

Needs and Risk Assessment Framework for Children's Social Care

(Please note this document is not operational before 14 October 2013)

1. Introduction

Our starting point is the Working Together 2013 statement of the principles underpinning our work to safeguard and promote the welfare of children. All of the principles and guidance in this framework are underpinned by training for staff and supported by a range of practice tools.

Child centred

The child should be seen (alone when appropriate) by the lead social worker in addition to all other professionals who have a responsibility for the child's welfare. His or her welfare should be kept sharply in focus in all work with the child and family. The significance of seeing and observing the child, with and without carers, cannot be overstated. With vulnerable parents, those with learning difficulties or substance misuse issues for example, it is understandable that professionals look to their needs especially because this will be at the forefront of the parents' minds. We must walk in the child's shoes, and understand what it is like for the child to live with such vulnerability. Some of the worst failures of the system have occurred when professionals have lost sight of the child and concentrated instead on their relationship with the adults.

Rooted in child development

Those working with children should have a detailed understanding of child development and how the quality of the care they are receiving can have an impact on their health and development. They should recognise that as children grow, they continue to develop their skills and abilities, so the same event affects the risk to them in different ways.. Plans and interventions to safeguard and promote the child's welfare should be based on a clear assessment of the child's developmental progress and the difficulties the child may be experiencing. Planned action should also be timely and appropriate for the child's age and stage of development.

Focused on outcomes for children

Any plan developed for the child and their family or caregiver should be based on an assessment of the child's developmental needs and the parents/caregivers' capacity to respond to these needs within their family and environmental context. The plan should set out the proposed outcomes for the child; progress against these should be regularly reviewed and the actual outcomes should be recorded – did we succeed in reducing risk? The purpose of all interventions should be to achieve the best for each child, recognising each child is unique. Each risk should clearly identify the danger to the child that will be prevented as a result of the planned intervention, and how this will happen.

Holistic in approach

This means having an understanding of a child within the context of their family (parents or caregivers and the wider family) and of the educational setting, community and culture in which he or she is growing up. The interaction between the developmental needs of children, the capacities of parents or caregivers to respond appropriately to those needs,

the impact of wider family and environmental factors on children and on parenting capacity, requires careful exploration during an assessment.

The ultimate aim is to understand the child's developmental needs and the capacity of the parents or caregivers to meet them and to provide services to the child and to the family members that respond to these needs. The child's context will be even more complex when they are living away from home and looked after by adults who do not have parental responsibility for them.

Ensuring equality of opportunity

The most vulnerable children are at greatest risk, because:

- **they are more likely to suffer harm** (for example neglect of the health needs of a disabled child will have greater impact);
- **they create additional pressures on parents** (for example, the challenges faced by parents with a new baby and how this impacts on their parental behaviour)
- **they are targeted by people who harm children** (children who are already vulnerable are more vulnerable to predatory sex offenders)

We must think about how children might be vulnerable, the systemic issues that increase this risk, and what can be done to counter this.

Involving children and families

In the process of finding out what is happening to a child it is important to listen to the child (both through observation and conversation), develop a therapeutic relationship with the child and through this gain an understanding of his or her wishes and feelings.

Practitioners should use a range of age appropriate tools to engage the child in describing their day to day experiences, hopes and feelings and these should be referenced in all assessments, including how the child's views will be addressed in the resulting plan.

The importance of developing a co-operative working relationship is emphasised so that parents or caregivers feel respected and informed; they believe staff are being open and honest with them and in turn they are confident about providing vital information about their child, themselves and their circumstances. The consent of children or their parents/caregivers, where appropriate, should be obtained for sharing information unless to do so would place a child at risk of suffering significant harm. Similarly, decisions should also be made with their agreement, whenever possible, unless to do so would place the child at risk of suffering significant harm. This includes being clear and transparent about working hypotheses and how these are being tested and evaluated.

Building on strengths as well as identifying difficulties

Identifying both strengths (including resilience and protective factors) and difficulties (including vulnerabilities and risk factors) within the child, his or her family and the context in which they are living is important, as is considering how these factors are having an impact on the child's health and development.

Too often it has been found that a deficit model of working with families predominates in practice (i.e. just seeing what parents/carers do wrong) and ignores crucial areas of success and effectiveness within the family on which to base interventions. Working with a child or family's strengths becomes an important part of a plan to resolve difficulties.

Integrated in approach

From birth there will be a variety of different agencies and services in the community involved with children and their development, particularly in relation to their health and education. Multi- and inter-agency work to safeguard and promote children's welfare starts as soon as it has been identified that the child or the family members have additional needs requiring support/services beyond universal services, not just when there are questions about possible harm.

A continuing process not an event

Understanding what is happening to a vulnerable child within the context of his or her family and the local community and taking appropriate action are continuing and interactive processes, not single events. Assessment should continue throughout a period of intervention and intervention may start at the beginning of an assessment. Crucially, a good assessment which fully engages the family and the child can in itself begin and support a change process and can therefore be an integral part of intervention.

Providing and reviewing services

Watch out for poor assessments that just recommend 'further assessment', without the action to support the child in the meantime. Action and services should be provided according to the identified needs of the child and family in parallel with assessment where necessary.

It is not necessary to await completion of the assessment process. Immediate and practical needs should be addressed alongside more complex and longer term ones. The impact of service provision on a child's developmental progress should be reviewed at regular intervals and should always be included in the evaluation of risk – what impact will the removal of services have on sustainable improvement in the child's life chances and safety?

Informed by evidence

Effective practice with children and families requires sound professional judgements which are underpinned by a rigorous evidence base, and draw on the practitioner's knowledge and experience. Decisions based on these judgements should be kept under review, and take full account of any new information obtained during the course of work with the child and family.

