Devon Children and Families Partnership

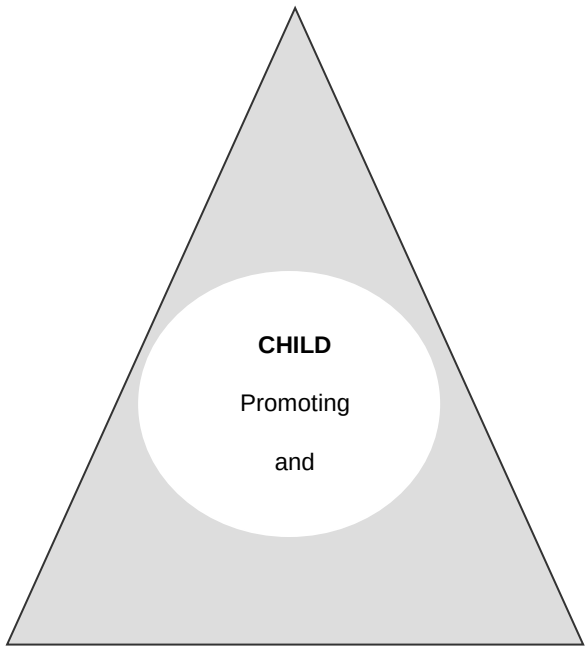
assessment, analysis & management of risk

dialogue

Learning Outcomes:

- The ability to break risk into component parts using known information and linking this to potential interventions
- Adopt a structured approach to risk assessment, informed by both professional judgement and standardised tools
- Analyse information, develop and test hypotheses, evidence conclusions with reference to theory, research, acquired knowledge and facts of the individual case
- Link risk assessment to the legal framework and threshold tool to help decide on necessary actions
- Roles, responsibilities and collaborative practice; dangerous dynamics between professionals and between professionals and families

The Assessment Triangle



Assessment Processes

'Fundamental to establishing the extent of a child's need is a child centred, sensitive and comprehensive assessment. Assessment should involve gathering a full understanding of what is happening to a child in the context of their family circumstances and the wider community, using a variety of sources of information. It must, therefore, be a joint or parallel assessment with all professionals concerned for the child's safety and welfare. Time needs to be spent making sense of this information involving the family where appropriate. Assessment processes should build up an increasingly clear understanding of a child's situation over time, building up a picture of continuous neglect or cumulative concerns about abuse where this exists. This should minimise the risk of repeated initial assessments not taking account of what has gone before'.(p28 The Protection of Children in England , Laming, 2009)

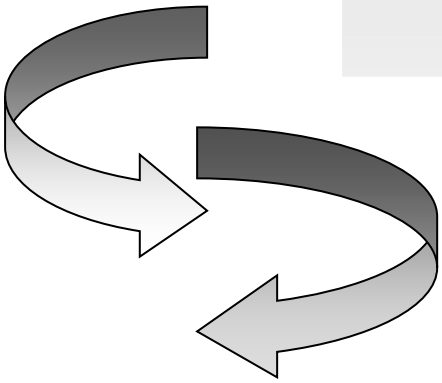
Chronology

Family **Professionals**

Genogram

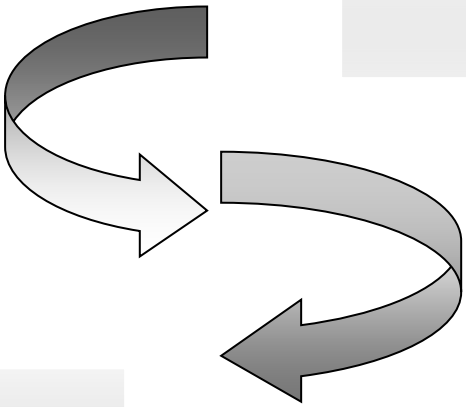
Life Events

History of professional involvement



Relationship with professionals

Interventions attempted



Responses to interventions

Other professionals involved

Common Errors in Reasoning in Child protection Work

Errors in reasoning in child protection work are not random but predicable on the basis of research on how people intuitively simplify the reasoning process in making complex judgements. Inquiries have produced similar criticism of services to children and families and many have concluded that the death of the child was avoidable and preventable, yet there is no systematic process of determining whether professionals are learning from mistakes.

What is the reasoning process?

Two forms of human reasoning have been commonly identified:

1. Analytic reasoning is characterised by a step by step, conscious, logically, defensible process

2. Intuitive reasoning is more of a cognitive process that produces the answer, solution or idea without the use of a conscious, logical, defensible process.

Reasoning and emotions

Social workers and other professionals are trying to understand and help other human beings. This means that skills in forming relationships are fundamental to obtaining the information that helps them understand what problems a family has, engaging the child and family and working with them to promote change. It should always be of paramount importance for social workers and other professionals to seek and be informed by the views and opinions of children. What does the child think needs to change to address their problem? How should the social worker go about making the change happen?

Rational/technical and managerialist approaches have emphasised cognitive elements of the task of working with children and families, on collecting information, and making plans. The focus of reforms has been on providing detailed assessment forms, telling the social worker and other professionals what data about families to collect and, how quickly to collect it. Less attention has been given to helping frontline staff acquire the skills to analyse the information collected.

The explicit, cognitive aspects of the work are important but provide an incomplete account. Knowing what data to collect is useful, but it is equally useful to know how to collect it; how to get through the front door and create a relationship where the parent is willing to tell the social worker and others anything about the child and family; how to ask challenging questions about very sensitive matters; and having the expertise to sense that the child or parent is being evasive. Above all, it is important to be able to work directly with children and young people to understand their experiences, worries, hopes and dreams.

Focusing on the centrality of relationship skills draws attention to the roles of intuitive understanding and emotional responses. Conscious logical thinking has quite rightly been highly valued as a human attribute, but the traditional view that it is inherently superior to intuition and emotion has been

overturned by developments in neuropsychology. Hammond (1996) argues convincingly for the need to see logical and intuitive thinking on a cognitive continuum where we use a different balance between them depending on what task we are carrying out. Solving a maths problem is at the analytic extreme while calming a frightened child uses intuitive understanding. The importance of our intuitive reasoning capacity is also illustrated by the difference in size between our conscious and unconscious capacities:

'It is estimated that our sense organs collect between 200,000 and 1 million bits of information for every bit of information that enters our awareness. Conscious perception represents only the smallest fraction of what we absorb from our worldly encounters. It is the tip of an iceberg'.(Thiele 2006)

Research in neuropsychology shows that our intuitive and emotional responses occur automatically and outside conscious awareness; we cannot choose to be only logical, thinking machines46. When a worker visits a home and the father behaves in a threatening manner, his or her body reacts automatically, generating stress hormones in response to the perceived threat. Similarly, when an experienced worker meets a family, he or she can quickly pick up an intuitive awareness of the state of the dynamics in the family, the warmth of the relationship between members, or the level of fear felt by a child. Appreciating the importance of both logical and intuitive understanding and the contribution of emotions offers guidance on the different training needs in using them to best effect.

