Assessment in Child Care

Using and Developing Frameworks for Practice

Second Edition

Edited by

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and
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Russell House Publishing

First published in 2003 by Russell House Publishing Ltd.

This Second Edition published in 2013
Russell House Publishing Ltd.
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Lyme Regis
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www.russellhouse.co.uk

British Library Cataloguing-in-publication Data:
A catalogue record for this book is available from the British Library.

ISBN: 978-1-905541-85-0

Typeset by TW Typesetting, Plymouth, Devon

Printed by IQ Laserpress, Aldershot, Hants

Contentment cultivates creativity.
Thanks go to Janet, Stacey and Emma
for delivering a happy and stable home ship from which to write.

Martin C. Calder

In memory of my father, John Hackett, 1929–2012.

Simon Hackett

Reviews of the first edition

'Essential reading for social workers, health and education workers, the police, legal advocates, youth offending teams and policy makers.'

ChildRIGHT

'Covers all aspects of how to assess, when to assess and what to assess . . . The strength of this book is in the range of perspectives about assessment theory and practice, which are supported by good evidence bases and interesting examples.'

Community Care

'This substantial publication is aimed at those seeking to develop and enhance their assessment frameworks for children in need and their families . . . The many contributors offer the reader both contextual and practical tools for use by social workers and other relevant staff.'

Care and Health

'An accessible volume, with learning organised in bite-sized chunks . . . almost encyclopaedic . . . a contemporary toolkit for assessors, and a good one at that.'

Young Minds Magazine

'Good practice guidance for evidence-based methods . . . The individual essays offer insight and wisdom into specific aspects . . . A key source book.'

CAFCASS Practice and Research Digest

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Introduction

Assessing is where theory, evidence and professional judgement collide. ***Assessment in Child Care*** *covers all aspects of how to assess, when to assess and what to assess . . . The strength of this book is in the range of perspectives about assessment theory and practice, which are supported by good evidence bases and interesting examples.*

From a review of the first edition in Community Care

The complexity of child assessment cases continues to challenge all professionals, and there is a great legal expectation that the latest and growing body of available evidence is not only accessed, but utilised to inform both the assessments and care planning as well.

The first edition of this acclaimed book has become, since initial publication in 2003, an established part of most 'must read and have on hand' lists for practitioners and postgraduates. This new edition will:

- Support and protect busy frontline workers.
- Help them to navigate the ever growing and expanding terrain in child care assessments.
- Guide them to deliver better outcomes for the children and families they work with.

Who this book is for

As was the case with the first edition, it will be valuable for all professionals involved in undertaking assessments of children in need and their families, including:

- Social workers whose specific remit is to complete formal assessments, whether in child protection, safeguarding or family support.
- Professionals from a wide range of other agencies and backgrounds, such as health, education, police, legal advocates, CAFCASS, voluntary organisations, Youth Offending Teams, Sure Start, Connexions.
- Workers addressing issues in those adults who are parents and need some understanding about when to make appropriate referrals as well as have some idea on how to integrate their information within child care assessment processes.

It is also essential reading for PQ Child Care Award candidates, and may also prove stimulating to those interested in doing further research, or formulating new policy in this area, as well as to students, lecturers and their libraries.

The current context

Hopefully this book will be of use to people working in all parts of the United Kingdom and beyond. The emphasis in some chapters on local legislation and context is greater than in others. But the over-riding emphasis in each chapter – on providing access to the underpinning evidence base – is the same. That evidence base draws on the published literature from many parts of the English-speaking world.

In the decade since the first edition was published, there have been many significant developments in the UK such as: the evolution of the Assessment Framework into the Common Assessment Framework and the Integrated Children's System; the Munro review of child protection; a change of government and with it a shift from bureaucracy to organisational butchery.

Also, at the eleventh hour, a concession in the 2013 edition of Working Together meant that workers could talk about the reality of what they work with every day – risk. The foresight of workers in Scotland saw this issue many years in advance of their counterparts in the rest of the UK, and the commissioning there of a risk assessment toolkit to assist frontline staff was greeted by staff as universally helpful (Calder, Sneddon and Mckinnon, 2012).

The new edition

As well as addressing the new contexts, this new edition also remedies some previous omissions, such as issues concerning parents with a learning disability. The excellent chapter by Khadj Rouf offers a very useful contextual mapping which includes issues pertinent to the exercising of professional judgement within this contested area of work and fills a void left by the omissions.

Everyone working in childcare assessments is feeling the pressures of the time. This has meant that the second edition has taken some considerable time to pull together. We trust that everyone's patience will be rewarded by this book's high quality chapters by experts in their fields. They each draw on up-to-date research and integrate that into a body of knowledge that constitutes high levels of established wisdom, to produce material whose purpose is to be helpful more than challenging.

This book, thanks to the efforts of all the chapter authors, is a significant and worthy successor to the first edition.

Martin C. Calder and Simon Hackett
June 2013

Calder, M.C., Sneddon, R. and McKinnon, M. (2012) *Risk Assessment Toolkit*. Edinburgh: Scottish Executive.

About the Editors

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Martin is Director of *Calder Training and Consultancy Limited* which he established in 2005, having managed the child protection and domestic violence services for Salford. Martin trains extensively on frontline assessment issues and also where the practical becomes political. He continues to be driven to develop and deliver a range of evidence-based assessment tools for frontline staff. He is now involved in addressing in significantly more detail issues facing frontline managers dealing with ever increasingly complex cases. Further details on his work and remit are available at www.caldertrainingandconsultancy.co.uk

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Brigid originally studied psychology and following qualification as a social worker practised in Edinburgh. She then worked at Dundee University on post-qualifying courses in child care and protection, at Stirling University as Senior Lecturer in Social Work and returned to Dundee as the Professor of Child Care and Protection. She is currently Professor of Social Work at Stirling University in the School of Applied Social Science and head of Social Work. Her research interests and publications are in the areas of child development, children's resilience, work with fathers and child neglect.

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Margaret has pioneered work in issues of disability and child protection. She has written extensively on the subject and is co-editor and co-author of the ABCD – *ABuse and Children who are Disabled* – training and resource pack. She chaired the BASPCAN Disability and Abuse Working Party and is on the Editorial Board of the *Journal of Adult Protection*. Margaret is disabled and is a qualified nurse and social worker. She is a certified counsellor and has an advanced certificate in Child Abuse Studies. She has also studied the issues of Christianity and Child Abuse. Margaret has lectured and taught extensively throughout the British Isles: her audiences have included police, social workers, health workers, clergy, pastoral workers, probation officers and medical staff.

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CHAPTER 1

Risk and Child Protection: Triangulation, Trials and Templates

Martin C. Calder

Introduction

The concept of risk occupies a pivotal position in current operational social work practice, yet there is surprisingly little written on the subject and the Department of Health (DoH) has jettisoned the term from official guidance spanning all children and their families (DoH, 1999, 2000). This is a worrying and dangerous development since the assessment and management of risk remains the core activity of social services departments. Indeed, child protection practice is significant in signposting star ratings, curtailing professional anxieties, effectively protecting children and it is often seen as the litmus test of how safe departmental policy and practice is. Workers and agencies stand or fall by their child protection practice – and risk management is at the heart of good child protection work.

