



Framework for the Assessment of Vulnerable Children & their Families

Assessment Tool and Practice Guidance

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The
University
Of
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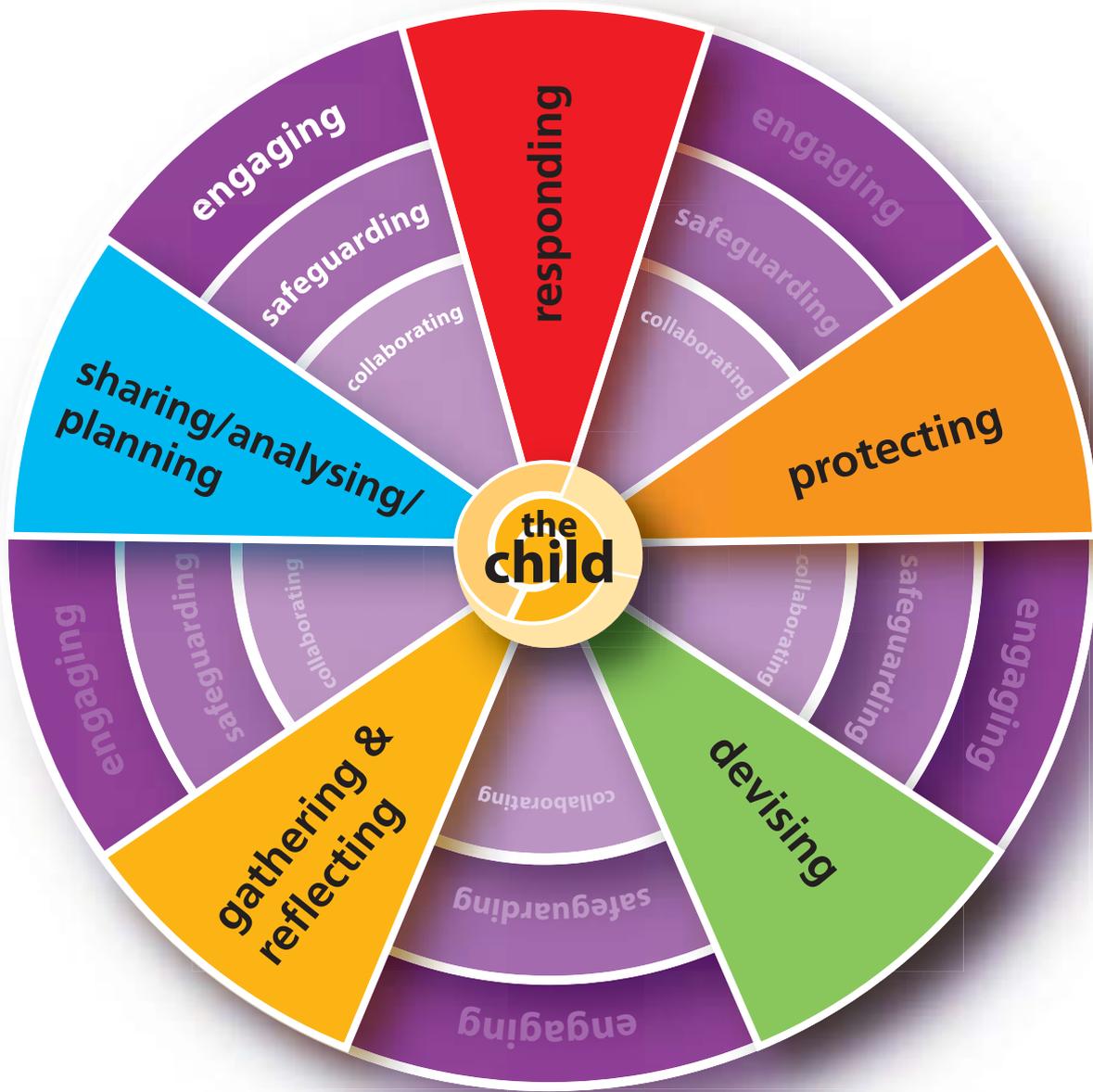
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April 2006

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The Assessment Wheel

Foreword

The Framework for the Assessment of Vulnerable Children and their Families was commissioned by three former health boards - the North Eastern Health Board, the South Eastern Health Board and the South Western Area Health Board (these Boards have now been subsumed into the Health Service Executive). The purpose of the project was to develop a template for assessment that would guide practitioners in responding to concerns about children by gathering information on all relevant aspects of their lives, and analysing this data in order to plan interventions that would promote better outcomes for these children and their families.

The project commenced in January 2002 and was funded for three years. The first nine months were spent undertaking a consultative process with a range of professionals from the three Health Boards with regard to the focus and format of the framework. Based on the information gathered at this stage, and in collaboration with representatives from the three Boards, a draft set of materials, consisting of an Assessment Tool and Practice Guidance, was produced. These were subsequently piloted in five sites during late 2003 and early 2004. An evaluation of the assessments undertaken by practitioners was conducted in 2004. As anticipated, this evaluation highlighted that some aspects of the Assessment Tool needed to be revised, and changes were then made to the original Assessment Framework. These were included in the revised version of the Assessment Framework submitted to the Health Boards in February 2005. However, bearing in mind the brief period allocated for piloting, the research team and the commissioning Health Boards considered that more time would be required to refine the use of the final step included in the Assessment Tool, i.e. the sharing and analysis of the data, and planning suitable interventions.

This document is essentially a work in progress. The Assessment Framework is currently in use in the pilot HSE areas in a variety of service contexts. It is envisaged that after a further period, when more experience of the use of the framework in practice has been gained, the materials will be re-evaluated and further revised before being finalised.

These revisions will take account of practitioners' experiences of undertaking assessments, as well as the systems, structures and training required to support full implementation of the Assessment Framework. Moreover, from the outset, the intention was for the framework to be applicable in multi-disciplinary settings as well as on social work teams. This poses quite a challenge given the different professional roles in the child protection and welfare network. The Assessment Framework is currently being used within the Health Service Executive both as a multi-disciplinary and as a single discipline (social work) approach. It is anticipated that learning from the various contexts and approaches that are now being utilised will further enhance the applicability of the framework and provide information about the structures required to facilitate its use.



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Introduction

BACKGROUND TO THE DEVELOPMENT OF THE ASSESSMENT FRAMEWORK

A considerable body of research has been carried out into child protection practices in different regions of Ireland during the 1990's (EHB/Impact, 1997; Buckley et al, 1997; Ferguson & O'Reilly, 2001; Horwath & Bishop, 2001; Horwath and Sanders, 2003; Buckley 2002, 2003). Likewise, child abuse inquiries have illustrated specific policy and practice issues that impact on the ability of services to protect children from ongoing abuse (Department of Health, 1993; Western Health Board, 1996; North Western Health Board, 1998). The research indicates that major developments have taken place in child care services and shows that a great deal of high quality protective and welfare work is being carried out with children who are at risk of being, or have been, abused. However, some areas of concern have been identified. These include:

- ▶ Disparities regarding the thresholds at which children and families are deemed eligible for service,
- ▶ Tensions between the level of resources invested in family support services as opposed to child protection investigation,
- ▶ Limitations in identifying and providing services for children in 'need',
- ▶ Inconsistencies in the nature of service provision.

For example, there has been a perception that assessment commonly acts as a 'rationing' process, and that services are provided only where evidence of child abuse or potential child abuse exists. There is also evidence that neglect is the most commonly reported and ultimately seriously harmful form of child abuse, but it does not always receive a consistent or child focused response from professionals. The absence of a common and comprehensive method of assessment, and disagreement amongst professionals on thresholds for interventions has tended to reinforce these weaknesses.

While all practitioners working in organisations that provide services to children and families will include assessment as a standard element of their work, the purpose and the nature of assessment may differ depending on the practitioner and service involved (Horwath and Sanders, 2003). However, lack of mutual understanding and inconsistent approaches to assessment can lead to

miscommunication between services and the result can be that families are subjected to repeated interviewing, or some of their needs may go unrecognised or, on occasion, the child may be left unprotected from harm. While assessments may have different aims, it is likely that information collected during the course of one type of assessment could be quite crucial to another. The more standardisation, agreement and consistency that exists between practitioners in relation to methods of assessment and terminology used, the greater the level of mutual understanding between practitioners about the needs of children and the better the potential outcome for children and families.

It was against this background that senior managers within the North Eastern Health Board, the South Eastern Health Board and the South Western Area Health Board, now the Health Service Executive, decided to commission Trinity College Dublin and the University of Sheffield to develop an Assessment Framework for Vulnerable Children and their Families. The purpose of the commission was to develop a framework that enables practitioners to remain child centred when undertaking assessments, standardises assessment practice and clarifies the roles of professionals contributing to the assessment.

The Assessment Framework comprises two parts; an Assessment Tool and a Practice Guidance.

AIMS AND OBJECTIVES

The broad aim of the Assessment Framework is to provide a standardised and systematic method of gathering, recording, analysing and making sense of the information necessary to inform effective and appropriate levels of child protection and welfare interventions at primary, secondary and tertiary levels. The Assessment Framework is designed for both individual and multi-disciplinary assessments.

In order to meet its aim, the Assessment Framework has the following objectives:

- ▶ To clarify the legislative and policy context in which assessments of vulnerable and at-risk children and their families should be conducted,
- ▶ To take forward and develop the underlying tenet of the Child Care Act, 1991, to identify children in need and to provide child care and family support services,
- ▶ To promote early intervention by demonstrating the range of factors that can impact on a child's development and welfare and the inter-relationships between them, thus providing a holistic and comprehensive assessment,

- ▶ To highlight the principles underpinning the assessment process,
- ▶ To demonstrate appropriate methods for assessing key features of a child's personal and social environment that impact significantly on their development and safety,
- ▶ To enable practitioners to keep an open mind when making judgements on a child and family's situation and to be aware of the sources of bias and error that can misguide the assessment process,
- ▶ To guide practitioners in identifying positive factors in a child's environment that may, if supported or developed, address need or reduce risk,
- ▶ To sharpen the capacity of practitioners to understand and analyse the information gathered in assessment,
- ▶ To raise the awareness of practitioners and frontline managers of the factors that influence decision making in assessment,
- ▶ To guide practitioners in using an evidence based approach to decisions about intervention and service provision,
- ▶ To enable the identification of gaps in services,
- ▶ To ensure that ongoing review of the effectiveness of interventions and services remains an integral part of work with children and families,
- ▶ To pinpoint areas for ongoing training and evaluation.

WHO SHOULD USE THE PRACTICE GUIDANCE AND ASSESSMENT TOOL?

The Assessment Tool gives details of the three concurrent activities and five steps that structure the assessment process and includes pointers to inform the assessment of vulnerable children and their families. It is anticipated that practitioners will make continuous reference to the tool when completing an assessment. The Practice Guidance is more detailed providing background and additional information obtained from research and literature to inform the assessment task and process. Practitioners should use the guidance to inform their assessment.

The Assessment Framework depicts assessment as a process, and the use of five steps gives the impression of a sequence. Some tasks necessarily follow each other, for example the assessment must start with an initial response and outline a plan, information must be gathered and it must culminate in an intervention plan. However, it is also likely that certain steps may

be prolonged, considered simultaneously or revisited from time to time. Further to this the tasks of engaging, safeguarding and collaborating are activities that must be considered continuously throughout the whole process.

The guidance is intended for all practitioners providing services for children, and should provide a template for identifying factors influencing children's safety and welfare, including their needs and any threats to their safety. It should be usable by any practitioner within his or her practitioner role.

Not all aspects of the Practice Guidance and Assessment Tool will have similar relevance to each child's particular situation, or the remit of the practitioner involved. However, it is important that practitioners are sufficiently familiar with all the significant aspects of a child's situation, as outlined in the Assessment Tool, and recognise when their own assessment is sufficient or where a fuller multi-disciplinary assessment is required.

HOW TO USE THE ASSESSMENT FRAMEWORK

The different parts of this document, which combines the Assessment Tool with the Practice Guidance, are together intended to provide comprehensive guidance to practitioners. The tool, which is in the first part of the document from pages 11 to 43 is relatively brief, focusing on the process of assessment and identifying all the areas considered to be relevant, and the Practice Guidance, which commences on page 45, provides more detail on the different areas. We advise that practitioners undertaking assessments always consult Section One of the Practice Guidance for additional information on each stage of the assessment process. Section Two consists of theory and research relevant to assessment, and is more likely to be used on a selective basis.

Links are made between the different sections in various ways. The coloured strips on the pages match the colours in the wheel representing the different activities and steps which comprise the assessment process. For example the colour red is used for 'responding', so that the red strip in the tool is linked to the red strip in the Practice Guidance, which elaborates on 'responding'. Coloured tabs in Section One of the Practice Guidance also match the coloured strips in the Assessment Tool. A book symbol with the relevant page number appears in both the tool and Section One of the Practice Guidance, which guides the reader to other relevant sections. The index at the back of the document also signposts the various topics in alphabetical order.





Introduction to the Assessment Tool

The Assessment Tool is designed to help practitioners complete child-centred assessments of vulnerable children and their families.

The assessment tasks and process are structured in terms of three concurrent activities and five steps; these are represented diagrammatically as a 'wheel'.

The three concurrent activities are:

- ▶ Engaging
- ▶ Safeguarding
- ▶ Collaborating

The five steps are:

- 1 Responding
- 2 Protecting
- 3 Devising
- 4 Gathering and Reflecting
- 5 Sharing, Analysing and Planning

The concept of child centredness is illustrated by a circle in the middle of the wheel with the words 'the child' on it, together with a 'spiral'. The 'spiral' illustration relates to one of the assessment steps – gathering information. The spiral depicts the three dimensions of a child's life about which information should be gathered and analysed to inform decision making and planning. These are:

- ▶ Whether and How Child's Needs are Being Met
- ▶ Parent/Carer Capacity to Meet Needs
- ▶ Community and Extended Family

It is crucial that the person carrying out the assessment 'knows' and has a good sense of the child beyond his or her basic needs. Specific guidance on this is detailed in the tool in the section entitled 'Knowing the Child', which follows Step 4 on page 40.

The assessment process may take place over a number of days, weeks or months depending on its purpose. It may be useful for a date to be agreed at the outset by which time the formal assessment should be completed. However, it is likely that assessment will need to be a continuous and consistent part of working with a child and family. It is not simply about gathering information but a process to empower families to find their own solutions and recognise their strengths and coping mechanisms.

An assessment is not always a straightforward, linear process in which steps are followed in a fixed order, but one in which certain steps may be prolonged, considered simultaneously or revisited from time to time. Accordingly, when carrying out an assessment using the five steps it may happen that each one is considered and addressed consecutively, however, it is equally likely that several parts of the process will be carried out concurrently. The activities of engaging, collaborating and safeguarding will be relevant throughout the entire process of assessment.

An integral part of the assessment process is judgement making. Professionals make different types of judgements at different points of the process (Hollows, 2003).

- ▶ The first type of judgement is a 'holding' judgement. These are speedy judgements often made at the point of referral, which are designed to ensure safety and stability for the child without reducing other options in terms of more long-term judgements.

- ▶ The second type of judgement is the 'issues' judgement. These are judgements based on a thorough analysis of the information gathered using the three dimensions of a child's life.
- ▶ Having reached a decision about the health and well being of the child, professionals need to make additional judgements called 'strategic' judgements. These involve professionals deciding how to respond to the identified needs of the child and family and on the basis of these decisions making plans that safeguard and promote the well being of the child.
- ▶ Judgement making does not stop here. Professionals should continue to make 'evaluative' judgements, which involve assessing the effectiveness of the plan as a way of meeting the needs of the child.

Gathering and Making Sense of Information: The Five Key Questions



While the gathering of information is signalled at Step 4 in the assessment process it is likely that information will begin to be gathered on the child and family from as early as Step 1, Responding, and that this will carry on throughout the assessment. As each piece of information is gathered, practitioners should reflect on the following five questions:

Q1 What facts, observations and opinions do you have to support the information gathered?

This means checking whether the information is based on fact or opinion and what evidence exists to support it. It also means thinking about whether the information is first hand or from a third party and how reliable it is, whether it came from a written report or whether it was given verbally?

For example a claim that a child's educational needs are not being met due to parental problems should be supported by specific evidence, i.e. number of days missed at school, evidence of academic attainment from school reports and willingness of parents to respond to a teacher's contacts etc.

Q2 What does this mean in relation to the child's safety, welfare and development?

This means that all information gathered should be analysed in respect of its meaning, positive or negative, for the child's safety, welfare and development within their current context.

For example, in the case of the child above, whether he/she is missing a lot of school days or

whether he/she is finding it difficult to concentrate in class and the impact of this on his/her ability to learn.

Q3 How do practice experience, research findings and literature inform this part of your assessment?

This means that any conclusions drawn about the impact on the child should be explicitly based on theory, practice experience and/or research findings.

For example, research provides information on the normally expected educational and academic ability of children at the different ages and developmental stages and the possible impact of parental problems on this.

Q4 Should an intervention be made now? If so what?

This means that it is important for the practitioner to consider the possibility of the need to take action at any stage of the assessment process.

For example, in the case of the above child, it might be appropriate to make an immediate referral to a home school liaison teacher and/or a education welfare officer before the assessment is completed.

Q5 Where is the parent/carer within the change process?

It is important to recognise that change is a process affected by the carer's ability, motivation and opportunity to change. Parent/carers need to both recognise the need to change and also be able to engage in the change process. This means determining how they will make changes to ensure the needs of the child are met and translating these ideas into action. Some parents/carers may initially resist or be ambivalent about the need to change; others may not be able to maintain change. Practitioners should consider the parent/carer's response to change throughout the assessment.

For example, in relation to the example above, does the parent/carer understand the impact of the child missing school? Are they willing to put effort into getting the child to school each day? Do they have the knowledge and skills to take the necessary steps?

Throughout the Assessment Tool, the importance of considering these five key questions will be signalled by this symbol



Practice Principles

This Assessment Tool has been developed on the basis of the seven practice principles. These are elaborated on the back cover and the Practice Guidance contains up to date literature and research findings associated with the application of each of the practice principles to the assessment of vulnerable children and their families.





The Three Concurrent Activities



ENGAGING



An assessment should be a dynamic, interactive process between practitioners and the child and family. How workers engage with the family will determine the quality of the assessment. The process of engaging the family will be ongoing throughout the assessment and not a discrete task. It is important to give consideration to the pace at which children and families can engage with the assessment.

At the outset:

- ▶ Consider and plan the initial approach,
- ▶ Contact the child and family and explain why this assessment is being undertaken,
- ▶ Ensure that all of the children are seen as well as parents/carers, including non-resident parents/parent figures,
- ▶ Consider how another practitioner might assist you in engaging the child and family,
- ▶ Consider what might be the most suitable environments for the initial contact and subsequent assessment,
- ▶ Consider how the child and family might feel and respond to the information that has been gathered thus far and how best to approach this.

Ongoing facilitation of engagement consists of the following tasks:

- ▶ Regularly checking with the family to see if their understanding of the rationale and aims of the assessment are still clear,
- ▶ Sharing the information which is being gathered with the child and family on an ongoing basis,
- ▶ Always being clear and explicit about issues, negotiating a way forward if an impasse occurs and looking at possible outcomes with the child and family,
- ▶ Recapping on the aims and objectives of the assessment at regular intervals,
- ▶ Explaining how information about the case is being obtained in order to address concerns,
- ▶ Enabling the family to identify their own needs, possibly in writing, and showing a willingness to consider different interpretations of the concern,
- ▶ Listening to how the child and family respond,
- ▶ Being open and honest with the family about the basis upon which plans are being made,
- ▶ Considering what contingency plans are to be employed in the event of the family withdrawing from the assessment.



SAFEGUARDING

Safeguarding means continuing to monitor a child's immediate safety even after the initial step of Protecting has been completed. It means ensuring that protective factors already identified continue to exist and being aware that some previously identified risk factors that have diminished may re-surface. Practitioners must remain open to the possibility that their initial judgment on the child's immediate safety may have been contingent on factors that are susceptible to change or may no longer exist.

The following questions should be addressed throughout the assessment:

- ▶ Is information regularly and frequently sought from relevant professionals in relation to the child's safety (e.g. nursing and medical staff; social worker; teachers; care staff and Gardaí)? How often?
- ▶ Has the child been seen regularly and frequently in a way that satisfies any concerns about his or her immediate safety (e.g. on his or her own, or in a fashion that would permit observation of any injury or harm)? How often?
- ▶ Have the child's carers been seen regularly and frequently in order to review any pre-existing concerns about the child's immediate safety?
- ▶ If the child's parent/carer agreed to any conditions in order to safeguard the child, is there sound evidence that each of these has been consistently adhered to?
- ▶ Have there been any changes in the child's living situation or household?
- ▶ Is the child now in contact with anyone who is likely to harm him or her? If so, what type of contact?
- ▶ In the event of key staff being absent or leaving their posts, are any monitoring agreements that were made at the outset of the assessment still being carried out?
- ▶ Is the immediate safety of this child part of the discussion at supervision?
- ▶ Does any emerging information being gathered as part of the assessment give rise to any new concerns about the child's safety, or add to any existing ones?



COLLABORATING



Multi-disciplinary collaboration is an essential part of the assessment process. Effective collaboration is the responsibility of every professional involved. Because of the individual nature of each case, the mix of disciplines and agencies may differ. It will be necessary for a key worker/coordinator  to be nominated. He/she should promote and facilitate effective collaboration during the assessment, particularly in relation to promoting *meaningful* engagement between a range of agencies and organisations. It would be beneficial to establish some norms regarding tasks, means of sharing information and to clarify what is involved in the assessment process at the outset. This would be best done at an initial planning meeting taking the following questions into consideration. These collaborations will need to be reviewed as the assessment progresses.

Roles and Responsibilities

- ▶ Which professionals need to be involved in the assessment?
- ▶ Is it clear what role each of them will play? (See table below)
- ▶ Is it clear what responsibilities in relation to the assessment each practitioner will have?
- ▶ How can you ensure that all the practitioners and their managers (intra and inter-agency) are sufficiently familiar with the Assessment Framework? What needs to happen if they are not?
- ▶ What are the most appropriate times and means of contacting those involved in the assessment?
- ▶ Does everyone have the necessary contact information?

Information Sharing

- ▶ What types of information are exchangeable and what are not?
- ▶ Do norms regarding confidentiality require clarification?
- ▶ What recording methods will be most helpful in ensuring the sharing and communication of information about the assessment?

Assessment Process

- ▶ What arrangements can be put in place to ensure that appropriate feedback is given to all relevant professionals not necessarily directly involved in the assessment, but involved with the child and family (e.g. schools)?
- ▶ What factors are likely to aid or impede collaboration?
- ▶ What agreement exists in relation to timescales?
- ▶ Have dates been agreed for meetings to plan the assessment, discuss the outcome of the assessment, make intervention plans and review progress?
- ▶ Is it clear what is expected from each participant at an inter-agency meeting in terms of written contributions?
- ▶ What strategies are in place to prepare carers and children for inter-agency meetings? (See Practice Guidance)
- ▶ How will difficulties that may arise in collaboration be resolved?

When having an initial planning meeting it may be useful to consider the pointers listed in Step 3, Devising.

Multi-disciplinary Contributions¹

Multi-disciplinary work is regarded as fundamental to good practice in child protection and welfare. Listed below are practitioners/ services who may be involved with a child and family and the type of information that they could provide.

Child Care Worker (Community and Residential)

- ▶ History of involvement in the family
- ▶ Interaction with parents
- ▶ Child's developmental, educational, health, emotional and social needs and abilities
- ▶ Child's perspective on family's difficulties and means of coping
- ▶ Child's care history
- ▶ Child's feelings and wishes for their family
- ▶ Child's likes and dislikes
- ▶ Child's relationship with parents/carers and sibling(s)
- ▶ Child's support networks and friendships
- ▶ Child's willingness to engage with practitioners and services
- ▶ Child's school attendance and opinion of school

Dentist

- ▶ Information on suspected or confirmed physical trauma or dental trauma
- ▶ History of involvement with the family
- ▶ Family's willingness to engage with services
- ▶ Parent/child interaction

Community Paediatrician

- ▶ Medical history of child, including hospital admissions
- ▶ History of involvement with the child and family
- ▶ Post mortem investigation of fatalities of children
- ▶ Family's previous contact with services in the hospital and the community
- ▶ Clinical and forensic evidence of child abuse

Early Years/Nursery Staff

- ▶ Physical health of child
- ▶ Emotional well being of child
- ▶ Developmental milestones child has or has not reached
- ▶ General appearance of child
- ▶ Child's way of playing
- ▶ Child's ability to perform tasks
- ▶ Child's level of appropriate social skills
- ▶ Parent/child interaction
- ▶ Parent/child relationship including separation issues and how that relates to attachment
- ▶ Parenting skills
- ▶ Parent's ability to follow advice given regarding children's needs

Social Workers (Health Service Executive)

- ▶ History of involvement with the family
- ▶ Information regarding current and past difficulties within the family
- ▶ Information regarding past interventions and outcomes with the family
- ▶ Information regarding the involvement of other disciplines with the family
- ▶ Family's pattern of functioning
- ▶ Needs of the children
- ▶ Parental issues and capacity
- ▶ Support networks available to the family
- ▶ Access to the family home
- ▶ Interactions and relationships between parents/carers and children
- ▶ Allegations and incidents of abuse
- ▶ Notifications
- ▶ Care history of the children

¹ Adapted in part from NEHB (2002) *Child Care Foundation Course, Children First. Protecting Children and Promoting Child Welfare.*

Family Support Workers

- ▶ History of involvement with the family
- ▶ Parental issues and parental capacity
- ▶ Difficulties within the family
- ▶ Children's experience of family life
- ▶ Children's means of coping with family difficulties
- ▶ Children's attendance at school and ability to do homework
- ▶ Children's support networks and friendships
- ▶ Relationship and interactions between children and parents/carers
- ▶ Parents/carers supervision of children
- ▶ Children and family's support networks
- ▶ Information regarding the involvement of different disciplines within the family
- ▶ Family's openness to practitioners and services
- ▶ Financial and budgetary situation of the family
- ▶ Employment history of carers
- ▶ Information regarding the family from the local community

Community Welfare Officer

- ▶ History of contact with the family
- ▶ Interaction between parents/carers and children
- ▶ Access to family home
- ▶ Information regarding difficulties within the family
- ▶ Information regarding support networks
- ▶ Information regarding the family from the local community
- ▶ Financial situation of the family
- ▶ Current benefits
- ▶ Employment history of the parents/carers

Radiographer

- ▶ Information on the type, frequency and number of injuries sustained by a child

Drugs/Aids/Alcohol Services

- ▶ History of involvement with family
- ▶ Past and current parental drug and alcohol use
- ▶ Parental HIV and AIDS status
- ▶ Parents' ability to protect their children from HIV infection where relevant
- ▶ Children's HIV and AIDS status
- ▶ Parental capacity to meet the needs of children
- ▶ Interaction and relationships between parents and children
- ▶ History of intervention with family and what has worked
- ▶ Family's willingness to engage with practitioners and services

Gardaí

- ▶ Past and current involvement with family and extended family
- ▶ Previous notifications to or from the Health Service Executive
- ▶ Reports of maltreatment
- ▶ Knowledge of issues related to aggression, assault, addiction, mental health issues etc.
- ▶ Knowledge of relevant orders e.g. Barring Order, Safety Orders

General Practitioner/AMO

- ▶ Physical and emotional development of child and carers
- ▶ Medical history
- ▶ Access to family home
- ▶ Parenting issues and their impact on parenting capacity e.g. alcohol use, mental health, learning disabilities
- ▶ Pattern of contact with GP and medical services
- ▶ Information regarding what interventions worked in the past
- ▶ Current and past use of medication
- ▶ Impact of medication on parental capacity
- ▶ Any potential health risks

Psychiatric Services

- ▶ History of contact with parent and family
- ▶ Information regarding family history and needs of the children
- ▶ Psychiatric diagnosis
- ▶ Possible impact of condition on parenting capacity
- ▶ Previous psychiatric history and the impact on parenting capacity
- ▶ Treatment progress
- ▶ Compliance regarding taking medication and impact on parenting of taking/not taking medication
- ▶ Attendance at appointments
- ▶ Availability and take up of services other than medication
- ▶ Availability and take up of family and community supports
- ▶ Emotional availability to children
- ▶ Emotional stability
- ▶ Interaction with children

Social Workers (Maternity and General Hospital)

- ▶ History of hospital admissions of parents/carers and children
- ▶ Difficulties within the family
- ▶ Health and medical needs of the children
- ▶ Interactions and relationships between parents/carers and children
- ▶ Initial bonding between mother and newborn baby and involvement of father
- ▶ History of teenage pregnancies within the family

Physiotherapist

- ▶ Gross motor development and analysis of cause of delay or abnormality
- ▶ Parental capacity regarding handling skills, general physical and play stimulation of the child
- ▶ Signs of non-accidental injury
- ▶ Parenting skills
- ▶ Attendance at appointments

Psychologist/Counsellor

- ▶ History of contact with parent and family
- ▶ Information regarding family history and needs of the child
- ▶ Level of cognitive and adaptive functioning
- ▶ Psychological effects of maltreatment
- ▶ Emotional and behavioural issues
- ▶ Mood
- ▶ Levels of self-esteem
- ▶ Psychological formulation and conceptualisation of the situation
- ▶ Feelings about the situation
- ▶ Social contacts
- ▶ Learning potential and need for additional support
- ▶ Information regarding what intervention worked in the past
- ▶ Interaction between parent and child

Disability Services

- ▶ History of involvement with family
- ▶ Information regarding disability and abilities of child
- ▶ Parent/carer's ability to understand and respond to the child's needs
- ▶ Impact of the disability on the family
- ▶ Family's ability to access the services that they require
- ▶ Family's view of quality of services provided
- ▶ Availability of services to meet child's particular need
- ▶ Financial implications of the disability for the family
- ▶ Availability of respite care
- ▶ Support networks available to the family
- ▶ History or incidences of abuse

Occupational Therapist

- ▶ Child development
- ▶ Development of functional performance
- ▶ Child's ability to interact with his/her physical and social environment
- ▶ Parent's understanding of child's performance problems

School

- ▶ Educational ability, development and progress
- ▶ Socialisation and behaviour with peers and adult staff
- ▶ Play
- ▶ Participation in social/leisure activities during and after school
- ▶ Emotional development, including self-esteem, self-worth, withdrawn/aggressive
- ▶ Liaison with home – is a home/school liaison teacher or education and welfare officer involved?
- ▶ Contact and relationship between the school and parent(s)
- ▶ Knowledge of siblings
- ▶ History of contact between the family and the school
- ▶ Child's ability to concentrate at school
- ▶ Completion of homework satisfactorily to deadlines
- ▶ Whether the child has appropriate books and equipment
- ▶ Whether the child has a school lunch and whether it is nutritious
- ▶ Whether the child is hungry or tired at school
- ▶ What the child says at school about home
- ▶ How the child is after the weekend
- ▶ How the child feels about school
- ▶ Any notable changes in the child's behaviour
- ▶ Whether the child is collected from school, if age appropriate

Voluntary Organisations (Service Specific)

- ▶ History of involvement with family
- ▶ Information regarding the difficulties and needs of children and parents/carers
- ▶ Family's willingness to engage with statutory services
- ▶ Family's support networks
- ▶ Family's way of coping with difficulties

Public Health Nurse

- ▶ Medical history
- ▶ The child's developmental history
- ▶ Information on deviations in normal development
- ▶ Birth history
- ▶ Attachment to carers
- ▶ Immunisation take-up
- ▶ Attendance at clinic and other appointments
- ▶ The parents' physical and emotional well being
- ▶ Information regarding parent's upbringing
- ▶ Parenting skills
- ▶ Roles taken on by parents and others in the child's life
- ▶ Impact of parenting issues on parenting capacity
- ▶ Family's current and past history of engaging with services
- ▶ Access to and information regarding the home environment and family life
- ▶ Information from neighbours, extended family and friends in the community regarding the family
- ▶ Involvement of extended family members and the existence of support networks
- ▶ Information on the development of siblings
- ▶ Observations of the health and well being of children in the home
- ▶ Referrals made

Speech and Language Therapist

- ▶ Child's speech and language assessment and development
- ▶ Parent/carer's capacity to understand and respond to child's difficulties
- ▶ Child and parent's ability and willingness to engage with the service
- ▶ Parent/carer's ability to work with speech therapy programme
- ▶ Attendance at appointments
- ▶ Difficulties within the family
- ▶ Child's perspective on difficulties within the family



The Five Steps



Step 1 Responding



Responding means noting the details of the referral, obtaining relevant information from the referrer, checking the child's current situation and safety and checking available records.

