Chapter Ten

Assessment in Kinship Placements: Towards a Sensitive, Evidence-based Framework

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Introduction

In Chapter 3 we articulated many limitations with the tools currently used to assess kinship placements. Drawing upon the available materials we identified the need for a sensitive, evidence-based assessment framework for kinship placements that would:

- Recognise that in most cases placements have already taken effect when the assessment is undertaken.
- Operate with a presumption that a placement within the family is the optimally desirable option other than where there is clear irrefutable evidence of risks that cannot be permitted or managed.
- Accept that kinship care is fundamentally different than stranger foster care and the primary goal must be the maintenance of the child within the (extended) family or friendship network – whether this is an informal family or formal service-driven placement.
- Understand that kinship carers have different profiles to those of 'mainstream' carers and integrate a consideration of this.
- Consider the multiple roles that a kinship carer may play for the child: caregiver, grandparent and parent.
- Acknowledge that the application of a higher threshold for accepting kinship placements as acceptable is discriminatory and unjust and represents risk enhancement for the child since it deprives them of better outcomes via kinship placements. *This requires an understanding of research evidence*.
- Acknowledge that the application of a lower threshold for accepting kinship placements is dangerous for children unless the risks have been clearly defined, assessed as manageable and resources committed to help support the risk management and planning process.
- Address kinship placement-specific issues such as contact that may require some structure and prohibitions if the child is to be effectively safeguarded.
- Introduce a risk component into the assessment process in an enabling (self-reported) way that balances assets with weaknesses and which prioritises the support required to sustain the placement.
- Consider the best legal route for the child and the carers and build the implications into the assessment.
- Shift towards the paradigm of empowerment recognised by Broad (2004).

Although there are acute limitations associated with the assessment framework it is unlikely to be replaced by central government for some considerable time. In order not to deskill workers or unnecessarily confuse them, our remedial framework starts with a re-conceptualisation of the assessment framework triangle to reflect the specific issues within kinship placement assessment. In doing so we will then extend it to embrace two further dimensions: the professional issues associated with the placement; and the need to conduct a risk assessment to safeguard the child.

Broad et al. (2001) called for comprehensive assessments of need to assess suitability and reduce the risk of placement breakdown. In so doing we needed to recognise that assessment is best undertaken between a social worker and a kinship caregiver in partnership, although we have some way to go on this.

As a starting point we are advocating an adaptation to the assessment framework triangle that reflects the need to assess the child, the birth parents and the kinship carers (see Figure 10.1). These dimensions reflect the complexity and uniqueness of the kinship placement: we are no longer restricting our assessment to one family situation (where we examine the parent's capacity to meet the child's developmental needs) but to the birth family, the kinship placement family, the impact of this for the child, as well as

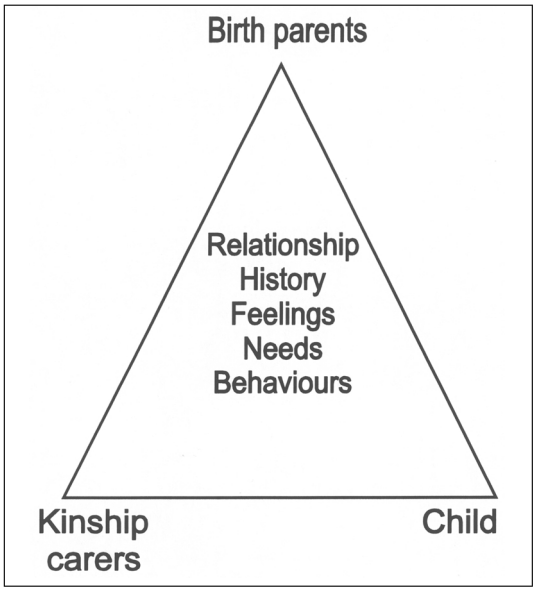

Figure 10.1 A preliminary structure to assess kinship placements

the unique tensions between different strands of the family over the new arrangements. Whilst this offers a structural solution, it also needs to be accompanied by an attitudinal change in workers to one that views kinship as the primary placement option rather than a secondary one when local authority resources are limited; and one that is enabling rather than approving.

Using this structure as our starting point, we will add in the necessary components that require assessment in all kinship placements. Before so doing, we feel it is important to re-name the different circumstances that may trigger a kinship care arrangement, as each signals the need for a modification of a generic model, with different areas requiring different emphasis and exploration. Kinship care arrangements may arise as:

- The first option for social services once the family situation has broken down.
- A final resort for social services after other care options have failed.
- A continuation of birth parent support already provided by the carer.
- An option selected by the young person themselves after a crisis at home. (Broad et al., 2001)

The origins of the problems may lie in child protection issues, an inability of the previous carer to cope, or the young person's difficult behaviour or problems. In situations where the child is being placed following abuse then the additional dimension of risk needs to be included and where it is an informal arrangement a strengths-loaded, mutually agreed assessment process should be the starting point. The context of the current increase of kinship care is relevant in that we have increasing numbers within the care system, a reducing level of choice especially for 13–16 year olds, and concerns regarding the quality of care provided.

Birth parents

Some birth parents may experience the removal of their child as bad, but this may be compounded if the child is placed with their parents or others; this information is public knowledge, and thus leads to multiple consequences for them in their home community; and the loss of their parent as they remember them in favour of someone who is prioritising the care of their child over their relationship and needs.

Child

The history that exists between the child and the carer often means that they have some understanding of the child's specific needs, how they may or may not have been met when living with their parents, and how they may be met or compromised in the future. This is important to build into any assessment as we are able to assess the needs of a specific child in contrast to stranger placements which are assessed to embrace a wide range of children, limited only by an age banding and/or ability level and gender. As such, any assessment of kinship carers should explore:

- The child's experiences of living in their birth family and the quality of previous care provided (positive and negative). The implications of the specific poor experiences such as domestic violence, intergenerational sexual abuse, drug and alcohol abuse and parental learning difficulties require additional consideration as they will continue to impact on the child, the wider family and the prognosis for outcomes.

- Their response to such experiences (resilient or vulnerable?).
- The impact of such experiences on their development to date and signposts for future behavioural or emotional responses and the carer's capacity to manage these or feel comfortable seeking assistance if they can't.

We need to assess whether the child is aware of and caught up in any conflict and how they make sense of this without assuming responsibility.

Workers also have a responsibility to consider the issues raised for any other children living in the household or who has significant contact with the kinship carer's family. Workers need to consider whether the number of children in the household will determine the level of care afforded to the subject child and whether there is likely to be any jealous responses which may create additional problems of child management for the carers. The wishes, feelings and needs of the carer's own resident and dependent children will impact on the stability of the placement and need to be explored.

It is useful to examine the nature of the impact of any harm within the family of origin necessitating the kinship care arrangement. Children may be resilient to harm or they may be adept at concealing impact via internalising behaviours such as depression or self-harm.

Resilience comprises a set of qualities that helps a person to:

- Withstand many of the negative effects of adversity.
- A resilient child has more positive outcomes than might be expected given the level of adversity threatening their development.
- Bearing in mind what has happened to them, a resilient child does better than they ought to do.

Rutter (1985) identifies three key factors associated with resilience:

- A sense of self esteem and confidence.
- A belief in own self-efficacy and ability to deal with change and adaptation.
- A repertoire of social problem-solving approaches.

It is therefore essential that workers examine the child's self-esteem and confidence, self-efficacy and social problem-solving approaches. We also need to consider how the caregivers encouraged resilience in their own children and how they can encourage this in the subject child. For a detailed description of the resilience literature the reader is referred to Calder, Peake and Rose (2001) and the resilience-vulnerability matrix within the Assessment Framework.

Kinship carers

Kinship care differs in a number of significant ways from stranger foster care, primarily due to prior knowledge and often experience of caring for the child.

Any assessment needs to address the specific supports that are needed to sustain such an arrangement so as to ensure continuity of care and maximising the child's needs being met. Indeed, the issue of support to kinship carers is one that features at the top of any list produced to reflect kinship carer's views and needs. Words such as collaboration and partnership appear regularly as a reflection that ideally any such placement enables a child to sustain meaningful connections and continuity that ensure permanence. However, partnership is not a panacea and is certainly not reflective of a common approach from workers. Calder (1995) identified four distinct partnership models that reflect the diversity of practice and which can explain why some approaches to partnership are experienced as alienating, controlling and unsupportive by some kinship carers. The four models of partnership as related to kinship placements appear below:

- **The expert model:** where the professional takes control and makes all the decisions, giving a low priority to the family's view, wishes or feelings, the sharing of information, or the need for negotiation. This might be understandable in the conduct of removing children from their birth family in situations of high-risk, but it serves no useful purpose when applied to kinship carers unless the objective is to undermine the placement.
- **The transplant (of expertise) model:** where the professional sees the carers as a resource and hands over some skills, but retains control of the decision-making. This is understandable in circumstances where little is known about the carers at the point of placement, especially if there are some objections from the birth

parents; but it should be a starting point rather than an end point.

- **The consumer model:** where it is assumed that the carers have the right to decide and select what they believe to be appropriate and the decision-making is ultimately in their control. This is clearly appropriate when they have care of the child and the placement has not been effected by the professionals; and it should represent a progression of the relationship with carers once relationships are established.
- **The social network/systems model:** where parents, kinship carers, children and professionals are part of a network of formal and informal development, and social support for the family and the child. They are capable of supplementing existing resources via the facilitation of the social worker who should draw more on the extended family while complying with statutory requirements. This is often where kinship carers would like to locate professional agencies: they are there to support them in their task rather than directing operations.

