

ANALYSIS & DECISION MAKING

Diversity Issues in the Training Setting

People who present courses for Reconstruct make some assumptions, even though we're supposed not to, about participants.

These are that the group will contain people from a diverse range of backgrounds, some visible some less visible, some personal some professional. This diversity will cover gender, race, sexual orientation, disability and a lot more including personal experiences, class and religious persuasion.

So this means that the course will

- be presented using variety because people have different learning styles,
- describe concepts using a variety of examples.

The presenters will

- avoid jargon (or at least explain it),
- be aware of individual differences within the group and respect these,
- avoid the stereotyping of particular groups in society,
- be aware of the effect of language,
- accept that everyone has the right and the responsibility to challenge.

Additionally the facilitators hope that participants will:

- arrive punctually and stay (but explain unavoidable absences),
- respect each other,
- maintain the confidentiality of sensitive information,
- recognise and value difference,
- share experiences,
- ask questions,
- challenge views constructively.

We hope that this will provide a useful framework within which learning and development can take place.

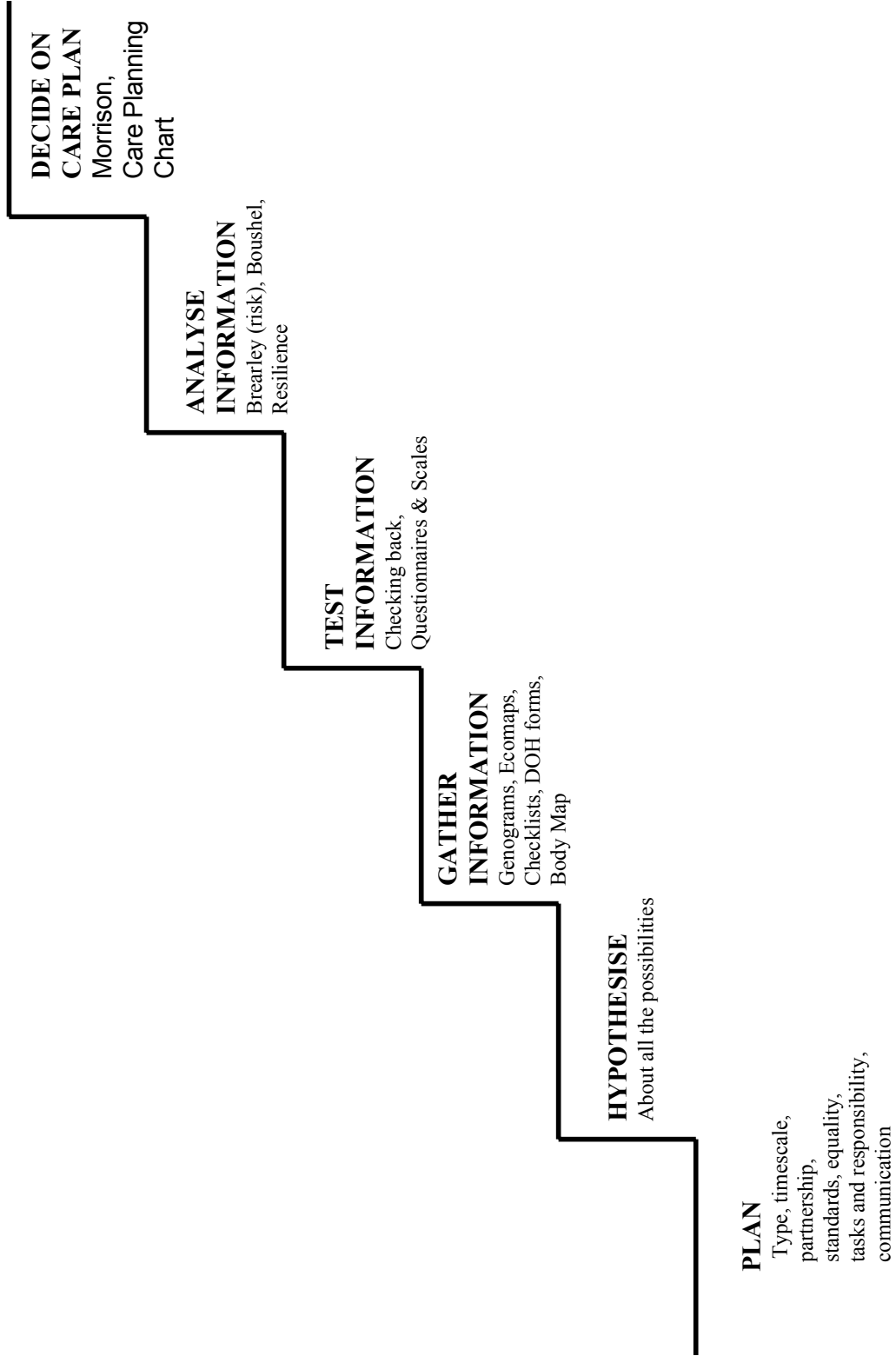
THE PROCESS OF ASSESSMENTS

The framework repeats the mistakes of earlier assessment systems by focusing on information gathering and not on the process of assessments, the route from referral to care plan. Reconstruct has developed a model based on work by Eric DeMello and John Yuille, called “stepwise”, see diagram overleaf. This illustrates the steps which the assessment team need to follow to produce an effective assessment and, more importantly, a care plan. The remainder of this chapter describes those steps and follows through the process of assessment.

THE PLANNING STAGE

Where a group of professionals, particularly those who do not regularly work together, are to jointly undertake an assessment, they need to agree not just how they will assess the family but also how they will work together effectively. In our experience workers tend to concentrate on the tasks they need to undertake in respect of the child and the family, but spend little time considering how they will maximise the groups' combined skills and knowledge, and support and complement one another's work. In addition, consideration should be given to developing strategies for resolving difficulties and differences of opinion.

A Stepwise Model For Children And Family Assessments



The type of assessment required

The initial child protection conference should give directions to the assessment team regarding the areas to be addressed in an assessment. In practice, assessment teams may only receive very general directions or be requested to “do a core assessment” and so need to agree in detail what areas require assessment. Group members will also need to clarify what is meant by an assessment. To a teacher, the request for an assessment of a child may have a very different meaning to the expectations of social services. Many professionals are still not familiar with the assessment framework.

The time scale

Time scales for some assessments have been set within the framework itself allowing staff seven days to complete an initial and 35 days to complete a core assessment. It would be a mistake to presume that these are the only types of assessments and other risk assessments and specialist assessments should be clear with regard to timescales. Everyone involved, including the family, should be clear about how long the assessment will take and what is expected of them at different stages. This is important for the following reasons:

- decisions about the child should not be unnecessarily delayed,
- the family will feel more empowered if they have a clear understanding of the time parameters and when decisions are likely to be taken,
- professionals contributing to the assessment need to be clear about how long they have for information gathering, when and where to provide information and when and how this will be evaluated.

Measuring parenting skills

It is important that the family and the professionals involved in an assessment know what indicators will be used to evaluate the family i.e. what is a reasonable level of parenting for the children in this particular family and how this will be measured.

There will not always be a consistent view within the assessment team. Agreement will need to be reached on what is a 'good enough' level of parenting so that the family can understand what is expected of them, what they will have to do to meet those targets, and what are likely to be the thresholds for de-registration or, in some cases, legal action.

In cases where these issues have not been discussed and some level of consensus reached, assessment teams can become split and unable to function, assessments can be flawed and decision making impaired. If dissension remains within the group, supervisory input or an early return to conference will be required. The process of discussing this issue will, in itself be helpful to the group in planning their intervention with the family.

Partnership

Another area where assessment teams require a consistent approach is the level of partnership which can be safely achieved with the family. Research by Thoburn, Lewis and Shemmings, from the University of East Anglia (1995) states that

'whilst failure to work in partnership can sometimes be attributed to aspects of the case itself or characteristics of family members, differences between cases where family members were informed, involved and consulted and those where they were not were almost always attributable to either agency policy and procedures or the social work practice, or both together.'

