan and further network appointments are then coordinated.
The aims of the GIDS are articulated by DiCeglie, (1998) and include recognition and non-judgemental acceptance of gender identity problems and working on any associated problems such as behavioural (i.e. school difficulties), emotional (i.e. mood disturbances) and relationship difficulties. They also include exploring secrecy versus privacy and/or the mind–body relationship by promoting close collaboration among different specialists. These aims empower the individual and their family who may feel shamed or at threat from the prejudices of society. The gender identity issue is considered holistically with relationships between the GIDS and the individual's local health services, education and other non statutory agencies fostered.
Intervention aims to allow mourning processes to occur for the young person and their family who have spent many years knowing the young person in their biological gender. Furthermore, the aims include the promotion of separation and differentiation, enabling the young person and the family to tolerate uncertainty in gender identity development and to sustain hope (DiCeglie, 2000). The network meetings are carried out with the young person and their families at the forefront of the process with the families needs and preferences met flexibly (i.e. for meetings to take place in the young person's locality). These meetings aim to reduce stigma through modelling and consultation on issues of gender aiding acceptance and understanding.

Examples of multi-agency working at the GIDS

Young people referred to the GIDS often prefer to be called a name other than their originally given name which they choose to better reflect their preferred gender and to be referred to using the accompanying pronouns. The following examples illustrate the multi-agency work carried out at the GIDS. The confidentiality of the families has been protected through changing all identifying details.

Taken from: Gender Identity Development Service 2020.

Available at:
https://gids.nhs.uk/eracleous-davidson-2009

Case Study: Alex

"Alex is a biological female who at referral was aged fifteen and presented as being unhappy with his biological gender. He also experienced a low mood and difficulties at school including bullying. We used the name "Alex" and male pronouns throughout our work out of respect for his wishes. Alex moved between the homes of his grandparents and his separated parents in North Wales as his mother had limited space in her home and was waiting to be re-housed by the local authority. Alex's mother lived with her five young children in council accommodation. The families all lived nearby so that Alex had regular contact with both of his parents and two sets of grandparents."

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Imagine you are coordinating a multi-agency support plan for Alex.

How could you ensure the key principles identified in the documents you looked at are followed?

- Designing support that addresses Alex's needs as a whole rather than individual 'problems.'
- Empowering Alex to positively contribute to designing this support.
- Bringing in a diverse range of professionals whilst making sure they share the same values and their different strengths are used?

Revisit the article

Available at
https://gids.nhs.uk/eracleous-davidson-2009

Read the paragraph entitled Alex and compare your support plan with the one the Gender Identity Development Service (GIDS) put in place for Alex.

Case Study: Alex (Best Practice)

A professionals' meeting was set up as part of the assessment process in order for representatives from the services already involved to meet together to coordinate their roles and to facilitate communication. The services involved included CAMHS, school and a voluntary agency which was mostly assisting Alex's mother with housing and financial issues. The meeting was held at Alex's local CAMHS and included representatives from all three organisations.

The meeting focused on strengths for example Alex had sought out a teacher at school who he felt was more sympathetic towards his needs and this teacher attended the meeting. The meeting aimed to reduce areas of stress for Alex by considering ways of managing Alex's gender identity issues across his life contexts. We discussed how, with the help of his teacher Alex could negotiate more appropriate ways of managing life at school. This information was then passed on to other members of staff at the school so for example, Alex was encouraged to use the disabled toilets in order to avoid having to choose between either the male/female toilets which he found difficult. Alex was also referred to by the name he chose and male pronouns as he requested at school (a deed poll change of name also followed). The information sharing and problem solving provided a bridge between the services.

The voluntary agency representative offered to work with the psychotherapist to help Alex engage with CAMHS by arranging for them both to meet Alex at a location nearer to their homes, more convenient and less stigmatising to Alex where the voluntary agency was based. This meant that Alex and his mother could have regular access to different professionals' who offered different support in the same place and at the same time thus minimising the number of appointments and travelling time and costs. Furthermore, the representative from the voluntary agency was able to speak with the teacher about the transition for Alex between Year 10 and Sixth Form College.