The following information needs to be obtained (from the referrer, existing records or from other professionals):

- ▶ Is this a new referral or have the child and/or family been known to the agency/professional for some time? If known, what information is on record?
- ▶ What are the child and family's identifying details (i.e. names, dates of birth, relationships, address)?

The following information needs to be obtained from the referrer

- ▶ Is their concern based on specific evidence? What is it?
- ▶ What is the referrer's involvement or relationship with the child and family?
- ▶ What is the opinion of the referrer regarding the safety and welfare of the child?
- ▶ What strengths can the referrer identify within the child and family?
- ▶ Does the referrer know of any Health Service Executive services that the family is already accessing?
- ▶ Has the referrer or other professional intervened with the child and family to address the issues identified?
- ▶ What are the gaps in the existing information?
- ▶ Do the child and family know about the referral? If not, why not?

- ▶ How will the child's welfare be affected if the concern remains unaddressed?

Holding ('speedy') judgements

- ▶ Is it necessary to make an immediate decision on the basis of this information in order to ensure safety and stability for the child?

Responding also involves making contact with the child and family and beginning the process of engaging them in assessment

REMEMBER TO ALWAYS CONSIDER THE THREE CONCURRENT ACTIVITIES



Step 2 Protecting



At the outset and throughout the assessment, consider whether there is an immediate threat to the child's safety. If any danger does exist, the following questions must be addressed and followed by an assessment of the child's immediate safety:

- ▶ Who has seen the child? Where? When?
- ▶ What indications of abuse and neglect are present?
- ▶ Is someone able to protect the child right now?
- ▶ Will the child be safe while the assessment is being undertaken?
- ▶ Who is the alleged perpetrator of the abuse?
- ▶ Are the child and alleged perpetrator in contact? If yes, what needs to happen to ensure the child's safety?
- ▶ What actions need to be taken at this point?
- ▶ Has all the necessary information been gathered?
- ▶ How well can the child protect him or herself?

In order to assess whether the abuse or neglect is likely to reoccur the following should be considered:

- ▶ The nature of the alleged abuse or neglect,
- ▶ The parent/carer/perpetrator's previous history of harming children,
- ▶ The parent/carer/perpetrator's previous history of violent tendencies towards adults,
- ▶ Any complicating factors such as drug/alcohol or mental health problems,
- ▶ Level of insight that the parent/carer/perpetrator has into his/her actions,
- ▶ Parent/carer's knowledge of the child's needs.

The child's immediate safety must remain a principal concern throughout the assessment. See Safeguarding (page 17)

REMEMBER TO ALWAYS CONSIDER THE THREE CONCURRENT ACTIVITIES



Step 3 Devising



Devising means outlining a plan for the assessment. This necessitates multi-disciplinary discussion, which will normally happen at an initial planning meeting. However, as the assessment unfolds, the plan may need to be reviewed and modified, so this is an ongoing process rather than a once off task. It should be considered alongside Collaboration (see page 18).

Devising an assessment necessitates consideration of the following:

- ▶ What is the purpose of the assessment?
- ▶ What is the time frame for the assessment?
- ▶ What information do we need to collect in this particular case and from whom?
- ▶ From what other sources should the information or advice be sought?
- ▶ Who is best placed to collect the necessary information?
- ▶ How will the child and family be involved in the assessment?
- ▶ What if the child and family fail to engage?
- ▶ What services need to be put in place at this stage?

REMEMBER TO ALWAYS CONSIDER THE THREE CONCURRENT ACTIVITIES



Step 4 Gathering & Reflecting



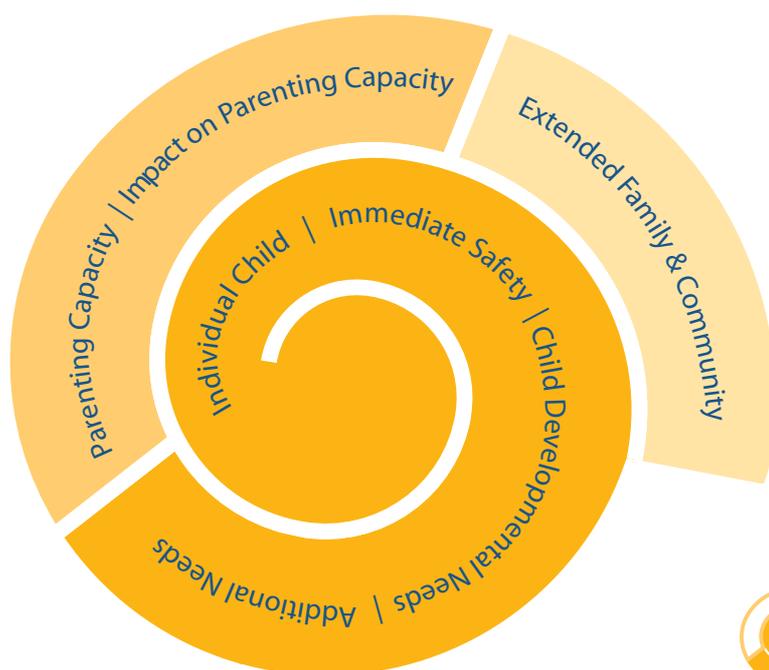
Gathering information about the child and family is an integral task and it is likely that it will carry on throughout the assessment rather than at one discrete step. Information gathered at each step in the assessment should build on information generated at earlier steps in the process.

Step 4 comprises two equally important interrelated activities: gathering and reflecting on information. To reflect on the information gathered the five key analytical questions should be applied to each piece of information generated.



Gathering Information

The 3 Dimensions of a Child's Life: The Spiral





The spiral depicts Three Dimensions to a child's life, which must be considered when completing an assessment. Consideration needs to be given to each of the Three Dimensions. All Dimensions should be considered concurrently in order to understand their mutual interaction and impact on the child.

The Assessment Tool outlines pointers to be considered in relation to each of the Dimensions. These pointers are intended to act as aide memoirs that practitioners or managers will use to guide their assessment of a child and their family. It is important to reflect upon the ways in which each Dimension impacts on the child's safety, welfare and development. It is also important to remember to listen to, observe and interact with the child. (See also the section entitled "Knowing the Child" on page 40).

It is vital for all disciplines working with children to be clear about their role in the assessment, be aware of the limitations of their professional judgement, to know where and at what point to link the child and family with additional services or when and where to refer them for further, more in-depth assessment.

The information generated must reflect the views of the child, the family and the practitioners involved. It is important for the practitioner conducting or coordinating the assessment to be clear with other practitioners and the family about the extent and limits of information sought, how the information gathered will be used and who will have access to it.

Dimension 1 Whether and How Child's Needs are Being Met

There are seven Child's Needs listed under Dimension 1. Within this Dimension consideration should be given as to whether the need is being met and also, importantly, 'how' or the manner in which the need is met. It is important to consider the relationship of care that exists between the carer and the child, for instance, are the child's needs met in a gentle, loving manner or is there an element of roughness, resentment or indifference? Likewise, with regard to educational needs, it is not enough to state that the child goes to school but rather it is important to consider how the child gets to school. Do they walk alone? Is that age appropriate?

It is equally important to consider how the child sees his/her own needs and how the parent/carer(s) and extended family and community see the child's needs.

It may not always be relevant to exhaustively explore every need. Variations on what needs to be considered may occur depending on the age and developmental stage of the child. However with each need identified it is important to consider it across the Three Dimensions.

When contemplating a child's needs, it is important to be mindful of additional needs experienced by some children. The additional needs experienced by some children relate to children with disabilities and complex health needs and children from ethnic minorities. These are detailed on pages 34 to 37.



Dimension 2 Parent/Carer Capacity to Meet Needs

Parent/carer capacity to meet the child's needs must be considered in relation to each of the child's identified needs.

It is important to look at how the parent/carer views their own capacity to meet their child's needs, how the extended family and community view the parent/carer's capacity and where appropriate the opinion of the child on the capacity of their parent/carer to meet their needs.

Furthermore, when considering parent/carer capacity to meet children's needs, it is important to consider the impact of certain issues on parenting capacity. These additional considerations are detailed on pages 38 and 39.

Dimension 3 Extended Family and Community

The extended family and community's ability to meet the child's needs and capacity to support the parent/carer to do so should be explored with regard to each relevant need identified.

This Dimension includes extended family members, siblings and the services involved in the child and family's life.

It is important to consider how members of the extended family and community view their capacity to meet the child's needs and also the perspectives of the parent/carer and the child on this.

Reflecting on the Information Gathered

FIVE KEY QUESTIONS

Information on the Three Dimensions of a child's life will be gathered by consulting records, talking with the child, talking with his or her parent/carers and extended family and consulting with other relevant professionals or services. As each piece of information is gathered, practitioners should reflect on the five key questions:

- Q1 What facts, observations and opinions do you have to support the information gathered?
- Q2 What does this mean in relation to the child's safety, welfare and development?
- Q3 How do practice experience, research findings and literature inform this part of your assessment?
- Q4 Should an intervention be made now? If so what?
- Q5 Where is the parent/carer within the change process?

Whenever you see this symbol consider the Five Key Questions



For more information on the Five Key Questions, see pages 12 and 13.

REMEMBER TO ALWAYS CONSIDER THE THREE CONCURRENT ACTIVITIES



The Three Dimensions of a Child's Life

Dimension 1

Whether and How Child's Needs are Being Met



Physical Development and Basic Care

- ▶ Food
- ▶ Clothing
- ▶ Stable accommodation with a secure living environment
- ▶ Warmth
- ▶ Hygiene
- ▶ Appropriate advice on smoking, alcohol consumption, substance abuse and sexual health and behaviour
- ▶ Development of self care skills

Medical Care

- ▶ Immunisation record
- ▶ Necessary medical checks or medical care
- ▶ General health, height and weight

Dimension 2

Parenting Capacity to Meet Needs



Parent/Carer's Capacity to Provide Basic Care

- ▶ Ability to provide a nutritious diet on a routine basis
- ▶ Ability to provide clean and seasonally appropriate clothing
- ▶ Ability to recognise and respond to the child's need for a secure and safe living environment
- ▶ Ability to provide a living environment that is both hygienic and warm
- ▶ Ability to meet the basic care needs of children where appropriate and encourage and teach basic care practices to children as they grow older
- ▶ Ability to meet the needs of children and young people for advice on smoking, alcohol consumption, substance use and sexual health and behaviour
- ▶ Ability to encourage the development of age appropriate self care skills

Parent/Carer's Capacity to Meet the Child's Medical Care Needs

- ▶ Attendance with child at medical appointments or encouragement of older children to attend
- ▶ Ability to meet child's medical requirements
- ▶ Ability to pick up signs of child's ill health and respond appropriately

Dimension 3

Extended Family and Community's Capacity to Meet the Child's Needs and/or Support Parent/Carers to meet those Needs



Extended Family & Community and the Child's Basic Care

- ▶ Availability of projects or activities where the child's basic care needs are met
- ▶ Role of school in meeting the basic care needs of the child
- ▶ Role of the extended family in meeting the basic care needs of the child
- ▶ Provision of shelter or accommodation for the child by members of the extended family or community
- ▶ Attendance of parent/carer at any activities or services which promote their parenting capacity
- ▶ Engagement of family in any formal family support services
- ▶ Involvement of child in any community activities
- ▶ Relationship of child with any significant adult who offers support or advice
- ▶ Cultures or current practices within the extended family and community that promote or impede standards of child care

Extended Family and Community and the Child's Medical Care

- ▶ Provision of GP or dental services
- ▶ Availability of child developmental or specialist clinics within reasonable proximity
- ▶ Health promotion activities within the community and school

Supervision and Safety

- ▶ Child's physical safety or lack of safety in the home and environment
- ▶ Child protected from inappropriate adult conversations, behaviours and concerns
- ▶ Child prevented from begging or selling
- ▶ Child given appropriate responsibility for self and others
- ▶ Guidance on inappropriate behaviour

Relationships, Attachments, Affections and Resilience

- ▶ Child's history and attachment strategy to their primary carers and significant others
- ▶ Relationships with peers of the same and opposite sex
- ▶ Stability of relationships in the child's life and the child's experience of bereavement and/or parental separation or divorce
- ▶ Evidence of resilience and the factors that support it

The quality of the attachment relationship between the child and the parent/carer underpins an assessment of the needs of the child.

Parent/Carer's Capacity to Provide Appropriate Levels of Supervision and Safety

- ▶ Ability to protect the child from potential hazards in the home
- ▶ Ability to protect the child from inappropriate behaviours within the home and awareness of the impact of these behaviours on the child
- ▶ Ability to protect the child from emotional and physical harm
- ▶ Providing the child with the appropriate amount of responsibility in accordance with age, ability and maturity of the child and normal practice within the community
- ▶ Awareness of the child's whereabouts
- ▶ Perception of misbehaviour and methods for handling it
- ▶ Ability to make judgements about the appropriateness of childminder/babysitter(s)

Parent/Carer's Ability to Meet the Child's Needs for Relationships, Attachments, Affections and Build Resilience

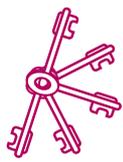
- ▶ Quality of attachment to the child
- ▶ Attitude to the child
- ▶ Ability to consistently demonstrate warmth, love and affection verbally, cognitively and physically
- ▶ Ability to sustain relationships and minimise changes of carer
- ▶ Ability to promote regular positive contact with extended family
- ▶ Willingness to accept support from those in extended family and community
- ▶ Ability to give constructive feedback on negative behaviours
- ▶ Influence of family history on current relationships

Extended Family and Community and the Supervision and Safety of the Child

- ▶ Provision of GP or dental services
- ▶ Availability of child developmental or specialist clinics within reasonable proximity
- ▶ Health promotion activities within the community and school

Extended Family and Community and the Child's Need for Relationships, Attachments, Affections and Build Resilience

- ▶ Child's current relationships with peers and appropriateness of these relationships
- ▶ Availability of appropriate individuals within the extended family and community to meet the child's need for warmth, love and affection
- ▶ Availability of practical support within the extended family and community
- ▶ Influence of family history and relationships
- ▶ Provision of opportunities for socialisation
- ▶ Factors which increase or reduce isolation of the child and family within the community
- ▶ Availability of other support and resources that promote resilience



The Three Dimensions of a Child's Life

Dimension 1

Whether and How Child's Needs are Being Met



Intellectual and Social Development

- ▶ Educational needs
- ▶ Opportunities for play, leisure and interaction with other children and adults
- ▶ Opportunities to acquire a range of skills and interests

Self-Care, Independence, Autonomy

- ▶ Age appropriate self-care skills
- ▶ Age appropriate independence
- ▶ Self awareness

Dimension 2

Parenting Capacity to Meet Needs



Parent/Carer's Capacity and the Intellectual and Social Development of the Child

- ▶ Importance attached to education, activities and social opportunities
- ▶ Provision of opportunities for play and leisure
- ▶ Ability to interact with the child and stimulate the child
- ▶ Encouragement of child's intellectual development
- ▶ Promotion of child's opportunities for development of skills and interests
- ▶ Involvement in child's education
- ▶ Recognition of the importance of stimulating and good quality child care, both within and outside the home

Parent/Carer's Capacity to Promote Self-Care, Independence and Autonomy

- ▶ Understanding the child's need to develop independence and autonomy
- ▶ Ability to help the child develop appropriate self-care skills
- ▶ Ability to help the child develop age appropriate independence
- ▶ Ability to help the child develop self awareness

Dimension 3

Extended Family and Community's Capacity to Meet the Child's Needs and/or Support Parent/Carers to meet those Needs



Extended Family and Community and the Intellectual and Social Development of the Child

- ▶ Child's attendance and performance in school
- ▶ Contact between the school and home
- ▶ Involvement of home school liaison/education and welfare service
- ▶ Child's attendance at and involvement in social clubs or organisations
- ▶ Availability of stimulating and good quality child care, both within and outside the home

Extended Family and Community and the Child's Self-Care, Independence and Autonomy

- ▶ Availability of opportunities for trips, outings away from home and general social skill development

Identity

- ▶ Respect and acceptance by their family/carers
- ▶ Praise and encouragement
- ▶ Positive messages about their gender, culture, religion, sexuality and family of origin

Parent/Carer's Capacity to Meet the Child's Identity Needs

- ▶ Ability to promote respect and acceptance by family and wider society
- ▶ Ability to praise and encourage the child
- ▶ Ability to give positive messages about the child's gender, religion, culture, sexuality and family of origin

Extended Family and Community and the Child's Identity Needs

- ▶ Respect and acceptance amongst extended family and wider community
- ▶ Role played by extended family and community in praising and encouraging the child

Additional Considerations in Relation to Dimension 1 (Whether and How Child's Needs are Being Met): Child's Additional Needs Children with Disabilities and Complex Health Needs



<p>Dimension 1</p> <p>Whether and How Child's Needs are Being Met</p> 	<p>Dimension 2</p> <p>Parenting Capacity to Meet Needs</p> 	<p>Dimension 3</p> <p>Extended Family and Community's Capacity to Meet the Child's Needs and/or Support Parent/Carers to meet those Needs</p> 
<p>Basic and Medical Care Needs</p> <ul style="list-style-type: none"> ▶ Basic and medical care needs specific to the disability or health needs ▶ Appropriate levels of autonomy in regard to meeting own basic and medical care needs 	<p>Parent/Carer's Capacity to meet Basic and Medical Care Needs</p> <ul style="list-style-type: none"> ▶ Ability of parent/carer to understand and meet the medical and basic care needs of their child with disabilities or health needs ▶ Ability to allow the child appropriate levels of autonomy in regard to meeting their own basic and medical needs 	<p>Extended Family and Community and the Child's Basic and Medical Care Needs</p> <ul style="list-style-type: none"> ▶ Provision of services within the community for the child and their family and the potential for equality of access to those services ▶ Family's awareness and use of such services ▶ Role of the extended family in meeting the basic needs of the child
<p>Supervision and Safety</p> <ul style="list-style-type: none"> ▶ Level of autonomy of a child with disabilities or health needs ▶ Potential for future independence of a child with disabilities or health needs ▶ Ability of the child to protect him or herself 	<p>Parent/Carer's Capacity to Provide Appropriate Levels of Supervision and Safety</p> <ul style="list-style-type: none"> ▶ Ability of parent/carer to understand and provide appropriate levels of autonomy ▶ Ability of the parent/carer to allow appropriate levels of independence to a child with disabilities or health needs ▶ Ability of the parent/carer to understand and appropriately address the behaviour of their child with disabilities or health needs bearing in mind both age and developmental level 	<p>Extended Family and Community and the Child's Supervision and Safety</p> <ul style="list-style-type: none"> ▶ Availability of extended family and community for childminding, babysitting and respite ▶ Availability of adapted facilities within the community for play and recreation

Relationships, Attachments, Affections and Resilience

- ▶ Child's feelings about their disability or health needs
- ▶ Ability of a child with disabilities or health needs to respond to those around them

Parent/Carer's Capacity to Meet the Child's Need for Relationships, Attachments, Affections and Build Resilience

- ▶ Ability of parent to appropriately respond and communicate with their child with disabilities or health needs
- ▶ Sensitivity to child's feeling about their disability or health needs
- ▶ Awareness of parent/carer of relationships between the child with disabilities or health needs and his/her siblings
- ▶ Impact of disability or health needs on parental attachment
- ▶ Impact of disability or health needs on parental relationship and their relationships with their other children

Extended Family and Community and the Child's Need for Relationships, Attachments, Affections and Resilience

- ▶ Capacity of extended family members and significant others to form a relationship with the child and understand and accept the level of their disability or health needs

Intellectual and Social Development

- ▶ Integration into family and inclusion in family activities
- ▶ Integration into school
- ▶ Acceptance and lack of negative stereotyping within school
- ▶ Protection from discrimination which may impact on the child's cognitive or educational capacity or development
- ▶ Participation of child in play and extra curricular activities
- ▶ Awareness, knowledge and understanding of own disability or health needs
- ▶ Specific emotional needs of a child with disabilities or complex health needs

Parent/Carer's Capacity the Intellectual and Social Development of the Child

- ▶ Parent/carer's awareness of and ability to address any negative stereotyping or discrimination experienced by their child
- ▶ Parent/carer's awareness of the impact of discrimination on their child
- ▶ Acceptance and understanding by family members of the child's intellectual and social development needs in the context of the their disability or health needs
- ▶ Parent/carer's understanding of and ability to meet the child's emotional needs which may not be commensurate with their developmental stage or chronological age

Extended Family and Community and the Intellectual and Social Development of the Child

- ▶ Promotion by school of integration and inclusion of the child
- ▶ School's and community's attitude towards negative stereotyping of children with disabilities or health needs
- ▶ Inclusion of children with disabilities or health needs in social clubs and organisations
- ▶ Availability of opportunities for play and extra curricular activities within the community

Additional Considerations in Relation to Dimension 1 (Whether and How Child's Needs are Being Met): Child's Additional Needs Children from Ethnic Minorities



<p>Dimension 1</p> <p>Whether and How Child's Needs are Being Met</p> 	<p>Dimension 2</p> <p>Parenting Capacity to Meet Needs</p> 	<p>Dimension 3</p> <p>Extended Family and Community's Capacity to Meet the Child's Needs and/or Support Parent/Carers to meet those Needs</p> 
<p>Basic and Medical Care Needs</p> <ul style="list-style-type: none"> ▶ Health difficulties of children arriving to Ireland from other countries ▶ Appropriate accommodation for asylum seekers, (including unaccompanied minors) and travellers ▶ Implication of frequent accommodation moves <p>Supervision and Safety</p> <ul style="list-style-type: none"> ▶ Appropriate levels of supervision and safety ▶ Provision of areas for safe play and recreation in temporary accommodation <p>Relationships, Attachments, Affections and Resilience</p> <ul style="list-style-type: none"> ▶ Staying in touch with family and friends in country of origin, if desired ▶ Opportunities to meet and get to know others from country of origin or ethnic background, if desired 	<p>Parent/Carer's Capacity to meet Basic and Medical Care Needs</p> <ul style="list-style-type: none"> ▶ Understanding of the available health and social services ▶ Barriers to their use of these services ▶ Asylum seeking parent/carer's possible reluctance to disclose medical difficulties due to asylum application ▶ Ability of asylum seeking parent/carer's to meet the basic and medical needs of their children while living on direct provision <p>Parent/Carer's Capacity to Provide Appropriate Levels of Supervision and Safety</p> <ul style="list-style-type: none"> ▶ Cultural norms around discipline and levels of parent/carer supervision ▶ Recognition and understanding of parental responsibilities within Irish child care legislation <p>Parent/Carer's Capacity to Meet the Child's Need for Relationships, Attachments, Affections and Build Resilience</p> <ul style="list-style-type: none"> ▶ Possibility/affordability of keeping in touch with family and friends in county of origin 	<p>Extended Family and Community and the Child's Basic and Medical Care Needs</p> <ul style="list-style-type: none"> ▶ Provision of required specialist services for children from ethnic minorities <p>Extended Family and Community and the Child's Supervision and Safety</p> <ul style="list-style-type: none"> ▶ Understanding by the community of cultural norms regarding the supervision and safety of children <p>Extended Family and Community and the Child's Need for Relationships, Attachments, Affections and Resilience</p> <ul style="list-style-type: none"> ▶ Inclusiveness of ethnic minorities within the community

Intellectual and Social Development

- ▶ Acceptance and lack of negative stereotyping within school
- ▶ Integration within school
- ▶ Protection from discrimination or racism which may impact on the child's cognitive or educational capacity or development
- ▶ Opportunities to learn about culture and history
- ▶ Opportunities to learn English and norms and mores of Irish culture

Parent/carer's Capacity and the Intellectual and Social Development of the Child

- ▶ Parent/carer's awareness of and ability to address any negative stereotyping, discrimination or racism experienced by their child
- ▶ Parent/carer's awareness of the impact of discrimination on their child
- ▶ Parent/carer's ability to teach their child about their culture and history

Extended Family and Community and the Intellectual and Social Development of the Child

- ▶ Acceptance and understanding of the child's school and community of their intellectual and social developmental needs in the context of their ethnicity
- ▶ School's and community's attitude towards negative stereotyping of children from ethnic minorities
- ▶ Provision of community activities that are inclusive of children from all ethnic backgrounds

Additional Considerations in Relation to Dimension 2: Issues impacting on Parent/Carer Capacity



Impact of Alcohol and Drug Misuse	<ul style="list-style-type: none"> ▶ History of drug and alcohol misuse including previous attempts at rehabilitation ▶ Willingness to engage with services ▶ Frequency and quantity of alcohol/drug misuse ▶ Impact on parenting of binge drinking ▶ Impact on parent and parenting capacity ▶ Impact on parent/carer who isn't misusing drugs or alcohol and their willingness to engage in support services ▶ Social consequences of the substance misuse ▶ Involvement of the child in substance misuse and the parent/carer's awareness of this ▶ Parent's awareness of the impact of their alcohol and drug misuse on the child ▶ How money is obtained for drug misuse ▶ Whether other substance misusers visit the family home 	Considerations Particular to Drug Misuse <ul style="list-style-type: none"> ▶ Parent/carer's ability to protect the child from exposure to drugs and drug use, needles, sources of HIV and Hepatitis infection and dangerous substances ▶ Involvement of child in procurement of drugs or money or as a courier
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Impact of Mental Health Difficulties	<ul style="list-style-type: none"> ▶ Past history of mental health problems ▶ The nature of the parent/carer's mental health difficulties and the patterns of behaviour ▶ Parent/carer's perception of their mental health difficulties and willingness to engage with services ▶ Willingness of the parent to take medication and its effect on the parent ▶ Impact of the mental health difficulties on the parent/carer's cognitive state, judgements and emotional availability to the child ▶ Expectations and responsibilities on the child when the parent/carer is ill ▶ Impact of a parent/carer's mental health difficulties on their partner and the level of insight and understanding that partner has into the difficulty ▶ Resources and networks that have assisted the parent/carer in meeting the needs of the child ▶ Parent/carer's awareness of the impact of their mental health problems on the child ▶ Parent/carer's contact with support services
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Impact of Parent/Carer having a Disability or Complex Health Needs	<ul style="list-style-type: none"> ▶ Size of family ▶ Parent/carer's general physical health and mobility ▶ Parent/carer's cognitive ability, language and/or communication skills ▶ Parent/carer's relationships ▶ Extent of parent/carer's knowledge about health care, child development, safety, responding to emergencies and discipline ▶ Expectations and responsibilities on child to play a caring role ▶ Financial situation ▶ Support systems available to and used by the parent/carer and their family ▶ Parent/carer's own experience of being parented and of receiving services as a child/young person 	Impact of Domestic Violence <ul style="list-style-type: none"> ▶ Forms of violence ▶ Past history of domestic violence ▶ Existence of previous or current Barring, Safety or Protection Order ▶ Parent/carer's ability to access and ask for help and whether they have ever done so before ▶ Impact of violence on the non-abusing parent/carer ▶ Child witnessing domestic violence and being physically at risk ▶ Abusing and non abusing parents' awareness of the impact of domestic violence on the child ▶ Evidence of steps taken by non abusing parent to protect child from negative impact
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Impact of Parenting Alone



- ▶ Financial and employment situation
- ▶ Support networks
- ▶ Experience of becoming a single parent, if relevant
- ▶ Self-efficacy
- ▶ Parent's awareness of the impact of their status as a single parent on the child
- ▶ Parenting alone as a single father

Impact of Having a Child with Disabilities or Complex Health Needs



- ▶ Parent/carer's attitude and understanding of their child's disability or complex health needs
- ▶ Impact of caring for the child on the parent/carer
- ▶ Liaison with professionals involved in the child's life
- ▶ Support networks
- ▶ 'Assessment fatigue'
- ▶ Impact on siblings of living with a brother or sister with disabilities or complex health needs

Impact of being Adolescent Parent/Carer(s)



- ▶ Social and economic consequences of being an adolescent parent/carer
- ▶ Impact on adolescent parent/carer's developmental tasks
- ▶ Impact on adolescent parent/carer's relationship with their parents and nuclear family
- ▶ Support networks
- ▶ Awareness of and ability to meet the needs of the child and protect the child given their own age and stage of development
- ▶ Willingness to engage with services

Impact of Being a Member of an Ethnic Minority Group



- ▶ Family income
- ▶ Accommodation
- ▶ Experiences of leaving country of origin and implications for the parent/carer's mental health
- ▶ Experiences of racism and social exclusion
- ▶ Asylum application
- ▶ Proficiency in speaking English
- ▶ Support networks

Impact of Parent's own Experience of being Parented



- ▶ Parent's history of attachment to their own parent/carers
- ▶ History of disruptions in parental care/relationship, e.g. long hospitalisations, placement in care, running away, bereavement, marital/relationship breakdown
- ▶ Parenting skills learned from own parent
- ▶ History of abuse
- ▶ History of domestic violence
- ▶ Parent's experience of receiving services as a child/young person

Impact of Social and Economic Factors



- ▶ Financial factors and the impact of parent/carer's socio-economic status on their ability to meet the needs of their children
- ▶ Housing and location and the capacity of the parent/carer to provide adequate accommodation conditions, e.g. space, privacy, safety, heat, light etc. and proximity to services
- ▶ Employment opportunities and parents/carers' attitude towards work
- ▶ Parent's educational history and impact on their ability to promote and support the child's education
- ▶ Impact of poverty on the family's perception of themselves
- ▶ Impact of living in a rural setting

Knowing the Child

As well as gathering information on the needs of the child and the manner in which the needs are being met, the practitioner must, as far as possible, try to get a 'sense' of the child, which requires more than factual information. As well as knowing the child the practitioner should, by the completion of the assessment, be in a position to describe an average day in the child's life during school term, if relevant, and during the holidays.