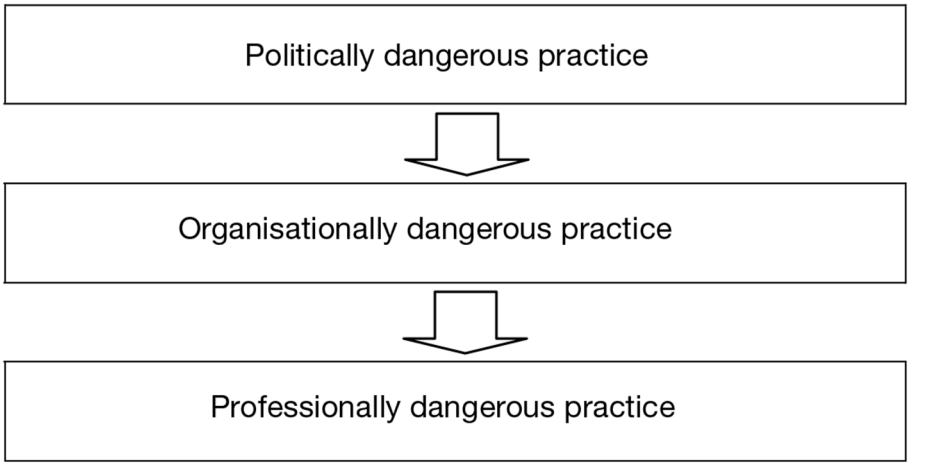
The Munro review (2011) challenged the deletion of risk when it was a core activity, the timescales dictating practice and the unhelpful conflation of section 47 enquiries and core assessments. It also suggested that the continuing expansion of safeguarding procedures was unhelpful and invited abbreviation. At the time of authoring this chapter the three draft consultation documents from government have not returned risk as a word or concept and no guidance on the conduct of risk assessments has been offered. Partial action on recommendations once again by government is ensuring accountability and reparative work needs to be undertaken either by safeguarding boards or individual teams and practitioners. This is time consuming and feeds subjective practice and a lack of any standardised approach.

Calder (2012) coined the term 'toxic context' to frame the environment in which many committed workers are attempting to undertake ever-increasingly complex risk assessments and where the civil courts are imposing an ever-higher threshold for 'beyond reasonable doubt' in the adjudication of court cases (Figure 1.1).

Some of the ingredients of each level of toxicity are identified in Table 1.1 below.

One of the main challenges arising from this poisonous environment is a fear of being left alone and making mistakes which result in being pilloried. This has also fuelled the hot potato of practice where professionals are anxious or feel under-skilled and pass on referrals for fear of

Figure 1.1: Toxic context



CHAPTER 2

Supervising and Managing Staff Undertaking Assessments

Jane Wonnacott

This chapter covers:

- Supervision and management in context.
- What do we mean by supervising and managing child care practice?
- Managing assessments – why is supervision important?
- Supervision and outcomes.
- The six stage cycle for supervising assessment practice.
- Working with poor performance.

> *Regular, high quality, organised supervision is critical, as are routine opportunities for peer learning and discussion. Currently not enough time is dedicated to this and individuals are carrying too much personal responsibility with no outlet for the sometimes severe emotional and psychological stresses that staff involved in child protection often face. Supervision should be open and supportive, focusing on the quality of decisions, good risk analysis and improving outcomes for children rather than meeting targets.*
>
> Lord Laming, 2009

Supervision and management in context

This chapter starts with a quote from Lord Laming's progress report regarding the reforms set in place following the death of Victoria Climbié in 2000 (Laming, 2003). The quote is significant because, despite calls for more effective supervision over a number of years (Reder and Duncan, 1999, 2003; Morrison, 2005; CWDC/Skills for Care, 2007) and national child protection guidance setting out the importance of supervision in safeguarding children (DoH, 1999; HMG, 2006) the quality of supervision in children's services has remained an issue.

Supervision in the field of child care practice is something which most people would argue is a 'good thing', but it is apparently a struggle to embed it effectively in our day to day practice. It is perhaps significant that the wording in the Government guidance, set out in the various *Working Together* documents issued over the past ten years or more, has hardly changed. Despite advances in research and knowledge in so many areas of child protection, the evidence base has been weak and has hardly changed since Rushton and Nathan (1996: 359) noted:

> *Very little research has been conducted into the extent, content and quality of supervision and management of child protection social workers, let alone whether it is being used to beneficial effect . . . No studies have identified methods and styles of supervision that are predictive of reduction of risk to children.*

Consequently, supervision has tended to follow the predominant trends within the management of child care services. With the advent of the new public sector management during much of late 20th and early 21st century, with its emphasis on performance management, task completion and targets, the focus of supervision, particularly in social work, also shifted in this direction. Both management and supervision became part of an audit culture which left little room for reflection, critical thinking and working with the emotional impact of the work. As a result serious case reviews continued to argue that supervision was failing to make a positive impact on practice, resulting in Brandon et al.'s (2008b) overview of serious case reviews noting that:

> *Effective and accessible supervision is essential if staff are to be helped to put in practice the critical thinking required . . . it needs to help practitioners to think, to explain, to understand . . . it is essential to help practitioners cope with the emotional demands of the job.*

A number of factors are now coming together which have the potential to shift the management and supervision of child care practice in a positive direction:

1. The work of the Social Work Task Force (2010) and the Social Work Reform Board (2010) has recognised the fundamental role that supervision plays in recruiting, and retaining, a high quality workforce.
2. The Munro *Review of Child Protection* (2010a, 2011a, 2011b) has put forward a clear argument, based on research and practice evidence, that relationship-based practice, incorporating a high level of critical thinking, is required to promote good outcomes for

CHAPTER 3

Assessment of Child Physical Abuse: Towards a Framework for Assessment

Martin C. Calder

Introduction

Whilst children have, of course, been physically abused by adults from time immemorial, the need to address this problem systematically, with an approach which goes beyond simple criminal sanctions, was only recognised fairly recently. The medical community was the first to start to understand the scale of the problem. The first published report in contemporary medical literature was in 1946 and the term 'battered-child syndrome' was coined in 1962. Whilst it is difficult to state accurately the level of physical abuse today, indicators of trends can be seen in the number of children whose names are included on Local Authority Child Protection Registers. At the end of March 2000 there were a total of 30,300 children on Registers in England (London: Government Statistical Office, 2000.) This figure represents 27 registrations for every 10,000 in the child population as a whole. Of these, 5,900 were registered for physical injury alone. The statistics collated over a five year period showed a reduction in the number of children on Child Protection Registers under the category of Physical Abuse: 8,703 in 1996 to 5,900 in March 2000.

The number of registrations for physical abuse has been reducing over the last decade, as the profile has changed to see a peak in registrations for neglect and emotional abuse. Some children whose physical abuse is only one symptom of more widespread harm such as exposure to domestic violence may be recognised as being at risk but may now be being recorded in a more harm- and intervention-focused category. However there can be no doubt that physical abuse continues to be widespread problem.

Research commissioned by the Department of Health shows that most UK children are hit, and around a third are hit severely (Smith and Nobes, 1997); and two children aged under-15 years die from abuse each week (Lazenbatt and Freeman, 2006).

More than 2,000 children call ChildLine each year with worries about other children who are being physically abused. Almost 30% of the children who call ChildLine about physical abuse say they have told no one else about it. Of those who had told someone else, 20% spoke to a friend, 16% spoke to their mother, 8% spoke to a teacher, 5% to their father, and 5% to the police (NSPCC, 2006).

NSPCC research has found that 21% of children experience some degree of physical abuse at the hands of their parents or carers. Two-thirds of those children experience 'intermediate physical abuse' (defined as occasional or regular violent treatment that may cause pain or marks, but does not lead to injury), while one-third suffer more severe physical abuse. Other research has found that 11% of parents of 11-year-olds report hitting them at least weekly, and that around one in six British parents report hitting children with implements such as belts, slippers or wooden spoons. Between 2001 and 2005, an average of 6,440 children per year were added to the child protection register in England because of physical abuse. However, research indicates that physical abuse, like other forms of maltreatment, is both under-reported and under-registered.

There will always be some element of under-reporting of physical abuse. Many children may disclose physical abuse to teachers or family friends, and they often do so indirectly, saying things such as 'I have a friend whose father hits them and hurts them'. Many children find it difficult to discuss the abuse that is occurring openly. They might be frightened, since many abusers threaten the child in order to make them remain silent and not discuss family matters outside of the home. Any disclosures by children of any age should be taken seriously and reported to children's services. Children will often cover up for abusive parents and not discuss the cause of an injury, even when questioned. The child may say, 'I can't remember', or, 'It was an accident'. Children who experience abuse from a young age often come to think that such abusive behaviour is normal.