The challenge for workers is to find ways of moving through the various models as they can be seen as a continuum that evolves as relationships develop. The costs of starting and maintaining an expert partnership is that it is always going to preclude permanency, as the locus of decision-making rests in the professional rather than the family domain. Any assessment of partnership potential may not always be greeted with enthusiasm from carers who have cared for a child for some significant period of time and who may have a detailed understanding of their experiences and needs while the professionals are both playing catch-up as well as making judgements about what they learn (see Laws and Broad, 2001).

Assessing prospective carers

A sensible starting point for workers is to get prospective carers to talk without prompts about the child, and their relationship with the child. This should give workers a good indication about their potential suitability as carers. Where there are a number of children involved in the placement we need to consider each child's needs alongside the need for placement together with the additional responsibility and stresses (as well as joys) this brings. Workers need to consider a number of factors with the carers that include:

- The carer's expectations of the child: bearing in mind the history of the child and the anticipated or known behavioural challenges this may bring.
- The carer's expectations of the care giving role: will they have sufficient resolve and energy to derive pleasure from the arrangement or are they simply motivated by a sense of duty to avoid professional solutions.
- Their understanding of loss and grief. There are a great many losses that carers may experience through accepting the placement and these include:
  - Interruptions in their life cycle: swapping retirement for raising a child.
  - Loss of time for friends and interests.
  - Loss of financial security.
  - Loss of role, such as swapping the grandparent role for one of parent.
  - Loss of their own children if they are concerned about the situation or circumstances that led to the placement, as well as their attitude about a continuing relationship on a significantly different footing, where the protection of the child has to be prioritised but often in a way that does not divorce them from supporting and helping them resolve their problems.

  It should be remembered that carers who have experienced multiple losses may not be well placed to help the child in their care deal with this issue. We also need to ensure that the assessment of loss addresses three specific areas:
  - The degree of pain, hurt, and stress that results from the loss.
  - Capabilities and experiences in dealing with loss.
  - Projected limits and tolerance for future losses and stressors.

  (Crumbley and Little, 1997)
- Their understanding of the potential impact factors of abuse for the children (see Calder, Peake and Rose, 2001 for a detailed review of this issue in relation to sexual abuse).
- Their capacity for behaviour management in a range of presenting circumstances, such as anger, acting out, etc. Are they flexible in their approach to discipline?
- Their capacity to work with parents and professionals and often to walk the tightrope between the two.

Workers need to explore the capacity of the carers to support relationships between the child and their parents, siblings or significant others. This is essential in the medium to long term as it relates to the child's developing sense of identity. This should include both maternal and paternal relatives as kinship placements often exclude one side of the birth family. This can be explored with well considered genograms and ecomaps in which both children and adults participate. We need to explore support needs in detail and develop a sense of acceptance that such requests will not be received and processed as admissions of failure.

The nature of the formal and informal support that carers can call in is an integral component of any assessment. There is a need to look at how best to sustain a kinship placement over time when the need for support may incrementally increase over time, linked to factors such as age and health.

Workers need to identify all the significant adults living in the home and involve them in an assessment even if there are no plans for them to be the primary carer for the subject child. This is essential if we are to examine not only the individual and what they can offer the child directly or indirectly but also whether there are any family dynamics that cause concern and require further assessment. This must be able to tolerate multi-causal explanations within families.

There is also a very clear need to assess both the kinship carers in some detail. Experience across social care assessments informs us that the primary focus of assessment is the female carer and the male carer is often an afterthought. This is inappropriate as we again need to examine their individual strengths and weaknesses, the respective roles and responsibilities assumed within the household, and areas of consistency and inconsistency or approach around areas such as discipline, involvement in day-to-day caring tasks with the child. For a detailed discussion around the engagement of men in assessment work the reader is referred to Hackett (forthcoming).

Workers need to assess the carer's motivation for caring for the child as there is a correlation between motivation and capacity to attain particular outcomes. Crumbley and Little (1997) identified a range of motivating factors for relatives:

- A sense of loyalty to the family, the partner or the child. They may express the conviction that families should take care of their own.
- A strong attachment to the child. Some caregivers have already assumed the role of primary or secondary caretaker at points in the child's life.
- Duty or obligation. These caregivers may feel trapped and even resentful.
- Guilt about the way they raised their own children or their role in the situation that led to the child needing placement.
- A desire to rescue the child from abuse, neglect, or being raised in the foster care system.
- Anger with the parent or the agency.

Social history

Taking a social history is a critically important part of the assessment and one which the Form F guides us more than the Assessment Framework. This might include:

- Developing a genogram with the family to identify who is who and also their significance, level of involvement and whether there is any relevant child protection or criminal background.
- Their childhood experiences: including patterns of care, roles and responsibilities, positive and negative memories, family boundaries, rules, identity, discipline, support towards independence, values and attitudes toward a range of issues, such as continuity of care, work-life balance, etc.
- Any prior evidence of abuse or neglect?
- Any prior experiences of social services involvement? If so, for what reasons? What is their recollection of the intervention? How does this relate to their current attitude towards professionals, especially social workers?
- How the couple met: what their roles and responsibilities are; their attitude towards their own children and the current presenting situation? What causes conflict and how is this resolved?
- How did they raise their children? Can they identify areas with hindsight that they did well and what they could have done better or differently (often with the benefit of hindsight)? Do they accept any responsibility for contributing to their children's problems? Have

they attempted to intervene and offset the risks to the child previously?
- What tensions exist currently within the immediate and extended family and what proposed management options can they identify/enact?
- How able are they to provide the necessary care and protection to the subject child? How willing and able are they for getting involved in interests, hobbies and activities? How will they adapt from their previous role with the child to one which has clear boundaries and structure? For example, how willing and able are grandparents in making the transition from indulgence to a more management role?

As CWLA (2003: 22) articulates well, 'Kinship carers are likely to understand the child's need for protection because they are aware of the situation that led to the child needing placement away from the family. On the other hand, the kinship family has come to the attention of the child welfare agency because of abuse, neglect, or substance abuse and the family dynamics that may have contributed to these problems need to be carefully assessed to determine if they are present in the kinship family as well'. Clearly issues remain if the carers cannot see that harm has occurred or accept it has happened but may struggle to manage the contact between the parents and the child. In such circumstances workers have to assess the capacity of the carers to protect the child from any future harm and this will be informed by their understanding of the areas of concern as well as their history of and capacity to enforce appropriate and safe boundaries. An indicator of this may lie in their prior ability to resolve or work with conflicts in a way that has not involved the child.

The analysis of change matrix (Appendix 1) provides us with a useful framework for assessing the capacity to protect alongside potential outcomes and which has been applied here to kinship placements (Calder, 2003).

There is a need to assess the capacity of the caregivers to provide safe care for the child and in doing so have one eye on reducing the likelihood of any allegation being made against them (see Calder, 2005 for detailed guidance on how to achieve this). When the child moves into the care of the caregiver they will often have experienced harm of some description and they may be exhibiting challenging behaviour for which the carers require some support and guidance. The caregivers may have difficulty in understanding and tolerating such behavioural problems that result from harm histories and they need information to help them understand as a preface to managing and hopefully tolerating it. In some cases, they may have been shielded from any such knowledge by the parents in the first instance and then by the child latterly: either out of a sense of loyalty or protectiveness. Regan and Butterworth (2005) have articulated this pictorially in Figure 10.2 where they separate out the visible behaviours that are in the carers' faces from the invisible origins of such behaviours. It is the invisible dimensions that need to be addressed if we are to meaningfully effect change. We can contain behaviours in the absence of cause but we can only effect change when we understand and locate the cause. The latter is also correlated with sustained as opposed to short-term change and for children this has to be our aspiration.

We are trying to work with the caregivers to provide a nurturing and safe environment that achieves some reparation from previous harm (see Figure 10.3) and which sees a reduction in the visible challenging behaviours to more developmentally positive behaviours, reflective of consistent parenting. In order to introduce such a discussion with the caregivers we can ask them what needs the child is likely to have based upon their past experiences; what behavioural responses have they witnessed or been aware of from the child thus far, and what care will the child require (over and above what has previously been offered) to try and help the child attain their appropriate developmental potential. We should also explore with them what previous experiences for the child will make them feel unsafe and how this might be addressed.

Rose and Savage (1999) have produced safe care plan issues to consider (see Figure 10.4) for such situations that can usefully bring the subject alive for the caregivers and the child and encourage the formulation of specific agreed rules of safe care for each child in the placement.

This might include broad issues of respect, judgements, morality, language, culture, religion. There also needs to be more specific messages for children who are looked after; i.e. being in care is not their fault; not the only one; not replacing/in competition with birth parents; it is right that plans are made with them about the future.

Rose and Savage (1999) have also produced a useful structure for the analysis and understanding of a child's behaviour (see Figure 10.5).

