Professional Curiosity

Adapted from guidance developed by [Somerset NHS Foundation Trust]

1 Introduction

1.1 Professional curiosity is an emerging theme in the Safeguarding Adult Reviews nationally. It has long been recognised as an important concept in Children's Services, but is equally relevant to work with adults.

1.2 This guidance was originally developed by Somerset NHS Foundation Trust and the Somerset Safeguarding Adults Board thanks the Trust for both the work undertaken to develop it, and permission for it to be adopted by the Board.

2 What is professional curiosity?

2.1 Professional curiosity is the capacity and communication skill to explore and understand what is happening with an individual or family. It is about enquiring deeper and using proactive questioning and challenge. It is about understanding one's own responsibility and knowing when to act, rather than making assumptions or taking things at face value.

3 Barriers to professional curiosity

3.1.1 It is important to note that when a lack of professional curiosity is cited as a factor in a tragic incident, this does not automatically mean that blame should be apportioned. It is widely recognised that there are many barriers to being professionally curious. Some of the barriers to professionally curious practice are set out below:

- **Disguised compliance**
  A family member or carer gives the appearance of co-operating with professionals to avoid raising suspicions, to allay professional concerns and ultimately to reduce professional involvement. We need to establish the facts about what is actually happening. We need to focus on outcomes rather than processes to ensure we remain person centred.
- **The 'rule of optimism'**
  Risk enablement is about a strengths-based approach, but this does not mean that new or escalating risks should not be treated seriously. The 'rule of optimism' is a well-known dynamic in which professionals can tend to rationalise away new or escalating risks despite clear evidence to the contrary.
- **Accumulating risk – seeing the whole picture**
  Reviews repeatedly demonstrate that professionals tend to respond to each situation or new risk discretely, rather than assessing the new information within the context of the whole person, or looking at the cumulative effect of a series of incidents and information.

- **Normalisation**
  This refers to social processes through which ideas and actions come to be seen as 'normal' and become taken-for-granted or 'natural' in everyday life. Because they are seen as 'normal' they cease to be questioned and are therefore not recognised as potential risks or assessed as such.
- **Professional deference**
  Workers who have most contact with the individual are in a good position to recognise when the risks to the person are escalating. However, there can be a tendency to defer to the opinion of a 'higher status' professional who has limited contact with the person, but who views the risk as less significant. Be confident in your own judgement and always outline your observations and concerns to other professionals, be courageous and challenge their opinion of risk if it varies from your own. Escalate ongoing concerns through your manager and use the SSAB Resolving Professional Difficulties guidance.
- **Confirmation bias**
  This is when we look for evidence that supports or confirms our pre-held view, and ignores contrary information that refutes them. It occurs when we filter out potentially useful facts and opinions that don't coincide with our preconceived ideas.
- '**Knowing but not knowing'**
  This is about having a sense that something is not right but not knowing exactly what, so it is difficult to grasp the problem and take action; commonly referred to as a 'gut feeling'.   However, a 'gut feeling' is not evidence, hence the need for professional curiosity.
- **Confidence in managing tension**
  Disagreement, disruption and aggression from families or others can undermine confidence and divert meetings away from topics the practitioner wants to explore and back to the family's own agenda.
- **Dealing with uncertainty**
  Contested accounts, vague or retracted disclosures, deception and inconclusive medical evidence are common in safeguarding practice. Practitioners are often presented with concerns which are impossible to substantiate. In such situations 'there is a temptation to discount concerns that cannot be proved' and concerns therefore going unrecorded.

3.1.2 A person-centred approach requires practitioners to remain mindful of the original concern and be professionally curious.

3.2 Retracted allegations still need to be considered and/or investigated wherever possible. The use of risk assessment tools can reduce uncertainty, but they are not a substitute for professional judgement. Results need to be collated with observations and other sources of information.

4 Other barriers to professional curiosity

4.1 Poor supervision, complexity and pressure of work, changes of case worker leading to repeatedly 'starting again' in casework, closing cases too quickly, fixed thinking/preconceived ideas and values, and a lack of openness to new knowledge are also barriers to a professionally curious approach.

5 Proactive Questioning

5.1 What being proactive means?

5.1.1 If you are proactive, you make things happen instead of waiting for them to happen to you. Active means "doing something. The prefix pro- means "before." So, if you are proactive, you are ready before something happens. The opposite is being reactive, or waiting for things to unfold before responding. Therefore, Proactive Questioning can be said to relate to creating or controlling a situation, being prepared for it, rather than just responding to it after it has happened, such as in a disclosure from a client. For example, if a someone you were working with disclosed domestic abuse or other abuse, how would you react? What questions would you ask?

