

Assessments Guidance

Including additional guidance due to the particular needs of the child or specialist detail required for the assessment

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Background

This guidance has been put together to support practitioners when carrying out an assessment of a child or young person.

The Child and Family Assessment is the assessment tool for all assessments on Frameworki.

Guidance is provided throughout the assessment on Frameworki using the  buttons.

Some of the guidance provided, was introduced as part of the assessment training which was delivered in summer / autumn of 2013 in advance of the introduction of the Child and Family Assessment and Frameworki.

Within this pack there is additional information for where the practitioner is carrying out an assessment and more guidance is required, due to the particular needs of the child or the specialist detail required for the assessment for example.

Child and Family Assessment Guidance

Assessment details:

Assessment Plan and timeframe for the assessment to be carried out

Initially planning may be undertaken primarily with the team manager, however as the assessment develops planning should be in partnership with other professionals. E.G. a pre-birth with family nurses, midwives, health visitors

- What is the reason for the referral, the assessment should address any concerns identified.
- Objectives and legal framework
- Theoretical basis
- Who needs to be seen, where and how often?
- Every assessment will include each child being seen and listened to on their own, or social work observations if assessing babies.
- If consent has been overridden, the reasons why and how this is addressed.
- Full assessments will include direct work with children. This would normally require seeing the child on a number of occasions.
- Consider whether any additional expert involvement is required e.g. Psychological assessment; AIM assessment
- Consider any additional needs of any family members (parents with learning difficulties may benefit from a PAMS assessment)

Timeframe

After Children's Social Work Service has been contacted about the family, a social worker will make a brief first Child and Family Assessment that should take no more than 10 working days. If they already have a Common Assessment we shall use this information to start with. At this point the team manager will make a decision about any further assessment needed which will take up to a further 35 working days. A Team Manager could decide that the family needs a full assessment (up to 45 working days) from the outset. If the child or the family require help immediately and can't wait for the assessment to be completed, we will try to provide this help before the assessment is finished.

Once the full Assessment is finished, a plan will be drawn up setting out what help and support will be provided and by whom.

Reason for undertaking this assessment/Presenting issues

This section should be completed prior to the beginning of the assessment and will draw on information already known about the child(ren) / young persons and family from the referral. It should include a statement about what is to be assessed and why and identify any particular issues to be explored further, including key issues to be addressed or causes for concern. This should clearly tell the family why we are involved and be written in plain language with no jargon

Child's profile / Story – 1

This section should tell the child's story.

- Childs, wishes and feelings, including non-verbal communication. Their understanding of the reason for social work involvement and their views on their own situation.
- Evidence of social workers direct observations / contact and information from other professionals.
- Is the child's development age appropriate?
- Being healthy – growth, development, physical/mental wellbeing, suitable health care and advice by parent/carer including dental/eye care, sexual health.
- Emotional and behavioural development – reactions and responses to change/stress, motivations, self-control/responsibility, personality.
- Education –Current and historical, attendance, home school relationships and achievements.
- Resilience factors – hobbies, interests, skills, trusted adults and/or peers.
- Identity – view of self/abilities, context of ethnicity, religion, first language; how does the child “fit” in the household/family, how do others describe them.
- Family & Social Relationships - including attachments (who to/nature), loss of significant figures i.e. bereavement, divorce, peer relationships, friends; understanding of own family; view of day to day life. Emotional warmth and interaction.
- Social presentation, including suitable dress for age, hygiene, support from parents to develop suitable self-care and independence skills.
- Parents view of the child, who they think is important for the child and relationships between those people.
- Grey Areas– identify any areas that are unclear or may be of potential concern for the child(ren) but need further time, clarity, or assessment.

Family History and Understanding of Family Relationships

These are the factors that should be considered as part of the assessment:

- Using the chronology identify themes and patterns including Child Protection or other social work involvement
- What works well in this family, parental and extended family strengths?
- All Parent/carers views of the assessments, wishes and feelings.
- Overview of each parent/carer's own history, childhood, experience of being parented, Health / patterns in the family e.g. illness, disability; where do they fit in their family, impact of diversity issues for parent and on parenting.
- Parent/carer current and historical relationships, how long together, how did they meet, strengths, conflict, Drug and alcohol misuse, offending, anti-social behaviour, domestic abuse and views on these.
- Summary of current and historic education/ work/training of parents and significant figures.
- Own opinion/understanding of how they are parenting including providing basic care/safety, guidance and boundaries; capacity to change.
- Who is seen as part of the family/support network, information about their siblings/extended family/friendships/ relationships with neighbours.
- Views of previous involvement with social care and other professionals.
- Domestic violence and abuse, what are each involved person's views and understanding of the violence / abuse and control factors.

- Grey Areas– identify any areas that are unclear or may be of potential concern for the child(ren) but need further time, clarity, or assessment.

Previous and current involvement of social work, other professionals and services

Check with the family which other agencies may have worked with them

- What support and by whom?
- What changed or stayed the same?
- Provide a brief summary of interventions provided by other professionals / agencies.
- Grey Areas –identify any areas that are unclear or may be of potential concern for the child(ren) but need further time, clarity, or assessment.

Needs and risks

This is your analysis of the information provided in the assessment.

- What does all of the information gathered tell you (and the family) about the child's situation and what needs to change?
- Identify the child's needs and how these can be better met and by whom, including family, wider networks and other professionals.
- Where there are protection risks what needs to change to minimise these risks. Identify any specific risks to or from either parent and how they relate to the safety of the child(ren).
- Complete this section for each child.
- Grey areas, identify any areas that are unclear or may be of potential concern for the child(ren) but need further time, clarity, or assessment.

Family Strengths and Protective Factors

Has a family group conference taken place, if so detail any identified strengths or protective factors from this meeting.

- What does the family do well and should continue to do.
- What services can support this
- What part do wider family and support networks play to support the family?
- How does this support impact upon parenting capacity?
- Grey areas, identify any areas that are unclear or may be of potential concern for the child(ren) but need further time, clarity, or assessment

Analysis and Professional Judgment

Use specific evidence from your assessment to support your analysis and professional judgment.

- Explore concerns identified within the referral and how these are being addressed.
- Parent/carer strengths
- Ability and willingness to change

- Identify areas of unmet needs Risks - what must change and why, what is non-negotiable
- Grey areas, identify any areas that are unclear or may be of potential concern for the child(ren) but need further time, clarity, or assessment

Recommendation including outline plan

Has a Family Group Conference, family support meeting, ICPC or other meeting resulted in a safe plan for the child?

Outline the specific actions that family members and other agencies need to undertake to address the needs and risks identified for each child.

Each person, professional or family member should know what they are responsible for and when the plan will be reviewed.

The plan should be realistic, have measurable outcomes with clear timescales (SMART targets).

The child and family must be told what may happen if they fail to co-operate or are unable to achieve the agreed objectives within the agreed time-scales.

Plans should not use jargon and should be written in plain language

Ten pitfalls in assessment and how to avoid them

Pitfalls	Strategies to avoid the pitfalls
1. An initial hypothesis is formulated on the basis of incomplete information, and is assessed and accepted too quickly. Practitioners become committed to this hypothesis and do not seek out information that may disconfirm or refute it.	Active, conscious hypothesising, testing to confirm/disconfirm Record uncertainties Critical reflection Evaluate the quality & source of information
2. Information taken at the first enquiry is not adequately recorded, facts are not checked and there is a failure to feedback the outcome to the referrer.	Go back to the referrer and check the details, distinguish between observation & opinion, ensure that the information has been accurately understood, ensure referrers receive feedback
3. Attention is focused on the most visible or pressing problems; case history and less “obvious” details are insufficiently explored.	Consider the context and the chronology Theme the chronology Summarise the chronology eg, 0-5, 6-11,12-16, 16 + Put the child’s voice into the chronology Use the chronology for analysis
4. Insufficient weight is given to information from family, friends and neighbours.	Give equal weight to referrals from family, friends & neighbours Ensure that “anonymous” is not interpreted as “malicious”
5. Insufficient attention is paid to what children say, how they look and how they behave.	Clearly understand the legal framework for seeing the child Be alert to the need to recognise patterns of parental resistance Make time for detailed direct observations of the child Find out from the child what a day in their life is like Consider how the child may be silenced by their circumstances
6. There is insufficient full engagement with parents (mothers/fathers/other family carers) to assess risk.	Dads! Dads! Dads! And other family members Engagement & honesty Understand the reasons and meaning of “lack of engagement” for individual families Use a clear framework to assess & analyse risk
7. Initial decisions that are overly focused on age categories of children can result in older children being left in situations of unacceptable risk.	Know that children’s services are biased towards intervening with younger children Respond robustly to “hard to help” neglected adolescents Monitor self & others for “over optimism” with older children Find out from the child what a day in their life is like Ask, if this child were younger, how would we respond?
8. There is insufficient support/supervision to enable practitioners to work effectively with service users who are uncooperative, ambivalent, confrontational, avoidant or aggressive.	Pay attention to how you feel, notice fear, anxiety, avoidance in yourself Demand quality supervision Have a clear strategy to keep you & others safe in vulnerable situations Joint Visits with other agencies Speak up when you feel fearful, threatened, intimidated: it is a sign of an effective practitioner
9. Throughout the initial assessment process, professionals do not clearly check that others have understood their communication. There is an assumption that information shared is information understood.	Check out how information has been received and understood When talking to other professionals, be curious about what they think and feel and how they understand the situation Be mindful of the desire of some people to deceive – maintain a “respectful uncertainty” & “healthy scepticism”
10. Case responsibility is diluted in the context of multi-agency working, impacting both on referrals and response. The local authority may inappropriately signpost families to other agencies, with no follow up.	Role Clarity Effective communication with other agencies, maximise verbal & face to face communication Confirm key decisions & reasons in writing

(Broadhurst et al 2010,

http://www.nspcc.org.uk/Inform/publications/downloads/tenpitfalls_wdf48122.pdf

The Stepwise Approach to Assessment

Plan

- Type of Assessment
- Timescale
- Partnership
- Standards
- Empowerment
- tasks and responsibilities
- Communication
- Engagement
- Purpose
- Who needs to be involved and how

Hypothesise

- About all the possibilities
- explore the reason for those hypotheses and consider how to seek to confirm/disconfirm them

Gather Information

- Genograms
- Ecomaps
- Checklists' Pro forma
- Interviews
- Files
- Other Agencies
- Chronology

Test Information

- Review hypotheses
- Are new ones emerging
- What evidence is there to confirm or disconfirm hypotheses

Analyse Information

- Use supervision
- But also think about the original concerns, new concerns, motivation, capacity and engagement, likelihood etc.

