Keeping children safe, protected and supported

Risk Management Toolkit

comms:4714

Lancashire County Council

www.lancashire.gov.uk

National Assessment Framework

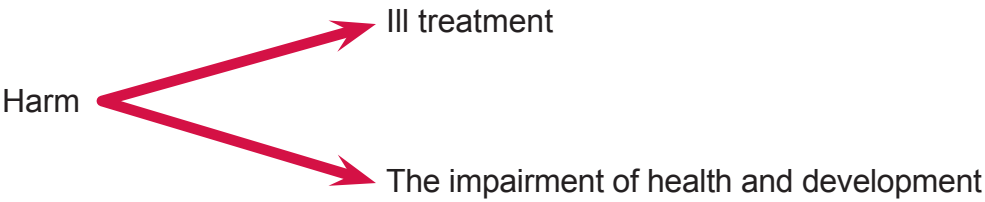
Ecological Transactional Model

National Assessment Framework from the Child's Perspective

Support from the family, friends and other people, school, enough money, work opportunities for my family, local resources, comfortable and safe housing.

Key Definitions

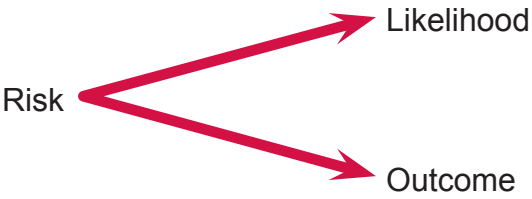
Harm:



Ill Treatment: physical, emotional, sexual abuse and neglect
Health: physical and mental
Development: emotional, social, behavioural, physical, intellectual

Children Act 1989 (s.31)

Risk: The likelihood of a future event the outcome of which may lead to loss, harm or damage