Being able to describe a day in the life of a child means knowing:

- ▶ What happens to the child in the morning? For example, does anyone get him or her up in the morning? Does he or she have anything to eat? Are clean clothes available? Does the child have a wash? Who, if anyone, is responsible for getting them ready in the morning?
- ▶ What are the arrangements for bringing him or her to child minder/nursery/school (as appropriate)? Is the child expected to make his or her own way or take siblings to child minder/nursery? Is this age appropriate?
- ▶ How does he or she spend the morning, whether at home, childminder, nursery or school? Is the child tired and/or hungry at school? If at home, is the child supervised?
- ▶ What happens at lunchtime? Is a lunch provided? What happens in the playground? Does the child have friends?
- ▶ Who collects him or her, if relevant, or is the child expected to find their own way home or take responsibility for other children? Is this age appropriate?
- ▶ What does he or she normally do after school (in term time) or during the day in the holidays? Is the child expected to care for him/herself and/or others? Are they expected to get food for themselves and others? Is this age appropriate? Is food available?
- ▶ Where does he or she play? At home? Outside? In a friend's house? Does he or she have friends over to his or her home to play? What type of activities does the child enjoy and what do they do? Does a responsible adult know where the child is and what they are doing? Is the child expected to run errands?
- ▶ Who is usually in the family home in the evenings? Is the child left on their own or in charge of other children or dependent adults? Is this age appropriate?
- ▶ Does the child have an evening meal?
- ▶ What does the child do in the evenings? In term time or otherwise?
- ▶ What happens about the child going to bed? Where does the child sleep? Does anyone tell the child when to go to bed? Do they have a bedtime routine? For example washing, brushing teeth, changing clothes?
- ▶ Who stays in the house overnight? What impact does this have on the child? For example is it too noisy for the child to sleep?

Knowing the child involves being able to describe:

- ▶ The child's personality, e.g. quiet, outgoing, shy, friendly, and give examples
- ▶ His or her favourite things, for example clothes, toys, food
- ▶ His or her dislikes
- ▶ His or her interests/hobbies, for example sports, art, computers, music, collecting things
- ▶ Who his or her favourite celebrities are
- ▶ Who he or she likes best
- ▶ What he or she likes doing outside school or the family
- ▶ Who his or her best friend is
- ▶ Who he or she would share secrets with
- ▶ Whether he or she has a pet? What it is and what its name is?
- ▶ What makes him or her sad or frightened?
- ▶ What makes him or her happy?
- ▶ What are his or her dreams, fantasies or ambitions?

A workbook would be ideal for eliciting this sort of information. In addition, to avoid the possibility of assessment focusing on too narrow a time frame, using a clock face², workers could record with the child and family what happens throughout the 24 hour day, and could potentially pinpoint a time when the family are most in need of intervention.

² Raynes, (2003)



Step 5 Sharing, Analysing & Planning

Step 5 occurs when all the professionals who have been involved in the assessment as well as the family and child (as appropriate) come together to share and analyse the information that has been gathered. The aim is to make decisions and formulate an intervention plan.

Preparing the Assessment Report

When compiling the assessment report, the following questions need to be addressed:

- ▶ Does the information give a good sense of the child as a person? Would it be possible, on the basis of the available information, to describe an average day in his or her life?
- ▶ Is the information about the child and family supported by clear evidence and is the basis for any opinions made explicit?
- ▶ How have the child and family's views been represented?
- ▶ What are the gaps in the information gathered? Information may be missing because it is either inapplicable or unobtainable. If this is the case are the reasons why explicitly recorded?
- ▶ Does the information gathered cover strengths as well as weaknesses?
- ▶ Have the five key questions been considered in relation to all of the information gathered?

See Practice Guidance (pages 85 and 86) for more information on demonstrating knowledge about the child whose needs are being assessed, and on using an evidence and strengths based approach when preparing the assessment report.

Sharing the Assessment Report

- ▶ The report is collated by the nominated key worker(s) and addresses the needs of the child across the Three Dimensions.
- ▶ This report is a summary of the analysis and highlights the questions that need to be considered and debated to facilitate decision making and planning with the child and family.
- ▶ All those involved in the assessment, including the child and family, are expected to make a contribution, either written or verbal, to this report.
- ▶ This report will have been shared with the child and family in advance of the meeting. This is a significant part of the process and time and support needs to be given to the family to absorb and respond to the information.
- ▶ The report should also have been shared, in line with local norms on the exchange of information, with other involved professionals prior to the multi-disciplinary meeting.

The Multi-disciplinary Assessment Meeting

- ▶ Ideally the meeting is chaired by a professional independent of the assessment process.
- ▶ Parents and children should be prepared for the meeting by their key worker, which also involves sharing the report with them. Good practice



indicates that the Chairperson should meet the child and family prior to the meeting.

- ▶ Parents and children, where appropriate, should also be invited to contribute to the discussion or to nominate a person to do so on their behalf.



At the beginning of the meeting each professional is given an opportunity to summarise their contribution to the assessment report highlighting the strengths, weaknesses and concerns regarding the child and family.

There are four tasks which need to be addressed at the multi-disciplinary assessment meeting, they are:

1. Sharing and analysing,
2. Making sense of the information,
3. Making judgements about the change required by the parent/carers to ensure that the child's health and development is being promoted,
4. Deciding what needs to happen? Formulating the intervention plan.

1 Sharing and Analysing

Using the information gathered about the needs of the child along the Three Dimensions identify the concerns about the health and well being of the child that led to the assessment and those which arose during the assessment.

Consider the strengths and vulnerabilities of the child and family using the following pointers:

- ▶ Vulnerability of child to abuse or neglect (current, further and/or future),
- ▶ Needs of the child met and unmet,

- ▶ The projected outcome for the child if the situation remains the same,
- ▶ Protective factors provided by adults,
- ▶ Child's resilience and ability to protect themselves,
- ▶ How far strengths will compensate for weaknesses, bearing in mind that strengths and weaknesses may not necessarily cancel each other out.

2 Making Sense of the Information

Bearing in mind the analysis of the concerns about the health and well being of the child and the strengths and vulnerabilities of the child and family, consider:

- ▶ Which of the child's needs are and are not being met?
- ▶ What aspects of parenting capacity need to be addressed in order to ensure the needs of the child are being met?
- ▶ What needs to change if the needs of the child are to be met?

3 Making Judgements about the Change Required by the Parent/Carers to Ensure that the Child's Health and Development is being Promoted



A judgement needs to be made by practitioners and the parent/carer regarding the parent/carer's ability and motivation to change. To reach such a judgement, the following should be considered:

- ▶ What judgements have you made about the 'issues' in this case based on the analysis of information gathered?
- ▶ How does the current situation fit with past patterns in this family?



- ▶ Does the parent/carer understand the concerns about the care of the child?
- ▶ What evidence is there that the parent/carer is motivated to change?
- ▶ What evidence is there that the parent/carer has the ability to change?
- ▶ What evidence is there that the parent/carer has the opportunity (supports and services) to change?
- ▶ What needs to happen to demonstrate that the parenting is good enough to meet the needs of this particular child?
- ▶ What evidence and examples do we have to show that the parent/carer has met the child's needs in difficult circumstances?
- ▶ Can this change happen at a pace that avoids further harm and promotes the health and well being of the child?

In some instances it may also be important to consider the child's capacity and motivation to address their contribution to the issues that led to the assessment, and to change.

4 What Needs to Happen? Formulating the Intervention Plan



- ▶ Make judgements about responding to the needs of the child and formulating the plan,
- ▶ Identify the desired outcomes for the child in relation to each of their unmet needs,
- ▶ What needs to happen to achieve these outcomes?
- ▶ How can this be achieved? By whom? With what?
- ▶ Assign key tasks and roles and consider the nature and frequency of communication needed to ensure the plan is implemented,
- ▶ Identify indicators of progress for each identified outcome – set specific short term and long term goals,
- ▶ Decide on a time frame for each identified outcome,
- ▶ Explore what will happen if the plan becomes unworkable,
- ▶ Set a review date to evaluate progress.

REMEMBER TO ALWAYS CONSIDER THE THREE CONCURRENT ACTIVITIES



Introduction

This Practice Guidance has been developed firstly to provide practitioners and managers with an introduction to the concept of the Assessment Framework and secondly to inform the use of the Assessment Tool. It is not a detailed procedural manual but is designed to assist practitioners identify the needs of children and to provide practitioners with the knowledge to use the Assessment Tool. The guidance is divided into two sections.

Section One focuses on the process of assessment. It follows the same sequence as the Assessment Tool and advises on how the different stages may be conducted. It offers pointers as to how different factors may be explored more closely. **Section Two** begins with an outline of the legal context in which assessments may take place, and goes on to explicate the practice principles underpinning the framework. It draws on recent research and theory to develop these areas. It is expected that practitioners will make more use of Section One to guide their assessments and will use Section Two, as required, as a resource to provide more information on different aspects of assessment.

Readers will note that some areas are given more attention than others – this reflects the emphasis given to certain aspects of practice by the practitioners who participated in the focus groups and the piloting of the framework, and also research findings which indicate that certain practice areas require special attention.

Practice Principles

Seven practice principles underpin this Assessment Framework. Section Two of this document discusses them in more detail.

1. **The immediate safety of the child must be the first consideration**
2. **Assessments should be child-centred**
3. **An ecological approach should underpin practice**
4. **Assessments should be inclusive and recognise the individual needs of all children irrespective of age, gender, ethnicity and disability**
5. **Multi-disciplinary practice is fundamental and an irreducible element of good practice**
6. **An evidence based and critically reflective approach should underpin assessment practice**
7. **High quality supervision should be provided and used by practitioners completing assessments**





Section One

The Assessment Process

The Assessment Tool illustrates and describes the process of assessing vulnerable children and their families, which is represented diagrammatically as a wheel. The assessment process is structured in terms of three concurrent activities and five steps.

The three concurrent activities are:

- ▶ Engaging
- ▶ Safeguarding
- ▶ Collaborating

The five steps are:

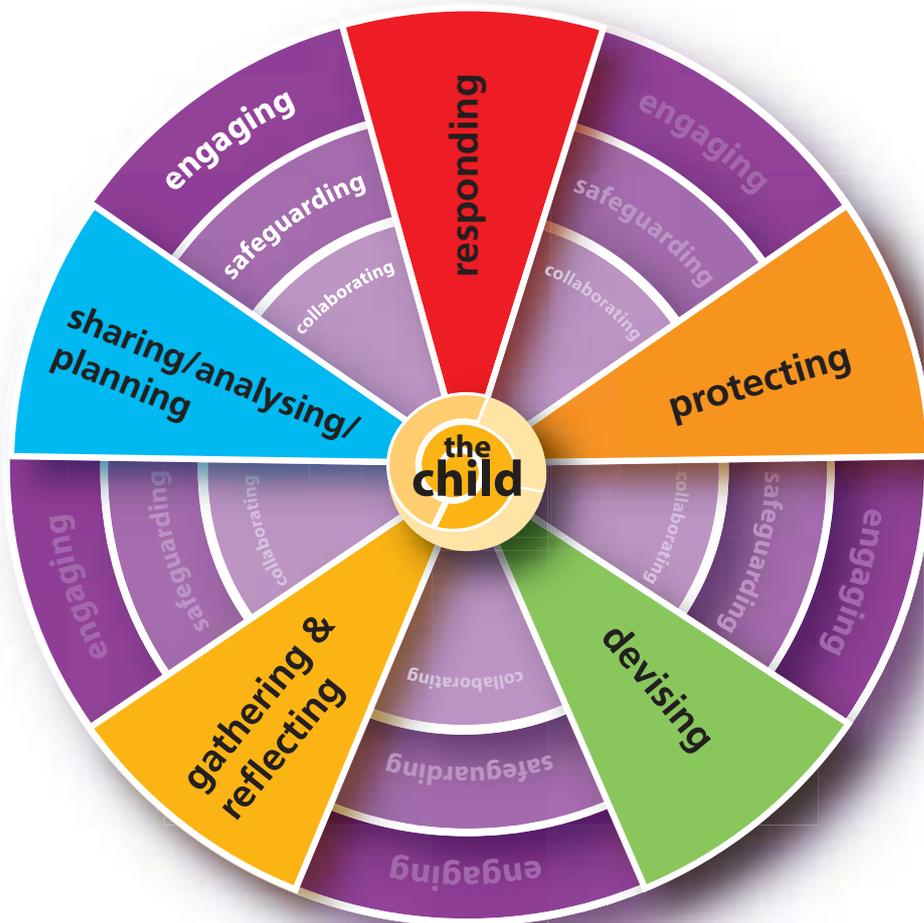
- 1 Responding
- 2 Protecting
- 3 Devising
- 4 Gathering and Reflecting
- 5 Sharing, Analysing and Planning

The concept of child centredness is illustrated by a circle in the middle of the wheel with the words ‘the child’ on it, together with a spiral. The spiral illustration depicts the Three Dimensions of a Child’s Life about which information should be gathered.

These are:

- ▶ Whether and How Child’s Needs are Being Met
- ▶ Parent/Carer Capacity to Meet Needs
- ▶ Community and Extended Family

This Practice Guidance provides the practitioner with some additional considerations to be borne in mind throughout the assessment.





Three Concurrent Activities



Engaging

How practitioners engage with the child and family will determine the quality of the assessment. It can be quite complex at times to engage a child and family that may be reluctant to enter a relationship with professionals or have been through the system many times before; therefore it is pivotal to give it due time and consideration.

The process of engaging the child and family will be ongoing throughout the assessment and not a discrete task. A key part of engaging is trying to help the child and family understand the purpose of the assessment and to help them reflect on what is happening in their lives and how to change and improve their situation. It is important to remember that family members and where appropriate, the child, will need to be prepared to attend meetings. Practitioners should prepare them in terms of what to expect and also the possible emotional impact that their attendance and content of the meeting may have upon them. It is also important that the concepts of confidentiality and sharing information are defined and agreed, so that there are no misunderstandings about who has access to the information that emerges during the assessment.

Children and families need to be told that any disclosures of current abuse (as defined in Children First) need to be reported to the Health Service Executive and An Garda Síochána. They also need to be told that any disclosures of past abuse of persons who are now adults will have to be considered for reporting if any evidence exists to suggest that the perpetrator may still be a risk to children. Practitioners should be aware that disclosures of past abuse are rarely straightforward and must be taken at the pace of the child or adult but never disregarded. (See also Practice Guidance, page X on preparing children and families for attending meetings).

The elements of practitioner style that are most valued by parents/carers are as follows:

- ▶ Being supportive,
- ▶ Listening carefully and effectively,
- ▶ Using skills that promote co-operation,
- ▶ Being matter of fact,
- ▶ Being 'human',
- ▶ Being friendly.

The elements that impact negatively are:

- ▶ Being bossy,
- ▶ Appearing uncaring,
- ▶ Being patronising,
- ▶ Using 'big words' that demonstrate power,
- ▶ Being hard to contact and not returning calls.

The following points should be considered when preparing to engage children and families in the assessment process:

Engaging the Child and Family

- ▶ Time should be spent with each member of the family, both together and separately, explaining the purpose and process of assessment,
- ▶ Time should be spent observing the interactions between children and carers,
- ▶ The inevitable power imbalance that will exist between the practitioners and the family needs to be acknowledged,
- ▶ Families who have been in contact with services over a long period may find the process of assessment repetitive and tedious and may experience what is termed 'assessment fatigue'. Sensitivity should be used in relation to asking factual questions to which they have already given answers. This may be minimised if workers read records beforehand and establish as far as possible what information already exists,
- ▶ Families should be assisted to understand that they have a lot to contribute to an assessment and be empowered to actively participate in it. This will be facilitated by, for example:³
 - Recognising that children and parents are experts on their own family,
 - Asking the child and family for their views as to why they are being assessed,
 - Negotiating with them the most suitable environment for the work to take place,
 - Letting the child and family identify their needs and their perception of the current problem,
 - Getting to know each family member's strengths and interests and use these when establishing rapport,
 - Agreeing some boundaries around the assessment in terms of what is expected of the child and family and what they can reasonably expect from the practitioners,

³ Adapted from Torode et al, 2001

- ▶ If appropriate in terms of the child and family's literacy skills, drawing up a contract with them so that they have a written record of the assessment process,
 - Giving information frequently and readily without waiting to be asked,
 - Giving the child and family an appropriate opportunity to record their feelings and perspectives in the assessment,
 - Giving the child and family access to what has been written about them and invite their comments on it,
 - Reviewing, with the child and family, the purpose and process of the assessment at regular intervals,
 - Facilitating the child and family to attend each meeting and ensuring that they understand the role of each practitioner involved,
 - Being as open, honest and transparent with the child and family as possible,
 - Empathising with the child and family whilst avoiding collusion,
 - Being prepared to explain the basis of all judgements about children's needs, and all decisions made during the assessment.

Research has shown that investigation and assessment of child protection and welfare concerns often focuses solely on the child's main caregiver. Children are not always included in a meaningful way. Siblings are not always included in the assessment, even though a serious concern about the welfare or safety of one child could reasonably give rise to a concern for other children living with the same caregivers. Fathers are sometimes excluded, as are carers who are unwilling to engage and those who have a history of aggressive behaviour (Milner, 1996; Ryan, 2000; Daniel and Taylor, 2001; Horwath and Bishop, 2001; Kingston, 2001; Buckley, 2003). It is important to make assessment as inclusive as possible. In Practice Principles 2 and 4, guidance is offered on some of the more challenging aspects of engagement:

Engaging Children & Adolescents

See Practice Principle 2 – Page 92

Engaging Siblings

See Practice Principle 2 – Page 93

Engaging Men

See Practice Principle 4 – Page 105

Engaging Involuntary and/or Aggressive Clients

See Practice Principle 4 – Page 106

Safeguarding

Safeguarding, as opposed to protecting, means maintaining a watchful eye on the child's safety throughout the duration of an assessment and indeed during the course of intervention. Even when the protecting step in the assessment has been processed, there is still the possibility that the immediate safety of a child who is vulnerable may become an important issue. All practitioners are aware of the constantly shifting dynamics in families, which can mean that a particular set of circumstances can change the status of a child from being vulnerable to being in danger. For example, a perpetrator may return to the family or neighbourhood; a previously stable programme of treatment or intervention for a parental problem may unravel; one of the carers may become involved in a new relationship or more information may emerge which could change the picture.

Research has noted a tendency for practitioners to adhere to original views and fail to integrate new information that may change a previously held opinion on a situation or for families to either shut out professionals or divert attention⁴ from children to parents without professionals realising that the child is no longer the focus of attention⁵.

Child abuse inquiries have demonstrated that at times, the provision of concrete solutions to a family's physical needs can divert professional attention from parenting or interpersonal issues that can ultimately prove more detrimental to children than the practical problem that has been addressed⁶. The Victoria Climbié inquiry noted a tendency for workers to dichotomise referred cases, i.e. on the basis of limited information classifying children as either in need (requiring support services) or at risk (requiring assessment)⁷ thus diverting cases away from investigation of potential abuse.

Sometimes children are placed in substitute care for safety reasons. These placements may be with approved foster parents or in residential care. Frequently, children are placed with relatives who are not yet approved under the Child Care Regulations, or other families who are not related and are also not approved foster carers. Placements of an informal nature may also occur, arranged by the families themselves. This placement or change of carer may occur at any time during an assessment. Notwithstanding the fact that the Health Service Executive may be assessing the family in line with the Child Care Regulations, practitioners need to be vigilant about the safety of

any child in this situation. The willingness of the substitute carers to provide care must be ascertained, along with their attitude to the child and his or her carers and their understanding of the reasons why the child has been placed with them. They must also be checked to see if there is any history of violence, sexual abuse or parenting problems in their family in the past, and if these factors exist, their impact on the safety of the child must be considered. If a fostering assessment is underway, liaison needs to be maintained between the worker assessing the family and the worker carrying out the assessment on the child's needs.

Practitioners must:

- ▶ Keep the child's safety in their consciousness and include it in any supervision discussions,
- ▶ Ensure that the child is seen frequently and regularly in a manner which permits the practitioner to assess his or her safety needs. Use quantitative as well as qualitative measures (e.g. count how many appointments were missed or concerns which arose rather than relying on an overall sense),
- ▶ Make it clear to parents/carers at the outset that part of the working agreement will include responding to any safety concerns about the child that may emerge during the assessment,
- ▶ Not allow positive relationships that have built up with parents/carers to interfere with professional responsibility, to be vigilant about threats to the child's safety and to respond to them quickly and openly. Employ 'respectful uncertainty' and 'healthy scepticism' in evaluating information⁸,
- ▶ Always check discrepant explanations about bruises, injuries or any indication of harm to the child,
- ▶ Make sure to read the entire record or file on the child so that any previous mis-diagnosis of safety issues can be checked and revised if necessary. If any information or documentation appears to be missing, it needs to be obtained. Any reports or faxes that are illegible need to be checked,
- ▶ Consider the impact of any changes in the household composition for the child's safety. For example, a new member would need to be included in the assessment even if he or she only joins the family at a later stage of the assessment.

⁴ Munro, 2002

⁵ Reder and Duncan, 1998

⁶ Laming 2003; Reder and Duncan, 1999

⁷ Reder and Duncan, 2004; Dale et al, 2002

⁸ Laming, 2003



Collaborating

Multi-disciplinary collaboration is an essential part of the assessment process and must be actively promoted throughout. Effective collaboration is the responsibility of every professional involved. Because of the individual nature of each case, the mix of disciplines and agencies may differ. There will be different models of multi-disciplinary assessment, for example, assessment teams comprised of different professionals who plan and conduct the assessment between them, or key worker/coordinator managed assessments where one person will take responsibility for drawing together the contributions of different disciplines and agencies.

However, in both the consultation processes prior to the development of the Assessment Framework and the evaluation process following the piloting of the draft Assessment Framework, the role of the key worker/coordinator has been identified as central. The key worker/coordinator is someone who undertakes the following tasks:

- ▶ Taking overall responsibility for the assessment,
- ▶ Allocating tasks to different professionals,
- ▶ Providing continuity and developing links, particularly with 'outside' agencies,
- ▶ Actively promoting participation from all relevant professionals and family members,
- ▶ Agreeing norms about what information may be shared with whom, and what is meant when the term 'confidential' is used,
- ▶ Overseeing the development of an assessment plan,
- ▶ Coordinating inputs,
- ▶ Planning multi-disciplinary meetings,
- ▶ Ensuring that there is a plan at the conclusion of the assessment,
- ▶ Providing or facilitating the provision of relevant training.

This person may also, depending on local arrangements, have responsibility for all assessments in the area.

It will be the responsibility of all other professionals involved in the assessment to:

- ▶ Familiarise themselves with the roles of all the disciplines and organisations involved and their expected contribution to the assessment,

- ▶ Read the relevant files, records and reports, in as far as they are accessible, of all the other professionals involved with the child and family,
- ▶ Establish strategies for the exchange of information relevant to the assessment (e.g. times when they will be contactable and the best means of communicating),
- ▶ Respond promptly to phone calls and messages and ensure that appropriate feedback and information is given to others involved in the assessment,
- ▶ Provide written reports for multi-disciplinary meetings.

Ideally, the assessment will commence with a multi-disciplinary meeting at which tasks will be allocated and a plan for the assessment will be agreed (see Step 3, Devising).

Efforts to promote and manage collaboration must be extended to children and families. For guidance on including families and children at multi-disciplinary meetings, See Step 5 (Sharing, Analysing and Planning).

It is important to acknowledge that achieving collaboration requires effort and is unlikely to happen unless energy and attention are directed to the process. See Section Two of this guidance (Practice Principle 5) for a more detailed discussion.





The Five Steps

STEP 1: RESPONDING

One of the aims of developing an Assessment Framework is to broaden out thresholds at which child protection and welfare concerns are assessed and addressed. The Assessment Framework also recognises the vital role played by the extended family and wider community in supporting families and providing early interventions to prevent the occurrence or re-occurrence of child abuse. As Children First (7.12) points out, many of the children who come to the attention of the Health Service Executive or other professionals are living in stressful environments, where the quality of their lives is affected by factors such as domestic violence, addiction, disability, mental health difficulties, behavioural difficulties or other sources of stress. Children living in these situations may or may not be considered to be abused according to the definitions given in Children First, but may have ongoing unmet needs that seriously affect their emotional, physical and psychological development.

- ▶ It is important that initial responses to referrals are made in the knowledge that child protection should be seen as part of an overall approach to promoting the welfare of children with identifiable needs. Reports which require a response will be those where concern is expressed about a child's welfare in relation to the quality of his or her home environment or the standard of care he or she is getting. Some of these reports will indicate that a child is being seriously harmed or is at risk of harm, but in other situations, the nature of the problem will be less clear and will require further assessment.
- ▶ The content of the referral should be carefully examined, taking account of the opinion of the referrer (who could be a parent, relative, member of the public or practitioner) and considering this in relation to the evidence that they cite or present. Their involvement with the child and family, and their view of the likely consequences if the problem continues should also be considered.
- ▶ A high percentage of concerns reported to child care agencies involve children and families already known to the service. It is possible that the child and family have already been in contact with public health nursing, public health doctors, social work, psychology or speech and language therapy, where different

types of assessment may already have been carried out. Ideally, a form of record management will exist that permits practitioners in all disciplines to be able to ascertain, within a short period of time, the pattern and type of problem previously presented, the factors that trigger a crisis and/or maintain the difficulty and the type of response that has worked effectively on previous occasions. All possible sources should be checked out, (including services in other areas in which the child and family previously lived) in order to pool existing information, avoid duplication and protect the child and family from repeated interviewing.

- ▶ An important principle to be employed when responding to a referral is the adoption of an inclusive approach towards the child and family. Partnership and the provision of services on a voluntary basis should be prioritised as the majority of families have strengths which, when supported and developed, may enable them to find a solution to the current difficulty.



STEP 2: PROTECTING

The first question to be addressed in all assessments is whether or not the child is currently at risk of harm, and what, if any, actions need to be taken in the short term to ensure his or her safety. It is vitally important to remember that the safety needs and the welfare needs of a child may differ at any time during the continuum of intervention, and this includes the assessment period (see Safeguarding). It is essential, therefore, to be continuously alert to factors that may threaten a child's safety.

If a child is considered to be at risk, but not in need of separation from his or her parents/carers, the changes that need to be brought about in order to reduce the current level of risk must be identified. It is vital to be clear about what precise indicators of risk currently exist, and specify not only the methods to be used to effect change, but the means of identifying that change has taken place (MacDonald, 2001).

Essentially, we refer to risk when the likelihood of something negative happening or not happening to a child is uncertain (see Section Two, Practice Principle 1). Risks are likely to be linked to:

- ▶ The vulnerability of a child:
 - Age, stage of development,
 - Ability to understand the incident as abusive,
 - Child's ability to protect themselves,
 - Presence or absence of protective factors (e.g. a protective parent or other adult) and proximity to the cause of risk.
- ▶ The possibility that the incident will re-occur e.g. ongoing physical chastisement rather than an isolated incident or slap,
- ▶ The likely negative impact on the child if the incident re-occurs (now, or at different stages in the future according to his or her level of vulnerability).

Consistent risk assessment should enable the clearest possible decision making. In assessing risk, the **detail** and **significance** of each incident need to be considered in addition to the number of incidents. Experience has demonstrated a tendency for practitioners to see a reduction in the number of incidents over a given period as reducing the risk to the child when this may not in fact be the case (Fitzgerald 1999). For example incidents of chastisement may reduce but the child may continue to experience a high level of criticism.

In line with the above, it is important to consider:

- ▶ The nature of the current incident or omission i.e. what was its impact on the child, was it a 'once off', was it linked with or complicated by circumstances that are short or long term in nature?
- ▶ The possible severity of any future incident.

Research has shown that examples of caregiver's personal characteristics, which are important determining factors in the prediction of future abusive behaviour, include⁹:

- ▶ Patterns of previous behaviour,
- ▶ Seriousness of previous incidents or omissions,
- ▶ Tendency towards violence,
- ▶ Experience of stress,
- ▶ Presence of complicating factors such as substance abuse or mental illness,
- ▶ Belief systems that accept maltreatment,
- ▶ Knowledge about the needs of children.

Thresholds

Gathering and making sense of information about a child suspected to be at risk of immediate harm can be a complicated task, but deciding that the child's level of care and protection is not sufficient to guarantee their safety is equally complicated. Reaching a 'threshold' in this context is essentially deciding the point beyond which decisive action on the part of a particular practitioner is necessary. The type of action most commonly considered is separating the child from his or her carers, but it may include other interventions. Research by Dalglish (2003) has shown that thresholds for action can vary between practitioners and agencies, even when information about children's situations is consistent. When deciding on action, it is essential to be clear about the link between assessed levels of risk and the levels of intervention required as follows:

- ▶ Be aware of the subjective factors that can influence decision making, for example the time of day that the referral is received and worker availability (See Practice Principles 1 and 6, Section Two of this Practice Guidance),
- ▶ Be aware of your own personal threshold and the reasons behind it,

⁹ Adapted from Risk Estimation System, Department of Child Youth & Family, New Zealand

- ▶ Focus on the cumulating information obtained during the assessment and critically evaluate this bearing in mind what is known about risks to children and effective interventions,
- ▶ ‘Evidence’ this information – use description rather than definition, specify the scale of harm and protective factors in relation to an objective measurement if possible, use examples and share this information with families and colleagues,
- ▶ Separate availability of resources from the perceived level of risk to the child,
- ▶ Understand the difference between professional experience, discretion and personal thresholds.