Thus there is a ladder of partnership (below) and families will be on a different 'step of the ladder', depending on the characteristics of the case and the stage which the case has reached in the child protection process.

- Full partnership - shared working but not necessarily equality
- Participation - influencing what is going on
- Involvement - being present
- Consultation - asked for opinions
- Keeping fully informed - information provided
- No partnership

It is also true to say that different professionals will be working with the family at different levels of partnership. This should be identified and consideration given to the role that these professionals should then play.

At the beginning of an assessment the professionals will need to consider how best to engage the family, and on what stage of the ladder. There will always be cases where the family refuse to engage, and a small number where to attempt to actively involve a family could put a child further at risk.

Assessment team professionals will also need to regularly jointly assess how effectively they are working in partnership, whether they are all working at a similar level, and what is the highest level of partnership they can achieve without jeopardising the welfare of the child.

Equality issues

Of course the impact of equality issues needs to be considered throughout the assessment process. I include this here because if it is not planned into the assessment, there will be no opportunity of introducing it later. When one considers that anti-discriminatory practice is; empathy, allowing children and families to explain their circumstances to you, addressing imbalance of power, considering the role that the identity of the worker plays in the process, considering issues of strength as well as weakness, checking out beliefs and hypotheses, being trustworthy and honest, attempting to improve partnership

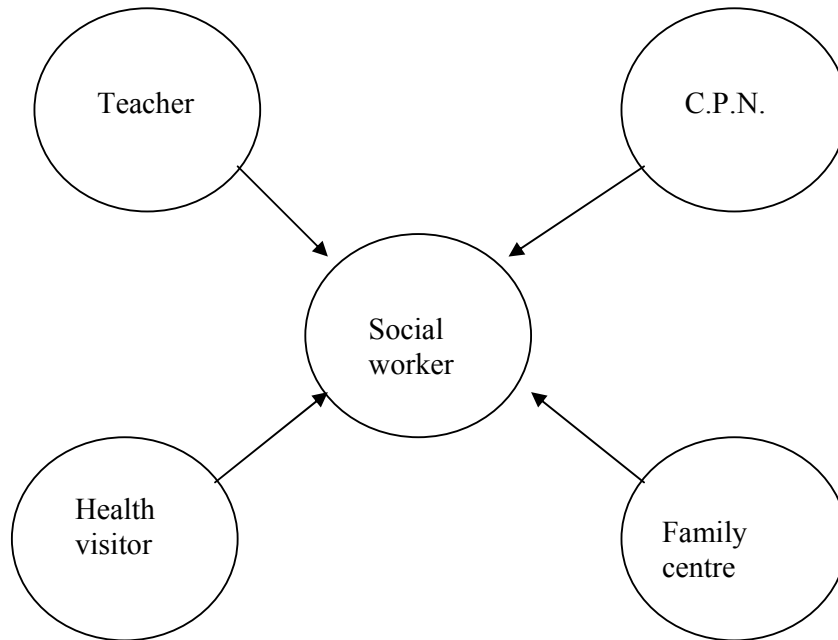
working at all stages of the process, combating power imbalances in the system, ensuring that institutionalised abuse is limited, appropriately using resources and systems to protect and promote children's health and development and understanding the effect of your professional power then it seems that a failure to work in an anti-discriminatory manner is, in itself, a failure of the social work service. How else should one work with children and families?

A good assessment will address the following questions of equality.

- Do family members need particular resources e.g. accessible venues, loop systems, childcare facilities, ethnically sensitive play equipment?
- How will the race and gender of the workers impact on the assessment? Can family members be better engaged by using certain workers? Will consideration be given to race and gender when tasks are allocated to assessment team professionals?
- What child rearing skills are expected of the family - are they based on euro-centric norms?
- Is the assessment focusing on women - can men who are significant to children be engaged? Farmer and Owen (1995) have noted that where children were least well protected professionals were working almost exclusively with the mothers, whilst the dangers were frequently from their male partners. Intervention, thus, had little impact.
- Are there issues which require specialist input to assess certain aspects of the family e.g. parents with mental health problems and learning disability?
- Does any member of the family have a first language which is not English. If so, can the assessment be carried out in that language? If not, it is likely that the assessment will provide an inaccurate picture, thereby putting service users at a disadvantage and children at risk.
- If there are no workers who can undertake the assessment in the appropriate language an interpreter must be used. Check out that the interpreter has the same first language as the family/service user and is acceptable to the family. Ensure the same interpreter can be used throughout the assessment, and involve them in all planning meetings so that they understand the tasks and processes involved.

Communication

Most communication between professionals is channelled through the key worker. Information is passed verbally or in writing to that one social worker. Of course, concerns about further harm must always be relayed direct to the key worker, or, in his/her absence, to a previously agreed person, but if all information is passed through that one person the dynamic outlined below occurs.



The key worker is in control of the information and takes decisions, the other professionals merely provide the information. This dynamic can result in key workers being overloaded while other professionals feel marginalised or have a lesser investment. It can also be a dangerous dynamic, because, as the book "Beyond Blame" (1993) identifies, when the pivotal worker is absent inter-agency communication is more likely to break down.

Assessment teams need to have rules about how they communicate. Could sub-groups take responsibility for completing parts of an assessment, and feed back their overall findings to the key worker? What responsibility does every member of the assessment team have for ensuring that action will be taken to protect a child?

To conclude this section, planning is essential to a good assessment, and should address the process of working together as well as the task of assessing the family.

Setting up checklist

The assessment framework is accompanied by a training pack entitled, "The Child's World" produced by the NSPCC and published by the Department of Health. I would recommend that the book accompanying this pack, entitled "The Child's World - Reader" be made available to practitioners. The pack produces a series of checklists which fits our stepwise model. The first of these entitled "setting up and beginning" is included overleaf.

Setting up and beginning

- What questions require answering through the assessment, what are the issues and what are the likely consequences for the child's health and development of the present situation?
- Is / are the child(ren) safe, now? Has there been or is there risk of significant harm?
- Who is most worried about this child or family - does any one else have concerns; are they the same? Who is requesting this assessment?
- Who is involved - which children, family members, workers, agencies, court?
- Has the family been assessed before and for what purpose(s)?
- Are there any special considerations?
- What is the family's first language, culture, religion or identity?
- Are any family members disabled? What is their main communication method?
- Is there a need for an interpreter?
- Who can help best understand and work with this family?
- Are there any likely or possible barriers to carrying out this assessment?
- Is there agreement with the family and between family members about the need for and purpose of the assessment?
- Is there agreement within the professional group about the need for and purpose of an assessment?
- Is there agreement about respective professional roles and responsibilities, what information will be shared and who has lead responsibility?
- Are other types of assessment concurrent?
- Are there adequate resources to carry out the assessment?

Is the worker competent and does he / she possess the necessary knowledge and experience to carry out the assessment working to the Framework?

THE Hypothesising STEP

Workers often remain narrowly focused on proving or disproving whether the immediate risk still exists and fail to consider the broader picture. The assessment team should consider all the possibilities regarding the harm that the child could be suffering, both within their family and the wider community. Each hypothesis should be addressed and only discounted when there is clear evidence to do so. Explicitly hypothesising about all possibilities ensures that every possibility is considered, assessment team members' attitudes and biases are addressed and the family can clearly understand what concerns the workers may have.

While this stage has been placed at the beginning of the assessment process in stepwise, it is important to recognise that this process should be repeated when any new evidence comes to light which may challenge previously held views.

The following case scenario illustrates the importance of hypothesising.

"Sylvia is a young woman with four children under the age of six, their ages are 1, 3, 4 and 6. The six year old, Amanda, has a learning disability and receives respite care.

Yesterday, 7 p.m. at bath time, a member of staff at the respite care unit noticed a red mark which looked like a hand imprint at the top of Amanda's leg. When asked about it she said that "mummy smacked her". Sylvia had previously phoned the unit to say that Amanda had a nappy rash which had left a mark at the top of her legs."