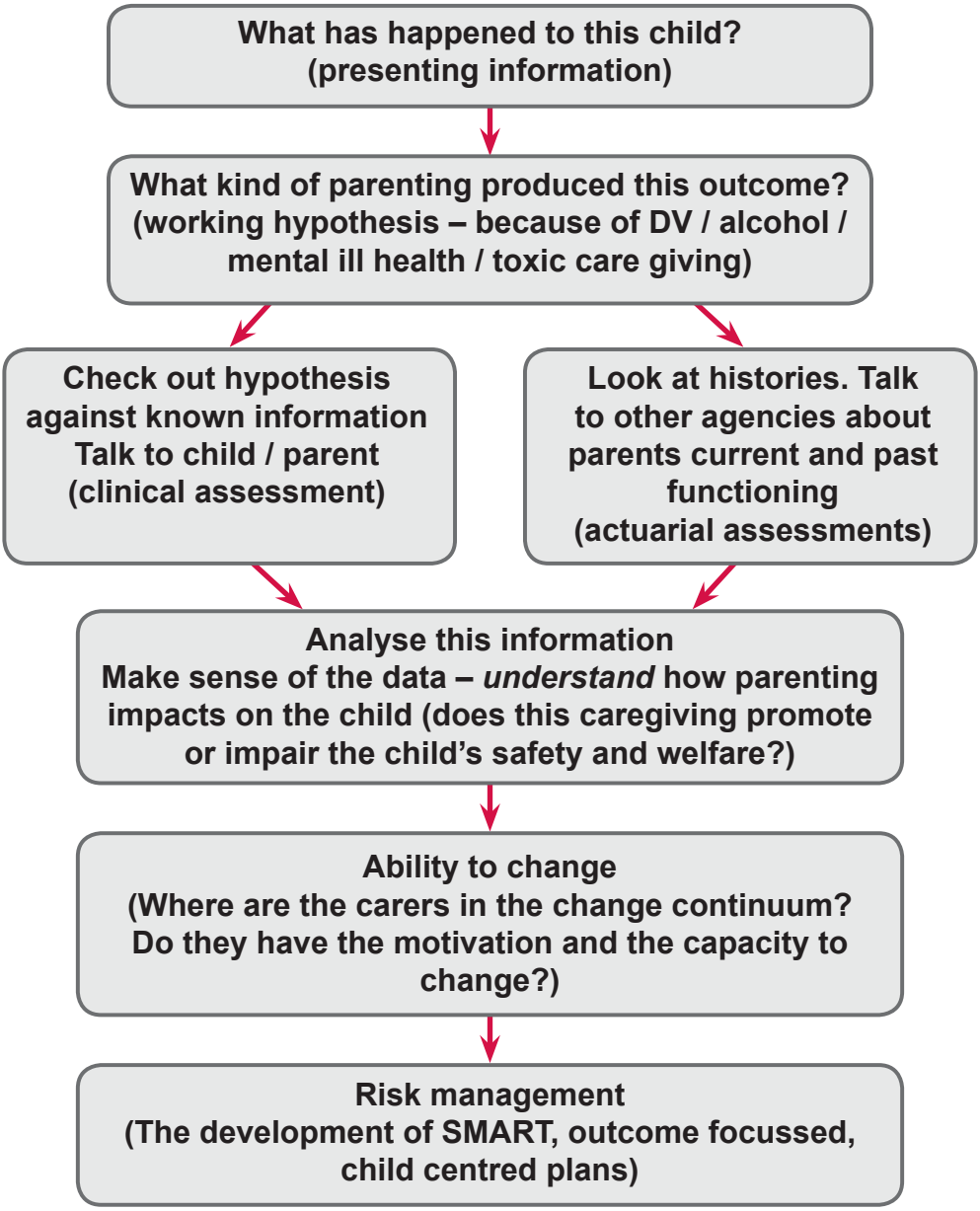


Risk Assessment: The collection of information (by clinical/actuarial means) about children and their families through the process of enquiry, observation and communication with others.

Risk Analysis: Making Sense of the data. The process of evaluating the impact of the child's exposure to the risk of harm and taking account of individual / family strengths and agency services that could reduce the likelihood of future harm.

Risk Management: The statement of plans and the allocation of responsibilities for translating the outcomes of risk assessments and analysis into practical measures to reduce risk.

How the Model Works



Underlying Risk Factors

Those elements that are ***often present in risk situations*** but which do not, of themselves, constitute a risk:

- Poverty
- Poor housing
- Lack of support network/isolation
- Experiences of poor parenting
- Low educational attainment
- Physical/learning disability (adult / child)
- Mental health difficulties (adult / child)
- Drug and alcohol use/misuse
- Victimisation form abuse/neglect
- Disordered/discordant relationships
- Previous history of non-violent offending
- Rejecting/antagonistic to professional support
- Behavioural/emotional difficulties in parent
- Behaviour/emotional difficulties in child
- Young, inexperienced parent
- Physical ill health (adult / child)
- Living in communities with potentially harmful values (FGM, HBV, use of excessive chastisement)

NB Whilst each underlying risk factors on its own does not constitute a risk, high numbers of underlying risk factors together could lead to a child being significantly harmed - need to assess impact.

High Risk Indicators

Those elements which, ***by their presence***, do constitute a risk:

- Previous involvement in child physical and sexual abuse/neglect
- History of being significantly harmed through neglect as a child
- Seriousness of abuse (and impact on the child)
- Age of the child (particularly if less than three years old)
- Incidence of abuse (how much abuse over how long a period of time)
- Record of previous violent/sexual offending (against both children or adults)
- Evidence of disorganised attachment in the adult
- Older child removed or relinquished
- Unexplained bruising (particularly in pre mobile children)
- Uncontrolled mental health difficulties (ie periods of hospitalisation)
- Personality disorders
- Chaotic drug/alcohol misuse
- Denial/failure to accept responsibility for abuse/neglect
- Unwillingness/inability to put child's needs first and take protective action
- Cognitive distortions about the use of violence and appropriate sexual behaviour
- Unrealistic, age inappropriate expectation's of the child
- Evidence of FGM, HBV, excessive chastisement etc within the family
- Inability to keep self safe

From the work of Dalgleish and Drew

Abuse Predictors

Research by Shemming and Shemming (2011) identified 3 predictors of abuse signalled by parental behaviour and 1 child related indicator.

The child related indicator

- **Disorganised attachment** – characterised by 'fear without solution' – exhibitions of bizarre behaviours displayed by children in anxiety provoking situations into which the care giver enters.