Decide on Care Plan

- Based on clearly identified needs and a holistic view of the child

Source: Barry Raynes in "Assessment in Child Care – Using and Developing Frameworks for Practice"

Editors: Marin C. Calder and Simon Hackett. Publisher: Russell House Publishing

Contents summary: <http://www.russellhouse.co.uk/pdfs/assinchildcare.pdf>

Tell me all about your day.....

Question	Factors to Consider	Notes
<i>Do you get yourself up in the morning?</i>	<ul style="list-style-type: none"> • Is the child expected to get themselves up? • Is there a regular routine or does it depend on the motivation of the carer? • Does the child have to take responsibility for carers and/or siblings in the morning? • Is an alarm clock/mobile phone used to make sure child is up in time for school/play school etc? 	
<i>Do you have anything to eat?</i>	<ul style="list-style-type: none"> • Is there usually food in the house? • What is available to the child? • Does an adult/sibling or child themselves take responsibility for preparing breakfast? • Is child given money to buy something on way to school? • If so what do they tend to buy 	
<i>What happens about getting dressed?</i>	<ul style="list-style-type: none"> • Are clothes readily available, clean and in a good state of repair? • Does the child have to find their own clothes? • Do they have their own clothing? • What happens about washing, etc..? • Does the child wash and brush their teeth in the morning? Is this appropriately supervised? • Are there facilities available, e.g. tooth brush? 	
<i>What happens if you are going to school?</i>	<ul style="list-style-type: none"> • How does the child get to school? • Who is responsible for getting the child to school? • Is the child responsible for other children? 	
<i>What happens at school?</i>	<ul style="list-style-type: none"> • What is the nature of the child's relationships with their peers, teachers and support staff? • What do they enjoy at school? • What do they find difficult? • What makes them happy and sad at school? • Do they have friends? • Are they bullied? • What do they do at playtime? 	
<i>What happens if it's the weekend or school holidays?</i>	<ul style="list-style-type: none"> • Is the child expected to look after other children and or the carer? • Are they expected to do errands, etc. for the carer? • How do they spend their time? • Do they have any friends? • Are they left unsupervised or allowed to undertake inappropriate activities? • What happens about food? (consider areas below) 	

Question	Factors to Consider	Notes
What happens after school?	<ul style="list-style-type: none"> • Are they collected from school and if so on time? • Do they stay for after-school activities? • Are they responsible for other children? • Do they have friends that they see? • What is the journey home from school like? (consider opportunities for bullying, etc) • Is there anyone at home when they arrive back? • What happens when they get home? • Do they have any caring responsibilities? • Is food available when the child gets home from school? 	
What happens in the evening?	<ul style="list-style-type: none"> • Is there food available? • What kind of food does the child eat in the evening? • What does the child enjoy eating best? How often do they have this? • Does anyone prepare an evening meal? If so does the family eat together? • If not does the child get their own food and/or get food for others? • When does the child usually have their last meal/snack? • What happens if the child says they are hungry? • Does the child spend their time watching TV? • Do they go out? Where and with whom? • Does the child enjoy games and toys? Which ones? Do they have toys? • What do the carers do in the evening? What does the child think about their activities? • Does anyone talk to the child or give them any attention? • Is the child left alone or expected to supervise other children in the evenings? 	
What happens at bedtime?	<ul style="list-style-type: none"> • Does the child have a bedtime? • Who decides when the child goes to bed? • Where does the child sleep? • Do they change their clothes before bed? • Do they have a wash and brush their teeth? • Does the child get disturbed? E.g. carers making a noise, child sleeping on settee. • Is the child left alone at night and/or expected to look after other children? 	

Taken from
‘Child Neglect - Identification & Assessment’
Jan Howarth. (Palgrave 2007)

AIM – Sexual Behaviours

Currently there are no local procedures within Leeds CSWS which embed the use of the AIM assessment framework for children under 12 years or adolescents who display harmful sexual behaviours.

However it is recognised that there remains a need for practitioners within CSWS to be able to assess harmful sexual behaviours displayed by children and young people. This will enable practitioners to complete thorough and evidence based initial and core assessments, in addition to producing robust care plans which clearly address the needs and risks presented by such children and young people.

In order to achieve this, a number of advanced practitioners have been trained to use both the AIM 2 adolescent and AIM under 12s assessment tools. Both models have been designed to help professionals identify the level of supervision the young person requires to manage risk, but also to outline the therapeutic needs that require addressing, in order to achieve the reduction /cessation of harmful sexual behaviours.

The AIM 2 initial assessment (adolescents) was developed from the original AIM model produced in 2001. The model is designed to assist in early stage assessments of young men who are of mainstream educational ability, aged between 12 and 18 years, who are known to have exhibited harmful sexual behaviour on one or more occasions.

The AIM 2 assessment model is based on four domains:

- harmful behaviours,
- development
- family
- environment

Thus the model links with the Child and Family assessment used in safeguarding children, where focus is on the last three domains and the ASSET tool used within the Youth justice forum, where the focus includes the first domain.

In this way it is intended that the model has relevance to both systems and draws on the skills of the professionals involved in each. (GMAP- pg19:2012) All four domains assess both static and dynamic concern and strength factors.

The under 12's AIM initial and core assessment framework should be used to assess problematic and/or harmful sexual behaviours displayed by children under the age of 12 years. The initial assessment requires practitioners to complete the AIM checklist to determine if the behaviours are healthy, problematic or harmful. Should the behaviours fall in the latter two categories, a core AIM assessment is triggered which involves the completion of a pattern mapping exercise.

Both assessment frameworks continue to be embedded in the process of practitioners using their professional judgement to collect, organise, evaluate and analyse information in order to arrive at an evidenced based assessment and recommendations for the safe and appropriate management of children and young people displaying harmful sexual behaviour. (GMAP: AIM2 manual 2012:4)

Currently, when trained practitioners are allocated to such assessments, it is expected that they will co –assess the case with the allocated social worker but take the lead assessor

role. The coordinator for sexually harmful behaviour will offer supervision throughout the process and will quality assure the final assessment report.

The coordinator for sexually harmful behaviour is able to co-assess cases with trained workers if they feel they require a higher level of mentoring in completing their first AIM assessment.

If it is felt an AIM assessment is required, discussion with the locality team manager and then coordinator for sexually harmful behaviour services should be sought in the first instance.

Court Assessment

The assessments required for court are no different to the assessments completed for all children and their families.

However if the matter is in the court arena you should ensure that the following guidance is applied to current assessments already completed that require updating, or assessments that are commencing:

- Refer to other documents wherever possible – avoid duplicating information within the assessment that can be found elsewhere (like chronologies for example). It is appropriate to comment on **what that information tells you** without repeating the information itself.
- Limit the information in the assessment to that which is relevant to the concerns in the case, and to the welfare checklist. Avoid long descriptions of events or issues that are not directly relevant to the concerns or useful from an evidentiary perspective.
- Ensure all sections are focused and analytical by always relating what the information means to the child.
- The Court always finds full genograms very helpful, and if they are undertaken comprehensively at the beginning of SW involvement, it can lead to early identification of potential kinship carers and avoid late presentation of family members.
- Do not be scared about using accepted research to underpin your analysis and recommendation. There is much current research that is accepted by the Court as the most up-to date thinking on particular aspects of our work.
- Ensure that your recommendation reflects your professional opinion, and be explicit about what evidence that opinion is based on.
- **Remember** – the Court now considers that the Social Worker is the expert in the majority of instances, and will want the Social Worker to give their expert opinion wherever possible. If you wish to request the instruction of another expert, you must be clear about why you (or anyone in the department) do not have the skills, knowledge or experience to give an opinion on that specific aspect of a case.

Child Sexual Exploitation

CSE is a form of sexual abuse and can have a serious impact on every aspect of the life of the child. CSE is broader than formal 'prostitution' - the spectrum of situations include seemingly 'consensual' relationships where sex is exchanged for attention, accommodation, food, drugs or gifts or involves serious organised crime and child trafficking

Any child or young person may be at risk of CSE regardless of their family background or circumstances. There are strong links between children at risk of CSE and behaviours such as absconding, bullying, substance misuse and self-harm and those with low self-esteem and poor self-image. Some children are particularly vulnerable such as disabled children; children looked after, care leavers, migrant children and unaccompanied asylum seeking children

Children are at risk of CSE from both people they do and do not know. Due to the nature of grooming methods used by perpetrators, it is common for the child or young person not to recognise that they are being abused. CSE can be organised or involve one perpetrator acting alone

Perpetrators target children and young people where they may be without adult supervision e.g. shopping centres, or social media

When carrying out an assessment where it is considered that child may be at risk of Child Sexual Exploitation the risk indicators and factors below should be considered.