Intuition is sometimes presented as a mysterious or mystical process, but its physical location and the features of the process are understood. It is only mysterious in the sense that it is generally an unconscious process that occurs automatically in response to perceptions, integrating a wide range of data to produce a judgment in a relatively effortless way. It is very rapid and relatively independent of language, oriented towards identifying patterns. It need not remain unconscious but can be articulated and this ability can be improved with practice. Supervision of casework typically involves helping practitioners draw out their reasoning so that it can be reviewed.

Biases of Intuition

1. **Distortion**. The emotional dimension can lead to distortions in workers' reasoning because of the unconscious influence it has on where attention is focused and how information is interpreted. For example, worker can feel such compassion for the neediness of a mother that he or she fails to see her child's suffering. Workers should always consider matters from the perspective of the child and ask themselves, 'What are the child's needs?'.

2. **Personal cost and impact**. The second harmful repercussion is on its impact on the workers themselves. Being exposed to the powerful and often negative emotions found in child protection work comes at a personal cost. If the work environment does not help support workers and debrief them after particularly traumatic experiences, then it increases the risk of burnout - emotional exhaustion, depersonalisation (or cynicism), and reduced personal accomplishment.

3. **Certitude and clinging to beliefs.** Intuitive reasoning can generates feelings of certitude and this characteristic makes it very attractive for the individual who is operating in a world of uncertainty. The downside of this is that the practitioner who has a 'gut feeling' about a case has a sense of confidence in

that judgment that can make the person cling to beliefs and resistant to change or challenge. Once we have formed a picture of a person or family, we have a strong tendency to keep to it, noticing any new information that supports it but tending to overlook or devalue any that challenges it. It is a major contributor to tragedies in child protection work: professionals, for example, form the view that the mother is co-operating well with them and fail to notice evidence that the children are suffering harm.

4**. A biased range of evidence**

Intuitive reasoning takes short cuts by being selective about the evidence it uses. Experience has taught us that certain types of evidence are fairly reliable markers so we do not need to look at the whole range.

Intuition pays most attention to evidence that is vivid, concrete, emotion-laden, and recent (although first impressions have an enduring impact). It tends to overlook evidence that is dull, abstract, emotion-free, and in the past. In social work, this bias is apparent, for example, in the tendency to focus on the present problem without looking at the history of the people involved and seeing whether there are perceptible patterns in how they behave. It is also demonstrated in the greater attention paid to the emotive contribution of a health visitor in a meeting than to the dry statistics on risk factors in a textbook.

5. Fundamental Attribution error.

When we are explaining other people's behaviour, we tend to ascribe it to internal personality traits. In contrast, when explaining our own behaviour, we tend to ascribe it to the context. You get angry because you are an aggressive personality; I get angry as a reasonable response to the provoking circumstances.

This bias is linked to the biased use of evidence. When we are observing someone else's behaviour, their person and their actions are the most vivid and concrete details. When explaining our own behaviour, we are more aware of what is going on around us, the context to which we are reacting.

In social work, this bias is apparent in the tendency to over-generalise about someone on the basis of very limited and specific observations. For example, a boy may be described as aggressive when all that the social worker has observed is that he was aggressive when in class with Teacher A. If we were to take this as a single sample of his behaviour and ask for more we might find that he gets on well with Teachers B and C, and with his friends in the playground. This then leads to explanations that focus on the *interaction* when he is aggressive rather than attributing it entirely to factors internal to the boy.

6. Hindsight error

Once we know what happened, we over-estimate how obvious it was (or should have been) to people beforehand. Social workers are most aware of this bias as the victims of it. When a child dies from abuse, the public hear the story of the social work involvement with the benefit of hindsight and become angry that the social workers at the time did not have the intelligence to see what is now so glaringly obvious.

Social workers can show the same bias with service users, blaming parents after an accident, for example, for not foreseeing a source of danger to their children, and overlooking the fact that the *likelihood* of it being a source of danger was minute.

Facilitating good reasoning – a shared responsibility

It is essential to recognise that we cannot avoid the biases of our intuitive reasoning: conscious awareness of them does not wipe them out of the brain. All we can hope to do is to recognise the vulnerability in ourselves and others and consciously try to spot biases and reduce them. Our reasoning is also fallible because we are working in conditions of uncertainty. We have limited knowledge of what is going on in service users' experience and limited capacity to predict what will happen, with or without our intervention. Our analytic skills can, however, strengthen our intuitions. Thiele (2006) offers the metaphor of seeing our analytic capacity as a personal trainer, taking the products of our intuition and subjecting them to critical scrutiny so that we can reach a higher standard of accuracy. This requires us to have what Lord Laming (2003) described as 'respectful uncertainty' towards our judgments.

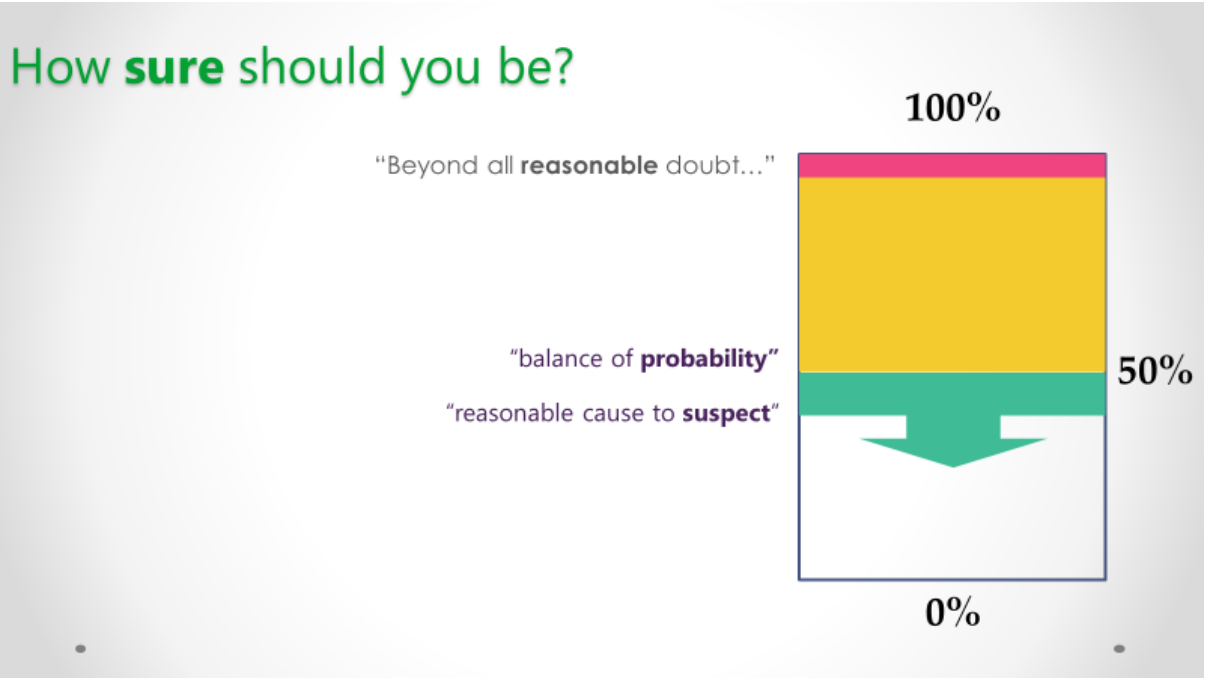
One obstacle to doing this, as research has shown, is that it is hard for people to be objective about themselves and police their own thinking. If they try to examine their judgements, their intuition will automatically produce all the evidence that backs them up and overlook counterevidence. Most of the strategies for improving reasoning involve trying to consider alternative perspectives or explanations and this is best achieved with help from others. A 'devil's advocate' who deliberately takes an opposing view is a valuable way of helping workers critique their own reasoning.