The parent related indicators are:

- **Disconnected and extremely insensitive parenting** – sudden changes in adult behaviour including frightened or frightening behaviour and disruptive emotional communication – often involves rough handling and aggressive language (see case study)

- **Low parental metallisation and reflective function** – reduced ability to appreciate others feelings and intentions – the mother who doesn't feed her baby because she isn't hungry herself. Parents with low reflective function often misattribute meaning to behaviour - 'she won't feed because she hates me' – very dangerous

- **Unresolved loss or trauma in the adult** – repressed or denied losses that re-emerging in conditions which remind parents of their own vulnerability – caring for children can do this. Parents may experience PTSD symptoms or dissociated experiences (blanking out)

Disorganised attachment in children is often the consequence of the parenting issues outlined above.

Framework for Analysis

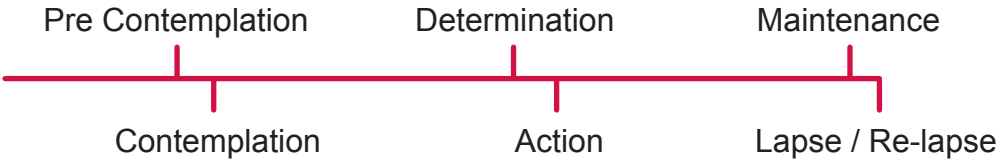
The key questions to be answered in the analysis of the information obtained through the process of risk assessment are…

- How far does the adult recognise and ***share the causes for concern*** and are they able and willing to put the child's needs first?
- What is the nature of the child's ***attachment*** to the parent and what is the parent's early life experience of attachment (how well was the parent parented?)
- What is the adult state of mind – are they physically and ***emotionally available*** for their child?
- What is the meaning of the child in the adult's life and what does the adult mean to the child?
- What stressors are experienced in the adult's life and what is their ability to regulate and manage these (adult resilience)? Is the adult able to keep him or herself safe (dv / substance abuse / mental health?)
- What environmental factors are helpful to the adult and protective of the child, and which are unhelpful and potentially harmful (additional stressors)?
- Does the adult have the ability and motivation to make and sustain the changes needed to safeguard and promote the child's welfare within the child's timescales?
- The impact of all of the above on the child and the child's resilience

The outcome of this process should be the explicit identification of the child's ***unmet*** needs and explicit identification of those issues that need to be addressed to support improved ***parenting capacity*** to achieve better outcomes for the child

Assessing Capacity to Change

The process of change follows a predictable pathway *



The following framework can be used to assess where the individual stands in relation to the causes for concern and their capacity to change

- Individual accepts there is a problem
- Individual accepts some responsibility for the situation
- Individual has some discomfort over the problem
- Individual believed things must change
- Individual sees self as part of the situation
- Individual sees that choices are possible
- Individual identified next step towards change

Each heading can be used as a prompt for further exploration. The Individual has to respond positively to each step for any realistic prospect of change

*** Prochaska and Diclemente (1992)**

SMART Plans

All plans (CP / CiN / Pathway / Care) should be developed using SMART principles and should be recorded on the Lancashire approved template which clearly identifies desired outcomes from professional interventions and the evidence needed to demonstrate the outcome has been achieved.

For Child Protection Plans

Specific: Every risk (HRI and relevant URF) identified in the risk assessment / analysis needs to be reflected in the risk management plan.

Measurable: Things can be measured in two ways, inputs or outcomes. Inputs are usually measured in terms of services offered.
Outcomes are measured in terms of impact of intervention (improvements)
Inputs are usually counted. Outcomes need to be assessed.

Achievable: Plans should be aimed at risk reduction not risk removal. There should be explicit statements about degree of improvement required (i.e. acceptable level of residual risk).

Realistic: This will depend on how intractable the problem is (how long / how severe) and the Individual's motivation and capacity to change.

Timely: Changes need to be made within the child's timescale to promote safety and welfare, not the adult's timescale.