Risk indicators	Factors to consider
Education	Truancing. Regular non-school attendance. Excluded, behaviour problems
Missing / running away	Comes in late, Stays out overnight without permission, Persistently reported as missing from home or care. Missing for short periods of time on a regular basis.
Sexualised risk taking	Inappropriate dress/ change in physical appearance. Meeting unknown adults / Getting into unknown cars Internet used to meet adults. Older partner (+ 5 years)
Rewards	Unaccounted for money, expensive items such as new mobile phone, jewellery.
Contact with risky adults / environments	Associating with other known sexually exploited children and / or unknown adults. Extensive use of mobile phone. Accessing unknown premises (homes) or known risky areas. Evidence of sexual bullying and/or vulnerability through the internet and/or social networking sites.
Coercion / control	Reported limited /reduced contact with friends, family or in placement. Disclosure of physical /sexual assault (later withdrawn) Physical injuries. Child's whereabouts is unknown/ estranged from family.
Sexual Health	Reported STI(s), Miscarriage(s), Termination(s)
Substance Use	Level of drug and alcohol use/ different. Increased/ Concerning/ Chronic.
Emotional health	Low self-esteem, self-harm, eating disorder. Attempted suicide, Violent behaviour, angry outbursts, offending

Other factors include:

Child: Witnessing/experiencing domestic violence, family conflict, Child 'Looked After', Homeless / sofa surfing, Learning disabilities, Financially unsupported, Migrant/refugee/asylum seeker; Sex with a child less than 13 years / with a disabled child

Family; Abuse and/ or neglect in family; Parental Substance misuse; Death, loss or illness of a significant person in the child's life; Adult prostitution; Parental Mental Health, Parental Learning Difficulty or Disability

Risk identification

The CSE Risk Identification Tool should be completed to aid identification of the level of risk to the child or young person

The Information Report should be completed and forwarded to the CSE and Missing Coordinator

Vulnerability and Risk should form an essential part of the child's plan

Child has additional needs due to disability or a complex health condition

The following pointers are for you to think of the additional information that is needed due to the child's disability and / or health needs

Disability

Be clear here but try not to jargonise or take it straight from a medical dictionary.

Does the child have a diagnosis?

People reading this need to know how the condition or impairment affects the child or young person so make sure you put next to each diagnosis how this manifests and how it limits or affects the young person, how it makes them feel and how the equipment they have to use impacts on them emotionally and socially.

If they have a health issue how the treatment plan will impact upon their life and do they understand their condition?

Think about the child's health history – have they met their developmental milestones if their disability / health has / will impact upon this.

Communication Needs

In the section about the child's preferred method of communication do not take it as read what school or the parents say. Often young people have reported that they will communicate in a certain way as that's all they are given and when asked what they would prefer to use they come up with other methods including behavioural and gesture methods.

All these need noting and please do not forget behaviour is a form of communication and should not be ignored. Often children and young people are labelled wrongly as having no communication when they do but it is neither verbal nor following a recognised pattern – but your work with the child or young person will give you a clearer insight into this.

If the young person or their family or carers will need an interpreter make sure you state this here and be clear about what dialect or method they use.

Do not assume if the young person is hearing impaired and from a different cultural community that BSL will be their preferred method of communicating.

If the young person uses a pathfinder or talkbox to help them communicate – make sure you see when the best time is for visiting to ensure they have access to this device.

If the child or young person is on medication check whether there are times when they are unable to engage due to the effect this may have either just before or just after taking it.

Understanding

This relates to things such as the following:

- how the young person understands what is asked of them
- how they appear to be able to listen to people when they talk to them
- what their understanding is of the language used around them – you need to take into consideration if they use BSL or Makaton or a talk box device and if this is used at home

Expression

This relates to things such as the following:

- how the child or young person is able to communicate – speech, noises, behaviour, movement, BSL, Makaton
- how confident they are in communicating
- how they structure their speech
- about naming and identifying objects, people and things in their life

Interaction

This relates to things such as the following:

- how they express themselves to others
- how they play with others
- how they are in small and large groups
- what they are like with peer groups in school or nursery
- about social behaviour such as knowing about sex and sexuality and about friendships and keeping safe

This should look at how people involve the child or young person in decision making about the things in his or her life. Also how the young person feels they are included in decision making. They may be asked but do they feel that their views opinions and wishes are heard or even valued.

If they need equipment to communicate or use a method to help them such as Intensive Interaction this needs stating here so that anyone possibly caring for them can see if they need any training or support to do this to enable the child or young person to feel comfortable and able to communicate to the best of their ability.

From your observations at home and at school (and maybe within respite settings) you will be able to note and reflect on how the child or young person's communication may differ in these settings.

If the parents struggle with communicating with the child or young person then who could help them with this – if they see that they need help?

Reason for Undertaking this Assessment / Presenting Issues

Is this assessment being completed to assess a Child in Need, for a child to access short breaks or due to safeguarding concerns?

Any team working with a disabled child – have universal and targeted services been accessed / notified – if so what services are involved and what services were unable to meet the needs of the child. Has a CAF been completed?

Reason for undertaking this assessment – Regional Specialist Team only

Is the child being assessed due to their health condition and subsequent treatment plan?

Child's Profile

Don't just talk to the parents – talk to the child / young person – what do they see are their strengths and weaknesses and how do they feel about undertaking things away from the family home. How are they affected emotionally if they receive respite – do they like it do they look forward to it. How do they feel about going to activities away from home?

Would they like to do more – don't assume anyone has ever asked a disabled child the same questions as one without health needs or a disability – they may desperately want to go to scouts or brownies but the parent or carer may not be aware you can get help to enable them to do this !

If you are observing the child in home and at school or at a placement make sure you state this and reflect on what is said and what you observe. Do they have an understanding of their disability / health needs and how do they feel about themselves?

Family History

This should look at how the parent/s care givers are trying to work to help the child or young person feel valued and loved within the family home or care setting.

How do the family work as a unit to support the child or young person through change or challenging situations which may affect the whole family?

Environmental Factors

If the child or young person is at an age where they want more independence or they need more privacy – how will this be accommodated within their current home or care settings? What sort of help does the young person want in relation to getting independence?

If the child has a shared care arrangement – are there adaptations and equipment available in all care giving settings which safely and appropriately meet the needs of the child or the young person and the people providing care for them?

If the young person has medication or incontinence pads or equipment – where is this stored?

Is it safe in relation to other young people or children within the home?

Things to consider in relation to safe care within an environment which need noting here are:

- Does the child or young person wander at night and if so how safe are they?
- How independent is the young person within the home or care setting?
- Do they turn taps on?
- Do they try to get out of the house? If so how are they kept safe is an alarm needed on doors and windows to alert care givers within the home or care setting to this?
- Does the young person have access to the kitchen area and is this safe?
- Is there a ramp to the entrance and exit to the property which is safe for the young person and anyone moving them to use?
- If there are stairs in the property is the child or young person safe to use them?
- If the child or young person is in a wheelchair are they able to get through the doorways?
- If the child or young person is in a wheelchair are they able to be safely taken up and downstairs?
- Is the child or young person able to use the toilet safely? Is there a toilet for them downstairs or do they have to be lifted upstairs if they need to toilet or do they have a commode?
- How does the child or young person wash or bathe – do they have a special bath or adapted bathroom – if not how are they bathed and is this safe for the person helping them?
- If the child or young person has oxygen how is this transported within the home?

- If the child or young person needs lifting – is there tracking and a hoist which is safe and suitable for his or her needs?

If the family have financial concerns ensure that they are signposted appropriately for benefits advice, DLA etc. Can charitable support be accessed to offer support?

This section should include any issues about how the family and the child or young person are able to access facilities and sports and leisure activities within their community. Would they like to do more – don't assume anyone has ever asked a disabled child the same questions as one without health needs or a disability – they may desperately want to go to scouts or brownies but the parent or carer may not be aware you can get help to enable them to do this!

Are there any resources within the area that the child or young person can access and are the family or care givers able to support them in doing this or would they benefit from someone independent to do this?

What amenities like doctor, dentist shops etc. are available within the neighbourhood? Does the family have to travel to get to these and is this a problem for them in taking the child or the young person if he or she has equipment such as a wheelchair or medical equipment to take with them?

If the young person has a condition such as an Autistic Spectrum Condition are they able to cope with the noise and business of social and leisure activities and events? If not how could they be helped to access these more happily or comfortably?

What does the young person want to do in relation to social and leisure activities? How do they feel emotionally about what they can and cannot access in relation to social and leisure activities?

Are they currently attending activities which are either way below or way above their capacity or understanding? If so what could you find in the Short Breaks Guidance and Directory or on the Intranet which may be more suitable and how could the child or young person get the most suitable and appropriate help to enable them to access this and build better and safe social relationships?

Regional Specialist Team only

How far is the family home from their treatment hospital?

Is the family home a safe environment for them to be discharged to from hospital?

Social Worker's Analysis

In this section there needs to be a clear analysis on what additional needs the child has due to their disability or health condition.

What part of these needs are the parents able to meet and how?

What do you analyse is unmet need and the risk it raises to the child?

Play

This section should look at issues such as the following:

- if the young person is able to engage in group play
- if the young person plays more with older or younger children/young people

- if the young person engages in more solitary play
- can the child/young person engage in turn taking activities
- can the child/young person differentiate between fantasy play and reality
- can the child/young person cope with changes in their play environment
- if the young person has obsessions about certain activities
- whether the young person is able to initiate play
- if the young person does not like a specific sort of play such as messy play or play involving textures

Stimulation

This section should look at issues such as the following:

- this should show what the child or the young person chooses to engage in for stimulation such as games preferred activities preferred

Leisure

This section should look at issues such as the following:

- how the young person deals with social and leisure activities whether they can cope with noisy environments
- what their behaviour is like when they are in busy social situations
- what activities or groups they may like to attend or do attend

What is the risk to the child's lifespan and / or safety due to their disability or health condition? Is there any risk associated with treatment?

Is an additional assessment required e.g. under the continuing care criteria, O.T. assessment?

Family Strengths and Protective Factors

This part of the assessment you will need to look at not only if the parents or carers are able to care safely for the child or young person but if they have the equipment they need to do this within their home/s.

Has a parent / carer assessment been offered and what was the outcome?

Talk to the parent/s or carer/s about how it feels to care for the child or young person and the parent carer assessment may inform more information about this and you may be able to reflect back to them what you feel are their strengths which can be very valuable if a parent or carer is at the stage of feeling very frustrated or exasperated due to their caring responsibilities or what they feel could be a significant lack of support.

Consider from whom the child accesses / receives emotional support.

Parents

- This should report on what you have observed during your visits to the child/young person during your visits to the home or care setting.
- What are the levels of attachment like between the mother and the child or young person?
- Describe the relationship mother and child/young person have been observed to have.