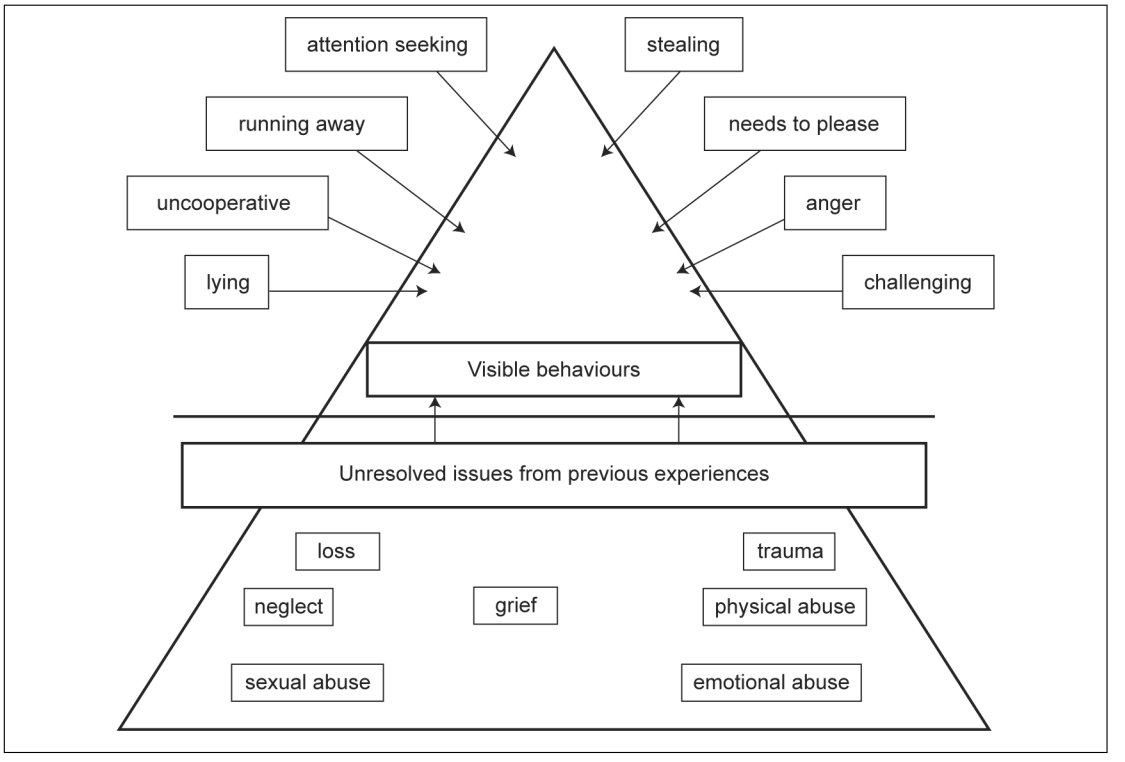

Figure 10.2 Triangle: A child who has had negative experiences

Impact issues

Workers need to consider how they can formally build impact issues for the caregivers into the assessment triangle recommended in Figure 10.1. The following issues are reported as the impact issues of being a carer:

- Shortage of money.
- Loss of freedom and independence.
- Overcrowding.
- Age and ill-health.
- Managing difficult behaviour.
- Managing birth parents and other relatives.
- Managing contact.
- Support issues (see Laws and Broad, 2001).

In many cases of grandparent caregiver assessment, issues of age and health feature heavily, and this is consistent with exploring the longer-term plans for the child. We know from research with grandparents (Pitcher, 2001) that there are consequences of assuming the caring responsibility for their grandchild and these include exhaustion, as well as loss of friends and a social life and disappointment. These need to be factored into an assessment of this nature. We also need to explore with the kinship carers the plans they have for the future, the plans they see as appropriate for the child, and the synchronicity between the two. We also need to examine in some detail their current life and then insert the child's timetable within this and look at what conflicts and clashes there may be as a basis of helping them determine whether they can defer their own needs to those of the child.

This is often coupled with generational differences: how they may describe the care that they offered their own children and that which they anticipate giving the subject child may not be consistent with contemporary parenting. For example, they may describe physical chastisement in their upbringing that did not harm them and as such they see objections to smacking as being overly tolerant. Some describe the administration of whisky as a means of calming a child and facilitating sleep, whilst this would not normally be accepted practice currently.

Issues of finances are relevant here also as many caregivers report severe financial

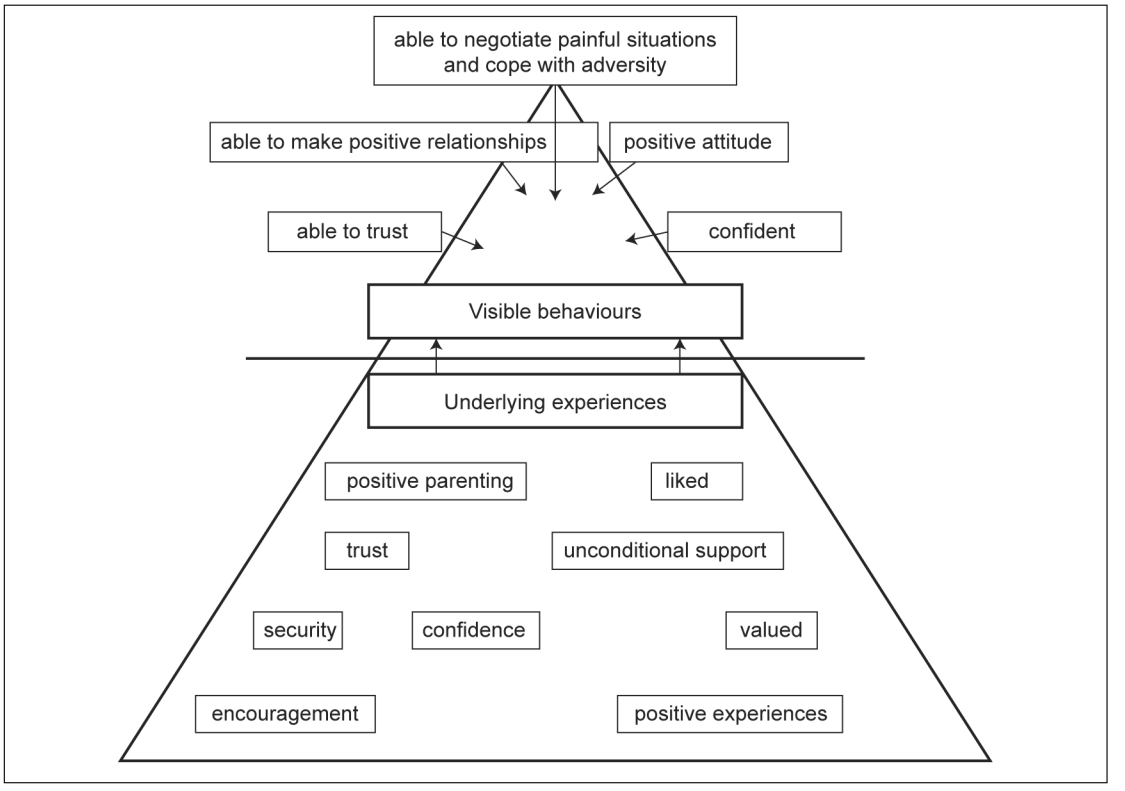

Figure 10.3 Triangle: A child who has had healthy experiences

constraints that may affect if not prohibit the caregiving offered.

Within any social history the workers need to consider both the factual information as it was provided and then move on to explore what reflections the caregivers have on previous patterns and past behaviour. It may be prudent to talk to the children and young adults who have been raised within the caregiver's family to benchmark information provided. Previous records from all the key agencies need to be examined and in some circumstances ex-partners need to be traced and interviewed. Formal references also need to be secured and contextualised specific to the subject child. Workers need to elicit the views of other children living in the household both to uncover their views about the placement as well as how and what they have been told about it. They may have anxieties about how to communicate this to their friends, they may feel marginalised or jealous or resent the fact that the carers' time has been further divided.

Figure 10.6 represents an adaptation of the original triangle where unless these issues are addressed then the potential is for them to compromise the carers from being able to deliver the appropriate parenting for the subject child.

A further variation of this might come in the shape of a diamond where we insert the carer issue into the original assessment framework triangle in acknowledgement that unless carers' needs are met then their parenting capacity for the subject child is likely to be reduced or more inconsistent (see Figure 10.7) (Calder, 2003b).

The following materials derive from DoH (2001) in relation to carers of disabled children but the considerations are exportable to kinship carers as follows:

1. **Carer's role**
   - Carer's choice – does the carer feel they have a choice?
   - How willing and able are they to provide care?

- Routines: including bathing, transporting, meals, bedtimes etc.
- Physical contact: between adults and children; how we comfort children; boundaries during play.
- Privacy: general boundaries and guidelines, e.g. toileting.
- Sexualised behaviour: boundaries that exist within the home.
- Discipline: the range of sanctions that are used within the household.
- Health and safety: for activities about the home, coping with emergencies, i.e. fire drill.
- Visitors to the house: understanding and commitment to the household's safe care practice.
- The fundamental messages that underpin everything that happens in the house (mission statement).

Figure 10.4 Reflecting safe care practices within the house (Rose and Savage, 1999)

Date/Day: *Time:*

Name of young person:

Was anyone else involved? Yes/No

If yes, who?

In what capacity were they involved?

If another child was involved, was this voluntarily?

Had force/violence/coercion/threats/bribes been used?

How did the other child react?

What emotional state were they in?

Brief description of circumstances

Do you know what happened directly before the incident?

Was there anything that triggered the behaviour?

If you had to intervene, what happened?

What was your response to the situation and young person?

How did the young person react?

What happened afterwards?

What was the young person's response?

Was the child's social worker/Family Placement Worker informed?

If so, who?

What was their response?

Anything else you feel relevant?

Figure 10.5 Record of Behaviour or Incident (Rose and Savage, 1999)

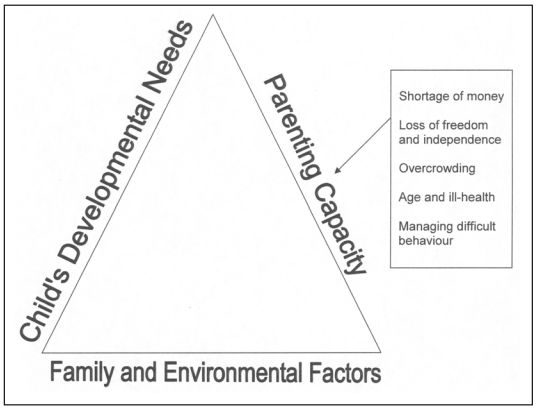

Figure 10.6 Adapting the assessment farmework to embrace kinship caregiving

- How much time is taken up with caring?
- Which parts of the role does the carer actively want to do (if any)?
- Which parts of the role can the carer manage without help?
- Which parts of the role does the carer find particularly difficult?
- Which parts of the role does the carer actively not want to do?
- Does the carer understand the condition of the cared person?
- Does the carer feel they would like training in how to manage any part of their role? (Moving and handling, stress, understanding the condition.)
- Does the caring role conflict with or undermine other family roles such as parent or breadwinner?
- What is the carer's perception of their situation?
- What is/are the outcomes the carer would like to see to help them in their role?
- What is the carer's view of the most important outcomes to achieve for the person they care for? Are these in conflict with the cared for person's view?
- Is the carer also a service-user or eligible for support, as a community care service-user?
- Where appropriate a weekly time sheet may help demonstrate the extent of the role/lack of sleep etc.