Because the context in which children live is rarely static, perceived or actual threats to their safety may escalate or abate at different times over any given period, even within the same 24 hour period (see ‘Knowing the Child’, page 40). It is therefore essential from the outset of an assessment that all involved professionals understand the necessity to pass on any concerns about harm noted by them to the key worker in order to ensure that they are addressed.

STEP 3: DEVISING

Getting Ready For An Assessment

Once it has been established that the child is safe, consideration can be given to planning a more holistic assessment. The purpose of the assessment should be linked to the concern that was first expressed about the welfare and/or safety of the child. It is important to be clear from the outset about the rationale for the assessment and the methods to be used for consulting other personnel and collecting information.

Ideally, the process of planning an assessment should begin at a multi-disciplinary meeting where the relevant professionals agree on the tasks to be completed and the division of responsibilities. They should also consider how they will ensure that the maximum use is made of the group's combined skills and expertise and how they will try to overcome any anticipated obstacles. Different perspectives on the meaning of assessment to different professionals should be clarified.

Planning the assessment also requires consideration of the following:

- ▶ Will certain information be difficult to access? It is also necessary to ascertain at this stage if special arrangements will need to be made, for example the need for an interpreter,
- ▶ To what extent will information be shared, and what feedback will be given to participants?
- ▶ Whose consent must be sought in relation to the sharing of information?

Timescales

The Assessment Tool does not recommend a time scale for completion of assessments in general terms. This is because circumstances will differ in different cases and children with additional needs may require a longer assessment, or, for example, families whose first language is not English may require the services of an interpreter which may impact on the length of time needed. However the tool does recommend that time scales should be agreed on in individual cases. Raynes (2003) advocates the use of agreed time scales so that:

- ▶ Decisions and interventions will not be delayed,
- ▶ The family will feel more empowered by understanding how long the process will take and when decisions are likely to be taken,
- ▶ Professionals will know how long they have for information gathering and when their contributions will be evaluated.

It is important to ensure that the child and family understand the purpose of the assessment and the likely benefits to themselves from participating in it. It is also important to note that practitioners can share information concerning suspected child abuse without breaching confidentiality (Department of Health and Children, 1999). However, sharing information that is more concerned with building up a picture of vulnerability, and not related to child abuse, is more complex. For this reason, the process of engaging the child and family and gaining their permission is extremely important and is one that requires attention throughout the assessment process (see Engaging). Confidentiality is as important an issue in relation to families, friends and neighbours as it is in relation to professionals. Care needs to be taken when interviewing members of the extended family and significant others within the family's support network to strike a balance between respecting an individual's right to privacy while at the same time tapping into an important source of valuable information.



STEP 4: GATHERING & REFLECTING

Practitioners should bear in mind that assessment is an ongoing process. At the start of the assessment certain areas may seem very relevant or irrelevant. However, as the assessment progresses and information is gathered, some concerns will abate, new ones may emerge and others may escalate. Therefore, gathering information using the Assessment Tool should be seen as a dynamic rather than a linear process.

Step 4 comprises two equally important interrelated activities: gathering and reflecting on information. The process of gathering information is represented as a Spiral depicting the Three Dimensions of a Child's Life about which information should be gathered. To reflect on the information gathered, the five key analytical questions should be applied to each piece of information generated.



Gathering Information

The process of gathering information is structured by the Three Dimensions of a Child's Life which should be considered concurrently in order to understand their mutual interaction and impact on the child.

Dimension 1 Whether and How the Child's Needs are Met

Dimension 2 Parent/Carer Capacity to Meet Needs

Dimension 3 Extended Family and Community's Capacity to Meet the Child's Needs and/or Support Parent/Carers to Meet those Needs

The Assessment Tool also emphasises the importance of bearing in mind not only whether a child's needs are met but 'how' they are met, this means, for example, taking into account the relationship of care that exists between the carer and the child.

When considering a child's needs, it is important to include all relevant considerations, including the additional needs experienced by some children. With regard to parent/carer capacity, the tool points to the importance of considering certain issues on parenting capacity.

Furthermore, as is outlined in the Assessment Tool, there is an element of circularity and mutual interaction between the Three Dimensions. This means that when considering the child's needs one also needs to consider how the child sees his or her own needs and how the parent/carer(s) and

extended family and community see the child's needs. When considering parent/carer capacity to meet the child's needs it is important to consider how the parent/carer views their own capacity, how the extended family and community view the parent/carer capacity and where appropriate, the opinion of the child on the capacity of their parent/carer to meet their needs. Finally, when considering how members of the extended family and community view their capacity to meet the child's needs it is also important to consider the perspectives of the parent/carer and the child.

The Assessment Tool outlines pointers to be considered in relation to each of the Dimensions. These pointers are intended to act as aide memoirs that practitioners or managers will use to guide their assessment of a child and their family. It is important to reflect upon the ways in which each Dimension impacts on the child's safety, welfare and development.

Practitioners may not always find it relevant to explore each dimension of a child's life. Variations on what needs to be considered will occur depending on the age and developmental stage of the child. The term parent/carer is used in the singular in most sections of the Assessment Tool and Practice Guidance. Where the child has more than one carer, information should be elicited from each of them.

It is very important for all disciplines working with children to be clear about their role in the assessment, to be aware of the limitations of their professional judgement, to know where, and at what point, to link the child and family with additional services or when and where to refer them for further, more in-depth assessment.

The information gathered must reflect the views of the child, the family and the practitioners involved. It is important for the practitioner conducting or coordinating the assessment to be clear with other practitioners and the family about the extent and limits of information sought, how the information gathered will be used and who will have access to it.

An elaboration of the Three Dimensions of the Child's Life is detailed below.

The Three Dimensions of a Child's Life

The Assessment Tool presents the Three Dimensions of a Child's Life side by side in a table in order to encourage practitioners not only to address the child's needs, but to take a *parallel* and *integrated* view of the different ways in which factors in a child's family and environment constantly interact in order to meet his or her needs. Considering them in this way facilitates the practitioner to merge the resulting information and provide a holistic picture.

This section of the Practice Guidance elaborates on certain areas highlighted within the Three Dimensions. These areas have been selected on the basis of research findings, which indicate that they need particular attention. They also reflect the views of practitioners during the consultation phases of the development of this Assessment Framework.

Dimension 1, Whether and How the Child's Needs are Met; the Assessment Tool identifies the child's need for **relationships, attachments, affections** and **resilience**. Further information on assessing whether this need is being met is provided below.



The Assessment Tool also points out that when contemplating a child's needs, it is important to be mindful of **additional needs** experienced by some children. These additional needs relate to **children with disabilities and complex health needs and children from ethnic minorities**. Further information on these needs is also provided below.



Dimension 2, Parent/Carer Capacity to Meet the Child's Needs; parental capacity must be considered in relation to each of the child's identified needs. In addition it is important to consider the impact of certain issues on parenting capacity. An elaboration on each of these issues is detailed below.



DIMENSION 1 CHILD'S NEEDS

Relationships, Attachments, Affections and Resilience¹⁰

Attachment and resilience are now regarded as key concepts in child protection and welfare, but research has shown that they are not always included in assessment (Graham, 1998; Kennedy, 1999). Some guidance on how to assess these areas is given below.

As outlined in the Assessment Tool, the key areas to be considered when assessing a child's relationships, attachments, affections and resilience are:

- ▶ Child's history and attachment strategy in relation to primary carers and significant others,
- ▶ Relationships with peers of the same and opposite sex,
- ▶ Stability of relationships in the child's life and the child's experience of bereavement and/or parental separation or divorce,
- ▶ Evidence of resilience and factors that support it.

The quality of the attachment relationship between the child and the parent/carer underpins an assessment of the needs of the child.

Attention to the following areas will assist the practitioner in assessing the child's attachment strategy:

Child's history and attachment strategy in relation to primary carers and significant others

- ▶ What is the nature of the attachment with the primary carer?
- ▶ Who else does the child have an attachment to?
- ▶ Who is important to the child at home, in the extended family, in school, in the community, in clubs, elsewhere?
- ▶ Does the child have someone who loves him/her unconditionally?
- ▶ Does the child have someone in whom they can confide?
- ▶ Who does the child seek out for consolation when distressed or upset?
- ▶ How does the child react to separations from and reunions with their caregivers?

- ▶ How do the child and parent/carer interact? For example flat, lack of emotion, engagement and enjoyment,
- ▶ How does the child interact with his/her siblings and significant others?
- ▶ Does the parent/carer understand and respond to the child's emotional cues of distress or need for support? For example distress or need for support,
- ▶ Does the parent/carer anticipate the emotional needs of the child? For example situations the child is likely to find stressful and does the parent/carer offer reassurance and support?

Relationships with peers of the same and opposite sex

- ▶ Does this child have any/many friends?
- ▶ How important are these peers to the child?
- ▶ How much time does the child spend with his/her peers?
- ▶ What activities do the child and his/her peers engage in?
- ▶ If the child has none or very few friends do they experience any of the following:¹¹
 - Emotional problems,
 - Less altruism,
 - Poor social skills in group entry, cooperative play and conflict management,
 - Less sociability,
 - Poor school adjustment,
 - Poorer school attainment.

Stability of relationships in the child's life and the child's experience of bereavement and/or parental separation or divorce¹²

- ▶ Has the child experienced losses? What impact have these losses had on the child?
- ▶ At what developmental stage did these losses occur?
- ▶ What is the child's understanding of the loss (e.g. why do they think parent has left)?
- ▶ What opportunities has this child had to process her reaction to these different losses?
- ▶ What are the important sources of continuity in the child's life despite the losses?
- ▶ Are there ways in which the practitioner can strengthen the connection to such threads of continuity?
- ▶ Does the child need to do any active work on grieving for losses at this point?

¹⁰ Adapted from Daniel, Wassell and Gilligan, 1999

¹¹ Schaffer, 1996

¹² Daniel, Wassell and Gilligan, 1999

- ▶ Does the child have a need for fuller or more accurate information concerning the circumstances surrounding any key past losses?
- ▶ If so, are there people of significance to the child who the child trusts and who may be able to help in the process of working through the loss?
- ▶ Are current caregivers properly briefed on the child's history of loss and the likely psychological reactions to such patterns of loss?
- ▶ Have the caregivers or other adults playing a significant role in the child's life had a chance to have training and/or discussion about the precise nature of loss and its likely impact in the child's life?
- ▶ Who are the people to whom this child/young person matters?
- ▶ What should be included in a list of this child/young person's social skills and accomplishments?
- ▶ Who or what constitute resources in assisting this child/young person to negotiate adversities and make their way in the world?
- ▶ How is the child/young person getting on in school?
- ▶ How able is the child/young person academically?
- ▶ Does the child/young person have a good relationship with his/her teacher(s)?

Evidence of resilience and factors that support it¹³

- ▶ Does the child/young person receive praise for doing things on his or her own?
- ▶ Does the child/young person know someone he or she wants to be like?
- ▶ Does the child/young person believe things will turn out all right?
- ▶ Does the child/young person do endearing things that make people like him or her?
- ▶ Is the child/young person willing to try new things?
- ▶ Does the child/young person like to achieve in what he or she does?
- ▶ Does the child feel that what he or she does makes a difference in how things come out?
- ▶ Does the child/young person like himself or herself?
- ▶ Can the child/young person focus on a task and stay with it?
- ▶ Does the child/young person have a sense of humour?
- ▶ Does the child/young person make plans to do things?
- ▶ What interests and talents does this child/young person have? Ask the child to identify these,
- ▶ Are these being developed in any way?
- ▶ What qualities does this child/young person have which other people find attractive?
- ▶ Which of the child/young person's qualities are helpful in dealing with adversity?

The quality of the attachment and relationships between the child and the parent/carer and other important carers will directly impact on how all other needs are met.

What is the child's strategy of attachment to his/her parent/carer and other important carers, including sibling and significant others?

Attachment strategies can be categorised as follows:

- ▶ Secure attachment,
- ▶ Anxious attachment,
- ▶ Ambivalent attachment,
- ▶ Avoidant attachment.

See Practice Principle 2, page 94, for a fuller explanation of these definitions of attachment

ASSESSING THE ADDITIONAL NEEDS OF SOME CHILDREN

All children have similar needs. However, children from minority groupings within society may have additional ones. It is also possible that their parents may experience additional pressures that affect their ability to meet their children's needs. Minority groupings include children with disabilities, children with complex health needs, children with HIV and AIDS, refugee children, asylum-seeking children and Traveller children. For the purposes of the Assessment Tool, children's additional needs are categorised as:

- ▶ Disability and Complex Health Needs
- ▶ Children from Ethnic Minorities

¹³ Source: International Resilience Project cited in Daniel and Wassell, 2002



Children with Disabilities and Complex Health Needs

When assessing a child with a disability or complex health needs there are certain considerations which need to be borne in mind, which are outlined on page 34 of the Assessment Tool. These considerations are additional to those suggested by the Assessment Tool for carrying out assessments with all children. They expand on five of the seven child's needs outlined in the Three Dimensions of the Child's Life, however physical development, basic care and medical care are considered under one heading; basic and medical care needs.

Basic and Medical Care Needs

The Assessment Tool recommends that practitioners consider the basic and medical care needs specific to a child with disabilities or complex health needs in terms of how such needs are met and whether the child has the appropriate levels of autonomy in relation to meeting these needs. Additional areas for consideration include:

- ▶ Is the level of autonomy the child has in meeting his/her own basic and medical needs appropriate to his/her ability?
- ▶ Are the child's needs for medication and therapies adequately and appropriately met?
- ▶ Does the child need assistance with intimate care such as toileting and washing? Who helps the child with this? Is this appropriate?
- ▶ Are there any difficulties feeding the child due to his/her disability or health needs?

Supervision and Safety

The Assessment Tool recommends that practitioners consider the disabled child's need for supervision and safety in terms of the level of autonomy that the child has, the potential that exists regarding their independence in the future and their ability to protect themselves. Additional areas, which could be considered, include:

- ▶ How dependent is the child with disabilities or complex health needs on the parent/carer to meet all their needs?
- ▶ What impact does this have on the parent/carer?
- ▶ What impact does it have on the child? What implications would there be for the child if they were to complain about the parent/carer?
- ▶ How much autonomy does the child have?
- ▶ Is this level of autonomy appropriate to their ability and awareness of danger or does it endanger their safety?

- ▶ Does the environment in which the child lives have any an impact on safety and supervision, for example a child with autism living on a farm?

Relationships, Attachments, Affections and Resilience

The Assessment Tool recommends that practitioners consider the child's relationships, attachments, affections and resilience in terms of their feelings about their disability or health needs and their ability to respond to those around them. Additional areas, which could be considered, include:

- ▶ Does the child have the ability to verbalise or communicate their thoughts and feelings?
- ▶ Does the parent have the understanding/ability to pick up non-verbal cues from the child and to use the child's way of communicating?
- ▶ What impact does an inability to do so have on those around them and on themselves?
- ▶ What is the child's view of how their parents have dealt with their disability or health needs?
- ▶ Is the child able to demonstrate affection and gratitude to those around him/her?
- ▶ What impact does an inability to do so have on their parent/carer and extended family and friends?
- ▶ Does the child understand what types of touch are necessary and appropriate thereby enabling them to protect themselves from sexual exploitation?
- ▶ What does the child say or understand about their disability or illness?
- ▶ Does the child have realistic expectations for him/herself?
- ▶ To what extent is the child treated differently to his/her non-disabled siblings and peers? Is this appropriate?
- ▶ What impact, both behaviourally and emotionally, does the child with a disability or health need have on his/her siblings?
- ▶ To what extent is the child able to participate in the activities enjoyed by their peers?
- ▶ Is the child subject to frequent hospitalisations, respite care or is she/he living in residential care? What impact does this have on their ability to sustain relationships with their friends?
- ▶ If the child is displaying behavioural problems could this be an indicator of parental stress rather than being related to their disability or health need?

Intellectual and Social Development

The Assessment Tool recommends that practitioners consider the intellectual and social development of a child with a disability or complex health needs in terms of how integrated they are in their family and school; whether they are experiencing any negative stereotyping within their school and what impact such discrimination may have on their cognitive and intellectual capacity and development; whether they participate in extra curricular activities and their understanding of their disability or health needs. Additional areas, which could be considered, include:

- ▶ What schooling is the child receiving?
- ▶ Is it commensurate with their intellectual and cognitive ability?
- ▶ Is it possible for the child to attend a mainstream school with supports?
- ▶ How integrated is the child into the school he/she attends? For example is disability and diversity valued within the school? Are all areas of the school wheelchair accessible?
- ▶ Does the child experience any discrimination or bullying during their structured school day and how does the teacher deal with it?
- ▶ Does the child experience any discrimination or bullying during the less structured part of their school day, for example in the yard, and how is this dealt with by the school?
- ▶ Does the child have friends in school?
- ▶ What relationship does the child have with his/her teacher?
- ▶ Has the child received appropriate levels of sex education?
- ▶ To what extent does the child have ongoing opportunities to learn to protect themselves from vulnerabilities? For some disabled children a greater level of repetition and focus on practical application may be necessary to facilitate their understanding,
- ▶ Does the child have opportunities for socialisation outside school?
- ▶ Is the child subject to frequent hospitalisations, respite care or is she/he living in residential care? What impact does this have on their education?
- ▶ Does the child experience any discrimination or bullying in their daily life, apart from in school?
- ▶ How does such discrimination or bullying affect him/her?

Children from Ethnic Minorities



Basic and Medical Care Needs

The Assessment Tool outlines basic and medical care needs of children from ethnic minorities, the appropriateness of the accommodation offered to asylum seekers (including unaccompanied minors) and travellers and the implication of frequent accommodation moves. Additional areas, which could be considered, include:

- ▶ What accommodation is the family living in?
- ▶ How much space and privacy does the child have?
- ▶ Does the child have a quiet space to do his/her homework?
- ▶ Is the child able/allowed to invite friends over? For example a child living in a direct provision hostel may not be allowed to invite friends over,
- ▶ Is this child invited to the homes of other children?
- ▶ What impact does the frequency of accommodation moves have on the child's social and educational development (friends, schooling)?
- ▶ What implication does the family's income have for the child?
- ▶ Are there any cultural mores which may impact on the parent/carer's willingness to use medical services, for example the gender of the doctor or a sense of stigma regarding mental health difficulties?

Supervision and Safety

The Assessment Tool recommends that practitioners consider the supervision and safety of children from ethnic minorities in terms of appropriate levels of supervision and safety and the provision of areas for safe play and recreation whilst living in temporary accommodation.

In relation to parent/carer capacity, the Assessment Tool suggests consideration of parental responsibilities within Irish child care legislation. It can be very difficult to get a balance between what is culturally acceptable, for example discipline and infant care practices in certain ethnic groups and what Irish society considers to be acceptable standards of parenting practice. In order to overcome this dilemma the Assessment Tool uses Irish legislation as a benchmark.

A specific issue which may be relevant when assessing the needs of unaccompanied minors is

their vulnerability to child trafficking and sexual exploitation. It may therefore be important to assess the safety of their contact with adults with whom their relationship is not certain.

Practitioners need to be aware that unaccompanied minors may present as part of a family unit when in reality they are not.

Relationships, Attachments, Affections and Resilience

The Assessment Tool recommends that practitioners consider the relationships, attachments, affections and resilience of children from ethnic minorities in terms of their ability to stay in touch with family and friends in their country of origin and having opportunities to meet and get to know others from a similar country of origin or ethnic background, if desired. Additional areas which could be considered, include:

- ▶ Does the child have friends both within and outside their ethnic group?
- ▶ How willing are children within the host community to befriend him/her?
- ▶ Has the child opportunities for socialising both within and outside their ethnic group?
- ▶ Does the child's accommodation type in any way hamper their ability to integrate into the community? How?
- ▶ If the child is in care, is the care placement appropriate to the child's ethnicity? How?

Intellectual and Social Development

The Assessment Tool outlines the additional intellectual and social development needs of children from ethnic minorities in the following terms: negative stereotyping and overall level of integration within school; the impact of discrimination or racism on the child's cognitive or educational capacity and development; the opportunities that the child has to learn about his/her culture and history and their opportunities to learn English and norms and mores of Irish culture. Additional areas, which could be considered, include:

- ▶ How integrated is the child into the school he/she attends? For example how much exclusive time does the child spend with the language teacher or resource teacher for Travellers?
- ▶ How multicultural is the school? For example what proportion of children are from ethnic minorities; do wall displays, resource materials

and books reflect the composition of the school community?

- ▶ Is cultural difference valued and diversity respected in the child's school?
- ▶ What is the school's attitude to providing education to children from ethnic minorities? For example what is the school's enrolment policy and practice in relation to ethnic minorities?
- ▶ Does the child experience racism and discrimination during their structured school day and how does the teacher deal with it?
- ▶ Does the child experience racism and discrimination during the less structured part of their school day, for example in the yard and how is this dealt with by the school?
- ▶ Does the child experience racism and discrimination in their daily life, apart from school?
- ▶ How does any racism or discrimination affect him/her?
- ▶ What does the child know about their culture, history and country of origin?
- ▶ What opportunities are there to learn about this?

DIMENSION 2 PARENTING CAPACITY TO MEET NEEDS

Issues Impacting on Parenting Capacity

When assessing the parent/carer's capacity (Dimension 2) to meet the child's needs, it is necessary to consider how certain contextual issues may affect them in different ways at particular times. This section offers guidance to practitioners on how to ascertain the impact on parenting capacity of:

- ▶ Alcohol and Drug Misuse
- ▶ Mental Health Difficulties
- ▶ Having a Disability
- ▶ Domestic Violence
- ▶ Parenting Alone
- ▶ Being an Adolescent Parent/Carer
- ▶ The Parent/Carer's Own Experience of Being Parented
- ▶ Caring for a Child With a Disability or Complex Health Needs
- ▶ Being a Member of an Ethnic Minority Group
- ▶ Socio-Economic Factors.

It is unlikely that **all** of the factors covered in this section will be relevant to an assessment. Practitioners can therefore be selective about which areas they choose to focus on.

Research indicates that it is misleading to suggest that all parents who suffer from a mental illness, problem alcohol or drug use or are victims of domestic violence are a danger to their children (Cleaver et al, 1999). It is very important, therefore, to avoid generalisations when carrying out assessments, and to be specific about the type of problem (i.e. type of mental illness – schizophrenia, depression or manic depressive psychosis etc), the way that the problem manifests itself, whether or not the parent/carer is on medication or receiving counselling, and the specific manner in which it impacts on parental capacity to meet children's different needs.

Impact of Problem Alcohol and Drug Misuse

The Assessment Tool outlines the following areas for consideration of the impact of alcohol and/or drug misuse on the parent/carer's parenting:

- ▶ History of drug and alcohol misuse including previous attempts at rehabilitation,

- ▶ Willingness to engage with services,
- ▶ Frequency and quantity of alcohol/drug misuse,
- ▶ Impact on parenting of binge drinking,
- ▶ Impact on parent and parenting capacity,
- ▶ Impact on parent/carer who isn't misusing drugs or alcohol and their willingness to engage in support services,
- ▶ Social consequences of the substance misuse,
- ▶ Involvement of the child in substance misuse and the parent/carer's awareness of this,
- ▶ Parent/carer's awareness of the impact of their alcohol and drug misuse on the child,
- ▶ Whether other substance misusers visit the family home.

Considerations Particular to Drug Misuse

- ▶ Parent/carer's ability to protect the child from exposure to drugs and drug use, needles, sources of HIV and Hepatitis infection and dangerous substances,
- ▶ Involvement of child in procurement of drugs or money or as a courier.

Listed below is guidance for each area outlined in the Assessment Tool.

History of drug and alcohol misuse including previous attempts at rehabilitation

- ▶ What is the parent/carer's history of drug and alcohol misuse?
- ▶ Have there been previous attempts at rehabilitation? How successful or otherwise were these? What precipitated the return to substance misuse?
- ▶ Has the parent/carer been hospitalised or imprisoned due to their substance misuse?
- ▶ Does the parent acknowledge that they have a drug/drink problem?

Willingness to engage with services

- ▶ Is the parent/carer linked to any addiction service?
- ▶ Does the parent/carer have any reservations about getting involved with services?
- ▶ Is the parent/carer, who is not involved in alcohol/drug misuse, in contact with any services?

Frequency and quantity of alcohol/drug misuse¹⁴

- ▶ What substance is being used?
- ▶ How much is taken?
- ▶ How is it obtained?
- ▶ When it is used, what is the pattern of usage?
- ▶ Where is it used?
- ▶ Who is it used with?
- ▶ What is the cost of the substance?
- ▶ What is the pattern of intoxication and withdrawal?

Impact on parenting of binge drinking

- ▶ When does the parent binge drink?
- ▶ What are the triggers?
- ▶ Where and in whose care are the children whilst the parent/carer is binge drinking?
- ▶ What specific impact does the binge aspect of this parent/carer's drinking have on their ability to look after their children?
- ▶ What is the ongoing impact of periodic binge drinking on the child?

Impact on parent and parenting capacity

- ▶ How much time is spent by the parent/carer procuring drugs/alcohol, or money for their acquisition, and how does this impact on the time and energy they have available to meet the needs of the child?
- ▶ Does the parent/carer experience any effects from the substance misuse such as: memory or concentration loss, irritability, paranoia, sleep deprivation, impaired judgement, altered mood, suppressed appetite, impulsivity, drowsiness, unconsciousness?
- ▶ If yes, how do these effects impact on the parent/carer's capacity to meet the needs of the child?
- ▶ Does the parent experience any emotional difficulties such as attention deficit, psychiatric and mood disorders?
- ▶ If yes, how do these impact on their capacity to meet the needs of the child?
- ▶ Does the substance misuse lead to unpredictable moods and behaviour which can negatively impact on the attachment between parent and child?

- ▶ Does the substance misuse cause the parent/carer to be angry or rejecting towards the child?
- ▶ What happens to the child if the parent is absent due to imprisonment, hospitalisation or detoxification?
- ▶ What are the effects of withdrawal on the parent and their capacity to meet the needs of the child?
- ▶ Does the child assume a parenting role when the parent/carer is under the influence of drugs/alcohol?

Impact on parent/carer who is not misusing drugs or alcohol and their willingness to engage in support services¹⁵

- ▶ Is there another parent/carer who is not engaged in substance misuse?
- ▶ How do the difficulties of the misusing parent/carer impact on the parenting capacity of the non-misusing parent/carer?
- ▶ Is she/he overly focused on their misusing partner to the detriment of the child?
- ▶ Does the non-misusing partner have to take on the roles and parenting tasks of their partner?
- ▶ What impact does this have on their availability to the child?
- ▶ Does the non-misusing parent/carer have sole responsibility for the 'negative' roles of parenting such as discipline and making rules?
- ▶ What impact does this have on their relationship with the child?

Social consequences of the substance misuse

- ▶ Has there been loss of income and employment due to the substance misuse?
- ▶ Is the household budget used to finance the substance misuse?
- ▶ Has or does the parent/carer engage in any illegal activity to fund the substance misuse?
- ▶ Has the family suffered any social isolation from friends and family due to a sense of shame, borrowing or stealing money or inappropriate behaviour?

Involvement of the child in substance misuse and the parent/carer's awareness of this

- ▶ Is the child involved in any substance abuse?
- ▶ If yes, why, what substance, how often, with whom, how is it financed?

¹⁴ Adapted in part from Harbin and Murphy, 2000

¹⁵ Adapted from Velleman, 2003

- ▶ How aware is the parent/carer of their child's substance misuse?

Parent/carer's awareness of the impact of their alcohol and drug misuse on the child

- ▶ How does the parent/carer define their substance misuse?
- ▶ Is the parent/carer aware of the potential for their substance misuse to negatively affect their child?
- ▶ Is the parent/carer able to ensure that their child's needs come first?
- ▶ Does the parent/carer make any alternative care plans, if necessary, for the child while engaged in substance misuse, imprisoned or hospitalised?

Whether other substance misusers visit the family home

- ▶ Do other substance misusers visit the family home?
- ▶ If yes, what level of contact or interaction do they have with the child?
- ▶ Does the parent/carer engage in misusing behaviours with others in the family home?
- ▶ What impact does this have on the child?
- ▶ Does the parent/carer use the family home for selling or acquiring drugs?

Considerations Particular to Drug Misuse

Parent/carer's ability to protect the child from exposure to drugs and drug use, needles, sources of HIV and Hepatitis infection and dangerous substances

- ▶ Does the parent/carer make any efforts to conceal their misusing behaviour from the child?
- ▶ Is the parent/carer aware of the various impacts that being exposed to drug taking may have on the child?
- ▶ Is the abusing parent/carer cognisant of the danger of exposing their child to needles or source of HIV and Hepatitis infection?
- ▶ Is the parent/carer able to protect the child from such exposure?

Involvement of child in procurement of drugs or money or as a courier

- ▶ Is the child involved in the procurement of drugs or money?

- ▶ Is the child being used as a courier of either drugs or money?
- ▶ Is the parent aware and concerned about the danger that this might put the child in, both in terms of his or her safety and in terms of introducing him or her to a drugs culture?

See also Practice Principle 3, page 98

Impact of Mental Health Difficulties

The Assessment Tool outlines the following areas for consideration of the impact of mental health difficulties on the parent/carer's parenting:

- ▶ Past history of mental health problems
- ▶ The nature of the parent/carer's mental health difficulties and the pattern of behaviour
- ▶ Parent/carer's perception of their mental health difficulties and willingness to engage with services
- ▶ Willingness of the parent/carer to take medication as appropriate and its effect on the parent
- ▶ Impact of the mental health difficulties on the parent/carer's cognitive state, judgements and emotional availability to the child
- ▶ Expectations and responsibilities on the child when the parent/carer is ill
- ▶ Impact of a parent/carer's mental health difficulties on their partner and the level of insight and understanding that partner has into the difficulty
- ▶ Resources and networks that have assisted the parent/carer in meeting the needs of the child
- ▶ Parent/carer's awareness of the impact of their mental health problems on their child
- ▶ Parent/carer's contact with support services

Listed below is guidance for each area outlined in the Assessment Tool.