2. Towards a single assessment

Initial and core assessments miss risk as an ongoing process. We need a child focussed single assessment process which meets the timescale for the child and is holistic in nature. The single assessment format, with relevant fields for the nature of concerns and both risks and needs as key requirements ensures consistency of approach to all children who are referred to, or who are receiving a service from the services in the area. Where the key issue identified is a danger or risk of significant harm to a child then the risk assessment tools linked to the framework **must** be used. In **all** cases, the **stepwise** model for assessment should be used.

3. Using this framework

This assessment framework should be applied for all assessment and case planning in relation to children, young people and families from the outset of referral or who are in receipt of services from the department. It provides a consistent framework for the identification, analysis and management of needs and of risk to children and young people, and should be read in conjunction with the Supervision Guidance, and the Quality Assurance Framework.

Where abuse or neglect of a child is known or suspected, the child protection procedures must be followed, and the risk assessment tools provided within this framework used to evaluate and manage the nature and level of risks to inform any child protection plan.

The same tools should be used to assess risks to children who are in receipt of other services, to ensure that their welfare is being promoted in line with the departments practice standards, and the achievement of best outcomes for those children.

Professor Eileen Munro's *Review of Child Protection – A child centred system*, acknowledges that risk and uncertainty are inherent in social work, and that organisations must move from 'risk averse' practices and processes, to those which are 'risk sensible'. That is, to systems which support the exercise of professional judgement, evidence informed practice, and critical appraisal skills, and which require professionals to work together with children and their families to understand their experiences and to engage them in finding and implementing solutions, wherever possible. Munro outlines in her earlier work, the key skills and knowledge required for professionals to operate in a safe and effective way, as follows:



- **Values:** all practice takes place in an ethical framework including, for example, consideration of the balance of rights and needs and awareness of discrimination in all its forms.
- **Reasoning skills:** ability to reflect critically on one's practice; and reason from a basis of experience and knowledge. Ability to understand the balance between intuition and analysis in one's own decisions; and the ability to make a conscious appraisal of risks and benefits flowing from actions.

- **Emotional wisdom:** awareness of the emotional impact of the work on oneself and others and the ability to deal with this and to use it as a source of understanding about behaviour of children, families, self and other professionals.
- **Practical wisdom:** folk psychology, social norms, cultural diversity; a combination of everyday skills and wisdom with enriched skills drawn from training and practice experience.
- **Formal knowledge:** Law, policies and procedures and theories; empirical research evidence drawn for example, from training and reading.

These skills underpin the effective assessment, analysis and management of risk of significant harm to children and young people and form the basis of training and staff development to support staff in utilising this framework.

The nature of risk

In risks affecting society as a whole, personal factors tend to play a minor role in judgement, because the impact of decisions is much more remote. Where the impact of decisions directly affects us, we are of course much more subjective in our judgements and this can overshadow 'objective' assessment - a key criticism made by many serious case reviews.

People are generally more averse to risks which are immediate, than to those which are long delayed. This is a factor in assessments of risk of physical abuse, where there is a possibility of immediate and visible injury, versus neglect, for example. Research highlights the fact that agencies are less effective in dealing with the latter, but also highlights the impact of intervention or the lack of it on the long term outcomes for children.

Individuals have a strong, but unjustified, sense of subjective immunity! They tend to under-estimate risks which they imagine to be under their own control, assume they can deal with familiar situations, and underestimate risk of events which are rarely expected to happen. That is, we engage in denial about risks due to our own subjective reality, rather than the facts before us. For Social Workers, this is translated as the 'rule of optimism', where we ignore signals which should alert us to dangers within families, and allow ourselves to be influenced by our own hopes for positive outcomes.

This means accepting that not all risks can be managed, and that indeed, risk is a positive aspect of life which enables children to develop positive coping skills and independence as they grow into adulthood. It is for this reason that the Children Act 1989 links 'risk' to the actual or likely significant harm of a child: the question of whether harm suffered by a child is significant relates specifically to the child's health and development. Their health or development should be compared with that which could reasonably be expected of a similar child and the parenting that we would reasonably expect them to receive from their parent or carer.

4. Slough's Needs and Risk Assessment Framework

There are many models for needs assessment and analysis of risk and a great deal of research evidence on what actually works for families in differing situations. Many of these have merit, and have a range of practice tools which can aid practitioners in identifying and meeting the needs of children and in identifying and managing risk, together with other professionals, children, young people and their carers.

In order to provide consistency of experience for children, and to support the on-going development of effective and reflective practice in Slough, this framework draws on a number of these models and provides guidance for all staff in how to proceed from initial referral to analysis and planning, and to effective and positive risk management, drawing on different evidence based approaches for different types of abuse.

The framework takes as it's starting place, *the Framework for the Assessment of Children in Need and their families, updated by Dalziell in 2011* to highlight the analysis of risk which was not clearly embedded within that framework. It uses the **step wise approach** developed by De Mello and Yuille and highlighted in Calder and Hackett's *Assessment in Child Care*, (2003). This model is the framework for all assessment work, and provides a clear and structured approach for all managers and staff.

Underpinning the approach to risk assessment and planning, are analysis tools for all child protection work – Paul Brearley's Hazards and Dangers approach, and the use of the risk and vulnerability matrix developed in the *Child's World*. For neglect and emotional abuse, practitioners are directed to the Salford Graded care scale, and for sexual abuse, to David Finkelor's 4 preconditions to offending, the offending cycle, and the impact on children, as identified in the work of Ray Wyre, Marcus Erooga, and the Lucy Faithful Foundation.

Reference is also made to the use of the *Signs of Safety* approach developed by Edwards and Turnell, and also to the use of motivational interviewing as a means of engaging with families and with young people.