CHAPTER 4

Assessing Neglect

Duncan Helm and Brigid Daniel

Introduction

It is estimated that 10% of children in the UK are currently experiencing neglect (Gilbert et al., 2008). Across the UK almost half the children who are subject to child protection plans are registered due to neglect (Action for Children, 2010). Neglect is a dangerous and damaging form of maltreatment for children of all ages. The youngest children are vulnerable to the impact of neglect as development in the early years is very rapid and so much of this development is dependent on the quality of care giving. Children in adolescence are vulnerable because neglect creates weak foundations upon which to build later development. The cumulative nature of its impact can mean that developmental gaps get wider, not smaller, as children grow.

In this chapter we will consider the challenges involved in undertaking a comprehensive assessment in cases of neglect. Current frameworks for assessment across the UK provide appropriate evidence-based structures for the collection and analysis of all the information that is needed to develop sensible intervention plans. However, assessment and planning in cases of neglect remain weak. Professional responses to the needs of neglected children do not appear to reflect professional understandings of the serious nature and consequences of neglect. We suggest that this is because more attention needs to be paid to some of the intangible organisational, professional and personal forces that operate under the surface. This chapter considers some of these forces and aims to support practitioners in identifying the factors that can get in the way of effective use of assessment frameworks in cases of child neglect.

Danielle Reid

Reviews of child deaths highlight some of the reasons given for the failure of professionals to refer neglected children to social work service. Danielle Reid was five years old when she was murdered by her mother's partner in 2002. Her death followed years of neglect. Many of the features of Danielle's life and the response of community and professionals to her needs are symptomatic of wider failings in the protection offered to vulnerable neglected children:

- A large number of children at the nursery had various vulnerabilities. Danielle did not stand out in that setting as having particular needs.
- Family members said that Danielle 'wouldn't tell on her mum really because she loved her mum'.
- In an effort to help Danielle's mother, verbal accounts were accepted in place of 'sick notes'. Absences were not cross-checked between Health and Education.
- Danielle attempted to befriend adults and neighbours. This 'resilience' may have been a factor in community and professionals not identifying Danielle as vulnerable and neglected.
- Social work services were short staffed and were lacking appropriate training and supervision.

Neglected children's needs

Most contemporary frameworks for the assessment of children's needs are based upon a triangular model which requires the practitioner to assess the interactions between three dimensions of the child's world:

- The child or young person's developmental needs.
- The capacity of parents or caregivers to meet those needs.
- The impact of environmental facts on care giving and developmental needs.

Given that these frameworks are supported by extensive guidance and policy already, this chapter will not replicate existing advice on technical implementation but will focus instead on the professional skills, knowledge and values required to negotiate these frameworks effectively.

CHAPTER 5

A Framework for Assessing Emotional Abuse

Celia Doyle

Introduction

Emotional abuse is an important but difficult area to assess, especially when it occurs as the sole form of abuse with little in the way of physical injury, physical neglect or allegations of sexual abuse to reinforce any concerns.

It has been explicitly recognised in the UK as a form of mistreatment requiring state intervention since 1980 when Government guidelines recommended the inclusion of 'emotional abuse' as a recognised category in child protection registers (DHSS, 1980; Fogarty, 1980).

State intervention in the protection of children is fraught with difficulty, partly because child abuse is a 'social construction'. Although the suffering of children is and always has been a reality, any distress is only recognised as a societal 'problem' requiring intervention when it comes to prominence as a result of 'groups asserting grievances or making successful claims for attention and resources' (Hallet, 1995: 23). A social problem emerges as such when powerful people in society agree to define a phenomenon as problematic. However, different powerful sectors may interpret the evidence differently and view the phenomenon as more or less problematic. For example, over the years in some instances of physical abuse, one person's maltreatment is another person's justifiable chastisement (e.g. Shumba, 2001). In emotional abuse, the lack of clear signs of injury or sexually exploitative incidents leads to dissention, fluctuating thresholds and different interpretations of any information gathered.

This chapter aims to provide suggestions for assessment and intervention in cases of emotional abuse, particularly when it is the main or sole form of abuse. It will establish the importance of identifying emotional abuse and look at the key contemporary issues for assessment, including its definition, characteristics and manifestation. Subsequently, there is a suggested framework for assessing emotional abuse, followed by guidelines on how practitioners can use the Assessment Framework domains and dimensions. Analysis of the information collected is then considered, and the chapter ends with conclusions and recommendations.

The importance of identifying emotional abuse

Egeland (2009: 22) observes that emotional abuse 'has devastating consequences for child development and functioning in a variety of areas'. It is now known that continued stress in early childhood can have an adverse effect on a child's developing neural networks and on the neuro-endocrine systems that regulate them (Anda et al., 2006). Moreover, the immature brain continues developing and there are indications that the adolescent human brain might be susceptible to the effects of elevated levels of glucocorticoids and, therefore, to stress (Lupien et al., 2009). In summary 'adverse experiences interfere with normal patterns of experience-guided neurodevelopment by creating extreme and abnormal patterns of neural and neurohormonal activity' (Perry, 2009: 241).

The types of carer behaviour featuring in emotional abuse are likely to cause stress. 'Terrorising' for example features heavily in emotional abuse cases, sometimes as much from witnessing partner violence as from direct threat (Doyle, 1997a; Trickett et al., 2009). Similarly rejection and denigration, referred to as 'spurning' in North American literature, also features prominently and will lead to insecurity and stress (Doyle, 1997a; Trickett et al., 2009). Therefore the implications for children living in fear and insecurity even if not physically or sexually assaulted are profound.

Some recent examples of these implications include research by Wright, Crawford and del Castillo (2009) who demonstrated that childhood emotional maltreatment can lead to negative internal beliefs about the self, leading to the formation of schemas of shame and defectiveness which are associated with depression and anxiety. Zurbriggen, Gobin and Freyd (2010) suggested that such feelings of depression and anxiety could explain their finding that childhood emotional

CHAPTER 6

A Framework For Assessing Failure-to-thrive

Dorota Iwaniec

The most basic needs of people throughout their lives are fairly simple; we need to get nutrition and to breathe air. From the moment of birth when babies are encouraged to take a breath and cry for the first time, it is clear that they can usually satisfy one of these needs by themselves. However, with the second requirement they will need a little help. Newborn babies and infants have to rely on parents or other caregivers to meet nutritional needs.

Childhood is a busy time with many things to learn and much growing up to do, both physically and psychologically. In a secure, stable and loving environment and fuelled by adequate nutrition, children will thrive, growing happily and healthily. They will become familiar with people around them, discover new things, and explore their environment in a confident way. In fact, parents are often heard to remark that they can see their children 'growing in front of their own eyes' at a remarkable speed. In reality, the newborn baby has already experienced its fastest period of growth during its development in the womb. During the first year after birth growth will be quicker than at any other period in childhood decreasing rapidly until the end of the third year, then continuing at about one-third of its postnatal rate until puberty. However, not all children grow at the same rate and there are various reasons for this.

Some children might fail to grow according to expected norms and show growth faltering because of illness, some because of inadequate nutrition, acute feeding problems, some because of abuse or neglect or parental lack of understanding of children's developmental and nutritional needs, and others because of being unwanted and rejected by carers, or because their mothers are depressed and cannot tune into the children's basic needs. There is seldom one factor which determines failure-to-thrive. The aetiology is multifactorial and often complex. Cases which come to the child protection services are usually associated with neglect, emotional abuse or rejection needing urgent attention. However, the number of children failing to thrive because of maltreatment is relatively small (Wright et al., 2006).

Failure-to-thrive children in comparison with their peers are significantly smaller and can be expected to have poor outcomes, they can be found in all social classes and levels of society. Without help at the early stages of growth faltering one can expect their physical growth, cognitive progress and emotional development to be negatively affected and can lead to extreme parental anxiety, disturbed mother-child interaction, especially, at feeding time, distortion of the relationship and attachment, and developmental delays (Iwaniec, 2004).