2. Breaks and social life

- Can the carer regularly get a break (at the appropriate time of day/week) to enable them to have time for themselves/leisure/time with friends?
- When did the carer last have a break i.e. time off for themselves, rather than time to go shopping or time to go to the dentist or doctor?
- Might the carer need a degree of active encouragement to take breaks and maintain their social life, to avoid social isolation becoming a problem at a later stage?
- Can the carer get a break to deal with wider responsibilities e.g. attending a child's sports day?

3. Physical well being and personal safety

- Is the carer well?
- Is the carer undertaking any tasks that put them at risk?
- Is there any aspect of risk in caring for the cared person?
- Is the carer stressed, anxious or depressed?
- Is sleep affected, if so how badly?
- Is the carer receiving any treatment?

4. Relationships and mental well being

- Is caring having an impact on relationships, either with the cared for person or other members of the family, friends etc?
- If the carer is a parent, is caring making this role harder?
- Are stress, depression, anxiety present or likely without support?
- Is spirituality significant to the carer? Are they able to maintain any spiritual practices or faith-related activities which are important to them?

5. Care of the home

- Are there any issues about care of the home?
- Does it all fall to the carer?

6 .Accommodation

- Are there any problems with where the cared for person lives? (long distance caring/lack of time to look after property)
- Can equipment/adaptations help?
- Is carer's own accommodation (if different) a problem?
- Should housing authorities be involved in the assessment?

7 .Finances

- Are finances a problem?
- Can the carer get the advice they need on benefits, managing debt, charges etc?

8. Work

- There should be no assumption that carers will give up work to care – how can they be supported?

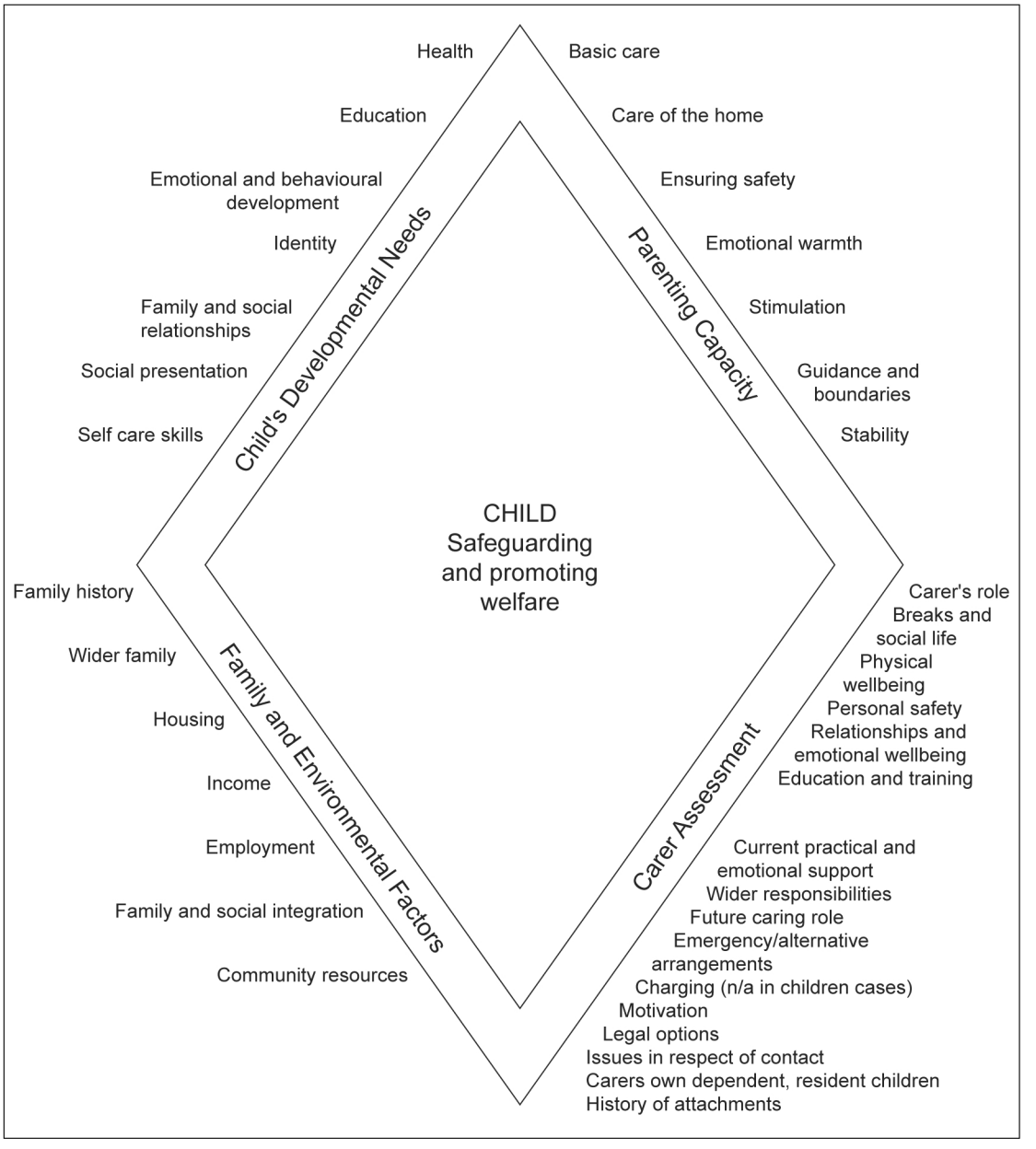

Figure 10.7 Kinship carer diamond (developed from Calder, 2004)

- Does the carer want to stay in work or return to work – what are the options?
- Is advice available on these issues, including advice for returners on benefits, charging etc so that the carer can make informed decisions on what is best for them in all the circumstances.

9. Education and training

- Does the carer want to develop their skills either work-related or otherwise?
- Are they at risk of having to give up education or training because of their caring role?

10. **Current practical and emotional support**
    - Who/what helps the carer at the moment?
    - Is there enough of this support and is the carer happy with receiving such support from these sources?
    - Is the carer aware of carer's support groups/counselling services etc in the area?
11. **Wider responsibilities**
    - What other wider responsibilities does the carer have – parent, child carer, other caring roles, work, volunteering etc?
    - Should other workers be involved to help advice on parenting and childcare issues or about services that might help?
    - Is balancing these responsibilities causing the carer stress?
    - Are other roles suffering or perceived to be suffering?
12. **Future caring role**
    - How does the carer see the future?
    - What factors are likely to affect the willingness or ability to care long term?
13. **Emergencies/alternative arrangements**
    - If the carer suddenly became ill what would happen?
    - What networks are there to support in an emergency?
    - Can a contingency plan be made?
    - Does the carer know who to contact in an emergency?
14. **Access to Information and Advocacy**
    - Are carers aware of how to get more information and who from?
    - Do they know about what to do if things go wrong or if they want to complain?
    - Are there sources of carers' advocacy locally they should be aware of?
    - If they have internet access, are they aware of *www.carers.gov.uk*?
    - Are they aware of *www.ukonline.gov.uk* which is developing a portal for carers' information during 2001?
15. **Agreed outcomes**
    - What are the agreed outcomes for the carer in relation to their health and well-being, quality of life, as well as the sustainability of their caring role?
    - Is there conflict between the carer and cared for person's desired outcomes?
    - Are Direct Payments appropriate in lieu of a service to give the carer flexibility?
    - Where is there disagreement?
    - Where may there be problems in delivering the outcomes?
    - Where particularly services are identified as the best way to deliver certain outcomes, what are the carer's preferences about the way such services might be delivered (e.g. timing, fitting in with routine, are Direct Payments appropriate in lieu of a service to give the carer flexibility?)
16. **Complaints and challenges**
    - It is important to ensure that carers and cared for people are aware of the local council's complaints procedure.
17. **Review**
    - When will the assessment be reviewed?
    - In considering timing of review – are needs likely to increase or fluctuate; is there risk to carer or user or frequent crises?
    - Who will be responsible for setting up review?
18. **Charging**
    - It is important that information on charges and financial assessment are clearly explained to both the carer and the parents as part of the assessment process.

Inter-relationships between these domains

The triangular structure (Figure 10.1) at the beginning is a relatively static one and this does not reflect two key considerations. Firstly the role of the professional and their agency in influencing the kinship care arrangement; and secondly recognising that unlike stranger foster care, the continued involvement of the parent with the kinship carer and the placement is much more likely. As a reflection of this latter set of unique circumstances, any assessment has to examine the ongoing relationships to try and predict the capacity of the parent and carer to work collaboratively to identify and then meet the child's needs. Conflict is common but not associated with placement breakdown (Broad, 2001).