Example of a SMART Plan

Issue and Desired Outcome	Action – by who and by when	How will we know the plan has worked
Issue Poor home conditions impact upon Jane's health **Desired Outcome** Home conditions will no longer make Jane's condition worse	Hire a skip – Jimmy Jones by 16/10/15 Provide cleaning materials and equipment – SW by 20/10/15 Clear the kitchen, bathroom, Jane's bedroom and main living areas – Jimmy Jones and Julie Jones by 23/10/15	Full skip removed from property Clean and tidy living areas observed in home visits Improved lung function (higher spirometer readings) Jane more mobile and active at school Jane says she feels better during 1:1's
Issue Lack of care routines effect Jane's health, welfare and development **Desired Outcome** Improved routines around feeding, personal hygiene and presentation for Jane	Family Support Worker to be allocated – SW Mary Martin by 16/10/15 Positive Parenting Course to be applied for – SW Mary Martin by 16/10/15 Parents to attend sessions and develop routine care strategies with Jane with support from FSW – Jimmy & Julie Jones by 30/10/15	Hygienic home conditions maintained Regular meal times with evidence of 'home cooking' Clean bedding and clothes for Jane. Positives reports from school on Jane's presentation and performance Jane talks positively about how she is cared for Jane has gained weight Jane says she is sleeping better and looks well rested

Analysis into Assessment

Additional Guidance

The purpose of this guidance is to offer further clarification on the relationship between the Lancashire Risk Assessment model (and the analytical framework it contains), the use of the National Assessment Framework and the Single Assessment process.

Making the Connection

Child's unmet needs
(including significant harm)

Explained by Parenting Capacity
Deficit

Explained by the Unregulated
Presence of HRI & URF

The assessment process is the collection of data through observation, enquiry and consultation with others. From this the assessor will understand ***what*** is happening (how well the child's needs are being met and the extent of the parent's capacity to meet the child's needs). Using the analytical framework contained in the toolkit the assessor should be able to provide and explanation for ***why*** things are as they are.

Assessment of need and risk are not the same thing. The assessment of risk is relatively easy. By collecting data about what has happened to the child (the abuse/neglect to which he/she has been exposed) and seeing this in the context of the HRI's that are present and any relevant historical data should enable the assessor

to conclude whether the child (on the balance of probability) has suffered or is likely to suffer significant harm.

Further assessment of

- Whether the adult shares the professionals concerns about what has happened
- Whether the adult is able to put the child's needs before their own
- Whether the adult is able to keep themselves safe
- The level of the adult and child's resilience
- Any family strengths or protective factors

will give an indication of how and where the identified risks can be managed (at home or through removal).

The outcome of the risk assessment is captured initially in the record of S.47 enquiry which then informs the development of a report for an ICPC from which the HRI's and relevant URF's constitute the outline protection plan.

The assessment of need and in particular ***unmet need*** is slightly more complicated. It begins with a clear understanding of the causes for concern or issues identified in the referral information and a review (and understanding) of any historical involvement (what were the issues, what were the interventions were and what were the outcomes). It is also helpful to identify which other agencies are/were involved with the family.

The assessment is conducted using the NAF and begins with an assessment of the child's ***unmet need***. (In reality the assessment of unmet needs, parenting capacity and family and environmental factors go on simultaneously, but for simplicity's sake they will be considered sequentially in this guidance).

The process of assessing ***unmet need*** is one of comparing where the child actually is at the time of the assessment in terms of their health, education, emotional and behavioural presentation ***with where they should be*** given their age and stage of development.

The gap between what the assessor observes in the child and the stage or level they should be at is the child's ***unmet need*** (this requires the assessor to have a working knowledge of normal child development at each stage). Closing the gap between where the child is and where they should be then becomes the intervention objective (i.e. what needs to be done to improve this child's health, education, sense of identity etc).

When writing up this section of the assessment the assessor must state ***explicitly*** under each domain the extent of the child's ***unmet need*** (largely met, partly met, largely unmet). The self-reported information by the parent about the child or from the child himself should be considered alongside the assessors observations and checked through consultation with professionals from other agencies (HV's, GP's Teachers etc).

One of the criticisms that is levelled at assessments is that they do not capture the child's personality and they do not suggest that the assessor has taken time to really get to know the child. This can be remedied by the assessor providing a rich description of the child's personality, presentation, demeanour and resilience (or otherwise) in the "identity" and "social presentation" domains of the assessment framework. The write up of each domain under "Child's Developmental Needs" should be concise and succinct and get to the heart of the issues (including as already mentioned the ***explicit*** identification of the child's ***unmet need***). It is not necessary to provide an extensive narrative. The assessor should seek to provide ***enough information*** to support the

conclusion rather than everything that they know.