When it became clearer that Alex fulfilled the diagnostic criteria for GID and wanted to move towards taking hormone blocking medication the GP was invited to the network meeting in order to think about the appropriateness and timing of this next step. Information was provided about the possible options, timescales and processes were discussed.

Our work with Alex highlighted the importance of the network system, having a shared understanding of his presentation and therefore consistency in approaches taken for example, with how to refer to Alex. An appreciation of each others professional roles, remits and resources helped both the professionals involved and Alex and his mother feel clearer about the professional input. Moreover, it enabled the establishment of open channels of communication and increased trust between colleagues from different settings which facilitated thinking about the holistic needs of Alex and reducing his number of appointments and the cost of getting there.

Taken from: Gender Identity Service.

Available at:
https://gids.nhs.uk/eracleous-davidson-2009

HANDOUT 6

Obstacle	How has each one been addressed in the Scunthorpe case study?	How is each obstacle addressed in your professional context?
Different professional approaches and perceptions of an issue.		
Lack of training opportunities.		
Poor communication between different agencies.		
Lack of clarity about roles.		
Misunderstanding and mistrust.		

Research into Common Barriers

The following is a summary (adapted from Cheminais, R. (2009) *Effective Multi-Agency Partnerships: Putting Every Child Matters Into Practice).* Each point noted in the Scunthorpe case is in this list.

The challenges that are identified with multi-agency working arise largely as a result of the complexities involved when practitioners engage in collaborative ventures.

1. Funding concerns in relation to sustainability, for example, conflicts over funding within and between different agencies; a general lack of funding for multi-agency training and development work and to cover accommodation and on-costs for service delivery.

2. Time – only a finite amount of time is available to respond to many different priorities; some services have waiting lists, for example, Children and Adolescent Mental Health Service.

3. Communication – ensuring clear routes for two-way communication between any one setting and other agencies and practitioners in order to exchange information and improve joined-up, co-ordinated working.

4. The danger of a lack of clarity arising about the roles and responsibilities of practitioners in a wider and more diverse children's workforce.

5. Adapting to working in a new and different context, for example, for health staff in a school or children's centre, as opposed to a hospital environment.

6. Competing priorities placing multiple demands and expectations on each setting and service, for example in repeated, changing government policy. Danger of initiative overload occurring if not well managed.

7. The management of different professional and multi-agency service cultures, for example, staff recruitment and retention processes, disparities in status, pay, conditions of service, working hours and working conditions. For example a health service works 24 hours a day, seven days a week and education does not.

8. Understanding each other's professional language and protocols.

9. Territorial issues – overcoming the reluctance to share equipment and facilities, professional jealousy and inter-agency mistrust.

10. Preventing too much 'referring on' or 'passing the buck' becoming too regular an approach being adopted to give the illusion of effective action having been taken.

11. Finding mutually convenient times for managers and practitioners to meet.

12. Problems of cross-authority working where health authority (primary care trust – PCT) and the local authority boundaries are different.

13. Additional stress and pressures arising from unsuccessful or disappointing attempts at multi-agency working having an adverse affect on staff morale and turnover.

14. The assumption that multi-agency partnership working must be adopted at all times, even when it may be inappropriate in some instances.

15. Lack of coherence in the aims, intentions and joined-up thinking between different agencies, resulting in role overlap or duplication of services.

16. Staff resistance to change both within any one setting and among multi-agency practitioners. A lack of understanding and appreciation about the reasons for change, and what the change process entails and the benefits it can bring to improving outcomes for children, young people and their families.

17. Engaging the 'hard to reach' parents/carers, families, children and young people with multi-agency service provision, education and lifelong learning.