Past history of mental health problems

- ▶ How long has the parent/carer had mental health problems?
- ▶ Is there a pattern of illness and "wellness" and is this predictable?
- ▶ What involvement has the parent/carer had with mental health services?
- ▶ What has been the parent/carer's experience of mental health services?

- ▶ Has the parent/carer been hospitalised in the past? What was their experience of that?

The nature of the parent/carer's mental health difficulties and pattern of behaviour

- ▶ What type of illness does the parent/carer have?
- ▶ Has it been formally diagnosed?
- ▶ What are the known symptoms and behaviours associated with this illness? To what extent does she/he display those?

Parent/carer's perception of their mental health difficulties and willingness to engage with services

- ▶ What level of insight or understanding does the parent/carer have into their own mental health difficulties?
- ▶ What level of insight does the parent/carer have of the impact of their mental health difficulties on the child?
- ▶ How willing is the parent/carer to link in with mental health services?

Willingness of the parent/carer to take medication as appropriate and its effect on the parent

- ▶ Is the parent/carer on any medication?
- ▶ What are side effects of any medication they are on?
- ▶ How willing is the parent/carer to take their medication?
- ▶ What is the implication for the parent/carer if they don't take their medication?

Impact of the mental health difficulties on the parent/carer's cognitive state, judgements and emotional availability to the child

- ▶ What level of care is the parent able to give to the child?
- ▶ Is the parent able to meet the child's needs?
- ▶ How consistent and predictable is the parent/carer to the child?
- ▶ How have the parent/carer's mental health difficulties affected the attachment between the parent/carer and the child?
- ▶ How able is the parent to interact with the child?
- ▶ Is the parent ever aggressive, rejecting, hostile or neglectful of the child because of their illness?

- ▶ What triggers the above emotions? Ask parent to specify.

Expectation and responsibilities on the child when the parent/carer is ill

- ▶ What role does the child play in the family when the parent/carer is ill?
- ▶ How appropriate is this role for the child?
- ▶ How aware is the parent/carer of the responsibilities assumed by their child when they are ill?

Impact of a parent/carer's mental health difficulties on their partner and the level of insight and understanding that partner has into the difficulty¹⁶

- ▶ Is there a second parent/carer who does not suffer with mental health difficulties?
- ▶ How do the difficulties of the other parent/carer impact on their parenting capacity?
- ▶ Is she/he overly focused on their unwell partner to the detriment of the child?
- ▶ Does the mentally healthy partner have to take on the roles and parenting tasks of their unwell partner?
- ▶ What impact does this have on their availability to the child?
- ▶ Does the well parent/carer have sole responsibility for the 'negative' roles of parenting such as discipline and making rules?
- ▶ What impact does this have on their relationship with the child?

Resources and networks that have assisted the parent/carer in meeting the needs of the child

- ▶ What support networks, both formal and informal, does the parent/carer have?
- ▶ Does the parent/carer have any access to respite care?
- ▶ What role do the supports in the parent/carer's life have with the child?

Parent/carer's awareness of the impact of their mental health problems on their child

- ▶ How aware of the child's needs is the parent/carer?
- ▶ How able is the parent/carer to meet those needs?
- ▶ How able is the parent/carer to explain their illness to the child?

¹⁶ Adapted from Velleman, 2003

- ▶ What insight does the parent/carer have regarding the impact of their difficulties on the child?
- ▶ What happens to the child if the parent/carer has to be hospitalised? Is the parent/carer able to plan for such an eventuality?

Parent/carer's contact with support services

- ▶ Is the parent/carer attending any mental health support services?
- ▶ If yes, are they in regular contact with the community psychiatric nurse?
- ▶ If yes, are they attending community based services such as group work or occupational therapy? How often?
- ▶ If yes, are they attending voluntary groups such as Aware? How often?

See also Practice Principle 3, page 99

Impact on Parenting Capacity of Having a Disability or Complex Health Need

In assessing the impact on parenting capacity of having a learning or physical disability or complex health needs, it is important to focus on the precise ways in which the disability appears to negatively affect parenting.

The Assessment Tool outlines the following areas for consideration of the impact of having a disability on the parent/carer's parenting:

- ▶ Size of family
- ▶ Parent/carer's general physical health and mobility
- ▶ Parent/carer's cognitive ability, language and/or communication skills
- ▶ Parent/carer's relationships
- ▶ Extent of parent/carer's knowledge about health care, child development, safety, responding to emergencies and discipline
- ▶ Expectation and responsibilities on child to play a caring role
- ▶ Financial situation
- ▶ Support systems available to and used by the parent/carer and their family
- ▶ Parent/carer's own experience of being parented and of receiving services as a child/young person

Listed below is guidance for each area outlined in the Assessment Tool.

Size of family

- ▶ How many children are in the family?
- ▶ What ages are the children?
- ▶ What is the age gap between the children?
- ▶ Do any of the children have particular difficulties, such as health problems, sleeping or feeding difficulties?
- ▶ What expectations are placed on the children?

Parent/carer's general physical health and mobility

- ▶ Does the parent/carer have any health problems associated with his or her disability? If so, do they have any effect on his/her ability to perform normal parenting tasks? Are they getting sufficient professional attention for their health problems?
- ▶ Is the parent/carer on any medication associated with his or her disability, if so, does this have any affect on his/her ability to perform normal parental tasks?
- ▶ Does the parent/carer's disability affect his/her physical mobility, if so, in what way, and does he/she have adequate aids to assist him or her?

Parent/carer's cognitive ability, language and/or communication skills

- ▶ If the parent/carer has a learning disability, have they been psychologically assessed to determine their level of intellectual functioning, and if so, what was the outcome?
- ▶ Does the parent/carer understand the meaning of what is being said to him or her?
- ▶ Has a speech and language assessment been carried out and, if so, what was the outcome?
- ▶ Is the parent/carer able to communicate in an understandable way with his/her child, and with others, such as the child's teacher?

Parent/carer's relationships

- ▶ Does the parent/carer have a relationship with a partner?
- ▶ If the parent/carer is in a relationship, is it adequately balanced (e.g. is the disabled parent/carer submissive? Is the partner supportive?)
- ▶ Does the parent/carer have regular contact with his/her own parents or in-laws? If yes, does the relationship enhance or inhibit the disabled parent/carer's parenting capacity?

Extent of parent/carer's knowledge about health care, child development, safety, responding to emergencies and discipline

- ▶ Does the parent/carer have sufficient understanding of the health care needs of children or, if not, the capacity to learn from professionals and retain the information?
- ▶ Can the parent/carer stimulate the child?
- ▶ Does the parent/carer play with and talk to the child consistently?
- ▶ Does the parent/carer show appropriate levels of warmth and affection to the child?
- ▶ Can the parent/carer's ability keep pace with their child's development i.e. learn new skills to respond to each phase?
- ▶ Would the parent/carer be able to deal with an emergency and be able to take action, for example, if a child got scalded or had an accident, or became suddenly ill, or if something in the house required fixing?
- ▶ Is the parent/carer able to discipline the child in an appropriate and consistent way?

Expectation and responsibilities on the child to play a caring role

- ▶ Does the parent/carer have appropriate expectations of the child's ability to perform self-care tasks?
- ▶ Is the parent/carer dependent on the child to meet the parent/carer's needs in a way that is not mutually beneficial?

Financial situation

- ▶ Are some basic living costs in this family higher because of the parent/carer's disability?
- ▶ Is the parent/carer in receipt of all the financial support to which he/she is entitled?

Support systems available to and used by the parent/carer and their family

- ▶ Is the parent/carer involved with a child welfare service, or separate service/s for persons with disabilities? If the latter, is there sufficient collaboration between the different services for important information to be communicated?
- ▶ How many professionals are calling to the family home? What are their various roles and could they be integrated better?
- ▶ Is the parent/carer willing to engage with a service that will support their parenting?

Parent/carer's own experience of being parented and of receiving services as a child/young person

- ▶ What was the parent/carer's own experience of being parented like? Was their disability accepted by their own parents/carers?
- ▶ Was the parent/carer ever abused as a child, and if so, what has been the long term impact of this?
- ▶ What kind of supports were offered to the parent/carer when he/she was a child?
- ▶ What kind of education or training did he/she receive?
- ▶ Was he/she cared for/educated in a residential or institutional setting and if so, how did this affect him/her? Did he or she have adequate parenting models?

See also Practice Principle 3, page 100

Impact of Domestic Violence

The Assessment Tool outlines the following areas for consideration of the impact of domestic violence on the parent/carer's parenting capacity:

- ▶ Forms of violence
- ▶ Past history of domestic violence
- ▶ Existence of previous or current Barring, Safety or Protection Order
- ▶ Parent/carer's ability to access and ask for help and whether they have ever done so before
- ▶ Impact of the violence on the non-abusing parent/carer
- ▶ Child witnessing domestic violence and being physically at risk
- ▶ Abusing and non-abusing parents'/carer awareness of the impact of domestic violence on the child
- ▶ Evidence of steps taken by non-abusing parent/carer to protect child from negative impact

Listed below is guidance for each area outlined in the Assessment Tool.

Forms of violence

- ▶ What form or forms does the domestic violence take? For example physical, emotional, sexual, financial?
- ▶ Is the non-abusing parent/carer subjected to emotional and psychological abuse as well as physical abuse?

- ▶ Is the violence constant or periodic?
- ▶ Is it possible to predict when and why the violence will occur?

Past history of domestic violence

- ▶ How long has there been violence in this relationship?
- ▶ Has the non-abusing parent/carer previously attempted to leave the relationship?
- ▶ If not, why not, what barriers to leaving are identifiable?
- ▶ What led to a return to the relationship?

Existence of previous or current Barring, Safety or Protection Order

- ▶ Is it culturally acceptable for the victim of domestic violence to take legal action against the perpetrator? If not, what alternatives are available?
- ▶ Did the non-abusing parent/carer ever procure legal protection?
- ▶ Did the non-abusing parent/carer receive help in procuring the protection and if so from whom?
- ▶ What did that help involve?

Parent/carer's ability to access and ask for help and whether they have ever done so before

- ▶ Has the non-abusing parent/carer asked for help/support before?
- ▶ If yes, from whom and what was the outcome?
- ▶ Is the extended family aware of the situation?
- ▶ Is the family known to any refuge or other domestic violence services?
- ▶ What are the implications, for the non-abusing parent/carer and the children, of taking steps to change the situation?

Impact of the violence on the non-abusing parent/carer

- ▶ What is the impact of the violence on the non-abusing parent/carer?
- ▶ What is the impact of the emotional/psychological abuse on the non-abusing parent/carer?
- ▶ Is the non-abusing parent/carer experiencing any depression, anxiety, suicidality, feelings of inappropriate guilt, worthlessness, or loss of concentration which could impact their parenting capacity?
- ▶ Is the non-abusing parent/carer engaging in any substance abuse as a consequence of the violence?

- ▶ What impact is the abuse having on the parent/carer's self esteem?
- ▶ What social supports does the non-abusing parent/carer have, how isolated is (s)he from friends and family?
- ▶ What is the physical impact of the violence on the non-abusing parent/carer?
- ▶ What is the impact for the family if the parent/carer has to be hospitalised?

Child witnessing domestic violence and being physically at risk

- ▶ How able is the non-abusing parent/carer to protect the child from violence and emotional/psychological abuse?
- ▶ Is the child physically at risk from the abusing parent/carer?
- ▶ Is the child at risk of sexual abuse from the abusing parent/carer?
- ▶ Is the child forced to participate in the violent behaviour?
- ▶ How does the violence impact on the child? For example emotional distress, social isolation, forced out of accommodation, behaviour changes, physical injury?
- ▶ Where is the child when the violence occurs?

Abusing and non-abusing parent/carer's awareness of the impact of domestic violence on the child

- ▶ What understanding and awareness does the non-abusing parent/carer have of the impact of the violence on the child?
- ▶ Has the abusing parent/carer ever sought or received any help with their behaviour?
- ▶ Has anybody engaged with the abuser?
- ▶ What understanding and awareness does the abusing parent/carer have of the impact of the violence on the child?

Evidence of steps taken by the non-abusing parent/carer to protect the child from negative impact

- ▶ What is the non-abusing parent/carer's understanding of the impact of the violence in their relationship on the child?
- ▶ What steps does the parent/carer take to protect the child when the violence is occurring?

See also Practice Principle 3, page 100

Impact of Parenting Alone

- ▶ The Assessment Tool outlines the following areas for consideration of the impact of parenting alone on the parent/carer's parenting:
 - ▶ Financial and employment situation
 - ▶ Support networks
 - ▶ Experience of becoming a single parent, if relevant
 - ▶ Self-efficacy
 - ▶ Parent/carer's awareness of the impact of their status as a single parent on the child
 - ▶ Parenting alone as a single father

Listed below is guidance for each area outlined in the Assessment Tool.

Financial and employment situation

- ▶ How are the family's income, housing, employment status and availability of child care impacted?

Support networks

- ▶ What support networks does the parent/carer have?
- ▶ Does the parent/carer have childminding available to enable him/her work or to socialise?
- ▶ What is the parent/carer's past and present relationship with the absent parent?
- ▶ What is the child's past and present relationship with the absent parent?

Experience of becoming a single parent, if relevant

- ▶ What were the circumstances that led to this parent/carer becoming a single parent (e.g separation, divorce, death of a partner, no relationship with other parent)?
- ▶ How is this experience viewed by the parent/carer?

Self-efficacy

- ▶ What impact has the parent/carer's single status had on their self esteem?
- ▶ Does the parent/carer experience any loneliness and/or isolation?

Parent/carer's awareness of the impact of their status as a single parent on the child

- ▶ What awareness does the parent/carer have of the impact of their single status on the child?

- ▶ Is the parent/carer aware of whether the child has other friends who live in single parent households?
- ▶ Is the parent/carer aware whether the child feels any sense of stigma?
- ▶ Is the parent/carer aware and supportive of the level of contact with the absent parent desired by the child?

Parenting alone as a single father

- ▶ What is the parent/carer's experience of professionals' attitudes toward his gender?
- ▶ How willing is the parent/carer to join parenting/support groups that are comprised predominantly of single mothers?
- ▶ Has the parent/carer experienced any gender discrimination toward himself as a single male parent?

Impact of Being an Adolescent Parent/Carer

The Assessment Tool outlines the following areas for consideration of the impact of being an adolescent parent/carer on the parent/carer's parenting:

- ▶ Social and economic consequences of being an adolescent parent/carer
- ▶ Impact on adolescent's developmental tasks
- ▶ Impact on adolescent's relationship with their parents and nuclear family
- ▶ Support networks
- ▶ Awareness of and ability to meet the needs of the child and protect the child given their own age and stage of development
- ▶ Willingness to engage with services

Listed below is guidance for each area outlined in the Assessment Tool.

Social and economic consequences of being an adolescent parent/carer

- ▶ What impact is there on relationships with peers?
- ▶ What impact is there on the adolescent parent/carer's opportunity to socialise and engage in age appropriate activities?
- ▶ What impact does the parent status have on the adolescent parent/carer's education?
- ▶ What impact does the parent status have on the adolescent parent/carer's ability to secure economic independence from his/her parents?

Impact on adolescent parent/carer's developmental tasks

- ▶ What impact has the conception, pregnancy and birth had on the adolescent parent/carer?
- ▶ What impact does the parental status have on identity development?
- ▶ What impact does the parental status have on development of autonomy and independence from own parents when the adolescent parent/carer may need to live with their parents for practical, emotional and financial support?

Impact on adolescent parent/carer's relationship with their parents and nuclear family

- ▶ What impact is there on the relationship with parent/carers when the adolescent parent/carer has to continue living at home longer than they would wish?
- ▶ Has the arrival of the baby caused overcrowding in the family home and what is the implication of this?
- ▶ What impact has the adolescent parent/carer's pregnancy had on their siblings?

Support networks

- ▶ Does the adolescent parent/carer have peers who are also parents?
- ▶ Does the adolescent parent/carer have supports outside of the immediate family?
- ▶ What role do the grandparents assume in the care of their grandchild? Is this an agreed role that is satisfactory to all?
- ▶ What role does the father of the child have in his child's life? Is this a consistent role that endures over time?

Awareness of and ability to meet the needs of the child and protect the child given their own age and stage of development

- ▶ What level of awareness does the adolescent parent/carer have of the needs of their child?
- ▶ Does the adolescent parent/carer have the ability to meet their child's needs?
- ▶ What insight does the adolescent parent/carer have into the impact of their age on the needs and care of their child?
- ▶ Have there been any attachment difficulties? Specify.

Willingness to engage with services

- ▶ Is the adolescent parent/carer engaged with any services?
- ▶ Does the adolescent parent/carer have any fears about being in contact with services due to his or her age or the age of the child's other parent/carer?

Impact of the Parent/Carer's own Experience of Being Parented

The Assessment Tool outlines the following areas for consideration of the impact of the parent/carer's own experience of being parented on their current parental capacity

- ▶ Parent/carer's history of attachment to their own parent/carers
- ▶ History of disruptions in parental care/relationship, e.g. long hospitalisations, placement in care, running away, bereavement, marital/relationship breakdown
- ▶ Parenting skills learned from own parent
- ▶ History of abuse
- ▶ History of domestic violence
- ▶ Parent/carer's experience of receiving services as a child/young person

Listed below is guidance for each area outlined in the Assessment Tool:

Parent/carer's history of attachment to their own parent/carers

- ▶ Who was the parent/carer's main caregiver when growing up?
- ▶ Does the parent/carer have a current relationship with their own parent/carer?
- ▶ How does the parent/carer describe this relationship?

History of disruptions in parental care/relationship, e.g. long hospitalisations, placement in care, running away, bereavement, marital/relationship breakdown

- ▶ How stable was the home environment when the parent/carer was growing up?
- ▶ Did any disruptions take place in the parent/carer's relationship with their parent/carer?
- ▶ If yes, what impact did the disruptions have on the parent/carer as a child?

- ▶ How were the disruptions dealt with by the family?
- ▶ Was the parent/carer encouraged to discuss how he/she felt about the disruptions?

Parenting skills learned from own parent

- ▶ How does the parent/carer describe their own positive and negative experiences of being parented?
- ▶ What aspects of their parent/carer's parenting are they replicating?
- ▶ What is their opinion of how they were parented?
- ▶ How was the parent/carer disciplined as a child?
- ▶ What is their opinion of how they were disciplined as a child?
- ▶ Taking into account how the parent/carer was parented, what involvement does the parent/carer's own parents have in the care of their grandchildren? Is this appropriate? (See Safeguarding, page 53, for further discussion)

History of abuse

- ▶ Is there a history of abuse in the parent/carer's own family?
- ▶ Was the parent/carer abused as a child?
- ▶ If yes, what form did this abuse take?
- ▶ Did the parent/carer disclose the abuse as a child?
- ▶ What were the outcomes of any disclosures made?
- ▶ Did they have any therapy/treatment as a result of the abuse?

History of domestic violence

- ▶ Is there a history of domestic violence in the parent/carer's own family?
- ▶ What form did it take?
- ▶ Was the parent/carer aware of the violence?
- ▶ How did it impact on the parent/carer?
- ▶ Does the parent/carer feel that the experience has influenced them in any way?
- ▶ Did the family receive any services because of the domestic violence?
- ▶ What was the parent/carer's experience of these services?

Parent/carer's experience of receiving services as a child/young person

- ▶ What services did the parent/carer receive as a young person?
- ▶ What was his/her experience of these services?
- ▶ Do such experiences influence their or their family's willingness to engage in services in the present day?
- ▶ How can this be addressed with the parent/carer and the entire family?

Impact of Having a Child with Disabilities or a Child with Complex Health Needs

The Assessment Tool suggests that, in order to assess the impact of a disabled child or a child with complex health needs on the parent/carer's parenting capacity, the following areas are considered:

- ▶ Parent/carer's attitude and understanding of their child's disability or complex health needs
- ▶ Impact of caring for the child on the parent/carer
- ▶ Liaison with professionals involved in the child's life
- ▶ Support networks
- ▶ 'Assessment fatigue'¹⁷
- ▶ Impact on siblings of living with a brother or sister with disabilities or *complex* health needs

Listed below is guidance for each area outlined in the Assessment Tool.

Parent/carer's attitude and understanding of their child's disability or complex health needs

- ▶ Has the parent/carer been able to come to terms with their child's disability or health needs?
- ▶ If they have not been able accept the disability what impact does this have on their capacity to respond appropriately to their child's needs?

Impact of caring for the child on the parent/carer

- ▶ How does the parent/carer cope with the day to day reality of meeting their child's needs which can be complicated, time consuming, unfamiliar, anxiety provoking, physically taxing and emotionally difficult?¹⁸
- ▶ What impact does caring for the child with disabilities or complex health needs have on their availability to their other children?

¹⁷ Shemmings and Shemmings, 2001

¹⁸ Marchant, 2001

- ▶ What impact does caring for a child with disabilities or complex health needs have on the parents/carers as a couple or as a family?
- ▶ What impact has caring for the child with disabilities or complex health needs had on the employment options of the parents/carers?
- ▶ What is the emotional and financial impact on the parent/carer of caring for the child with disabilities or complex health needs?

Liaison with professionals involved in the child's life

- ▶ Is the parent/carer able to effectively liaise with the oftentimes numerous practitioners involved in the care of their child?
- ▶ To what extent is the parent/carer able to integrate the differing perspectives they may receive from the professionals involved regarding treatment options and prognosis?

Support Networks

- ▶ Does the parent/carer have appropriate levels of support available to them, such as respite, babysitting etc.?
- ▶ Does the parent/carer need or receive any practical help (e.g. cleaning)?

'Assessment Fatigue'

- ▶ Have the family been through a lot of assessments?
- ▶ What impact does this have on the parent/carer's willingness and ability to participate in another assessment?

Impact on siblings of living with a brother or sister with a disability or complex health needs

- ▶ What do the siblings of the child concerned understand about their sibling's disability or health need?
- ▶ How does it impact on them and their relationship with their sibling?

Impact on Parenting Capacity of Being a Member of an Ethnic Minority Group

The Assessment Tool suggests that, in order to assess the impact of being a member of an ethnic minority group on the parent/carer's parenting capacity, the following areas are considered:

- ▶ Family income
- ▶ Accommodation
- ▶ Experiences of leaving country of origin and

implications for the parent/carer's mental health

- ▶ Experiences of racism and social exclusion
- ▶ Asylum application
- ▶ Proficiency in speaking English
- ▶ Support networks

Family income

- ▶ What income does the family have and how does this impact on the parent/carer's ability to meet the child's needs?

Accommodation

- ▶ What accommodation does the family live in and how does this impact the parent/carer's ability to meet the child's need for age and gender appropriate space and privacy?

Experiences of leaving country of origin and implications for the parent/carer's mental health

- ▶ Did the parent/carer experience any traumatic experiences en route to the host country?
- ▶ If yes, what impact have these traumatic experiences had on the parent/carer's mental health and their subsequent ability to meet the needs of the child?

Experiences of racism and social exclusion

- ▶ How does racism and social exclusion impact on the parent/carer?
- ▶ What understanding and appreciation does the community have of the family's ethnicity and cultural norms? Give examples.
- ▶ What impact does this have on the parent/carer and the family?

Asylum application

- ▶ Is the parent/carer reluctant to disclose information to the practitioner because of the practitioner's perceived role in their asylum application?

Proficiency in speaking English

- ▶ What is the parent/carer's literacy level?
- ▶ Is the parent/carer able to communicate in English?
- ▶ Is there a need for an interpreter?
- ▶ Does the parent use their child as an interpreter or a scribe? What are the implications of this?
- ▶ Is the parent/carer comfortable disclosing personal information through an interpreter or asking a child or 'stranger' to read for them?

Support Networks

- ▶ Does the parent/carer have any support available to them from friends or family? For example is there someone who could baby-sit the children to allow the parent/carer to have some time to themselves?
- ▶ Is the parent/carer reluctant to engage with service providers out of fear, a lack of trust, previous negative experiences with people in authority or a fear of contributing to a negative stereotype about their community?

Impact of Socio–Economic Factors

The Assessment Tool outlines the following areas for consideration of the impact of socio-economic factors on the parent/carer's parenting:

- ▶ Financial factors and the impact of parent/carer's socio-economic status on their ability to meet the needs of their children
- ▶ Housing and location and the capacity of the parent/carer to provide adequate accommodation conditions, e.g. space, privacy, safety, heat, light etc. and proximity to services
- ▶ Employment opportunities and parents/carers' attitude towards work
- ▶ Parent's educational history and impact on their ability to promote and support the child's education
- ▶ Impact of poverty on the family perception of themselves
- ▶ Impact of living in a rural setting

Listed below is guidance for each area outlined in the Assessment Tool.

Financial factors and the impact of parent/carer's socio-economic status on their ability to meet the needs of their children

- ▶ What are the levels of income and the ability to meet the needs of the family on this budget?
- ▶ Do the parent/carers consider themselves to be good at managing money?
- ▶ How does this impact on their willingness to provide adequate food, clothing etc. for the child?
- ▶ How does the parent/carer use money made available to them for the purpose of meeting children's needs?
- ▶ How and by whom is the family's money managed?
- ▶ Are the family receiving all they are entitled to?

- ▶ Are gambling or substance abuse impacting the financial situation of the family?
- ▶ Does the family have any debts?
- ▶ What is the impact of the family's socio-economic status on the health of the family and their general well being?
- ▶ Have the family received any budgetary advice? Is this something they need and would consider?

Housing and location and the capacity of the parent/carer to provide adequate accommodation conditions, e.g. space, privacy, safety, heat, light etc. and proximity to services

- ▶ What is the condition of the home that the family lives in?
- ▶ What is the impact of the living conditions on the family's well being, e.g. adequate level of heating?
- ▶ Is there space for children to play and do homework?
- ▶ Are there appropriate levels of privacy for all family members?
- ▶ Are there any potential dangers to the location of the family home?
- ▶ Is the family home near services?

Employment opportunities and the parent/carers' attitude towards work

- ▶ What is the employment status of family members and how does it impact them?
- ▶ What is the impact of work commitments on the availability of time for parents/carers and children to interact?
- ▶ Are parents/carers and children spending long periods of time commuting to and from work and child-care?

Parent's educational history and impact on their ability to promote and support the child's education

- ▶ At what age did the parent/carer leave school?
- ▶ Did they obtain any certificates or qualifications?
- ▶ Did they attend any adult education or third level courses?
- ▶ Is there evidence that the parent/carer prioritises their child's education?
- ▶ Is the promotion of education consistent with the parent/carer's culture?

Impact of poverty on the family perception of themselves

- ▶ Does the family see themselves as financially disadvantaged?
- ▶ What indicators of poverty do they identify?
- ▶ How do the parent/carer see their financial situation as impacting on their parenting and on their children?
- ▶ What is the worker perception of the impact of the parent/carer's financial situation on their ability to meet their children's needs?

Impact of living in a rural setting

- ▶ What impact does living in a rural setting have on the capacity of the parent/carer to meet their children's needs? Including the following: availability of transport and services, pollution and traffic free atmosphere, space for playing,
- ▶ What is the attitude of members of the community towards this child and family?

STEP 5: SHARING, ANALYSING & PLANNING

Step 5 occurs when all the professionals who have been involved in the assessment as well as the family and child (as appropriate) come together to share and analyse the information that has been gathered with the aim of making decisions and formulating an intervention plan.

As outlined in the Assessment Tool, there are three components to this Step:

- ▶ Preparing the Assessment Report
- ▶ Sharing the Assessment Report
- ▶ The Multi-disciplinary Assessment Meeting

Preparing the Assessment Report

The Assessment Tool lists a number of considerations that need to be borne in mind and included in the final assessment report. Of central importance is the need to have a clear picture of the child concerned, and for all information about the child and family to be supported by clear evidence and to cover strengths as well as weaknesses.

Demonstrating knowledge about the child whose needs are being assessed

A disturbing finding from child abuse inquiries (see, for example, Laming, 2003) and research (Parton, Thorpe and Wattam, 1997; Horwath and Bishop 2001; Buckley 2003) has been that while practitioners may be very knowledgeable about certain aspects of a child's development or situation, this knowledge is often fragmented, or else gleaned through people in the child's life rather than the child him/herself. This means the child is 'constructed' through someone else's eyes. Practitioners should be able to check that an assessment has been carried out in a child centred manner by asking themselves if they can describe a typical day in the child's life. This will reveal not only information about a child's needs, strengths, vulnerabilities, relationships and social context, but a true and irreplaceable sense of the child him/herself (See **Knowing the Child**, page 40).

Evidence based

An **evidence based approach** requires that each inference or conclusion is based on sound information which has been witnessed or elicited about the child and/or family but also on what is known about the subject. Knowledge will be required regarding normal stages of child development and associated psychological theories such as attachment

and resilience in order to make judgements about the impact on children's development and welfare of various factors in their environment. Clear definitions of physical, emotional and sexual abuse and neglect, their causes, associated behaviours and long term effects will be required. It will also be necessary to draw on knowledge about how various social, cultural and economic factors and circumstances impact on parents' ability to meet their children's needs. Practitioners must, at this stage, draw on their own knowledge and/or consult with relevant colleagues who may have more specialist knowledge, and consider, on the basis of the information gathered in the different categories, whether the child's needs are being adequately met.

Strengths and weaknesses

Most children and families are aware of the power imbalance that exists between themselves and child welfare and protection agencies, but the use of a strengths based approach gives the message that service users are competent and have a useful part to play in assessment, thereby reducing the sense and the impact of the inequality that inevitably exists. The assumptions underlying a focus on strengths are:

- ▶ Every person has strengths and potential,
- ▶ People can learn in a positive way from adverse experiences,
- ▶ Most familial social contexts have strengths and resources to offer,
- ▶ Most people will feel encouraged when their abilities and achievements are positively affirmed.