5.2 Asking Questions

5.2.1 Questions can often lead people in a certain direction and limit what they say. This has the disadvantage that workers may end up finding out only what the questions are designed to elicit, rather than what it is they really need to learn. This can reflect the worker's own bias and presuppositions. It is therefore important to have an understanding the communication skills that may assist a professional to gather information from service users and carers of all ages.

5.2.2 Wherever possible, to get the fullest and most accurate picture, we should encourage people to communicate their views, thoughts and feelings at their own pace and in their own words.

5.3 Types of questions

5.3.1 Question types can fall into five main categories; these being Open, Closed, Focused, Prompts and Leading Questions. A brief overview of each type can be seen below.

5.4 Open Questions

5.4.1 Wherever possible we should start off interviews with open questions which allow people to tell their stories, feelings and concerns in their own words.

- 'How can I be of help?'
- 'I want you to tell me what happened - in your own words' (Trevithick, 2005: 160).

5.4.2 Sometimes people will struggle with open questions, though, particularly if they are feeling overwhelmed and don't know where to start, or if they are not used formulating their thoughts and feelings into such an open space, if this is the case then more focused questions can be helpful.

5.5 **Closed Questions**

5.5.1 Closed questions ask for very specific information often in one-word answers like yes or no. They may be useful if you are after a very specific piece of information, e.g. 'Have you seen the doctor?'

5.5.2 Closed questions need to be used carefully, though. By moving away from gaining people's narratives in their own words they may steer the conversation away from what the service user really wants to convey but doesn't know how to interrupt. They can also risk closing a conversation down. This can be an unhelpful spiral that it is particularly easy to get into with young people, particularly if they're not keen on professional contact, for example:

- 'How are you?' 'OK.'
- 'How is it in your placement?' 'Fine.'

5.5.3 Moving back to more focused, but open questions is likely to be more helpful in such examples (Malekoff, 1994).

5.6 **Focused Questions**

5.6.1 Focused questions enable the worker to follow a particular line of enquiry and gain more detail. Some focused questions may remain quite open, still encouraging the person to tell things in their own words as much as possible. Some examples are:

- 'What is it like for you being a carer?'
- 'Can you tell me about a typical day in your household?'

5.6.2 Other questions narrow the focus down much further to clarify matters, for example:

- 'What are the ways that being a carer causes you stress?'

5.6.3 Questions beginning with 'how', 'what' or 'when' are often more helpful than 'why', which can feel both accusing and overly authoritarian (Seden, 2005: 29).

5.7 **Prompts**

5.7.1 Prompts are empathic words, short phrases and non-verbal communications, which workers can use to encourage people to talk to them about issues of concern. These may be helpful when people are struggling to put things into words, or if they have worries about how what they are saying may be received or acted upon. Prompts like these can encourage someone to continue talking:

- 'I'm guessing that you don't know which way to turn at the moment.'
- 'Tell me more.'
- 'That sounds really hard.'

5.7.2 Non-verbal prompts can be equally powerful or encouraging. They are where the worker stays silent but shows interest, care and empathy through body language or sound:

- 'Mmmm... Uh-huh.'
- nodding occasionally
- attentive bodily position (perhaps leaning slightly)
- appropriate (but not intrusive) eye contact.

5.8 **Leading Questions**

5.8.1 Leading questions are phrased in a way that suggests some kind of answer. It's important to be wary of these as the respondent is more likely to answer what they think you want to hear rather than what is real or true. This may be particularly true when someone, either an adult or child, is particularly vulnerable, confused, or in a powerless situation. The professional can run the risk of 'putting words in their mouths' (Seden, 2005).

5.8.2 Think about these three ways of asking a question:

- Are you finding Shane difficult?
- I guess you must be finding Shane difficult?
- Tell me the ways in which you find Shane difficult?

5.8.3 The first is a straightforward closed question to which the client/service user could answer yes or no.

5.8.4 The second gives the impression the worker is expecting the client/service user to say yes. Whilst this might be helpful in encouraging the client to share difficult feelings, it might be harder for him/her to deny it if it's not true.

5.9 The third is focused, and enables the client/service user to elaborate in his/her own words.

6 Further resources

6.1 A learning resource/exercise relating to Asking Questions, is provided by the Social Care Institute for Excellence and can be accessed via https://www.scie.org.uk/assets/elearning/communicationskills/cs04/resource/html/object4/index.htm

7 References:

- https://www.scie.org.uk/assets/elearning/communicationskills/cs04/resource/html/object4/index.htm

- Malekoff, A. (1994.) 'A guideline for group work with adolescents', Social Work with Groups, 17(1-2), p. 5-19.
- Seden, J, (2005) Counselling Skills in Social Work Practice, Open University Press, McGraw-Hill Education, Maidenhead, Berkshire.
- Trevithick, P. (2005) Social Work Skills: A Practice Handbook, Maidenhead, Open University Press.