Various hypotheses which could be made about this case are that

- Sylvia has smacked and injured Amanda and regularly does so because she dislikes and does not want to care for this child
- Sylvia has smacked and injured Amanda and is likely to do this again because she is under considerable stress
- Sylvia has smacked and injured Amanda because she is under stress but is unlikely to do this again if she receives support
- Sylvia has smacked and injured Amanda, but has never done so before and is unlikely to do so again
- Another adult within the family has smacked and injured Amanda
- Another adult within the community e.g. school, respite care unit has smacked and injured Amanda
- Another child has injured Amanda
- Amanda is being sexually abused and the mark has resulted from her being forcibly held down
- The red mark has been caused by an accidental injury or rough handling
- The red mark is the result of a self-injury
- The red mark is a nappy rash

All of these, or a combination of some of them are possible. The reason why Amanda stated her mother had smacked her if this was not the case, would need further assessment. But whatever has happened, this family is likely to be under considerable stress, and deserve a service which considers all possibilities and provides an appropriate and holistic response to their needs.

THE Information gathering STEP

Information for the assessment should be gathered from all adults who are significant to the child, plus, of course, from the child. The assessment team will need to be clear about their reasons for approaching people. Members of the extended family, people who are not relatives but act as carers e.g. childminders or friends, workers in voluntary community organisations and other professionals can all provide valuable information, but parents need to be aware that they are being asked to contribute and issues of confidentiality will need to be addressed.

There are a range of tools available to assist workers in gathering information, and some are outlined in this section. Many of the tools can be used equally well with adults and children, but will need to be adapted to meet particular needs e.g. the age and understanding of the child, the abilities of parents with learning disabilities. For babies and young children or children with severe learning disabilities who have limited or no language skills detailed observation using specialist workers e.g. nursery nurses can provide invaluable information.

Genograms

The use of genograms (or family trees) is becoming more common in many agencies but their use is sadly still not universal. Some suggested symbols and structure are given overleaf.

Genograms are particularly good for working with families to clarify complex relationships, to indicate gaps in knowledge and to make visible intergenerational and life cycle issues. They can be used to gather information and to work therapeutically.

As they can be powerful in raising painful and suppressed memories, it is important to explain what a genogram is and what it is likely to raise before undertaking this task. Some of the symbols used can have a considerable but unintentional impact. For example the use of X to symbolise the death of a family member may be very hurtful. Family members should be asked what symbols they would wish to use.

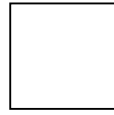
Workers sometimes avoid genograms because they feel the result often looks a mess, or the family structure is so large that they have difficulty drawing it on one sheet of paper. But this misses the main point of the exercise which is to help the family provide information which they think is important and assist them to see patterns and gain insights. Once the process is completed a neat version can be produced.

It is recommended that before using genograms workers should draw and discuss their own genogram not only to learn how to structure them but to experience the feelings which they can raise.

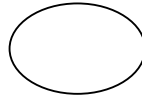
Genogram or Family Tree

Taken from *A Guide to Comprehensive Assessments - HMSO*

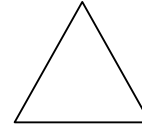
Genogram symbols



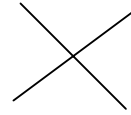
MALE



FEMALE



GENDER UNKNOWN
(E.G. PREGNANCY)



DEATH

UNIONS:

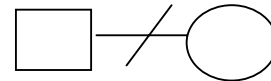
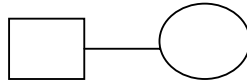
MALE

FEMALE

DEATH

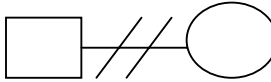
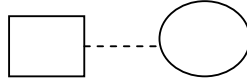
UNIONS:

ENDURING
RELATIONSHIP
(MARRIAGE OR
CO-HABITATION)

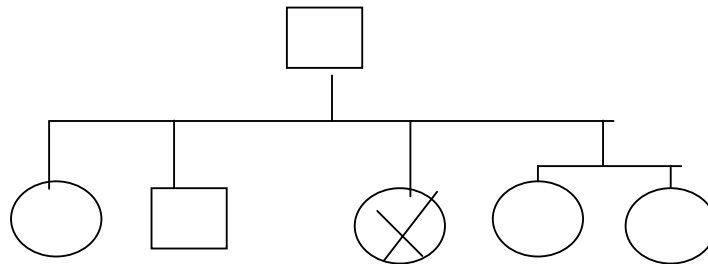


SEPARATION

TRANSITORY
RELATIONSHIP



DIVORCE



FIRST CHILD SECOND CHILD MISCARRIAGE OR ABORTION TWINS

A dotted line should be drawn around the people who currently live in the same house.

Compiling a genogram or family tree.

A genogram or family tree covering three or more generations may be compiled using these symbols. Social workers who have not drawn a genogram before should practice it with colleagues beforehand. In order to compile a genogram, the worker needs a large sheet of paper, pen or pencils (various colours if possible) and a table at which to work.

Other relatives in addition to parents and children can be involved in compiling the genogram. More than one session may be needed if the exercise is used to discuss the family's history in detail and to enter significant dates and other information. Working on a genogram also provides the social worker with an opportunity to observe family relationships, for example: how open family members are with each other, how ill they respond to each other's needs,

Ecomaps

Additional information can be gained from ecomaps, an example is included overleaf. At the moment this tool is used even less often than are genograms. These focus on the relationships children and family members have not only with their relatives but with significant others like friends and pets, with organisations such as schools and family centres and with pastimes and activities. Information can be gained on who and what are important to each family member, whether relationships are supportive or stressful and the extent of their support systems.

Ecomaps should not be seen as a static record of the child or families ecosystem. Family relationships change - children may feel hostile towards a parent one week and have resolved the conflict the following week. Therefore ecomaps should be undertaken on a number of occasions to map the changes.