- What are the levels of attachment like between a father/step father or partner if there is one within the household?
- Describe the relationship father/step father or partner and child/young person have been observed to have.
- If there is shared care arrangements how does the child or young person relate to the other adult care givers within the other care setting?
- Is there a clear difference between the roles of the parents/adult caregivers within the home?
- How do the parent/s/adult care givers react to any challenging behaviour from the child/young person?
- How do the parents meet the differing needs of their children especially if a single parent?
- How do the parents support each other / work together in relation to the child's disability / health condition?

Siblings

Here you should comment on what you have observed during your visits to the home or care setting in relation to siblings or step siblings.

- How does the child/young person interact with their siblings/step siblings?
- What is their opinion of them?
- How do the siblings/step siblings react to the child/young person?
- What is their opinion of their brother or sister?
- Is the child/young person able to respect the privacy of their siblings/step siblings
- If the child or young person has much younger siblings should they ever be left alone with them – what is their awareness of safety?

Wider Family, Other Care Givers Friends and Peers

Here you should comment on what you have observed during your visits to the home or care setting in relation to their wider family, peer groups and any friends they have including things like:

- Do they see their grandparents? (if so do they see maternal and paternal and if so how often and how do they react to this)
- What is the child or young person's view of their grandparents? – seek the views of the child/young person and their family/care givers.
- Do they see their wider family? If so where and when and what is their opinion of this and how do they behave – seek the views of the child/young person and their family/care givers.
- Does the child/young person have friends?
- Do they go to see friends or do they stay at home most of the time
- What is the young person's view of who is their friend
- How does the young person react to people of the same age? Do they prefer the company or to play with older or younger people – what have you observed during your visits to home and school.

Analysis and Professional Judgement

Don't forget to look at the non-material things – what would the young person like to do if they had the support – how do the things in their life make them feel and if they are not happy – how could they get some help and support from a trained health professional to resolve this?

- Is the need in the home, out of the home, in relation to care, independence or leisure activities?
- Does the child's needs meet the criteria for Short Break provision?
- Does the analysis of need concur with the reasons for undertaking this assessment?

Recommendations including outline plan

Does your recommendation include further assessment support from other agencies?

- Continuing Care
- Learning Disability Nurses
- CAMHS
- Occupational Therapy
- Other local authority SW services
- Referral to charitable sources.

This section will be reviewed when the Education Health and Care Plan is introduced in September 2014.

Domestic Violence

1. Are you concerned that there is domestic violence in a family you are working with?

- Common indicators include physical injuries; anxiety and distress; frequent appointments and missed appointments; reluctance to go home; mental ill health; alcohol and substance misuse, self-harm and attempted suicide. The woman may appear vague, frightened, anxious, depressed and/or distressed.
- Is there a history? Check any available records. A victim may have been to your agency previously and presented with some of the common indicators mentioned above. Many women experience repeat incidents of violence and harassment before disclosing to anyone. The frequency and severity of DV incidents often increases over time. Check if tagged as MARAC case.
- Common indicators for children include: anxiety and distress, sudden changes in behaviour, withdrawing, acting aggressively, difficulty separating, increase in stress related illnesses, bedwetting, school absences etc.

2. How to approach the issue

- See the victim alone and in private.
- Ask direct questions sensitively. This forms part of routine enquiry so all women are asked.
- If she is accompanied, do not insist on seeing her alone. Arrange an alternative, safer opportunity.
- Be honest about why you are asking.
- Explain your confidentiality procedures.
- Use a registered interpreter if required.
- If violence is denied record that she has been asked and her response.
- Explain that you may ask her again at future meetings.

3. Routine Questions

Research shows that women are more willing to disclose their experience of domestic violence if they are specifically asked about it. It is therefore important to ask about domestic abuse in a direct but non-threatening and sensitive manner. For example:

“Many women experience violence and abuse from their partners so we ask all women about this. Can you tell me about your relationship, do you ever feel frightened by your partner?”

Women should be told about why the questions are asked i.e. because of the extent of domestic violence, the need to monitor it to ensure women receive adequate services, to enable staff to refer women to appropriate agencies and provide her with useful information.

4. What if domestic violence is disclosed?

- Emphasise confidentiality.
- Be clear about any limits to confidentiality.
- Be clear about the boundaries of your role.
- Ensure availability of information about agencies and other support she can access.
- Sign post and/or refer appropriately with her consent.
- Explore with the woman her understanding of the impact on her children.

5. Children

- Recognise the links between abuse of women and abuse of children.
- Ask if children are aware of, have witnessed, been involved in the violence.
- Wherever possible, provide child friendly play areas/supervision and interview the woman separately.
- Never use children as interpreters.
- Talk to the children about domestic violence where appropriate.

6. Safety/Risk assessment

- Assess with the woman the current risk to herself, children or any vulnerable adults in the household.
- If applicable, use your agency's risk assessment tool.
- Identify a place of safety if she is in immediate danger.
- If there is no immediate danger, discuss short term and long term safety planning.
- If appropriate undertake a DASH risk assessment and refer to MARAC.

7. Information and support

- Offer the woman support by listening to her and believing her.
- Do not be judgemental.
- Emphasise that she is not to blame for the violence.
- Place the responsibility for the violence with the abuser.
- Offer opportunities for on-going support.
- Provide information about specialist support, local agencies.
- Offer support to access these agencies.
- Respect her decisions if she does not want further help, is not ready to leave or address the situation, but make it clear she can come back another time.
- Share information proportionately with partner agencies, including referral to MARACs, and seek her consent to do so.

8. Additional Issues for Women from Vulnerable Groups

Be aware of a victim's personal circumstances and any additional needs she may have as well as the additional barriers to support she may face, for example:

- Disabled women may face disability discrimination and often feel they are not listened to or believed. They may be dependent on their carer who is also their abuser.
- BME women may experience racism, honour based violence, be concerned about immigration issues or have no recourse to public funds.

This is not an exhaustive list but provides some prompts on the additional issues that need consideration. It is essential not to stereotype but to treat each woman as an individual and listen to her specific issues and respond accordingly by providing relevant information or referring to specialist services.

9. Action Planning

- Assess the impact of the domestic violence on the children.
- Identify with her any action she will take.
- Identify any action you will take on her behalf.
- Make arrangements for future support or follow-up meetings.
- Make referrals with her consent.
- Indicate any information which will be shared with colleagues to ensure consistent support.

- Agree measures to ensure her safety e.g. how to contact her safely.
- Refer to MARACs where appropriate.

10. Remember

- She may have experienced abuse for many years.
- She may not have access to money.
- She will already have tried many ways to manage the violence.
- She will want the violence to end but may still want the relationship.
- A woman is most at risk at the point of leaving or when she has recently left a violent partner.
- You may be the first person she has told about the violence.
- It is important that you give her the same level of respect and support whether she stays with the abuser or not and how ever many times she comes back. Sustained support is what helps women protect themselves and their children. Try not to rush her into making decisions she is unsure about.
- Encourage and support colleagues to adopt good practice.
- Challenge or report bad practice.
- Never give her details to anyone without her consent or careful consideration of the level of risk. Do not agree to pass on messages between her and the abuser.
- Do not insist on or suggest joint sessions with her partner. Mediation or counselling in domestic violence situations can make women more vulnerable or put them at further risk.

11. Responding to Perpetrators

Many male perpetrators will deny and minimise their actions due to feelings of shame. This shame often flips into anger and aggression.

- Be aware of your own and colleagues' safety, particularly when denying information to a perpetrator.
- Never disclose any information about the woman.
- Do not agree with any comments the perpetrator makes that could be seen as agreeing with, or justifying, his actions.
- Encourage him to seek help for himself.
- At all times treat the perpetrator with respect. Don't allow your distaste for what he has done lead to you dismissing him or disengaging with him. Your positive communication with him could be the trigger to him seeking help.
- Talk to someone from the Council's Domestic Violence Team if you are uncertain of what to do.
- Always have the appropriate telephone numbers available for you or him to seek advice.

12. Record Keeping

- All of the above needs to be documented to provide as full a picture as possible to ensure consistent support.
- Records need to be clear and accurate as they may be used to provide evidence in any future legal action within either the criminal or civil justice systems or for the purpose of a Domestic Violence Homicide Review or Lessons Learned exercise.

What Women who have experienced domestic violence in Leeds tell us

Working with domestic violence the best Social Workers:

- ✓ Have a signed agreement that works both ways with a phone number on the bottom to ring if the Social Worker hasn't done what they said they were going to do.
- ✓ Many women are unaware of issues before they are read out in court.
- ✓ Bear in mind you've been given a bad name. Most people will think you are trying to take their children away from them. Make it clear you are there to help.
- ✓ The service is child based, it's not holistic – it needs to look at Mums and children together.
- ✓ Understand that I might 'choose' to stay with him because I am frightened or controlled (even though I might appear to not to be). Never treat the victim like they're the bad one, it's the perpetrator that's violent. It's often very difficult and complex to leave.
- ✓ Listen to me, take time, respect me and check out I understand. They don't put themselves enough in your situation, more empathy and understanding needed. It's hard to communicate those complex feelings.
- ✓ Explain what their job is and what I need to do.
- ✓ Understand how hard it can be to look after children and day-to-day life and make big and safe decisions.
- ✓ Try and help or challenge my partner/boyfriend/husband. But only if you know the woman's in a safe place, this can backfire and the woman gets hurt, get permission before you do. Make sure you tell him he is responsible for his violent/abusive behaviour. Don't add stress to a woman's situation by making them face/challenge a man you are too scared to approach.
- ✓ Don't put on a plan that I should leave him, put that you will help me to keep me and my children safe.
- ✓ Don't talk in jargon. Otherwise you're not really making sense. Be direct. Don't go all round the houses if you've got something important to say. Be really clear about important things.
- ✓ Do what they say they are going to do. Don't keep us waiting for a visit that isn't going to happen. Respect our need to live a life around the appointments. If you can't make an appointment please let us know.
- ✓ Think how hard it is to be talked about in meetings.
- ✓ Help me like they would a friend (I know you're not my friend) but would you just expect them to leave, would you say that what they need is a meeting? Teat us respectfully. They do come round like you're just another case, just another file and then they're rushing off when you've still got questions.

