Brief glossary and definitions

Actuarial v Clinical Risk assessment: actuarial means using agreed statistical formulae to calculate risk. Clinical means using professional practice-wisdom and expertise to assess it, but in a structured way. The two can be combined. Very advanced thinking uses 'chaos theory' too but that's beyond the scope of this aide.

'Covert surveillance/High engagement' means lots of direct work with families with repeated 'here to help' message, plus constant 'watching' of family functioning: this improves parenting. Little direct work with occasional but athoritarian 'monitoring' does not work.

'Closure' means families keep out the external world, including extended family and professionals.

Feigned compliance (or disguised compliance), is where 'closed' families pretend to open up to workers under pressure, which wrongly lowers professionals' concerns.

'Flight' is when families move to avoid scrutiny - either literally move address or metaphorically by eg swapping schools or GPs

Kolb cycle: look it up. Method for reflecting on one's lived experience as caseworker; can be used to improve learning and practice: a good supervision tool.

Mind-mindedness: ability to empathise with child's experience, thoughts and feelings.

Rule of optimism: where workers accept the most innocent explanation for neglect or abuse without sufficient questioning or evidence.

Static v dynamic risk factors: static means a feature that cannot be changed eg person's age, a troubled childhood, or previous convictions. Dynamic means something that can be changed, including by social work intervention eg homelessness or current psychosis.

Bibliography

Barlow & Scott (2010) 'Safeguarding in the 21st century where to now'. Dartington: research in practice nb the full text is available at www.rip.org.uk

Calder (ed) (2008) 'Contemporary risk assessment in safeguarding children' Russel House Publishing

Howe (2005) 'Child Abuse and Neglect: Attachment Development and Intervention'. Palgrave

Reder et al (1993) 'Beyond blame: child abuse tragedies revisited'. Brunner-Routledge

Reder & Duncan (1999) 'Lost Innocents: a Follow up Study of Fatal Child Abuse'. Routledge

For more information please contact Mick Cunningham, head of service practice development, on 01753 690944 or email mick.cunningham@slough.gov.uk.

Produced by Slough Borough Council ED/5879/24-01-13

Risk Assessment Aide Memoire

With families, use multi-agency 'covert surveillance' plus 'high engagement' for change, not 'overt surveillance plus low engagement' (see glossary of terms).

Listen to the child

The quality of the relationship between parent and child trumps all other factors. Don't assume 'natural love' for a child by parents. Check the 'meaning' of the child to the parent. Is the child seen as a joy, a person, a thing, a 'carer', a burden, a possession, a reminder of bad things?

Get specific. What specific risk factors/behaviours need to change? Specify what the desired protective factors, or alternative safe behaviours would look like. Aim for these.

- Past behaviour is the best predictor of (un-reformed) future behaviour. Learn the family history. Use independent sources for this, not just self-reporting by the family. Do a geno-gram.
- Don't ignore anonymous referrals.
- Always ask about fathers, boyfriends/girlfriends/partners, and always check backgrounds and assess them.
- Don't use stereotypes (race, gender etc) to wrongly raise risk level. Don't use cultural/class relativism to wrongly minimise it.
- Family's physical environment: is it safe, child-friendly eg food available, clean, no hazards, children's equipment/toys?
- Look for signs of family strength and child's resilience to build on - but avoid the rule of optimism.
- Risks increase at weekends/bank-holidays - plan for this.

www.slough.gov.uk
Slough Borough Council

- Always review and revise assessments and plans in light of new information or new significant events.
- Be alert to unexpected or increasing parental 'cries for help' - these can indicate imminent risk of harm.
- 'Feigned compliance', 'flight' or 'closure' mean family, especially child, unavailable to staff. Increases risk.
- Risk increases when workers leave or cases transfer.
- Address the likely impact of any harm arising from risks if these are not minimised. A medium risk might still mean a high impact on a child.
- Address the costs and benefits to the child and family of intervention as opposed to no, or less, intervention.

Parents' attributes – positive and negative

- Parents' evident ability to see the world from the child's perspective ("mind-mindedness"): positive if present, worrying if not.
- Parents' evident ability to have consistent positive regard for child - positive if present, worrying if not.
- Parents' own relationship - positive or negative?
- If parents say child deliberately causes bad behaviour/difficulties, or harm then risk increases. Especially if child pre-teen.
- Parent/carers' own developmental history from childhood onwards - positive or negative? Ex-LAC can increase risk.
- Parents' own 'un-met' need - how much does this reduce their ability to prioritise child's needs?
- Patterns - avoid seeing incidents in isolation: do chronology of positive and harmful parenting actions.
- Parents' real engagement, or not, with professionals ie not feigned, not 'flight', not close-down. Needs to be real.
- Parents' acceptance or not that their behaviour needs to change; otherwise, be extra vigilant to risks.
- Parents' usual mood - realistically hopeful, content, sociable, or unrealistic, hopeless, idealised, miserable, anti-social, angry.
- Parental support - what resources or people are available and used 24/7, material and human, professionals and kin?
- Stressors and dis-inhibitors: money, attitude, drugs/alcohol, ill -health, people ('bad influence/draining'), victimised, life-crises.

Child's attributes – positive and negative

- Child's own view/reports of care received.
- Evidence from child's PIES - physical appearance/progress, intellectual progress, emotional state, social life - positive or not.
- Child's age - does this make child safer or not?
- Child's level of need eg high dependency owing to complexity, disability, compromised health can increase risk.
- Child's usual demeanor -content, cheerful, appropriately reserved: or sad, disengaged, inappropriately friendly?
- Child's observed response to parent - does child respond positively, or is s/he demanding, challenging, fearful, watchful?
- Child's evident resilience.
- Frequency of child's contact with a protective, nurturing adult professional or kin - much contact is positive, little is negative.
- Child's evident boundaries - appropriate or not.

Think the 'un-thinkable'

Case management and supervision
Start with the child, stay with the child

- Use critical reflection/Kolb cycle to understand what informs practice and decisions on the case.
- Follow procedures.
- Record as per procedure.
- Know the difference between actuarial and clinical risk assessment. Neither is 100% predictive. Know the difference between static and dynamic risk factors. Read some risk management literature.
- When working with abusers, don't be a rescuer (eg 'they're blameless as they suffered as a child too') or a punisher (eg 'we're going to get him'). Both will cloud judgement of risk.
- Ask what to do in a case if unsure, don't plough on through pride, or fear.
- Avoid groupthink. Play Devil's Advocate in a safe way.
- Acknowledge fear of getting it wrong or fear of users (including physical/psychological threats) and manage it.
- Staff can accommodate abusive behaviour/suffer 'Stockholm-syndrome too': watch for this and manage it.
- Be mindful of unexplained, unrealistic changes in workers' (managers') position re risk in a case. Unpick why if evident.
- Always check if personal life events are impacting negatively on a worker's performance or management of risk Be ready for cases resonating with your own or workers' history and manage this.
- Always factor in signs of family strength and resilience.
- Always ask about the child's presentation/views.
- Avoid 'White Coat syndrome' - don't defer to powerful colleagues' judgement of risk if they cannot or will not explain basis for it.