Supervision

Supervision that includes a critical appraisal of the assessment and planning for a child and family, therefore, should be seen as central to good practice in reducing error. It is essential that this is prioritised and contains reflective and analytic components in addition to planning

Additional References

Thiele L. (2006), The Heart of Judgment: Practical Wisdom, Neuroscience, and Narrative, p 121
K Hammond Human judgement and social policy
Oxford: Oxford University Press, 1996



Working Together specifically adopts the legislative terminology of 'significant harm' in preference to the use of the word "risk" - to avoid confusion given the different contexts and methodologies associated with "risk"

When assessing whether a child is suffering, or likely to suffer, significant harm local authority children's social care will of course draw on a wide variety of information including the outcomes of relevant risk assessments or judgments provided by other agencies and professionals to inform their own evidence based assessment.

Risk assessment

		Impact			
		Low	Concern	Harmful	Significant harm
Likelihood	Very unlikely	LEVEL 1			
	Possible		LEVEL 2		
	Suspected			LEVEL 3	
	Likely				LEVEL 4
	Almost certain				

Impact

- Low – LEVEL 1 - No injury or cause for concern
- Concern – LEVEL 2 - A young person isn't doing as well as they should, although there is no evidence of harm.
- Harmful LEVEL 3 - Harm means ill-treatment or the impairment of health or development, including for example, impairment suffered from seeing or hearing the ill-treatment of another.
- Significant harm LEVEL 4 - Neglect, physical abuse, sexual abuse or emotional abuse including for example, impairment suffered from seeing or hearing the ill-treatment of another.

Likelihood

- Very unlikely - An event that could happen, but is almost certain not to happen
- Possible - An event that could happen
- Suspected - There is an indication that something has happened or may happen
- Likely - Something you believe is more likely to happen than not
- Almost certain - Something that will happen unless action is taken

Action

- Level 1 – universal services
- Level 2 – Single agency focused support
- Level 3 – Multi-agency work – early help – keep watching for child protection risk
- Level 4 – Child Protection - referral

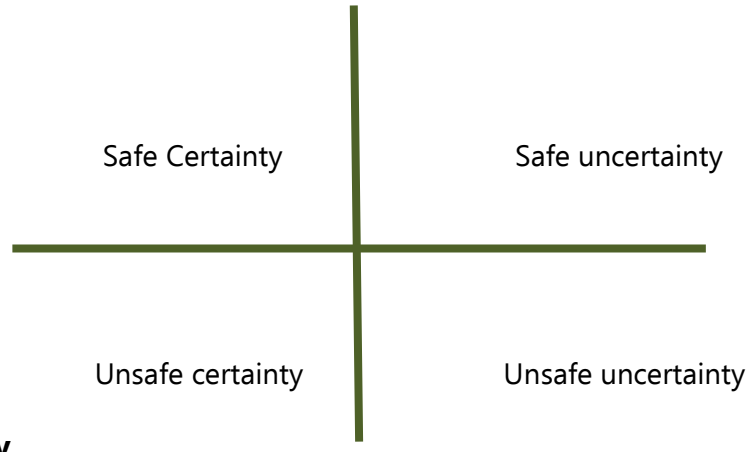
Dilemmas in practice - how do we position ourselves with issues of certainty and uncertainty ?

Child protection and safeguarding children and young people has become dominated by practice that is procedurally driven and where management responses may not take account of the complexity of human behaviour. This approach reduces service users to straightforward and the complexity around uncertainly is not acknowledged

Practice decisions cling on to certainty and eliminate risk through the application of proceduralised responses and the setting of tasks to complete. Enabling practitioners to develop the capacity to engage with risk and acknowledging uncertainty is important. The aim is for practitioners to become thoughtful, flexible and critical and allows for the ability to change our mind

The quicker we are to reach a view, the less opportunity there is for dialogue and therefore the risk of misunderstanding the information is greater. The less curious we are the danger is that we may understand too quickly and we are more likely to find ourselves in 'premature certainty'

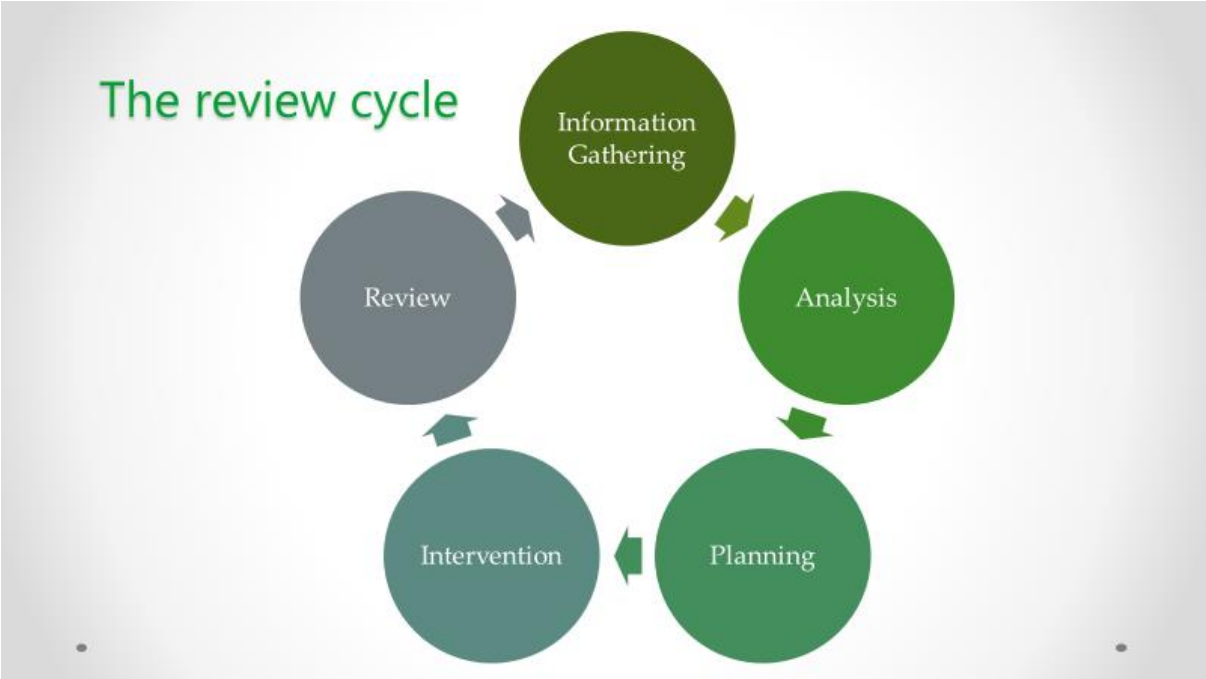
Should we be embracing uncertainty?