A similar method is used when assessing “Parenting Capacity”. The assessor compares the level of care actually provided under each domain with what would be expected from a reasonable parent in similar circumstances. The gap between the ***care that is offered*** and ***what could be expected*** is the parenting capacity deficit. It is usually because of these deficits that the child’s identified ***unmet needs*** are as they are.

It is in the assessment of parenting capacity that the connection between the single assessment process and the risk assessment model is most clear. It is in this section also that the bulk of the analysis (explaining why things are as they are) takes place.

As an example it may be that there are significant parental deficits in providing basic care. This needs to be ***explained*** not just ***described***. The explanation may be because the parent themselves was neglected as a child (HRI) and as a consequence has no “mental model” of what “good enough” care looks like or it might be that the parent is a chaotic drug user (a different HRI) and is preoccupied with their addiction at the expense of the child’s care.

Another example might be a deficit in relation to ensuring safety. This too needs to be explained and it maybe that because the parents’ own childhood was so poor and they themselves are so emotionally needy that they are willing to prioritise their relationship with a violent partner (HRI – inability to keep self- safe) over the needs of their child.

Using these examples the structure for this part of the assessment then is clear... the assessor identifies the level of parenting capacity under each domain and explains the deficit by reference to the

impact of HRI's (and relevant URF's) on the parents' ability to provide adequate care.

Fundamental to assessing parenting capacity (for all domains, but particularly in relation to emotional warmth, stimulation and guidance and boundaries) is an assessment/understanding of the attachment bond between child and parent.

In the course of the assessment the assessor should seek to understand the experiences of being parented of the parent who is being assessed (as how they themselves were parented has a powerful influence of how they parent). Apart from asking general questions about their childhood the following questions are helpful

- Who did you like to spend most time with?
- Who did you miss most when you were separated from them?
- Who did you feel you could always count on when you needed help?
- Who did you turn to for comfort when you were feeling low?

Information from this line of enquiry will provide the assessor with an insight into the physical and emotional care experienced by the parent who is being assessed and may explain some of the findings from the assessment of their own child's unmet needs.

In assessing attachment it is important that the assessor spends sufficient time with the child and parent(s) together to ***observe*** the nature of the attachment as well as obtaining information from conversations with both parent and child. Data from these sources will give an insight into the adults' emotional availability to the child and the meaning of the child to the adult and the adult to the child. This information will be useful in explaining any parenting deficits in

relation to providing emotional warmth, stimulation and guidance and boundaries.

As with the write up of the “Child’s Development Needs” domains, the write up of “Parenting Capacity” needs to be succinct and explicit (i.e clearly state the extent of the parenting deficit) with some analysis and as to why the situation is as it is (making reference to attachment assessment, HRI’s and URF’s). The write up should not ***simply be a description*** of the parenting behaviour that has been observed in the course of the assessment.

The procedure for assessing “Family and Environmental Factors” domains is exactly the same as for child’s needs or parenting capacity. The domains of “family history and functioning” and “family’s social integration” are probably the most important aspects of this element of the assessment.

The final part of the process is to bring all this data together into the analysis component of the Single Assessment record. This analysis should provide an explanation for why the situation is as it is and connects the outcomes for the child (the degree to which their needs are met or otherwise) with the parenting capacity strengths or deficits that have been identified in the assessment

Suggested Model for Analysis

1 Include a rich description of what the child is like including how they present, what kind of personality they have, the level of their resilience, what are they good at, what they like, what they say and what they want now and in future.