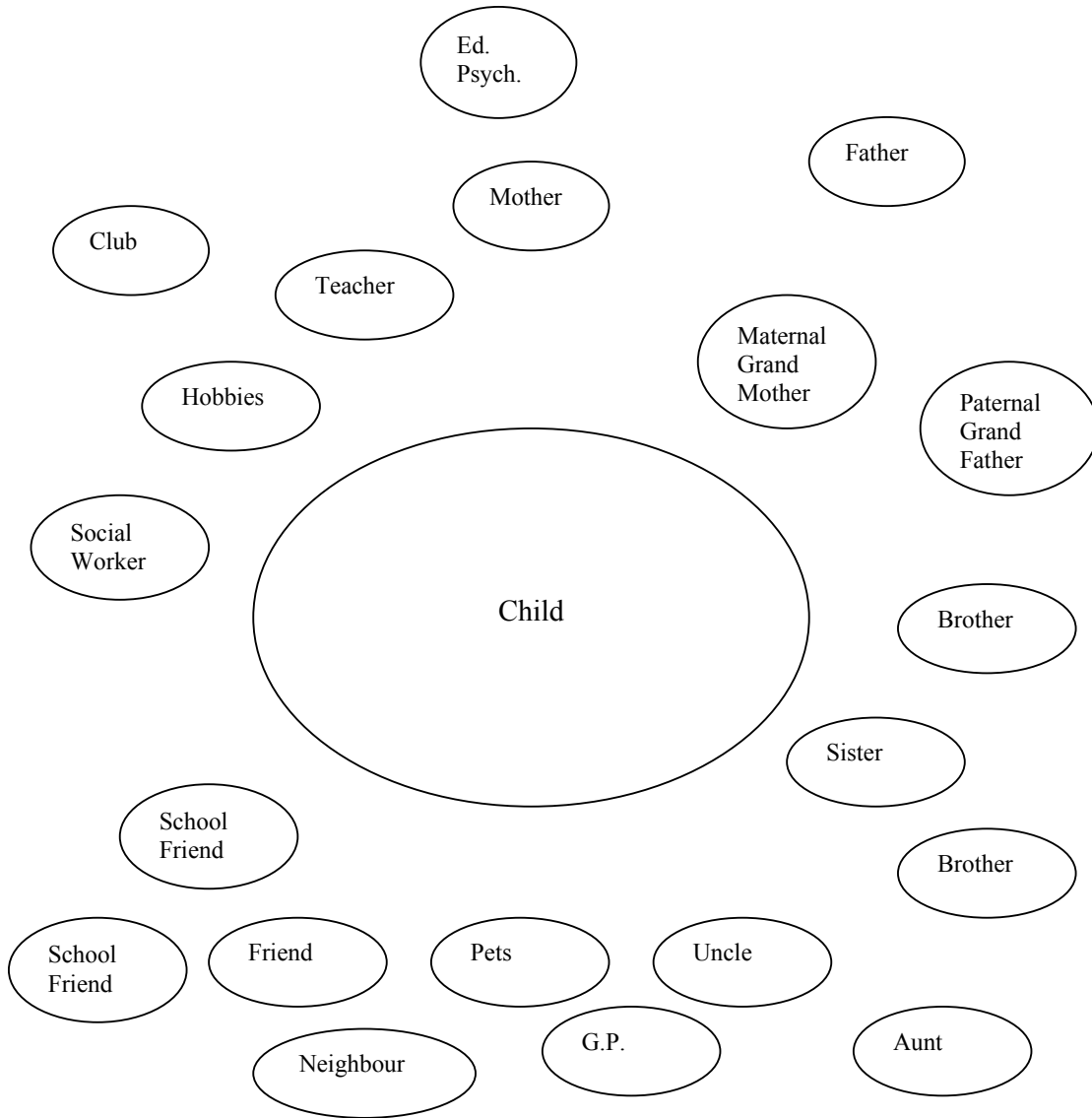
It is preferable, particularly when working with children not to draw ecomaps on paper but to use moveable objects to represent their ecosystem. Play people can be used or cardboard circles on to which can be drawn happy, sad and angry faces. The child can then choose the appropriate play person or face to represent themselves and the people or things they are identifying as significant and be able to move them around to indicate what their feelings are and how they can change.

This type of approach is empowering as it gives children and families greater control over the information-giving process, it can provide information that a structured question and answer session would not illicit, and may help families to gain insights and to self assess their own situations.

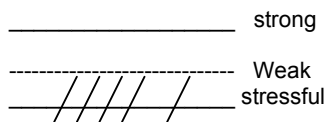
The stepwise model places analysis towards the end of the process. Later in this chapter I will be outlining an analytical model designed by Margaret Boushel, which details the child's protective environment, page 30. It is worth noting at this stage that an ecomap contributes to the completion of Margaret's model.

Ecomap

Taken from a Guide to Comprehensive Assessment – HMSO



Place child or couple or family in centre circle.
 Identify important people, organisations or past-times and draw circles as needed.
 Draw lines between circles where connections exist.
 Use different types of lines to indicate the nature of the link or the relationship.



Inter-agency incident chart

The incident chart overleaf is an essential tool for recording information gathered about the possible harm to a child.

The book "Beyond Blame" (1993) notes that workers involved in assessing families "often did not have available to them a framework within which to organise information and observations about the family or consider their implications". The authors were struck that in a large number of the child death cases they reviewed events were considered in isolation from each other and so the accumulating evidence of the risk was not observed and no coherent overview or strategy emerged.

Inter-agency incident charts provide a brief, chronological record of each incident during a child's life which has led a professional to believe that the child may be suffering harm, the date when it occurred, who noted the incident, brief explanations by both the child and the carer, and what action was taken.

They should be kept at the front of files of all workers involved in an assessment and

- provide an easily accessible record of all significant incidents,
- make visible patterns of harm e.g. the duration and severity of the harm, whether incidents are increasing or decreasing in frequency, specific periods of high risk,
- enable assessment team members to compare the information they have about incidents and explanations given and note whether there are inconsistencies,
- help workers not to become single incident focused,
- ensure that multiples of similar single incidents that happen over a short period of time and are observed by different professionals are all recorded and not erroneously seen as a single incident,
- provide an index based on dates to help workers locate the fuller records,
- can be attached to the final assessment report, thus providing the conference or court with information that is clearly formatted.

Many social services departments use incident charts (usually called critical incidents) but fail to realise that their greatest value is as an inter-agency information tool. A good process will allow room for contributions from all agencies. These charts can be completed at assessment team meetings, conferences, planning meetings and reviews.

THE TESTING AND EVALUATING STEP

The testing and evaluating stage of an assessment is particularly important, but often given limited attention. Workers frequently use most of the time allotted to the assessment to gather information and produce a report that details this but fails to evaluate the information or draw conclusions.

Although post-registration assessment work is an inter-agency task it is usually the social worker who evaluates the information, and consequently members of the assessment team from non social work agencies are not involved in this process. This is not good practice as inconsistencies, different interpretations of evidence gathered and differences of opinion may only come to light as the report is being presented to conference or court.

Parents also need to be involved in this process, and arranging assessment team sessions to jointly test and evaluate the findings will ensure that parents are given a forum in which to understand, discuss and contribute to the conclusions that are being reached before the report is produced.

The risk assessment checklist

Those involved in evaluating information will need tools to assist them. The risk assessment checklist (see overleaf) can be used by individuals in their assessment work and as a basis for joint discussion within the assessment team. The checklist asks a series of questions which will assist workers to consider the type and level of harm a child may be suffering, the possible effects of that harm, the likely outcomes of intervention, the safety factors in the child's environment and the potential for change within the family.

Associated with the checklist are a range of tools, some of which have already been covered at the information gathering stage. Tools like the incident chart will help to answer very clearly questions such as 'Are the injuries/incidents acute/cumulative/episodic' and 'What is the severity and duration of the harm?'. Genograms and ecomaps can assist discussions on 'What does the child mean to the family?' and 'What are the strengths and weaknesses of the family?'. Further tools associated with the checklist are outlined in the following section.

Risk Assessment Checklist

- Does / could the suspected harm meet the definitions of abuse in the child protection procedures?
- Are there cultural, linguistic or disability issues which could impact on the level of risk to the child?
- Are the injuries / incidents acute / cumulative / episodic?
- What is the severity and duration of the harm?
- When and how is the child at risk?
- Did the injuries / incidents result from spontaneous actions, neglect or intent?
- What are the parents / carers attitudes and response to your concerns?
- How willing are they to co-operate?
- Is their explanation consistent with the injuries / incidents (Is there need for a medical)?
- What does the child mean to the family? What role does the child play?
- What are the effects on the child's development? What may be the long-term effects?
- What is the child's reaction to and perception of the harm?
- What are the child's needs, wishes and feelings regarding intervention and likely outcomes?
- What may be the effects of intervention?
- Are the injuries / incidents likely to re-occur?
- What are the protective factors?
- What are the strengths and Weaknesses of the family?
- What is the potential for change within the family?
- How safe is the child?

What are the possibilities?
What are the probabilities?
How imminent is the likely risk?
How grave are the likely consequences?

Can the level of risk that has been identified be safely and satisfactorily reduced by the voluntary provision of services? If so intervention and services outside of the formal child protection process should be the preferred option.

The questions in this checklist have been drawn largely from *Messages from Research H.M.S.O. 1995* and from *Beyond Blame; child abuse tragedies revisited. Reder, Duncan and Gray. Routledge 1993*

Continuums

Some questions in the checklist can be difficult to answer e.g. 'Did the injuries/incidents result from spontaneous actions, neglect or intent?' Workers may feel they have insufficient evidence or there are differences of opinion. Families may have made a statement which workers are not sure whether to believe or not.

The continuum is a tool to assist discussions about such issues. Simply draw a horizontal line to represent the continuum; as an example, anxiety about whether an injury could have resulted from poor supervision or from intent.