Safe uncertainty

- The position is not fixed
- It allows for new explanations and is consistent with the notion of a respectful, collaborative and evolving narrative
- It allows a framework to emerge that takes on different possibilities rather than seeking information to fit a premature view
- It allows for change to occur
- It allows for different views to be acknowledged and discussed and for professionals and families to challenge
- Is seeks explanations for the difficulties as oppose to dealing with uncertainty by doing a 'task' that seeks compliance and therefore superficial certainty

Risk Analysis Questions



What is the harm?
What exactly am I worried about? What behaviours am I concerned about? What is the lived experience for the child and what does it feel like for the child living in this harmful environment?

Who is causing the harm / who is responsible? What is the severity of harm?
If the answer is I don't know , how am I going to find out?

What is causing the harm?
Either individual parent / carer circumstances or family circumstances

Are there any family/ individual beliefs that support the harm?
Are there any family / individual beliefs that are helping the harm to be reduced?
Are their 'exceptions' to the harm the child is suffering and identify what the adults are doing to provide any safety for the child? Is safety provided by any other protective factors?

What is going well and what does the child/ YP themselves bring in terms of resilience factors including talents, personality, self esteem, positive identity etc.
What is the impact of the harm for the child? What are the likely outcomes of this for the child if the harm continues? What does the child want to happen? - *Short term and long term*
What is my view about the harm continuing?

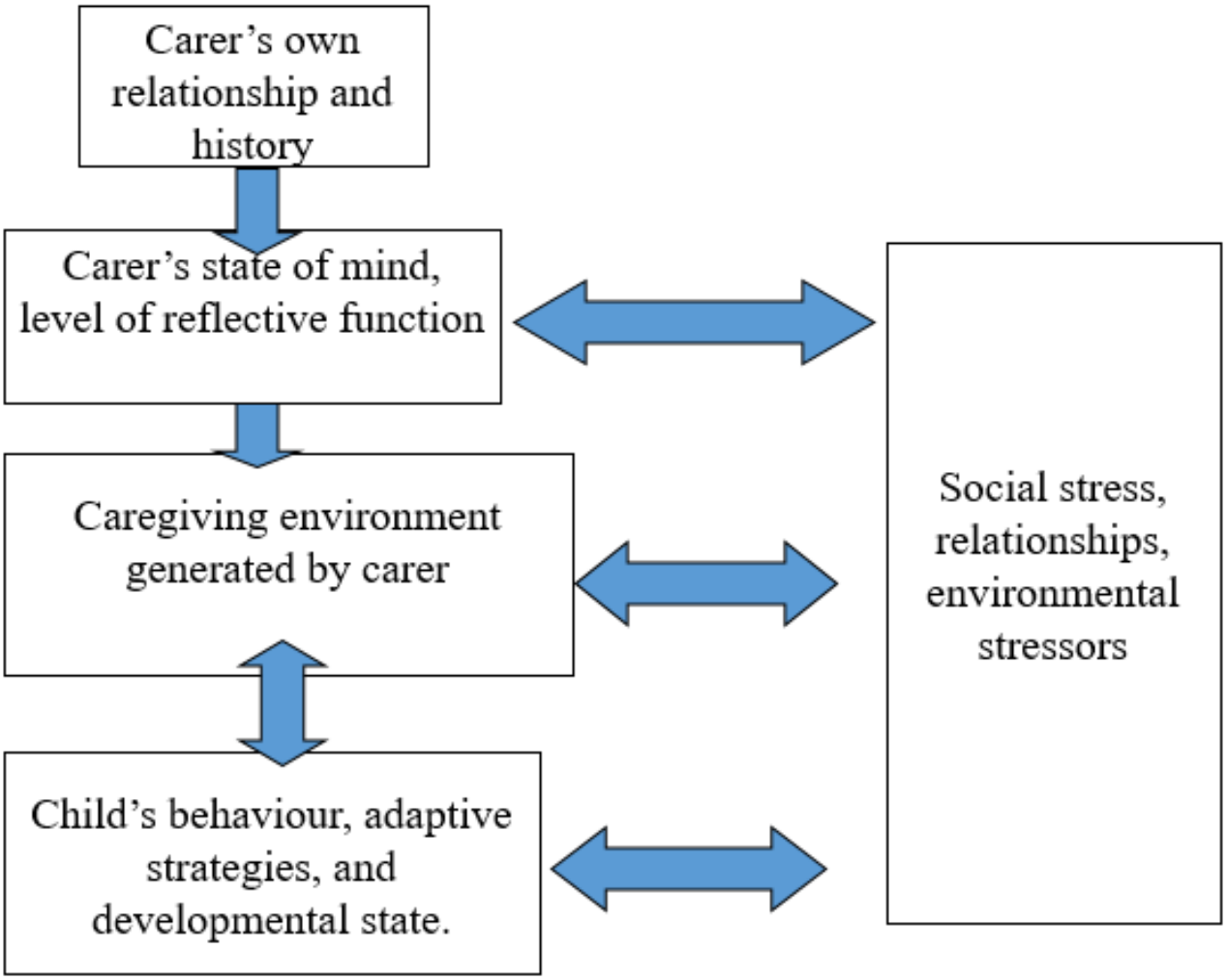
In what circumstances does the harm occur and do those factors need to be present for the harm to occur? What factors seem to increase likelihood of the harm reoccurring and what seem to reduce the likelihood? What is the parents/ carers view about this?

Exactly what are we seeking to change in order to make this situation safer for the child? What is the view of the parents/ carers about this?
What is the plan for addressing this?

With thanks to Vic Tuck, Jane Wiffin and Janet Lee

An Ecological Transactional Perspective

(*Brandon et al 2002. 2008; Cicchetti and Valentino 2006)



The assessment needs to give an understanding of the parent -child interaction, the children's psychosocial development and the child's care and protection. This is informed by the carer's state of mind and the ability to keep the child in mind. Caregivers state of mind is informed by the parents relationship history, their own experiences of being parented and the current pattern of interactions with the children, partners, peers and professionals.