- ✓ Know what services and support I can get. Help women to build trust in them or it always be too hard to be open about your situation.
- ✓ Don't gather evidence, but help us, help me be the best mother I can be. Be open about what you are doing e.g. if you are watching the children
- ✓ Help me explain to our children.
- ✓ Don't judge.
- ✓ Explain why you have to check my bedrooms. Or anything else you check.

Assessment and intervention with domestically abusive men

Six key factors that are significant in understanding domestic abuse and can form a framework for your assessment:

1. Childhood attachments

Research suggests that a majority of court mandated interpersonally violent (IPV) perpetrators, and a significant minority of IPV perpetrators found in general populations, have a disorder of their personality, with the prominent disorders being borderline personality disorder (BP) and anti-social personality disorder (ASPD).

Research also suggests there are a sub-group of batterers who were insecurely attached to their partner, likely to experience depression, and have BP personality traits (i.e. an intense fear of being abandoned). They will go to great lengths to prevent this, with extreme reactions within relationships, including impulsivity and extreme displays of emotions. Alcohol can play a part within this.

This sub-group are also likely to have a criminal record for non-violent offences and substance use problems. Those men who score highest on BP traits also used the most physical aggression and controlling and emotionally abusive behaviours. The cause of this behaviour is usually related to early experiences of childhood abuse, separations, losses and disruptions which lead to poor adult emotional regulation and a fragile sense of self.

There is also a connection between Anti-Social Personality Disorder (ASPD) and Borderline Personality Disorder (BPD), substance use and domestic abuse. Many people with ASPD and BPD misuse substances

Additional Note: Therapeutic Alliance and IPV Treatment

Research on client reactance suggests that approaches that are perceived as reducing freedom to make choices are particularly counterproductive with clients who show a defensive, dominant, autonomous and non-affiliative personality style, such as those with ASPD or psychopathy.

2. Anger Management:

There has been a lot of discussion in the area of domestic abuse around the role of anger in explaining why some men are violent and abusive. It has been thought that men's abusive behaviour is generally premeditated and this is certainly the case for some men to varying degrees. For other men however, their violence in particular is not premeditated and they need to learn anger management techniques to keep their partner physically safe.

Men who have anger management problems will typically self report losing their temper and having verbal and physically violent outbursts in a variety of settings. Most importantly their violence will not be solely directed towards their partner. These men are also likely to have criminal convictions for reactive violence.

It should be noted at the same time that men who have anger management issues may also have difficulties with premeditated, controlling behaviour. Typically, the controlling behaviour does not include physical violence but will be expressed through bullying and intimidation, in an attempt to stop their partner doing something, or alternatively make their partner do something. Where there is pre-meditated use of violence in a relationship a weapon may have been used and there may also be evidence of stalking or persistent harassment.

Pre-meditated violence and controlling behaviour is likely to be linked to the perpetrators damaged attachment style.

3. Culture, Religion and IPV

Culture and religious views are complicated and varied. They are not homogenous and vary according to where we live and who we associate with. There is evidence that that cross-culturally women's empowerment is related to their victimisation and the perpetration of violence and abuse. Historically a patriarchal culture predominated within western society although this is now much less the case. We need to be clear therefore in our assessments exactly how cultural and religious beliefs have impacted on the perpetrator.

We need to assess whether the perpetrators beliefs about women, relationships and the use of violence have an impact on his behaviour towards his partner. As with substance use and IPV we need to decide whether culture (whether it be on a micro or macro level) and religious beliefs are:

- Unrelated to IPV: In this scenario the man does not have oppressive or concerning beliefs about women, relationships or violence.
- Used to rationalise IPV use: In this scenario there is not a connection between his beliefs and abusive behaviour but he uses cultural justifications for his abuse. These justifications mask deeper issues in his life.
- A direct cause of IPV: Beliefs about women, relationships and violence are deeply engrained in the perpetrators thinking and will be evident through the way he talks about these issues in everyday life.
- An additive effect: There are other significant factors behind his abusive behaviours but his beliefs about women, relationships and violence contribute to his abusive behaviour.

4. Substance Use and IPV Treatment:

Both alcohol and some drugs are associated with an increased risk of reactive or emotionally driven aggression. There is also a connection with the severity of violence. However, the connection is complicated and we need to assess whether the substance use and IPV is:

- Unrelated. In this scenario the man would be violent /abusive whether he used substances or not. Evidence: The man is as likely to be abusive when not using substances as when he is using substances :
- Used to rationalise IPV use: In this scenario there is not a connection between his substance use and abusive behaviour but he uses s/u as a justification for his abuse.
- A direct cause of IPV: In this scenario, s/u is the primary cause of his abuse. Evidence: Both parties report positive, non-abusive behaviour when sober and abuse when using.
- An additive effect: Substance use makes violence and abuse, and also the severity in many cases, more likely.
- A cause of conflict: The man's s/u causes arguments due to the financial and social impact of his s/u. The conflict then results in abusive behaviour.

5. Lack of Empathy

Developing empathy might, quite rightly, be considered another relationship skill but it has been separated because of its key influence in reducing physical violence. The more we are able to appreciate our partner's perspectives the less we are likely to behave in an abusive manner. There are some simple exercises that can be used with men to start this process.

6. Relationship Skills

Many of the people that we work with have been raised in dysfunctional families. This does not mean that they have been traumatised by their experiences, but they may not have observed the many and varied skills that are required to keep a relationship functioning in a positive progressive way. They may love their partners and genuinely want the best for them but at the same time, have never learnt how to have an argument without behaving in an abusive or controlling manner. Similarly they may never have been taught to listen to their partners, or respect their feelings, particularly anger. They may be too passive or aggressive and have never fully grasped how to be assertive. There are numerous skills that men can be taught to help them behave in a more respectful way towards their partner.

In reality, all of us have areas in our relationship where we could do better. Teaching relationship skills is likely therefore to be necessary with all the men we work with and is likely to be in addition to some of the other categories noted above. The worker needs to identify which of the skills the man is most likely to benefit from learning and should be done in an order that prioritises the women's safety.

How do we work with abusive men (Assessment and Intervention?)

Reassure, get the man's story. Listening to someone's story is not colluding! You need to hear this story so that you can contextualise their behaviour. Think of a time when you have been seeing a doctor and they have not listened to your explanation of symptoms. They may (or may not) come up with the right diagnosis but we do not feel respected!

- **You don't need to challenge everything he says.** (Even if you don't agree!) Occasionally emphasise, this is his perspective without being judgemental. 'So, from your perspective...' This enables him to tell his story without him thinking you agree with him!
- **Encourage the person to consider his partners perspective,** 'how would your partner describe the incident'? Listen to whether they can actually do this, this is an important indicator for the readiness and ability to change.
- **Treat an honest account with as much suspicion as a minimising, denying and blaming account!** M,D,B is good, it shows discomfort with the behaviour, honesty is only good if it is accompanied by discomfort.
- **It doesn't really matter if they deny the index assault as long as they admit elements of abusive behaviour.** The more time has elapsed since the behaviour, the more likely we are to admit it, it's quite normal! If he says he hit her 3 weeks ago but not last night, work with what he is giving you. Whilst his denial really disrespects his partners experience, by working with where he is at you can reduce the risk for the future, which is probably what his partner wants the most.
- **Agree they should not expect their partner to be interested in the discussion.** If you do some work with a man they will often say that they are going to go home and discuss the work with their partner. Their motives for this could be very mixed. Warn them against this, it may cause an argument and it is quite likely she is not interested. Similarly, if you set homework this should not be done by or with his partner.

Intervention with men in Leeds

There is not a significant amount of help or support for men in Leeds although this is not different than many areas of the country.

- **IDAP and safer Relationship programmes.** Court Mandated DV Perpetrators have access to IDAP and safer Relationship programmes. These are 27 and 14 sessions in duration and are built around the principles of power and control and skill based teaching.
- **STOP Programme** is focussed on both power/control principles and anger management when working with dv perpetrators.
- **Making Safe Scheme** run by Foundation Housing offers support to men in finding alternative accommodation for men motivated to leave an abusive relationship.
- **Safer Leeds Perpetrator Scheme** offers assessments on men to children social care clients where DV has been identified as an issue in the risk management plan, and to MARAC men. These men can also receive up to 12 hours intervention work from qualified workers

Missing checklist for Vulnerability and Risk Management

1. Chronology of all previous absences / missing events

- Dates
- Length of time absent or missing

2. Summary of the details of the most recent missing event or unauthorised absence that has triggered the need to manage the risks

- Where did the child go / places stayed at and found at people the child/young person went missing with and
- in whose company were they found
- how long they were absent or missing
- What happened
- How often has this happened like this

3. Details of other vulnerability risk factors: e.g. learning disability, head injury, CSE

Provide details of:

- risks to self
- risk from others and to others
- patterns of behaviour
- sources of vulnerability and risk information

4. Summary of details of Return Interview

- What did they say
- Why did they go absent / missing
- What is the assessment of the person who carried out the Return Interview

5. Eco map of:

- known acquaintances
- places for absence
- phone numbers
- risk markers

6. Protective Factors to reduce the risk

- What is already in place
- What other things help

7. Analysis of risk

-

8. Outcome of strategy discussion / meeting if held

9. New actions to manage the risk and to be incorporated into the Child's Plan

- What needs to happen to keep the child safe
- What needs to happen to support the child not to go absent or missing

Parenting Assessment Manual (PAMs)

What is it?

The Parent Assessment Manual (PAM) is a comprehensive, assessment tool for use with vulnerable families, including parents with learning disabilities.

PAMS 3.0 is a complete Parent Assessment Application used by Social Workers, Psychologists and other professionals across the UK and abroad. The PAMS assessment was developed by Dr Sue McGaw (a nationally renowned Clinical Psychologist in the field of working with parents with learning disabilities) and South Coast Solutions.

The PAMS assessment tool was originally written for parents with Learning Disabilities; it allows all parents to access the system fairly whatever their level of ability.

When working with parents with a Learning Disability practitioners should always refer to the Good Practice Guidance on Working with Parents with a Learning Disability, Department of Health and Department for Education and Skills, 2007 (www.dh.gov.uk/en).

