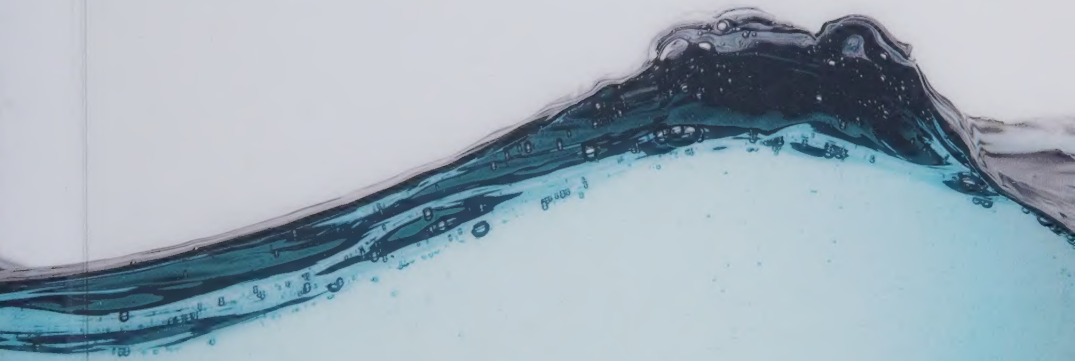
JUDITH MILNER | STEVE MYERS | PATRICK O'BYRNE



FIFTH EDITION

ASSESSMENT IN SOCIAL WORK

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5th edition

JUDITH MILNER, STEVE MYERS
AND PATRICK O'BYRNE

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INTRODUCTION

As with previous editions of the book, the changes we have made reflect primarily the revisions in legislation and guidance on how to undertake high-quality assessments. We have seen increasing divergence between the four nations as their respective legislative basis has developed, so that it is becoming even more important that practitioners keep pace with the guidance in their particular geographic location. Various initiatives come and go, so that what was high-profile guidance (for example, *Every Child Matters; Troubled Families*) has faded because of disappointing evaluations, political change and austerity. New ways of thinking and working are introduced reflecting current preoccupations and the socio-economic context, some of which are not always complementary, such as the emergence of the problem-based 'ACEs' (adverse childhood experiences) in children's social work but strengths-based practice in adult services. The call for more effective interdisciplinary, multi-agency, interprofessional working is still heard in this current edition as it has been in all previous editions of this book, and it may be that although different professions meet and talk more frequently, they still need to learn to understand each other.

Whatever the socio-economic context and challenges, a (student) social worker still needs to go about making sense of people whom they come across, recognizing that they live in a particular locality that will have its own interpretation of the guidance and specific community strengths and resources to draw on. Our own social work training included a 'community profile' of the areas we were learning in which provided an opportunity to reflect on the meaning national legislation and guidance had in the areas that we were located. Parents who are struggling to raise their children may well have experienced adverse events in their own childhood, but having an 'ACE' does not make you responsible for poor housing, sexually predatory men, closure of your local Surestart or suspension of your Universal Credit.

In the introduction to the last edition, we stated that *change always happens*, and we find ourselves able to restate this very solution-focused insight to the world we live in now. Yet some principles remain the same, such as the need to work with people who are experiencing hurt and harm with respect, with dignity, with humanity and in ways that are empowering. Our assessments need to enable people to live richer lives underpinned by choice and the ability to take risks, minimizing the potential for harm through

supported decision-making and management through comprehensive inter-professional working.

Social work has been subjected to significant change both through educational initiatives such as Frontline and Think Ahead and because of reductions in local authority budgets. The last edition was written at a time when their impact was beginning to be experienced and their impact has escalated in the subsequent years. Our previous concerns about the ethics of undertaking high-quality, in-depth, inherently intrusive assessments when the resources to meet needs are simply not there have become more pointed, leading to frustrations and demoralization for both service users and social workers. Social workers are often coordinators of assessments, fragmenting people into specific problems that are dealt with individually by specialists rather than coherently or holistically. We believe that social workers should have the skills and confidence to undertake assessments and other direct work that is of worth and quality, underpinned by values that place the person at the centre of the process. The body of research that recognizes the link between inequality, poverty, ill health and social problems continues to grow (e.g. Featherstone *et al.*, 2018), making recognition of this a key element of any assessment. Social workers, because of their commitment to social justice, are well placed to speak truth to the powerful social forces that impair the ability of people to achieve their hopes and dreams.

A thread throughout this book is the use of language, and how we talk about the people we work with is more than just descriptive – it can be laden with moral assumptions and judgements about the nature of problems and who is responsible for them. For example, a parent who is working with social workers to retain care for their children may be seen to be demonstrating 'disguised compliance'. This is both puzzling and patronising – the parent is doing what is asked of them but apparently not in a way that professionals believe. There is no way for the parent to prove that they are 'genuinely' compliant once this term is introduced, as being more compliant may still be viewed only as 'being more disguised'. 'Frail elderly' is another term that reduces any agency or particular strengths the person has into a label that shouts vulnerability and the need for protection and control. Any choices the person has are placed in the context of this risk and this can lead to decisions being made for them. If a life without risk is a life not worth living, then we are in danger of compromising the quality of someone's life by overriding their wishes on the basis of who we think they are rather than their individuality. Some approaches to assessment can overemphasize psychological aspects and marginalize or ignore the social context, leading to blame, shame and stigma. It is perhaps easier to locate blame with an individual and try to change them, rather than understand and change the social forces that create many of our problems.

These are complexities that we introduce throughout the chapters, including problematizing approaches that are often simply taken for granted

as being 'good', such as anti-oppressive practice and cultural competence. We have a critical eye on all claims to truth and invite readers to reflect on the content of the chapters through various exercises which have been updated from our own practice and that of others. The chapters have been substantially refreshed and updated to reflect changing research, legislation, policy and practices. We hope that this book will assist social work students, lecturers and practitioners to undertake quality, collaborative assessments that lead to effective, appropriate and empowering outcomes for people.

1 ASSESSMENT IN THE TWENTY-FIRST CENTURY

What this chapter is about

In this chapter, we look at the difficulty of defining assessment. How theory and research influence social workers' hypotheses about the focus of assessment is then addressed, as is the impact of legislation and government guidance in recent years and the complexities arising from the emphasis on managing risk.

Main points

- Definitions of assessment.
- How hypotheses are formed and checked.
- The changing legal context and its impact.
- Evidence-based effective practice.
- Handling information overload.

Defining assessment

Although Crisp *et al.* (2005) found that there was no universally agreed definition in social work, most textbooks on assessment offer some definition related to one or more of the five stages of assessment proposed by us (Milner *et al.*, 2015). Coulshed and Orme (2012) said it was an ongoing process in which the service user participates, the purpose of which is to understand people in relation to their environment; it is the basis for planning what needs to be done to maintain, improve and bring about change. Dyke (2016) said it is a process of professional judgement or appraisal of the situation, circumstances and behaviour of the service user and it might involve risk assessment, whereas Griggs (2000) said it is about ascertaining need.

More comprehensively, Smale *et al.* (1993) held that realistic assessment has to address the whole of the task, engage in ongoing negotiations with the full range of people involved in the situation and their possible solutions and

address the change, care and social control tasks so as to go beyond the individualization of social problems as the focus for assessment and intervention. Compton and Galloway (1999) described assessment as the collection and processing of data to provide information for use in making decisions about the nature of a problem and what is to be done about it. It is a cognitive process: it involves thinking about the data, and the outcome is a service plan which provides a definition of the problem for work objectives or solutions to be achieved, and an action plan to accomplish the objectives. For Hepworth *et al.* (2002), assessment is a fluid, dynamic process of receiving, analyzing and synthesizing new information as it emerges through the entire course of a given case. Mainstone (2014) makes the point that meeting the needs of each family member and protecting the vulnerable from harm often mean that several different assessments have to be brought together before a holistic understanding can be reached. Furthermore, sometimes specialist assessments offer new insights or difficult, contradictory information.

The *Working Together to Safeguard Children* guidance (DfE, 2018) states that, whatever the legislation the assessment is being made within, the purpose is to gather important information about a child and family; to analyze their needs and/or the nature and level of any risk and harm being suffered by the child; to decide whether the child is a child in need (section 17) and/or is suffering or likely to suffer significant harm (section 47); and to provide support to address those needs to improve the child's outcomes to make them safe. Additionally, and echoing Hepworth *et al.* (2002), the guidance recommends that the assessment should be 'a dynamic process, which analyzes and responds to the changing nature and level of need and/or risk faced by the child' (p. 25). We look at this in more detail in Chapter 10.

Our definition

Assessment in social work is a five-stage process of exploring a situation by:

1. *Preparing* for the task.
2. *Collecting data*, including perceptions of the service user, the family and other agencies of the problem and any attempted solutions.
3. *Applying professional knowledge* (practice wisdom as well as theory) to seek analysis, understanding or interpretation of the data.
4. *Making judgements* about the relationships, needs, risks, standard of care or safety, seriousness of the situation, and people's capacities and potential for coping or for change (is the progress good enough?).
5. *Deciding* and/or recommending what is to be done, plus how, by whom and when, and how progress will be reviewed.

In this definition, *analysis* is about making sense of events and statements, arriving at an overall picture and an understanding of what is happening, and perhaps giving some thought as to how the situation has come about, using one or more of the theoretic 'maps' (Chapters 5–9). *Judgement* is about what is good enough and what is not, what is dangerous and what is reasonably safe, what is of a reasonable standard and what is not. *Decision-making* is about future action or inaction and aspects of that action, with a plan for carrying it out and reviewing it. Described thus, it seems almost simple, but of course it is anything but in most cases. Even the question of what data to collect, what is relevant, what is enough, and so on, makes the very start of the process difficult and many of the frameworks that have been written are little more than checklists to ensure nothing relevant is forgotten in stages 1 and 2 of work with particular service user groups. Where it is needed most – in stages 3, 4 and 5 – there is less guidance. We will return to examining frameworks in Chapter 3; first we consider some of the debates over what knowledge informs the process.

How working hypotheses are developed

Traditionally, social work texts have expressed agreement that assessment is a key element in social work practice, in that without it workers would be left to react to events and intervene in an unplanned way (see, for example, Coulshed *et al.*, 2006). Having agreed on the centrality of assessment in the social work process, some texts have then dismissed the subject in a few pages. Apart from giving some brief homilies on counter-checking facts and hypotheses and the necessity of reassessing wherever appropriate, most writers made a list of information-yielding sources and then departed from the subject to other aspects of the social work process. Exceptions include Middleton (1997), Clifford (1998), Parsloe (1999), Holland (2010) and Mainstone (2014), who have written books specifically on assessment.

However, gathering information, sifting it carefully and coming to an 'objective' and 'accurate' conclusion are by no means as unproblematic as this implies; assessment has never been the scientific, easy-to-learn activity that many writers pretended. For example, Coulshed and Orme (2012) compared assessment with a social study that avoids labels and is reached as a result of logical analysis of data which has been collected carefully and systematically. They implied that editing needed to be done but made no suggestion as to how this skill could be acquired, although editing shapes the way information is collected and selected for the initial assessment (Sheldon, 1995), and later information is processed selectively and discretely if it fails to confirm the initial hypothesis (Reder *et al.*, 1993; Milner, 2008b).

THEORY INTO PRACTICE

Mohammed and Tracy's children were removed from their care following discovery that Mohammed was violent towards Tracy, that their home lacked some basic amenities, and that they regularly entertained large numbers of young people who were known to misuse substances. Mohammed and Tracy obtained the tenancy of a more suitable house in a nearby town, the address of which they kept from their previous acquaintances. They were angry and upset throughout the subsequent child protection assessment process, being particularly aggrieved at what they perceived as a lack of acknowledgement of their efforts to meet the concerns which had led to the removal of their children. After Mohammed beat Tracy again, she ejected him from the house and was hopeful that she would regain the care of her children. She found the questions asked as part of the continuing assessment offensively intrusive and tended to respond in either an angry or a tearful manner. The social worker accepted that Tracy had done everything demanded of her but continued with care proceedings on the grounds that Tracy's 'hostility' would make it impossible for her to work with Social Care if the children were returned on a supervision order.

- How could the information collected by the social worker have been interpreted differently?

Viewing assessment as unproblematic and unbiased in itself creates a gap between theories of problem causation and intervention, a gap in which the service user is often squeezed to fit the social worker's ideas about the nature of people and how best their problems could be addressed. This has been recognized for some time in social work practice. Denney (1992), for example, found in his study of probation reports that many of the assessments seemed to contradict the form of work being advocated. The most commonly used interventions were largely individual rather than social, although there have been some protests:

> If we are to maintain the integrity of 'community' care, 'social' service and 'social' work, we have to confront the constant tendency that we all have to regress to the individualization of people's problems. (Smale and Tuson, 1993, p. 30)

Similarly, Barber (1991) expressed dismay at the tendency towards 'reductionism' in which social work became equated with casework and individual solutions were found within the psychopathology of individuals and their interpersonal relations. Harrison (1995) refers to this as the 'forensic gaze', suggesting that it gives rise to 'placebo solutions'. He illustrates his point with the example of a refugee mother of five children.

> Mrs. Rusha lost half her family, struggled through a civil war, fought her way to England, studied in the evenings for a decent job and then popped out to the shop, leaving a 10-year-old in charge of the family. She was then 'threatened' with parenting skills training.

This was a solution firmly embedded in a belief that family pathology is the key to much abuse and neglect rather than one, minority, analysis of the context of abuse. Why the preoccupation with individual casework? Scourfield (2003) makes an important point about the impact of theory and research on the development of working hypotheses: '[S]ocial workers take up *selected and condensed messages* from this literature, which are passed on to colleagues through occupational cultures' (p. 111, *our emphasis*). For example, he found that the persistence of psychodynamic ideas about the emotional well-being of children in social work practice meant that social workers dig for sexual abuse as an explanation of current family dysfunction: '[I]t seems that social workers want to get beyond the surface of observable family situations to find unpleasant secrets rather than locate causes of problems that can lead to helping strategies' (Scourfield, 2003, p. 127). 'Digging' for secrets not only is subjective data collection but also is deeply resented by service users:

> They failed me with my sexual abuse. My social worker never even turned up for the court case, even though she promised. I took an overdose after the court case and then she turned up ... before, she was just digging, thinking it was something else, like a problem at home. (Milner, 2004)

It also skews the assessment, leading to inappropriate interventions being prescribed. The Criminal Justice Joint Inspection of responses to children and young people who sexually offend Criminal Justice Board (2013) found that 'most of the work to address offending behaviour was not delivered as identified in various plans, and interventions were not always informed by assessments' (p. 7).

PRACTICE EXAMPLE

Nadia, a girl subjected to a single sexual assault by a peer acquaintance, was assumed to require counselling because of the traumatic nature of the event. She was referred to a group for girls who had been sexually abused, yet left after one session because the rest of the group had been systematically abused by members of their families over a long period of time, an experience to which she could not

relate. Nor did the therapy address her specific needs. Questions were asked about her 'denial' (a psychological concept of dubious validity) as she had been subsumed into a category 'abused' without any sense of the complexity and individuality of her own experience. She had been constructed as a victim, which became her identity with all the expectations of this (Myers and Milner, 2007, p. 2). As psychological explanations locate problems and solutions within people, they categorize rather than individualize people.

There are several important assumptions being made here:

Checking assumptions 1

The counselling offered to Nadia is predicated on assumptions that sexual abuse is always traumatic, that it is likely to be repressed (so the person will deny or forget much of it), and that it needs to be sensitively drawn out through the counselling process before the person can 'move on'. Check out the basis of this assumption by reading one of the following texts:

Storr, A. (1966) 'The concept of cure'. In C. Rycroft *et al.* (eds), *Psychoanalysis Observed*. Harmondsworth: Penguin.