In recent years the failure-to-thrive label was replaced by growth faltering to avoid the pejorative use of the word 'failure'. However, growth faltering in early infancy is dealt with by the health visitor or GP (more serious cases by paediatricians) and as a rule they are resolved relatively quickly. Failure-to-thrive cases are far more complicated and usually require intensive multidisciplinary intervention and provision of services. Such children are often put on the Child Protection Register or are even taken to court.

The effects of early malnutrition may be extensive given the rapid period of growth, particularly brain growth (Wynne, 1996). However when interventions are put in place the effects can be dramatic with children showing accelerated growth and improved behaviour after a short period of time.

This chapter will deal with the assessment of children who fail-to-thrive generally, and specifically with those whose growth and developmental failures are associated with psycho-social aetiology and come to the attention of social workers or other statutory agency. A range of factors relevant to failure-to-thrive, as indicated in the Assessment Framework triangle, will be discussed and supported by the research findings. Some assessment instruments, developed and tested by the author over 20 years will be provided.

Special emphasis will be given to identification of the major problems, measurements of physical

CHAPTER 7

Sexual Abuse Assessments: From Perpetrator Friendly to Perpetrator Challenging Frameworks

Martin C. Calder

Introduction

Sexual abuse is a rapidly expanding term both operationally and legally and against this backcloth we have a consistently reducing number of children being made the subject of inter-agency child protection plans. This chapter will offer a summary overview of assessment considerations for male perpetrators living in families, as addressing wider considerations of young people, children, females, learning disabled, internet, sexual exploitation and much more would produce a landscape chapter devoid of depth and detail. I have published extensively in these areas elsewhere (see Calder 2001, 2002, 2004, 2005, 2006, 2009, 2011; Calder, Peake & Rose, 2001).

One of the principal challenges for social workers is the inability to formally use the word 'risk' in our assessments, and the current framework for assessment with its heavy focus on strengths offers a perpetrator-friendly approach that requires remedial action to hold them accountable for their behaviour. Another challenge is to understand the acute limitations of the criminal-justice-focused assessment tools that are actuarially constructed and focus on re-offending rather than presenting behaviours of concern. As I indicate in Chapter 10 on domestic violence, sexual offending rarely occurs in isolation: it can co-exist with domestic violence, animal abuse and child abuse (Calder, 2008a). Other challenges are about ensuring we adopt a meaningfully holistic approach that allows for us to acknowledge change and for us to also remember that we need to assess whether this is permanent or temporary (Calder, 2008b).

Triangular trickery: enhancing the triangle to meet 'fit for purpose' criteria

There are some positive elements of the framework: it adopts an ecological approach, expects us to build on strengths as well as identifying weaknesses and moves us towards evidence-based interventions. Unfortunately these are insufficient to compensate for its limitations in circumstances of sexual abuse. The principal limitations of the framework in this area include:

- There is little commissioned research from the Department of Health to inform the required evidence base, other than a book on outcomes of treatment (Jones and Ramchandani, 1999).
- The reader (Horwath, 2000) that is designed to equip practitioners when applying the generic framework to sexual abuse cases contains only two chapters of 3,000 words each (Erooga and Print, 2000; Print and Erooga, 2000).
- There is no acknowledgement that sexual abuse cases present us with unique issues and dynamics that need to be addressed in a particular way. It is not viable or desirable to try and use the general approach when a specific one is indicated.
- It is a myth that there is an evidence-base in **all** the various sub-arenas of sexual abuse that could inform our intervention even assuming that the overarching framework was sound.
- The framework is premised on the need to shift cases from the child protection arena to the lower end of the children in need continuum. In doing so, it has jettisoned the concept of 'risk' as this was equated with section 47 investigations. This is a misguided notion based on a misunderstanding of the term, and it has ostensibly re-framed 'risk' as 'need'. This is a dangerous development in the sexual abuse arena, and arguably provides a dilution to the notion of responsibility for the perpetrator. It is also at a time when the field of sexual abuse research is refining and extending the concept of risk assessment to provide us with a better structure through which we can effectively intervene.
- The pro forma assessment documentation does not fit with the core assessment tool developed

CHAPTER 8

Serious Injuries to Infants: Key Risk Assessment Considerations

Peter Dale

Introduction: why is this an important area?

There is perhaps no greater challenge for child protection systems than that of intervening appropriately, proportionately and sensitively with parents and wider family members, when an infant in the family has sustained serious injuries that may not have been accidental. In the immediate aftermath of the events that resulted in the injuries, the parents (including when they are responsible) are likely to be in varied states of shock, numbness, confusion, disbelief, agitation, distraction and fear (particularly when the injuries are life-threatening). A range of assessments will invariably follow, over many months to come.

Initial safety assessments

Whilst urgent medical treatment is under way, child protection professionals (at this stage usually social workers and the police) have to make rapid initial assessments regarding the immediate safety of other siblings (usually older) and whether the injured infant can be returned to parental care when ready to be discharged from hospital. Such assessments often have a fundamental impact on the long-term outcome of the case, in that children placed in temporary stranger foster care at this point are much less likely to be eventually returned home than other children who remain with a parent or family member (Waterhouse, 2001; Waterhouse et al., 2008). Initial safety assessments can be subject to significant specific sources of bias and error (Broadhurst et al., 2010) – e.g. over-optimism, or over-pessimism about the immediate safety of a child.

Specialist medical assessments

In many cases the 'treating' doctors and subsequent specialist medical experts (e.g. paediatrics, radiology, haematology, orthopaedics, neurology, ophthalmology) agree that the identified injuries were unlikely to have been caused accidentally. Also, that the explanation provided by the parents or carers at the time of admission was not adequate to explain the injuries; and that the parents or carers in charge at the time would (or should) have known that the infant was seriously unwell. In other cases, opinions about the causes of the injuries may remain uncertain, and different views may arise between specialist doctors. Eventually, often many months hence, the family court will be the arbiter of the matter through a judgment that the injuries were either non-accidental, or accidentally caused.

Between 2005 and 2010, an important case took place in the Family and High Court in England with regard to rebutting the common professional assumption that an unexplained serious injury to an infant is *necessarily* caused by maltreatment. At the age of three-months, baby William Ward was found to have a spiral fracture to his lower right leg. The treating consultant paediatrican and an expert witness (consultant radiologist) considered that (in the absence of a parental explanation) the fractures (there was uncertainty about the number of fractures) were diagnostic of abuse. Almost two years passed before the 'fact finding' hearing in the Family Court. Judge Isobel Plumstead finally concluded that the parents presented no threat to William, declaring in her judgment: 'There is no cogent evidence that these parents injured their son'. Mr and Mrs Ward subsequently won a legal fight in the High Court for this important judgment to be made public.* The court accepted the evidence of Professor David (an expert witness paediatrican) that in this and many other cases, *police and social workers were wrong to assume that an unexplained injury could normally be attributed to child abuse*.

* Doctor A & Ors v Ward & Anor [2010] EWHC 16 (Fam) (08 January 2010).

CHAPTER 9

Pre-birth Assessments: Context, Content and Collaboration Considerations

Martin C. Calder

Introduction

Since the first edition several key developments have taken place that impact on pre-birth assessment practice. The first is the context where we have several initiatives promoting early identification and intervention and which try and prevent problems rather than resolve them once they have occurred. The second consideration is the emergence of very clear evidence that clarifies the impact of harm to the young baby's brain and how the early months and years lay down a lasting platform for future pathways. Thirdly we have a systemic issue where lots of professionals armed with the term 'pre-birth risk assessments' see this as a social care issue rather than a shared responsibility: there is a very real need to refocus on the need to assess in order to maintain the baby and the mother and her partner together wherever possible. All this occurs in a climate where we are conducting many more assessments pre-birth and where there is an associated increase in the number of removals at or post-birth, and a real challenge is the maintenance of reasonable contact to further the post-birth assessment.