How to access advice and support with PAMs

Advanced Practitioners (APs) within Leeds should have access to the PAMS software and accompanying resources and a number of APs across the city have been trained in the PAMs Assessment. Before embarking on a PAMs assessment, you should contact an AP in your team or your area and find out who can support you with this.

Court reports

As the PAMs assessment process is a recognised report within Court; some Judges are already asking if workers are qualified to complete them, for some cases they can reduce the need for psychological assessments or Independent Social Work assessments which are between £1,500 and £3,500 per report.

However PAMs assessments should not be carried during court proceedings as they can take a long time and are very much focused upon observations; this can be difficult if children are not in the care of their parents and would have to rely upon observations of contact which is not always appropriate or feasible. The PAMs assessment should be carried out prior to Court proceedings

There has also been some criticism of the PAMS model as it does not always accurately assess risk and is more focused upon 'teaching methods'. PAM is not a psychometric test and there are no cut-off criteria for "good enough parenting". The tool is not a substitute for professional judgement or experience. Other approaches should also be used.

What does it cover?

It covers:

- child care and development
- behaviour management
- independent living skills
- safety and hygiene
- parents' health
- relationships and support
- and the impact of the environment and community on parenting

Each parenting skill area within a domain is assessed for:

- Parental knowledge
- Quality of parenting skills
- and the frequency of parenting practice

By breaking elements of parenting down into testable components PAMS starts to make an assessment of quality that is evidence-based. After completion, the assessor has a clear visual family profile of functioning that target parenting support needs, as well as child protection issues.

Based on the Parental Knowledge-Skills-Practice Model the PAM provides professionals with a structured and practical approach to the assessment of parents and their children (0-19 years).

What format is it in?

PAMS 3.0 is an extensive professional software CD-ROM application which includes:

- Clinical Assessment forms
- Worksheets
- Graphical Parent Summary
- Profiles and automatic Report Generation

The PAMs assessment tool is very defined and the worker populates forms and then the report is formatted from this. The report is very quantifiable which means that is not likely to be challenged therefore leading to less delay and clearer outcomes being known for vulnerable children within the city.

PAMS 3.0 has been developed to present information within a format that interfaces well within the Framework for the Assessment of Children in Need and their Families (2000) and the Common Assessment Framework (DfES, 2006).

PAMS 3.0 can be used as a Screening Tool or as a **Comprehensive Specialist Assessment**.

PAMS 3.0 simplifies the measurement of parental capacity and automatically consolidates the assessment data into template reports to assist the assessor with their report writing.

PAMS provides an evidence based assessment which, is intended to reflect more accurately parents knowledge, skills and practice and was developed from twenty years' experience of working with very low functioning parents, many of whom were illiterate and limited in terms of basic life skills.

In addition to the PAMS 3.0 software, a spiral bound Instruction book, knowledge book and parent booklet are included with each pack. The instruction book is an excellent reference and guides the assessor on how to use and apply PAMS 3.0 during and after clinical assessments.

Single Assessment Report and Joint Assessment Report

A Single Assessment Report processes and displays assessment data for one parent.

Also, a Joint Assessment Report processes and displays assessment data for two parents
The Reports will include:

- Data tables
- Report Summary
- Worksheet Profile
- Worksheet Summaries
- Observation Graph
- Targeted Worksheet Skills

The **Report Manager** enables practitioners to customise the report by choosing personalised settings.

In addition **PAMS Capacity Reports** capture information about a **parent's progress** over time therefore enabling practitioners to accurately assess parents potential for change and therefore inform future planning.

Workers can also choose to use some of the **PAMS worksheets** to inform assessments and **do not necessarily need to use the full software package** provided that they accurately reference the worksheets within their assessments.

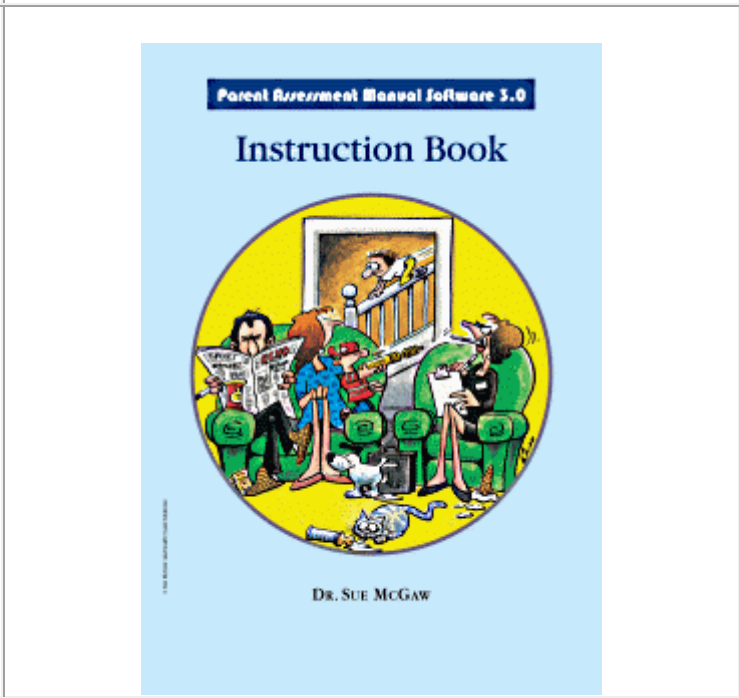
Below is an example of the various stages of a PAMS assessment

In addition to the PAMS 3.0 software, a spiral bound Instruction book, Knowledge book and Parent booklet are included with each pack (see below for more details).

Most of the PAMS 3.0 (Parent Assessment Manual Software 3.0) components are detailed below. Almost every component in PAMS 3.0 can be printed.



PAMS 3.0 is very well documented. A spiral bound **Instruction Book** is included. This 66 page book is an excellent reference and guides the assessor on how to use and apply PAMS 3.0 during and after clinical assessments.

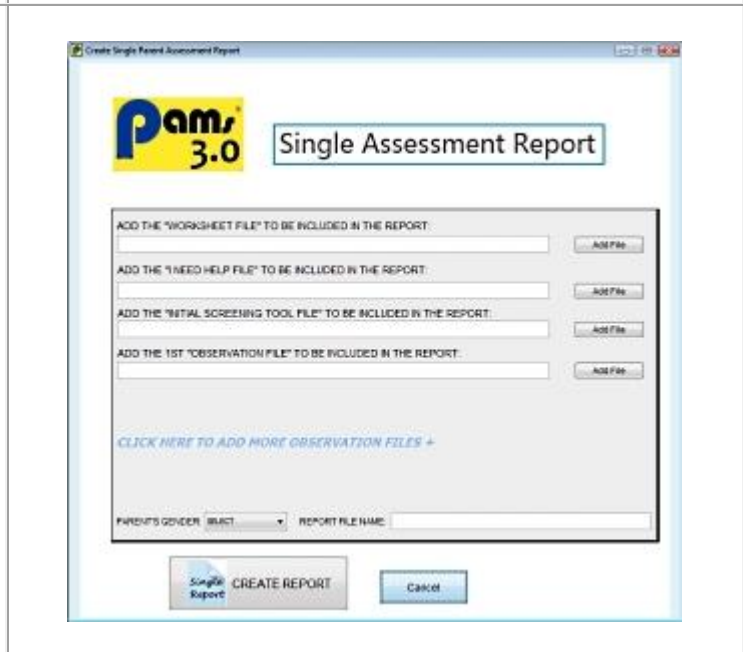


The **Report Manager** assists you in creating a report. Choose between a Single, Joint or Capacity Reports (generated as a Microsoft Word document). The Report Manager enables you to customise the report by choosing personalised settings.

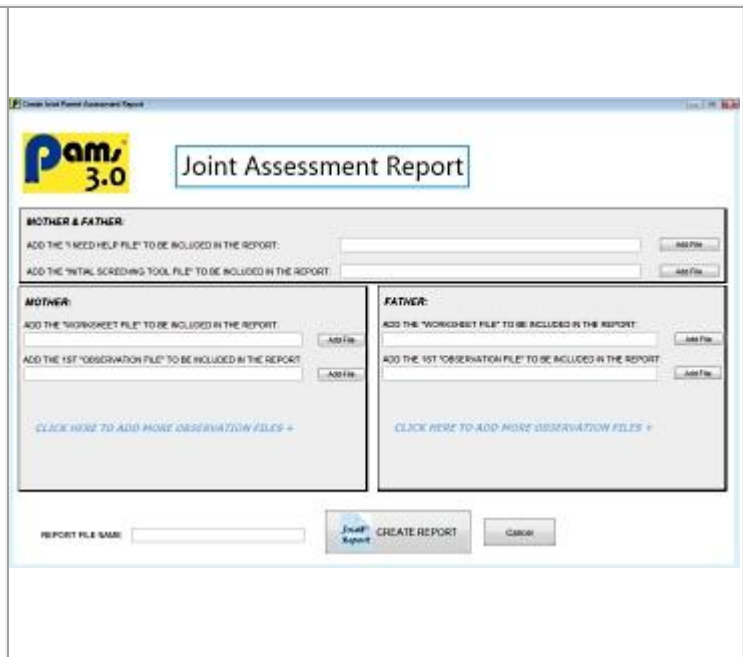


Click on images for full size view

A **Single Assessment Report** processes and displays assessment data for one parent. The Report will include Data tables, a Report Summary, Worksheet Profiles, Worksheet Summaries, Observation Graphs and Targeted Worksheet Skills.