Source: Analysing child death and serious injury through abuse and neglect: what can we learn? Brandon et al (2008)

Some Risk Assessment questions where domestic violence is known/suspected

Pregnancy & the unborn child

• Has the woman been assaulted in the past year?
• Is the woman being prevented from accessing maternity services?
• How many pregnancies/terminations of pregnancy (TOP) have there been?
• Has the woman suffered miscarriages in past pregnancies?
• Is the current pregnancy from a new relationship?
• Is the woman in premature labour?
• Has she had premature/pre-term deliveries in the past?
• Is the pregnancy the outcome of a sexual assault?
• Is the abuse becoming more frequent, intense or severe?
• Is the woman planning to leave the abusive partner?
• How much does the woman feel at risk?
• Is there any additional factor such as mental health problems, substance misuse, and disabilities?

Children

• Are children being harmed either directly or indirectly?
• Have there been threats to harm/kill the children?
• Have weapons been used? If yes, what weapons?
• Can the child access help?
• Does the child have any unexplained injuries?
• Are children witnessing the abuse of another?
• If "yes" to witnessing:
  - What is the child doing when the abuse is taking place?
  - Are other siblings present?
  - Are the children being used as shields?
  - Are the children intervening to try and stop the assaults?
  - Are children involved in perpetrating assault?
• Have the children been prevented from leaving the house when an assault has taken place?
• Are the children being used as carers to younger children or the abused parent?
• What is the impact on the child's access to the learning environment?
• Has the child got a support network from other family/friends?
• Are young children accessing the surveillance checks offered by the primary health care team?
• What is the impact on the child's psychological/mental development? eg substance misuse, eating disorders, self-harming, running away, teenage pregnancy?

Parental Contact with Abusive Parents

• Where children have been separated from the abusive parent, what are the contact arrangements?
• Are the contact arrangements safe?
• Are the contact arrangements formal, ie arranged by the Family Court?
• Have there been threats to remove the children from the area/country?
• Is contact being used to pressure/gain access to the mother?
• Is conflict or violence (including threats or emotional abuse) used handover?
• Are there any injunctions in place?

Some Risk Assessment questions with parental substance misuse

Parents' Drug and/or Alcohol Use

1. Are the parents aware of the worker's responsibility for the protection of children? The needs of the child are paramount and the resulting limits to confidentiality.
2. Is there a drug-free parent or supportive partner or relative?
3. Is the drug or alcohol use by the parent
   - experimental?
   - Recreational?
   - Chaotic?
   - Dependent?

4. Does the user move between categories at different times? Does the drug use also involve alcohol?
5. Are the levels of childcare different when a parent is using drugs and when not using?

Accommodation and Home Environment

6. Is the accommodation adequate for children?
7. Are parents ensuring that rent and bills are paid?
8. Does the family remain in one area or move frequently, if the latter, why?
9. Are there other drug users or alcohol misusers sharing the accommodation? If there are, are the relationships with them harmonious, or is there conflict?
10. Is the family living in a drug using community?
11. If the parents are using drugs do children witness the taking of drugs?
12. Could other aspects of the use constitute a risk to children (eg conflict with or between dealers, exposure to criminal activities related to drug use, violence)?
13. Is there evidence of domestic violence?

Provision of Basic Needs

14. Is there adequate food, clothing and warmth for the children?
15. Are the children attending school regularly?
16. Are the children engaged in age-appropriate activities?
17. Is there any evidence that the child(ren) are misusing drugs or implicated in parental drug misuse?
18. Are the children's emotional needs being adequately met?
19. Are there any indications that any of the children are taking on a parenting role within the family (eg caring for other children, excessive household responsibilities etc)?

Procurement of Drugs

20. Are the children left alone while their parents are procuring drugs?
21. Because of the parent's drug use, are the children being taken to places where they could be "at risk"?
22. How much are the drugs costing?
23. How is the money obtained?
24. Is this causing financial problems?
25. Are the premises being used to sell drugs?

Storage of Drugs and Disposal of Containers, Syringes and Needles

26. If drugs (legal or illegal) are being used in the home, are they stored safely, out of the reach of children?
27. Have the drug users been advised about the safe storage of drugs and the risk to children of consumption of methadone etc?
28. Are parents in touch with local specialist drug treatment programmes and how regular is their contact?
29. Are the containers and implements used for administering the drugs safely disposed of after use, to ensure there is no risk to any children?

Family Social Network and Support Systems

30. Do parents and children associate primarily with:
    - Non-users?
    - Both?
    - Other drug users?
31. Are the relatives aware of drug use? Are the relatives supported?
32. Will parents accept help from relatives and other non-statutory or professional agencies?

Parents' Perception of the Situation

33. Do parents see their drug use as harmful to themselves or to their children?
34. Do the parents place their own needs before the needs of the children?
35. Are the parents aware of the legislative and procedural context applying to their circumstances (eg child protection procedures)?

Some Risk Assessment questions where alcohol is being used

1. Pattern of Alcohol Use

Who is using alcohol? One or both of the parents/carers?
What category of use is being demonstrated?
• Every day drinking – how long for? How much? Which drink?
• Binge drinking – how long for?
• When was the last drink?
• Is there use of other substances or medications?
• How long has this been the pattern of use?
• Do you know what situations trigger inappropriate use of alcohol?

2. The Context of Alcohol Use

The Child's View

• What does the child know or understand about the parental use of alcohol?
• Does the child require information about alcohol and parental misuse?
• Does the child need support to understand the consequences? This could be supported by social workers, by psychotherapists or by group work.
• Is the child reporting domestic violence in this family?
• What is being done about this?

Parental Views about their Alcohol use

• Do they acknowledge their use?
• Do they see it as harmful to themselves or their child(ren)?
• Have any attempts been made to address the alcohol use? What helped/didn't help?
• Is the parent able to say what they drink?

3. Consequence of Alcohol Use

a) For child(ren)

• Are they meeting growth and developmental milestones?
• Do the child(ren) drink alcohol? With/without the parents' knowledge?
• Are they attending school regularly?
• Are there other school-related issues – ie changes in behaviour or achievement, absenteeism, bullying, racism?
• Are they engaged in age-appropriate activities?
• Are the child(ren)s emotional needs being adequately met?
• What is the relationship like between the parent(s) carer(s) and the child(ren)? Are there any power issues?
• Are the child(ren) assuming parenting responsibility [make reference to pattern of alcohol use and age of the child(ren)], either for parent(s) or siblings? If so, how often and how old is the child? Are the child(ren) left alone? How frequently, are they

left with alternative carers? Who are these carers and how often does this occur? Are alternative arrangements suitable, safe and appropriate?

b) Parent/carer

• Are there related health problems for parents who are drinking?
• Are these specific to the individual? Do they affect parenting responsibilities as well?
• Are they seeking medical advice? Seeing to own needs adequately?
• Is there a consistency of care provided for the children?
• Are there indications they are attempting to withdraw without medical assistance?