Poor supervision _____ Intent

Each professional places a cross on the line to indicate where their 'gut feelings' tell them they are between the two possibilities. This will clarify whether all the professionals hold a similar opinion, one worker is seeing the case differently or the group is completely split. The reasons why professionals may disbelieve the family, hold different views or feel anxious when there appears to be little evidence of risk requires open discussion and probably further work to obtain more information about the areas where there is high anxiety or dissension.

Professionals may wish to use this tool with or without parents present, but should always share their final conclusion with the family.

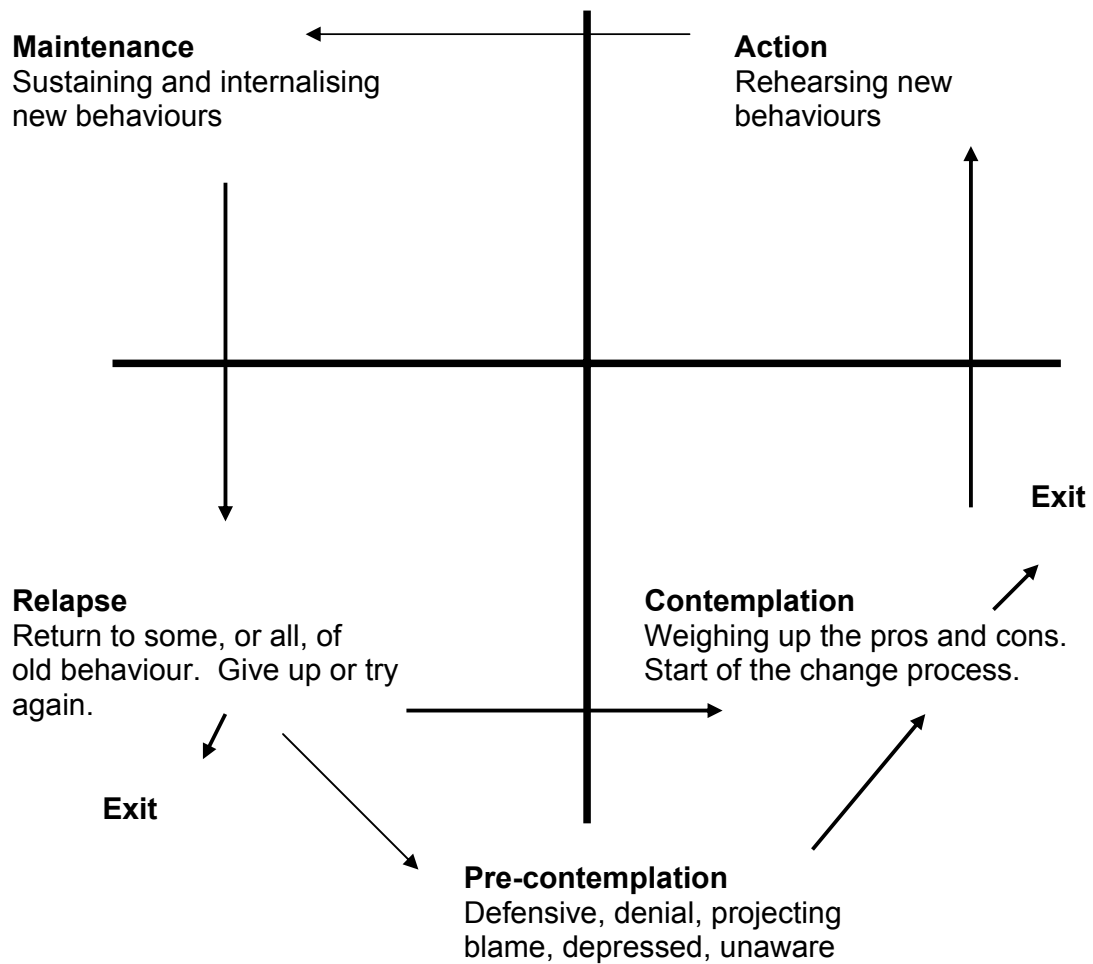
Model of change

The final tool in this section (see overleaf) looks at the potential for change within the family, and is based on a model originated by Prochaska and DiClemente and adapted by Tony Morrison.

The model can be used to evaluate the potential for change. Morrison points out that change takes time and families need the opportunity to weigh up the pros and cons of changing their child care practices. Most families enter the child protection process at the pre-contemplation stage when they may be in denial or unaware of the nature or the effects of the abuse. Anxiety, procedures and the perceived need to get on with the assessment may make professionals rush families through both the pre-contemplation and the contemplation stage and into the action phase. Yet the contemplation stage of the change cycle is essential to help families understand the consequences of their actions, what their options are and that change is possible, and assessors should allow families a reasonable time to progress through this stage. Only when a family is ready to move on can they productively begin using resources to rehearse new parenting styles.

Assessments tend to focus on the action stage when families are receiving a high level of support which enables them to function more effectively. But the assessment must also consider the maintenance and relapse stages. Families need to have strategies for maintaining new behaviour when they have less support and may meet resistance from friends and other family members who may not want them to change.

Comprehensive Model of Change



Source: T. Morrison in Adcock M. and White R. "Significant Harm" 2nd edition. Croydon, Significant Publications

The model also accepts that relapse is a normal and incremental part of the change process, and that any assessment needs to identify what strategies the family and their informal support networks may have to deal with future lapses. Where families have shown that they have developed and successfully used relapse prevention plans it is likely that the outcome for the child will be more positive.

THE ANALYTICAL STEP

Analysis and decision making checklist.

The Child's World has a further checklist for this step. It is worthwhile checking this out at the beginning of the analytical step as it informs the work that needs doing.

- Is the assessment providing adequate evidence to analyse before making judgements leading to decisions about future actions?
- Is the worker distinguishing between fact and opinion?
- Is there reasonable cause to suspect that a child is suffering, or is likely to suffer, from significant harm?
- Has the assessment revealed significant unmet needs for support and services?
- If the decision is not to provide services, this is itself a decision. What is the next step?
- Is the worker able to evaluate evidence drawing on his / her understanding of theory; for example, child development?
- Is the worker drawing on knowledge of research?
- Is the worker informing the family (including the children) of the outcome and recommendations arising from the assessment?
- Is the supervisor ensuring that rigour and challenge form part of their supervision?
- Is the supervisor able to ask questions, to challenge and probe where necessary? This may mean asking obvious or unpopular questions.
- Is the supervisor encouraging both factual analysis and reflective practice?
- Is the supervisor able to address the areas of potential impact on the worker?
- Is there a supervisory agreement in place that allows for constructive challenge and feedback?
- Is the supervisor evaluating how the worker is currently making judgements?
- What is given priority and why?
- Which factors are marginalised and why?
- Which factors are causing most discussion and debate in terms of determining priority and why?
- What is this saying about their current practice?

THE CHILD'S PROTECTIVE ENVIRONMENT

One of the most critical issues to assess is the safety of a child and a framework developed by Margaret Boushel (See Diagram overleaf) provides an excellent assessment tool.