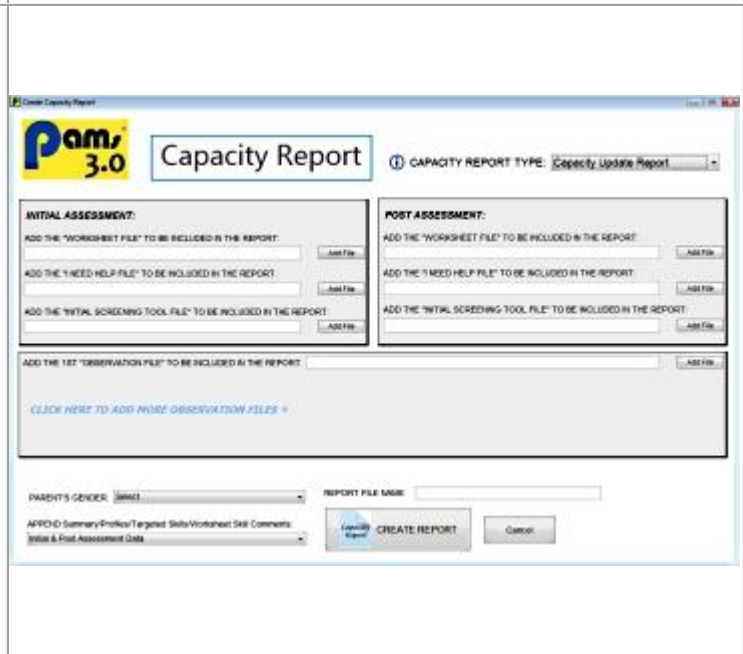


A **Joint Assessment Report** processes and displays assessment data for two parents. The Report will include Data tables, a Report Summary, Worksheet Profiles, Worksheet Summaries, Observation Graphs and Targeted Worksheet Skills.

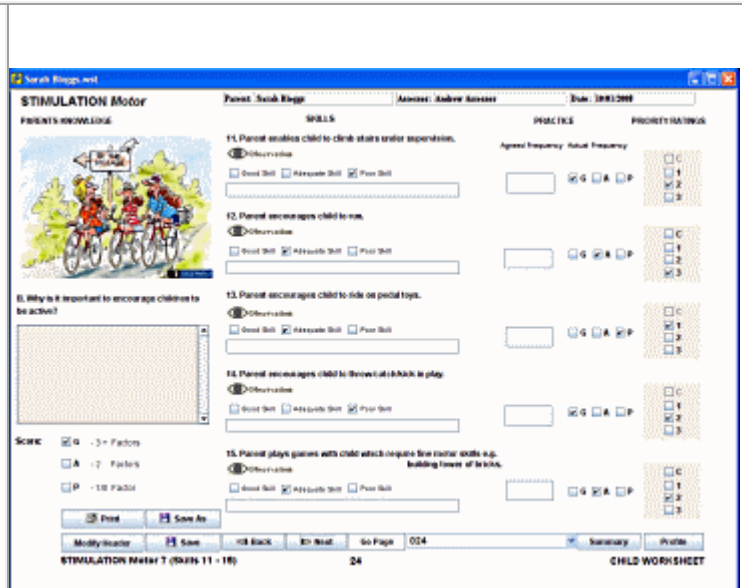


PAMS Capacity Reports capture information about a parent's progress over time. Two types of Capacity Report are available. These include the Capacity Update Report and the Capacity Teaching Report.

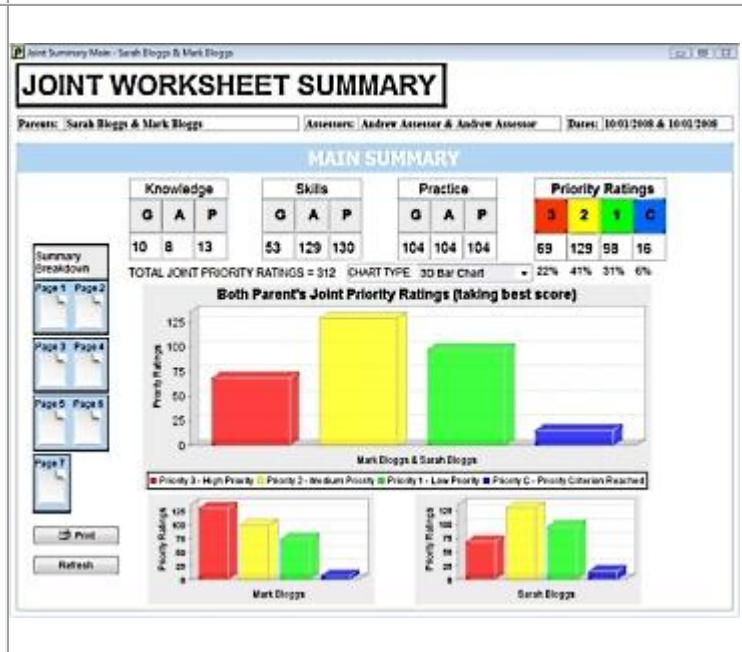
The Report will include Data tables, a Report Summary, Worksheet Profiles, Worksheet Summaries, Observation Graphs and Targeted Worksheet Skills.



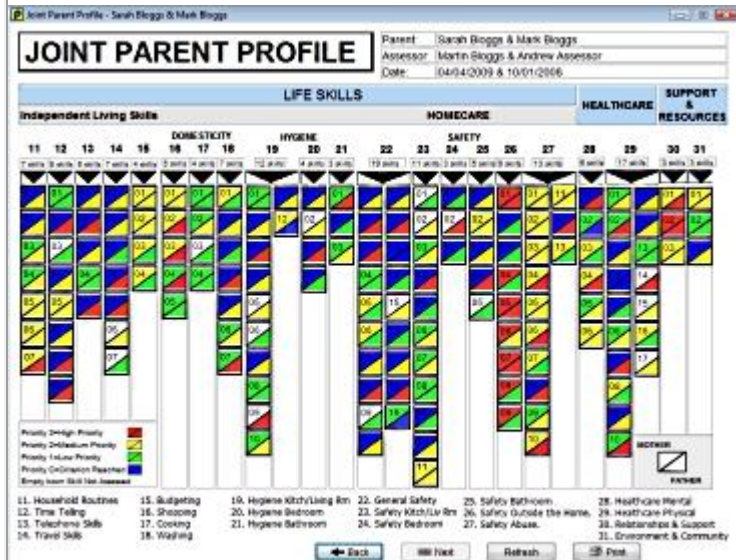
PAMS 3.0 consists of **94 Worksheets** which need to be completed by professionals during the clinical assessment process. The PAMS 3.0 software will perform error checking on all data input into the worksheets to maintain integrity.



Graphical Summary is produced after all worksheet data has been entered. Five different chart types can be selected. Single Summaries can be produced for each parent assessed. Joint Summaries combine the assessment of 2 parents (taking the best score of both) to produce a graphical summary as a couple.



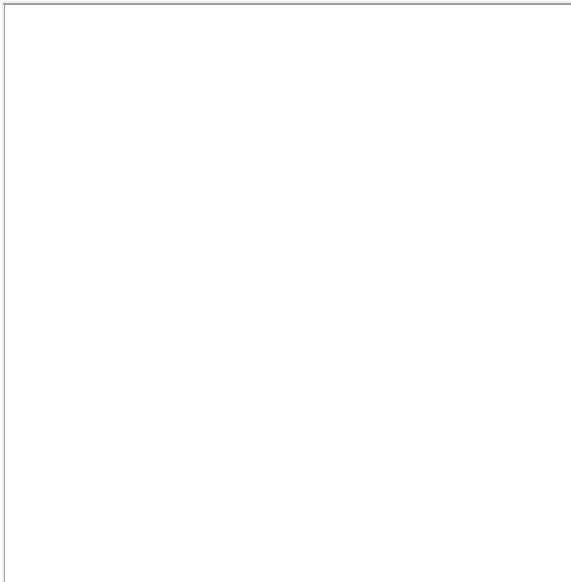
Graphical Profile is produced after all worksheet data has been entered. Single Profiles are produced for each parent assessed. Joint Profile combines the assessment of 2 parents to produce a graphical profile as a couple.



This spiral bound **Parent Booklet** is to be completed by the parent. This booklet provides an alternative method for the assessment of skills that are difficult to observe. It is skill specific rather than exclusively knowledge based.



The **Initial Screening Tool (IST)** is to be completed by the referrer or another professional who knows the family well. The assessment domains on the IST have been condensed into 15 sections, for ease of completion. IST scores are useful for making comparisons across families so that their needs can be prioritised.



Parent Recruitment Manual Software 3.0

Initial Screening Tool

NAME of Parent		DATE		ADDRESS	
				M <input type="checkbox"/> F <input type="checkbox"/> Sub <input type="checkbox"/>	
Mother: _____		Date of birth: _____		ASSESS	
Father: _____		Date of birth: _____		SCORE	
Child: _____		Date of birth/DOB: _____		CPI: _____	
Child: _____		Date of birth/DOB: _____		CPI: _____	
Child: _____		Date of birth/DOB: _____		CPI: _____	
Child: _____		Date of birth/DOB: _____		CPI: _____	
Child: _____		Date of birth/DOB: _____		CPI: _____	
Child: _____		Date of birth/DOB: _____		CPI: _____	
Address: _____				Tel: _____	
GP: _____		Address: _____		Tel: _____	
Social Worker: _____		Address: _____		Tel: _____	
Health Visitor: _____		Address: _____		Tel: _____	
Other: _____		Address: _____		Tel: _____	

* Estimated Date of Delivery * Child Protection Register * Current Assessment Framework

All of the PAMS 3.0 skills have been designed to be clearly observable. More complex parenting skills can be assessed in greater detail using the **Observation Form**. This data is then transferred on to the worksheets at the post-assessment stage.

Observation Form Quality & Frequency of Practice

Parent Recruitment Manual Software 3.0

INSTRUCTIONS

1. Use Worksheet Details and Worksheet. All being observed.
2. Click + or - buttons in Good/Adequate/Poor column each time skill is observed.
3. Use KEY to define quality of practice (Good/Adequate/Poor).
4. Finally, grade on either C.A.P. overall. Transfer to observational skills box on worksheet.
5. Click GRAPH button to present the data graphically as a Report.