All these things stated, the template for undertaking assessments remains valid to date. The only challenge remains one of depth: since there are many initiating problems pre-birth then we need to drill down using far more specialist assessment tools associated with the primary presenting problem. As such assessors are well advised to supplement each of the areas with more detailed evidence and assessment tools to suit the needs of the case. The various chapters in this book should offer a starting platform.

Messages from serious case reviews (Ofsted, 2011)

Ofsted reports have consistently highlighted that babies less than one year old have been the subject of a high proportion of serious case reviews. Their 2011 report provided a thematic analysis of 482 serious case reviews that Ofsted evaluated between 1 April 2007 and 31 March 2011 and focused primarily on babies less than one year old.

The report identified some recurring messages concerning babies less than one year old. In too many cases:

- There were shortcomings in the timeliness and quality of pre-birth assessments.
- The risks resulted from the parents' own needs being underestimated, particularly given the vulnerability of babies.
- There had been insufficient support for young parents.
- The role of the fathers had been marginalised.
- There was a need for improved assessment of, and support for, parenting capacity.
- There were particular lessons for both commissioning and provider health agencies, whose practitioners are often the main, or the only, agencies involved with the family in the early months.
- Practitioners underestimated the fragility of the baby.

A common finding in the sample of cases of babies subject to a serious case review was that there had been failings in the pre-birth assessment process and, as a consequence, in the resulting actions. These shortcomings ranged from cases where no pre-birth assessment had been carried out, even when agencies were aware of risk factors that would have justified an assessment, to other cases where the pre-birth assessment was delayed, over-optimistic or of poor quality. Another message is the importance of not closing cases too quickly after the baby's birth. In one serious case review, an infant girl became seriously ill while in the sole care of her father: she died aged less than four weeks and abuse was suspected to have been a factor in her death. There had been previous concerns about the father, which had led to the removal of a child from the care of the father and his then partner because of injuries that were thought to have been non-accidental. In addition, the mother had been looked after for much of her

CHAPTER 10

Domestic Violence: Untangling the Complexity to Inform Assessments

Martin C. Calder

Introduction

There are so many places to start with such a big and seemingly growing problem that is rightly attracting consistent high profile legislation guidance and support from government. It is the complexity that poses many challenges to workers and organisations seeking to protect adults as a primary means of protecting the children. The current central assessment guidance is a blunt instrument in this regard and workers require access to key developments in the available evidence if they are to achieve the outcomes that children deserve.

This chapter has to focus on male perpetrators of domestic violence simply because of space constraints and the reality that they comprise in the majority of perpetrators. I am separately assembling a compendium of evidence-based materials on areas that deserve similar coverage: female perpetrators, young people as perpetrators, unborn children, to name but a few (Calder, forthcoming a, b). I have also published elsewhere in relation to contact considerations in domestic violence cases (Calder and Regan, 2008).

Impact considerations

Perpetrators of domestic violence operate in a sophisticated way, designed to control their victims and disable independent thought and action. Any attempt to break out of the straightjacket heightens rather than reduces risks, thus restricting actual or perceived exit options. Professional ignorance or resource constraints can replicate the original harm by unwittingly mirroring the perpetrator's controlling behavior. Professionals can expect victims to make straightforward decisions, such as the need to separate from the perpetrator, without acknowledging the fact that the perpetrator has systematically eroded financial and emotional independence, created a context of dependency and fear, and robbed them of self-esteem and other essential components necessary for resilience-building or resilience retention (Calder, 2006).

Perpetrators of domestic violence share many of the characteristics of sex offenders in that their primary motivating feature is the exercise of power and control. They groom the environment over a period of time to render the potential for disclosure, belief and professional action almost impossible. Children fear the cost of disclosure, and their opportunities are often narrowed through perpetrator threat or through the systematic undermining of their critical relationship with their mother. Children may fear the costs of disclosure in terms of disruption to their siblings, peer networks and family relationships. Women fear the costs of leaving since they are at elevated risk, physically and emotionally; and fear potential stalking, especially if contact application to their children, might achieve this. Indeed, the number of children killed in court-ordered contact and the risks from domestic violence related stalking are both high (Calder, 2003). Figure 10.1 sets out the range of impacts of domestic violence for children.

Many perpetrators restrict their behaviour to specific places or contexts such as the home environment. For example many hold down professional jobs and externally present as pillars of the community. However, they perpetuate physical, sexual and emotional abuse as well as neglect. Their control of the family is rarely restricted to the mother and there is evidence of direct harm to children other than the witnessing or awareness of domestic violence. More actively they may groom the children to perpetrate harm to their mother, particularly in their absence, to ensure a 24 hour, 7 days-a-week regime of control. This may be coupled with their behaviour towards the mother which has independently drained her of the energies necessary for parenting. Children also expect protection from their mothers and may apportion blame to her for not leaving the perpetrator or naming and shaming his behaviour.

CHAPTER 11

Assessing the Needs of Disabled Children

Jane Wonnacott, Anne Patmore and Margaret Kennedy

Introduction

When a disabled child is referred to Children's Social Care for an assessment the reasons may range from a request for a practical service through to concerns about the risk of significant harm. The introduction of the Framework for the Assessment of Children in Need (DoH, 2000) was a step towards providing those with responsibility for undertaking these assessments with an approach which focused on the needs of the whole child, rather than just one aspect of their life. However, the framework was not initially designed with disabled children in mind and although there have been attempts to adapt it this has not always been successful and parents have found it overly intrusive when a basic service is requested. They also have the right to request a carer's assessment (The Carers and Disabled Persons Act 2000) and there can be challenges in integrating the needs of parents as carers of the child with the child-focused assessment under Section 17 of The Children Act 1989.

Historically timescales for completion of childcare assessments have not taken account of the increased complexity of many assessments with disabled children, particularly where the child does not use voice as a means of communication. Also the authors, in their work in training professionals who work with disabled children, continue to find instances where the views of the child are not heard and, in some cases, risks are not understood or responded to. The move towards more professional autonomy in assessment practice (Munro, 2011) may enable a more flexible approach, although it will be vital that this continues to remain child-focused. This chapter concentrates on some fundamental principles and practices that need to be in place whatever assessment framework is used, and explores:

- The importance of the social and ecological models as a foundation for effective assessments with disabled children.
- The context within which assessments take place.
- The impact of organisational frameworks.
- The role of the team.
- Working with the child and family.

Social and ecological models: the foundation for assessment practice

The Munro review (2011) has been helpful in highlighting the role that bias can play in assessment and decision making. Bias may stem from our own attitudes and values, and this is particularly relevant in work with disabled children where the impact of society's perception of disabled people can unconsciously influence our responses.

The *social model* is a way of understanding the position of disabled people and children in the world in which they live. It was conceived by disabled people (Morris, 1999; Oliver, 1999) as a way of challenging the accepted premise that disabled people were 'defective' and therefore needed to change. Historically, disabled people have been portrayed negatively within literature and the media (Shakespeare, 2000) leading to a view that to be disabled was a 'bad' thing which needed either to be eradicated or remedied. Thus the *individual model* (previously referred to as the 'medical' model) became the established approach towards disabled people, aiming to change disabled people via medical intervention rather than addressing the disabling barriers within society. The pervasiveness of this model can still be seen in the way that disabled people may be portrayed as needing sympathy (rather than empathy) and the language of tragedy that is used at the time that impairment is diagnosed.