4. Social Network/Support Network

• Are relatives/friends aware of use and extent?
• Do parents and child(ren) have association with other alcohol users? Frequency? Where?
• Are parents/carers accepting help from relatives, statutory/non-statutory services?
• Do children have their own network – ie friends, activities outside school?

Accommodation and Home Environment

• Do the parents/carers ensure that rent and bills are paid?
• Does the family network subsidise the household budget in any way?
• Does the family remain in one locality or move frequently, if so, why?
• Do other alcohol users meet frequently in the home or share the accommodation? Are the children supervised adequately in these circumstances?
• Is the home secure? ie tenancy/repossession?
• Are the basic necessities provided – adequate food, clothing and warmth for the children?
• Where is the alcohol stored? Is this safe from the children?
• Is there evidence of domestic violence?

5. Conclusions

• What is your professional view of the problem?
• If the situation is unsatisfactory, what should change to reduce the risk of significant harm to the child(ren)?
• What options/services are available to help?
• How can the family strengths be encouraged and supported?
• Where does the evidence come from for your conclusions, is it reliable?
• Conclusions made should take into account language and cultural considerations.
• When should you review your concerns with other professionals?
• Who else has concerns about this family?

• What other agencies are involved in the family, with which member and for what purpose? (Health, Education, Play and Day Care Services are very likely, and Police, Probation and Children's Services are possibly involved.)

Some Risk Assessment questions for parental mental health issues

Some factors associated with a greater likelihood of parents struggling to meet their children's needs and ensure their safety include:

• the impact of the illness on the adult (being a parent *and* having a mental illness), especially chronic severe illness with comorbid disorders, such as episodes of mental illness complicated by substance misuse or the presence of a personality disorder

• poor compliance with treatment, problematic relationships with professionals and diagnostic uncertainty

• parental personality factors (pre-existing and/or exacerbated by the illness, eg irritability, hostility, inability to cope, self-preoccupation, etc)

• a history of overdose and self-harm (prior to and especially since having children), especially when there has been more than one such action

• a parent's own experience of severe childhood trauma and adversity, including discontinuities in carers and experience of abuse and being 'looked after'.

• a history of violence (as perpetrator or a victim) with unstable, discordant parental relationships

• environmental stressors outweighing support and protective factors – for example, poor-quality support and social isolation in association with multiple adversities such as discrimination (on grounds of gender, ethnic minority status and mental illness), material deprivation and poverty

• parents with a learning disability

Practice guidelines (for psychiatrists)

Child care professionals should be consulted if there are any concerns about child safety and welfare and where there is evidence of:

• persistent negative views expressed about a child, including rejection

• ongoing emotional unavailability, unresponsiveness and neglect, including lack of praise and encouragement, lack of comfort and love and lack of age-appropriate stimulation

• an inability to recognise a child's needs and to maintain appropriate parent-child boundaries

• ongoing use of a child to meet a parent's own needs

• distorted, confusing or misleading communications with a child including involvement of the child in the parent's symptoms or abnormal thinking, including, for example delusions targeting the child, incorporation of the child into a parent's obsessional cleaning/contamination rituals, or keeping a child at home because of excessive parental anxiety or agoraphobia

• ongoing hostility, irritability and criticism of the child

• inconsistent and/or inappropriate expectations of the child

Parental psychiatric diagnosis

Depression, substance dependence and personality disorders occurring together in various combinations and at various points in time are the most frequently reported psychiatric conditions affecting parents who abuse their children (Famularo *et al*, 1986; Zuravin, 1988; Falkov, 1997; Rydelius, 1997; Hogan, 1998; Murphy *et al*, 1991).

Parents with a diagnosis of dissocial personality disorder are more likely to exhibit hostile and irritable behaviour towards their children than parents with any other disorder. Given the long-standing difficulties in making and sustaining relationships, such parents can find it particularly difficult to relate to a child in an age-appropriate way. This may be because of difficulty in distinguishing their own needs from those of their child or a lack of understaning about differences in children's needs compared with those of adults (Bools *et al*, 1994; Feldman *et al*, 1995). Impulsivity may lead to ill-considered physical discipline (smacking/assault) rather than verbal negotiation. High rates of comorbid Axis I disorders add to parental needs, difficulties in engagement with services and poorer prognosis regarding mental health and capacity to meet children's needs.

Although psychotic illnesses are less common than depression or anxiety disorders and substance misuse, they afflict a substantial proportion of parents who kill their children (D'Orban, 1979; Falkov, 1996).

Practice guidelines

Children who adapt well to a parent's mental illness will typically exhibit at least some of the following:

• older age at the time of the onset of their parent's illness (because of reduced opportunities for exposure to difficulties and development of a greater range of potential coping resources)
• being more sociable and able to form positive relationships (having an easier temperament)
• greater intelligence
• a parent who has discrete episodes of mental illness with a good return of skills and abilities between episodes
• alternative support from adults with whom the child has a positive, trusting relationship
• success outside of the home (eg at school, in sport).

Adapted from: Patients as parents, Addressing the needs, including the safety of children whose parents have mental illness. Council Report June 2002, Royal College of Psychiatrists.

We recommend the development of similar questionnaires with regard to identifying the needs of parents, carers, or pregnant women with disabilities and their children.

Professional Dangerousness

Key examples of professional dangerousness

1. **Rule of optimism:** Professionals tend to want to believe that all is well for the child. Even when the indicators of abuse are visible there is a tendency to explain them away and be convinced that the child is safe. This is a form of denial and probably the most common form of dangerous practice. In one case the social worker saw the child looking sick but afterwards saw her with the family on an outing. He allowed himself to believe the latter to be proof of the child's safety and thought his original concerns to be unfounded.

2. **The Stockholm syndrome:** This theory is based on hostage situations where the people taken hostage begin to identify with the cause of the terrorists. It is a survival mechanism common in child abuse cases. Sometimes a parent or abuser is powerful and intimidating, perhaps critical of professionals and the worker will begin to see the adult's point of view rather than the child's. It is one way that the worker feels safe at the expense of the vulnerable child.

3. **Professional accommodation syndrome:** The worker may mirror the child's retraction of abuse, deny the reality of the abuse and be keen to be persuaded that any allegation by the child must be suppressed. Any other possible reason for the abuse will tend to become accepted in preference to considering the possibility that abuse has occurred.

4. **Exaggeration of hierarchy:** Adults of low status who report abuse may not be heard or taken seriously even though they may be close to the child eg neighbours, friends or a nursery worker. A psychiatrist, lawyer or paediatrician will probably get their important opinions heard more readily by other professionals. In one child abuse scandal the cook in the children's home had a wealth of information about the child abuse taking place but was not interviewed by the inquiry.

5. **Concrete solutions:** Professionals respond swiftly to abuse situations with practical solutions such as housing, washing machines, or money rather than by investigating and attempting to verify the alleged abuse.