Bass, E. and Davis, L. (1988) *The Courage to Heal: A Guide for Women Survivors of Child Sexual Abuse*. New York: HarperCollins.

Dolan, Y. (1991) *Resolving Sexual Abuse*. New York: Norton.

Selekman, M. D. (2002) *Living on the Razor's Edge*. London: Norton.

Warner, S. (2001) 'Disrupting identity through visible therapy: a feminist post-structuralist approach to working with women who have experienced child sexual abuse', *Feminist Review*, 68(1): 115–39.

Barber (1991) complains that the problem with much casework theory is that the sole unit of concern and the focus of all analysis is the individual. The research by Sinclair *et al.* (1995) into assessments of young people accommodated by a local authority also expressed concern about the tendency of 'traditional' assessments to concentrate on searching for the origins of past problems. They comment: 'However it is defined, assessment was commonly associated with identifying a problem, the purpose of which was to find an appropriate resource or solution' (Sinclair *et al.*, 1995, p. 130). Given that resources available to social workers have always been restricted, it is not surprising that they have been lured into locating the solution within the individual. There are several reasons why social workers find a broad, social assessment particularly difficult to undertake and present successfully to their managers.

Assessment of individual need is affected by expediency because there is pressure on workers to construct their assessments so that they fit into

existing resource provision. The pressures of expediency may mean that it is easier as a consequence to subsume some individual needs under more general family needs when one is faced with uncooperative family members. For example, Bebbington and Miles (1989) found that a combination of poverty and lack of available social support led to children being accommodated; Bilson *et al.* (2017) found that deprived families experience significant levels of child protection investigations; and Bywaters *et al.* (2016) found that poor socio-economic circumstances are a contributory causal factor of child abuse and neglect confirming that 'most people enter residential care because of the relationships they have, or do not have, in their social circumstances and not just because of their individual characteristics' (Smale and Tuson, 1993, p. 26). Similarly, mental health problems are more likely to result from a range of adverse factors associated with social exclusion than from individual characteristics (DoH, 1998, p. 6).

When one is faced with the miseries of poverty, inadequate housing and poor employment conditions, it is easier to seek psychological explanations for events rather than explore complex interactions between the social and psychological dimensions of problems. The 'psychologizing' of social problems in this way has been referred to as 'therapy to help you come to terms with your rats' by practitioners who are only too aware of the fate of an accurate assessment. Agency function rarely permits social workers to address major problems rooted in social deprivation and, at the same time, hold them responsible for attempting to operationalize a care plan that is not founded on a realistic social assessment.

Equally damaging is sociological reductionism (attributing all social phenomena to social structures alone), as a number of child deaths in families of different cultures demonstrate (see the Climbié report as an example of these). Indeed, research shows that a different approach to child protection assessments is taken depending upon whether the subject of inquiry is a case of physical or sexual abuse – the former tending to focus on parents and the latter on children (Corby, 2000), although this creates difficulties where children are victims of adult sexual abuse but have also been encouraged to sexually abuse their younger siblings. Should the assessment focus on the child's needs or other children's safety (Myers and Milner, 2007)? Scourfield (2003) looks at how working hypotheses are developed from feminist sociological research into sexual violence, with men seen as a threat to children. He found that social workers interpreted the research in a way that formed a rigid template for assessing safety: sexual offenders were viewed as inherently recidivist and thus exempt from the fundamental tenet of social work: universal respect; thus, women who refuse to leave such partners are constructed as failing to protect rather than as women in need. This distorts the reality of sexual abuse for mothers, who typically vacillate between believing their partner's assertions of innocence and their children's disclosures (Milner, 2004). This does not necessarily mean that a mother is either in denial or failing to safeguard her children (for a fuller discussion, see Turnell and Essex, 2006).

Checking assumptions 2

What evidence do you have that sex offenders are inherently dangerous and recidivist? Check this out by reading the following:

Craig, L. and Hutchinson, R. B. (2005) 'Sexual offenders with learning disabilities: risk, recidivism and treatment', *Journal of Sexual Aggression*, 11: 289–304.

Soothill, K. *et al.* (2000) 'Sex offenders: specialists, generalists, or both?', *British Journal of Criminology*, 40: 56–67.

Hanson, R. K. (2004) 'Sex offender risk assessment'. In C. R. Hollin (ed.), *The Essential Handbook of Offender Assessment and Treatment*. Chichester: Wiley.

Checking assumptions 3

How likely are child sexual abusers to become adult offenders? Check the evidence for this by reading:

Hackett, S. (2004) *What Works for Children and Young People with Sexually Harmful Behaviours?* Barkingside: Barnardo's.

Bateman, J. and Milner, J. (2015) *Children and Young People Whose Behaviour is Sexually Concerning or Harmful*. London: Jessica Kingsley Publishing.

Cowburn, M. and Myers, S. (2016) *Social Work with Sex Offenders: Making a Difference*. Bristol: Policy Press.

There remains a rightful place for psychological explanations in assessments; the real issue is to remain cautious (Sutton, 2000) and avoid blaming or pathologizing individuals by ascribing to them the cause of their difficulties that stem from injustice, disadvantage and deprivation. Barber (1991) clearly argues that external difficulties cause and interact with internal difficulties.

How does this happen? The 'social' frequently becomes 'psychological' and vice versa; the disempowered develop 'learned helplessness', for example, and resource improvement may not be a helpful solution on its own. Many service users either 'lack the purchasing power to seek solutions to their problems or are constrained by the courts to submit to social work' (Barber, 1991, p. 29). Common to both instances is a lack of control over some of the important events in their lives, and therefore a 'psychology of empowerment' is useful. Powerlessness generates despair, listlessness and lethargy, people internalizing the views of oppressors, blaming themselves and developing dysfunctional, self-defeating thought processes and behaviours so that, in Freire's (1972) terms, 'the oppressor lives inside'.

Social work hypotheses underpinning assessment are encouraged by what has been called an 'individual dependency-led model' (Dalrymple and Burke, 1995), leading to what Lindow (2000) refers to as 'clientism'; that is,

simply by *being* a client of social services, people's judgements about themselves and their differences are seen as inferior to those of social workers, who become the experts in problem-solving. As Braye and Preston-Shoot (2010) say, 'To be chosen for state intervention somewhat lowers citizenship status, confirming the neediness as some form of pathology' (p. 37). None of us is objective in our assessments as we tend to weight some piece of evidence more heavily than others, particularly negative information. There are also two other effects of this *selective attention*: vivid, distinctive or unexpected data are perceptually more salient. The subjects of social work assessments are most likely to encourage these effects, the reason for their referral being usually one which is distinctive. As they will initially be seen when they are at their 'worst' (an overload of negative information), they will then present the assessor with an initial impression that is difficult to dislodge.

Thus, service users' potential and possible solutions are often ignored. This leads to social workers clinging to their hypotheses and interventions in the face of considerable failure. For example, child protection social workers who hold strong beliefs about the importance of attachments in healthy personality development undertook lengthy assessments consisting of ten sessions with parents discussing their attachment experiences, without ever once observing the parents parenting their children. The results were that mothers not uncommonly were prescribed counselling to come to terms with previous experiences of abuse before their children could be returned home, despite the mothers exhibiting many mothering skills and capacities (for a fuller discussion see Milner, 2001). Similarly, Dobash *et al.* (2000) base their understanding of domestic violence on a concept of male abuse of power, with interventions predicated on the principle of challenging abusive men in groups. Their research into the men's analyses of their behaviour revealed that the men located their violence in domestic discord and desperately wished to stop arguing and fighting with their partners and that their narratives were so impoverished that they did not understand the concepts of male power underpinning the prescribed group 'challenging'. Dobash *et al.* (2000) reframe these findings as more 'denial' in need of further challenging. The group work interventions researched had a high dropout rate; however, rather than reassess in the light of service user views, the authors recommend more of the same but backed up by a court mandate. The working hypothesis that domestic violence is the misuse of male power over known women became so entrenched in social work assessments that female violence or couples fighting was constructed as 'fighting back' and totally ignored (for an overview, see Milner, 2004, 2008a, 2008b). For example, faced with permitting a father to care for his children after his partner left the home following the extensive couples' fighting when they were both coming down from drugs, a female social worker said: 'We did everything we could to keep the children with the mother and get her to separate from the father. It goes against everything I stand for to have had to place them with the offender [the father]'. The lack of evidence to support the effectiveness of this

approach has led to the phasing out of these (Integrated Domestic Abuse) programmes and their replacement with the more therapeutically oriented Building Better Relationships (BBR) approach (Hughes, 2017).

Checking assumptions 4

To what extent is female violence always a defensive response to men abusing their power? Check this out by reading the following:

Grady, A. (2002) 'Female-on-male domestic abuse: uncommon or ignored?' In R. Young and C. Hoyle (eds), *New Visions of Crime Victims*. Oxford: Hart.

Muptic, L. R. *et al*. (2007) 'An exploratory study of women arrested for intimate partner violence: violent women or violent resistance?', *Journal of Interpersonal Violence*, 22: 753–74.

Milner, J. (2008b) 'Working with people who are violent towards their partners: a safety building approach', *Journal of Family Therapy*, 30: 29–53.

Roddy, J. (2015) *Counselling and Psychotherapy after Domestic Violence*. London: Palgrave Macmillan.

Lindow (2000) suggests that pessimism and persistence with an original planned intervention are caused partly by the compartmentalized thinking that characterizes much service delivery, the latter imposed largely by legislation which is based on preventing something rather than enabling independence – a shift towards risk assessment. Also, treating people in separate groups according to age or impairment or defined status can powerfully enhance *stereotyping*. There can be some truth in stereotypes – indeed, people give strong signals by the way they present themselves, indicating the categories to which they consider themselves to belong. The danger is that information on which categorization is made may be faulty because of the selective attention errors mentioned above or because differences from a stereotype that indicate a person's uniqueness may be ignored. For example, a social worker with a stereotype of Asian families to do with the importance of family networks assessed an Asian woman as depressed owing to social isolation because she had no links with her extended family. This completely ignored the fact that she had made a conscious decision to move away from her family, whom she saw as the cause of her problems in the first place.

Primacy effects work on stereotyping in a peculiar manner. If the first impression is a good impression – which will be weighted heavily for both distinctiveness and primacy effects – a halo effect can sometimes operate in which a person's very positive characteristics colour one's perception of their various other characteristics. This is quite different from picking out strengths and resources as well as dangers in assessment work and can have grave consequences when too much is expected of people. Another inherent danger in stereotyping is that it tends to produce negative as well as positive self-fulfilling

prophecies about people. Putting people into erroneous categories tends to perpetuate myths about them, as has been amply demonstrated by research into social class, race and gender effects on educational achievement. The results of research into social work attitudes show that social workers are, like everyone else, susceptible to stereotyping effects, with concomitant self-fulfilling prophecies. Davis and Ellis (1995) found that when social workers were responsible for allocating scarce resources, they labelled people who appeared knowledgeable about their entitlements as 'demanding' and those who tried to exercise choice or challenge workers' judgements as 'fussy' or 'manipulative'.

We suggest that, in new situations, social workers routinely ask themselves 'How is this person similar to others – how might they be categorized?' and then ask 'How are they *different*?' The most common way in which service users are categorized is by age, but this is not always helpful.

THEORY INTO PRACTICE

Jeff is a young man who physically abused his partner but had also been sexually abused by his foster father and is about to lose his job. Should he be the subject of a risk assessment or a needs assessment?

Cassy, aged 15, is her disabled mother's primary carer but was being physically abused by her alcoholic father. Should she be assessed as a young carer or as a child at risk of significant harm?

A risk assessment would probably mean that neither of their own descriptions of themselves would be considered: Jeff viewed himself as a child in need whereas Cassy viewed herself as an adult with responsibilities. If they were to be appropriately compartmentalized for service assessment and delivery, Jeff would be best served by a children and families team and Cassy by an adult care team, although their particular risks and needs do not actually compartmentalize neatly.

While social workers remain within a problem-solving narrative which pays little attention to the complexities of assessment, it is very difficult for them to make social rather than individual assessments, as the former would highlight what is currently well hidden; that is, the moral issues involved in making judgements about what is and what is not desirable social behaviour. It is not surprising, therefore, that social workers tend to drift towards psychological reductionism, to analyzing and working on the individual service user. And this service user was for a long time most likely to be a woman. Despite service user compartmentalization, the majority of carers are women (58 per cent – CarersUK, 2015), as are the majority of service users (for an overview, see Braye and Preston-Shoot, 1995), although most people's lives are more complex.

PRACTICE EXAMPLE

Lynne's mental and physical frailty cast her as needy (deserving), vulnerable, dependent and incompetent. The influence of scarce resources meant that when her son lost his flat through unpaid rent and moved in with her, he was recruited as her main carer. She then had several hospital admissions following overdoses and facial bruising which she told neighbours was caused by her son but which she vigorously denied in hospital. A reassessment of her as victim of adult abuse floundered on the possibility of further risk to Lynne of re-abuse and the loss of her main carer. In actual fact, this family's relationships were more complex than carer and cared-for. They were interconnected in that they both were grieving the recent deaths of Lynne's husband and older son; they were interdependent in that the son needed a home with his mother and she depended on him to pick her up after falls and arrange medical treatment; and neither of them had any other close emotional contact. Thus, they were simultaneously vulnerable and competent and their desires for independence and choice were stifled by assessments which were framed in the 'either/or' of needs/risk.

The changing legal context and its impact on practice

The sweeping reforms embodied in the welfare and education legislation enacted in England in the early 1990s, with the emphasis on the family and its informal networks as an essentially private arena for the provision of care – a view of the family as an independent economic unit, clarified the distinction between assessment and intervention but added a new set of values for social workers. (The legislation varied in Wales, Scotland and Northern Ireland. For examples of how assessment practice was affected, see Cree and Myers, 2008.) These included partnership, empowerment, multi-agency cooperation and value for money. Assessment was separated from intervention, which became 'care planning', the former being focused on the identification of the objectives of care and the problems to be tackled, and the latter being focused on the actual selection of appropriate means to meet these needs.

However broadly welcome the new legislation was to social workers, it had two major influences on assessment practices. First, by separating assessment from intervention and social workers from much 'hands-on' intervention, it removed them from the source of their practice theory. Second, it made their values explicit. It did not increase resources, suggest new interventions or state how the people social workers traditionally 'individualized' were to be increasingly valued by society. While providing much-needed

definitions of assessment, the new legislation had the effect of leaving social workers in a vacuum between the old and new styles of working and/or encouraging a checklist mentality. However, some of the blame for the vacuum lay with agency management, whose role was to equip staff for change; the law itself cannot directly govern practice.

Although all the major pieces of legislation (the Children Act 1989, the National Health Service and Community Care Act 1990, the Criminal Justice Act 1991 and the Education Reform Act 1993) emphasized assessment as a separate and important activity, with the Children Act and the National Health Service and Community Care Act having the same ideological underpinnings, it was the latter which most clearly spelled out precisely what is meant by assessment: '[T]here has clearly been detailed thinking on the purpose and nature of assessment activity and this is reflected in the impressive range of documents which have been produced by the SSI on this topic' (Sinclair *et al.*, 1995, p. 42).