Attitudes and values may therefore be reflected in our use of language. Within the child care field, the meaning of the phrase 'disabled children' is quite different to 'children with disabilities'. The former is describing the social model, where there are disabling barriers and the child is 'dis-abled' by society, whereas the latter uses the word 'disability' to describe the child's impairment. Disabled people have consistently argued for the social model use of language, but in children's

CHAPTER 12

Learning Disability and Parenting – Improving Understanding and Interventions: Doing The Basics Well

Rikki Sneddon

Introduction

Improved awareness of the potential strengths and limitations of Learning Disability and how these can impact upon parenting is necessary to assist better understanding of the needs of the adult carers involved as well as those of the children they care for. Such understandings can then be applied to support improved single and multi-agency approaches towards interventions, greater sensitivity to the needs of all parties and more informed exercise of statutory authority as and when this may be required.

As Mencap UK have noted, such awareness and understanding provides a critical start point as 'the day-to-day lives of people with Learning Disability and their families have always been much affected by the way they are perceived and treated by the communities they live in'. Moreover, despite there being a more informed grasp of Learning Disability and the potential needs and risks presented for parents with this condition, the prevalent attitude and perception of Learning Disability over the last three decades has been one of intolerance and lack of understanding.

Looking a little closer at Learning Disability and parenting then requires active consideration of what's currently known in order to build the picture of not only how it's perceived, but also how it's understood and addressed as well as what characterises it within the wider social context. Among other things this entails a need to explore and examine something of how Learning Disability is defined currently.

I'd like to touch on some of these aspects here, providing an overview that walks some of the landscape of Learning Disability. In doing so I will draw upon material that I had previously pulled together for the purpose of training multi-agency staff in this area of work. The general aim being to raise awareness of professional staff working with children and families such that together we may enhance shared understandings, improve interventions and hopefully secure better outcomes for those involved. This chapter thus does not seek to comprehensively cover all that is relevant here but rather to establish a shared knowledge base around Learning Disability and parenting that may provide useful foundation as well as give pointers to future areas for further development and exploration.

Defining and framing Learning Disability

Presently; Learning Disability is framed as 'A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) with a reduced ability to cope independently (impaired social functioning) which started before adulthood, with a lasting effect on development' (DoH, 2005).

Thus, key elements of cognition/intelligence and social functioning, the age of onset and the enduring nature of the condition have been identified as central to framing whether Learning Disability prevails or not. Learning Disability is complex however, it is not simply about intelligence, cognitive skill or IQ (intelligence quotient) and as such it can and does reflect widely varying levels of ability. This is something in part echoed in the way that Learning Disability has been categorised across levels of ability as either Profound (IQ of less than 20), Severe (IQ of 20–35), Moderate (IQ of 35–50) or Mild (IQ of 50–70). Across this spectrum of ability parents with Learning Disabilities are most likely to be from the mild to moderate categories as adults with severe disabilities are less likely to become parents.

That noted, all levels of Learning Disability are to be viewed as points on a spectrum: there are no simple or clear dividing lines between them, or indeed between people with mild Learning Disabilities and the wider population. While current figures project that approximately 2.2% of the population have a Learning Disability within the spectrum of mild to profound another 6.7% of the population are thought to fall within

CHAPTER 13

Parents With Mental Health Problems: Assessing and Formulating Parenting Capacity, Embedded Within a Service Context

Khadj Rouf

Aims of this chapter

I begin this chapter by locating myself within a context, because one of the key messages in my contribution to this book is that context matters. We are all located within systems, and systems shape our thinking and behaviours.

I am a clinical psychologist working within an NHS based adult mental health service. Clients are referred via their GP or via another member of the community mental health team, who may already be working with referred individuals. Mental health issues such as severe anxiety, depression or psychosis, are the primary reason for referral.

Within such a context, psychological therapy is offered to clients within a multi-disciplinary setting. Referred adults are often seen in a clinic setting, and usually come to appointments on their own. In the main, adults are seeking individual psychological intervention, but it is important to consider child welfare as part of this work when clients are parents (or carers). The other typical scenario in clinical practice is when clients raise historical allegations of abuse, which should alert professionals to potential ongoing safeguarding issues posed by the alleged abuser (Rouf, 1997). Workers need to consider the family as a whole, which means thinking about dependent children and relatives who may take on a caring role for their family member or be an important part of their recovery. It may also involve considering risks posed by alleged abusers when abuse has remained undisclosed until the person has spoken to their GP or a mental health worker.

As a reader, you may be working in a different setting with a different remit. You may see mainly children, mainly adults or you may see families together. You may see them in a particular setting, and have a number of people to see within one day. You may have a number of pressures and expectations upon you, which will shape your thinking and how you behave. You may work in a setting where you are thinking about risk constantly (such as social work) or where risk assessment is less common (such as teaching in a primary school).

It's important to consider how some of the information presented here may need adapting to your own setting. The information is offered to provide guidance to thinking, but how this is applied to individual cases has to be underpinned by reflective supervision and team discussion.

The purpose of this chapter is to help workers to:

- Understand the legal context of mental health and child protection.
- Have an understanding of how mental health problems can impact on parents and children.
- Know what to consider when assessing parental mental health.
- Know what to consider when pulling information together into an overview of a case.

The chapter gives case examples based on composites from clinical work, to illustrate common scenarios. These can be found in Appendix 3.

Introduction

Mental health problems are common within the general population, and there is evidence that social disadvantage is associated with a higher than normal incidence of ill health (Melzer et al., 2004). It is estimated that at any one time as many as 9 million adults experience mental ill health. Approximately 30% of adults with mental ill health have dependent children (Ofsted, 2013).

Where parents have mental health problems, this can seriously impact on parenting capacity but this is not always the case (Cleaver et al., 1999). Some research indicates that parental mental health problems can have a direct negative impact on children's well-being, and in some cases, can

CHAPTER 14

Parental Alcohol Misuse: Evidence-Informed Assessment Considerations

Martin C. Calder and Anne Peake

Introduction

Alcohol is a significant factor in our society. Used in moderation, it can be a source of enjoyment, celebration and relaxation, a positive part of our social and family lives. Whilst many of us use alcohol positively to enhance our lives, there is growing recognition of the physical, personal and social damage alcohol causes through misuse.

In our society, alcoholic drinks are widely consumed, socially acceptable and indeed thought desirable in many contexts. Alcohol is often associated with status, power, conviviality, attractiveness, and achievement (Collins, 1990: 1). It is thus very difficult to determine what is and what is not alcohol-related. In 1987, the population of England and Wales spent £17 billion on alcohol, equivalent to £370 for every adult in Britain (Faculty of Public Health Medicine, 1991). In 1996, £189.5 million was spent on promoting alcohol (Alcohol Concern, 1997).

Yet taken in excess, it may also lead to damage and even death to the drinker and others. Many definitions of alcohol misuse have been proposed, and the common criteria appear to be:

- Interference with life functioning, including personal, work or family.
- Continued use despite adverse consequences.
- Psychological or physical dependence.
- Loss of control over drinking.
- Withdrawal symptoms upon discontinuation of drinking.

Nastasi and DeZolt, 1994

The publication of 'Safe Sensible Social – the next steps in the National Alcohol Harm Reduction Strategy' (June 2007) heralded renewed Government emphasis on the need to address pernicious problems which have so far evaded efforts to reduce them. It identified three 'groups' of drinkers which needed particular attention: under-18s, 18–24 year old 'binge' drinkers (defined as 'drinking alcohol at least once a month and feeling very drunk once a month) and 'harmful' drinkers – usually middle-aged people drinking at home whose consumption may put them at risk without them realising it.

People have different patterns of alcohol and drug use, which invariably start with 'experimentation'. Many people do not take the use of alcohol or drugs much further; some, if they choose to use them again, will use them 'recreationally' e.g. with a meal, only at celebrations, visit to a concert, or at a 'rave'. Some people, however, do go on to use substances on a regular basis, with a psychological compulsion and physical need (i.e. 'dependency'). Clear distinctions between experimental, recreational and dependent use are difficult to define. Instead, it may be more helpful to focus on whether the use of the substance is problematic. The latter is generally accepted to include physical, social, psychological and legal problems related to intoxication, excessive consumption or dependence resulting from use of a substance.