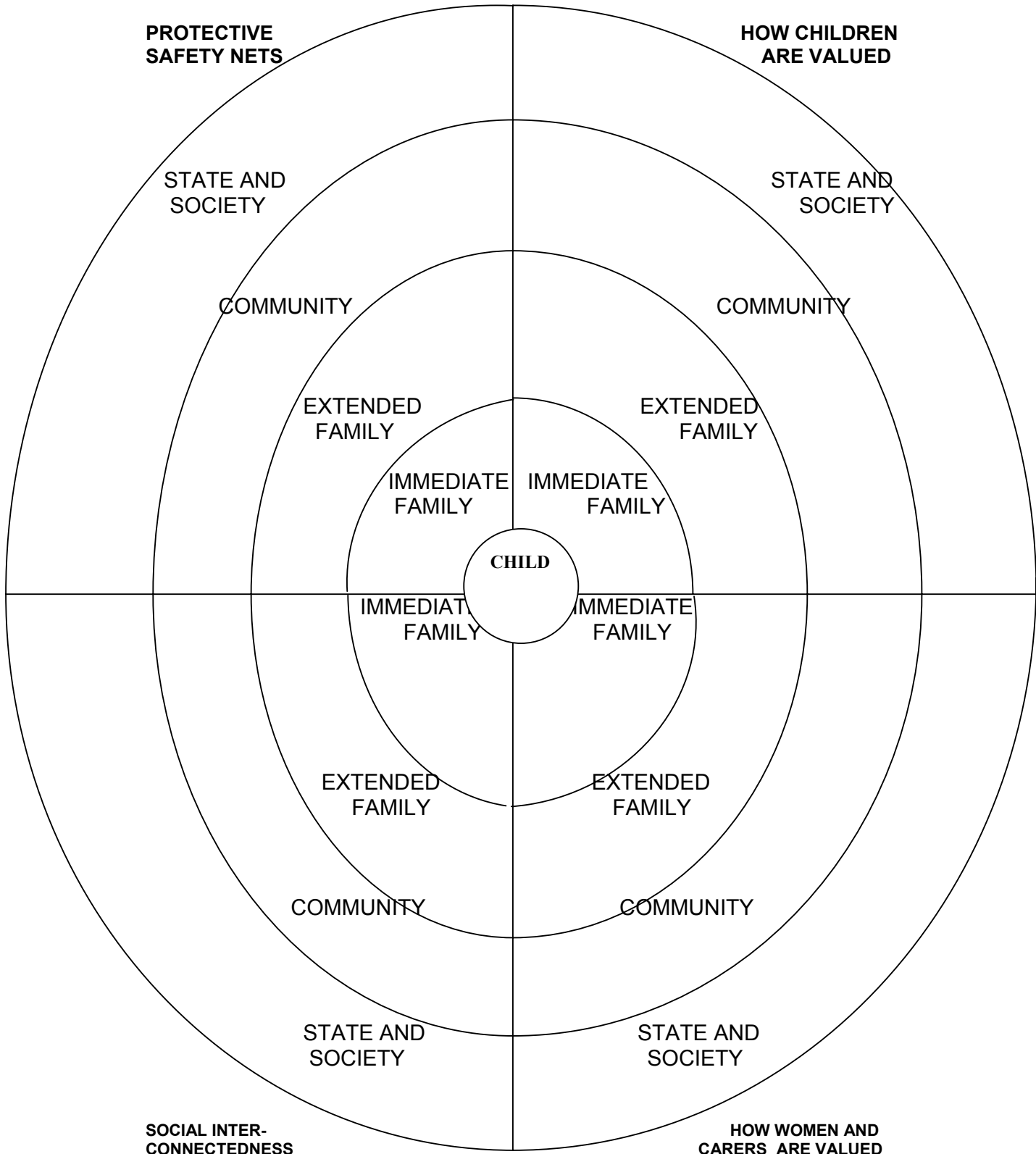
This framework has the child at the centre of an ecosystem, surrounded by their immediate family, then the extended family, the local community and, finally agencies from state and society. Four key factors are identified for assessment.

- The value accorded to the child,
- The value and status accorded to the child's mother and other key carers,
- Social interconnectedness - whether or not the child and family can make use of the protective safety nets and how included they are with society,
- The protective safety nets - the formal and informal sources of protection.

Professionals need to consider each of these in relation to the different sections of the ecosystem. In the quadrant which examines the value accorded to the child consideration should be given to the extent to which a child both is valued and feels valued within their immediate family, the extended family, the local community, school etc. plus how the state values the child in terms of making resources available for their welfare.

The quadrant which focuses on how women and other carers are valued raises issues identified in research by Farmer and Owen (1995) i.e. that if carers' welfare needs are not adequately addressed by family, community and state that this will have implications for the health, development and protection of their children.

THE CHILD'S PROTECTIVE ENVIRONMENT



Social interconnectedness refers to how the networks operate that link the child with the different parts of their ecosystem. A child may be poorly parented at home, but if they are able to easily access good support from relatives, peers, youth leaders, school etc., they will fare better than a child who is similarly poorly parented but has little or no access to support networks.

The protective safety net relates to how individuals in the child's ecosystem would use the networks operating between them to take action and alert the appropriate agencies to protect the child from harm.

By shading in each of the sixteen sections, dark shading for strong, no shading for non-existent, a pattern emerges. This can show the level of support which exists within the child's protective environment, where the strengths and weaknesses are, whether there are gaps in the worker's knowledge, and the areas where further work should be undertaken.

Once the assessment team have evaluated the information they should be able to order their evidence and reach conclusions about the risks and what solutions there may be for meeting needs. This discussion should take place before the report is produced. The following tools assist this part of the process.

Resilience

Research is continuing into what make some people able to weather adversity and misfortune while others become hurt and damaged by the same experiences. The “International Resilience Project” used the following definition. “Resilience is a universal capacity which allows a person, group or community to prevent, minimise or overcome the damaging effects of adversity”. The following act as useful indicators of vulnerability and resilience in terms of the domains of the framework.

CHILD

| Sources of vulnerability | Sources of resilience |
|--------------------------|-----------------------|
| Young age | Higher IQ |
| Disability | Good attachment |
| Earlier history of abuse | Good self-esteem |

PARENT/CARER

| Sources of vulnerability | Sources of resilience |
|-------------------------------------|--------------------------------|
| Domestic violence | Social support |
| Serious substance misuse | Positive parental childhood |
| Chronic serious psychiatric illness | Good parental health |
| | Good relationship with sibling |
| | Education |
| | Work role |

FAMILY AND ENVIRONMENT

| Sources of vulnerability | Sources of resilience |
|---------------------------------|------------------------------|
| Run down neighbourhood | Committed adult |
| Poor relationship with school | Good school experience |
| Weak fabric of social support | Strong community |
| Poverty | Good services/supports |
| Social isolation | |

The project has also provided further thoughts which may enable a worker to consider the resilience present in children.

I HAVE

- People around me I can trust, and who love me no matter what.
- People who set limits for me so I know when to stop before there is danger or trouble.
- People who show me how to do things right by the way they do things.
- People who want me to learn to do things on my own.
- People who help me when I am sick, in danger or need to learn.

I AM

- A person people can like and love.
- Pleased to do things for others and show my concern.
- Respectful of others and myself.
- Willing to be responsible for what I do.
- Sure things will be all right.