2 Comment on the degree to which the child's needs are unmet in relation to each domain and relate this to parenting capacity deficits (including explanations). This need not be an extensive narrative as the bulk of the analytical work will have been done in the earlier sections of the assessment

As an example…

Because of her own neglectful upbringing M/S Smith has no mental model of what good enough care is like and has no experience of providing this. As a consequence Jimmy has significant unmet needs in relation to his health including poor nutrition leading to inadequate weight gain, outstanding immunisations, untreated squint and poor dental hygiene. There are similar concerns in relation to Jimmy's education. His school attendance is poor and as a consequence his educational development is delayed. There are concerns also that he may have a learning disability, but this has not been assessed due to his poor attendance and his Mother's unwillingness to consent to an assessment. The explanation for this situation lies largely in the fact that Ms Smith had a difficult time at school and she does not value or prioritise Jimmy's education. It is also the case that because of her own lack of self-worth and perceived lack of intelligence that she finds schools intimidating and is reluctant to speak to teachers.

Jimmy presents as a shy, lonely, anxious and introverted boy. He lacks confidence and has low self-esteem. This impacts significantly

on his ability to make friends and participate with other children in games and activities. Jimmy's presentation can be ascribed in part to the poor attachment relationship he has with his Mother. Jimmy was an unwanted pregnancy and it was only with some reluctance M/S Smith was persuaded (by her family) to go full term and to keep him. She was never warmly disposed to Jimmy and has been a remote and distant figure throughout his childhood.

She is generally emotionally unavailable to Jimmy and he appears to be of little value to her. As a consequence Jimmy is an extremely emotionally needy child who would be vulnerable to abuse and exploitation in future. This vulnerability would be exacerbated by the lack of interest M/S Smith exhibits towards her son and the lack of supervision she provides him. (for a further examples of this kind of write up see "Analysis into Assessment" training handbooks and further prompts within the Toolkit).

Make reference to parental and child resilience and any strengths, positives or mitigating factors in the situation (if present)

3. Motivation and capacity to change
Once the social worker has a full and proper understanding of the child's unmet needs and parenting capacity it is necessary to complete an assessment of parental motivation and capacity to change using the model provided within this toolkit.

4. Summarise and conclude
The level of analysis in the earlier part of the single assessment then makes the recommendations for the key issues in the CiN or CP plan easy to identify.

So, in the case above… *from the evidence available Jimmy is a child with significant unmet needs who is at or close to the significant harm threshold.*

In this case the plan would need to focus on improving Jimmy's basic care (under each element explicitly state the desired outcome and what the evidence for this would look like).

There needs to be a strategy to improve his school attendance and to have his Learning Difficulty assessed.

There needs to be work on his self confidence and self-esteem and the attachment bond difficulties need to be addressed either through a "repair strategy" (working with Jimmy and his mother together) or a "replacement strategy" (who else in the family can offer Jimmy emotional warmth… the role of a Family Group Conference)

The plan would also need to address Jimmy's possible vulnerability to abuse/exploitation.

Support with the Risk Model

- The Advanced Practitioners will hold regular consultations regarding the implementation of this model.

- Why not take a copy of the toolkit to your supervision with a view to working through specific cases with your manager?

- Prior to a Child Protection Conference have a read through the toolkit and familiarise yourself with the issues within the case using this framework.

- Risk assessments are not separate to Child and Family Assessments – they are integral to them. Speak to your manager or Advanced Practitioner for further support on how to integrate analysis of risk into the assessment.

Useful documents/further reading and websites:

Motivational interviewing (there are numerous articles available on this topic)

Safeguarding Assessment and Analysis Framework (SAAF) by the Child and Family Training Group. This can be accessed on line.

Lancashire's Continuum of Need and Thresholds Descriptors Document.

Risk Management Toolkit | Guidance notes

Additional guidance notes for children with disabilities (SEND teams).

Children with Disability

Additional Guidance

The Children Act 1989 at S.17 (10) (c) states “a child shall be taken to be in need if he is disabled”. This means that all children with disability (SEND) are by definition “in need” and therefore eligible for a single assessment. It also means that a disabled child can be “in need” without evidence of deficit or compromised parenting. This guidance is applicable to all disabled children including both physical and learning disabilities.

An underlying principle of the 1989 Act is “children first”. For the purpose of this guidance this is to be taken to mean the subjects of SEND assessment are to be regarded primarily as children who have a disability rather than disabled people who happen to be young. The assessment of the child’s disability is usually a medical matter (involving paediatricians, psychologists, etc). The purpose of the assessments undertaken by CSC are to understand the whole child and to ensure that as well as putting in place measures to counter the impact of disability, the child’s talents and abilities are also recognised and promoted. All workers need to be aware that many disabled children are assessed in relation to what they can’t do rather than what they can and should actively avoid a similar model of practice.