6. **Assessment paralysis:** Sometimes professionals feel helpless and incapacitated. It might be thought that change is hard to achieve because the family have always lived in an abusive way and it is just their way of life. Chronic neglect and inter-generational sexual abuse are often ignored because of this attitude.

7. **Stereotyping**: Professionals may make assumptions about how families bring up their children. These may include cultural stereotypes. In one case the stereotype of the black grandmother being able to cope with every situation falsely portrayed her as a protector of the child against a powerful and abusive adult within the family.

8. **False compliance:** Parents may be able to convince professionals that they are cooperating to protect the child but in fact a skilled practitioner who can analyse parental behaviour will be open to considering the possibility of them being abusive.

9. **Omnipotence:** Professionals believe that they know the best interest of the child and will not revisit their perceptions in the light of new evidence.

10. **Closure:** Families may shut out professionals. Calls go unanswered, appointments are missed, curtains are closed and doors locked. Child deaths from abuse are often preceded by closure. This dynamic may be mirrored by professionals avoiding contact with the family.

11. **Role Confusion:** Professionals may be unclear about tasks and assume that someone else is responsible for protecting the child. In child protection everyone has prime responsibility for the safety of the child. Clarity of decisions is essential. In one case a health visitor said she would see the baby and the social worker assumed that the health visitor was visiting the home. Instead, she was seeing the baby at the clinic and no-one saw the appalling conditions in the home.

12. **Children unheard of parent and carers unheard:** Every child abuse inquiry highlights the central importance of listening to the child. Although children do find it hard to speak of abuse it has been shown that prior to a child's tragic death they have often forewarned someone in authority about the risk. Similarly prior to fatally harming a child, carers often raise the alarm by telling a professional that they are afraid of hurting the child or they cannot cope.

13. **Information which is emotional, recent and vivid takes precedence over the old:** Inquiries inevitably demonstrate that there was, among agencies, a great deal of knowledge and understanding about actual or potential harm to the child. New information must be examined in the context of prior facts. The importance of chronologies to allow analysis cannot be over emphasised. This information must be transferred as a family moves between authorities. This is sometimes referred to as the Start Again Syndrome which prevents practitioners

from having a clear understanding of a case based on past information (Brandon *et al*, 2008:11)

14. **Non-compliance with statutory procedures:** Inquiries commonly report that legislation, policy and practice are sound but that professionals did not comply with their implementation. When child protection procedures are in place such as conferences and strategy meetings, children generally become safe. Formal procedures allow for collation and analysis of all available information.

Additional messages about professional dangerousness from Serious Case Reviews.*

15. **Overwhelmed professionals and organisational capacity:** The 'health' of agencies and their capacity to deal efficiently and effectively with the volume and demands of safeguarding children work. Includes strain in front line workers ; lack of fully staffed fully supported workforce; frequent and confusing changes in practitioners and managers; high sickness levels; no continuity of service; delay; overwhelmed workers may not grasp complexity and make good professional judgements.

(interacts with 1) hostile families to produce low expectations and low energy and 2) chaotic, overwhelmed, unsupported families 3) false compliance

16. Professional confidence and uncertainty: leads to struggle to challenge decisions and behaviour of their multi agency colleagues when they feel the child is at risk;

(interacts with Exaggeration of hierarchy; non-compliance with statutory procedures; role confusion (assumption others dealing) and efforts not to be judgemental)

17. Efforts not be judgemental becoming failure to exercise professional judgement : keenness to acknowledge successes of disadvantaged adults using their services – deficits missed.

(interacts with to professional confidence; hostile families)

18. Silo Practice: failure of professionals to look at the child's needs outside their specific brief

(interacts with to lack professional confidence, efforts not to be judgemental; overwhelmedness)

19. Fixed views: view or mindset is formed and becomes fixed/rigid. Examples:

'Neglect case mindset' ;'Rough handling' Men as 'good dads' or 'bad dads' – rather than fully assess their history/profile/parenting.

(interacts with omnipotence, silo practice, not being judgemental, overwhelmed professionals)

20. Inconsistent and inadequate supervision: complex stressful work requires regular, knowledgeable supportive, reflective, analytical supervision where planning also takes place. (interacts with overwhelmed professionals, silo practice and fixed views

(interacts with false compliance, overwhelmed professionals ,levels of cooperation, rule of optimism,non compliance with procedures, role confusion, children unheard)

21. Lack of authoritativeness : Parents/carers needing to be challenged and confronted about poor parenting, targets set and timescales with a tight interagency grip on and ownership of the intervention/ plans.
(interacts with false compliance, efforts not to be judgemental; supervision, fixed views)

22 Threshold of intervention: A pattern from SCRs - 53% receiving Children's Services intervention, 12-18% CP Plan, therefore 47% with additional needs or universal services. Laming said "child protection does not come labelled as such". Need to be aware of risks across all levels of need. Also questions of how to get sufficiently qualified staff at all levels of intervention .
(Interacts with overwhelmed professionals and organisational capacity, fixed views, disguised compliance, levels of cooperation)

23. Co-morbidity of parental substance misuse, parental mental ill health, domestic violence and poor living conditions: While the presence of these factors does not predict abuse, they do increase the risks of harm to the child and often present a hazardous, and frightening home life for the child and a toxic caregiving environment. Risk assessment needs to get to grips with this with good questionnaires and inter-agency working)
(Interacts with false compliance, overwhelmed professionals, fixed views, silo thinking, efforts not to be judgemental, lack of authoritativeness)

24. Overwhelmed chaotic families: 'negative' family support, drugs, violence, mental ill-health, criminality, numerous moves; fires and other accidents.
(interacts with overwhelmed professionals and organisational capacity)

25. Levels of Cooperation: - cooperation and high cooperation, it is not a spectrum. Some family members may cooperate, others not and it can change quickly. Some families cooperate with some agencies, not others. As well as being separate dynamics, families can and do mix passiveness and aggression as a resistance pattern. Remember professionals can provoke cooperation/hostility as well as diffuse it by positive engagement skills. While with good cooperation there is a chance that the child may be seen but harm go unnoticed, there is a danger that with hostile families, services might be withdrawn, children become more isolated/unprotected, families move/go missing.
(interacts with overwhelmed professionals, co-morbidity, lack of authoritativeness, disguised compliance)

26 Care and control conflicts: Parents' own childhood experiences of adverse parenting leave them with unresolved conflicts that spill over into relationships in adult life with partners, children and society. Conflicts about: being cared for/ caring for others and /or self control, wish to control others, or fear of control by others
(interacts with Co-morbidity (25 above), levels of cooperation, children unheard,)

*Sources:1. Understanding Serious Case Reviews and their Impact A Biennial Analysis of Serious Case Reviews 2005-7. UEA/DSCF. Marian Brandon et al 2000. 2.Serious Case Review : Baby Peter. Executive Summary February 2009 LSCB Haringey.