In order to promote the use of a strengths based perspective when carrying out an assessment, practitioners should consider:

- ▶ Acknowledging the power held by all participants in assessment,
- ▶ Giving priority to the child and his or her parent/carer's version of events,
- ▶ Avoiding generalisations and stereotyping, recognising that the notion of children's needs and parenting capacity can have different meanings for professionals, children and their parents/carers and that safety and welfare are the priorities,
- ▶ Avoiding blame or simple cause and effect explanations,
- ▶ Focusing on what the child and family want for themselves,

- ▶ Ensuring that children and families are given full information about the assessment process and understand it to the best of their abilities,
- ▶ Showing respect and believing what children and their parents/carers say,
- ▶ Understanding cultural norms and avoiding reinforcement of oppressive or discriminatory practices,
- ▶ Using a common language,
- ▶ Being open to new information, positive or negative, during the assessment and later,
- ▶ Focusing on evidence leading to informed judgement, rather than intuition on its own.

Sharing the Assessment Report

The Assessment Tool recommends that the assessment report is shared with the child and family in advance of the meeting. Such an endeavour warrants the following considerations:

- ▶ If families have not already seen the records on which the report is based, prepare them for the fact that they may disagree with or be upset by its contents,
- ▶ Allow time for families to absorb the contents of the report; this may necessitate meeting them on several occasions,
- ▶ Communicate in clear, jargon free language and consider producing the report in a different medium for children or persons with disabilities. The report should be translated if English is not the family's first language,
- ▶ Families may experience the reports as very negative. Draw their attention to any positive aspects that they may have overlooked,
- ▶ Provide family members with an opportunity to challenge interpretations of information and add their own challenges or clarifications to the report.¹⁹

The Multi-disciplinary Assessment Meeting

Ideally, practitioner and inter-agency collaboration will have already been operating in the earlier stages of assessment, with varying levels of input from different practitioners depending on their current or former involvement with the child and family. Whatever the level of collaboration, it is desirable, that at this stage in the assessment process, the information that has been generated is shared in a multi-disciplinary forum, whatever format this takes.

To elaborate the pointers outlined in the Assessment Tool, guidance is provided below on facilitating children and families to participate in multi-disciplinary meetings, assessing parental motivation to change, influences on judgements made by practitioners and formulating the intervention plan.

Facilitating children and families to participate in multi-disciplinary meetings

Inclusion of children and families in multi-disciplinary meetings is fundamental to full collaboration. However, consideration should be given to impact on children and families of meeting a large number of professionals, some of whom may not be known to them. This should be borne in mind when deciding who to invite to such a meeting.

Reference to the child protection conference protocol developed by the Southern Health Board (Gilligan and Chapman, 1997) should help promote meaningful participation, for example:

- ▶ Children and/or parents/carers should be reassured in advance that the purpose of their participation is to enable them to join in discussion and planning, not to be judged by any other participants. The likely process and outcomes of the multi-disciplinary meeting should be explained to the family beforehand,
- ▶ All participants in a multi-disciplinary meeting should be made aware of and if necessary, prepared for the intended presence of children and/or their parents/carers,
- ▶ Parents/carers and children attending a multi-disciplinary meeting should be facilitated to bring a support person or advocate, whose identity should be clarified by the chairperson to the rest of the participants,
- ▶ Sensitivity will be required to reduce tensions naturally experienced by family members attending a multi-disciplinary meeting. Waiting outside a room can be very stressful, so delays should be minimised and the chairperson of the meeting should meet the family in advance,
- ▶ The content of any reports likely to be referred to at the multi-disciplinary meeting should have been discussed with the family in advance by either the professional who has prepared the report, or the key worker,
- ▶ The roles and responsibilities of each participating professional, including the reason why they are attending the meeting, should be explained to the child and/or parents/carers,

¹⁹ Holland, 2004

- ▶ The chairperson needs to ensure that children and/or families' participation is active by inviting their contributions and responding to them,
- ▶ The family should be given an opportunity to clarify anything that is said during the meeting,
- ▶ All participants should endeavour to put the child and/or parents/carers at their ease by making eye contact, addressing them by name and including them in the discussion,
- ▶ The chairperson must ensure that the child/or parents/carers understand the implications of any decisions or recommendations.

Assessing Parental Motivation to Change

The Assessment Tool outlines four tasks, which need to be addressed at the multi-disciplinary assessment meeting. Of central importance is the task of considering the parents/carers' ability and motivation to carry out any desired change. The basis for judging the likely impact of delayed development or unmet need on the child's safety and welfare should be the evidence that currently exists about the short and long term outcomes for children who have experienced similar difficulties.

Change is only likely to occur if carers have both ability and motivation to change as well as the opportunities to do this. Ability means knowledge and skills, motivation refers to desire and opportunities are the socio-economic factors that may effect the situation (Horwath, forthcoming).

The model developed by Prochaska and DiClemente, adapted by Horwath and Morrison (2001) for assessment in child welfare, can be usefully applied to the assessment of parental motivation and capacity to change. This model is underpinned by the beliefs that change does not always happen immediately, that relapse is a normal part of the process and that differential levels of support may be required at different stages of the change process. It consists of five stages:

- ▶ Pre-contemplation
- ▶ Contemplation
- ▶ Determination
- ▶ Action
- ▶ Maintenance

Morrison (1998) has also identified seven steps of contemplation that a parent/carer may move through on their journey towards change, these are:

- Step 1 I accept there is a problem
- Step 2 I accept that I have some responsibility for the problem
- Step 3 I have some discomfort about the problem
- Step 4 I believe that things must change
- Step 5 I can see that I can be part of the solution
- Step 6 I can make a choice
- Step 7 I can see the next steps towards change

In line with this model, assessment of parental motivation to change may be conducted by exploring:

- ▶ Whether and how far a parent/carer understands the concerns that others may have about their behaviour, and the impact of their behaviour on their children,
- ▶ How strongly a parent/carer is committed to the process of change, and how much belief they have in their capacity to change and what optional ways of changing they are prepared to consider,
- ▶ How much responsibility the parent/carer is prepared to accept and how much effort they are prepared to put into changing,
- ▶ How far the parent/carer can focus on and carry out the process of change,
- ▶ How far the parent/carer can stay committed to the process of change despite occasional discouragement and failure, and how far they can re-commit after relapse.

Influences on Judgement

Judgements are normally made by practitioners on the basis of a combination of information from theory, research, practice wisdom, experience, intuition and an analysis of factual information. The whole area of child welfare and protection is dependent on a range of constantly moving and interacting dynamics, and can therefore be uncertain and unpredictable. It is not always susceptible to empirical testing or technical analysis or solutions, and therefore is particularly subject to human error and a range of different influences that can impact in different ways, depending on the context. It is imperative that practitioners acknowledge the inevitable prevalence of different types of influences on their decision making in order to avoid errors. Supervision is the obvious forum for reflecting on and challenging

judgments, but it is important that practitioners constantly question themselves about the validity of their conclusions and ask themselves what factors may have impacted on them. Practitioners should ask themselves:

- ▶ Is there anything in the relationship between myself and the child and/or family that is colouring my judgement?
- ▶ Are any inter-practitioner or inter-agency issues affecting my judgement?
- ▶ Is there anything in my own agency/organisation (e.g. difficulties, ethos, instability) that is affecting my ability to make an objective judgement?
- ▶ Am I subject to any biases, prejudices or tendency to stereotyping in relation to this child and/or family that might affect my judgement? Am I able to separate my personal/political views from the matters at hand?

Formulating the Intervention Plan

Decision making occurs at the point where the information has been analysed and the needs, strengths and vulnerabilities have been identified. Practitioners must now consider whether the threshold requiring practitioner intervention has been reached and agree on short and long term aims. It requires attention to some basic, but in-depth, questions. At this stage the following six questions should have been addressed:

- ▶ What are the causes of concern (i.e. how are the child's needs not being met)?
- ▶ What are the patterns of occurrence?
- ▶ What strengths appear to mitigate or prevent the problems/deficits?
- ▶ What factors appear to maintain the problems/deficits?
- ▶ What changes are needed in order to sufficiently reduce the negative effects of the problems/deficits? (Considering all dimensions of the assessment).
- ▶ Do the parent/carers have the capacity and motivation to bring about sufficient change?

The decision on how to move forward will be determined by reflecting on the answers to the

above questions and addressing the next four:

- ▶ Is the child safe enough in this situation while changes are taking place?
- ▶ What are the short and long term goals²⁰ for the child?
- ▶ What type of interventions will be needed in order to achieve each of these aims?
- ▶ What are the likely consequences for the child if changes do not occur?

When a decision has been made about the desired outcomes for the child, decisions then need to be made about further action. Tasks and responsibilities must be allocated, process and outcome goals identified and a system put in place for evaluating progress.

²⁰ MacDonald, 2001, categorises goals in child welfare as 'process' goals and 'outcome' goals. Outcome goals are the end point changes one is aiming to bring about. Process goals are those changes that need to be brought about in order to achieve outcome goals. Research, (Hogan, 2002) highlights that practitioners can confuse 'outcomes' and 'outputs'. An outcome is a qualitative measure and is described in terms of meeting the needs of the child; an output is a quantifiable way of measuring this. For example, if a child is not attending school, the long term goal may be to ensure that the educational needs of the child are being met, the output could be regular school attendance.



Section Two

INTRODUCTION TO SECTION TWO

Section Two of this guidance focuses on the principles underpinning the Assessment Framework. The practice issues currently considered most relevant and challenging will be covered under these headings.

It is not expected that practitioners will consult Section Two each time they carry out an assessment. It is essentially intended as a resource, which may be consulted regarding specific aspects of the work.

Practice Principles: Introduction

Overall, the Assessment Framework is intended to provide a standardised and systematic method of gathering, recording and making sense of information about vulnerable children, with a view to making early and appropriate interventions. The framework is based on a number of practice principles which should shape the nature of assessment and determine the way in which it is carried out. These principles were developed out of the consultation process held at the outset of this project, and reflect the views of managers and practitioners in the three Health Service Executive Areas within the context of current legislation and research on best practice. Practitioners should constantly reflect on how far their routine assessment practice reflects these principles and ensure that their approach is consistent with the ethics and values upheld by them. The seven principles, which are explicated in this section of the Practice Guidance, are:

1. The immediate safety of the child must be the first consideration
2. Assessments should be child-centred
3. An ecological approach should underpin practice
4. Assessments should be inclusive and recognise the individual needs of all children irrespective of age, gender, ethnicity and disability
5. Multi-disciplinary practice is fundamental and an irreducible element of good practice
6. An evidence based and critically reflective approach should underpin assessment practice
7. High quality supervision should be provided and used by practitioners completing assessments

PRACTICE PRINCIPLE 1

THE IMMEDIATE SAFETY OF THE CHILD MUST BE THE FIRST CONSIDERATION

Practitioners are urged to repeatedly evaluate whether the child is safe in his or her current situation. Essentially, this means assessing whether the child is at immediate risk of significant harm from his or her caregiver and how likely it is that the child will be harmed if no action is taken. While assessment of the child's immediate safety is normally the first action taken after a referral is received, research demonstrates that judgements can become blurred as time goes on and dangerous assumptions can be made about the child's safety. Fitzgerald (1999), who has considerable experience of conducting child abuse inquiries, has noted that practitioners tend to see a reduction in the number of 'incidents' over a given period as consequently reducing the risk to the child when this may not be the case. Likewise, Munro (2002) found that practitioners will sometimes see improvements where there are none, because they developed a particular mindset at the outset of an assessment. The report of the Victoria Climbié Inquiry (Laming, 2003) was very critical of practitioners who tended to focus on welfare needs without attending to the vital matter of whether the child at the centre of the inquiry was safe in his/her current situation.

Pre-requisites to assessing a child's immediate safety are:

- ▶ Getting good quality information,
- ▶ Organising information in a structured way,
- ▶ Making a judgement that achieves a balance between experience, theory and sound evidence and does not overly rely on intuition,
- ▶ Being explicit about the factors that are influencing judgement,
- ▶ Recognising that judgements are affected by the experience and skills of the worker as well as the level of supervision, support and resources available.

Methods of assessing a child's immediate safety vary considerably. One common method is the use of checklists of vulnerability factors; for example, single parenthood, history of being abused as a child, parental addiction, social isolation, premature birth and difficulties in caring (Greenland, 1987; Browne and Saqi, 1988). These lists were generally derived from factors which recurred in cases where serious abuse had occurred. They can be useful in terms of organising information and enabling workers to focus on fact

rather than intuition. However they are liable to provide a high degree of false positives (finding risk where it is not present) and tend to ignore the more dynamic elements of parental behaviour which change from week to week according to circumstance (Dingwall, 1989). Analysing patterns of behaviour is generally more effective (see below). Checklists are not normally culturally sensitive, and research shows that they do not achieve consistency between different workers (Munro, 2002). There are more sophisticated actuarial methods, for instance Bayes Theorem (see MacDonald, 2001), which employs a mathematical formula to determine the probability of, for example, a parent/carer repeating a behaviour that injures or damages their child. While it is generally regarded as improving prediction, this method is treated with caution by practitioners because of the mathematical rigour required²¹.

Another risk assessment model that has gained more popularity is one developed by Brearley (1982) who categorises factors in terms of dangers, hazards and strengths (with an assumption that strengths compensate for dangers). This model was further developed by Bedford (1987) who subdivided hazards into those which are pre-disposing and those that are situational, again suggesting that strengths minus hazards equals risk. Hazards can be defined as an existing factor or action/event or lack/deficiency which introduce the possibility or increase the probability of an undesirable outcome.

However, as Reder, Duncan & Gray (1993) have shown, practitioners' ability to make informed decisions relies on sound information but is equally determined by the interplay of a number of systems. These systems relate to interactions within and between families and agencies. In a similar vein, a later model, proposed by Dalgleish (2003), seeks to separate the process of information gathering from making decisions about interventions, emphasising that factors in the practitioner's experience and context are likely to impact on their final conclusions, regardless of the nature of data collected. He identifies 'worker effects' in terms of organisational culture, practice norms, fear, optimism, pessimism, ideologies, values, current events, defensiveness and isolation. Thus when using assessment models workers must consider personal biases.

The Assessment Tool has drawn from the New Zealand Risk Estimation System (Department of Child, Youth and Family, New Zealand), which concentrates strongly on past patterns of caregiver behaviour.

The research components that underpin the New Zealand Risk Estimation System are:

- ▶ Once a person has been a perpetrator of an incident of maltreatment, the likelihood that this behaviour will recur is increased when compared to the likelihood of this behaviour occurring prior to the individual becoming a perpetrator,
- ▶ The greater the severity, frequency or recency of maltreatment, the greater the likelihood of recurrence,
- ▶ The younger the child, the greater the potential severity of injuries,
- ▶ The likelihood of reoccurrence is increased by the degree to which the functioning of the perpetrator and/or their partner is impaired by substance abuse and mental health issues,
- ▶ If a partner is an active participant, or does not or cannot oppose the maltreatment, the likelihood of reoccurrence is increased. Conversely, a partner who actively opposes the maltreatment may lower the likelihood of reoccurrence,
- ▶ People who are violent in any context are more likely to behave in a violent manner with their children than someone who never uses violence as a means of coping with difficulties,
- ▶ If caregivers perceive children as objects, or merely as extensions of themselves, there will be a higher likelihood of the reoccurrence of maltreatment than if the children are understood to be intrinsically valuable,
- ▶ The greater the level of dysfunction within the family, the greater the likelihood of further maltreatment,
- ▶ The greater the level of stress experienced by the caregiver, the greater the likelihood of further maltreatment,
- ▶ The greater the disconnection of a caregiver from their family and community, the greater the likelihood of further maltreatment,
- ▶ The greater the relationship distance between the adult male caregiver and the female child, the greater the likelihood of sexual abuse,
- ▶ Female children are more likely than male children to experience sexual abuse within the family,
- ▶ The greater the severity of an instance of maltreatment, the greater the probable severity of a future instance of maltreatment carried out by this perpetrator.

²⁴ For further discussion of these approaches see Mac Donald, 2001 and Munro, 2002.

REACHING THRESHOLDS

Research by Dalgleish (2003) demonstrates that decisions made on thresholds for action can differ amongst practitioners and agencies even when the information about the child is consistent.

Thresholds can be high or low in response to:

- ▶ Practitioners' value systems (e.g. keeping children in their families is a priority),
- ▶ The amount of support that practitioners get from management,
- ▶ Practitioners' previous experiences of working in this area; for example after experiencing a placement breakdown a practitioner may be less willing to take action, after a child is re-injured a practitioners may be more willing to take action. This may occur in the absence of any change in their ability to detect the need to take action,
- ▶ Available options for intervention,
- ▶ Practitioners' perceptions of other agencies,
- ▶ Thresholds set by individual teams.

The Assessment Tool has drawn from research studies based on child protection practice which take account of the full range of factors involved in decision making (Reder, Duncan & Gray, 1993; Fitzgerald 1999; MacDonald 2001; Munro, 2002; Buckley, 2003; Horwath and Sanders, 2003). When assessments of a child's immediate safety are being made using the Assessment Tool, practitioners should refer to the sections in the guidance on analysing and decision making in order to integrate all the elements involved.

Recommended Reading

Adcock, M. & R. White (2000), *Significant Harm: Its Management and Outcome*. Croydon: Significant Publications.

Cleaver, H., Wattam C. & Cawson P. (2000), *Assessing Risk in Child Protection*. London: NSPCC

Cooper, A. (2005) 'Surface and Depth in the Victoria Climbié Inquiry Report' *Child and Family Social Work*, 10: 1-9.

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PRACTICE PRINCIPLE 2

ASSESSMENTS SHOULD BE CHILD-CENTRED

The Assessment Framework is designed to be child centred. By this is meant that the main focus of assessment will be the health and well-being of the child, and that practitioners, by addressing all the dimensions outlined in the Assessment Tool, will come to understand the impact of the child's environment on his or her developmental needs. The Tool is designed to highlight ways in which the welfare of the child is or is not being promoted and issues regarding safeguarding the welfare of the child.

Ensuring that an assessment is child centred involves consideration of the following:

- ▶ Engaging Children
- ▶ Engaging Siblings
- ▶ Direct Work with Children and Adolescents
- ▶ Assessing Attachment Patterns and Levels of Resilience

Engaging Children

Central to carrying out an assessment that is child centred is effectively engaging the child. It is important to bear the following considerations in mind:

- ▶ Check out the child's previous experience of assessment and intervention. This can be done by talking directly to the child him or herself and checking any existing records,
- ▶ Consider who is best placed to work with him or her,

- ▶ If the child has a positive or affirmative attachment with somebody outside their immediate family it might be valuable to consider their involvement in the assessment,
- ▶ There may be a need for the completion of specialist assessment, for example if there is evidence that sexual abuse may have occurred, or if the child has complex health, learning or behavioural problems. This can take place in tandem with the current assessment and could include some joint work,
- ▶ Become familiar with the cultural norms of the family and community that the child lives in and understand the impact they may have on the assessment,
- ▶ Allow time for trust-building,
- ▶ Use appropriate techniques and media for communicating (see below),
- ▶ Be careful not to subject a child to multiple interviews.
- ▶ Work with older children and adolescents can necessitate the use of mediation skills and conflict resolution²³,
- ▶ It is important to explore both sides of an issue with older children,
- ▶ It is likely that young people and their parents or carers will see difficulties in different ways and will have different desired outcomes,
- ▶ Young peoples' desire for change will usually be located in the context of immediate practical concerns and preoccupations,
- ▶ Young people will be more likely to give more information about themselves to a worker who shares something about their own life²⁴ although care must be taken regarding what information is disclosed.

Techniques for engaging the child

There are certain techniques that can be employed by the worker to assist in engaging the child in the assessment process. These are:

- ▶ Be creative and flexible,
- ▶ Use the child's greatest area of interest to facilitate the work,
- ▶ Bring them on activities and outings,
- ▶ Use discussion techniques as well as straightforward questions,
- ▶ Use play, drawing and painting,
- ▶ Use direct work with the child and their parents or current caregivers,
- ▶ Observe the child in a variety of settings, including school, at play and at home,
- ▶ Use EcoMaps, Life Story Books and Life Plans to encourage the child to discuss their family,
- ▶ It is important for anyone who is going to engage a child in an assessment to have a "tool kit", the contents of which must be specific to the age of the child²².

Working with Teenagers

There are some particular considerations that need to be borne in mind when working with teenagers, such as:

Engaging Siblings

The focus of assessment may be on a single child who has elicited concern in unique circumstances. However, even if they are not the focus of assessment, it is important to involve siblings for the following reasons:

- ▶ Living in the same family may not mean that all siblings share similar relationships with parents/carers, but if the basic needs of the referred child are not being met, it is necessary to inquire into the safety and welfare of other children living in the same situation. The matter of whether or not all siblings in a family require the same depth of assessment should be decided at the outset,
- ▶ Even if concerns about the safety and welfare of other children in the family are absent, siblings will be a source of information with regard to the child, the capacity of parents/carers and the extended family and community,
- ▶ Siblings should be engaged with directly, using an age appropriate medium.

Direct Work with Children

Research and child abuse inquiries have indicated that practitioners do not always put children at the centre of assessment, and do not always engage meaningfully with them (Horwath, 2001; Buckley, 2003; Laming, 2003). Direct work with children is a crucial element of the assessment task. Bannister's (2001) work has been adapted below in order to offer some guidance to practitioners.

There are five critical components in direct work with children²⁵: seeing, observing, talking, doing

²² Fahlberg, 1994

²³ Brandon et al, 1998; Department of Health, 1995

²⁴ Fahlberg, 1994

²⁵ Department of Health, UK, 2000

and engaging. The tasks can be divided into four stages:

Stage 1 Initial contact and establishing rapport

- ▶ The chronological and developmental age of the child needs to be considered when deciding how to engage him or her in the assessment. It is important to bear in mind that the child's cognitive ability may have been adversely affected by the experiences that they have had, for example early traumas, parental separation, domestic violence. Knowledge of the child's cognitive ability is essential in determining what can be accomplished with them,
- ▶ It is important to consider how the child communicates and to use a vocabulary that is child centred and appropriate to the developmental stage of the child. This is particularly important with disabled children,
- ▶ It is essential to build rapport with the child and this task should take precedence over all others at the beginning of an assessment. This can be helped by there being one consistent person working with the child and where at all possible and appropriate, parents should be involved in preparing the child for an assessment,
- ▶ The worker must be responsive to hearing what the child has to say, what their feelings and wishes are and how they understand what is happening within their family,
- ▶ Once rapport is established, more factual questions can be asked.

Stage 2 Establishing a safe environment for the assessment to take place

- ▶ When establishing a safe environment, there are certain considerations to be borne in mind:
 - Where would the child like the assessment to be carried out?
 - Is the child's home a neutral, safe place where the child can speak freely?
 - Will there be somewhere private and free from interruptions in the child's home that could be used for the assessment?
 - Does any available location hold any negative associations for the child?
 - Outings can be advantageous as they provide an opportunity to develop a relationship with the child. However, caution is required to ensure that inappropriate discussions do not occur in public places,

- Using a location other than the child's home, which is familiar to the child, can trigger memories, good and bad,
- Public places like restaurants and playgrounds can be distracting and lack privacy; conversations can be interrupted at a crucial point,
- Many children are comfortable talking about their feelings when they are travelling in the back seat of their worker's car.
- ▶ As well as these practical considerations, the creation of a safe environment also relies on the worker's ability to engage the child to such an extent that they feel willing and able to communicate their feelings, needs and wishes without thinking that they might be punished, laughed at or ignored,
- ▶ It is also important for boundaries to be set around what is acceptable and what is unacceptable behaviour,
- ▶ An agreement also needs to be reached about the boundaries of confidentiality in the relationship.

Stage 3 Reassuring and clarifying

- ▶ Children need reassurance and clarity regarding what will happen to the information that they provide to the worker and who will have access to it. It is important to be honest and not offer false assurance,
- ▶ Children's interpretation of situations and their needs may differ from that of their parents and they need to be reassured that their opinion is valid and important.

Stage 4 Therapeutic containment

- ▶ Children need reassurance that what they have said has been properly heard and understood,
- ▶ They need to know what implications there are, if any, to what they have disclosed,
- ▶ A child can become very attached to the worker carrying out the assessment. The manner in which an assessment is ended should be informed by the child's attachment history.

Assessing a Child's Attachment Patterns and Level of Resilience²⁶

It is now well recognised that attachment and resilience are key concepts in child welfare. A child centred approach must focus on assessing these areas. Attachment has implications for the child's functioning including their capacity to trust, learn, concentrate, play and socialise. Attachment

²⁶ Adapted from Daniel et al, 1999

relationships are important because they give the child access to responsive adult care. In turn this impacts on the child's internal working model of relationships as being potentially supportive and positive.

A successful primary attachment should ideally take place within the first year of a child's life. Primary attachments can be formed with more than one adult. The attachment may form despite abusive behaviour on the part of the adult. The following points are important to bear in mind:

- ▶ Children are likely to have a hierarchy of attachments to people in their lives,
- ▶ Children need people to whom they are special,
- ▶ Siblings often form an important part of a child's attachment network.

It may be helpful to think of secondary attachments as serving an important safety net for children should the primary attachment fail to materialise or break down for some reason.

Patterns of Attachment - Definitions

- ▶ Secure attachment – the child is able to explore in confidence from a base of security in the relationship,
- ▶ Anxious attachment – the child is anxiously preoccupied with the parents' availability or responses,
- ▶ Ambivalent attachment – the child shows signs of both wanting and fearing closeness. In other words the child may have mixed feelings about intimacy with adults and be therefore demonstrating an ambivalent attachment,
- ▶ Avoidant attachment – the child avoids close contact with carers.

Resilience

Resilience is defined as "normal development under difficult conditions" (Fonagy et al, 1994). Resilience implies identifying a child's strengths and helping them to build a protective network around themselves so that they can better cope with adversity. Levels of resilience are positively associated with healthy attachments.

In assessing a child's resilience, consideration needs to be given to intrinsic qualities within the child and extrinsic factors within the child's social environment, their family and community, which operate as protective factors and enable them to cope better with adversity.

Indicators of Resilience

Research²⁷ has suggested that there are a number of indicators that workers can look for in children, which will give a good indication as to how resilient they are:

- ▶ The child has someone who loves him or her unconditionally,
- ▶ The child has an older person outside the home he/she can tell all about problems or feelings,
- ▶ The child is praised for doing things on his/her own,
- ▶ The child knows someone he/she wants to be like,
- ▶ The child believes things will turn out all right,
- ▶ The child does endearing thing that make people like him/her,
- ▶ The child is willing to try new things,
- ▶ The child likes to achieve in what he/she does,
- ▶ The child feels that what he/she does makes a difference in how things come out,
- ▶ The child likes him/herself,
- ▶ 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.

Building Blocks of Resilience

It has been suggested that there are three essential building blocks to resilience²⁸:

- ▶ A secure base,
- ▶ Good self esteem,
- ▶ A sense of self efficacy.

Six Domains of Resilience

There are six domains of resilience that should be explored as part of the assessment process²⁹. These are:

1 Secure Base

There is a clear relationship between the presence of a good attachment relationship and resilience in the face of adversity.

2 Education

Educational achievement is associated with good outcomes for children. School can provide a child with an alternative secure base, opportunities for achievement and advancement, improving self-esteem and opportunities for positive contacts with peers and adults.

²⁷ Source: International Resilience Project cited in Daniel and Wassell, 2002

²⁸ Gilligan, 1997

²⁹ Daniel and Wassell, 2002

3 Friendships

Having friends plays an important role in the development of resilience. Interacting with friends and learning social skills will help children to survive better in society and be better able to form relationships as adults.

The lack of friends during childhood is associated with a range of problems³⁰:

- ▶ Emotional problems,
- ▶ Immature perspective-taking ability,
- ▶ Less altruism,
- ▶ Poor social skills in group entry, cooperative play and conflict management,
- ▶ Less sociability,
- ▶ Poor school adjustment,
- ▶ Poorer school attainment.

4 Talents and Interests

Engaging children in their talents or interest provides them with opportunities to enjoy activities, which will positively impact their self-esteem.

5 Positive Values

Having positive values and being able to respond to others in a responsible and caring way is associated with resilience. The ability to engage in such 'prosocial' behaviour is related to the emotional and cognitive development of a child and their ability to empathise with others.

6 Social Competencies

The capacity for social competencies has been linked with resilience. Social competencies are seen to be linked to whether a child can possess and use the ability to integrate thinking, feeling and behaviour to achieve social tasks and outcomes valued in their context and culture.

Social competencies have been defined as:

- ▶ Perception of relevant social cues,
- ▶ Correct interpretation of social cues,
- ▶ Realistic anticipation of obstacles to personally desired behaviour,
- ▶ Anticipation of consequences of behaviour for self and others,
- ▶ Generation of effective solutions to interpersonal problems,

- ▶ Translation of social decisions into effective social behaviours,
- ▶ Expression of a positive sense of self efficacy.

Recommended Reading

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³⁰ Schaffer, 1996

PRACTICE PRINCIPLE 3

AN ECOLOGICAL APPROACH SHOULD UNDERPIN PRACTICE

An ecological approach to assessment necessitates consideration of a child within the mutually influencing contexts of family and extended family, friends and community, and socio-economic environment. It is only by considering these contexts that a full understanding of a child's development and behaviour can be achieved (Brooks-Gunn et al, 1993, cited in Jack, 2001). It is also vitally important that the strengths and protective factors in a child and family's environment are considered as compensatory factors which may mitigate against some of the identified problems. This section will cover, firstly, the different elements of a child's environment, secondly, the factors in parent/carer lives that may affect their parenting capacity and thirdly, the use of a strengths based perspective.

Different Elements of a Child's Environment

Family and extended family

- ▶ Families exert a very powerful and long lasting influence over children (Jack, 2001). It is very important to consider family structure, relationships within the family, family difficulties and the absence of important family members, in particular parents,
- ▶ It is widely accepted that the early family environment that a child lives in will not only influence his or her development and future life chances but also the kind of later environments that a child will encounter and the skills, behaviour and attitudes they will develop (Rutter, 1984 cited in Jack, 2001),
- ▶ Children can overcome early adversity within their family environment (Pilling, 1990, cited in Jack, 2001) but the greater the number of problems that they experience the more difficult it is for them to do so and the greater the negative impact on their development (Garmezy, 1994 and Werner and Smith, 1992, cited in Jack, 2001),
- ▶ A child's relationship with extended family members, for example a grandparent, can be an important factor in promoting their resilience against adversity. The availability of a sympathetic and supportive extended family member may provide the child with a listening ear, advice and a place to stay when needed,
- ▶ Assessment of parental capacity is very important when consideration is being given to whether a child's needs are being met within

their family. A range of issues such as mental health, substance abuse, own experience of being parented, marital difficulties and domestic violence can influence parental capacity (Jack, 2001) but influence is very individualised and depends on a range of factors.