I CAN

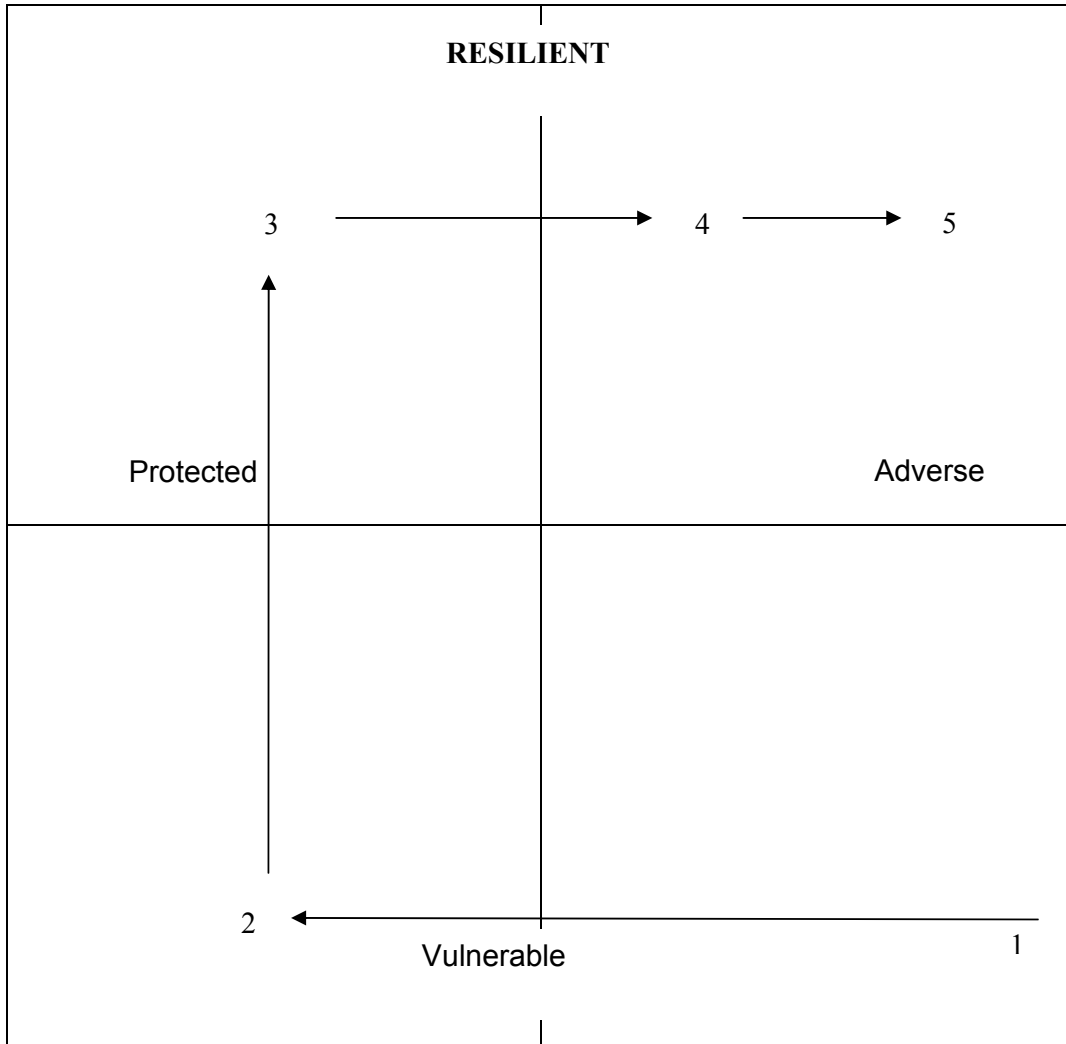
- Talk to others about things that frighten me or bother me.
- Find ways to solve problems I face.
- Control myself when I feel like doing something not right or dangerous.
- Figure out when it's a good time to talk to someone or take action.
- Find someone to help me when I need it.

Further issues

- The child has someone who loves them unconditionally.
- The child has an older person outside their home they can talk to about problems and feelings.
- The child is praised for doing things on its own.
- The child can count on their family being there when needed.
- The child knows someone they want to be like.
- The child believes things will turn out all right.
- The child does endearing things that make them liked.
- The child believes in power greater than seen.
- The child is willing to try new things.
- The child likes to achieve.
- The child feels that what they do makes a difference to what happens.
- The child likes itself.
- The child can focus on a task, and stay with it.
- The child has a sense of humour.
- The child makes plans to do things.

Resilience and protection

Completion of Margaret Boushel's "Protective Environment" and consideration of the child's resilience can be plotted on the following 2x2 matrix produced originally in the Child's World.



In this model the child is plotted depending upon their resilience and protective environment. Position (1) represents a vulnerable child living in very adverse circumstances. The ideal quadrant is top left but it is not possible to make that move in one step. Typically the child may be removed to a foster home or another member of the family, which is represented by the move to (2). However the child's own resilience will only improve if his/her carers and the professionals around them are able to work with the child directly on issues of self-confidence, reliance and identity. If successful the child then moves quadrant to (3). If the child returns home either in a planned or unplanned way they will now be at (4) or (5) depending upon how much the family have been able to improve their own situation.

A model for risk assessment

This tool is a set of questions produced by Paul Brearley, see diagram 13, for analysing the evidence regarding risk to a child. By considering the possible dangers and then dividing the hazards i.e. the things that might cause the danger to occur, into two types - predisposing and situational - workers and the family are helped to examine the processes which may lead to a child being harmed and actions which could cause or prevent situations from becoming dangerous. This model also focuses on strengths in family and community networks which can be used to reduce risk and also gaps in information i.e. what the professionals have not been able to find out during the assessment.

A model for risk assessment (Paul Brearley)

1. List the dangers in this case
 - *A danger is something you want to avoid, so what possible events would you fear in these circumstances? Rank these dangers in order of their significance.*
2. List the hazards in the case
 - *A hazard in this context is something which might result in a danger being realised. Something that helps to bring about the circumstances you want to avoid.*
3. Divide the hazards into two:
 - a) Predisposing hazards
 - b) Situational hazards
 - *A predisposing hazard makes the danger more likely. It is something that creates vulnerability, though it may need to be activated by something else, perhaps a situational hazard.*
 - *A situational hazard is something that happens, and which has an immediate effect directly related to the danger*
4. List what you consider to be strengths in this case
 - *Strengths are those factors whose effects counteract the danger, and make it less likely to become a reality.*
5. Identify the additional information which you believe to be necessary.
 - *Evaluating the information you already have may indicate that there are some important gaps in your knowledge, gaps which should be filled (if possible) before a final assessment is arrived at.*
6. Indicate the decisions you feel should be taken.

For each stage of the analysis, try to answer the question WHY?

THE CARE PLANNING STEP

The forms leave little space for detailed report writing. I worked with a group of social workers in Birmingham. We examined reports in the light of some of the principles inherent in the framework; child centred, involves the family, builds on strengths and protective factors, is rooted in child development, ensures equality, covers inter-agency issues and is evidence based. The following guide, designed by Mary-Anne Proctor of Reconstruct draws upon their material.

A GUIDE TO WRITING REPORTS FOR CORE ASSESSMENTS

Introduction and background

You need to introduce the report by outlining the reasons for it and the legal framework. If for Court you should add your qualifications and dates obtained and make further reference to "Reporting to Court under the Children Act" published by HMSO.

The introduction should contain a list of concerns (if relevant) and some consideration of the need for change allowing the reader to consider these issues throughout.

The introduction should include a short, relevant history of the family and should finish with a chronology of significant events. All comments here about relevant history should be elaborated upon later in the report.

It is appropriate to include a genogram of the family.

Details of the plan that has been followed need to be given. This will include details about the process including number of visits, who was invited to be present, who was present, observations of interaction, behaviour etc.

Be careful to distinguish between fact and opinion. You could describe here tools used and the research that informed the work

You need to outline contact with other professionals and consideration of the impact that you and other worker's identities may have on the assessment

You should clearly set out how this report fits with other reports (which, if relevant, should be contained as appendices).

Inter-agency issues

You must ensure that you liaise with other professionals involved with the child and the family. To work effectively you must have a good knowledge of other agencies their role and responsibilities.

You need to gain information about the relevant professional's input and their assessments. You should be clear about any specific areas you want them to address. Ensure all areas in respect of multi-agency links are highlighted

You should share information with other professionals about the SSD assessment and ensure joint working. Together you can identify if there are any gaps in knowledge.

If there is disagreement between professionals you should describe this in the assessment and consider its effect on it.

Within the report cite other relevant agencies. If there are a number of professionals involved it may help to draw a diagram

A good report will show time/dates when liaison takes place with other agencies.

Make sure you list previous assessments from SSD and other agencies.

Always be clear about who was doing what, why and how.

Evidence Based

When carrying out the assessment always make sure that you check out information to ensure that facts are correct.

This should include information that supports your hypotheses as well as information that argue against them. It should also include information from other professionals.

If possible

- get corroboration for self reports, talk to other people, carry out observations of relationships, child management, boundaries etc.

e.g. check school attendance, clinic attendance

Test out hypotheses

Make sure you are objective

Ensure that you make a clear distinction between first hand information and hearsay evidence.

Ensure that you can identify actual events to support any view that you take.