However, the provision of this framework does not replace the professional responsibility of practitioners to keep themselves updated in relation to evidence informed practice and the further development of their own skills and knowledge in order to support effective professional judgement and practice wisdom. Managers and practitioners will also develop and use their own tools for direct work with children and their families which add to the evidence base for individual assessment, and the department encourages staff to share these with senior managers and to link them to this framework via the intranet to support the continuous development of best practice.

5. Recording risk – the Slough Needs and Risks Assessment Table

Write down the things you are worried about. We tend to focus on the most immediate risks – be analytic and note the other issues too: these risks sometimes have the most impact (for example, it is believed as many children die from neglect as from physical abuse, yet we still focus on the 'blue light' work). We are also not always there for families – we change jobs, we have other priorities, the case is closed and then allocated to someone else. Our written record ensure continuity for the family in both service and awareness of the risks we have seen.

Begin from the beginning: From the first referral, record the risks as you go. We have designed the Risk profiling table to be there at each step of the way – referral, assessment, each element of the child protection process, supervision/management discussion, review, closing summary.

Your risk assessment will guide your plan: Evaluate and re-evaluate in the light of emerging information. Think about what needs to be done to build on strengths where possible, and remove risks where required.

Think about the child: The risk profiling table applies to each specific child. You must think about the specific impact of a risk on each child in a family. For example, being left home alone impacts very differently on 15 year old, 5 year old and 5 week old children.

The Risk profiling table is a place to summarise the risks you identify in the Stepwise approach (see section 6) and is summarised by the following questions:

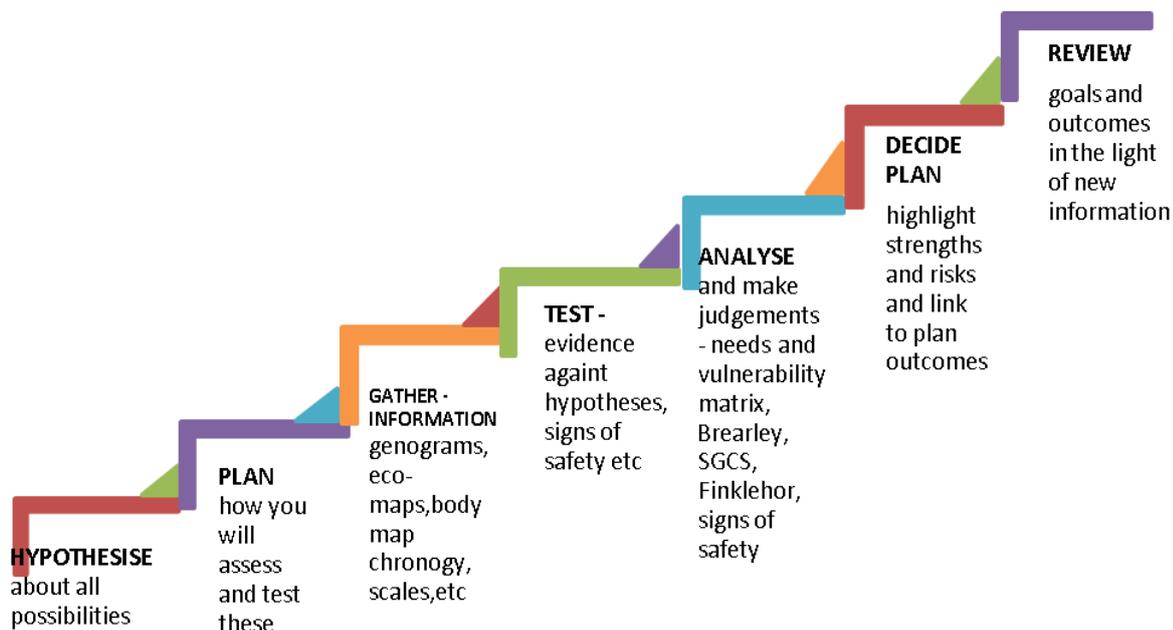
- Enter the date and the source of the information
- What am I worried about – specify the thing that gives you concern in very brief terms. This helps quickly appreciate the range of risks to a child. For example:
 - Physical
 - Sexual
 - Neglect
 - Emotional
 - Domestic abuse
 - Risk to staff
 - Health
 - Parenting Capacity
 - Parental mental health
 - etc
- Impact:
 - Very significant harm – high levels of acute harm
 - Significant harm – s47 criteria met
 - Harmful – action that is not good for a child’s welfare but does not meet the criteria for significant harm
 - Low – issues that warrant making a note of but are not harmful
- Likelihood:
 - Imminent – issues that will happen very soon without intervention
 - Very likely – issues that have a high likelihood
 - Likely – you believe this risk may affect the child
 - Suspected – you have insufficient information to decide, but recognise there is a real risk
 - Possible – you do not suspect there will be harm, but the likelihood warrants making a note
 - Low – everything is possible, but there is no appreciable chance
- Chance of change
 - Predisposing/static
 - Situational/dynamic
- Detail - enter the detail of the risk from the source (this can be cut and pasted).
- Analysis – what is there that exacerbates (e.g. access to the child) or mitigates against the risk (e.g. strengths)? If you identify strengths reduce the impact or likelihood accordingly.

- Action – note any actions you identify that may change the risk assessment. For example, to ascertain whether the carer is aware of the risk and effective in countering it, or to see whether the young person will reduce their drug use with the support of the local team.

6. THE STEP WISE APPROACH

Slough has adopted a model developed by Reconstruct Ltd. based on work by Eric DeMello and John Yuille, called “**stepwise**”, see diagram below. This illustrates the steps which any assessment team will need to follow to produce an effective assessment of needs and risks and a plan that positively manages risks and meets the identified needs in a way which is appropriate to the individual child and family concerned. The use of the term ‘team’ refers to the professionals and the family members who will together carry out the assessment and then implement the plan, together with the family and family network. It also includes the social work manager who must ensure that the assessment and plan are sufficient to manage the identified risks to the child concerned, and to meet their needs. Supervision is a key tool in which each of the steps can be evaluated, hypotheses discussed, and evidence tested.