Although s. 17 of the Children Act 1989 gave local authorities a general duty to safeguard and promote the welfare of children in need, there was little reference to the assessment of children 'in need' in the guidance accompanying the Act (Tunstill, 1993). As a consequence, women, who were most likely to be on the receiving end of assessments, were subject to a bewildering variety of formats depending on the location of the social worker within a specific specialization with its own particular assessment definition. Take, for example, the following hypothetical scenario of Mrs. Edwards:

> Mrs. Edwards is a depressed black woman living in poor material circumstances with three children, two of whom have problems at school, and a partner who is due to be paroled from prison where he is serving a sentence for aggravated burglary. She has no near relatives, although she is a regular churchgoer.

Prior to the introduction of the Care Act 2014 and the Child and Families Act 2014, Mrs. Edwards would have found herself subjected to several varied and contradictory assessment formats. Now the social worker would make a joint assessment where relevant agencies work together to avoid the person undergoing multiple assessments.

The social worker and other professionals could undertake, with the agreement of the people involved, a combined assessment, where an adult's assessment is combined with a carer's assessment and/or an assessment relating to a child so that interrelated needs are properly captured and the process is as efficient as possible (DHSC, 2018).

THINKING POINT

We discuss current guidance more fully in Chapters 9 and 10, but as legislation and guidance change more frequently than people's problems, we ask you here to examine your specific national legal mandate and guidance – how would you approach the task of assessing Mrs. Edwards?

Evidence-based practice

A further complication in assessment work is the growing trend to promote evidence-based practice. While the definition of this is being widened to include not only research but also government guidance, the work of theorists and other writers, and practice wisdom and experience, there are two main strands to evidence-based practice; the *first* is research evidence into problem causality, evaluation for knowledge as opposed to accountability (for a fuller discussion of the purposes of evaluation research, see Lewis and Utting, 2001). This 'evidence' influences the 'facts' selected during the assessment process, determining whether the focus is on needs, risks, potential or resources. For example, the evidence from *attachment* studies provides an explanation for dysfunctional behaviour at any stage of the life span (for an overview, see Howe, 1995) and is widely used in assessments, particularly in adoption, guiding and informing a range of interventions aimed at fulfilling attachment *needs*. Other evidence provides possible indications of increased *risk*, for example, the link between early cruelty to animals and subsequent abusive behaviour in adulthood (see Piper, 2003). In the case of the former, biases necessarily creep in – mainly to do with neglecting the wider social context of families as intrapersonal relationships are explored (Jack and Gill, 2003); in the latter, a checklist mentality is encouraged – despite prediction checklists being shown to be crude and unreliable measures of risk (for an overview, see Corby, 2000, pp. 186–9). Thus, simpler diagnosis is achieved at the expense of false certainty – a certainty that is hidden as social workers rarely make clear their preferred theories about the nature of people to the service users they are assessing. This denies the service user the possibility of participating fully in an assessment. When given this opportunity, they often define themselves differently. For example, when we advertised a domestic violence service for adults who wished to change their abusive behaviour, we found that three of the first ten adults to avail themselves of the service were women in same-sex relationships. As other programme designs were underpinned by 'evidence' that domestic violence is the result of the abuse of male power, interventions consisted of groups for heterosexual men and refuges/support services for heterosexual women, thus effectively denying resources to lesbian, gay and bisexual people.

The *second* strand of evidence-based practice takes a more pragmatic view, being concerned primarily with effective practice. Chapman and Hough (2001) see this concern as arising partly from an increase in the probation service's caseload which coincided with pressures of cash limits and partly as a reverse of the 'Nothing Works' pendulum. Outcome research has indicated that some probation interventions were more effective than others (see, for example, McGuire, 1995) and this shifted the focus of assessment work away from needs in favour of extensive assessments of risk of harm, offender motivation, and the targeting of effectiveness-based work using specific models such as that devised by Kemshall (1996). Caution has been expressed in social work that evidence-based practice can ignore the reflective, interactive and creative process of the work, leading to formulaic interventions that roll out the same approach to all those categorized as having the same problem. As Plath (2013) notes, this privileging of approaches that lend themselves to easy measurement does have the potential to reduce complexity and is of limited value, as many situations

> ... require multifaceted responses for which standardized treatment evaluations are generally inappropriate. The implementation of evidence-based practice in social work entails more than replicating standardized interventions. It involves a critically reflective decision-making process, informed by a range of relevant research and other evidence. (p. 234)

Details on outcome research into the effectiveness of particular social work methods are included at the end of the 'map' chapters (5–9).

Evaluation research undertaken to establish accountability ('Did It Work?') is often regarded as particularly sound research because of the impartiality of the 'stand aloof' researcher (Lewis and Utting, 2001; Newburn, 2001) but biases still exist. Macdonald (2000) suggests that synthesizing the effectiveness literature is fraught with difficulties in that literature reviews often contain biased summaries, that much of the research is out of date at publication, and that it is rarely updated in the light of new evidence. Indeed, any evidence on effectiveness that exists may well reflect a well-researched, tried and tested approach, rather than new and innovative ways of working. Paradoxically, the drive to deliver approaches supported by current evidence may well exclude the introduction of approaches that have the potential to be more effective. Lack of evidence for an intervention may be due not to its ineffectiveness but rather to the lack of adequate resources available for the evaluation (research is expensive and time-consuming), the limitations of the evaluation processes (research is complex and fraught with methodological differences) or the difficulties of trying to bring order to understanding the 'messiness' of people's lives. Webb (2001) also points out that evidence-based practice is limited by other complex phenomena involved; for example, much decision-making is not rationally determined or subject to control.

There is also 'a degree of ambiguity over the extent to which "what works" for children is the same as "what works" for families and "what works" for society as a whole' (Glass, 2001, p. 17). Generally, research in social work does not meet the expectations of an evidence-based practice culture (Thyer, 2002).

Smith (2004) makes the important point that, whatever the evidence, some practitioners are not only more skilled than others but also better at deciding what evidence is relevant to a particular case; thus, success may be evidence not that a particular theory works but simply that the worker is skilled:

> What matters or should matter in making choices among theories is whether a given theory is helpful in a particular context in relation to a particular problem, not whether it has consistently demonstrated its predictive power. (Smith, 2004, p. 16)

In making a choice of a particular theory or specific research findings, the practitioner also needs to be aware that others involved in the case may have different preferences. This is especially true where the assessment is a joint or team one (Gould and Kendall, 2007; Mainstone, 2014). At least, this may limit the contributions of some practitioners where they lack the status of others; at worst, it will confuse the service users.

Handling information overload

Despite the growing volume of frameworks and checklists, for the busy social worker trying desperately to keep up to date with all the new information contained in the research literature and the procedures and responsibilities laid down in government guidance, selecting what information is relevant to them remains the biggest problem in assessing for a specific purpose (either risk or needs) and being fair. The social work literature, research evidence and government guidance have been, and sometimes remain, vague about how this task is to be undertaken, yet they are central in that the process controls the nature, direction and scope of social work intervention, an intervention that may well affect a service user's entire life.

It is rarely possible to have a single purpose when dealing with families in trouble. Their real-life situations involve the assessing social worker in attempts to achieve a satisfactory balance between diverse needs, recognized risks and restricted resource provision or between considering whether some intervention should be attempted as against the restraints of time. And there always exists the tendency to drift not only towards psychological reductionism as a placebo solution to inadequate resources but also towards risk assessments as a response to continuous public castigation of social work efforts. Despite the principle that individuals should be allowed to assess the risks to

themselves, should an older person be found to have died alone at home, it is likely that social work will be found culpable.

Whatever the difficulties with the effectiveness research, it has at least identified the core skills of successful assessment work. These include being punctual, reliable, courteous, friendly, honest and open: 'Staff who lack integration between their values and behaviour lose credibility with the people with whom they are working' (Chapman and Hough, 2001, 1.53). Similarly, the DoH (1999) identified listening, being non-judgemental, having a sense of humour, straight talking, and being trustworthy as essential elements of good professional practice (3.40). This brings assessment work back to basic social work principles and considerably clarifies the task.

Being straightforward with people and embracing the complexities of their lives actually help make sense of the sometimes competing requirements in assessment activity. Despite their similarities, people are actually very different in how they deal with their difficulties and so do not fit neatly into existing categories of service provision. Nor do they define themselves as carer or cared-for, or abused or abuser, or competent or vulnerable. These categories are more blurred in the everyday realities of their lives. Service users are capable of making assessments about their own needs and risks and the resources they would find useful and thus are potentially able to do much of the work for the assessor – even where risk factors are high, such as in cases where child abuse is strongly suspected but denied (Essex *et al.*, 1996). This is recognized in the guidance on adult abuse (DoH, 2000b), where it is recommended that social workers assess their assessments by learning from experience – including user/carer views on how interventions have worked for *them* (3.19), reflecting what Lymbery (2001) refers to as the breaking down of barriers between service users and social workers to create a 'new professionalism' that encompasses values of empowerment, advocacy and anti-oppressive practice as part of everyday social worker thinking. We examine anti-oppressive practice more fully in the following chapter.

As for uncertainty, we see it as a positive element. We invite social workers to resist the pressure for certainty because *uncertain is how things are*. It is striving for certain ground under our feet, not the uncertainty itself, that causes stress.



Summary

- A preoccupation with individual casework has inhibited the development of *social* assessments.
- Assessments have tended to locate the problems of family dysfunction not only in individuals but also in individual mothers.
- Assessment practice is beginning to move towards a balance of interests and external factors and more respect for service users' attitudes and views.

- Legislation defined assessment as an activity separate from intervention. Assessment activity is defined differently in each new piece of legislation.
- Differing emphases on risk, needs, resources and options make it difficult for social workers to develop an overarching framework for all their assessments. A dual focus on risk and safety is easier to accommodate in assessment frameworks than needs and risk.
- Assessments are best evaluated for their effectiveness in terms of the resulting decisions on service users' lives.
- Finding and using evidence for practice are complicated and require a critical understanding of research.
- Social workers need to learn to live with uncertainty and to communicate it to others while stating firmly what their own professional experience tells them should be done.



Further learning activity

- What is your strongest belief about the nature of people?
- Find evidence to support this.
- Find evidence that contradicts this.



Further reading

Gehring, K. and Vaske, J. (2017). 'Out in the open: the consequences of intimate partner violence for victims in same-sex and opposite-sex relationships', *Journal of Interpersonal Violence,* 32(23): 3669–92.

Holland, S. (2011) *Child and Family Assessment in Social Work Practice*, 2nd edition. London: Sage.

Mainstone, F. (2014) *Mastering Whole Family Assessment in Social Work: Balancing the Needs of Children, Adults and Their Families*. London: Jessica Kingsley Publishing.

Milner, J. and Myers, J. S. (2017) *Using Solution Focused Practice with Adults in Health and Social Care*. London and Bristol: Jessica Kingsley Publishing.

2 ANTI-OPPRESSIVE PRACTICE

What this chapter is about

In this chapter, we examine the origins of anti-discriminatory practice (ADP) and anti-oppressive practice (AOP) in the radical social work of the 1970s, and how it has been developed by Dalrymple and Burke (2006), Thompson (2003) and Burke and Harrison (2009). The complicated nature of power is then discussed and the interplay between the various '-isms' is examined. The implications for assessment are detailed, particularly the importance of negotiating perceptions and recognizing diversity. There follows a critical comment on the lack of an adequately agreed definition of what constitutes equality; the nature of knowledge; and the fluidity of social divisions which complicates AOP. The chapter concludes with suggestions on the basic elements of effective AOP, those which promote genuine partnerships in the assessment process.

Main points

- Wider theoretical issues: origins of AOP and ADP and the complexities of power.
- The 'isms': class, race and gender (the 'big three') and other social divisions such as religion, sexuality, disability, age and language.
- The implications for assessments: negotiating perceptions, similarities and differences, and acknowledging diversities.
- Critical comments on the complexities of anti-oppressive practice, equality and rights.
- Cultural competence and its role in social work.
- Outcomes in research measures and the effectiveness of AOP.

Wider theoretical perspectives

ADP and AOP has its roots in the radical social work movement of the 1970s which was informed by humanistic and social justice values, raising awareness of how poverty and deprivation affected the lives of service users. The 1980s saw an increased awareness of inequalities arising from gender and ethnicity as well as class, culminating in the seminal work of Hugman (1991), who drew attention to the inadequate concept of rights which had underpinned citizenship in Western liberal democracies (p. 215) and the inequalities arising from this. AOP is based on a belief that social work should make a difference so that those oppressed may regain control of their lives and re-establish their right to be full and active members of society. To this end, say Dalrymple and Burke (1995), practitioners have to be political, reflective, reflexive and committed to promoting change. Reflection and reflexivity mean that they need to be critical of their everyday practice to ensure that they do not abuse their power, but having a commitment to challenging inequalities is viewed as central to effective AOP (Burke and Harrison, 2009). ADP (Thompson, 2017) focused more on managing diversity on the grounds that the result of negative discrimination is generally one of oppression, thus avoiding too narrow a perspective of equal opportunities. Central to both AOP and ADP are the notions of empowerment and emancipation.

Thus, social work practice has moved away from traditional approaches emphasizing a need to diagnose the problems of individual people and their families (largely through psychological knowledge) towards a more emancipatory form of practice which locates those individuals within their social contexts, particularly the structural patterns of society that perpetuate inequalities (for a fuller discussion, see Thompson, 2017). The traditional values of social work have been accommodated to some extent; for example, unconditional acceptance becomes respect for clients' dignity and strengths, self-determination becomes promotion of choice, and non-judgementalism becomes non-discrimination and anti-oppression. However, combining individualism, social collectivity and an understanding of oppression in all its forms involves accommodating overlapping psychological and social theories, creating a practice tension that is not easily resolved. At the most basic level, psychological theories underpinning different methods of interventions, those which social workers commonly use to 'shape' their assessments, were developed primarily as means by which individuals could be better understood by 'experts'. Attempts to graft on notions of empowerment to existing theories ignore their inbuilt Eurocentric and professional bias.

Despite their benevolent intentions, these theories essentially reflect the power relationships that exist between us all (Dalrymple and Burke, 2006). These existing power relationships are basically white, male, healthy, employed and Western-dominated. McNay (1992) suggests that, while all

oppressions are important, gender, race and class are more central to the profit base of our economy and therefore have a greater effect on how lives are lived and dominated (for example, by the exploitive division of labour). Although advocating that other social divisions should be extended, Payne, G. (2006a) still considers race, class and gender the 'big three'. Clifford (1994) writes that the material basis of social divisions is a governing factor in understanding real lives, going on to suggest that good practice requires the participation of workers whose personal experience of oppression gives them a counter-hegemonic understanding of material as well as cultural and personal differences. Similarly, attempting to reduce the complexities of this practice tension to personal prejudice or structural disadvantage, what Thompson (2017) refers to as psychological and sociological reductionism, can actually increase discrimination; a rigid interpretation of social structural oppression having the capacity to dehumanize social work and result in formulaic interventions (see, for example, Featherstone and Trinder, 1997) as much as a rigid interpretation of psychological knowledge has the capacity to story an individual *as* a problem rather than a person with a problem (see, for example, White, M., 1995a). We will address these complexities but this chapter will first examine what the various forms of oppression have in common, in particular the abuse of power.