The issue of loss spans all the domains and it is important not only to assess them in relation to the child, the carers and the parents but also to explore how they interact and the degree of impact. One of the key issues for assessment relates to the redefinition of roles and responsibilities, that arises from the kinship care arrangement. As previously indicated, carers assume a parenting role from the parents, and this may either be welcomed or frowned upon by

the child, as well as leaving many children confused by the changes. Great care is needed to examine how children experience these changes and what the adults need to do to ensure this is not aggravating the harm they may have experienced.

It is important to assess the nature of the relationship between the parents and the kinship carers. This should include a historical as well as a current dimension as past capacity to work together is a useful indicator of how the future relationship may be managed; as well as how well they have concealed any conflict from the child.

In all these areas workers have to remember to link this to an assessment of the impact on the child of the new arrangement (as well as any prior harm) and also to link this to levels of risk, prognosis for all the parties to work together to achieve a mutually agreed outcome or goal, the potential to deal with and sustain change.

The issue of contact is a critical consideration in arrangements of this nature. Workers need to be clear about the nature of the relationship between the child and the parents and then move on to examine whether the caregivers have any concerns about the contact, and how comfortable they would be in managing these concerns: prior to and after with the child as well as during if they are deemed the appropriate supervising officers. Considerations need to include a safety plan if things go wrong, for example if the parents present under the influence of drink or drugs or threaten or use violence (verbal as well as physical).

Family group conferences

ne mechanism for bringing family members together for both assessment and planning purposes is the Family Group Conference or meeting. Originated in New Zealand, Maori (New Zealand's indigenous people) had hotly contested the widespread removal of children from their homes that had characterised the past. In response, they advanced the view that decisions must involve the families, including *whanau* (all those descended from common grandparents), *hapu* (clan) and *iwi* (tribe) and should not be usurped by professionals. The outcome of the debate was agreement that issues around children and young people should be resolved in partnership between the state and families. The underlying intention was to involve families, to give families responsibility to deal constructively with the presenting concerns and to restrict the power of professionals, in particular the power of social welfare professionals. At the same time, it was seen to be the state's responsibility to provide services that can support families and provide for the needs of children and young people in ways that are culturally appropriate and accessible.

A family group conference (FGC) is a formal meeting *in care and protection cases*, for members of the family group to discuss with social workers what needs to be done to make sure a child or young person is safe and well cared for. They are a mechanism that enables the formal state systems to work in partnership with informal family and community systems, recognising the knowledge and expertise of family and informal systems and recognising the knowledge and expertise of professional systems. Family group conferences put families in charge of the decision making; the process strengthens families and respects and affirms each family's unique cultural experience. They operate very differently from existing decision making mechanisms that are dominated by professionals and tend to take away the responsibility for decision making from families and the community and often discourage the participation of the family. Family group conferences make sure that power and responsibility is more evenly shared between the family/community (informal) and professional/agency (formal) networks. Family group conferences harness and build on the knowledge, strengths and resources in families and communities. They provide a framework for families, the community and agencies to work collaboratively to safeguard and promote children's welfare. The FGC is a means of balancing children's need and right to be safe, with their need and right to be in a family. Professionals are expected to play a low key role in the family group conference. Overall, conferencing offers a participatory option that empowers families and allows them, without increasing the stigma or blame, to play a pivotal role in arriving at decisions about their children. It provides a clear mechanism for ensuring that the voice of the child is heard within the decision-making process. It offers increased clarity about professional roles and responsibilities, and accountability for practice to family members. Where there are concerns about

risks to the child the model leads to improved risk assessments, targeted protection plans, and plans which the family are committed to implement; and it tackles social exclusion and strengthens communities (Calder, 2004).

A professional dimension

Professional practice is often dictated by procedures and protocols that can be experienced by all involved as constraining if they are applied in a blanket inflexible way. Clear processes and systems operate for the assessment and approval of stranger foster carers that are not easily replicated in kinship care. For example, the latter often emerges in an informal, unstructured or occasionally in an emergency way.

As we have identified earlier, the attitude of the worker and/or the agency to kinship care placements is significant, and may be contingent upon whether it emerged as an informal family arrangement or was created by professional request. Whilst this is an important indicator of attitude toward the placement, workers need to build relationships, assess need and mobilise any required support simultaneously. Since placements may have already taken place or need to be made imminently (precluding the need for short-term foster or residential care), workers should have this embedded in their work as it is a central pivot of the assessment framework (DoH, 2000). Experience tells us that delayed service provision following need identification can be an aggravating risk factor that requires professional management. Any intervention must be designed to enable the family to care for the child and provide the needed connections and continuity that ensure permanence. Kinship carers invite professionals to premise their assessment and decision-making with a belief that they are uniquely qualified to care for the child given the family context and pre-existing relationship, and are more likely to work actively and with a problem-solving outcome in mind. Workers who approach their task from a different starting point are unlikely to forge a meaningful relationship with the kinship carers and worse still are likely to induce or compound fear, distrust and anxiety that are disabling and may potentially deflect their attention and energies from the child.

We know from the experiences of families within the child protection arena that:

- Doing to families does not create an environment conducive to engagement or change.
- Excluding families from the decision-making process heightens resistance, lowers motivation and creates a 'them and us scenario'.
- Families will not sign up to or implement plans they have not been party to constructing or with which they fundamentally disagree.
- Involving families in plans enhances ownership and this is correlated with greater and more sustained change.
- Working together successfully requires the integration of formal and informal systems.
- The roles and responsibilities of professionals are often unclear and this impedes the construction and implementation of the child protection plans.
- Task allocation is idealistic rather than realistic.
- The focus on registration deflects us from planning and risk assessment (Calder, 2004).

There is a considerable body of research in relation to partnership that is relevant here. We know that parents value certain characteristics of professionals in the execution of their jobs, and these include:

- Communication which is open, honest, timely and informative.
- Social work time with someone who listens, gives feedback, information, reassurance and advice, and is reliable.
- Services: which are practical, tailored to particular needs and are accessible.
- An approach which reinforces and does not undermine their parenting capacity.

One example of poor practice is where we attempt to communicate honestly what the process will involve and maybe what some of the concerns are that need to be explored yet this is wrapped up in professional jargon and acronyms which alienate and dis-empower the kinship carers. We need to think carefully about what we want to communicate and then examine the options available to achieve this end. Workers should be alert to the fact that just because something has been communicated it has not necessarily been either received or understood by the other party.

The breadth of the assessment considerations should inform the choice of the worker assessing the suitability of the placement, and should

ideally be conducted by co-workers with family placement and community-based social worker practice assessment. The requisite minimum knowledge base for staff includes an understanding of child abuse and neglect, child development, the impact of separation, loss and harm on children, family systems and structures, negotiation and conciliation, and building and maintaining formal and informal networks of support.

It is essential that workers retain their basic assessment skills and maintenance of the process when conducting kinship assessments. It is not a case of throwing the baby out with the bathwater but about building on established foundations. Adaptation and flexibility are essential ingredients of practice. In this sense, the following represents a summary of essential assessment considerations.

The stepwise assessment

One exemplary model for workers is the stepwise assessment (Samra-Tibbets and Raynes, 1999), which invites workers to attend to tasks in a sequential order in detail to maximise the information available. In the first block, *planning* is essential. This is often left out by professionals, as they feel pressured to get on with the task. There needs to be a careful look at what information they already have, and what still needs to be gathered. There needs to be some agreement on channels of communication, as it is unrealistic for the worker to expect to know everything at every stage of the process, as in a responsibility chart.

The second block attends to issues of *hypotheses*. This is defined in the dictionary as 'a starting point for an investigation'. There is evidence to show that workers sometimes begin the assessment with one particular hypothesis and gather evidence to support this. This can be dangerous as it actually forms a conclusion before the assessment has begun. The workers should consider all possible hypotheses, be open minded in gathering evidence, and prioritise hypotheses only where there is clear evidence to do so. They need to take a step back from the early intervention in order to generate the maximum number of possibilities, so as not to shut down any avenue prematurely. The initial hypothesis is necessarily speculative and is used as the basis for gathering more information that will either confirm or refute it.

In the third block, there is a need to *gather information*. Nothing is more sterile than information collecting for the purpose of information collecting, as would be likely using the existing Assessment Framework recording forms or the BAAF Form F. The kind and amount of information collected will be dictated by the defined problem for work and the preliminary goals that are established. It is difficult to deal with areas of data collection concretely because the specific areas to be explored depend on the situation. There are, however, some principles that should be considered:

- It is a joint process and the client should be involved in helping to determine the areas to be explored.
- The client should be aware of the sources being used for data collection (e.g. they may not always be asked for their permission).
- There should be a connection between the problems identified and the data collected, and the client should be aware of any connection.
- It is critical to explore all areas the clients see as connected as well as helping them to understand the areas the worker seeks to explore.
- Data collection goes on all the time, but it is critical to the problem identification, goal setting, and assessment stages of work.
- It is crucial that the worker understand the client's view of all areas of data collection – their thinking, feelings and actions.

There is a tendency to gather too much information, and we need to guard against too much information as well as irrelevant information. The information must be analysed and analysis can only be properly achieved through evidenced-based practice. We may modify our original hypothesis many times as the new information is gathered from the family. Since the major purpose of a hypothesis is to make connections, how information is gathered is extremely important. The worker must take a neutral position and try not to imply any moral judgements or to align themselves with any one faction of the family. Change often comes about through the worker's ability to stand outside the family and gain a holistic view. The intervention is then geared at the most relevant of the presenting problems. In gathering information, it is helpful to keep the following questions in mind:

- What function does the symptom serve in stabilising the family?
- How does the family function in stabilising the symptom?
- What is the central theme around which the problem is organised?
- What will be the consequences of change?