Where risks or needs are immediate these steps can be taken very quickly in order to secure the immediate safety of the child, which must take priority. The steps then provide a structure for reflection and proper analysis leading to an effective longer term plan.



STEP ONE: HYPOTHESISE

The word *hypothesis* has its origins in ancient Greek and means ‘a *proposed explanation for a phenomenon*’ (Wikipedia – online dictionary). In modern day usage, a hypothesis is a provisional idea or explanation which has to be evaluated or tested. The idea needs to be either confirmed or disproved. The hypothesis should be ‘falsifiable’, which means it is possible for it to be shown to be false, usually by observation. Even if confirmed, the hypothesis is not necessarily proven, but remains provisional.

Hypothesising is a core activity within social work assessment. Holland (2004) states: *“The cornerstone of analysis in assessment work might be seen as the process of building hypotheses for understanding a family situation and developing these until they include a plan for the way forward.”*

This process of building, testing out and discarding hypotheses starts at the earliest point of contact. As soon as a referral is received into a social work team the practitioner will begin consciously or unconsciously to form some hypotheses of what is happening within the family. They would certainly check out some of their hypotheses during an initial conversation with the referrer and may even ditch one or more of them at this stage. The formation of various hypotheses and the decision taken about the steps needed to investigate the matter further will be influenced by a range of factors, for example: practice wisdom, personal values, and formal knowledge.

Munro highlights the fact that *“The single most important factor in minimizing errors (in child protection practice) is to admit that you may be wrong”* (Munro 2008: 125).6

In risk assessment Raynes in Calder and others (2003) suggests that workers often remain narrowly focused on proving or disproving whether the original risk or perception about a family remains and fail to consider the broader picture, or alternative hypotheses about what is happening and why. Practitioners should therefore consider **all** the possibilities about what is happening and address each hypothesis, only discarding it when there is clear evidence to do so.

Stepwise requires that this is considered as part of a structured approach and that forming, testing out and discarding hypotheses needs to be a clear and recorded part of any assessment process.

The practitioner should record the possible hypotheses to which they are working and this needs to be done in a way that shows a) it's only a hypothesis not a conclusion, and b) that it's a reasonable hypothesis based on information to hand at that time (including research info) in order to avoid any later suggestion of bias/premature judgement. Planning the nature and source of information to be collected, should enable practitioners and managers to test out all possible hypotheses in the analysis stage, to prove or disprove the likelihood of one of them being the case in this situation. This will require use of the analysis models underpinning this framework.

In essence, at this step, practitioners should be asking: *“What are we worried about? What is the possible danger or harm to the child?”* *If our hypotheses are correct, what needs to happen?”*

Record the risk you identify in your hypotheses in the Risk profiling table in the section about what you are worried about. Note the type of risk and the potential impact on the child. Record how worried you are (e.g. **suspected**, where you need to find out more but are concerned there is a likely risk). Is this a predisposing (fixed/enduring/static) risk or something you are more likely to be able to change (situational/dynamic)

Where hypotheses relate to actual or likely abuse of a child, the child protection procedures must be followed, and the assessment planned as part of a strategy discussion or meeting.

STEP TWO: PLAN

All assessments require planning, which addresses how the assessment, including risk assessment, will be conducted. This includes agreement not just on how workers will assess the family but also how they will work together effectively with others. 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 combined skills and knowledge of other agencies, and how they can support and complement one another's work. Assessments should be multi agency, and should draw on the information held elsewhere, and on the child's records, if these already exist.

Briefly note any plan to address a specific risk in the actions section of the Risk profiling table.

Understanding the impact of current concerns and risks must include an understanding of the history and therefore the significance of current events in the child's life experience. Building and accessing a good chronology, and using this to inform current analysis is central to good risk assessment. *(this could link to guidance on chronology writing and on the chronology on protocol)*

Planning for the assessment must relate to the working hypotheses identified in step one, and identify what information must be collected to disprove or evidence the validity of one or more of these. Planning in itself, with other professionals may lead to one or more of these being discarded and at the next step it will be important to clearly identify for parents and other professionals what working hypotheses are now being explored. For example, in relation to suspected or alleged sexual abuse, the hypotheses may include

The child is being sexually abused by X – or by someone else

The child (or someone else) has said or done something which is being misinterpreted

There is inappropriate handling or poor boundaries

The child is experiencing other forms of abuse or difficulties

The assessment will then need to focus on what information is needed to test out these hypotheses, and given that it is potentially a child protection issue, this will need to be planned via a strategy discussion unless initial enquiries at the referral stage clearly evidence that the sexual abuse hypotheses are not valid. Child protection procedures should be considered.

Where the child protection hypotheses are validated, or cannot be discarded as a result of initial assessment and action, following the step wise approach, an initial safety plan must be put in place for the child up to and including the convention of a child protection conference. The risk assessment tools outlined in the analysis step should be used to underpin this.

Where the child is subsequently made subject to a child protection plan, risk assessment and action is managed through the core group. The initial child protection conference should determine the overarching plan, and the core group will take this forward, ensuring that risks continue to be evaluated and the impact on the child assessed as the plan develops and is reviewed.

Timescales

Everyone involved, including the family, should be clear about how long an assessment will take and what is expected of them at different stages. This will be particularly relevant when mandatory government timescales are removed, and we adopt a local assessment framework. The following factors should underpin all decisions in this planning stage:

- *Decisions about the child should not be unnecessarily delayed and immediate risks must be acted on in a proportionate manner*
- *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 and management of identified risks 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*

Where the primary purpose of the assessment is risk assessment, the time scales will be dictated by the child protection process, and reference should be made to the pan Berkshire child protection procedures.