Every person with an alcohol problem is different. When a person with an alcohol problem is in a family where there are children, there are often concerns about the welfare and safety of the children. This chapter endeavours to provide a framework for examining the presenting problems of a family/professional network where an adult has an alcohol dependency problem. The framework conceptualises the problems in terms of elevated risks to children in the same household and offers a framework to guide professional intervention.

The size of the problem

It is impossible to give precise figures for the children and young people who are living in families where alcohol is misused because so much alcohol misuse is hidden and because many studies examine adult rather than parental drinking. HMSO (1996) provided figures suggesting that in England and Wales 8.5 million people (6 million men and 2.5 million women) drink above the medically recommended levels of

CHAPTER 15

The Assessment of Parental Substance Misuse and Its Impact on Childcare and Child Wellbeing

Fiona Harbin and Michael Murphy

Introduction

This chapter is not just about the assessment of child care; it is about measuring the reality of family life, when parenting and child care are affected by significant parental substance misuse. The chapter begins by examining the connection between substance misuse, parenting and child welfare. We subsequently review the crossover between the childcare and substance misuse systems. It continues by exploring the usefulness of the Assessment Framework (DoH, 2000) and the Common Assessment Framework (DfES, 2005) suggesting ways in which these frameworks can be developed and augmented to be more effective in this assessment area. It ends with the inclusion of the child's perspective and begins to explore what should follow our assessment.

In a society in which substance use is the norm for many young people (Parker et al., 1998) and parents (Cleaver et al., 2007) it is important to distinguish between *use* and *misuse* of substances. In terms of family life, experimental and social use of substances are not usually harmful. It is where parental use becomes dependent and chaotic that the impact on the child's wellbeing increases. For the sake of this chapter we will use substance dependence as the key indicator of substance misuse. SCODA's (1997) definition of substance dependence is as follows:

> *A compulsion or a desire to continue taking a drug or drugs in order to feel good or avoid feeling bad. The compulsion or desire is usually initiated following previous repeated use of the drug and is difficult to control.*

The chapter includes the misuse of all illegal substances, legal 'highs' (e.g. methadone) and the misuse of prescribed medication (Reay, 2008). This chapter does not concern itself specifically with the misuse of alcohol, as this is detailed in the preceding chapter by Calder and Peake. However most of the assessment issues discussed in this chapter relate not only to drugs and prescribed medication but also to alcohol. Many parents use a number of substances (poly drug use) which often include alcohol. It is also common for many people who manage to abstain from illicit substances to begin to misuse alcohol as a substitute drug. It can be very difficult to treat the two separately as the causes for the use of both are often very similar, where the misuse of any substance is often a means of coping with difficult aspects of our lives. As one rather cheerful mum on an estate in England pointed out, her 'menu' of substance use can be quite complex and extensive:

> *I'd put drink first in a way, cos I drink every day. I don't have crack every day. As often as I can, but not every day. I'd say cannabis was number three. I just smoke it every day. Whiz, I do a lot of whiz and I do Es as well and Valium.*
>
> Smith and Honor, 2004: 11

The assessment tools considered in this chapter are clearly designed for the thorough assessment of the impact of any parental substance misuse on children and families.

Our definition of a parent will be a wide one, including all those who take on a parenting role with regard to a given child. This includes parents, grandparents, siblings, other involved family members, foster carers and any other adult carers.

Changing patterns of substance misuse can be reflected in the changing patterns in child care systems. The Labour Government (1997–2010) embraced the importance of collaboration within child care systems at all levels of concern, from the Common Assessment Framework (2005) to the introduction of the Local Children's Safeguarding Boards (Children Act 2004). This commitment to a more holistic and collaborative approach impacted on the provision of services provided for families experiencing parental substance misuse. The DCSF gave local examples of good multi-professional practice and in 2009 launched guidance for a joint approach to the provision of services for substance misusing parents and their families. The Labour

CHAPTER 16

Involving Children and Young People* In Assessments

Helen Charnley, Grace Roddam, Dave Laverick annd Jane Wistow

Acknowledgements

Thanks to Billy, Casey, Chantel, Craig, David, Davine, Daniel, Glen, Helo, Jack, Jade, Jody, Jordan, Joseph, Josh, Katharine, Kirsty, Lee, Lee, Louise, Marcus, Mark, Mathew, Megan, Rebecca, Ryan, Shannon, Tina and Tom for their invaluable contributions to this chapter and whose experiences shape the young people's model of assessment.

Be a real person and remember it's my life, not yours. Perhaps you should remember what it's like to be young.

Introduction

In this chapter we start by addressing the question: 'Why involve children and young people?' We explore different meanings of involvement and assessment before presenting children and young people's own experiences and their proposals for a model of good assessment practice. We end by considering the wider tensions that limit positive assessment practice.

Why involve children and young people?

Children and young people's involvement in social care assessments has firm foundations in international conventions, national legislation and professional codes of practice. Article 12 of the United Nations Convention on the Rights of the Child (1989) refers to children's rights to express their views freely about all matters that affect them, although these rights are limited by questions of age and maturity that are subject to adults' judgements of maturity. In the English context, the 1989 and 2004 Children Acts are underpinned by a principle of respect for children based on a growing body of evidence that although children have been systematically excluded from decision making processes as a result of prevailing power relations between children and adults, they are capable of being actively involved in key decisions that affect their lives (James, 2009). The principle of respect requires local authorities, as far as is reasonably practicable, to ascertain the wishes and feelings of children before making decisions relating to them (Children Act, 1989 s 1[3]) and the creation of a Children's Commissioner as an independent champion for the views and interests of children reinforces political acknowledgement of children's rights to make their views known. Codes of practice for social care workers refer to respect for service users' rights. But rights-based arguments are controversial not least because they challenge the taken-for-granted power that adults exercise over children. Some adults perceive children as being primarily 'in need of protection' while others recognise that children, as a social group, are oppressed by adults and need explicit rights in order to be able to legitimately address imbalances of power (Axford, 2008; Freeman, 2010). These tensions are reflected in uncertainty about the most effective ways of working with children (Luckock et al., 2007) and the uneven development of children and young people's involvement in decision making.

Examination of wider processes of participation can help us gain a more nuanced understanding of the processes and outcomes of children's involvement in assessment. We are surrounded by powerful waves of interest in, and support for, children and young people's participation in decision making (Simmons, 2007; Davey, 2010), planning and policy making (Danso et al., 2003; Wright et al., 2006), wider democratic processes (Invernizzi and Williams, 2007) and research (Kellet et al., 2004). But although children's participation is a firm fixture on the social work agenda, it remains highly contested (Tisdall, 2006). To move forward we need better understandings of adult child relations, of children's agency and children's use

*The terms 'children', 'young people' and 'children and young people' are used interchangeably throughout the chapter reflecting their use in a wide range of circumstances and publications.

CHAPTER 17

Re-assessing Fatherhood: The Absence of the 'New Man' in Social Work Practice

Lena Dominelli

Introduction

Popular discourses are imbued with notions of the 'new man' who is engaged in family life, supporting the mother, caring for the children and developing good emotional relationships with them. However, the work of Scourfield (2006), Featherstone et al. (2010), Strega et al. (2008), Heslop (forthcoming) and Casey (2012) reveal that social workers largely ignore fathers in their practice and continue to operate within dominant gendered relations that ascribe caring to women and providing for the family financially to men (Hearn and Morgan, 1990) and the paradigm about fathers popularised by Pleck (2004) and rooted in the 'good dad-bad dad' binary. In social work discourses, this binary is articulated in practice as the 'asset-risk' dichotomy. And, in the eyes of many practitioners, fathers are considered 'risks' not 'assets'.

I explore these issues in this chapter by considering how men *perform* fatherhood, that is, constitute their identity as fathers through their awareness of and engagement with how the 'good dad-bad dad' binary operates in their lives when they are enmeshed in social work practice. This performativity according to Butler (2009) involves the performance of gender relations through the division of men and women into two groups of antagonistic human beings whose relationships are embedded in dichotomous terms within forms of masculinity and femininity that affirm the dominant, obligatory or hegemonic norms when social actors reproduce these relationships through the exercise of power. These relationships encompass the parenting skills of both men and women through the dichotomy of the 'good dad-bad dad' and the 'good mother-bad mother' binaries.