Cleaver et al. (1998) identified a useful list of the blocks to identifying risk and include:

- The unknown – that is knowledge of signs and symptoms and knowledge of the law that was not adequate.
- The known but not fully appreciated – the need to identify what is important from a 'flood of relevant data'.
- Interpretation – being able to correctly interpret information in the context of assessing risk.
- Objective and subjective information – failure to distinguish fact from opinion, being too trusting and uncritical.
- Unappreciated data – information may not be appreciated if it has come from a source which is distrusted.
- The decoy of dual pathology – information may be missed if the receiver is decoyed by a different problem.
- Certainty – investigators may have a false sense of security about a particular interpretation (e.g. medical assessments of sexual abuse in Cleveland).
- Competing tasks within the same visiting schedule, e.g. fostering and child protection.
- The known and not assembled – individuals may hold information which they can withhold or which is not pieced together with the rest.
- Not fitting the current mode of understanding – this has also been described as a loss of objectivity, and the importance of supervision is highlighted.
- Long standing blocks – assumptions made at an early stage which influenced later interpretation of information (p9).

The fourth block requires the information collected be *tested* out. Professionals will bring information gathered, as well as the concerns that they have had, in order to assess the level of risk to the children, and the potential for change in the family. Strategies for doing this and for involving the family will need to be agreed.

In the *decision* block, the professionals are being asked to make recommendations for the longer-term plan, and this is a recommendation to the fostering panel and court. In the *evaluation block*, we should consider the future risk to the children, the potential for change within the family, recommendations for future action and the resources required to achieve them. The assessment needs to move beyond the changes required, to identifying whether change is possible, and what motivations exist for change. Accompanying this must be some hope of reaching the goal, an ability to consider what has gone wrong and some opportunity for change in the situation. The assessment should differentiate between factual information and unsubstantiated information, and opinions. It should aim to enhance the potential within the kinship carers and the parents at all times, rather than undermining it, and a failure to achieve this can result in a refusal to engage in the assessment process. We shouldn't forget that the assessment is where the protective intervention meets the therapeutic one.

Strengths-based approach

We have already made great play of the need to work in a partnership way with caregivers and in order to facilitate this best then we need to employ a strengths-based approach. This is apparent within the Assessment Framework in an unbalanced way as it ignores risk by eliminating it from the professional vocabulary. However there are some merits to the strengths-approach (see Calder, 1999).

The strengths' perspective clearly demands that we adopt a different way of looking at individuals, families and communities. All must be seen in the light of their capacity, talents, competencies, possibilities, visions, values and hopes, however dashed and distorted these may have become through circumstance, oppression and trauma. Personal qualities and strengths are often forged in the face of abuse and oppression (Saleebey, 1996).

The strengths' perspective is rooted in the belief that people can continue to grow and change; that many of the barriers people, labelled as belonging to 'disadvantaged groups', face in meeting basic needs for shelter, food and positive community participation, tend to come from educational, political and economic exclusion based on demographic rather than individual characteristics.

For social workers to shift towards the strength's approach they need to have some understanding of its underlying beliefs. They must also not lose sight of the need to take appropriate action to protect children whenever necessary. The following summary is offered to workers in this context, as the strengths' approach cannot be adopted on a blanket basis without reference to individual circumstances. The social worker doesn't change people, but aims to act as a catalyst for clients' discovering and using their resources, to accomplish their goals (Saleebey, 1992). This makes it less likely that workers will 'rescue' clients and more likely to reinforce their strengths, even in a crisis.

Any proactive approach to child protection focuses on family strengths and capability in a way that supports and strengthens family functioning. All families have strengths and capabilities. If we take the time to identify these qualities and build on them rather than focusing on correcting deficits or weaknesses, families are not only more likely to respond favourably to interventions, but the chances of making a significant impact on the family unit will be enhanced considerably. A major consideration as part of strengthening families is promoting their abilities to use existing strengths for meeting needs in a way that produces positive changes in family functioning. This can be achieved by using empathy or attempting to promote some mutual agreement between each other.

Using the principles of the strengths' perspective with abusing families may be the only chance to empower families to change their behaviour. Yet uncovering strengths cannot be accomplished in a simplistic manner, as they 'are not isolated variables, but form clusters and constellations which are dynamic, fluid inter-related and inter-acting' (Otto, 1963). Developing a strengths-based practice involves a paradigm shift from a deficit approach to a positive partnership with the family, and will involve:

- The relationship between a worker and a family must be reframed from an adversarial one to a helping alliance and partnership with the family. This suggests a major emphasis on the engagement phase.
- Empowering individuals and families to discover and use the resources and tools within and around them.
- Integrating knowledge of resilience in workers as it may be crucial to families in overcoming future risks (DePanfalis and Wilson, 1996).

Although the child abuse field has just begun to apply the strengths' perspective to its repertoire, there is a catalogue of documented benefits to date:

- An emphasis on strengths as well as on risks increases the opportunity for developing a helping alliance – a crucial element in achieving positive treatment outcome and risk reduction.
- Positive reinforcement for positive conditions and behaviours is more effective than trying to convince or coerce individuals to alter negative conditions or behaviours.
- Cultivating strengths offers the opportunity for more permanent change.
- Emphasising strengths helps family members build in successes in their lives, which in turn should help them more effectively manage crises and stress.
- Helping families through short-term positive steps empowers families to take control of their lives.
- Celebrating successes changes the tone of treatment, for both client and helper.
- Communicating a true belief that a family can change destructive patterns helps to promote more long-lasting change (DePanfalis and Wilson, 1996).

Whilst we should shift towards a strengths-led approach to children's services, we cannot overlook or shirk our statutory responsibilities to continually assess risks and dangerousness to those children we are seeking to protect (Clark et al., 1990).

DeJong and Miller (1995) have described several interviewing questions that a worker can use to uncover client strengths related to the goals of clients:

Exception-finding questions

hese are used to discover a client's present and past successes in relation to the client's goals. Eventually these successes are used to build solutions, e.g. an alcoholic who has tried of their own volition in the past to stop drinking but has lapsed. Most families can offer one exception and the worker can then explore how this happened, particularly how the client contributed to this.

Scaling questions
These are a clever way to make complex features of a client's life more concrete and accessible for both client and worker. They usually take the form of asking the client to give a number from 0 to 10 that best represents where the client is at some specified point, e.g. Do you accept the need for social work help to resolve the problem? This scale can be used repeatedly at different points of the process. The responses form the basis of the follow-up questions from the worker that should aim to uncover, affirm and amplify the client's strengths.

Coping questions
These questions accept the client's perceptions of their situation (however desperate) and then move on to ask how the client is able to cope with such overwhelming circumstances and feelings. As the worker helps the client to uncover coping strengths, their mood and confidence usually rise. Sometimes new ideas for coping emerge that the client has never thought of before. Where clients return to the problem descriptions and associated feelings of discouragement, the worker should listen/empathise, before returning to a focus on strength's exploration and affirmation.

'What's better?' questions
These are useful in continuing the work of building solutions and uncovering client strengths. It increases the chances of uncovering exceptions and associated strengths that are the most meaningful and useful to the client at the present time. By asking what is better since the last time focuses on the process of work and change.

Risk dimension

Calder (2003c) has produced a generic risk assessment, analysis and management model designed to resurrect risk into all our assessments in a way that acknowledges strengths and risks and looks at ways in which we can balance them and come to informed and evidence-based decision-making. The significant questions for any risk assessment should include:

- What is the time frame for which the risk assessment is being carried out?
- What is the nature of the abuse or neglect that we fear might occur or continue?
- Assess all areas of potential risk.
- Define the behaviour to be predicted.
- Current incident of concern
- Take into account both internal and external factors.
- Locate the risk.
- Identify any risk heightening factors.
- Be aware of risk factors that may interact in a dangerous manner.
- Examine the nature of the risk factors.
- How serious are the consequence of it occurring for the child, for the child's family and for the agencies involved?
- What are the strengths in the situation being analysed?
- Do any risk reducing factors exist?
- What are the prospects for change in the situation and for growth?
- What can be offered to build on strengths and combat weaknesses?
- What is the risk associated with intervention?
- What is the family's motivation, and capacity, for change?

This can be represented once again in a diamond package that inserts risk back in to the assessment (see Figure 10.8) (Calder, 2004b).

Desired outcomes

Outcomes are an essential driving force for all involved in trying to intervene effectively to safeguard a child. CWLA (2003) identified five desirable outcomes of kinship care:

- The child will be protected and nurtured.
- The child's developmental needs will be met and any delays will be addressed.
- The child will maintain connections to important people from his or her birth family.
- The child will have lifelong connections to a family.
- The child's caregivers will be able to work with the agency and with community resources so that the services and supports he or she needs are provided (p18).