Where the focus is on needs assessment and danger or risk of significant harm to the child has not been identified as an issue, the timescale will be identified by the team around the child, in agreement with the family and the social work team manager.

Evaluating parenting skills

It is important that the family and the professionals involved in the 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. The use of the tools underpinning this framework should be openly shared with the family, to enable them to contribute their views and to influence the outcome, including being clear about what is expected of them and why. We must explain what we want to do unless to do so might compromise a child's safety or compromise a criminal enquiry.

Andrew Turnell and Steve Edward's *Signs of Safety* model provides a method of engaging families in understanding what is needed to keep their child safe and to clarify their involvement and the expectations of agencies. At its simplest this can be understood as containing four domains for inquiry:

1. What are we worried about? (Past harm, future danger and complicating factors)
2. What's working well? (Existing strengths and safety)
3. What needs to happen? (Future safety)
4. Where are we on a scale of 0 to 10 where 10 means there is enough safety for child protection authorities to close the case and 0 means it is certain that the child will be (re) abused (Judgment).

What we are worried about, that is our hypotheses and our supporting evidence, must be shared with the family and their views sought about what these mean to them, and what they think professionals would need to see to be confident that the dangers and risks to their children are being managed and reduced.

This involves a skilful approach to families, which moves from simply sharing information and telling families what must change, to appreciative enquiry – seeking to understand the family context and perceptions, and asking them, given what professionals are worried about, they think they need to do or can do to reassure professionals about that information and their child’s welfare. Practitioners will need to demonstrate their willingness to understand the family perspective whilst maintaining clarity about the actual and possible danger to the child and what actions the department will need to take if this is not resolved. Central to this is the direct work with family members, and with children to understand and challenge family dynamics and behaviour, and transparency about the actions and intentions of professionals. Further guidance is available in the tools section of this framework.

Where neglect is suspected or actual, the Salford Graded Care Profile should be completed with the family over several sessions. Similarly, the use of Finkelhor’s four preconditions in sexual abuse can be very helpful in educating potentially protective parents in the initial stages of risk assessment and in working with them to protect their children in the longer term.

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 and protection so that the family can understand what is expected of them, what they will have to do to meet those expectations, and what are likely to be the thresholds for children no longer needing a child protection plan, or in some cases, for 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 a child protection 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

Turnell and Edwards state that;

“Constructive relationships between professionals and family members, and between professionals themselves, are the heart and soul of effective child protection practice.”
(2010:18)

Similarly, Munro’s principles for a child centred system include ‘working with families’. This means being clear with them about concerns and risks and, through, for example, motivational interviewing, and ‘signs of safety’ interview techniques, engaging them wherever possible in identifying and putting into place the measures that will keep their children safe.

The models adopted by Slough are based on transparency about our needs and risk assessment approach and this will support a relationship from the outset in which the safety and wellbeing of children is the paramount concern, and where families, and carers, are enabled as far as possible to play an active part in assessing and managing the actual and likely risks to their children.

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 and Diversity issues

The impact of equality issues needs to be considered throughout the assessment process. Anti-discriminatory practice involves; empathy, allowing children and families to explain their circumstances, 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.

A good assessment will use a diversity model and will address these issues. - see **Practice Guidance for safeguarding children in minority ethnic culture and faith (often socially excluded) communities, groups and families** published by the pan London Safeguarding Children Boards, 2011, and available on the intranet.

STEP THREE: GATHER INFORMATION

Information for the assessment should be gathered from all adults who are significant to the child (including separated or estranged parents depending on the specifics of the case), plus, of course, from the child. The assessment team will need to be clear about who, when and why they are approaching people. Issues of confidentiality and consent will need to be addressed as per the pan Berkshire Child Protection procedures.

There are a range of tools available to assist workers in gathering information, many of which can be used equally well with adults and children, but which 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. Key to all of these is the role of direct observation of the interaction between family members and the quality of care given to children. The Salford Graded Care scale places huge emphasis on this, and regardless of whether this specific tool is being used, it is crucial that practitioners note their observations and use these as part of their evidence base when forming judgements in the analysis stage of assessment. Clarity about the interpretation of observed action can also form the basis of helpful, if challenging, discussion with parents about what needs to change and why.

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.

Information gathering tools

The use of **genograms** (or family trees) is a particularly helpful way to engage families and 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. Once the process is completed with the family, a neat version should be produced on the child's record.

Eco-maps are also a useful visual tool but should not be seen as a static record of the child or families eco-system. Family relationships change - children may feel hostile towards a parent one week and have resolved the conflict the following week. Therefore eco-maps should be undertaken on a number of occasions to map the changes. It is preferable, particularly when working with children not to draw eco-maps 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 assess their own situations.

Scales, and questionnaires - To accompany the Assessment Framework, the Department of Health developed a number of models, scales and questionnaires for social workers to use in their work with families, children and adolescents. These can form part of the workers 'tool box' to help assess different aspects of risk, neglect, emotional abuse, resilience and vulnerability, as well as models of change and are available on the intranet.

The use of these tools will assist analysis later in the stepwise model.

STEP FOUR: TEST AND EVALUATE

This stage of any assessment, and particularly risk 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 which details this but fails to evaluate the information or draw conclusions. This step requires asking: *"Is my information right? Have I missed anything? Do I understand correctly- or have I misunderstood something? Have I proven or disproven one or more of my hypotheses about what is happening and am I now in a position to state what is actually evidenced or still of sufficient concern for me to be worried about possible danger or harm to the child?"*

Although it is usually only the social worker who evaluates the information gained through a risk assessment, this is not good practice as inconsistencies, different interpretations of evidence gathered and differences of opinion may only come to light as the assessment report is being presented to parents, other professionals, a conference or a court. Following this testing step at this stage will support a more accurate analysis which parents and other professionals are able to understand as they have been engaged in proving or disproving the hypotheses about danger or risk of harm and know what the areas of disagreement and consensus are likely to be.