Power

Power is a significant element in every relationship and a main motivating influence. Indeed, all relationships, whether between one individual and another, between one group and another, or between rulers and subjects, can be said to be the result of power. In social work, power may be legitimately used to empower others in AOP or illegitimately used to oppress others in malpractice. Power is also an element in the competitiveness of life, of the struggle for resources, employment and education. Social workers, too, can experience a lack of power, and this can help them to understand service users better, but, crucially, the concern for social workers is when power is used to exclude and marginalize: Thompson (2017) urges us to recognize the power of social workers in terms of knowledge and expertise; access to resources; statutory powers; and influence over individuals and agencies. In work with marginalized people, we seek to counteract negative images of self, negative life experiences, blocked opportunities and unrelenting physical and emotional distress. Thompson (2017) argues that it is essential to take a three-track approach that links the personal (P) with the cultural (C) and structural (S). P refers to personal/psychological factors and also to practice and prejudice; C refers to culture, commonalties, consensus and conformity; and S refers to structural aspects, social forces or the socio-political dimension. Thompson describes P as being embedded in C and C in S yet as all interacting with each other:

> It would be naïve to assume that professional practice can make major changes at the structural level. However, empowerment, by assisting people to take greater control over their lives, can have a significant impact at the personal level, thereby making a contribution at the cultural level and, in turn, playing at least a small part in undermining inequality at the structural level. (Thompson, 2003, p. 221)

It is optimistic to think that empowerment can be actualized just by minor tinkering with social workers' preferred theories. Traditional family therapists and psychodynamic counsellors have not readily addressed the complaints of feminists and black people that their theories lack an appreciation of the impact of patriarchal power on women and the impact of racism on black people. Their adaptations have been largely cosmetic and have done little to make social workers more confident about what empowerment, partnership and choice actually consist of (see, for example, Macleod and Saroga, 1988; Cavanagh and Cree, 1996; Jeffrey, 2011). It is naïve to underestimate the difficulties in operationalizing empowerment strategies – powerful people (and powerful theories and methods of intervention) are resistive to yielding power: 'Power concedes nothing without demand ... the limits of tyrants are precise by the endurance of those they oppress' (Douglas, quoted in Dalrymple and Burke, 1995, p. 14). Social workers are not in a position to *give* people power, and their aim to *help reduce* the powerlessness that individuals and groups experience is likely to be limited by other individuals' and groups' investment in power positions *and* in the complex nature of power.

There is an important psychological legacy left by powerlessness that includes lethargy, despair and listlessness – 'learned helplessness' – and, as Freire (1972) called it, a 'culture of silence' in which there is an apparent acceptance of servitude and dependence. The marginalized subscribe to the myth that they get what they deserve, and internalize, and are possessed by, feelings of alienation and worthlessness. Social workers can unconsciously reinforce this message through well-meaning attempts to recognize diversity; for example, the commonly used term to describe young people 'as confused about their sexuality' is not used to mean 'that a person has doubts that they are gay and considers that they may be heterosexual; it is a code for thinking about being gay' (Milner and Myers, 2007, p. 2). As Hicks (2007) points out, seeing lesbians, gays and bisexuals as fixed types with needs that need to be understood and met by social workers neglects the important question of the power of social work to *produce* these categories.

Powerlessness is not necessarily expressed in terms of easily defined oppressed groups; it is much more diverse and complex (1980). Foucault questions the relevance of ideas about power as primarily repressive by counterposing the idea of power as being both repressive *and* productive,

exercised not possessed and coming from the bottom up rather than being imposed from the top down (Sawicki, 1991).

For example, children, a perhaps easily identifiable oppressed group, are not entirely powerless. Foucault considers resistance and power to be interrelated. Marshall and Dixon (1988) discuss the relevance of the 'discourse' in which children place themselves as necessary for understanding the complexities of their power relationships. Thus, a child at school might be seen to be oppressed in terms of teacher discipline but may be acting in a children's discourse in which the teacher's power discourse is irrelevant. Marshall cites an example of a classroom incident involving young children and a female teacher in which two young boys temporarily positioned the teacher as a subordinate through the use of sexually explicit language. The teacher was unable to reassert control as the dichotomy between adult and child had been redefined as one between male and female, wherein the males are more powerful. The author concludes:

> Thus, through some discourses, children are able to enact strategies that gain power for themselves in relation to adults and can be experienced by adults as powerful. However, in the context of institutional adult authority these [strategies] may produce situations where children are excluded [from school] and can be seen as *powerfully powerless*. (Marshall and Dixon 1996, p. 104, our emphasis)

Appreciating that service users can be oppressed but, simultaneously, 'powerfully powerless' helps social workers to understand their own sense of frustration and powerlessness with looked-after children who truant, abscond or continue with the 'undesirable' behaviour that led them to enter the care system in the first place. These are not merely damaged and powerless children in a simple relationship with a powerful welfare network; they are active participants in the various facets of their lives, exerting power often outside the linear relationship with the professionals in the welfare network (see, for example, Barrett, 1997; Taylor, 2004; Fook, 2012). Similarly, social workers will be familiar with service users who are the most easily identifiable as oppressed – poor, old, downtrodden, disadvantaged families – who exhibit resistance through the only power mechanism available to them, the people Dale *et al.* (1986) refer to as 'passive-resistant'. This form of resistance can be very powerful indeed. Cockburn (1991) suggests that we need to recognize power as multidimensional in that it is spread around and that almost all of us share in it a little. Similarly, she argues that power is not always negative in that it can mean capacity as well as domination.

The 'isms'

It is clear that some 'isms' are more powerful than others at various times. If we measured them on a simple scale of 'isms' training, we would suspect social workers in the 1980s to have been more likely to have undergone 'race awareness' training than any other. This may have reflected the concerns of the time about the pervasiveness of racism, but it may also have been influenced by the fact that black men have much in common with the most easily identifiable powerful group in our society – white men. There are suggestions that masculine solidarity will make blackness the most important issue, deflecting attention from the issue of male power. As two white, male probation officers said at the time, 'There is more that joins men across class and disability, and even race and sexual orientation, than divides them' (Cordery and Whitehead, 1992, p. 29).

THINKING POINT

- An exercise during a social work course invited students to describe themselves in three sentences. The white students tended to describe individual characteristics, experiences, gender, likes and dislikes but rarely specified their ethnicity. The black and Asian students tended to highlight their ethnicity amongst other issues.
- What do you think are the reasons why the white students did not include ethnicity?
- What do you think are the reasons why the black and Asian students included ethnicity?

In the 1990s, feminist critiques placed gender more centrally in the anti-oppression debate (see, for example, Butler, 1990 and Fawcett *et al.*, 1996), with practice wisdom incorporating notions that are pro-feminist. Not only is it potentially oppressive to promote any particular 'ism' in that it creates a hierarchy of oppression that elevates one form of discrimination above others, it also ignores the interrelatedness and complexities of the various 'isms', most notably race, gender, class, age, disability and sexual orientation. Aldridge (2006) notes the decline in the social significance of Catholicism in the UK and examines the roots of Islamophobia, suggesting that religion is a cultural resource on which individuals and groups draw for identity, motivation, mobilization and legitimacy and, as such, is a volatile and unpredictable resource which has the capacity for increasing both social cohesion and social conflict. The effects of immigration on UK populations will increase religious diversity as much as ethnic diversity and further complicate AOP.

THINKING POINT

- How does your religion or non-religion relate to your ethnic identity?
- To what extent would you say that you have chosen your own religious or non-religious identity?
- How would you distinguish between religious hostility and racism?

The interrelatedness of the 'isms' is evident in our earlier scenario of Mrs Edwards and her family. For example, if we take seriously that to separate racism and sexism is to deny the basic truth of black women's existence (Dalrymple and Burke, 2006), how do we seek to understand our hypothetical black woman discussed earlier? And how is this complicated by the possibility that the assessing social worker may be black or white, male or female, gay or straight, young or old and thus have different personal experiences of oppression and power *vis-à-vis* not only the potential service user but also their own institutional authority? Race, class, gender and sexuality interrelate powerfully with obvious categories masking hidden ones. Myers (2007a) gives the example of a black, significantly disabled woman at a conference who chose not to attend a workshop on her 'obvious' categories. Instead, she opted to attend a workshop for lesbians as this was the only category that other people would not automatically assume *for* her (p. 78). The concept of intersectionality has developed as a critical feminist approach that explores how differences between women are thought of and performed (see Krumer-Nevo and Komem, 2013 for an example of this in social work).

Ageism, particularly, tends to be regarded as an additional category which increases the treatment of old people as non-persons. There is a dehumanization inherent in old age as 'negative images of and attitudes towards older people, based solely on the characteristics of old age itself, result in discrimination' (Hughes and Mtezuka, 1992, p. 220). Ageism is compounded by the fact that assessing social workers may have some similarity to potential service users in that they are black or white, male or female, gay or straight, but they are never old. Although they can remember what it was like to feel the oppression of youth, they can rarely anticipate what it will be like to be old. Perhaps worrying about their own futures, they tend to homogenize older people as automatically ill and deteriorating, inflexible, miserable, unproductive and dependent, although older people actually find old age a better experience than anticipated (Ray *et al.*, 2014). Sexuality tends not to be considered in the assessment of needs of older and disabled people (Myers and Milner, 2007):

> Being disabled following a stroke means, apart from anything else, I'm more dependent on my children. My relationships with

> my lesbian friends have changed dramatically. My daughter is in a way relieved that she can think of me as granny instead of a lesbian, I'm respectable, I've even got a sort of status, but it means keeping quiet about the most important part of my life. I'm well looked after, but if I want to go to a gay pub or a woman's day concert, I have to arrange things with my friends, sneaking around like I did when I was a teenager. (Cited in Young, 1999, p. 154)

The 'isms' also compete in complex ways. This is not so much in creating 'deserving' categories of service users but in constructing people as either/or, as victims or perpetrators, as cared-for or carers. The organizational structuring of social work departments serves to separate 'isms' and create competition; for example, disability teams rarely have the word 'family' tacked on in the way that children's teams do. Similarly, the notion that social workers 'are there' just for the child neglects the needs of parents (Morris *et al.*, 2018). The team in which the assessing social worker is located probably influences whether disability and age are prioritized or gender and class. In the latter, the evaluation of gender, through feminist empowerment models, has shifted from highlighting mothers' perceived deficiencies, allowing men to disappear (see, for example, Milner, 1993), to a tendency to construct men as either threatening or useless (Scourfield, 2003). This is particularly evident in risk assessments where violence is an issue and there is a need to construct one person as a perpetrator. Similarly, Wise (1995) cites an example of a young working-class woman, deserted by her violent husband, impoverished, isolated and unhappy, who deals with her despair by getting drunk and forgetting to come home to her young children. She argues that a feminist empowerment model would ignore the fact that the children are the most vulnerable people in this situation. And that a men-as-threatening model underpinning assessments of domestic violence ignores the reality that same-sex violence exists at similar levels to heterosexual violence in intimate relationships (Renzetti, 1992; Leventhal and Lundy, 1999) and the levels of female-on-male violence (Milner, 2004, 2008a; Dutton and Corvo, 2007).

However complex, unequal power relations are still at the root of social injustice. Those who benefit most from any relationship are those with the most power, so an assessment of, for example, mothering needs to look at a woman's lack of power and resources, rather than at her personality, or at least at the interaction between these two aspects. Additionally, Thompson (2017) draws our attention to the importance of oppression through the use of language. There is interplay between language and social structure, with language helping to reproduce social values. For example, feminine is a 'marked' category in language where there are pairs of words, such as actor and actress. The word 'actor' functions as neutral term but 'actress' is formally marked as feminine. Close examination of descriptions in case records will usually indicate 'marking' for subjects who are neither male nor white. The use of the term 'ethnic' is often a shorthand for 'non-white', presuming

that white people do not have an ethnicity but are the norm, and white people are often 'de-raced' in discourses. What the various 'isms' have in common is the core value of equal opportunity. Any effective assessment needs to consider the impact of its absence and the absence of equal access to resources. Any fundamental solution to the problems of oppressed groups must include policies that address all elements of oppression. These policies are difficult to formulate because of the complexities mentioned earlier and because of vested power interests, so social workers need to be aware that their efforts to develop AOP will not necessarily be well supported. Organizational policies and procedures are as much a barrier to partnership initiatives in child protection work as are family characteristics (Thoburn *et al.*, 1995; Cleaver and Walker, 2004; Munro, 2011).

Implications of anti-oppressive practice for assessments

Dalrymple and Burke (2006) propose that an ethical framework for assessment needs to include the following:

- Assessment should involve those being assessed.
- Openness and honesty should permeate the process.
- Assessment should involve the sharing of values and concerns.
- There should be acknowledgement of the structural context of the process.
- The process should be about questioning the basis of the reasons for proposed action, and all those involved should consider alternative courses of action.
- Assessment should incorporate the different perspectives of the people involved.

Constructing understandings

If assessment findings are to be considered valid, to have 'truth', the authors' assumptions and biases must be addressed. Likewise, if an assessment is to show a valid understanding of the subject, it must address the 'differences' gap between writer and subject, their mutual subjectivity, their different backgrounds and experiences of life. Social workers have needs too, and if these are not met, they function less well. Social workers are taught and expect, like mothers with their families, to put the needs of others above their own. Recognizing their own feelings lays upon them the charge that they are bad social workers. How we function can have an impact on how we see the functioning of others, so any meeting for assessment purposes involves the meeting of two complex subjective worlds.

Social workers also come from the world of the organization, and service users usually have ideas about those organizations that colour how they see social workers and affect the emotional impact they each have on the other. A social worker who over-identifies with organizational procedures risks losing sight of the subjectivity and specific needs of the user, while a social worker who over-identifies with organizational policy risks unfairly rejecting individual need and failing to challenge and improve those policies. On the other hand, a social worker who over-identifies with service users risks failing in responsibility to the organization and in the fair assessment of priorities. It has long been recognized that it is important to strike a balance between what the service user wants and what intervention the organization considers sufficient for satisfactory functioning which requires recognition of our own values, feelings and biases, and the ability to engage in dialogue with the subjective world of service users in an open, reciprocal way (Sainsbury, 1970). For example, Richards (2000) comments that a user-centred approach requires information-getting and provision that is meaningful to an older person and sensitive to their efforts to analyze and manage their situations and that these efforts are often revealed in narrative form which can be overlooked in an organization-led assessment.

A conversation, what Freire (1972) refers to as a 'critical dialogue', can be developed in which experiences are shared and differences acknowledged. A shared narrative encourages the development of mutual understanding, deficits in mutual understanding can be acknowledged and a 'moral dialogue' ensue. Where this dialogue is not achieved and service users are perceived as uncooperative, the conclusions reached by assessors are greatly affected. For example, a key factor in whether abused children are accommodated or allowed to remain with parents is often whether the parents are cooperative; that is, they acknowledge the evidence of harm done, accept responsibility for their part in causing it and agree to measures to avoid its reoccurrence, including a programme for monitoring and/or changing their behavior. This dialogue has been found to go more smoothly where parents conform verbally and agree to a plausible explanation in comprehensive risk assessments. It seems more likely that a parent who conforms in this way will form a positive relationship with the assessing social worker, and it is this relationship that appears central to the outcome (Holland, 2000). (For a fuller discussion, see Chapter 10.) Thus, the outcome of the meeting between social worker and service user is crucially affected by whether their relationship is oppressively adversarial or anti-oppressively cooperative; the social worker has responsibility for promoting cooperative working. In making assessments for services, too, there needs to be *negotiation* over issues of fairness, need and availability of resources as understood by both sides. For example, it is important to explore how an old person's need for day care relates not only to the carer's need for a respite break but also to the availability (or otherwise) of culturally appropriate services.

Where there is a difference of gender, race or class between social worker and service user, there seems to be a tendency to focus unduly on deficit and/or risk rather than on *strengths* and seeking to establish how people's control over aspects of their lives can be increased. We all, social workers and service users alike, have unmet wants, and if these are ever to be met, we must make our story visible and look at the stories of others, to see our situations not as 'no exit' places but as places capable of reform. In this way, we can gain awareness of where our oppressions are located and of how structural as well as psychological obstacles operate, and have a sense of our ability to be agents of change and locators of resources. This requires the capacity to deal with self-blame, to attribute problems to unfair structures rather than people when that is the case, and to develop necessary supportive networks.