Friends and neighbours

- ▶ Similar to the availability of someone within a child's extended family, if a child has an enduring and positive relationship with someone outside the family, such as a youth leader or a teacher, this can promote resilience and positively impact on their ability to deal with adversity within their family and their parent's inability to meet their needs,
- ▶ Support and assistance provided to parents by friends, neighbours and the community can also positively impact on the development of children living in adverse circumstances. Options with regard to childminding, for example, can be generated by supportive friends thereby relieving some of the pressure on parents in times of stress,
- ▶ There is a lot of research evidence to show that the family which is well integrated within the community and has a lot of support networks that can be relied upon in times of adversity will fare better than those who do not (Canavan, Dolan and Pinkerton, 2000). However, consideration needs to be given to the quality of the relationships that the child and family have, as poor relationships can have a negative effect on children and families and can increase stress rather than reduce it,
- ▶ A close confiding relationship for mothers rearing young children has been shown to be very important (Jack, 2001).

Environmental factors

- ▶ Research has shown that houses, communities and neighbourhoods in which families live can have an influence on both parenting capacity and children's development. Considerations such as whether the house has facilities suitable to the children's ages and stages of development, whether there are adequate cooking facilities and sleeping arrangements, whether it is clean and warm and whether it is safe are all important issues to look at (Jack, 2001). A cold, dirty house, for example, can negatively affect a child's development as it can result in frequent ill health and absenteeism from school and isolation from peers,

- ▶ The physical surrounding of the community that the family live in and the availability of services and amenities warrant consideration. How readily available childcare is, for example, to a lone parent with young children may influence that parent's ability to adequately meet the children's development needs,
- ▶ Particular consideration needs to be given to issues of access, services and amenities both in the household and in the community where there is a disabled family member,
- ▶ Research has shown that the factors cited by communities as endangering the protection or safety of their children are often at variance with established child protection agendas. These include bullying, street gangs, heavy traffic, the presence of dangerous objects like burnt out cars, and lack of policing (Wright, 2004). Links between the Health Service Executive and other service providers in the community could usefully address some of these factors,
- ▶ School has been recognised as a potentially very positive source not only of education and development, but of opportunities for promoting a child's resilience (Gilligan, 1999; Daniel et al, 1999). It is now well established that academic success contributes to cognitive development, raised self-esteem, social competence and job opportunities. It is also now recognised that a positive school experience promotes friendships, hobbies, interests and social skills generally. Evaluation of school attendance and performance are vital elements of effective assessment. Links between the Health Service Executive and schools need to be constantly reviewed and maintained,
- ▶ Efforts to strengthen the social networks of families and children should be part of community based interventions. Positive opportunities within communities for social interaction and for people to meet, greet and get to know one another or the availability of leisure and recreational services or play areas for children will have an influence on the family (Jack, 2001, 2004),
- ▶ The socio-economic status of the family will impact the family's well being. The employment status of the adults in the household will exert an important influence as will the parent's educational achievements and ability. It has been shown that earnings in later life are influenced by the earnings of parents during childhood (Garbarino and Sherman, 1980, cited in Jack, 2001). Further to this, research has

demonstrated that the risk of psychiatric difficulties increases threefold for men and women when they become unemployed (Bebbington et al, 1981, cited in Jack, 2001). The incidence of parental psychiatric difficulties will of course exert an influence on children,

- ▶ The overall link between poverty and health is well established; people who live in poverty are more likely to suffer from poor physical and psychological health and this includes children. This is linked to the fact that poverty is not an isolated phenomenon but rather that it has an adverse effect on housing and education as well as health.

Factors in a Child and Family's Environment that Affect Parent/Carer Capacity

It is important when assessing factors that affect parental capacity to avoid generalisations and be specific about each aspect of the factor, including frequency, nature and precise effect on parental behaviour. It will be necessary for practitioners to be informed about, for example, different types of mental illness and/or different types of drug use and their likely effect on parental behaviour. Consultation with colleagues working in specialist services is recommended and a list of specialist reading is given at the end of this section. The following paragraphs outline some general issues, highlighted in research, about domestic violence, mental health problems, problem alcohol and drug use and single parenthood. As the research findings demonstrate, many of the negative effects are common to more than one type of problem.

Impact of problem alcohol and drug use on parenting capacity

When assessing the effects of alcohol and drug use, it is important to be specific about the nature of the problem behaviour, the pattern of usage, the type, for example, of drug being used, and the patterns of behaviour that prevail. Some general effects are discussed below.

A disorganised lifestyle, one that is dominated by alcohol or drug use, can leave parents with little time or energy to meet the needs of their children. Memory and concentration can be impaired by the use of alcohol or drugs or medication used to treat mental illness and can leave parent/carers struggling to meet their children's needs.

Drug and alcohol misuse can leave parent/carers unaware of or unable to meet their children's more basic primary care needs, for example excessive use of alcohol may leave a parent unaware of meal

times and unable to cook. Drug and alcohol misuse can result in the household budget being diverted away from essentials such as food, clothing and bills.

Excessive drinking or drug use during pregnancy can result in babies being born with damage to their central nervous system or with behaviour such as poor feeding, tremors, irritability and occasional seizures. Such behaviours can have a negative impact on the development of a secure attachment between child and parent. Parent/carers may be insensitive to their child's signals, particularly infants.

Social consequences of problem alcohol and/or drug use can include the following:

- ▶ Loss of employment and resultant loss of income,
- ▶ Use of household budget to finance drug and alcohol misuse,
- ▶ To supplement income, the parent/carer may engage in illegal activity such as drug dealing or prostitution,
- ▶ The standard of accommodation may deteriorate due to negative consequences of alcohol/drug misuse, for example violent outbursts and the destruction of property that isn't repaired or due to the parent's lack of interest in the accommodation. This can result in poor hygiene standards,
- ▶ Non payment of bills can result in basic amenities being cut off,
- ▶ Isolation from friends and families due to a sense of shame or unpredictable and malicious behaviour,
- ▶ Disorganised lifestyle, inconsistent and ineffective parenting.

Problem drinking and drug use, which is not accompanied by other family stressors, present fewer risks to children. The effect is also likely to be lessened if family life is harmonious and one parent/carer is available to ensure the emotional and physical well being of the children (Cleaver et al, 1999).

Impact of mental health difficulties on parenting capacity

Research demonstrates a wide diversity of capability amongst parent/carers experiencing mental ill health. Some display impressive parenting, including warmth, sensitivity and understanding of

their children's development and needs. The opposite extreme are those whose children have died in their care (Falkov, 2002). Mental health difficulties can impact the parent/carer's ability to maintain consistency, predictability and to be a physical presence in the child's life which can have an adverse effect on the attachment process. Different types of illness e.g. schizophrenia, depression and manic depressive illness, are likely to have different effects, and the crucial variables are whether parent/carers are linked with services, attend services, and take medication as directed (see Cleaver et al, 1999).

Research carried out on mothers' suffering from depression has indicated that they respond less to their baby's cues or may do so in a controlling rather than facilitating manner (Cox et al, 1987). Parental apathy and despair may inhibit their ability to empathise with and appropriately respond to their children's needs. Other studies indicate that depressed mothers are more disorganised, unhappy, tense and irritable than non-depressed mothers. They are shown to be less effective, show more anger and are less playful with their infants (Bettes, 1998; Field et al, 1990, cited in Cleaver et al, 2001).

Parent/carers who suffer from certain mental illnesses may exhibit rapid mood changes which can be difficult for the child to understand or predict. A parent/carer may change, for example, from being caring, loving and entertaining one minute to being violent, argumentative and withdrawn the next leaving the child feeling very confused and at fault for the mood changes.

Young children are most at risk from parental mental illness when they are the victims of aggressive acts of hostile behaviour or are neglected or suffer parental rejection (Rutter, 1996; d'Orban, 1979; Falkov, 1996, cited in Cleaver et al, 2001). When parent/carers have mental health difficulties there is an increased risk of medical problems for their children and an increased risk of hospitalisation. On the positive side, the presence of a well, supportive partner or spouse will greatly affect the impact that a parent/carer's mental illness has on their children. It is important to ascertain through assessment, not only the effects of parental illness on children, but how aware the parent/carer is regarding their illness, its impact on the child and how or if they explain their symptoms and behaviour to the child (Falkov, 2002).

Impact of a disability on parenting capacity

Assessment of parents with disabilities should be similar to any other assessment of parenting capacity, but with particular attention to certain relevant factors. It is important to note that the participation of parents/carers who have either learning or physical disabilities may need to be assertively facilitated as this is a group that are not always able or enabled to represent themselves adequately (Cotson et al, 2001). The support offered to parent/carers with learning disabilities can be inconsistent for a number of reasons, a significant one being that services for adults and children are delivered separately. This can result in parent/carers with disabilities not coming to the attention of child welfare services unless a serious concern is noted. While research (Booth and Booth, 1993) has shown that the relationship between parental competence and child outcome is not straightforward and that there can be too much emphasis on the inadequacies of parents with disabilities; it has to be acknowledged that certain parenting deficits can be common, including³¹:

- ▶ Failure to adjust parenting styles to changes in the child's development,
- ▶ Lack of verbal interaction with the child,
- ▶ Insufficient cognitive stimulation,
- ▶ Tendency to over generalise instructions,
- ▶ Inconsistent use of discipline,
- ▶ Lack of expressed love, warmth and affection.

Stevenson (1998) cites another three possible difficulties:

- ▶ Not being able to foresee trouble (i.e. not being one step ahead as most parents are),
- ▶ Not being able to manage situations that are diverse and complex,
- ▶ Rigidity in thought processes, which makes adaptation to changed needs or situations problematic.

Many parents living in the community with a physical or learning disability can be 'invisible' for a number of reasons, including:

- ▶ A wish to avoid attention which focuses on their disability as a negative trait,
- ▶ Many public places where parents are often seen are inaccessible to persons with disabilities,

- ▶ Disabled people are still not recognised by advertisers or the media as people who lead family lives,
- ▶ The fear of having their child removed is very common amongst parents with a disability; therefore contact with professionals may be deliberately avoided (Campion 1995).

It is likely that parents/carers with disabilities will be linked to a number of agencies, therefore a multi-disciplinary approach to assessment is particularly relevant. The fragmentation of voluntary and statutory adult and child services poses particular challenges. It is vitally important to achieve a balance between ensuring that all the family's needs are being met by the appropriate services and the potential for an overwhelming number of professionals to make regular calls to the home. Some of the problems identified by research include the perception of disability services to be seen exclusively as advocates for the parents and child welfare services to be seen as focusing exclusively on the children, to the neglect of the parents' needs (Cotson et al, 2001). It is essential that roles and responsibilities of all involved professionals be clarified, so that the complementary contributions of each service are established and understood.

Research indicates that the number, age and spacing of the children in a family with a disabled parent/carer plays a major role in determining parental coping ability (Reeder and Lucey, 1995). In assessing the impact on parenting capacity of having a learning disability, it is important to focus on the precise ways in which the disability appears to negatively affect parenting. As Campion (1995) points out, it cannot be categorically stated that disability means that a parent will neglect the physical care of his or her child. More awareness of the many families that are functioning well will make it possible to learn from them what the significant factors are.

Impact of domestic violence on parenting capacity³²

There is a growing body of research demonstrating the impact of domestic violence on the welfare and safety of children. Studies show that women who are victims of domestic violence experience multiple and serious problems, such as depression and post traumatic stress symptomatology, inappropriate guilt, problems with concentration, feelings of worthlessness and other associated symptoms. Domestic violence is also associated with substance abuse by women. However, caution should be used

³¹ Booth and Booth, cited by Stevenson, 1998

³² Adapted from Cleaver et al, 1999

in making direct links as it is inappropriate to claim that it is the physical violence per se that is solely responsible for these problems (Stephens and Mc Donald, 2000). Many physically abused women are also subjected to psychological abuse and this can occur more frequently and sometimes more chronically than the physical violence and therefore the effects can be more pernicious. Women who leave a violent relationship may face feelings of loneliness, uncertainty about the future, financial concerns of becoming a single parent and fear about not meeting the emotional needs of their children.

The concentration in the research literature on the experiences of women who are victims of domestic violence tends to feed into the perception that domestic violence is generally inflicted by men on women. However, there is a growing body of evidence suggesting that a significant proportion of women perpetrate violence (Mc Keown and Kidd, 2002). This perception tends to be diminished by the fact that men inflict more injuries on women than vice versa therefore women are more visible in the services, coupled with the fact that there is greater range of services for female victims. The fact that male victims of domestic violence are more reluctant than female victims to either report or seek help also minimises the notion that men are likely victims. Given the links that we now know to exist between anti-social violent and sexually abusive behaviour and the witnessing of domestic violence by children it is important that practitioners open their minds to the possibility that a male carer may be the victim of undisclosed domestic violence.

Low self esteem in victims of domestic violence can be perpetuated by the psychological and emotional abuse that often occurs alongside physical abuse. This can include vilifying, blaming, ridiculing, harassing and criticising and can lead the victim to question their self worth and their personal adequacy (Stephens and Mc Donald, 2000). Domestic violence can also inhibit the victim's ability to have positive social contacts and can lead to social isolation and lack of support. Ability of the parents to protect the child from witnessing or experiencing the domestic violence can clearly be impeded by all of these effects. Other parental difficulties can include the physical impact on the parent of physical and sexual assaults, and the consequences for the family in the event of the victim being hospitalised.

The effect of domestic violence on the care of infants and young children can be significant, for example, it can lead a mother to neglect her

physical needs during pregnancy. Poor attendance at clinic appointments may put an unborn child at risk. Once the baby is born, domestic violence can impact on the parent/carer's ability to maintain consistency and predictability, which can have an adverse effect on the attachment process. Attendance of a young child at pre-school or school may be hampered by a mother attempting to conceal the evidence of a violent home. Research also demonstrates a link between domestic violence and physical abuse of children (Mullender, 1996).

When considering all of the above factors, it is important to remember that while the effect of single factors on parental capacity may be minimal, research shows that an accumulation of more than one factor can have a far more undermining impact on a parent/carers' ability to meet their children's needs.

Maintaining A Focus on Strengths and Protective Factors³³

A criticism identified by research in child protection and welfare work is the tendency of professionals to focus on single, negative, events to the exclusion of less visible or dramatic but potentially positive features in a child's environment. A recurrent theme throughout this Assessment Framework is the importance of empowering children and families by acknowledging their ability to use their own strengths and resources to resolve their difficulties. This process not only acknowledges the unique knowledge of family members and promotes trust between them and professionals, but it is undoubtedly more effective in ensuring the workability of interventions and raising the likelihood of positive outcomes for children. One of the first factors to acknowledge is that many children and families who will be participating in assessment have lived in stressful circumstances of one kind or another, yet have survived to this point, not without difficulty, but through using whatever resources were available to them to the best of their capacities.

The problem situation³⁴

The process of assessing for strengths should begin when defining the problem situation (as opposed to the 'problem person'), establishing what it means to the child and/or parent/carer, what outcome they want and the expectations they hold of whatever intervention is chosen. It is important that children and families are facilitated to present their own version of events rather than constructing their lives and situations from a professional or agency perspective. In the process,

³³ Adapted from Saleeby, 1997

³⁴ Cowger, 1997

they are likely to reveal their strengths and abilities and give examples of how they have resolved difficulties in the past.

Identifying strengths

Strengths can be categorised as environmental and personal.

Environmental strengths can be defined as strong family networks (nuclear and extended); community and social networks including neighbours and friends; institutions such as churches, schools, associations and voluntary organisations; access to resources; services designed to address universal needs and provide primary care and services designed to provide early intervention where difficulties exist.

Personal strengths can be defined as a child or parent/carer's interpersonal skills, physical and mental health, insight, experience, personal traits (e.g. sense of humour, kindness, loyalty, patience, reliability), problem solving, culture, reasoning ability, self-esteem, openness, resilience, intelligence, motivation and talents. These categories are not exhaustive and the range of strengths to be measured will vary between different situations and depend on the purpose of the assessment.

The miracle question

Workers should encourage families to consider examples of strengths in relation to each dimension of the child's life. It can be useful to identify obstacles or impediments to the exercise of strengths in different contexts. It is also important, when reviewing patterns in the past lives of children and families where problems have previously arisen and been addressed, to note what factors resolved the problem as well as those that appear to have maintained it. Techniques such as the 'miracle question'³⁵ demonstrate that the child or parent has not only insight, but the capacity to construct solutions to their own difficulties.

Other questions that might be asked in seeking out strengths could be about how the child or parent dealt with a problem in the past, what or who has helped them, what was it like when things were going well for them, what their hopes and dreams are, what they like about themselves, what other people like or admire about them.

It is important during this process to acknowledge the difficulties that have been experienced by children and parents/carers, but to try and focus on the strategies they have used in the past to cope

with the intention of affirming their capacities and building on them.

Recommended Reading

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Jack, G. and Jordan, B. (1999) 'Social Capital and Child Welfare' *Children and Society*, 13:242-256.

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35 In Brief Solution Focused Therapy, a 'miracle' question can be asked, i.e. if, by tomorrow, the problem had disappeared, what changes would have occurred in the meantime? This type of questioning can be very effective in identifying not only the desired outcome and the nature of any changes that would achieve it, but the process that may be involved.

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PRACTICE PRINCIPLE 4

ASSESSMENTS SHOULD BE INCLUSIVE AND RECOGNISE THE INDIVIDUAL NEEDS OF THE CHILD IRRESPECTIVE OF AGE, GENDER, ETHNICITY AND DISABILITY

Child welfare professionals today deal with a wide range of clients from a variety of ethnic and cultural backgrounds as well as people with different types of disability. Each child and family, however, has a right to expect the same quality of service as the next person and there is an onus on professionals to acknowledge and understand the needs of these heterogeneous groups. The groups that professionals may encounter include: refugees, asylum seekers, unaccompanied minors, residents from different cultures, Travellers and children and adults with disabilities.

Employing the principle of inclusiveness means that assessment should be non-discriminatory and inclusive of all children and families regardless of race, ethnicity or disability. It should also be gender sensitive and inclusive of all family types. This section looks first at the assessment of children with disabilities, and goes on to explore issues regarding the assessment of children from minority groups. The Travelling community is discussed separately. This section also looks at the process of engaging fathers/father figures in assessment, engaging involuntary or aggressive clients and it looks at issues pertinent to working with non-abusing mothers.

Children with Disabilities and Complex Health Needs

To a large extent children with disabilities and children with complex health needs have the same needs as other children. However, some particular considerations need to be borne in mind.

Particular vulnerabilities of children with disabilities and complex health needs³⁶

- ▶ Research suggests that children with disabilities are at an increased risk of abuse by virtue of their disability (Department of Health, UK, 1993; Westcott, 1993). More specifically it has been shown that children with disabilities, across a range of different impairments, were almost four times as likely as their non-disabled peers to be neglected (Sullivan and Knutson, 1998 cited in Kennedy and Wonnacott, 2005). This study also found that children with disabilities tended to be maltreated at earlier ages and that pre-school children with disabilities suffered more from abuse, including neglect, than older children – it is therefore important to be alert to the possibility of neglect early in the life of a child with disabilities,
- ▶ Children with disabilities and children with complex health needs may have sensory difficulties and/or a limited ability to communicate. They may not have the ability to verbalise that they are being abused,
- ▶ Children with disabilities and children with complex health needs are usually very dependent on their carers and may have very little control over their lives,
- ▶ Children with disabilities and children with complex health needs might not disclose abuse because of a fear of not being believed or of losing their carer,
- ▶ Children with disabilities and children with complex health needs are seen as different and are treated in ways different to their non-disabled peers,
- ▶ Children with disabilities and children with complex health needs may be subject to frequent hospitalisations,
- ▶ A lot of children with disabilities live in residential care and research indicates that children living in residential care are two to four times more likely to be subjected to abuse than those living in the community (Rindfleisch & Bean, 1988; Rindfleisch & Rabb, 1984; Shaughnessy, 1984; cited in Department of Health, UK, 1993),

³⁶ Adapted from: Department of Health, UK, 1993; Department of Health and Children, 1999

- ▶ Children with disabilities may not receive the same level of general education and sex education as their non-disabled peers. A lack of sex education places children with disabilities in a particularly vulnerable position with regard to sexual abuse,
- ▶ Parents and carers may take some time to come to terms with their child's disability or health needs,
- ▶ Caring for a child with disabilities or complex health needs can be complicated, time consuming, unfamiliar, anxiety provoking, physically taxing and emotionally difficult (Marchant, 2001),
- ▶ Children with disabilities and children with complex health needs may have intimate care needs,
- ▶ Children with disabilities and children with complex health needs may be in contact with a number of professionals and agencies without there being a coordinated approach,
- ▶ Children with disabilities and children with complex health needs may have a limited sense of danger and inability to see warning signs,
- ▶ Children with disabilities and children with complex health needs may be overly compliant towards adults,
- ▶ Children with disabilities and children with complex health needs may be perceived as having limited reliability as witnesses. This may add to their vulnerability and increase the likelihood of their being targets,
- ▶ Supports available to most parents, such as babysitting and other informal supports, are not as available to the parents of children with disabilities and complex health needs,
- ▶ Children with disabilities may not have the same equality of access to services as their non-disabled peers, which may make them more vulnerable.

Some literature and research suggest that a social model should be used when looking at the impact of a disability on a child, thereby moving the focus of attention away from the child's impairment and concentrating on the 'disabling barriers' present in society that lead to the child being 'dis-abled' (Kennedy and Wonnacott, 2005).

Minority Groups

Work with refugees and asylum seekers needs to be considered in the current legislative context as this

exerts an influence on the needs of these children and families and on the services that professionals can offer.

Considerations particular to those who are seeking asylum:

- ▶ Asylum seekers and unaccompanied minors may be particularly reluctant to share information with Health Service Executive personnel, out of fear that it will be used against them in their application for asylum. It is therefore important to separate the Health Service Executive's role from that of the Department of Justice, Equality and Law Reform,
- ▶ Being an asylum seeker in Ireland, for the most part, means living on a very restricted income and not being permitted to seek employment. This has implications for the family's economic circumstances and overall well being,
- ▶ Particular attention should be given to the needs of asylum seekers, refugees and unaccompanied minors on the basis of the experiences that they have had prior to their arrival in Ireland. Traumatic experiences may include detention, violence and torture, separation and loss of friends and family members, hardships encountered on their journey to Ireland and the adjustment to living as an asylum seeker or refugee.

Mental health and refugees/asylum seekers

- ▶ Asylum seekers, refugees and unaccompanied minors are likely to be traumatised by their experiences and therefore at risk of psychological disturbance which may manifest itself in emotional and/or behavioural problems.

Experiences which can positively impact on refugee and asylum seeking children and families³⁷

- ▶ Gaining refugee status or leave to remain,
- ▶ Family reunification,
- ▶ Improvement in living conditions,
- ▶ Being permitted to leave the direct provision scheme,
- ▶ Increased integration in the community in which people are living.

Use of interpreters

When completing assessments with children and families where English is not their first language, careful consideration needs to be given to how the family will be communicated with and the use of interpreters. Consider the following³⁸:

³⁷ Torode et al, 2001

- ▶ The implications of using family members as interpreters, particularly in situation of domestic violence,
- ▶ Co-ordinating the presence of a third person,
- ▶ Establishing a relationship through a third person,
- ▶ Presumptions of mutual understanding when using an interpreter,
- ▶ Whether the interpreter is putting their own interpretation on questions and answers,
- ▶ Whether the interpreter is embarrassed and therefore selective about the information that is being interpreted,
- ▶ Interpreter's familiarity with the community and their perception of the child and family and vice versa,
- ▶ Loss of meaning through interpretation,
- ▶ Confidentiality and privacy issues when using an interpreter,
- ▶ Whether the family feel that they can trust the interpreter,
- ▶ Access to interpreters.

Travellers

It is widely accepted that Travellers form a distinct ethnic minority. Murphy et al (2000) have asserted that Traveller culture meets all the prerequisites of an ethnic group: the group is biologically self-perpetuating, the group shares fundamental cultural values, the group share a field of communication and interaction, there is a membership which defines itself and is defined by others and the group is subject to oppression.

Considerations particular to travellers

- ▶ Nomadism encompasses more than just travelling; rather it is a mindset that shows in all aspects of Traveller lifestyle. The nomadic lifestyle of the majority of Travellers may make it challenging for a worker to keep in contact with the family,
- ▶ Family and extended families form very important support networks within Traveller families,
- ▶ Travellers are traditionally self-reliant,
- ▶ It is important to understand Travellers' practices and norms in relation to extended family support systems, economic activities, gender, gendered division of roles within families, hygiene rules, history, religion,

language, accommodation, health and welfare (Cemlyn, 2000),

- ▶ Travellers have a history of being fearful or suspicious of authorities, particularly police,
- ▶ Travellers make less use of social services than non-Travellers. This may at times be due to a sense of hostility from other clients,
- ▶ It may be important to engage in outreach work and visit halting sites in order to link the child and family in to the assessment,
- ▶ The principal concern of a Traveller family may be the condition of the site they are living on,
- ▶ It is important to bear in mind that pre-literacy and illiteracy are commonly experienced by Travellers,
- ▶ It may prove useful to involve the specialised assistance of Traveller organisations in the assessment,
- ▶ When working with Traveller families where domestic violence is an issue particular attention should be given to ensuring that women fully understand and have access to their legal rights,
- ▶ If a Traveller child is in a settled family care placement, particular consideration should be given to the impact of this on the child (Kelly, 2001; Pemberton, 1996).

Travellers with disability

- ▶ Travellers with disability comprise an almost invisible minority,
- ▶ Travellers' usage of disability services appears to be low,
- ▶ Travellers may lack the awareness or confidence to seek disability services,
- ▶ Travellers may have no access to community support services such as home help, occupational therapy and physiotherapy,
- ▶ Disabled Traveller children may become institutionalised at a very early age because of the inaccessibility of Traveller accommodation.

Engaging Men: Fathers and Father Figures

Engaging men and fathers in an assessment, or indeed any therapeutic or helping relationship, is an area that warrants particular attention within the context of engaging a family. The importance of paternal roles has been stressed in the literature for a long time, yet research continues to demonstrate

38 Adapted in part from Torode et al, 2001

the focus of intervention continues to be the mother (Milner, 1996; Ryan, 2000; Horwath and Bishop, 2001; Buckley, 2003).

Two critical factors in a child's family life, which will influence their well being, are the economic and material situation of the family and the relationships within the family (MacDonald, 2001). Fathers play a particular role in relation to both of these factors. The presence of fathers or father figures within a family tends to have a positive effect on the material well being of the family and consequently the educational outcomes for children. Further to this the presence of fathers in a child's life and non-conflictual parent-parent relationships both positively contribute to the well being of the child. Where fathers have a high level of parental involvement, by agreement between the parents, children have increased cognitive competence, perform better socially and academically and have less stereotyped beliefs (Lamb 1997, cited in Ryan, 2000).

Excluding fathers or father figures from assessment can mean that both positive and negative effects of an important element of the family relationship may be missed. When engaging fathers in assessment, practitioners should bear the following points in mind:

- ▶ Physical absence of fathers/father figures should not be equated with psychological absence,
- ▶ It is not advisable to make a second-or third-hand assessment of the father/father figure's role in a child's life,
- ▶ It is unfair to put a child's mother in the situation where she is allocated all responsibility for her child's safety and welfare and forced to mediate between her family and child protection and welfare services,
- ▶ It is important to ascertain how a father/father figure understands his role as a responsible parent, positive role model and carer,
- ▶ It is important to ascertain a father/father figure's role in the child's everyday life, how he understands and meets the child's needs, how much time he spends with the child, and the nature of the relationship that exists between them,
- ▶ It is important to ascertain the degree to which the father/father figure and the child's mother agree on aspects of parenting, particularly boundary setting and discipline,
- ▶ It is important not to apply different standards of care to fathers/father figures.

Engaging Involuntary and/or Aggressive Clients

Dealing with families who are resistant or hostile to assessment can be very challenging. It is useful to begin by considering the reasons for their negative view. These may include the following:

- ▶ Lack of choice about their involvement in the assessment; for example, where a court order obliges a person to take part in the assessment or where it is stipulated as an alternative to some legal action being taken,
- ▶ Resentment and anger about the fact that someone made a referral about them which is critical of their parenting practices,
- ▶ Different goals and understanding of the reasons for the assessment,
- ▶ Negative past experiences and/or a negative perception of child welfare agencies,
- ▶ Desire to avoid dealing with difficult and painful issues,
- ▶ Feeling of powerlessness,
- ▶ Lack of trust and/or dislike of the practitioner,
- ▶ Fear of the outcome of the assessment.

Reluctance or aggression can manifest itself in a number of ways³⁹:

- ▶ By being willing to only discuss certain areas,
- ▶ By not turning up for appointments or by not being at home when a practitioner calls,
- ▶ By not answering or returning phone calls,
- ▶ By being verbally or physically threatening or abusive,
- ▶ By minimising or dismissing the difficulties that have been identified,
- ▶ By keeping professionals away from the home; for example by only attending office appointments or keeping professionals on the door step.

While reluctance and aggression are difficult to deal with, there are certain responses that the worker must avoid⁴⁰:

- ▶ Becoming impatient or hostile towards the client,
- ▶ Ignoring the fact that the client is resistant and therefore not addressing the issue,
- ▶ Lowering the expectation of how involved the family member needs to be,

³⁹ Adapted from: Shemmings and Shemmings, 2001

⁴⁰ Adapted from: Shemmings and Shemmings, 2001; Trotter, 1999

- ▶ Allowing the involuntary family member to have undue control over the assessment,
- ▶ Being unrealistic about the need for all family members to be willing to engage with services,
- ▶ Believing that all family members must like, trust and get on with the worker if the assessment is to be accurate and successful,
- ▶ Colluding in the non-involvement of involuntary clients in the assessment process because they are difficult to work with,
- ▶ Punishing or blaming the reluctant family member,
- ▶ Projecting the opinion of previous workers' reports on the situation.