Be prepared to accept that there could be contrary conclusions.

Do not make assumptions. Any statements you make must be supported by dated examples

You should use research to support findings and underpin your recommendations. Ensure that research is clearly and consistently referenced throughout the report

Any statements you use from the child, family or others need to be clearly sourced, and use quotation marks and ascribe the statement to the person who said it.

Concentrate less on historic events and more on current events.

Ending/conclusion

Your Analysis must make sense

There should be a summary of the factual information and the thought process involved in reaching your recommendations.

Again references should be made to Department of Health research as a minimum and, if you choose, further research that supports your analysis.

Make sure you use information from the assessment to form conclusions.

There should be a logical flow and the analysis should point to conclusions and recommendations. Refer back to evidence when drawing conclusions.

There should be no contradictions. Ensure that the assessment is consistent
To help clarify your reasoning you can summarise information at the end of each section if it is a long report.

In your recommendations ensure that you reflect on the assessment, looking at positives, negatives, weaknesses, strengths & changes in a balanced way
Any recommendations you make must be clear, provide a list of them.

Measure what the situation is against what the situation should be.

Consider a prognosis of change (i.e. how likely is change?). Importantly consider how long can the child/ren wait for change – if they can wait at all?
If you are considering care proceedings always provide evidence that the threshold criteria having been met.

THE CARE PLANNING STEP

Care planning process

This diagram (with a completed example) enables the development of thinking from assessment of need to care plan. Needs are identified and written as objectives in the first box. (Be careful to set these objectives at a suitable level, not too high “improve quality of life” not too low “institute a toileting regime” but somewhere in the middle “to remain at home safely”). Workers then consider possible solutions which should include family strengths and universal children’s services (toy library) as well as statutory services. It is important to be creative. For example a service-led response to a child with speech delay is likely to be a referral to speech therapy whereas, as the diagram example shows, there are a range of solutions which could draw upon both formal and informal resources, be cost-effective and are often more empowering. Once the resources have been identified thought needs to be given to the targets and monitoring arrangements. How will you know when you are being successful and how will you find out? These should reflect the objectives, e.g. the child’s speech improving not the process, e.g. did the child go to speech therapy?

OBJECTIVES

To reduce child's language delay

POSSIBLE SOLUTIONS

- To improve child's language through language development programmes.
- To assist mother to stimulate and talk to her child by addressing her depression and providing her with parenting knowledge and skills.
- To provide play opportunities,
- with other children and with other adults.
- To encourage adults in the child's informal support network to spend more time with the child.
- Medical checks regarding possible physical problems.

POSSIBLE RESOURCES

- Speech therapy
- Family centre, direct work with child/parents
- Mental health services
- Parenting classes
- Parent's support group
- Playgroup
- Parent & toddler group
- Play workers to visit the child at home
- s.17 money to enable contact with extended family

MEASUREMENTS

- To reduce delay from 12 months to 6 months in 1 year.
- Bedtimes to be good times with stories read by parents

MONITORING ARRANGEMENTS

- Reports on outcome of language development programme
- Discussion with and observation of parents
- Liaison with medical health services
- Observation visits of child in play provision and at home
- Discussion with extended family
- Feedback on medical examinations and treatment

Care plan system

The final pages of the assessment framework core assessment forms contain tables which relate to care planning. The problem with this part of the framework's process is that, having sub-divided the situation into twenty dimensions these pages fail to bring everything back together again. Not very ecological!

The linear nature of the design implies that there is one outcome per objective whereas this is not the case, one objective can have a number of desired outcomes and one outcome can measure a number of objectives. Also objectives cannot be limited to one domain. Take, for example "to improve the relationship between parents and child", this must be a fairly common objective. Which dimensions should it be in? Basic care?, ensuring safety?, emotional warmth?, stimulation?, guidance and boundaries?, stability?, family's social integration?, wider family?, family history and functioning?, emotional and behavioural development?, identity?, family and social relationships?, social presentation? It would be easier to list which dimensions it wouldn't be covered in. I therefore recommend the following format designed by Reconstruct which does not mention domains and dimensions as these have no part to play when considering the ecological nature of the child's world.

A good care plan will differentiate between high and low level objectives, will set measurements against these objective, will list tasks and who will carry them out and identify systems for monitoring success. Our care plan format allows the assessment team to pool the information gleaned from the assessment, consider the situation as a whole and identify, via the care planning process described above, objectives, tasks, targets and monitoring arrangements.

A guide to good care planning.

1. If written correctly needs and objectives are the same thing.
2. Objectives must be needs led and must not mention services.
3. Objectives should not be set too "high" (vague and long term) nor too "low" (precise and short term).
4. Separate tasks from objectives.
5. Use family and universal services as well as more focused services.
6. Write what will be done.
7. Each objective should have at least one measurement.
8. One measurement can measure more than one objective.
9. Measurements should combine both "hard" (measurable) and "soft" (less tangible) elements.
10. There should be specific arrangements for monitoring progress.

Overall description of the issues to be addressed and the broad objectives to be achieved.

Objectives

Measurements

Monitoring arrangements (how, by whom)

| Task | Person/Agency | Frequency | Timescale |
|-------------|----------------------|------------------|------------------|
| | | | |

CONCLUSION

In this chapter I have described a process, rather than a framework, of assessments based around a “stepwise” model. This process has been demonstrated to a large number of social services departments and is successfully used by Reconstruct’s own social workers. I have commented upon the assessment framework, highlighting its strengths and weaknesses.

I believe that the framework is a vast improvement on the “orange book” and support the notion of an inter-agency assessment framework. I do not believe that this assessment framework will stand the test of time without adaptation. I am particularly disappointed in the lack of analytical and planning tools in the core assessment records and their unsuitability for use with disabled children. I hope that the publication of this book along with other work will encourage the development of improved resources to help professionals in the difficult task of identifying need and risk and appropriately improving the situation of children and families.

References and Bibliography

- Ahmed, B. (*Black Perspectives in Social Work*) Venture Press 1990
- Boushell, M. () *Child Protection Assessments*. School for Policy Studies University of Bristol
- Brearley, P. (*Risk and social work*) Routledge, London and New York
- Calder M. and Howarth J, (*Working for children on the child protection register*”, Ashgate 1999.
- Coleman, R. and Cassell, D., (1995) 'Parents who misuse drugs and alcohol' in Reder, P. and Lucey, C., (eds) Assessment of parenting: Psychiatric and psychological contributions London and New York, Routledge.
- DoH, (1995), Child Protection, Messages from Research, London, HMSO
- DoH, (1995), Looking After Children Forms, London, HMSO
- DoH, *A Child's World*
- Falkov, A, (1996), Fatal Child Abuse and Parental Psychiatric Disorder: an analysis of 100 ACPC Case Reviews, London, HMSO
- Farmer, E. and Owen, M., (1995), Child Protection Practice: Private Risks and Public Remedies, London, HMSO
- Harper, N. (1996), Children still in Need: Refocusing child protection in the context of children in need, London, NCH Action for Children
- Katz, I., (1997), Current issues in Comprehensive Assessment, London, NSPCC
- McBeath, G and Ibb, S (1990) 'Child Protection language as professional ideology in social work' in Social work and Social Sciences Review, 2.2, 122 - 145
- McGaw, S. and Sturmey, (1994) 'Assessing parents with learning disabilities' in Child Abuse Review, Vol 3, 36 - 51
- Phillips, M and Dutt, R, (1990) Towards a Black Perspective in Child Protection, London, Race Equality Unit, NISW
- Reder, P., Duncan, S. and Gray, M., (1993) Beyond blame: Child abuse tragedies revisited, London and New York, Routledge
- SSI, (1993), Inspecting for Quality: Evaluating Performance in Child Protection, London, HMSO
- Thoburn, J., Lewis, A. and Shemmings, D., (1995) Paternalism or Partnership? Family Involvement in the Child Protection Process, London, HMSO