Outcome measurement and prognosis

Pitcher (2001) identified a useful structure for balancing the risks and benefits for a child of a

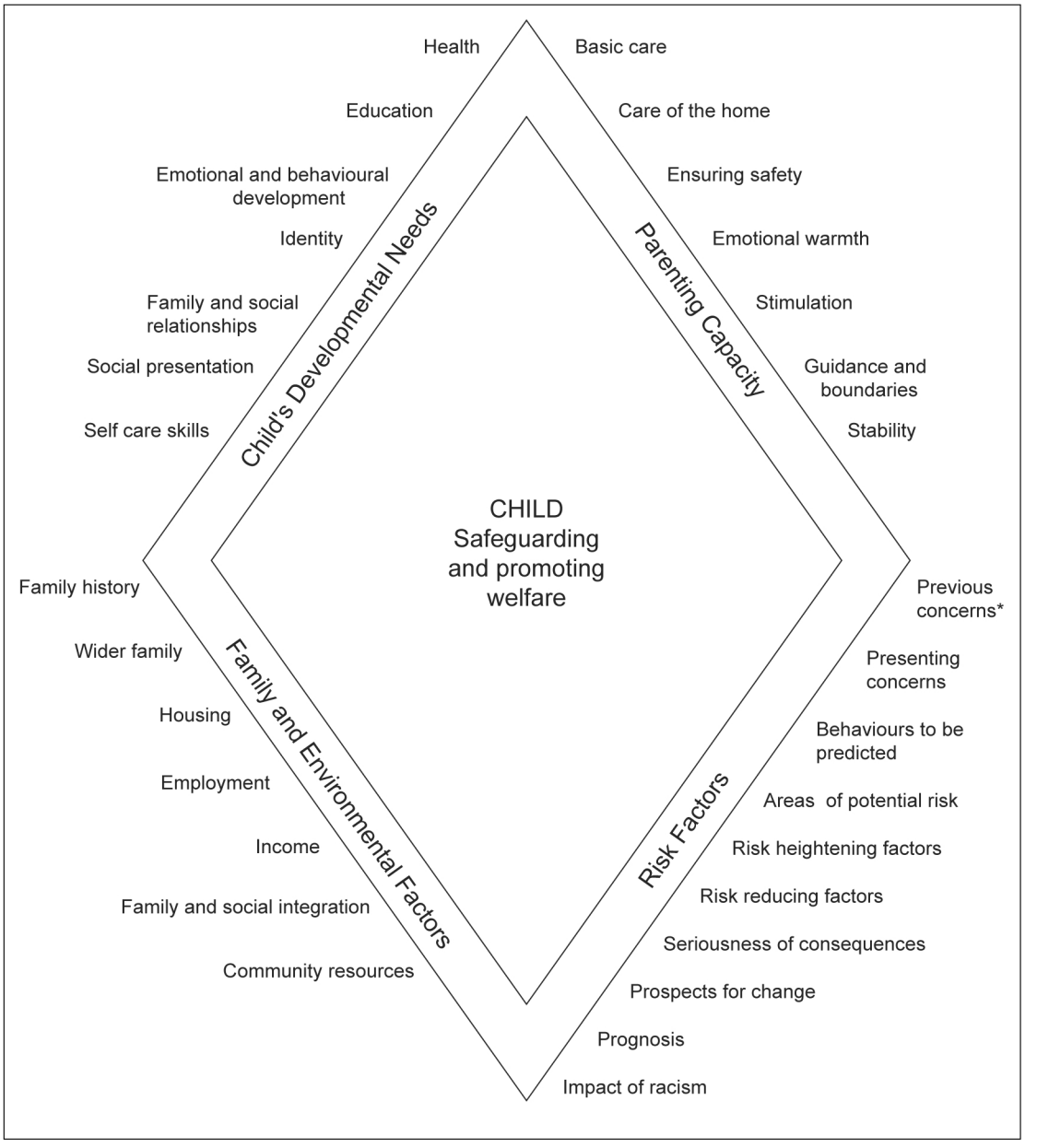

Figure 10.8 Risk factors

grandparent placement that is worth mention here (see Figure 10.9).

An early decision to discount carers is appropriate following a viability assessment, and any continuing concerns about their understanding of, and ability to meet, the child's needs is the critical consideration. In reaching such a conclusion, however, we do need to be alert to the time element involved in processing the information and moving through shock and denial to acceptance. Discounting a kinship placement does not prohibit an exploration of continued involvement of some kind in the child's life, or accepting that a future placement may be a viable option, and emergency action is rarely justified to remove a child from a

Potential benefits	*Issues for assessment*	*Potential risks*
1. Family is likely to see the child as less problematic than would a non-relative carer	Child's need for care	1. There may be concerns about age, health, housing etc.
2. A less drastic change for the child, especially if there is already a strong bond	Child's need for stability and continuity	2. It cannot be assumed that the child knows, or likes the relative
3. It is usually what the child wants	Child's need for identity	3. Other values may be more important. Best interests.?
4. Greater likelihood of lifelong contact with all family members	See Chapter 9 this volume	4. The child may remain in a dysfunctional family system
5. Child can see that some members of their family have succeeded	Family's relationship towards birth parent	5. The carer may be very negative toward the birth parent, or conversely be collusive
6. If a parent feels less threatened good quality contact is more likely		6. The family is less likely to receive money, training and ongoing professional support
7. The child is less likely to worry about their parent		7. Social services' involvement or control may seem intrusive or unnatural
8. Placement less likely to break down, or need professional support	Family's need for professional support	

Figure 10.9 Analysing assessment information (Pitcher, 2001)

placement unless what can be offered is similar or better. It is this critical threshold which many social services are struggling to cross, and we cannot ignore the emerging literature and research basis supporting the efficacy of kinship care placements. Conversely, workers do need to guard against continuing a placement simply because there is no better alternative, there is pressure to sustain the placement for this reason alone and it has nothing to do with the child's needs and safety.

Kinship care must be properly explored for all children and young people. The new Special Guardianship Orders will heighten this requirement (Talbot and Kidd, 2004). Black children, facing the destructive impact of racism, are particularly vulnerable and this must be recognised. Institutional racism was again confirmed by the MacPherson report (1999). International evidence suggests that kinship care has acted as a buffer against racism, yet Ince finds that we still have to ask.

> *To what extent can local authorities continue to apply an ethnocentric approach to child care practice when there is a growing need to make a critical appraisal of outcomes for black children and young people who are looked after and being prepared for leaving the care system?*
>
> (Ince, 2001)

Kinship care, however, must not be seen as an easy or simplistic option, and as Broad (2001) concludes 'Kinship care is not simply another placement choice with a single function. It is multi-functional, carrying important child protection, family support, and placement functions' (p159).

Assessments must balance strengths, difficulties and attend to risk. They must address the capacity to change and empower families to do so. These are complex and skilled tasks and professionals deserve support and resources to develop practice in kinship care. If professionals are unsupported then children and young people are unsupported. Children and families deserve skilled intervention. Children and young people should live within their families, whenever this is possible: this is a strong legal principle and should be the fundamental value base of all professional intervention with children and families.

Consider the views of this 15 year old young woman, living a four hour drive away from her birth family with a female adult kinship carer:

> *I have no space and no bedroom, sometimes I get to sleep in the bed but mostly I sleep on the pull out bed in the lounge. There's no space for friends to visit, no room for my brother to stay, no room to study, no privacy but I am the lucky one. My brother lives with a stranger, (a foster carer). I feel happy where I live.*

References

Broad, B., Hayes, R. and Rushworth, C. (2001) *Kith and Kin: Kinship Care for Vulnerable Young People.* London: NCB.

Broad, B. (2004) Kinship Care for Children in the UK: Messages from Research, Lessons from Policy and Practice. *European Journal of Social Work*, 7: 2, 211–27.

Broad, B. (Ed.) (2001) *Kinship Care: the Placement Choice for Children and Young People.* Lyme Regis: Russell House Publishing.

Calder, M.C. (1995) Child Protection: Balancing Paternalism and Partnership. *British Journal of Social Work.* 25: 6, 749–66.

Calder, M.C. (1999) Towards Anti-oppressive Practice with Ethnic Minority Groups. In Calder, M.C. and Horwath, J. (Eds.) *Working for Children on the Child Protection Register: An Inter-agency Practice Guide.* Aldershot: Ashgate.

Calder, M.C. (2003) *A Prognosis Framework for Cases Involving Sexual Abuse Within the Family: Practice Guidance Series Paper 2.* Leigh: Calder Training and Consultancy.

Calder, M.C. (2003b) *Carer's Assessments for Parents of Disabled Children.* Salford City Council: Child Protection Unit.

Calder, M.C. (2003c) *RASSAMM: Risk Assessment, Analysis and Management Model.* Leigh: Calder Consultancy.

Calder, M.C. (2004) *Origins and Location of the Family Group Conferences in the Structures and Systems.* Presentation to Flintshire Family Group Conference Chairs, June 2004.

Calder, M.C. (2004b) Child Protection: Current Context, Central Contradictions and Collective Challenges. *Representing Children*, 17: 1, 59–73.

Calder, M.C. (2005) Allegations of Abuse against Foster Carers: Prevention, Protection and Procedural Considerations. In Wheal, A. (Ed.) *The RHP Companion to Foster Care.* 2nd edn. Lyme Regis: Russell House Publishing.

Calder, M.C. with Peake, A. and Rose, K. (2001) *Mothers of Sexually Abused Children: A Framework for Assessment, Understanding and Support.* Lyme Regis: Russell House Publishing.

Child Welfare League of America (2003) *A Tradition of Caring: A Guide for Assessing Families for Kinship Care.* Washington, DC: CWLA.

Clark, B., Parkin, W. and Richards, M. (1990) Dangerousness: A Complex Practice Issue. In Violence against Children Study Group's, *Taking Child Abuse Seriously.* London: Unwin Hyman.

Cleaver, H., Wattam, C. and Cawson, P. (1998) *Assessing Risk in Child Protection.* London: NSPCC.

Crumbley, J. and Little, R. (1997) *Relatives Raising Children*. Washington, DC: CWLA.

DeJong, P. and Miller, S.D. (1995) How to Interview for Client Strengths. *Social Work.* 40: 6, 729–36.

Depanfilis, D. and Wilson, C. (1996) Applying the Strengths Perspective with Maltreating Families. *The APSAC Advisor.* 9: 3, 15–20.

DoH (2000) *Framework for the Assessment of Children in Need and Their Families*. London: HMSO.

Hackett, S. (forthcoming) Engaging Men. In Calder, M.C. et al. (Ed.) *The Carrot or the Stick? Encouraging More Effective Practice with Involuntary Clients.* Lyme Regis: Russell House Publishing.

Ince, L. Promoting Kinship Foster Care: Preserving Family Networks for Black Children of African Origins. In Broad, B. (Ed.) op. cit.