It is important when undertaking assessments of SEND that the same principles of inclusion and engagement apply as when assessing non-disabled children. In order to ensure that the voice of the disabled child is heard workers should make every effort to communicate with SEND at a level which is commensurate with their age, stage of development and level of understanding. Workers should expect that such assessments may take more time than is usual and should not be deterred from going at the child’s pace simply to meet deadline targets.

It is a fact that the safety and welfare of all children is best promoted when they have strong attachments and their parents are emotionally available and display warmth towards them. This is an issue that needs to be fully explored in assessments of all SEND. In the course of the assessment workers must explore the meaning of the child to the parent.

S.17/CAF Assessments

It is usual for SEND to have been the subject of many assessments and information already gathered should be accessed in the course of the single/CAF assessment. It is also important to involve other agencies in the assessment process to obtain both a holistic understanding of the child's needs as well as an insight into the services and resources available to support the child and family going forward.

When undertaking assessments on SEND, workers who lack expertise should have access to informed advice on the nature of the child's disability and it's likely impact on functioning, though this will vary from child to child and will need to be checked out with the family as the assessment progresses.

In the course of the assessment the worker should consider:

- the impact of the disability on the child's health, welfare and development
- any disabling barriers (stereotypical thinking etc) that the child faces
- strategies to mitigate the impact and overcome the barriers
- the additional demands on parenting capacity as a consequence of the child's disability
- explicit statements about the nature and extent of the child's unmet needs
- proportionate intervention strategies
- explicit desired outcomes with evidence of achievement

Section 47 Enquiries

While being disabled is not of itself a high risk indicator, it is important to recognise the increased vulnerability of SEND CYP to abuse and neglect. There is a considerable body of research to support this view. It is also well known that SEND CYP are significantly under-represented in the child protection planning process.

What the research suggests is:

- SEND CYP are at a greater risk of physical, sexual and emotional abuse and neglect than non-disabled children
- SEND CYP at greatest risk of abuse are those with behaviour/conduct disorders. Other high risk groups include children with learning difficulties/disabilities, children with speech and language difficulties, children with health-related conditions and deaf children
- SEND CYP in residential care face particular risks
- Bullying is a feature in the lives of many SEND CYP.

Factors that increase risk and lessen protection for SEND CYP include:

- Attitudes and assumptions – a reluctance to believe disabled children are abused; minimising the impact of abuse; and attributing indicators of abuse to the child's impairment
- Barriers to the disabled child and their family accessing support service
- Issues related to a child's specific impairment – e.g. dependency on a number of carers for personal or intimate care; impaired capacity to resist/avoid abuse, difficulties in communicating; and an inability to understand what is happening
- Limited opportunities for disabled children to seek help from someone else

- A lack of professional skills, expertise and confidence in identifying child protection concerns and the lack of an effective child protection response

Bearing these factors in mind when making S.47 enquiries, social workers must undertake this task from a position of “sceptical disinterest”. They must use the same values and principles as they do when assessing non-disabled children. They must beware of accepting parental explanations for actions or behaviours (which they attribute to the difficulties experienced in looking after SEND CYP) that they would regard as questionable or unacceptable for non-disabled children (locking children in rooms or strapping them to chairs, etc).

When considering the outcome of S.47 enquiries social workers must always entertain the possibility of a “differential diagnosis” – that the satisfactory explanation for a child’s injuries or condition might be true, but also they might be the result of abusive and/ or neglectful behaviours. It is important that social workers take advantage of reflective supervision and offer their analysis of the findings to the challenge of their supervising manager.

It is customary for SEND CYP to be the subject of long term CiN or CAF plans during which time social workers (and others) develop supportive relationships with parents. It is important to recognise the inherent tensions in maintaining such relationships while recognising the need to be constantly vigilant as to possibility of safeguarding issues and the need to take action should these emerge. Staff involved in the long term support of SEND CYP and their families should have access to workers with safeguarding experience and expertise and should receive regular reflective supervision on their case load.