Each hypothesis should be tested against the evidence gathered and the findings of the assessment must be evaluated by the 'team' including the family. The analysis of risk should then be undertaken jointly with them, unless this places the child in greater danger and/or there is immediate risk which needs to be addressed through emergency action, as outlined in the child protection procedures. Emergency action to protect should not however remove the need to follow the step wise process once the child is in a safe place.

Professional supervision will also provide the opportunity for practitioners to reflect on the evidence and it's relevance to the initial hypothesis and resulting analysis of risk. At this stage, the practitioner should be using the theoretical models outlined below as a frame of reference, and checking back with others about the validity of their hypotheses and conclusions and the accuracy of the data collected.

STEP FIVE: ANALYSE

Children in Need

All children who are in Need as defined by the Children Act 1989 will have some needs which require assessment and potential support and those needs should be analysed within this model, which is based on the *Framework for the Assessment of Children in Need and their Families*. Needs may also include needs for protection, and where these are identified, at any stage in an assessment process, the risk assessment tools outlined below must be used.

Needs assessment must also focus on this specific child's needs in these specific circumstances – they should not be couched in terms of services, or generalised statements such as 'needs to be safe, to achieve etc.'" All children need to achieve the 5 outcomes outlined in the Children Act 2004, but intervention and support must focus on more specific, localised needs which will identify and build on the strengths and protective factors already present in the family and community network, and which will eventually enable the child to achieve good outcomes with the support of universal services.

For example, the child may have developmental and speech delay. Their *needs* are not necessarily for speech and language therapy, but are to be able to communicate with adults and peers. This can be achieved in a number of ways which might include speech therapy, but might not! Quality time with parents may suffice together with support for parents in reading and talking to their child.

Research is continuing into what make some people, including children, able to weather adversity and misfortune while others become hurt and damaged by the same experiences. This has led to the concept of 'resilience' as a key characteristic which can be identified and developed in children, and in their support networks, to ensure that they have the best possible life chances. 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 3 domains of the *Framework for the Assessment of Children in Need and their Families*.- child development, parenting capacity, and environmental factors.

Child

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

Parent or /carer

Sources of vulnerability	Sources of resilience
Domestic violence	Social support
Serious substance misuse	Positive parental childhood does this mean own childhood?
Chronic serious psychiatric illness	Good parental health
Severe learning disability	Good relationship with sibling
History of victimisation – abused as a child	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	
Inter generational cycle of abuse	

We could link the framework to our guidance on the toxic trio at this point??

You should also use the tools available with this framework to consider the following questions when assessing resilience 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 likes others and takes pleasure in doing things that make them be liked in return.
- The child believes in power greater than seen – has a conscience or sense of right and wrong .
- 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.

The outcome of analysis should be to establish:

What are the dangers to the child?

What are strengths in the family, and wider network that might prevent that danger from happening?

What needs to happen to meet the child's needs and to achieve the desired outcome – the prevention of the danger happening?

How will we know we have made a positive difference – what are our success factors?

If we are evaluating the impact of a plan,

What difference have we made? How do we know the danger has been averted?

Has anything else changes, and if so, what impact does this have on our analysis?

This discussion should be held by the core group, the team around the child, in supervision or initially between 2 workers and then shared with the core group or with

other involved professionals in order to produce as 'objective' an outcome as possible. The matrix diagram available on the intranet could be used to facilitate this discussion

Risk analysis

Risk analysis can be defined as '*establishing the likelihood that a particular event will occur*'. Much of the work is therefore necessarily the collection of information which will enable the professional to make a predictive judgement about risk in particular families. However, the most difficult aspect of this process has always been the analysis of the information collected - What weight are we to ascribe to particular factors?

In risk analysis, whilst the risks and vulnerability model referenced above provides a useful basis for assessment, the relevant tools outlined below should also be used.

Physical Abuse, Neglect, Emotional Abuse and Sexual Abuse

Paul Brearely: Hazards, Dangers and Protective Factors

This model is based upon a set of questions developed by Paul Brearley and used initially in risk assessments carried out by the NSPCC. By considering the possible danger and then dividing the hazards – the things that might cause the danger to occur – into two types, workers and the family are helped to examine the processes which may lead to a child being harmed, and to consider how this might be avoided. It is consistent with the approach taken by the Assessment Framework as it focuses upon both adverse and protective factors in the family and community networks that might heighten or reduce the danger to the child. It also encourages professionals to identify gaps in information and their implications for child safety.

The following steps should be taken:

1. Summarise the information which you have collected in relation to the factors present in each area being assessed, i.e. child's developmental needs, parenting capacity, family and environmental factors.
2. List the dangers – what are we worried about in relation to the danger of harm to the child. This should be specific, for example, that y will be/is being neglected by mum/dad, y has few friends and is becoming isolated and introverted, is vulnerable to strangers and may be sexually exploited, engaged in criminal activity etc. The *danger is something you want to avoid, so what possible events would you fear in these circumstances?* Consider not only the significance of these dangers, but the chances of them occurring
3. List the hazards in the case and divide them into two - *a hazard is something which might result in the danger being realised, or which increases its likelihood - something which brings about the danger you want to avoid - refer to the adverse factors in the Assessment Framework.*
4. Hazards should be divided into those which are predisposing, or **static**, and those which are situational, or **dynamic**.

- predisposing hazard - *something which creates vulnerability and therefore makes the danger more likely. It may need to be activated by something else, such as a situational hazard*
- situational hazard - *this is something which happens, and which has an immediate effect directly related to the danger*

Predisposing hazards (static factors) are the sort of risks which are factual, and usually fixed at the time of the assessment, for example, the child is under 5 years old and has special needs, or a child has been sexually abused (and is therefore vulnerable to further abuse).