Strategies for dealing with reluctance⁴¹ include:

- ▶ Accepting that some reluctance and resistance is normal,
- ▶ Using opportunities to explore with the family the reasons behind the resistance,
- ▶ Exploring which styles of communication best suit the client,
- ▶ Modelling a secure attachment style by being available, predictable and consistent,
- ▶ Reaching an agreement with the family on the aims and objectives of the assessment. The initial focus should be on modest and easily attained goals,
- ▶ Identifying with the client any positive experience of professional interventions and identifying the key factors that made it a positive experience,
- ▶ Looking with the family at the possibility of involving another person in the assessment,
- ▶ Being clear about the ground rules of the assessment, including confidentiality, attendance at appointments, how decisions are made and the complaints procedure,
- ▶ Making aims and objectives attractive and advantageous,
- ▶ Being clear about what happens if resistance continues,
- ▶ Agreeing strategies for achieving goals and monitoring and evaluating progress,
- ▶ Giving emotional and practical support.

Strategies for dealing with aggression include:

- ▶ Attention to the Health Service Executive's guidance on safety and protection of staff,
- ▶ Joint visiting, particularly with more experienced staff.

Note: Supervision has a very important role to play in helping workers to fully understand reluctance and aggression, how it can manifest itself, what responses to avoid and how to develop strategies for dealing with it (See Practice Principle 7). Supervision needs to facilitate the worker to understand the nature of any threats and offer guidance on the most efficacious and safe approach to take. When inducting inexperienced staff, line managers should emphasise that concerns about dealing with reluctant or aggressive clients are not a failing or a weakness on the part of the worker and encourage them to discuss their concerns with a supervisor so that supports can be provided, e.g. joint visiting with a colleague or manager.

Men and aggression

Research shows that practitioners may be reluctant to engage with male service users who have a reputation for violent or aggressive behaviour (Milner, 1996; Reder & Duncan, 1999; Buckley, 2003). This can result in a failure to report concerns of child maltreatment (Horwath and Sanders, 2003). If the father or father figure is aggressive or threatening, the worker needs to be able to rely on clear organisational policies in relation to staff safety and the presence of sufficient resources to back up such policies. If the father or father figure is alleged to have abused one or more of the children in the family, the acceptance of some degree of responsibility may be necessary prior to engagement. Care needs to be taken not to collude with a reluctant or involuntary father or father figure by focusing the assessment on the mother. However, a hostile or violent father or father figure may inhibit a mother from cooperating with the worker.

There is a balance to be struck when offering fathers an opportunity to reflect on the impact of their behaviour on their children. If past experiences are used as an explanation for current behaviour it is possible that it can become an excuse for unacceptable behaviour, which could lead on to the assertion that aggression is out of the control of the individual. Nevertheless, interventions with women take account of childhood experiences and anti discriminatory practice dictates that we should give the same opportunity to men. Work with men who are

⁴¹ Adapted from: Shemmings and Shemmings, 2001; Trotter, 1999

aggressive does not mean excusing aggressive or abusive behaviour and does not preclude addressing areas of responsibility and self-control. At the same time such work must be underpinned by equal consideration of the child's needs (Daniel and Taylor, 2001).

Working with Non-abusing Mothers

An issue that has been commonly identified in research is a tendency for practitioners to have unrealistically high expectations of mothers whose children have been abused by a partner or ex-partner (Hooper, 1992; Sharland et al, 1996; Buckley, Skehill & O'Sullivan, 1997; Buckley, 2003; Colligan and Buckley, 2004). This tendency commonly manifests itself in the way that practitioners withdraw support and close cases on the basis that once the mother is aware of the abuse and has pledged to protect the child, no other intervention is necessary. Yet, it is pointed out (Sharland et al, 1996) that the most predictable emotions experienced by mothers following the discovery of their child's abuse are shock, guilt, and a profound sense of grief and loss. The discovery process itself has been likened to a bereavement, where the mother may experience the following losses⁴²:

- ▶ Loss of the innocence of her child,
- ▶ Loss of the trust of her child (who may blame her for not stopping the abuse earlier),
- ▶ Loss of confidence about her capacity to parent,
- ▶ Loss of esteem amongst family, friends and neighbours,
- ▶ Loss of privacy,
- ▶ Loss of a partner,
- ▶ Loss of financial support from her partner.

In addition, she is likely to be dealing with the problems experienced by her child in the aftermath of abuse. What can sometimes be perceived by practitioners as indifference or impaired capacity to protect children can, in reality, be a reflection of the mother's possibly slow progression through the process of coming to terms with the fact that her child was abused whilst in her care.

It is important to recognise that a mother's ability and willingness to participate in assessment will be affected by these experiences. It is important for practitioners to be sensitive to the sense of loss and helplessness being experienced by a non-abusing mother and to attempt to empower her by:

- ▶ Acknowledging that the responsibility for the abuse lay solely with the perpetrator,

- ▶ Negotiating permission before initiating any kind of assessment or examination,
- ▶ Assuring the mother that her own support of the child is more important than any which is offered externally,
- ▶ Being sensitive to the fact that the mother may have been physically, sexually and emotionally abused herself by the same perpetrator,
- ▶ Attending to the family's material needs if relevant,
- ▶ Being flexible – keeping the door open if initial offers of support are rejected.

Recommended Reading

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⁴² Hooper, 1992

PRACTICE PRINCIPLE 5

MULTI-DISCIPLINARY PRACTICE IS FUNDAMENTAL AND AN IRREDUCIBLE ELEMENT OF GOOD PRACTICE

While a range of statutory and non statutory agencies are involved in providing primary health and welfare services, it is normally the Health Service Executive that have responsibility for the provision of services at a secondary and tertiary level. However, it is important that any lead taken in this area is supported by the other agencies and organisations in the region that provide services to children and families, whatever their principal remit. Irish child abuse inquiries (Department of Health, 1993; Western Health Board, 1996; North Western Health Board, 1998) have highlighted:

- ▶ Difficulties with inter-agency and inter-professional co-operation in child protection work,
- ▶ Differing professional perspectives,
- ▶ Fragmentation or relinquishment of responsibility by different professionals,
- ▶ Weakness in the integration by professionals of discrete pieces of information in order to form a complete picture of a child and family's situation.

These findings strongly indicate the need for a balanced and comprehensive approach to assessment at a multi-disciplinary level. One of the benefits of multi-disciplinary work is the pooling of different specialisms and levels of expertise.

What is Multi-disciplinary Practice?

It is important to clearly define multi-disciplinary work, which, for assessment purposes has two meanings:

- ▶ The involvement of a number of disciplines and professionals, each bringing their own expertise, e.g. a speech and language therapist or a family support worker working with the same child and family, focusing on different aspects of his or her development and social environment,
- ▶ The integration of discrete pieces of information culminating in a complete picture and shared understanding of a child and family's needs and the formulation of a holistic plan of intervention to meet those needs.

The first type of multi-disciplinary work depends on the availability of professionals and services in a specific area, while the second is more complex and depends on a number of agreed strategies and

associated supports for its effective implementation.

The fact that inadequate communication and co-operation has been cited as a root cause of many failures in child protection and welfare practice underscores the reality that effective multi-disciplinary work is not something that develops organically. In contrast, it is a process that needs to be carefully negotiated and consistently maintained. Professional groups or organisations providing services for children in one area have different levels and periods of involvement with child welfare and with each other. They operate within different structures and cultures and have diverse aims, objectives and orientations as well as having various levels of power and responsibility in relation to child care policy and legislation. Social workers, public health nurses, child care and family support workers, speech and language therapists, medical practitioners, education welfare officers, psychologists, disability services, services for unaccompanied minors and child and adolescent services are more likely to have as their main focus the promotion of child health and development, welfare and safety. At a different level and with a less exclusive focus on child welfare and protection; addiction services, adult mental health services, hospitals, police, refuges, services for refugees and asylum seekers and community welfare officers will be offering services to children either directly or through their families. School staff and community and voluntary organisations will also have an important role in the promotion of child welfare, though their primary focus will be on education and recreation.

Preparing for the Assessment

When preparing for a multi-disciplinary assessment it is important to bear in mind some of the problems associated with multi-disciplinary practice. Problems in inter-agency and inter-professional work stem from professional differences and structural obstacles (Hallett & Birchall, 1992; Reder, Duncan and Gray, 1993; Buckley, 2000a; Buckley, 2005). These include differing:

- ▶ Professional priorities, for example is child protection core business?
- ▶ Knowledge about child welfare and child abuse,
- ▶ Understanding of professional roles within the child protection and welfare system and
- ▶ Absence of strategies for sharing information.

Rapid turnover of staff add to these difficulties, as professionals do not get opportunities to develop

effective interpersonal relationships. This is a particular problem in areas where services are fragmented and opportunities for contact are scarce.

Adherence to the commonly agreed definition of needs and thresholds to intervention contained within the framework should ensure more appropriate referrals and a more consistent understanding of the nature of vulnerability and risk.

The Assessment Process: Promoting Multi-disciplinary Work

At an individual supervisory and practice level, adherence to the following practice norms should encourage effective multi-disciplinary assessment:

- ▶ Identifying one point of contact for referral and receipt of information in order to ensure that it is managed carefully and efficiently,
- ▶ Communicating information about roles. It cannot be assumed that all disciplines working in the Health Service Executive and other children's services understand the nature, extent and limits of each other's roles. It would be helpful for each of them to have an up to date list of personnel and written information about each person's function and the service they deliver. Likewise, services not specifically targeted at children (e.g. drugs services, adult mental health) would benefit from having information about how to identify vulnerability and the steps to be taken in response,
- ▶ Building on already existing channels of communication by trying to improve coordination between professionals with heavy workloads or inflexible working arrangements, particularly teachers and members of An Garda Síochána, that limit their availability for meetings or discussions. This can be achieved by identifying specific personnel between whom information can be shared, and agreeing the most appropriate contact times and means of contact. It is important to have arrangements that will endure beyond staff changes,
- ▶ Consideration of the appointment of a 'link' person with a specific networking brief,
- ▶ Agreeing between disciplines and agencies what type of information is exchangeable and what isn't. While there are clear guidelines under Children First for the sharing of information about suspected child abuse, the sharing of information about less specific or evidence based concerns is more sensitive and not privileged to the same extent. Adult services appear to find this problematic and potentially detrimental to their relationships with service users,
- ▶ Showing openness and respect for other people's views and contributions both in their own fields and in relation to child protection and welfare,
- ▶ Paying attention to detail such as providing feedback following referral or during the course of assessment, returning calls and messages,
- ▶ Keeping a child centred focus that takes into account the interplay of various factors in a child's life,
- ▶ Avoiding collusion, bearing in mind that debate and consideration of alternative options and explanations is the best way of reaching a sound decision. Being aware of the pressures to avoid conflict and agree with group decisions,
- ▶ Avoiding jargon and keeping to simple and understandable terms and definitions when communicating between disciplines,
- ▶ Ensuring that each professional is clear about their roles and responsibilities vis a vis the assessment,
- ▶ Ensuring that the professionals working together share a common understanding of the task and their expectations of each other,
- ▶ Ensuring that professionals agree with the family who will do what and in what timescale,
- ▶ Ensuring that systems are agreed for managing conflict and difference,
- ▶ Ensuring that systems are agreed between the professional group for sharing information and working together on the assessment.

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PRACTICE PRINCIPLE 6

AN EVIDENCE BASED AND CRITICALLY REFLECTIVE APPROACH SHOULD UNDERPIN ASSESSMENT PRACTICE⁴³

The focus on 'evidence' in child protection work has been criticised because it has been associated with a forensic style approach that seeks only to find signs that a child has been harmed, ignoring the less dramatic and visible aspects of child need and vulnerability. However, taking an evidence based approach to assessment does not mean exclusively concentrating on abuse. Essentially, as Hill (1999 page 20) has observed, 'good practice ought to derive from research evidence about either the nature, causes and typical pathways of social problems, or about the success of particular methods to deal with those problems'. This means:

- ▶ Ensuring that assessments make specific links between children's needs and factors within their environment including the nature and quality of parenting that they are receiving. It is not sufficient to work on the basis of generalised statements, for example, that a child has a 'neglected' appearance or that their carer is a drug user or has a mental health problem and therefore is not capable of looking after them – factually based information must be specified about which particular aspect of the child's presentation gives rise to concern, or which aspect of parental care is affecting the child in which particular respect and what the short and long term effects of that are likely to be,
- ▶ Conducting assessments in a systematic and structured fashion,
- ▶ Presenting information at multi-disciplinary meetings and conferences in a manner that allows other participants to be confident that the opinions presented are grounded in fact and backed up by theory,
- ▶ Ensuring that conclusions are based, not on intuition, but on sound evidence, drawn from knowledge about children's developmental needs and the effects of not meeting those needs as well as the short and long term effects of different types of disadvantage and maltreatment,
- ▶ Selecting interventions based on what is known about their effectiveness in particular cases and matching particular needs with appropriate services.

⁴³ Adapted from MacDonald, 2001

Adopting an evidence based approach means drawing on *information about the child and family* from all relevant dimensions of their situation i.e. the three dimensions in the Assessment Tool, as well as *evidence from research* about the impact of various factors on a child's safety and welfare, and the known efficacy of proposed interventions. Practitioners need to be informed about:

- ▶ Normal stages of child development and associated psychological theories such as attachment and resilience in order to make judgements about the impact on children's development and welfare of various factors in their environment,
- ▶ Definitions of physical, emotional and sexual abuse and neglect, their causes, associated behaviours and long term effects,
- ▶ The types of children that are more likely to be vulnerable,
- ▶ The impact of social, cultural and economic factors and circumstances on parents' ability to meet their children's needs. These could include poverty, homelessness, isolation, mental illness, history of abuse, single parenthood, domestic violence, disability, problem drug and/or alcohol use,
- ▶ The way that different aspects of a child's environment interact and change,
- ▶ The effect on parenting capacity and impact on children of factors like domestic violence, disability, mental illness, drug and alcohol abuse,
- ▶ The various elements of parental motivation and capacity to change.

Attention to the following concepts will assist practitioners in making structured, evidence based assessments.

Specificity

The use of unspecific terms in recording the initial referral, for example, using words like 'probably' and 'usually' can contribute to a sense of vagueness about the difficulties and leave the process more prone to error and misinterpretation. A more structured and less intuitive approach to assessment can help to check some of these potential distortions. It is important to avoid bias by considering whether all dimensions of a child's situation have been considered, and whether all sources of evidence, including already known information, has been considered.

Objectivity

Assessments that are subjective can be avoided by going through an exercise of deliberately challenging perceptions and being open to a range of information that may change initial opinions. It is important to ensure that the views of all relevant persons are considered, particularly those of the child. The status, experience and roles of informants should not reduce, or increase their credibility. If a critical, open-minded approach is taken it will enable the consideration of rival explanations. It is important to consider whether the evidence of concern about a child fits plausibly with the explanation given by the parent, and to check out any doubts (MacDonald, 2001; Munro, 2002).

Self Awareness in Relation to Thresholds and Standards

It is frequently assumed that the process of gathering information about a child and their family will highlight areas of need and concern and that appropriate plans for intervention will automatically suggest themselves. However, research shows that even when evidence is comprehensive, judgements about thresholds of need and decisions regarding action to be taken can sometimes vary. They can depend on a number of factors, including the practitioner's own previous experiences, both positive and negative, of working with similar cases, or on whether something has happened within the recent experience of the agency that may influence the type of decision to be made. It is important for practitioners to be very explicit about the process by which they assign thresholds of seriousness to the various indicators of need, vulnerability and risk that they have compiled (Dagleish, 2003). The combination of practice wisdom and reference to theory and hard evidence involved in making judgments should be carefully considered. It is also essential to be aware of what standards are being used as a measure for thresholds, and whether the standards are based on theory, experience, the law or expediency.

Transparency

All rationalisation should be transparent so that each conclusion should be available for 'audit', i.e. a new practitioner or manager reviewing the case should be able to track each conclusion and decision back to the piece of evidence that underpinned it without the need to make assumptions or guess why it was reached. All interpretations should be *explicitly linked to the evidence on which they are based*.

Integration of Theory

Some practitioners, particularly those whose assessments must be based on aspects of children's lives that are not easy to quantify, can be reticent about explicitly drawing on theory when either recording information or presenting reports (Stevenson, 1997; Graham, 1999; Buckley, 2003). However, evidence based assessment must draw on and integrate research findings at both the analysis and planning stages. Using research to provide evidence can provide the following benefits:

- ▶ It can encourage a deeper level of reflective practice,
- ▶ Resources will be targeted more efficiently,
- ▶ It can build increased professionalism,
- ▶ It can clarify and inform thinking,
- ▶ It may lead to a new approach or confirm an existing one,
- ▶ It can add to bargaining power when making a case for resources,
- ▶ It can provide a baseline to monitor progress and achieve better outcomes,
- ▶ It can assist workers to challenge their own and other's assumptions about practice,
- ▶ It can help to present a case in court⁴⁴.

The absence of explicit reference to theoretical evidence can undermine the value of a report and can mean that it is taken less seriously. Likewise, it is important to be eclectic in the choice of theory and avoid over reliance on one perspective either because it is popular, available or has been the subject of recent training.

Common sources of evidence include:

- ▶ International and national research studies,
- ▶ International, national and local statistical data,
- ▶ International and national policy, regulations and practice guidance,
- ▶ SSI reports and standards,
- ▶ Child abuse inquiries,
- ▶ Free online resources such as www.scie.org.uk (Social Care Institute for Excellence, UK) or <http://www.aifs.gov.au/nch/afsapubs.html> (National Child Protection Clearinghouse, Australia).

It can be difficult for practitioners to find the time to seek out, critically review and apply relevant

research literature. Journal clubs or practice development groups can provide support and help develop structured approaches to evidence based assessment.

Using a Critically Reflective Approach

The implementation of the framework will only be child-centred if professionals undertaking assessments pay attention to the relevance of all aspects of a child's situation; their own development, their family, extended family and community when assessing a vulnerable child and their family. It is essential to get the balance right; if workers over or under emphasise one of the dimensions at the expense of another, the assessment loses its child-centred focus.

Over Emphasis on the Child's Needs

The child's developmental needs can become the almost exclusive focus of the assessment with only minimal consideration of parenting capacity or social context. In this situation, professionals assess the impact of maltreatment on the child but the causes in terms of parenting capacity and social context are minimalised. Interventions resulting from this type of assessment can ignore parenting issues and the parenting environment. The assessment is not child-centred because the child is not seen in the context of their world rather their needs are seen in isolation and the focus is on the presenting problem e.g. the child's behaviour rather than an understanding of the underlying causes. Child blaming can occur.

This form of assessment can occur if, for example, it is completed by child care professionals who do not believe they have the remit or skills to assess parenting capacity but do not take compensatory action by engaging with professionals possessing these skills. Alternatively, an over-emphasis on the child's developmental needs may happen if parents refuse to co-operate with the assessment. In this situation, the assessment may focus narrowly on the available information thus limiting the potential to make a comprehensive assessment (Horwath, 2002).

Over Emphasis on Parenting Capacity

It occasionally happens that practitioners empathise or over-identify with the carers and the needs of the child can be marginalised. An over-emphasis on parenting capacity may also occur if the focus of the assessment becomes one carer. This is likely to be the case if the other carer is aggressive or perceived to be uncooperative (Farmer and Owen 1995; Horwath and Bishop 2001; Buckley,

⁴⁴ Hackett, 2003

2003). In this situation, the parenting capacity of the uncooperative carer is ignored. In cases of child maltreatment professionals tend to focus on the mother whether or not she was responsible for the maltreatment (Ryan, 2000; Daniel and Taylor, 2001; Horwath, 2002; Buckley, 2003). Yet, the absence or presence of fathers has a significant impact on the child. If this impact is ignored then possible causes of child neglect can also be ignored. An over-emphasis on parenting capacity may also occur if professionals perceive good enough parenting as carers doing their best even if they fail to meet the needs of their children (Horwath and Bishop, 2001).

Over Emphasis on Socio-Economic and Family Factors

Empathy with carers can also result in an unbalanced assessment that stresses family and environmental factors. As Stevenson (1998) notes, professional standards can sometimes be reduced because of the dire living situations of many families and because social workers become used to clients 'bumping along the bottom'. Pessimism about the possibility of changing a family's management of their situation can also cause practitioners to ignore environmental factors (Buckley, 2003). As a consequence, the impact of structural factors such as poverty or bad housing on the child's development, safety and welfare can get lost.

Over Emphasis on Professional Networks

Staff who work in under resourced services with vacancies and high staff turnover are inevitably going to feel stressed and want to protect their workloads. This in turn can result in workers using coping mechanisms that will distort assessments and impact on a child-centre approach. Morrison (1998) highlights specific coping mechanisms associated with high rates of stress. These include naïve optimism, tactics of escape or avoidance, confrontative coping and acceptance of too much responsibility. These mechanisms impact on the way in which professionals relate to each other. They can also cause workers to prioritise their own needs over the needs of the child and can result in negative and pessimistic stereotyping of colleagues, for example, public health nurses or teachers declining to refer cases to social work because of an anticipated non-response (Faughey, 1997; Nadya, 2002; Baginsky 2003; Berry, 2003; Buckley, 2005).

Under/Over Emphasis on Culture and Diversity

Fears of being perceived as racist or oppressive mean that workers can pay too little or too much

attention to issues of race and disability (Dingwall, Eekelaar and Murray, 1995; Laming, 2003). For example, behaviours such as over chastisement or begging which can impact on the child can be accepted as normal within certain communities. Research has shown that practitioners can operate different standards where Traveller children are concerned (Task Force on the Travelling Community, 1995; Berry, 2001). Alternatively, practitioners may not recognise difference and make judgements accordingly. A common judgement is that children from Asian families have few toys and therefore are disadvantaged without thinking about the different ways in which these children are stimulated.

Marginalising Children in Need

Despite the development of family support services within each Health Service Executive region, there remains a concern that in a context of high pressure and limited capacity, resources are diverted mainly into services dealing with suspected child abuse rather than early intervention to prevent vulnerable families reaching crisis point (Ferguson and O'Reilly, 2001; Buckley, 2002). Children who are at risk of abuse or have been abused must receive an immediate and comprehensive response from statutory services, and Children First has been developed in order to ensure that action is taken when such cases arise. Yet, most children coming to the attention of Irish Health Service Executive and child welfare agencies are 'in need' rather than 'abused' (Ferguson and O'Reilly, 2001) and responses should not be confined to the harder end of child protection. Vulnerabilities appear to be strongly associated with developmental delay and parenting difficulties which in turn are linked with factors such as poverty, homelessness, addiction, disability, domestic violence, emotional trauma, parental mental health problems, all of which impact on parents' ability to meet children's needs (Cleaver et al, 1999). Hence, it is important that children in need are not excluded from services and that the type of evidence sought in assessment is not confined to signs or disclosures of abuse but extends to consideration of the impact of maltreatment on the child's general well-being.

Child abuse inquiries and policy documents going back as far as the Task Force Report on Child Care Services (Department of Health, 1980) have repeatedly recommended a strengthening of family support and preventative services to meet the needs of vulnerable children and pre-empt significant harm. It is particularly important therefore to have an Assessment Framework that can identify signs of vulnerability in a specific and

clear manner, sufficient to compel and direct early intervention. Otherwise there is a danger that the dominant focus on investigation of abuse might exclude or obscure evidence of need in situations where child abuse is not a factor.

A Narrow Child Protection Focus

It is equally important that an assessment framework quickly alerts professionals to risks of significant harm for children who are in need of protection from abuse. This framework views maltreatment broadly in view of a family's overall needs but also in terms of their vulnerabilities. It is also important to bear in mind that new information can trigger a concern about risk at any time during the assessment process. Thus a framework needs to recognise that assessment is an ongoing process.

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PRACTICE PRINCIPLE 7

HIGH QUALITY SUPERVISION SHOULD BE PROVIDED AND USED BY PRACTITIONERS COMPLETING ASSESSMENTS

The successful use of this Practice Guidance will depend on the prior existence of certain factors. The guidance in itself will not achieve improvements in children's safety and welfare without the application of sound and informed professional judgement. This in turn will depend on the availability and quality of supervision and support, and a minimum level of practitioner knowledge about both the factors associated with child welfare and those that impede its promotion and maintenance. Supervision and consultation with a line manager is therefore necessary to provide opportunities for practitioners to reflect on their assessments. These consultations are likely to take place within both formal supervision and via informal consultation as the practitioner works with the framework.

Effective Supervision

The quality of an assessment will depend on two principal factors:

- ▶ The quality of information gathered,
- ▶ The quality of analysis brought to the information.

The following questions are designed to bring the supervisor's attention to the issues identified above. The questions are divided up between those that can be used to explore the rationale behind the "on the hoof" consultation and those to be used for actually supervising the assessment.

On the Hoof

- ▶ Why are you approaching me now?
- ▶ Why does a decision have to be made now?
- ▶ Do you have all the information at hand that I need in order to make an informed decision?
- ▶ If not, is it possible for me to make a decision without this information?

- ▶ What do you think we should do and why?
- ▶ How do you feel about this case?
- ▶ What do you think we should do next?
- ▶ What is influencing our decision making, for example time of day, other priorities etc?

Supervising the Assessment

The following checklist, taken from MacDonald (2001), provides a measure for judging the quality of an assessment and may also be useful as a guide for recording. All answers to the questions should be positive and a 'no' will indicate a gap in information.

Does the assessment:

- ▶ Begin with a clear statement of the purpose of or reasons for the assessment?
- ▶ Say what was done in order to complete the assessment (and some indication of why)?
- ▶ Confirm that the purpose of the assessment was explained to all family members concerned and record their responses?
- ▶ Confirm that the nature of the assessment and the expectations if placed on family members was made clear at the outset and records the responses of family members?
- ▶ Contain a summary of who is who in the family, possibly in the form of a genogram?
- ▶ Contain a social history?
- ▶ Provide evidence that the reasons why a certain kind of information is being sought is understood by family members, possibly as a statement to that effect?
- ▶ Contain the expressed views of all key parties, including children?
- ▶ Provide evidence that the views of the children have been sought/obtained in ways that are age-appropriate?
- ▶ Provide evidence that when indirect methods are used to obtain children's views (e.g. play) the theoretical or empirical basis used to organise the session(s) is made clear and appropriate caution is used in interpreting the findings?
- ▶ Use a number of sources of evidence (from different people, and including other professionals)?
- ▶ Use a number of different types of evidence (including standardised measures, direct observation, official records/growth charts, as well as interview data)?
- ▶ Take a critical approach to the evaluation of evidence e.g. consider alternative explanations, include attempts to measure problems, i.e. frequency, duration, intensity?
- ▶ Provide evidence of a broad based approach to data collection, covering all levels of influence relevant to child development and well being?
- ▶ Provide evidence that the questions asked and topics covered reflect an up-to-date and sound knowledge base relevant to the main presenting problem(s)?
- ▶ Make it transparent to the reader why certain areas have been probed and others left?
- ▶ Make explicit any theoretical assumptions made when recording and interpreting information, e.g. regarding the nature of attachment and its implications for development, the reasons for neglect etc. and – if known – the empirical support for such an assumption/theory?
- ▶ Consider alternative explanations or interpretations when drawing conclusions about the significance of particular aspects of a family's history or present circumstances?
- ▶ Include a problem formulation? That is, a summary statement of the assessor's understanding of how a set of affairs has come about, what is maintaining the problem or problems and what is preventing their resolution?
- ▶ Provide a rationale for the choice of problem formulation, when alternative explanations or conclusions are possible?
- ▶ Phrase the problem formulation in a way that it can easily be shown to be wrong?
- ▶ Provide evidence that information has been shared with family members and differences of opinion have been either resolved or noted if irresolvable?
- ▶ Make suggestions for interventions which are logically related to the problem formulation?
- ▶ Say what level of help is necessary?
- ▶ Say from whom this assistance should be sought?
- ▶ Indicate likely frequency, duration and intensity of assistance required?
- ▶ State clearly how progress/improvements will be monitored, including both qualitative and quantitative indicators?
- ▶ State clearly how one will be able to tell if the intervention were to prove successful?

- ▶ Make suggestions for an appropriate system of recording?
- ▶ Identify a maximum period for review?

An important supervisory task, in addition to the above, is to acknowledge and address the coping mechanisms that are commonly employed by practitioners in order to manage the emotional nature of the task. These mechanisms include:

- ▶ The fixed idea – adhering to one hypothesis regarding a case irrespective of other information available that may refute the hypothesis. For example, the view that improving the family's accommodation situation would lead to automatic resolution of other problems,
- ▶ Over-optimism – focusing on the strengths in the family and underplaying the weaknesses,
- ▶ Over-pessimism – focusing on the weaknesses and issues and ignoring the positives,
- ▶ Over-identification – the worker sees the situation from the point of view of only one family member,
- ▶ Fixed belief – an attitude or belief about the case distorts the assessment, for example gay parents should not care for children,
- ▶ Groupthink – the professionals working together on the case develop a view about the situation and disregard other perspectives.

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CONCLUSION TO THE PRACTICE GUIDANCE

GOOD ASSESSMENT PRACTICE: MAKING ASSESSMENTS BASED ON SOUND PROFESSIONAL JUDGEMENT

The aim of the Practice Guidance has been to guide practitioners through the different stages involved in the process of assessment and explore the different aspects of the seven practice principles underpinning assessment of vulnerable children and their families. It has highlighted the importance of practitioners being constantly on the alert regarding a child's safety, employing a sound knowledge of child development, working comprehensively and inclusively with families, taking a multi-disciplinary approach, using an evidence base, and building in good supervisory practice. It has also constantly reminded practitioners of the inevitable occurrence of bias and distortion in this uncertain and often pressured area of work and cautioned them to constantly reflect on their practice and use supervision to facilitate this.

Practitioners are encouraged to consult recommended texts when appropriate, and to keep in touch with relevant research, policy documents and inquiry reports. The notion of best practice is constantly evolving and the nature of the work means that it is a dynamic and unpredictable area, which is sensitive to a number of economic and political variables at any given time. The only enduring certainty is that the task of promoting the welfare of vulnerable children will be achieved by a combination of professionalism, practice wisdom and evidence based work, supported by an environment that remains open to learning and further development.

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Practice Principles

Seven practice principles underpin this Assessment Framework.

1. The immediate safety of the child must be the first consideration
2. Assessments should be child-centred
3. An ecological approach should underpin practice
4. Assessments should be inclusive and recognise the individual needs of all children irrespective of age, gender, ethnicity and disability
5. Multidisciplinary practice is fundamental and an irreducible element of good practice
6. An evidence-based and critically reflective approach should underpin assessment practice
7. High quality supervision should be provided and used by practitioners completing assessments