Laws, S. and Broad, B. *Looking after Children within the Extended Family: Carer's Views.* Leicester: De Montfort University.

Otto, H.A. (1963) Criteria for Assessing Family Strengths. *Family Process.* 2, 329–37.

Pitcher, D. (2001) Assessing Grandparent Carers: A Framework. In Broad, B. (Ed.) *Kinship Care: The Placement Choice for Children and Young People.* Lyme Regis: Russell House Publishing.

Regan, L. and Butterworth, J. (2004) Safe Care. In Wheal, A. (Ed.) *The RHP Companion to Foster Care* 2nd edn. Lyme Regis: Russell House Publishing.

Rose, K. and Savage, A. (1999) Safe Caring. In Wheal, A. (Ed.) *The RHP Companion to Foster Care.* Lyme Regis: Russell House Publishing.

Rutter, M. (1985) Resilience in the Face of Adversity. *British Journal of Psychiatry.* 147: 598–611.

Saleebey, D. (Ed.) (1992) *The Strengths Perspective in Social Work Practice*. New York: Longman.

Saleeby, D. (1996) The Strengths Perspective in Social Work Perspective: Extensions and Cautions. *Social Work.* 41: 3, 296–305.

Samra-Tibbets, C. and Raynes, B. (1999) Assessment and Planning. In Calder, M.C. and Horwath, J. (Eds.) *Working for Children on the Child Protection Register: An Inter-agency Practice Guide*. Aldershot: Arena.

Talbot, C. and Kidd, P. (2004) Special Guardianship Orders-Issues in Respect of Family Assessment. *Journal of Family Law.* 34, 273–80.

Appendix 1 Analysis of change tables

Focus of assessment	*Hopeful prognosis of change*	*Possible prognosis for change*	*Poor prognosis for change*
Partner of perpetrator			
Role in disclosing process.	Brought concerns to attention of child protection authorities immediately. Present during investigative interview (naming reality).	Delayed bringing concerns to child protection authorities. Minimal involvement during investigative interview (encourages denial).	Failure to take action. No involvement in investigation (encourages denial).
Understanding cause for concern.	Belief of child. Self motivation to engage in work. Co-operation with child protection authorities.	Partial belief/partial denial of allegation/ disclosure. Motivation to engage in work due mainly to external factors but also some internal factors present. Compliance with child protection authorities.	Disbelief or denial of allegation/disclosure. Refusal to co-operate. Motivation coming only from external factors e.g. legal proceedings/case conference proceedings.
Understanding of identified risks.	Awareness and understanding of risks that perpetrator presents. Awareness and understanding of role as protector. Ability to carry out role as protector.	Awareness of risks that perpetrator presents but limited understanding of what this means. Awareness of role as protector but limited ability to carry it out.	Awareness of risks but does not accept their existence. Unable to carry out role as protector.
Perception of role of self, victim, perpetrator, other family member's in relation to the abuse.	Awareness and understanding of: • each family member's role • responsibility for abuse is perpetrators • own failure to protect in past • acknowledgement of feelings around this e.g. guilt • sharing this awareness with victim and other family members	Partial awareness and understanding of: • each family member's role • difficulty in accepting reason why child did not disclose sooner • partial acceptance of failure to protect child in past • difficulty in communicating this to victim and other family members	Child seen as responsible for the abuse. Denial of role as protector in past and therefore no recognition of failing to protect.
Impact of disclosure on partner of perpetrator.	Acceptance that disclosure has impact on self and some awareness of what this is. Shares this information with professionals.	Partial denial of impact on self. Lack of awareness of the need to consider impact.	Total denial of impact on self and inability to talk about the abuse.
Relationship with perpetrator (partner). Insight into own victimisation and manipulation.	Independent of partner. Has had physical and emotional space from perpetrator through separation – allows for deeper understanding of manipulation and grooming by perpetrator.	Degree of dependency on perpetrator. Has had physical and emotional space to carry out work but not through separation. Therefore, ability to challenge perpetrator's manipulation and grooming remains limited.	Dependent on perpetrator. No physical and emotional space in which to resolve issues. Lack of awareness and understanding of manipulation and grooming.

Appendix 1 *(continued)*

Focus of assessment	*Hopeful prognosis of change*	*Possible prognosis for change*	*Poor prognosis for change*
Partner of perpetrator (continued)	Has challenged perpetrators manipulation and grooming. Insight into abusive relationship and sharing with professionals. Communication pattern between couple – open. Fully exercising her parental role i.e., protector, disciplinarian and in the setting of boundaries. Resolution of impact of abuse on self.	Lack of full insight into relationship with perpetrator. Communication patterns improving between couple. Attempts to exercise parental role within this context. Therefore, there may be a degree of protectiveness. Partial resolution of impact of abuse on self.	Abusive relationship still present and manipulation and grooming is still continuing. Communication patterns closed between couple. Denial of impact of abuse on self. Inability to protect children.
Knowledge and understanding of sexual offending history.	Full knowledge and understanding of partner's sexual offending history. Open communication patterns between couple regarding offences. Insight and understanding of manipulation and grooming. Ability to understand cause for concern and identify risks. Awareness of protective measures and ability to carry these out.	Some knowledg e and understanding of partners sexual offending history. Limited communication patterns between couple regarding offences. Level of minimisation by perpetrator of abuse. Has a desire to protect children but ability to do so is limited due to lack of full knowledge and understanding of offending history.	Little knowledge and understanding of partners sexual offending history or knowledge of sexual offending but limited understanding. Little communication evident between couple regarding offences. Level of denial by both parties present. Lack of ability to understand the risks.
Relationship with victim.	Good attachment patterns. Positive feelings towards the child and acknowledgment of conflicting feelings in past. Awareness and understanding of impact of abuse on child. Ability to meet child's emotional, psychological and social needs. Fully exercising her parental role i.e. protector, disciplinarian and in the setting of boundaries.	Impaired attachment patterns due to abuse. Unresolved ambiguous feeling towards the child. Own needs unresolved therefore difficulty in meeting child's needs and understanding impact of abuse on child. Attempts to exercise parental role. There may be a degree of protectiveness.	Poor attachment patterns and failure to meet child's developmental needs. Denial of impact of abuse on child. Own needs unresolved and take priority. Inability to exercise parental role appropriately. Inability to protect victim.
Relationship with other children.	Positive relationship with each child. Clear roles and boundaries. Open communication patterns where appropriate information is shared.	Some difficulty in relationship with children. Roles and boundaries unclear, communication difficult but willingness and acceptance of need to change.	Poor relationship with some or all of the children due to lack of insight of needs or ability to meet these needs.

	Supportive of their involvement in work with professional. Ability to meet each child's needs. Awareness of vulnerability and the risks and therefore the need for protection. Fully exercising her parental role i.e. protector, disciplinarian and in the setting of boundaries.	Supportive or ambivalent of their involvement in work with professional. Conflict between needs of the partner of the perpetrator and needs of children. Attempts to exercise parental role. There may be a degree of protectiveness.	Roles and boundaries blurred, communication closed. Lack of awareness or ability to change. Unsupportive of involvement in work with professionals. Inability to exercise parental role appropriately. Inability to protect victim.
Early history and background.	Has had positive attachment and parenting experiences. Awareness and understanding of how own background history influences ability to meet children's needs and be a protector.	Experienced disruptions in attachment and development. Some awareness and understanding of impact of life experiences on the present. Has an abuse history – not fully resolved. Conflict in meeting own needs and children's needs.	Poor attachment experiences and unmet developmental needs. Abusive history undisclosed/unresolved. Abuse may still be going on.
Knowledge of extended family where abusive history is suspected and confirmed.	Full knowledge and understanding of extended family abusive history. Open communication patterns between couple (and extended family). Ability to understand and identify risks from extended family. Ability to be protective with children.	Some knowledge and understanding of extended family abusive history. Communication patterns limited between couple (and extended family). May understand – and to a degree identify risks from extended family. Desire to protect but ability may be limited due to lack of knowledge.	No knowledge of extended family abusive history or Knowledge of extended family history and little understanding. Lack of communication between couple (and extended family). Denial of abuse or seriousness of abuse by family members. No acceptance and understanding of risks.
Expectations and hopes for future: Reality versus ideal.	Realistic expectation of time to complete work programme. Understanding and acceptance of the changes that need to take place-present/future. Understanding of impact of abuse on victim/sibling/self and acceptance that all family members require intervention at some level. Understanding of perpetrators need to accept responsibility to be involved in work Understanding that needs of children override needs of self and perpetrator.	Tension between different perspective's regarding length of time involved in process of change – client versus professionals. Difficulty in accepting need and understanding reasons for the involvement of all family members in the change process. Continuing conflict between competing loyalties to perpetrator versus victim (siblings). Unresolved conflict of needs – self versus children.	Unrealistic expectations of work needed, length of time of process of change and time needed to reduce risks or desire that contact with professional ceases. Denial of need to be involved in work with professionals. Does not adhere to protective strategies or understanding reasons why they are in place. Opposition to involving all family members in the work. Needs of perpetrator and self over- ride the needs of victim's siblings.

Appendix 1 *(continued)*

Summary of analysis of change	
Focus of assessment	*Prognosis for change* (Indicate if hopeful, possible or poor and reasons why.)
Partner of perpetrator	
Role in disclosing process	
Understanding causes for concern	
Understanding of identified risks	
Perception of role of self in relation to the abuse	
Impact of disclosure on the partner	
Relationship with perpetrator. Insight into own victimisation and manipulation	
Knowledge and understanding of sexual offending history Focus of assessment	
Relationship with victim	
Relationship with other children	
Early history and background	
Knowledge of extended family	
Expectations and hopes for future: reality vs ideal	