By and large, we attribute our successes to our own efforts and our failures to events outside ourselves. However, we judge other people oppositely. This is called an 'attributional bias'. The first part of this, attributing positive outcomes to stable, personal factors and negative outcomes to unstable, external factors, is called 'a self-serving bias' (see, for example, Miller and Ross, 1975). This is actually a healthy thing because it not only helps us to make sense of unexpected events but also protects our self-esteem and public image. The social worker who is named in a child death inquiry will probably see this as resulting from a lack of resources or bad luck, whereas all other workers will probably be quite sure that their assessments would have been better. The tendency to attribute causes oppositely when observing other people is called 'fundamental attribution error'. This arises from *overattribution* and *defensive attribution*, both of which can serve to insulate observers from anxiety. If other people are considered *personally* responsible for their misfortunes, the same fate cannot befall the observer. This means that we are all predisposed to victim blaming – even where the 'victim' is clearly constrained and controlled by situational factors. Thus, it can be seen that we have an inbuilt tendency to prefer social work interventions that locate the problem within the subject. It is not only that it is easier to 'work' on the subject rather than social circumstances; it also makes us each feel more individually secure.

Thus, social workers need to avoid blaming and, instead, identify service users' competencies and to affirm their experiences, so that self-confidence can grow. This requires asking for their stories; listening to and taking them seriously help to build confidence and a sense of being valued. This can be achieved quite simply through offering written assessments for editing by the service user, taking care to avoid *recording distortions*. Prince's study of agency records (1996) found that 'Records actually occupy a "hot seat" in the power relations between social workers, their managers and consultants, and functioned not only as an index of power but also as a bearer of meanings, codes, resources and emotions' (p. 180). Once something is written down, it gains authority and causes individuals to be captured and *fixed* in writing. This is

particularly important since recording has become diagnostic rather than simply factual. Records can create the impression of the possession of an objective and detached view that does not actually exist. With the introduction of service user access to files, there is also reluctance to record assumptions, although they remain in the social worker's head. This manifests itself in the form of whispers in the interagency group or the use of euphemisms in reports, particularly court reports. As it is neither possible nor necessarily desirable to provide, for example, every poor black female service user with a poor black female social worker, there will inevitably be large gaps between service users and social workers. This will be even more obvious when differences in sexuality, religion and culture are considered. However, AOP dictates that workers *acknowledge* and seek to *bridge* these gaps. Being open about one's own culture and values and about one's lack of knowledge of the other person's beliefs is essential at the beginning of any involvement. This is followed by an invitation to service users to help the social worker see life as they see it.

THEORY INTO PRACTICE

Katie is a young, black, out lesbian. She is assessing Jennifer, an older, disabled, black widow. In line with the recommendation to take account of the strengths the older person can bring to bear on their needs, she identified Jennifer's membership of her local church choir and involvement with Bible groups as a source of support and opportunity to make a contribution. It becomes obvious as the conversation develops that Jennifer's understanding of the Bible means that she considers homosexuality to be sinful.

- **What are the essential considerations for AOP in this scenario?**
- **To what extent should Katie be open about her beliefs and values?**
- **Which dimension of AOP is most useful here?**

Social workers ought not to be too proud to ask the service user to help them understand how class, race or gender factors are affecting their situation. Without such a humble, 'one-down' stance, male white social workers, for example, will rightly be seen by women and black service users as coming from another world (see, for example, Jordan, 1989; hooks, 1991, 1993). Equally, it is important that class is examined; social workers are sensitive to the effects of personal poverty on service users, but less attention is paid to the impact of living in impoverished communities. For example, there is evidence that social workers routinely neglect the environmental dimension in their assessments of children and families in need (Jack and Gill, 2003).

Social workers have been criticized for failing to acknowledge the strengths and coping strategies of minority groups. We suggest that one way this can be corrected is by respectfully asking the service users to share their story of struggle and survival in the face of social structural inequity, by asking not only about their wounds but also about their capacity for self-nurturing, not only about their lack of a sense of entitlement and justice but also about the strengths derived from their membership of their community group and also any stresses that that membership might sometimes cause (for example, see Denborough *et al.*, 2006, who described the work of service users as 'experience consultants'). Sometimes, says Strom-Gottfried (1999), the *absence* of difficulties in a particular area of functioning can constitute a strength. This work involves social workers sharing some similarities and differences in their experiences of both power and oppression.

THINKING POINT

An exercise during a social work course asked students to look around the room and find someone who was different from themselves. They were then asked to discuss together their reasons for choosing each other, exploring the perceived differences that had led them to make the choice. They were then asked to spend time finding out all the similarities between them.

- How do you think this exercise helps to understand difference?

Bridging the gap is still an unclear area of practice, with agencies tending to stress the need for professional boundaries and workers finding it difficult to be truly empathic (White, 1995b). While personal disclosures that are not necessary for a true engagement with the service user are inappropriate, if there is to be a moral dialogue leading to an appreciation of the other's world view and values, and an understanding of their perceptions and attributions, then social workers have to acknowledge at least their lack of cultural sameness and their need to be helped by the other to understand. We are not saying that it is possible to close the enormous gaps of race, gender, class and ethnicity, only that we can acknowledge and reach across them, inviting the other person to reach across to us, and hopefully making real human contact that will be accepting, respectful and mutually empowering.

Our position as social workers who purport to empower service users demands that we be aware of our own social construction of knowledge and of the influences of our roles and agencies. Social workers' values interact with the very essence of their work in constructing accounts of people's lives and in making judgements on the basis of these accounts. As social workers encourage people to give their own accounts of their lives, they also have to take account of their own lives (Clifford, 1994). They need to be aware of the consequences of their theoretical maps and to seek to move from a

'reproductive' approach towards an 'abductive' one in which collaborative accounts draw more on the concepts and meanings of service users. In their places of work, they also need to own up to their deficits of experiences and knowledge of particular groups, seek to establish community links with groups whose experience and insights are useful to their work, and work towards maximizing the range of experience within their staff group. Tamasese and Waldegrave (1996) refer to this as *just therapy*, countering both individual and institutional discrimination through making one's work accountable to subjugated groups by consulting always with local communities or colleagues who have more similarity with the service user. Epston (1998) recommends that the worker is also active in assisting service users to develop *communities of concern* from which they can not only gain confidence and strength but also provide a forum for education, and Yuen and White (2007) look at gender, culture and violence in narrative practice.

Working with differences

We argue throughout this book for assessing social workers to remain open to the idea that there are multiple interpretations of each person-in-a-situation and to ensure that their assessments are underpinned by the principles of AOP. This is far from simple, requiring much more than the acquisition of a list of anti-discriminatory tips or how to respond to people who seem 'different' and the development of a 'correct' attitude towards challenging the various 'isms'. There is the danger of dogmatism and further stereotyping of service users when dominant narratives are subscribed to wholeheartedly; for example:

> I believe there are some times when totalisation is absolutely necessary. It would be self-indulgent and morally unacceptable not to support the anti-racist forces that are attempting to unite black people, and a white person has no right to tell black people how to organise their resistance. However, I believe that solidarity with anti-racism should not be equated with an uncritical and knee-jerk acceptance of ... antidiscriminatory orthodoxy. (Katz, 1996, p. 213)

PRACTICE EXAMPLE

Such anti-discriminatory orthodoxy was evident in the response of a group of residential staff to the young female residents being targeted by pimps and drug pushers. The home accommodated mainly white young people but was located in a predominantly Asian community. Staff had received antiracism training and subsequently

developed good working relationships with the local community. Although both staff and residents were being seriously harassed by a small group of adults, supported by up to 30 youths, when they refused to allow the adults access to the young women, they felt powerless to do anything about what had become nightly abuse (mooning, banging on doors and windows, bricks being thrown). This was because the 'abusers' were Asian and the (white) staff feared being accused of racism – and undermining their relationships with the local community. This particular interpretation of ADP ignored the fact that there were three groups of people at risk whose needs were not being met: the staff, the young white women targeted, and the young Asian men who were being drawn into criminal activity by the adult pimps and pushers.

Acknowledging the ethnicity of the youths was an important factor in constructing a safety plan; they lived in an area of educational and economic disadvantage and were additionally disadvantaged by their racial positioning in a shrinking job market. While they should not be pathologized on the grounds of ethnicity, to be colour-blind to their racial disadvantage is equally racist (see, for example, Ahmad, 1990). An assessment was undertaken via a group meeting of residents, staff, senior management, local police, and local members of the community, advised by two Asian social workers. This meeting thus brought together all concerned parties, creating a 'community of concern' (Epston, 1998). It became clear that members of the local community already had plans in hand to deal with their identified concerns about youths being drawn into crime through disaffection with their career opportunities. Equally they, too, were worried about the danger of the female residents being drawn into prostitution and drug use and appalled at what the staff and residents were suffering each evening. Enabling minority groups to have their voices heard in this way is much more important than assuming that to intervene would be potentially racist.

Social work practice has had to engage in cross-cultural working within increasingly diverse multicultural societies, recognizing that racism and discrimination exist for minority groups in ways that are demeaning and sometimes deadly. One response to this has been the development of 'cultural competence', the 'strategies used by social workers to increase self-awareness, knowledge and skills in working with members of diverse groups' (Sundar and Ly, 2013, pp. 131–2). It is viewed by some as a central attribute for good

professional practice and a culturally competent service has been described as having four elements: 'acceptance of and respect for cultural differences; analysis of one's own cultural identity and biases; awareness of the dynamics of difference in ethnic clients; and recognition of the need for additional knowledge, research and resources to work with clients' (Lum, 1999, in Sundar and Ly, 2013, p. 132). There is an emphasis on reflection and understanding of the self, exploring how our culture influences our attitudes and behaviours, particularly towards those who are different from us.

This approach may appear to be attractive to those who are committed to providing the best service possible to everyone regardless of who we and they are, but there are some conceptual and practical difficulties with the notion of cultural competence that make its application problematic. Park (2005) argues that the idea of culture within cultural competence tends to be fixed, static and essentialist in nature, taking for granted what is actually a complicated and dynamic process. It assumes that culture is homogenous for all members of a specified group and there is the danger that it imposes expectations of norms that are unhelpful for those within the categorization. The focus tends in practice to be on the culture of the other, rather than acknowledging that we are all culturally situated, thus making social work and the social worker 'cultureless'. Understanding and knowing about a culture are controlling processes, where the assumption is that enough knowledge can be gained to judge those within a different cultural space (Dean, 2001). Thus, the social worker is able to intervene from a position that assumes prior knowledge which does not require consultation with the service user's individual experience – they know about the culture and assume that this is applicable for all members of that group. Additionally, those with 'culture' are often storied as having problems because of it, such as young black men being viewed as sexual predators because of perceptions that their 'culture' is sexist and views women as objects. White people are viewed as the cultureless norm against which others are judged and against which they fail (Morton and Myers, 2016).

THINKING POINT

Recent criminal cases of groups of men abusing young women have focused on their Asian culture to explain this behaviour.

- What cultural explanations are there for those white men such as Jimmy Saville who abused large numbers of children?
- What are the differences in the explanatory stories for both groups?
- Why do you think this is?

THINKING POINT

Social work students were invited to consider the following scenario:

A British Asian woman had chosen to break with her family as she felt they were expecting her to perform in a 'traditional' gendered manner, whereas she preferred the lifestyle of her white women friends. She enjoyed going out at weekends and had chosen to drink and smoke as well as divorcing her husband whom she felt had been rather controlling but had been a 'nice' man. She admitted that she occasionally drank too much and also gambled, and she asked for help in dealing with these problems.

When asked to consider the reasons why she may be experiencing problems, the students quickly identified 'loss of culture' as being the main issue.

- What do you think?
- What may be the consequences of using this analysis?
- What assumptions are being made about her?

Rather than taking an approach that is about becoming an expert in another's culture and being able to set aside our own cultural baggage (if this is ever achievable – see Yan and Wong 2005), Sundar and Ly (2013) outline how social workers can take different routes to working with difference. Talking with the individual about their understanding of their situation, rather than making cultural assumptions, is a constructive way to avoid the pitfall of imposing your understanding rather than hearing theirs. Ben-Ari and Strier (2010) discuss how differences can be respected through the processes of interactions, opposed to the acquisition and application of knowledge. Respect comes from what we do rather than what we know. Sundar and Ly highlight the work of Nylund in continuing to develop the concept of 'critical multiculturalism' for teaching social work students, and indeed one of us has used elements of this in their teaching practice. Critical multiculturalism (Nylund, 2006, p. 30, cited in Sundar and Ly, 2013, p. 133):

1. Recognizes the sociohistorical constructions of race and its intersections with class, gender, nation, sexuality and capitalism.
2. Creates pedagogical conditions in which students interrogate conditions of 'otherness'.
3. Challenges the idea of social work as an apolitical, transhistorical practice removed from the power struggles of history.
4. Makes visible the historical and social construction of whiteness.

This approach enables social work students to consider how the taken-for-granted assumptions of whiteness are actually important to reflect on if we want to understand the processes of creating the 'other'. Instead of asking white students to learn about other cultures, we purposefully explore how they came to see themselves as white and what that means (Dyer, 1997). This avoids the painful experience of white students asking black students about their experiences or assuming that black students can guide them through the myriad of 'other' cultures, a little like a tour guide. It also opens up a far richer understanding of diversity than merely cultural signs and symbols, the disparagingly called 'saris, samosas and steel band syndrome' (Dei, 1996 and Khan, 2000, in Sundar and Ly, 2013, p. 134) where shallow cultural artifacts are displayed for the entertainment and edification of the majority. One of us visited a children's home where the (white) manager, when asked about diversity practice there, proudly pointed to a picture on the wall of black children in sub-Saharan Africa and said that this proclaimed their commitment to multiculturalism.

THEORY INTO PRACTICE

Both Karla and Andy were 15 years old, each of them the eldest child in a single-mother family living in conditions of moderate economic hardship. Both had statements of special educational needs which meant that they were seriously behind their peers academically and found the classroom a constantly humiliating experience. They had both been permanently excluded from school for extreme violence to other pupils at break times. The permanent exclusions followed a series of fixed-term exclusions despite remedial teaching (which had resulted in improved reading and writing skills) and attendance on 'anger management' programmes (which had little effect). They both ascribed their fighting to retaliation to racist taunts about which they said the school did nothing, a factor about which they were considerably aggrieved. Karla, however, was the daughter of a white mother and black father, living in a predominantly white, rural area. The school from which she was excluded contained mostly upper working-class, white pupils, with a substantial minority of middle-class pupils; the majority of minority ethnic pupils belonged to this group. Andy, on the other hand, was a white child, attending an urban school with predominantly Asian pupils. This school had a well-developed support system for pupils with special educational needs and an had explicit anti-racist policy. Although pupils tended to make marked *progress* at this school, it ranked much lower in terms of academic *achievement* than Karla's school.

- What approach should the assessing social worker take in these two instances?
- What are the similarities and differences between the experience of Karla and Andy?
- How do you respond to their being both victims and offenders?
- What are the personal, social and cultural oppressions that they faced?