KEY

GOOD SKILL: Well demonstrated well without help
 ADEQUATE SKILL: All demonstrated but some needed reminding
 POOR SKILL: Not attempted/attempted but unsuccessful

Select Worksheet Details: Select Worksheet Skill:

STIMULATION LANGUAGE * Press enter and repeat on child's workstation (F5)

DATE dd/mm/yyyy	PRACTICE			COMMENTS
	GOOD	ADEQUATE	POOR	
SESSION 1	<input type="button" value="G"/>	<input type="button" value="A"/>	<input type="button" value="P"/>	
CLEAR BOX	<input type="button" value="G"/>	<input type="button" value="A"/>	<input type="button" value="P"/>	
SESSION 2	<input type="button" value="G"/>	<input type="button" value="A"/>	<input type="button" value="P"/>	
CLEAR BOX	<input type="button" value="G"/>	<input type="button" value="A"/>	<input type="button" value="P"/>	
SESSION 3	<input type="button" value="G"/>	<input type="button" value="A"/>	<input type="button" value="P"/>	
CLEAR BOX	<input type="button" value="G"/>	<input type="button" value="A"/>	<input type="button" value="P"/>	
SESSION 4	<input type="button" value="G"/>	<input type="button" value="A"/>	<input type="button" value="P"/>	
CLEAR BOX	<input type="button" value="G"/>	<input type="button" value="A"/>	<input type="button" value="P"/>	
SESSION 5	<input type="button" value="G"/>	<input type="button" value="A"/>	<input type="button" value="P"/>	
CLEAR BOX	<input type="button" value="G"/>	<input type="button" value="A"/>	<input type="button" value="P"/>	
SUMMARY TOTAL:	0	0	0	OVERALL OBSERVATIONAL GRADE: _____

Observation data (from the Observation form above) is presented as a **Graph** at the click of a button.

Pre-birth Assessment

1. Introduction

There are a range of circumstances where social workers may undertake pre-birth assessments.

The pre-birth assessment will be completed using the 'Child and Family Assessment' format and be completed within 45 working days (9 working weeks).

2. Planning

Multi-agency planning commences as soon as possible after the pregnancy is confirmed to plan the assessment.

It needs to be established who will undertake the assessment. It is good practice for assessments to be co-worked. Other relevant agencies will contribute to the assessment. The assessment should take place as soon as possible to enable decisions to be made in good time.

The impact of parental difficulties should be informed by professional advice and understanding from relevant agencies such as addiction services, disability services and mental health services etc., who should be involved in the planning of the assessment.

Where English is not the first language, or there are literacy or communication issues this should be taken into account in the planning stage. The use of an interpreter or advocate should be considered. Workers need to be aware of any risks to their own safety during the assessment and these may need to be addressed in supervision.

3. Purpose and Aims of the Assessment

The purpose and aims of the assessment are to undertake a thorough assessment of individual and family functioning and home circumstances. It is to identify the previous and current concerns in a family and the family's perception of these.

A further aim is to identify the strengths and positives within the family. The assessment will assess the potential and ability to maintain changes; identify support networks and identify risk to the child post birth and other children in the family.

The outcome of the assessment will identify the course of action, for example child in need plan, child protection plan or legal action.

A referral should be made to the Family Group Conference service at the start of the assessment process. This is to identify the support network for the child post birth, and identify any alternative carers in the event that parent(s) cannot provide care.

Additionally, there should also be an early referral to the local children's centre.

4. Working Agreement

It is good practice to draw up a written agreement between the Children's Social Work Service and parents. The agreement should outline the reason for the assessment, its purpose and aims, how the assessment will be carried out. This should be agreed at the multi-agency planning meeting at the start of the assessment:

- Areas to be covered in the assessment

- Dates, times, venues of sessions and who will attend each session
- How the assessment will be shared and with whom
- Expectations of those participating in the assessment
- What parents can expect of the Assessor(s)

Parents should be seen alone and as a couple. Extended family members may need to be contacted. Assessment sessions will normally take place at the family home and local area office. One of the sessions in the family home should assess the home environment and preparations made for the baby's arrival.

It should be clearly stated that part of the process will be to liaise with other agencies.

5. Area to be covered

Assessment should follow the guidelines set out for completion of a child and family assessment.

In addition the following areas should also be addressed:

- Individual history of parents, including any offending history;
- Assessment of strengths / safeguards
- Assessment of risks
- Parental understanding of concerns
- Practical arrangements for baby's care
- Capacity for and motivation to change

6. Practicalities in Undertaking the Assessment

The task of completing the work is a joint task and it is recommended co-workers alternate responsibility for leading and recording the sessions. Levels of experience and expertise need to be taken into account when planning who will lead a session.

The sessions should be recorded as fully as possible and typed as soon as possible following the session. Keep all rough notes for future reference as these may be required in Court.

Both co-workers need to meet with the supervisor jointly to discuss progress with the assessment and any developments or difficulties. It is important to review the progress of the assessment mid-way through.

The timescale is 45 days and needs to be adhered to.

7. Dealing with specific situations

Any difficulties which arise during the course of the assessment should be discussed as soon as possible with your manager. Any early indications of positive change should be clearly recorded, along with an analysis of the impact and meaning of this.

8. Going Forward

The assessment report should make a clear recommendation about identified risk to the expected baby, any protective factors and any service required, that would enable the parent(s) to provide care for the child.

The family plan from the family group conference should be provided to, and considered within that process. If a decision is taken to hold an Initial Child Protection Conference, the report (or the conclusion) may be submitted to the conference.

This conference should take place 6-8 weeks prior to the estimated due date of the child.

If a decision is taken not to hold a conference then the Team Manager should convene a meeting to discuss the outcome of the assessment and any future planning, based upon the family group conference plan where available.

Where the identified risk is deemed to be high and seeking legal advice is recommended, the case needs to be presented to the Head of Service Decision and Review Panel (HOSDAR) for consideration. A Local Authority solicitor will be allocated if HOSDAR agree that the Public Law Outline process is required or care proceedings should be initiated at birth.

It is the responsibility of the allocated workers to ensure the family, the hospital and all other professionals are fully aware of the plan for the child post birth, and it is clearly recorded on Frameworki should the birth happen outside office hours, with unambiguous language.

If removal at birth is planned the Team Manager should convene a planning meeting with appropriate hospital staff and police to plan management of the birth and subsequent removal.

Assessment of a perpetrator of child sexual abuse

This can be used where there has been a conviction or allegation.

With the partner/non-abusing parent the assessment focuses on:

- **Background** - this area needs to explore the person's own background, any events or experiences that in particular may increase their vulnerability.
- **Relationship history** - Explore the current relationship with the offender as well as all previous relationships. Consider for any emerging patterns.
- **Childcare history** - It is important to explore the person's parenting history. This might be different for each child if more than one child in the family. Consider attachment in relation to all the children.
- **Attitude towards the offence and child protection concerns** – explore the person's understanding of the offence and what their view of any associated risk may be. It is helpful to ascertain their views on child abuse and ability to recognise signs and indicators of abuse.
- **Emotional resilience** - does the partner have the emotional tools and strength to protect the child. The strain on the person cannot be ignored. Often they are expected to supervise all contact between children and the perpetrator and this can cause additional emotional stress on the family. Their ability to deal with and manage this is crucial as provides insight into their emotional resilience both now and in the future.

With the perpetrator/offender or alleged perpetrator the areas covered in the assessment need to include:

- **Context of the assessment** - explain the reason and purpose of the assessment clearly to all parties. An assessment agreement is helpful that clearly sets out the reason, purpose, areas to be covered and expectations.
- **Current circumstances** – explore the current circumstances including living arrangements, support networks, finances.
- **Relevant background information** - this needs to include any previous child protection concerns, criminal history, childhood experiences, and any other significant events.
- **Relationship and sexual history** - this is a vital part of the process and needs to include all relationships and patterns of behaviour.
- **Relationship(s) with his children, the abused child and the children's needs** – this is particularly helpful when looking at risk where the abused child is not the perpetrator's own child or when internet offences is a factor.
- **His/her account of the allegations/convictions/sexual abuse** - Allow the person to give his/her account in their own words with minimal interruption when they are talking about the abuse. Once they have done this it is important to explore events that led to

the offence and thought processes and what happened after. Is there denial, remorse, insight displayed by the offender?

- **His/her response to past supervision/treatment/counselling** - If the person has received treatment previously, consider why this has not worked in preventing further offending.
- **Joint interview** – this is often a very difficult meeting as involves the offender and the partner/non-abusing parent. It allows for an open discussion about the offence and observation of responses in the presence of partners. It also allows assessors to observe dynamics in the relationship and if there is any oppression or controlling behaviours.
- **Future wishes/ambitions and view of intervention/services** - this area needs to explore what the offender wants for the future and what they feel their support needs are.

Analysis and conclusion

It is important to analyse information gathered and responses of both parents when examining risk of child sexual abuse. The assessment needs to remain child focused.

The conclusion needs to highlight:

- The level of risk posed
- The partner/non-abusing parent's strengths and deficits
- Any other protective factors
- Any recommendations

Lucy Faithful Foundation

The above guidance has been adapted from the Lucy Faithful Foundation model which uses a two way approach focusing on the perpetrator/offender and risk, but also the partner/non-abusing parent.

Geraldine Smith

Geraldine Smith's 'Assessing the non-abusing parent's ability to protect' model also provides a framework for assessments. The Therapeutic Social Work Team delivers training in using this model.

Internet Offending

Internet offending is a new area for social work assessments and therefore it is vital to use research to inform any assessments. Research around internet offending is becoming more easily available and the Child Abuse Journal provides good insight into recent research.

Some literature can be dated and not easy to interpret into assessments however '*Child Sexual Abuse and the Internet: Tackling the New Frontier*' by Martin Calder provides a clear focus on the issues and guidance for assessments.

There are also many other publications which can be helpful and the Lucy Faithful Foundation have an extensive reading list.

In relation to internet offending/accessing child abuse images, in addition to the above guidance social work assessments need to:

- Establish if there is any risk of viewing offender becoming a contact offender. This is referred to as "crossover".
- Establish if the offender has used the internet for the purposes of grooming or gaining access to children.

[Lucy Faithful Foundation](#)

This document will be reviewed from September 2014

Review to include:

- Addition of section for Person Posing a Risk to a Child
- Addition of section for Looked after children – longer term
- Consideration of whether guidance is required for assessment when next step is support to be provided in Targeted or Universal services.
- Any required updates to disabled child section in light of introduction of Education Health and Care Plan in September 2014
- General review of content