Situational hazards (dynamic factors) are more dynamic, and concern events or developments in the case, such as parents stop co-operating, or the protective parent decides to re-unite with the child's abuser, or a parent loses their job and faces debts and stress as a result

The latter are factors which are more likely to be amenable to change, and should be the key focus of the child protection plan. They may also indicate the greatest level of risk. The more hazards identified the greater the level of risk.

Mark your decision in the Risk profiling table as Predisposing or Situational.

Next, list what you consider to be the **strengths** in the case - those **protective factors** whose effects counteract the danger and make it less likely to become a reality.

Now you need to **balance these out**, by making direct links between hazards and strengths and their inter-relationship between the three Domains so that you are making a professional judgement about which strengths offset which hazards. What are the remaining hazards? Can these be offset by the provision of services or by further work? In what way, and upon what evidence do you base your judgement? Unresolved hazards will increase the likelihood of the danger being realised. This will be your risk outcome - is it acceptable? You should also refer to the weighting guide below. The risk assessment format in protocol follows this process through.

Risk Weighting

This involves listing the identified dangers, hazards, risks and protective factors in the relation to each of the 3 Domains of the *Framework for the Assessment of Children in Need and their Families* then ascribing a weight to each factor as follows:

Adjust your assessment of the impact of the impact and likelihood of the risk taking into account the assessed strengths and other factors you have discovered.

Repeat the process including different support services as possible protective factors, and determine whether this lowers the total sufficiently for the core group to agree that the risk is acceptable. You should include in this exercise what the optimum level of service should be, and then repeat it to reflect what is actually available *and used by the family?* How significant is any mis-match?

Obviously the weight ascribed to each factor will be crucial to determining the final outcome, and this can only be a matter of professional judgement based upon our knowledge of research into child abuse and the long term impact of adversity on children.

Research suggests that adverse factors, or risks, within the Domain of Parenting Capacity tend to have a more significant impact than those in other Domains, and that these should therefore be more highly weighted than other factors.

Research is also clear that the greater the number of adverse factors present, the higher the likelihood of poor long term outcomes for children. The advantage of this model is therefore that it reflects the presence of a high number of adverse factors with a high overall score, and therefore will provide a clear indication that intervention is needed to safeguard and promote the child's welfare.

Supervisory guidance should be used to ensure that decisions arising from an assessment are shared, agreed and lead to an appropriate level of service provision and intervention, with clear measurable objectives related to the outcomes sought for the child.

Neglect and emotional abuse

The Salford Graded Care Scale should be used for all situations where actual or likely neglect is the key risk identified in the information gathered to date. It is also helpful in emotional abuse in focussing discussion on the behaviours that demonstrate this so that professionals can be specific about what it is that needs to change. It is designed to be completed with the family, over several sessions, and can be adapted to suit the individual family circumstances and to engage them in discussion and debate about what is reasonable for children to experience. Young people can also be asked to complete it and a comparison made between their perceptions and those of their parents or professionals.

Sexual Abuse

David Finklehor identified four preconditions for sexual offending:

- **Motivation - Predisposition to offending**/ sexual predisposition to children (being sexually aroused by children, sometimes including having an emotional congruence with children which becomes sexually motivated or driven)
- **Overcome internal inhibitors – distorted thinking** (ie. Overcome conscience or moral taboo, self- persuasion that it is not wrong, children like it, etc. Use of alcohol to lower own inhibitions?)
- **Overcome external inhibitors – create opportunity** (groom or manipulate the environment to disempower any protective adult and ensure one does not get caught; consciously or unconsciously put oneself in a position where there are vulnerable children and an opportunity for 'temptation')
- **Overcome resistance** - undermining or overcoming the child's resistance to the sexual abuse (groom and manipulate the child – threats, persuasion, trickery, use of alcohol or drugs)

Finklehor's model has been greatly developed through the work of the NSPCC, Barnados, and the Lucy Faithful foundation and it provides a helpful and evidence based framework

for understanding the experience of the child and the potentially protective parents and network, and therefore a means of evaluating and managing risk.

Some assumptions that can be made

Child Sexual offenders are not an homogenous group. They will cover a spectrum of behaviour and preferences from those who will only offend once, in certain circumstances, against one child, to those who prefer boys, or girls or prepubescent children of either sex, to those who believe that children have a right to sex with adults and have no preference for age or gender. Others believe that they are showing the child 'love'. Whatever the nature of offence, there will be certain similarities which can assist both in identifying the level of risk and in understanding the child's experience, and that of the non-abusing parent.

- The alleged abuser holds a position of power in the family and family network
- All offences are premeditated.
- The role of fantasy and masturbation is central.
- The offender will try to deny all/some of the offence by denial, e.g., justification, distortion, minimisation.
- They will seek to lay the responsibility for the offence elsewhere- usually on the child or the non-abusing parent.
- They will say that the offence is '*out of character*'.
- They will have built up a compulsive cycle of behaviour.
- The offender will say '*I won't do it again*'.
- There is no "cure", only control.

The offender's behaviour will follow the following pattern:



The cycle is characterised by denial, excusing and justifying of behaviour, and the alleged or actual abuser will have followed this cycle and may have done so over a period of years. For prolific offenders, the cycle will be completed in a matter of hours and there may

be minimal guilt following the assault on the child. The important factor for initial assessment of risk is to consider the first stages of the cycle in terms of the level of planning and manipulation carried out by the alleged offender to gain access to the child.

This will give some insight into the experience of the child and the protective adults, as they will have been manipulated to gain their trust and to isolate the child from someone who might protect them, or who will believe them when the abuse is discovered or disclosed.

The child themselves may well also believe that the abuse was their fault, and for many young people, that no abuse has actually occurred but that they have been engaged in a relationship based on 'love'. The abuser will have created in the child fear of consequences, shame, confusion, or loyalty as a result of the 'special attention' which has surrounded the abuse. The child may well mourn the loss of this aspect of the relationship, which has taken the place of a healthy loving parental relationship.