Of course, neither Karla nor Andy was a passive recipient of their secondary socialization processes. They had actively constructed their own identities. By asking them to elaborate on their initial accounts, it became clear that gender was the more significant element in their different identities. Both reacted to frustration and humiliation at school by 'getting into a temper' both at home and at school, but Karla was not comfortable with an identity of a 'fighting' girl. Racism turned out not to be her major issue (although it had been at her junior school) and she actively wanted to change her behaviour. Andy, on the other hand, coped with humiliation in the classroom (where his masculine identity was a subordinate one) by developing an oppositional masculinity in his social world. He not only was violent at home and in the playground but had further developed his racist behaviour by entering shops owned by Asian people and instigating fights. His oppositional masculinity also had sexist overtones – he refused to undertake any chores in the home on the grounds that that was 'what women are for'; at the same time, he took considerable pride in not hitting women: 'that's no fun, they can't fight back'. His mother had difficulty in accommodating his masculine identity as he was now becoming too large and dangerous to his younger siblings for her to construct him as subordinated owing to his special educational needs. The day-to-day reality of his being at home all day owing to the school exclusion led to her tentatively reconstructing him as 'threatening'.

Assessment, therefore, demands a sophisticated analysis of gender, particularly as regards the way in which boys can develop different masculinities simultaneously (Messerschmidt, 2000). However, Cockburn (1991) maintains that there is a danger in the idea of 'multiple masculinities' in that it deflects attention from the consistency in men's domination of women and children at systemic and organizational levels: 'Troubled' masculinity may be, but male power is defending itself systematically and ferociously' (Cockburn, 1991, p. 216). Masculinity does not fall from the heavens, however, but is constructed by masculinizing practices, and there is evidence that the way in which men construct 'men-ness' affects masculinities as well as femininities (Connell, 1987). Not all men are dominant; not all dominate. Mackinnon (1987) says that men can be raped, feminized, even 'unmanned':

'they may even be de-gendered ... for as women differ in their status, so do men in their power' (Mackinnon, cited in Evans, 1995, p. 150). For example, small boys and disabled, old and gay men are 'feminized' in that they are not considered 'real men' (see, for example, Marshall, 1981; Arber and Ginn, 1991; Mac an Ghaill, 1996). The process of construction of black masculinity is more complex and reversed, with black men being 'overgendered' and exoticized, and their physicality unduly emphasized (see, for example, Westwood, 1996; Denney, 1992). This construction of men as 'real men' or 'female men' or 'ultra-men' supports the claim of Sampson *et al.* (1991) that while gender is only one among many sources of power, it is central. Men have the institutional power of patriarchy, but, at the same time, often experience themselves as powerless in some contexts (Milner, 2004).

There is danger here of social workers operating what Jenkins (1996) refers to as a therapeutic tyranny. For example, it is insufficient to challenge violent men 'elegantly' and with compassion (Thompson, 2003; Gondolf, 2007) on the grounds that feminist research and theorizing show them to be in need of educating about their (assumed) misuse of patriarchal power. Effective AOP would not dismiss their stories as cognitive distortions but rather would listen to them and reflect critically on what this means in terms of practice (see, for example, Healy, 2005).

PRACTICE EXAMPLE

Annie is chairing a review meeting in the North of England at which it is confirmed that Social Care's plan for Kelly and John's children is adoption. Towards the end of the meeting, contact arrangements are discussed, with the professionals commenting that the interaction between parents and children is good. Annie asks the parents if this is their view. John looks up from comforting Kelly, who is in floods of tears, and says 'Yes, love'. Annie responds with 'My name is Annie. Do not call me love'. John leaves the meeting also in tears, commenting 'I call everyone love. I didn't mean anything by it'.

Hamner and Statham (1999) set out a feminist approach that looks at the similarities and differences between female social workers and female service users. Where two women are involved, the *commonalities* include the shared experiences of life in a male-dominated society, double workloads (paid and domestic), living with men, often as subordinates, and caring for dependents. They frequently include the experience of poverty, connected perhaps with being divorced, separated, a lone parent or restricted to part-time employment. In Social Care departments, many women service users' problems are clearly caused or aggravated by the men with whom they live. Many women's resources are overstretched or inadequate because of

responsibilities for children or other dependents, poor housing, less access to education, health problems, transport problems and low pay. In addition, their situation and hardship are often compounded by a lack of facilities such as day care, nurseries and formal and informal support networks.

When one makes assessments, therefore, it may be helpful to ask some of the following questions of all potentially oppressed service users:

- What expectations do you feel you are not meeting?
- How do you feel you are coping?
- Do you expect too much of yourself?
- Are your burdens such that no one should be expected to do better than you?
- How good do you feel about who you are?
- How appreciated are you by others?
- Could your difficulties be due more to lack of resources than to lack of ability?
- What traditional supports are lacking for you in this day and age?
- What particular strengths have helped you to keep going?
- Where could we start building a network of support?

Equally, *diversities* need to be acknowledged (Thompson, 2017). Differences in status, power, role, lifestyle, race, culture, sexuality, religion, education, work possibilities, access to community resources, degree of stigma and hope are elements of the differentiation of social worker from service user. This also applies to male and female social workers with male service users. These differences create the gap we were discussing earlier, and a dialogue is required that will result in at least a touching of minds across the divide. It may be, for example, that one woman's experience of living with a man has been abject humiliation, and another's enrichment and growth; the latter needs to learn of the pain of the former, what self-nurturance was possible, and what strengths and strategies enabled survival or escape. Devore and Schlesinger (1991) make the useful point that while white workers need to be aware of service users' possible fear of racist or prejudiced treatment, black social workers need to avoid the 'stance that says "I've made it, why can't you"' (p. 191), expecting black service users to 'shape up' and not let the side down. The gap between middle-class (often) female social workers and white male members of the so-called 'underclass' can be just as wide. Blair's (1996) study of black pupils excluded from school showed that both pupils and their parents saw class as an important determinant of teachers' treatment of them. What emerged from the study was a 'complex picture of personal and institutional factors which highlighted the relationship between gender, "race", class and age' (Blair, 1996, p. 21).

PRACTICE EXAMPLE

Alan noticed that his mother, aged 90 and suffering from a stroke, was being neglected by the nursing home. He found another home where he felt sure standards were better, but the home in which she was residing called in a social worker because they felt that the resident did not wish to move, despite the fact that she had told her son that she did. The social worker interviewed the mother and agreed she did want to move but failed to confirm this to the other home, which was waiting for this approval before they could receive the resident. In the meantime, owing to this delay, the bed at the second home was taken by someone else. Alan met with the social worker and her manager to complain, but he felt they were not interested in his problem, denied that his mother wanted to move and would not answer his questions about their earlier acknowledgement that she had so wished. He came away from the meeting having had no sense of engaging with the workers; he said he 'might as well be talking to folk from space; snobs who couldn't give a monkey's curse for my sort; wouldn't listen to me, so I gave 'em hell'.

Critical comment

The interplay between social divisions is both complex and fluid; thus, 'correct' AOP is continually contested. The major proponents of AOP sidestep important philosophical and conceptual issues in their anxiety to prescribe ways of promoting empowerment and emancipation. For example, Thompson (2003, p. 10) admits that we are a long way from an adequate theoretical understanding of the intricacies and subtleties of promoting equality. It is problematic to prescribe ways of addressing inequalities and promoting social justice without a definition of equality. Similarly, Dalrymple and Burke (1995) equate inequalities with inequalities of opportunity. This is but one strand of the equality debate. Turner (1986) lists four types of equality:

- *Ontological equality*: the fundamental equality of persons as human beings; for example, equality before God.
- *Equality of opportunity*: to achieve desirable ends.
- *Equality of conditions of life*: people starting at the same point (no advantages from cultural capital).
- *Equality of outcomes*: positive discrimination to compensate for significant inequalities of condition.

Baker *et al.* (2004) suggest that equality and inequality are so complex that we should perhaps be more interested in people's well-being or welfare. This would involve equality being regarded as equality of:

- Respect and recognition.
- Resources.
- Love, care and solidarity.
- Power.
- Working and learning.

An emphasis on inequalities at the expense of developing an adequate theory of equality also neglects the fact that inequalities are fluid. It is interesting to reflect on Hugman's 1991 statement on the inadequacy of the concept of rights; the Human Rights Act not only has had the effect of drawing attention to abuses of human rights but also has highlighted the complexity of competing rights and the need for recognition of human responsibilities. This will influence the future development of AOP. This is not simply about empowering individuals within a linear social-worker-to-service-user relationship; there needs to be respect for all the people in each social work situation being assessed and acknowledgement of their responsibilities towards each other at individual, family, agency and community levels: 'a restored belief in the role of the social worker at the level of *practice* can then provide the basis for a renewal of confidence in social workers' ability to impact on the other levels' (Lymbery, 2001, p. 382).

The notion of empowerment itself has been questioned, and Jeffrey (2011) has raised key concerns about the nature and practice of the concept. She states that

> This term has had such a 'feel-good' factor [in social work] that its meaning has rarely, until recently, been fully analyzed and challenged. Instead, it has been taken for granted that empowerment must ... be a good thing, and in the interests of service users. (Jeffrey, 2011, pp. 55–6)

Jeffrey identifies three main criticisms of empowerment. First, there is an assumption that there is a group of people who have the power and knowledge to decide on who and how to empower, reinforcing the subordinate status of a disempowered group. Rather than the 'disempowered' group making their own decisions on their needs, this is done to them by the group with knowledge-power. 'Individuals are not perceived as subjects or agents of their own destiny; but rather as objects of another group's concerns' (Jeffrey, 2011, p. 56).

Second, empowerment can be very reductionist when it attempts to utilize categories and group identities. It often lays claim to improving the lot of marginalized or oppressed groups (for example, lesbians and gay men) and deals with people as if that identity were the totality of their being. Yet this denies the increasing recognition that identities are fluid and changeable as well as much more complicated than a simple label indicates, and there is the potential to assume that the needs of the individual are coterminous with the (perceived) needs of the group, whereas this may not be the case. A further complication is that if an individual does not conform to the (externally imposed) group expectations, then they may be seen to be 'in denial', having 'false consciousness' or some other deficit due to their damaging experience of oppression. The empowerment analysis may paradoxically become disempowering.

Third, empowerment tends to view the world in the binary opposites of powerful/powerless, so that the powerful decide on what terms to give up or give over power to the powerless. Fook (2012) discussed how this process of being given power can be experienced as being disempowering and is dependent on the largesse of the powerful group, a situation that is essentially patronizing. Being described or labeled by others as 'powerless' or 'victims' can be very problematic and reduces any sense of personal agency those so labelled may have.

Outcomes

The anti-oppressive literature is singularly lacking in research measures into the effectiveness of anti-oppressive assessment practice. Partly, this reflects a gap in the research literature generally; outcome research has tended to focus on the outcomes of interventions, and, by implication, service user satisfaction with services provided. These studies indicate that effective AOP is as yet underdeveloped. For example, the British Social Attitudes Survey (Robertson *et al.*, 2018) study of service users' experiences health and Social Care services found low levels of satisfaction. The Cleaver and Walker (2004) study showed that where parents reported being involved in the assessment and planning process, this was mainly where the focus was on families in need. Satisfaction levels were lower in child protection cases and there was little evidence of children being consulted. These findings are discussed in greater detail in later chapters.

A major reason for the lack of outcome research into AOP is, however, the very real difficulty of constructing a research study into a concept that is so complex and fluid. As Dominelli (2009) points out, the term has been developed conceptually in a number of different directions. And the practice that is required to respond sensitively to oppressions may flounder as various oppressions and values compete with each other, as can be seen in the following case:

THEORY INTO PRACTICE

Robert is a 50-year-old Rastafarian whose partner has left him following a long period of the drink-fuelled couple's fighting. He is caring for their three children, Tyrone (12 years), Carly (9 years) and Omari (3 years). Tyrone's head of year became concerned after Robert visited the school to discuss Tyrone's disruptive behaviour in class as Robert said that he would give Tyrone 'a licking' when he got home. She has reported this to Social Care, who visited Robert at home to assess his care of the children. They have advised Robert on constructive ways of disciplining children, but he disputed their suggestions. He argued that doing well at school is the key to achievement for his children and that his older children from an earlier relationship have all done well in life, so he isn't going to change his ideas now. He was also scornful of the social worker's views on parenting on the grounds that she is young and has no children of her own. He said that he drinks only when the children are not there and that he separated from their mum because it was not good for them to see their parents fighting. His physical care of the children is excellent and his house is clean and tidy with many toys and books.

- How would you respond to Robert?
- What else would you need to do to gain a fair assessment of his parenting?

Respectfulness is, we suggest, a more useful starting point for AOP than attending separately to the various 'isms'. We have only occasionally heard service users complain of insensitivity which could be located within an 'ism'. Much more frequently, they complain about being treated disrespectfully in more general terms of courtesy: social workers always being late, calling without making appointments, coming 'in numbers', writing things down about them but not sharing this with them, not being open and honest, not listening to them, and 'treating us like children'. At the same time, service users are held accountable should they behave in the same way; for example, 'If I'm late for a meeting, it goes down in the minutes. It counts against me. If they're late, and they always are, no one says a thing'. Thoughtless disrespectfulness of this sort creates a new 'ism", namely being a service user whose time and privacy are not important. We invite the reader, therefore, to become reflexive researchers into their own AOP.

A primary value in recent government publications, and enshrined in the law, is that of *partnership*. While this entails respect in every sense, it also needs to be shown (in records and in fact) by providing good explanations

for our work and our assessments, providing people with copies, fully engaging them in care planning, reviewing progress jointly with them and ascertaining their wishes and views. We provide a possible questionnaire format to be completed by service users at the conclusion of your initial assessments, although you can probably improve on it:

1. How satisfied were you with the way the first contact was made with you?
2. Did your social worker explain fully the reasons for the assessment?
3. Did your social worker explain what was involved in making the assessment?
4. Were assessment interviews held at a place where you felt comfortable?
5. Were appointments arranged at times that were convenient to you?
6. Did your social worker arrive on time?
7. Did your social worker listen to your views?
8. Did your social worker encourage open and honest discussion?
9. Were you satisfied with how your social worker handled any disagreements about the assessment?
10. Did your social worker show that s/he understood your difficulties?
11. Was your social worker respectful towards you?
12. Did you get to see the assessment report in draft form and comment on it?
13. What questions would you have liked to be asked that your social worker didn't ask?
14. Have you any important qualities that your social worker missed?
15. How satisfied are you that the plan will meet your needs?
16. What could your social worker have done better?
17. From your experience of being assessed, what is the most important message you would like to pass on to the social work team that would help them improve services?



Summary

- Power, abused, is the main oppression; unequal power is at the root of injustice.
- Power concedes nothing until it has to.

- Power is complicated: within a postmodern framework, it is both repressive *and* productive.
- Powerlessness is linked to learned helplessness and is then all the more devastating.
- Oppressed people can have superior knowledge of the human condition.
- The 'isms' are frequently interrelated and competing.
- Anti-oppressive practice dictates that social workers acknowledge and seek to bridge the gaps between themselves and service users in order to facilitate a negotiating of perceptions in each situation.
- To avoid being oppressive, social workers need to listen to people, validate their experiences and work collaboratively to seek out competence and promote a sense of personal agency.
- A focus on human rights, putting people's well-being first, showing respect and working in partnership, will go some way towards achieving the beginning of equality for service users.



Further learning activity

- As a group, agree to a working definition of what constitutes effective anti-oppressive practice.



Further reading

Banks, S. (2012) *Ethics and Values in Social Work*, 4th edition. London: Red Globe Press.

Crabtree, S. A., Hussain, F. and Spalek, B. (2016) *Islam and Social Work. Debating Values, Transforming Practice*, 2nd edition. Bristol: Policy Press.

Fook, J. (2012) *Social Work: A Critical Approach to Practice*, 2nd edition. London: Sage.

Morton, J. W. and Myers, J. S. (2016) 'Identity, difference and the meaning of "culture" in health and social care practice'. In A. Ahmed and M. M. Rogers (eds), *Working with Marginalised Groups: From Policy to Practice*. London: Red Globe Press, pp. 21–35.