Risk Management

The following questions are good for reflecting and challenging yourself on your understanding of a case. They are also excellent for supervision

The child

Have the child's developmental needs been assessed and concerns/unmet needs identified and recorded? Is the child suffering or likely to suffer harm? Are their concerns or any factors in the child's life which may increase the likelihood of significant harm continuing?

Identify protective factors /strengths – they are likely to counteract concerns. Identify protective factors / strengths for the child - they are likely to counteract concerns. Think here about the 'exceptions' to the harm the child is suffering and identify what the adults are doing to provide any safety for the child?

Has the child been seen and spoken to? How did the child seem and what was the evidence for this? What was observed about the child's relationship with parents/ carers and with siblings? What opportunities have there been for the child to express their view?

What other information is available from others known to the child and what is their relationship to the child? Siblings can be a source of expertise. Is the information consistent or are there differences of views?

What does the child know about social care involvement? What do they want to happen?

The family

Has parenting capacity been assessed within the family and environmental context? Have concerns/unmet needs and strengths been identified? What is the current view of the parenting capacity in relation to the child? What is known about the parent/ carers relationship with the child?

What is known about the parental/ carers history? The carers state of mind is informed by their relationship history and current pattern of interactions with the child. The meaning the parents/ carers give to their own needs and others is critical in risk assessment. What is their ability to hold the child in mind and what explains this if they are not able?

What are the sources of information that have contributed to this view, and are these views consistent or are differences apparent?

Cultural review – what is known about families with this culture and life experience? What are the expectation of these children, in relation to their needs, their care and their lives? What might surprise me about this family and what prejudices (positive or negative) do I hold? What impact might the assessment have on this family's life and on their perception of how they can be helped by professionals?

Are there particular factors to be considered such as race, culture, language, religion, disability or gender and how are these being incorporated into the assessment? Are the family's values, beliefs and traditions understood?

Do the family understand the purpose of their contact with social services and other agencies? What is their understanding of what is happening and why?

Is there parental co-operation? (remembering that professional interventions do not always make sense to families and therefore they may not engage with services but may still be willing to work). Also, non compliant parents can be protective and compliant parents can be non protective. Has the worker got to the complexity of the professional and family relationship?

Risk assessment

What exactly is the harm the child is experiencing and what exactly are we trying to prevent from occurring? What is the cause of the harm? Exactly what are we seeking to change in order to make this situation safer for the child? It will be necessary to explore the values, attitudes and feelings of the parent or carer which underpin the problematic behaviour. Professional may give parents tasks or things to do, without being clear about exactly what needs to change and what outcome is needed for the child.

Identify factors in the child's life which are likely to increase the likelihood of significant harm continuing - (need to take account of the interaction of different factors and the cumulative impact for the child) – here the risk factors are being identified

What is the interplay between the protective factors and the risk factors? Which outweighs the other? What level of weight is given to each and how did you decide that?

Assess the probability of future harm by considering:

- How often has this harm occurred to the child before?
- Over what period of time has it occurred?
- What are the circumstances in which the harm occurs?
- Consider the 'usual' internal and external factors. Eg. Internal are what the adult and child brings to the situation thoughts, emotional state of adult, arousals, triggers etc.
  External are the situation, environmental factors, poverty, actions of others, support etc.
- If the harm has occurred before, is it possible to identify what the situations had in common? What factors were present? Do they need to be present for the harm to occur?
- What reinforces the harmful behaviour? Which factors seem to increase the probability of the harm occurring? What factors seem to decrease the likelihood of harm?

- Parental co-operation – remembering that professional interventions do not always make sense to all families and therefore they may not engage with services but they may still be willing to work

The worker *(this is about **you**, or could be about the person you are supervising)*
Has the supervisee understood the purpose of involvement and their role and responsibilities in the case, including their legal mandate?

Is the worker able to engage with the family and can they communicate with them? Is the worker clear about the outcome that is needed from the piece of work? How have they been able to explain that to the family?

Are there any issues which pose particular difficulty for the worker in working with this family, and how could these be addressed? Are their dynamics between the worker and the family and is there anything in the professional relationship that is undermining the workers assessment?

How does the worker think and feel about the case? Are there sources of anxiety for the worker?

Managing the case
Have procedures been followed and the necessary forms and tasks completed?

Are decisions and plans being tracked to ensure that they are being followed through? How do I know this? Are the outcomes clear? Do they need to be reviewed or changed?

Is the legal mandate for involvement with the family clear? Are the family aware of this?

Are issues of consent clear in gaining the co-operation of the child and family and sharing information with others?

Has the practitioner the interviewing skills required for assessing and working with this family?

What is your analysis and what is this based on? What is the next step? Have all the options been considered and the impact on the planning process for each option?

How do you think and feel about the situation now at the end of the discussion?

Planning
What exactly needs to change to keep the children safe? What are the risks to the child if they don't change?

Identify the outcomes, actions, resources and services needed to boost the strength and range of protective factors
Identify the outcomes, actions, resources and services needed to reduce the risk factors

What is the time scale for change?

Risk Principles

Adapted from ACPO (Police) guidance and contained in The Munro Review of Child Protection: Final Report – *A child-centred system, May 2011)*

Principle 1:
The willingness to make decisions in conditions of uncertainty (i.e. risk taking) is a core professional requirement for all those working in child protection.

Principle 2:
Maintaining or achieving the safety, security and wellbeing of individuals and communities is a primary consideration in risk decision making.

Principle 3:
Risk taking involves judgment and balance, with decision makers required to consider the value and likelihood of the possible benefits of a particular decision against the seriousness and likelihood of the possible harms.

Principle 4:
Harm can never be totally prevented. Risk decisions should, therefore, be judged by the quality of the decision making, not by the outcome.

Principle 5:
Taking risk decisions, and reviewing others' risk decision making, is difficult so account should be taken of whether they involved dilemmas, emergencies, were part of a sequence of decisions or might appropriately be taken by other agencies. If the decision is shared, then the risk is shared too and the risk of error reduced.

Principle 6:
The standard expected and required of those working in child protection is that their risk decisions should be consistent with those that would have been made in the same circumstances by professionals of similar specialism or experience.

Principle 7:
Whether to record a decision is a risk decision in itself which should, to a large extent, be left to professional judgment. The decision whether or not to make a record, however, and the extent of that record, should be made after considering the likelihood of harm occurring and its seriousness.

Principle 8:
To reduce risk aversion and improve decision making, child protection needs a culture that learns from successes as well as failures. Good risk taking should be identified, celebrated and shared in a regular review of significant events.

Principle 9:
Since good risk taking depends upon quality information, those working in child protection should work with partner agencies and others to share relevant information about people who pose a risk of harm to others or people who are vulnerable to the risk of being harmed.

Principle 10:
Those working in child protection who make decisions consistent with these principles should receive the encouragement, approval and support of their organisation