I combine Donzelot's (1997) insights about the family with those of Foucault's (2001) instruments of governmentality to show that the exercise of power in work that caring professionals undertake with fathers with children is negotiated around the 'good-dad-bad dad' fathering dichotomy. This binary is reproduced through social work practice that affirms traditional gender roles and divisions of labour rather than those that feed off recent discourses associated with the 'new man' that Bennett (2012) argues are less evident in the popular media. If social workers were to re-assess their understanding of fathers in terms of their performance of fatherhood and potential to change their behaviour, I suggest that they could support women's requests for a more equitable sharing of child rearing responsibilities. These duties, as research in more egalitarian societies like Norway shows, continue to be undertaken mainly by women, although substantial numbers of men are involved (Kittergød and Lappegård, 2010).

I also argue that while practitioners have to be mindful of the real 'risks' that some men pose to the well-being of women and children, it is also inappropriate to label all men as 'risks' and leave it at that. Failure to undertake specific assessments of fathers' potential or actual contributions to families may result in social workers missing the opportunity to support fathers who engage appropriately with children and ease the weight of their care on the mother, as the following mother in a research project I was involved in claims:

> *the thing is, how can [social workers] say 'well, he has to be gone'. The kids cry for him . . . he's been a dad role. He'll make homemade play-dough with them. Or bring them to the park and not just sit there on the bench reading a magazine . . . He'll be there getting dirty, pretending to be a horse . . . but [social workers] don't see that . . . they don't care about that . . . at all.*
>
> Dominelli, 2003

Responding to this plea, good practice requires social workers not to utilise stereotypes about men or women in their work with families, but to undertake specific assessments of the actual 'risks' posed by any particular man to children or women. Examining the specifics of the

CHAPTER 18

Assessments and Social Ecology: The Importance of Community

Gordon Jack

Introduction

Families living in what they experience as either supportive and socially integrated or, conversely, threatening and socially fragmented local environments will be in no doubt about the importance of community for their health and well-being. The extent to which parents consider that they can trust their neighbours, rely on the support of nearby relatives and friends, have confidence in the school and other local resources used by their children, and perceive the local environment to be safe, are all likely to play a major role in their family's quality of life (Bronfenbrenner, 1979, 1986).

The concept of 'community' is one of the most widely and often imprecisely used terms in the social welfare literature, but it continues to have salience because it conveys a sense of the physical and social environments within which a great deal of human interaction occurs. For the purposes of this chapter the term 'community' will be used to refer to the web of personal relationships, groups, networks, traditions and patterns of behaviour that exist amongst those who either share geographical locations or common interests (Standing Conference for Community Development, 2001). In this context 'social ecology' is understood to refer to the range of community-level factors which exist in particular settings, influencing amongst other things the nature and quality of relationships found within them.

In what follows, the research evidence detailing the influence of community-level factors on the health and well-being of adults and children is reviewed first of all. This is followed by an examination of the ways in which two of the most important aspects of the social ecology of communities, social networks and social capital, can be assessed. The chapter concludes by considering the implications of recognising the importance of community for practice with children and families.

Community-level influences on health and well-being

Social networks and child maltreatment

Some of the clearest examples of the way that community-level factors influence the well-being of children and adults are provided by the findings of a series of studies investigating variations in child maltreatment rates between neighbourhoods in different cities in the United States carried out by James Garbarino and his colleagues. An early study in Omaha, Nebraska, found that much of the variation in rates of officially recorded child maltreatment between different neighbourhoods was explained by the socio-economic and demographic characteristics of their residents (Garbarino and Crouter, 1978). Nine factors, including measures of poverty and affluence, unemployment, household composition, overcrowding, educational attainment, ethnic background and stability of residence, explained almost eighty per cent of the variations in recorded child maltreatment rates. Very similar findings have been reported in other studies examining the effects of social ecology on rates of officially recorded child maltreatment (e.g. Zuravin, 1989; Coulton et al., 1995). So, the characteristics of the people who live in particular geographical communities can be seen to account for the majority of the variation in rates of child abuse and neglect found between them.

Subsequent work by Garbarino and his colleagues in different areas of Chicago examined what *other* factors in the social ecology of neighbourhoods, this time matched for their socio-economic and demographic characteristics, accounted for any remaining variations in rates of child maltreatment. The first study of this type involved interviews with parents living in two matched neighbourhoods with different rates of child maltreatment to identify their main sources of stress and support (Garbarino and Sherman, 1980). The neighbourhood with the higher rate of child maltreatment was found to be dominated by

CHAPTER 19

A Framework for Assessing Parenting Capacity

Simon Hackett

Introduction

The assessment of parenting is a notoriously, and perhaps inherently, value-laden area of child welfare practice (Jones, 2000; Daniel, 2000; Budd and Holdsworth, 1996). Practitioners who are making judgements about other people's parenting need a sound conceptualisation of parenting which is grounded in the best available research evidence and theoretical knowledge. Such a conceptualisation has to be broad enough to embrace the dynamic nature of parenting tasks across a child's lifespan, the challenges of and threats to effective parenting, and the processes and mechanisms that link parental behaviours and child developmental outcomes. It is therefore vital that practitioners are both alert to the impact of their own values and also ask themselves the following core questions at all stages of the assessment process:

- On what am I basing my judgements about people's parenting?
- What factors am I emphasising?
- What are the implications of emphasising these factors?

This chapter therefore seeks to help practitioners to develop an evidentially-sound conceptualisation of parenting and to offer some guidance as to how parenting can be assessed, exploring and building upon the notion of parenting capacity first introduced in the DoH (2000a) *Framework for Assessment for Children in Need and their Families*. I start by discussing the concept of parenting capacity, before going on to explore the dimensions of parenting. I then offer an integrative model for the assessment of parenting capacity which builds upon the DoH triangular model. This includes a functional model of parenting assessment which encourages practitioners to examine the fit between parenting behaviours and child need. Attention is also given to research into parenting styles. In the final section of this chapter, the focus shifts to the process and content of assessments of parenting capacity, with practical guidance as to what to include in parenting capacity interviews and observations.

The concept of parenting capacity

One of the key concepts introduced in the DoH Assessment Framework is the notion of 'parenting capacity'. This was highlighted as one of the three sides of the Assessment Triangle, alongside the child's developmental needs and family and environmental factors. The introduction of this concept represented not merely a change in terminology, but embodied a fundamental conceptual shift in thinking in relation to the assessment of parenting issues. Surprisingly, the defintion of the term 'parenting capacity' was not given a great deal of attention within the Assessment Framework document itself, nor indeed the accompanying Practice Guidance. However, it is perhaps most clear what is intended through the statement:

> *Children's chances of achieving optimal outcomes will depend on their parent's capacities to respond appropriately to their needs at different stages of their lives.*
>
> (DoH, 2000b, p9).

It is important to open up 'parenting capacity' and to explore some of the key elements associated with the term. Prior to the publication of the Assessment Framework in 2000, assessment practice had often relied on the notion of 'good enough parenting'. The advent of the Assessment Framework, however, encouraged practitioners to move away from assessing whether someone's assessed level of parenting is 'good enough' in any given situation to a broader and more dynamic view of their capacity to meet their children's needs within their familial, social and environmental contexts. This conceptual shift has many important practice ramifications.

One of the problems with viewing parenting as 'good enough' or 'not good enough' is that it suggests that parenting can be seen, and indeed assessed, outside of its environmental and developmental context. In other words, evaluating a person's parenting as 'good enough' has tended to be used to imply that this is likely to be persistent over *time* and *place*. It may also suggest that being a 'good enough' parent is a characteristic inherent to that person. However, it