Ryde, J. (2009) *Being White in the Helping Professions. Developing Effective Intercultural Awareness*. London: Jessica Kingsley.

Thompson, N. (2017) *Anti-Discriminatory Practice*, 5th edition. London: Red Globe Press.

3 EFFECTIVE ASSESSMENT PROCESSES

What this chapter is about

This chapter discusses the effectiveness of assessment frameworks in social work practice. How assessments are regulated and monitored are considered. There follows a discussion of different types of assessment before a framework for assessment utilizing the reflexivity of social research methodology is proposed. The chapter concludes with an outline of the stages of assessment.

Main points

- Wider policy perspectives: assessment frameworks, monitoring assessments, and performance indicators.
- Assessment as a process or an event.
- Approaches to assessment – three models.
- A framework for assessment.
- The stages of assessment.

Wider policy perspectives

The development of assessment frameworks

Following publication of the document *Modernising Social Services* (Cm. 4169, 1998), assessment frameworks were devised to improve interagency cooperation, involve service users more fully, and provide the basis for achieving the outcomes to be set out in *Every Child Matters* and *Our Health, Our Care, Our Say*. Good-quality assessment is vital if service users are to be provided with the services which they want and need and which effect positive change in terms of the outcomes set out in the government documents. To this end, the Common Assessment Framework (for children and their

families) and the Single Assessment Process (for adults and older people) were designed to promote more effective identification of additional needs by:

- Coordinating the collation of information by workers from different agencies.
- Avoiding service users giving personal details several times.
- Identifying a lead professional with overall responsibility for the assessment and subsequent intervention.
- Listening to the views of all family members and discussing differences of perspectives.
- Giving as much weight to family perspectives as agency requirements.
- Focusing on solutions that all parties can agree on.
- Using evidence that is observable rather than speculation.
- Being open about why information is being recorded and what will be done with it and giving families copies of assessments and care plans.
- Delivering on actions.
- Keeping an eye on progress and regularly reviewing the initial assessment.

Monitoring assessments

The acid test of an effective assessment is satisfaction with subsequent decisions and actions on the part of service users and service providers. The Personal Social Services Research Unit undertook a systematic evaluation of the development and implementation of the Single Assessment Process, and the results indicated that there were difficulties in achieving a comprehensive multi-agency assessment (Challis *et al.*, 2010), and measures are still being created to understand how satisfied older people are with the process (Abendstern *et al.*, 2012). Horwath (2011) highlighted strengths and problems in the application of the assessment framework which underpinned the children's Common Assessment Framework, but systematic evaluation of the effectiveness of these assessment processes has been patchy. Turney *et al.* (2011, p. 13), in their review of the research into assessments of children in need, found that poor-quality assessments typically feature:

- Gaps and inaccuracies in the information collected (or included in the file record).
- Description rather than analysis of the information presented.
- Little or no indication of service users' (including the child's) views.

Conversely, good-quality assessments:

- Ensure that the child remains central.
- Contain full, concise, relevant and accurate information, including a chronology and/or family and social history.
- Make good use of information from a range of sources.
- Include analysis that makes clear links between the recorded information and plans for intervention (or decisions not to take any further action).

The selection of appropriate performance indicators for assessing whether or not people get the services they want and need is problematic. Since 2007, the Office for Standards in Education, Children's Services and Skills (OFSTED) has had responsibility for the inspection of local authority provision for vulnerable children, and from November 2013 there has been one inspection framework for child protection, services for looked-after children and care leavers and local authority fostering and adoption services (OFSTED, 2013a). This approach makes a judgement on the recording and practice of child protection using a framework of areas to explore, including for example that 'Risk is identified, responded to and reduced' and the 'Quality of assessment and help – timely, comprehensive, analytical, of high quality, identifies risk, needs and protective factors, including parental capacity?' (p. 62). The analysis is based on the professional judgement of the inspectors, and measurement is not prescribed but open to their experience, although assessments should be within the *Working Together to Safeguard Children* 2018 guidance.

THINKING POINT

How would you know when the local authority you work in has achieved the following outcomes?

'Children and young people who are, or who are likely to be, at risk of harm or who are the subject of concern are identified and protected. Help is provided early in the emergence of a problem and is well coordinated and recorded through multi-agency arrangements. Thresholds between early help and statutory child protection work are appropriate, understood and operate effectively. Records of action and decision are clear and up to date. Children and young people are listened to and heard. Social workers build effective relationships with them and their families in order to assess the likelihood of, and capacity for, change. Risk is well understood, managed and regularly reviewed. Children and young people experience timely and effective multi-agency help and protection through risk-based assessment, authoritative practice, planning and review that secures change'. (OFSTED, 2013b, p. 13)

There are few performance indicators for families' experiences of assessment, although there is much in the research literature that indicates a substantial degree of dissatisfaction; see, for example, the research into gay adoption experiences (Hicks and McDermott, 2018); Brandon *et al.* (2007) on parental involvement in the Common Assessment Framework; Bowey and McGlaughlin's study of older carers of adults with a learning disability (2007); Read's (2000) research into the contradictory demands that successive assessments make on the mothers of disabled children; and Morris *et al.*'s (2018) study of the experience of birth families, adoptive parents and adopted young people.

THINKING POINT

- Choose an assessment you have made where you have been pleased with the outcomes.
- Identify the key performance indicators relevant to the service user group assessment.
- To what extent has your assessment met these?

Evaluating service user satisfaction with the decisions arising from what are often lengthy and carefully undertaken assessments is also fraught with difficulty because the service user is only one person to whom the social worker is accountable. Davies (1997) suggested that accountability is a complex concept in social work because the worker has to balance service user needs with agency requirements, often underpinned by a legal mandate. This is the source of the tension between risk, needs and resources which bedevils all social work assessments. Additionally, this balance needs to have some sort of match with the assessing social worker's own ideals or sense of personal duty which brought them into social work in the first place. These ideals, and skills, can easily become eroded by agency requirements, especially the demands of adhering to local protocols which emphasize case management at the expense of direct practice with service users. What is clear from the research is not only that there is a high level of service user dissatisfaction but also that social workers are disillusioned at all levels of service delivery (see, for example, Munro, 2011).

Assessment as process or event

Whatever the service user group, it seems generally accepted that assessment is more than a one-off event. However, outcomes research shows that this is largely a myth. Social workers almost invariably seek to confirm their original hypotheses (see, for example, Sinclair *et al.*, 1995; Kelly and Milner, 1996a; Scott, 1998). This poor practice can sustain prejudice and make

AOP difficult to achieve. Scott's Australian study of hospital and community child protection social workers (1998) provides the most detailed evidence of this tendency. Prior to the new assessment formats, social workers used a framework of assessment that gave salience to a narrower range of factors than that specified in agency guidelines, being influenced most heavily by risk factors (see, for example, Challis *et al.*, 1990). They tended not to consider situational and interpersonal conflicts, although these are the main reasons for older people being admitted to residential care in this country. After risk factors, resource limitations had the most influence, with the result that needs factors were largely ignored. As yet, the new assessment frameworks do not appear to have changed this practice for adults (Clarkson *et al.*, 2007; Abendstern *et al.*, 2012), and environmental factors are not receiving more consideration in the assessment of children and their families (Jack and Gill, 2003).

To support a hypothesis developed at the initial assessment conducted within this constricting framework, Scott (1989) found that social workers sought confirming data rather than disconfirming data and that their reasoning was not supported by hypothesis development or exploration. Kelly and Milner (1996b) also found this tendency towards verification of an initial assessment, which meant not only that there was no re-evaluation of the assessment but also that the social workers' range of options was reduced until they were left with no option but to close a case. They also found that social workers used self-justification to support the initial hypothesis. This most commonly took the form of persisting with the care plan, on the grounds that it needed time to work – despite clear evidence that the plan was ineffective (see also Turnell and Essex, 2006).



THINKING POINT

Checking your assumptions in practice

- Select a case where you consider the service user to be uncooperative.
- List the points that you and the service user disagree on.
- What confirming data do you have to support your point of view?
- What theory/hypothesis underpins your analysis of this data?
- What other theory/hypothesis would disconfirm your hypothesis?
- Have you explored this disconfirming knowledge thoroughly and fairly?

Sheldon (1995) similarly found that social workers used their interviewing techniques to 'shape' assessment data until they fitted a favourite theoretical model. Equally, he found that after one-off assessment, new information simply built up haphazardly on files, statements purporting to

sum up problems and guide further actions being no more than lists of alleged factors loosely thrown together with little information on where they had come from or how they interacted.

While it is easy to sympathize with the resource and risk factors that constrain social work assessments, it is important to recognize that an initial assessment is the most influential determinant in the subsequent management of service user problems. Despite social worker complaints about feelings of powerlessness in the multi-agency arena, their assessments provide the frame available to the case conference and influence its decisions. We will discuss this process in more detail later, but here we wish to make the point that there is no evidence that assessment is an ongoing process that is improved by the involvement of a formal multi-agency group. It is largely an important, single event in which the assessing social worker is the lead professional.

Three approaches to assessment work

Smale and Tuson (1993) identify three different models of assessment, which appear to be closely linked to the salience given by social workers to risk, resources or needs factors:

1. *The questioning model.* Here, the social worker holds the expertise and follows a format of questions, listening to and *processing* answers. This process reflects the social worker's agenda and corresponds to the assessment style noted by Sheldon (1995) in which the data are 'shaped' to fit the social worker's theories about the nature of people. These theories are most likely to be psychodynamic or cognitive-behavioural in nature.
2. *The procedural model.* In this, the social worker fulfils agency function by gathering information to see whether the subject fits the criteria for services. Little judgement is required, and it is likely that checklists will be used.
3. *The exchange model.* All people are viewed as experts on their own problems, with an emphasis on exchanging information. The social workers follow or track what other people are saying rather than interpreting what they think is meant, seek to identify internal resources and potential, and consider how best to help service users mobilize their internal and external resources in order to reach goals defined by them on their terms. This model fits with task-centred, solution-focused and narrative assessments.

Smale *et al.* (1994) make it plain that they consider the exchange model the desirable one: 'Routine, service-led "assessments" are the antithesis of an empowering approach to assessment and care management' (Smale *et al.*, 1994, p. 68). This, however, is not to say that there are not helpful questions that can deepen understanding, and these questions will flow from some theoretical map, as will be clear in later chapters.

We would suggest that the questioning model is most likely to be used when risk factors provide the main emphasis of the assessment, the

procedural model fits the assessment subject to resource constraints and the exchange model comes nearest to meeting a needs-led assessment. The questioning and procedural models are often found in combination, while the exchange model embraces the principles outlined in government guidance. It is the only model which has the clear potential to lead to re-evaluation.

Smale *et al.* (1994) provide a daunting list of the skills and values that would be involved in such endeavours. These include the following:

- Joining with people yet developing a neutral perspective.
- Adopting the central skills of authenticity, empathy and respect.
- Empowering workers and service users so that essential decisions are located with the people who know most about the problems.
- Reinventing practice, being creative.
- Addressing social problems as a failure of a network of people.
- Testing the fallibility of existing theory and knowledge in each new situation.

We hope that this book will provide some practical guidance, some useful tools and a choice of theoretical maps from which to develop more understanding, without causing workers overload and confusion.

There are obvious difficulties that must be addressed if assessing social workers are to balance risks, needs and resources within an exchange model. These three aspects cannot be totally separated – a major need is often the restoration of the person's own problem-solving potential and the mobilization of his/her inner resources. There can never be a truly neutral perspective, although there can be explicitness. Service users prefer social workers to be explicit even where they do not agree with the perspective. Explicitness aids authenticity, but empathy and respect are more problematic than the social work literature admits. For example, a study of women social workers and women service users found that 'commonality with service users, beyond the experience of intermittent empathic feelings was regarded as either impossible or deeply problematic' (White, 1995b, p. 150). And it is difficult to show respect when social workers themselves are so little respected by service users and the general public. Neither social workers nor service users are likely to be empowered to the point where they will be entrusted with essential decisions. It is also difficult to be creative and reinvent practice when you are subject to criticism much more frequently than praise and when your best efforts are undervalued.

Addressing social problems in terms of a malfunctioning of networks of people is perhaps the most useful starting point for improving social work assessments. Smale and Tuson (1993) consider it naïve to assume that local supportive networks exist 'in nature', and this is perhaps the major difficulty in actualizing the values and principles outlined in government guidance. Jordan (1990) refers to effective informal supportive networks as welfare with a small 'w', and it is individuals who lack this sort of welfare who require

Welfare with a capital 'W'. The purpose of social work, we propose, is, first, the provision of a formal network of Welfare and, second, the development of an informal network of welfare – attention to the environmental dimension of the common assessment framework will show that many service users lack effective informal networks or that their networks are either unsafe or inappropriate to constructive care and change. This purpose would underpin all assessment work, subsuming the principles of empowerment, participation, cultural sensitivity, multi-agency cooperation and value for money. We suggest an overarching framework below.

Using research methods in assessment

Although we recognize that it is extremely difficult to undertake a thorough assessment in a political climate that emphasizes risk assessment at the same time as it limits resources and does not take need seriously, we do not think that social workers should accept these implicit constraints at the first point of assessment. As Chapman and Hough (2001) comment, effectiveness-led practice helps both practitioners and managers target their energies, time and scarce resources, confirms the impact of their work with individuals, and provides greater job satisfaction.

We were struck by how the difficulties and deficiencies of social work assessments mirror early criticisms of social research efforts that attempted to move away from strictly quantitative, 'objective' research in order to achieve a better depth of understanding of human realities by using 'grounded' theory (Glaser and Strauss, 1969). Here, social researchers made no attempt to avoid the 'subjectivity' of the individuals and groups studied, allowing their subjects to tell their own stories, with themes and theories subsequently emerging from the data. This research method has obvious similarities with the exchange model of assessment proposed by Smale *et al.* (1994) in that it is founded on the basis of 'joining with people'; and it is supported in the new assessment frameworks' emphasis on listening to people and discussing differences of perspective openly.



THINKING POINT

Recall someone you know who has difficulty communicating through of lack of speech, learning difficulty or dementia. Then read:

Iveson, C. (1990) *Whose Life? Community Care of Older People and Their Families*. London: Brief Therapy Press, pp. 81–3. Or

Brewster, S. J. (2004) 'Putting words into their mouths? Interviewing people with learning disabilities and little/no speech', *British Journal of Learning Disability*, 32: 166–9.

How can you adapt these ideas to assist you in assessing the needs and wishes of your service user?

This type of research suffers from the same problems as social work assessments in that no matter how one tries to allow the theory to flow from the data, researchers do (however unconsciously) hold theories about the nature of people, and there is always the danger that data will be 'shaped' to fit these theories: 'Researchers cannot have "empty heads" in the way that inductivism proposes; nor is it possible that theory is untainted by material experiences in the heads of theoreticians' (Stanley and Wise, 1991, p. 22). However, this potential problem has been much better addressed by social researchers, and the qualitative methodologies developed have much to offer in the development of improved assessment processes.

Social work training devotes a great deal of time to the 'values' considered important in social work practice, but we have found that while students can talk intelligently about values, they find it difficult to demonstrate how they can be held accountable for values in action. They seem to think that appropriate action will necessarily flow if they have the 'right' attitude. For example, in our hypothetical scenario, we would expect social workers to be able to understand that Mrs Edwards, as a black woman, experiences double (and perhaps conflicting) oppression, and feel sympathy for this, but we would doubt that they could explain to her how this would actively affect their assessment. They would probably – and, we would suggest, fruitlessly – attempt to empathize with her. While empathy is necessary for joining with her, it is not sufficient.