Finklehor also suggests the following categories to help professionals understand the impact of child sexual abuse:

- traumatic sexualisation,
- stigmatisation ,
- betrayal and powerlessness.

Each category includes the process by which the perpetrator sets up the abuse, as well as its impact on the child or young person, and the impact will relate to many factors, including the relationship with the abuser, the length of time, the severity of abuse and the degree of emotional manipulation and betrayal. Every child is different, and every assessment must recognise this and seek to understand the child's experience of the offender cycle.

In assessing risk, the practitioner must also consider:

What is the role of the non abusing parent, if there is one? Are they complicit, or are they potentially protective?

Research and experience tells us that, in the majority of cases, the mother is unlikely to have known, or if they have suspected are unlikely to have been able to cope with the implications this involves. Their initial reaction is therefore most likely to be one of denial and research suggests a reaction which is akin to bereavement – shock, denial, anger, confusion, depression, acceptance.. The non-abusing parent has usually been targeted and groomed – how did they meet? How has the perpetrator undermined the relationship between the mother and her child so that external inhibitors have been overcome?

However, it is also possible that the woman is complicit, or indeed is the main perpetrator, and this hypothesis needs to be considered at the initial stages and either discounted or evidenced to the extent that it is at least, a continuing possibility. Research suggests that women abuse for different reasons than men, and assessment and intervention will require a different emphasis in the longer term. However in the short term the process is the same – to avert the danger of further abuse for the child and to identify safe caring adults who will help the child to recover whilst longer term plans are put in place.

Where there is a non abusing parent, the key focus of assessment and intervention needs to be on rebuilding the relationship between this adult and the child if the family are to heal and recover.

This grooming may have extended to wider family and friendship networks, and also to community and work environments. Potentially protective adults may not therefore believe the child and, as above will experience very powerful emotions associated with bereavement.

An alleged offence in a family, must give cause to questions about the alleged perpetrator's interaction with and access to other children.

These assumptions should form the basis of risk assessment and planning aimed at protecting children in future and repairing the damage to familial relationships in order for the child to be believed and accepted and for therapeutic recovery work to begin.

The risk assessment should consider static and dynamic factors (see earlier comment re these terms), that is, predisposing and situational factors as outlined in the Brearley model.

Offenders

The Structured Assessment of Risk and Needs used by the National Offender Management Service identifies four main domains of dynamic risk factors for the abuser:

- Sexual interest
- Social and emotional functioning
- Distorted attitudes
- Self management

Assessment of the risk posed by alleged offenders and those who are convicted of sexual offences against children must be carried out by qualified and experienced practitioners, and should run alongside the protective plan for the child and work with the protective family network.

STEP SIX: DECIDE THE PLAN

All assessments should lead clearly into a plan which stems from the identified risks and strengths in the family, and should start from the overall goal, that is the prevention of a poor outcome if the child's needs are not met, or in the case of risk assessment, the protection of the child from the identified danger, for example, sexual abuse by X.

It should then list each risk and need, and the action required, by whom and when, to address that risk. This will take the form of key objectives and tasks which must be **SMART**

Specific
Measurable
Achievable
Realistic
Time bound

The principles set out in the previous steps must also be applied, in that the plan must be clearly communicated to all involved and families must be supported to understand what exactly is expected of them, why, and by when.

It should also be clear what level and type of support will be offered to enable them to meet the objectives of the plan, plus what the consequences will be if tasks are not undertaken and objectives are not met.

The Plan will usually be agreed at a formal meeting, either at a child protection conference, a child in need planning meeting, or a core group, and must be owned by all involved.

Child protection chairs will expect to see a completed assessment using the **step wise** framework, and underpinned by the relevant analysis tools for the type of abuse or harm identified as an issue for the child. Where there is more than one danger or type of abuse, the conference should make a decision about what the greatest priority is in terms of risk to the child – this can be identified through use of the Brearley assessment model, which can then be supported by other tools such as Finklehor.

STEP SEVEN: REVIEW

All assessments which lead to a plan for a child will be subject to regular review to ensure that they are making a positive difference to the child and to the level of risk posed to them. Whilst this will usually happen as part of the child protection, children in need or children looked after reviewing process, it is imperative that plans are also reviewed in supervision in the light of any change in the child or adults' circumstances and the impact of this on the identified risk factors and strengths.

Supervision should be proactively used to monitor the progress of risk management plans and to re-evaluate the risk analysis in the light of new information, including, for example, changes in social worker or failure to access or achieve a service which is part of the protective plan.

Child Protection Conferences

All child protection conferences should be informed by risk assessment carried out within this **stepwise** framework, and using the analysis tools which are associated with the identified dangers or risk of harm to the child. This means that all risk assessments will include an analysis using the Brearley model, and will be informed by the following:
Emotional abuse and neglect – the Salford Graded Care Scale
Sexual Abuse – Finklehor

The management of Child Protection conferences will also draw upon the *signs of safety* model and will ensure that all participants, including parents, are clear about:

1. What are we worried about right now? (Past harm, future danger and complicating factors)
2. What's working well? (Existing strengths and safety)
3. What needs to happen now? (Future safety)
4. Where are we on a scale of 0 to 10 where 10 means there is enough safety for

child protection authorities to close the case and 0 means it is certain that the child will be (re) abused (Judgment)⁵.

This will lead to a clear and defined plan focussed on the safety of the child, and on action which is proportionate to the level of concern and identified dangers as evidenced in the assessment.

Initial conferences may require a longer and more in depth assessment using the stepwise approach and the core group should be responsible for managing this and the resulting analysis and recommendations to the review conference.

Risk analysis is a dynamic process and must be continuously reviewed against the framework and models provided here.