Social researchers are much clearer about how they will be held accountable for their value stance because they will have prepared a statement of intent that is quite clear about relevant ethical issues – what they are, how they influence the research and how the researcher will 'behave' rather than just 'think' or 'feel'. For example, researchers in this field are very much aware of the sensitive nature of their research (Renzetti and Lee, 1993), particularly the fact that they are 'joining with people' who are less powerful than themselves – what Walford (1994) refers to as 'researching down'. Therefore, they give careful thought to how they can protect their subjects from harm as a result of their endeavours *before* they begin the data collection phase. Social workers could give more consideration to the possibility that they may do harm as well as good. Their interviewing skills are so well developed that they may elicit disclosures that have little direct bearing on the referral they have received (what service users describe as 'digging'; Scourfield, 2003) and that could also put service users at risk – particularly where there is potential violence in the family. It simply requires the social worker to decide what the boundaries are and clearly state the purpose of the assessment. Sainsbury (1970) maintained that the purpose of making assessments was primarily to represent the individual or family in its struggle for resources, but it should include drawing attention to any form of inequity that may be operating as well as an understanding of the individual or family dynamics. He added that assessments need to include some consideration of why the situation is described as a problem and how far the agency is responsible for dealing with it.

This recognition of the nature of one's agency function is part of every assessment and includes considering whether the user in question is able to use the help that the agency can give.

Additionally, it means thinking about possible interview schedules at an early stage and deciding how wide-ranging any interviews can be. The 'open' interview proposed is recognized as particularly problematic in social research (Robson, 2002) and may leave vital areas unexplored. It is most likely that a semi-structured interview format will be the most appropriate one, and social work assessors could do well to consider the careful design of these in social research (see, for example, Bryman, 2004). Focus group research methods are also particularly effective in generating a rich understanding of participants' experiences and beliefs (Morgan, 1998).

In social research, this phase is accompanied by the drawing up of a plan to identify the key informants – the people, the documents and the agencies with the data needed for the assessment. This has the advantage of both broadening the range of data collected and setting limits on its potentially inexhaustible source (Coulshed and Orme, 2006). Social researchers also give thought at this stage to how data derived from verbal and written sources will be compared and evaluated (Jones, 1994) and how the data will be checked for authenticity (Forster, 1994).



THINKING POINT

Read through a case file where you have made a recent assessment.

- What are the main sources of information that led to your initial hypothesis?
- Are there any sources of information you have neglected to follow up?
- What questions did you fail to ask the service user? (Check this with that person.)

Possible explanations will exist at this stage in both social research and social work assessments; in the former, however, they are more likely to be explicit and contain details of how they will be checked. Intuition may be accurate but should be testable. Even where there is only a single explanation, disproof is as important a consideration as proof. This means that when the data collection is complete, not only will themes emerge but also data that do not 'fit' easily with these explanations will not be discarded. Interpretations can then be extended and evaluated (Jones, 1994), the data will be checked for authenticity (Forster, 1994) and multiple hypotheses can be developed. This process could be usefully incorporated into social work

assessments to guard against the tendency of social workers to be heavily influenced by the first item of data collection and the resulting premature hypothesis development. Subsequent government guidance provides basic checklists to aid this process, but these checklists need to be more systematically used, developed and refined.

Utilizing this approach in assessment activity would enable social workers to cope with the 'cognitive dissonance' that Scott (1998) noted was regularly avoided and to fulfill Smale *et al.*'s (1994) exhortations to reinvent practice and be creative in each new situation.

Social researchers are also more careful than social workers in recording and handling data. Huberman and Miles (1994) refer to this as the 'orderliness' of sound qualitative research via good data display. This can take the form of verbatim transcripts, but, rather than remind social workers of their experiences of verbatim recording during training, we suggest that other forms of data display would be equally effective. These include 'memos' (Field and Morse, 1985), flip charts and working diagrams. Memos are particularly useful for storing data that do not seem to 'fit', retaining them for later consideration, while flip chart displays are useful in supervision sessions to ensure that discussion does not centre on one factor to the exclusion of others. Working diagrams such as well-developed genograms and ecomaps are valuable items of data display at this stage of the assessment. All forms of data display can be created with families.

Clear data display aids the next step of social research – the identification of emerging themes. These are noted in the first instance and then 'collapsed' into categories (Burnard, 1991). Only after this process has been carefully undertaken are decisions made about the priority of emergent themes. The social researcher has to demonstrate how interpretation and analysis of data are as free from bias as possible. This is done by what is known as 'reflexivity'.

Reflexivity

Reflexivity is a term that is understood in various ways, depending on the writer, and it can become confused with 'reflection' and 'critical reflection' or 'relational reflexivity', so let us briefly state what we mean by these words:

- We use 'reflection' to mean thinking about an action or a choice afterwards, looking back on it and perhaps learning from a mistake. This, however, leaves the action unchanged.
- We take 'reflexivity' to mean reflecting during an action and thereby changing what we are doing – reflection in doing rather than after doing.
- We consider 'critical reflection' to have two meanings: (1) questioning given knowledge or practice in the light of wider issues, changes, world

views and outcomes; (2) the same as reflexivity, so the context should indicate which meaning is being used.

- We use 'relational reflexivity' to mean being reflexive along with a service user, for example asking service users 'Is this a useful question for you?' or questioning with them one's ideas about them, to mobilize their resources or possibilities.

For a full discussion, see D'Cruz et al. 2007.

Reflexivity is a broader and potentially more useful way of checking assumptions than the usual one-to-one supervision between line manager and practitioner. The role of line manager is a difficult one as it involves facing both ways within agency structures, and it may not encourage creativity. Reflexivity involves checking one's interpretations of the data with people who do not necessarily have a vested interest – colleagues and/or long-arm supervision – and, of course, checking with informants. The aim is not to establish 'truth'; there will be many truths and many realities that require various ways of knowing and being in order to appreciate the full diversity of meanings and understandings that exist. More simply, what is needed is a clear formulation of the situation that 'fits' with a range of other people's perceptions and is 'testable in practice' (Sheldon, 1995, p. 114). The case conference (we explain the problems of group pressures on consensus in detail in a later chapter) is not the most effective forum for good reflexive practice, but acquiring multi-agency views separately and then attempting to make sense of the possibly conflicting results will assist in getting more depth into the assessment and a formulation of possible problems and solutions that have broad agreement among key informants.

Reflexivity in a group of colleagues is enhanced if it is carried out in two stages. The first is the *how to* stage. This consists of the group listing hypotheses that flow from the heading 'In this situation it is really a question of *how to* …'. For example, in assessing a situation in which a seriously abused and neglected child has been thriving well with foster parents for four years but the birth mother wants the child, now ten years old, to return to her and the child wants to live with her and her abusive partner, it could be a question of how to:

- Collect evidence to oppose the application, or
- Assess what support the birth mother would need to be able adequately and safely to mother the child, or
- Find ways of making the birth mother's home safe, or
- Use the law to remove the dangerous partner, or
- Find ways of maintaining residence with the foster parents *and* a relationship with the birth mother.

Only when the key worker decides (usually in consultation with a senior colleague) which of these (or other) directions to take does the second stage begin, namely that of '*go and* ...'. This is a second brainstormed list of suggestions or options from which the worker can select, picking out what would be the most immediately useful to *go and* do. This process helps to counter the *group think* tendency noted in case conference decision-making (this is discussed in more detail in Chapter 10).

The process of gaining depth of understanding of data begins with looking at the question 'In what ways is the problem a problem, and for whom?' It involves weighing up the situation, tentatively patterning the data, finding theoretical ideas that illuminate and help to interpret the story and make sense of it, then applying some of the theoretical maps to gain analyses, understandings or new accounts, drawing inferences (reasoning from the known to the unknown) and finally considering how to test the interpretations and recommendations. This process may go on after the meeting with the user(s), and it may be necessary to re-interview to check out ideas and share insights. Then there is the consideration of what resources are needed and what resources can be mobilized. This should always include the user's own internal and external resources and what intervention would be needed to mobilize these, so that, ideally, it is not just about meeting need now but meeting it in such a way that the individual's and family's resources are strengthened for coping for the future. Sainsbury (1970) adds that we should always consider whether it is necessary to intervene at all and whether there are any negative consequences from doing or not doing so.

By depth, we do not mean that social workers must know everything about their subject from cradle to grave. A preoccupation with past events has been a positive hindrance in social work assessments – and it runs on the unrealistic assumption that social workers can change people completely. Rather, 'depth' means taking care and time in reaching helpful explanations or analyses of what is happening and how things could be improved – being more rigorous and systematic. Thorough exploration of data from a number of sources means not only that social workers will have a wider range of alternatives, thus preventing 'stuckness', but also that we will become clearer about our practice theory. There is nothing wrong with checking whether data fit our existing theory as long as we actually know what it is and can explain it to people; because in our view theory is the servant of data, we recognize when the data do *not* fit our theory, and we are prepared to revise and expand our theory and consider other analyses. This does not mean that we have to explain to service users that we are using, say, a social skills training or a psychodynamic approach, but it does mean that we should be able to explain to service users what views we hold on how key social roles work and what explanations we have for their malfunctioning, being explicit about our views on the nature of people.

THINKING POINT

- Read through an assessment or an assignment you have written.
- Identify any words used in the document that have specific meaning to social workers (for example, attachment, boundaries, failure to protect and proactive).
- With a colleague, practice explaining in simple English exactly what these words mean to you and how you might explain them to service users.

As distinct practice theories are difficult for many social workers to articulate clearly – students usually say that they are eclectic (we will present an explanation of the main ones used in social work practice in subsequent chapters) – we will not only outline the theories but also include the implications for assessment of each theory. We do not offer them as prescriptive guides but rather regard them as a series of potentially useful maps to consult once one has identified the territory it is wished to cover.

If a social work assessment is undertaken with the same methodological rigour as sound qualitative research, it will necessarily include the following:

- A clear statement of intent which also demonstrates how one can be held accountable for one's values.
- A systematic approach to data collection from an identified range of sources which is carefully checked for authenticity and which identifies gaps in information.
- The development of more than one hypothesis about the nature of the problems and solutions.
- A clear statement on how the final judgement can be tested in terms of demonstrable outcomes.

As we emphasized earlier, the acid test of the assessment is satisfaction with subsequent decisions and action on the part of service users (empowerment in practice) and service providers (evidence of change for the better). There should also be social workers' own satisfaction at not being 'stuck'. We present below the stages of such an assessment process in a linear model, although some parts of the sequence will overlap because re-evaluations will necessarily emerge during the process of checking the hypotheses.

The stages of assessment

(Note: This long list is not meant to be prescriptive; rather, it is suggestive of various possible steps in various assessments.)

Preparation

- Make a list of key informants – people, documents and agencies. Keep this on file so that gaps in the information source are clearly visible.
- Prepare a schedule for collecting data from *all* key informants. Adapt agency checklists for this purpose.
- Decide on an interview schedule. If it is inappropriate to use an open interview format, make a list of essential questions to which answers are needed. Keep this on file, but give copies to the informants where this will be helpful.
- Prepare a statement of intent that includes purpose, what one is able to do, limits and how one will be accountable for one's values. Although this may be given verbally to potential service users, keep a copy on file.
- Make a note of early (tentative) explanations.

Data collection

- Prepare a contents page for the file, listing the documents and where they can be found.
- Store the data display on file, marking it clearly with details of who can have access to it. Store working diagrams, memos and so forth in a plastic folder at the back of the file.
- Check verbal data for authenticity by repeating, summarizing and so on. Provide key informants with copies of ongoing summaries for further checks.
- Check written data for factual accuracy and mark unsubstantiated opinion clearly.
- Consider widening the data sources if the accuracy is doubtful or there are obvious gaps.
- Do not discount any data at this stage but note obvious incongruities or inconsistencies.

We use the term 'data' simply to signify factual information. Because facts do not always speak for themselves and there is an element of subjective interpretation in most information-gathering, a distinction is sometimes drawn between 'data', which are unprocessed and raw, and 'information', which is interpreted and integrated into other knowledge. However, we favour data collection with as open a mind as possible, an awareness of biases if possible, and 'weighing' and 'analysis' as separate as possible, allowing for the spiral of theory and data discussed in the next chapter.

Weighing the data

- Consider how serious the situation is or how well the client is functioning in the circumstances.
- Identify persistent themes or patterns emerging from the data and list them.
- Cluster the themes and begin ranking them in order of priority.
- Check priority ranking with the key informants.
- Identify gaps in the data.
- Identify a group of people who will help with reflexivity.
- List the people to be consulted, noting their comments on file.
- Weigh the risks involved.

Analyzing the data

- Identify theoretical perspectives and use them to gain depth of analysis (see Chapters 5–9).
- Develop more than one hypothesis, especially around what the goal of intervention might be.
- Reach useful but tentative explanations for the situation.
- Test the explanations for possible theoretical 'fit' (also what language could have talked them into being).
- Check this with the key informants.
- Run a final check of all the data to guard against the selective use of information.
- Consult with the 'reflexive' group again, if necessary.
- Develop further explanations and list the ways in which they can be tested.

Utilizing the analysis

- What help is needed by the user? By others?
- List the outcomes one hopes to achieve and the consequences one hopes to avoid.
- Clearly explain how these outcomes can be measured.
- Prepare an intervention plan.
- Establish an independent mechanism to monitor outcomes. This could include supervision, a multi-agency group or service users.

- Prepare a draft report that lists sources of information, analysis and initial judgement (see Chapters 10 and 11, which will also address risk).
- Obtain feedback on the report and revise it, noting any disagreements with one's judgement and the reasons for them.

We have emphasized the need to develop more than one explanation for the data collected because this seems to provide the most effective countermeasure to the problem of 'shaping' the data (noted earlier). Sheppard (1995) argues that this is one element in assessment that justifies the status of assessors as professionals, the others being the development of precision and clarity in the understanding of the use of concepts and theories and becoming continually sensitive to disconfirming information (pp. 187–8). Additionally, a premature framing of the data has the effect of influencing the progress and outcome of a case regardless of the more usual checks such as supervision and interagency consultation. We will discuss framing effects in more detail in Chapter 10, but we present an illustrative example here to show how developing multiple explanations improves the assessment process.

A probation officer presented the following scenario at her local risk assessment case conference with a view to deciding whether or not the service user should be registered as a potentially dangerous offender.

PRACTICE EXAMPLE

Troy, a 44-year-old white British man, had collected his children for a contact visit and taken them to his club, where he became drunk. He took the children home early and discovered his wife having a meal with another man. There was an argument and Troy left. After brooding about the incident, Troy drank further and then returned to the family home, armed with a knife. A fight ensued during which the new man friend suffered a punctured lung, his wife was cut and bruised, and the children became very distressed. Troy was arrested and bailed. Six weeks later, immediately after the preliminary divorce hearing, he once again got drunk and returned to the family home, where he shouted insults and threw a milk bottle through the window. He was sentenced to four years' imprisonment for the wounding and three months for the criminal damage.

The probation officer put the following explanations to the risk assessment meeting:

1. This man is in serious danger of reoffending because:
   - He has a history of offending (housebreaking, stealing, taking without owner's consent, and drug offences).

- Taking a knife indicated premeditation.
- The assault had serious consequences.
- The man cannot accept that his marriage is over.
- He has little consideration for the effects of his behaviour on the children, the 5-year-old having to undergo counselling following the fight.
- His drinking is uncontrolled.
- He has little to do with his time since he was made redundant.
- His wife reports previous domestic violence following drinking. He denies this or suggests that he must have had 'blackouts' after drinking.

(Sources of information: the offender, his wife and police records.)

2. This man's behaviour was a 'one-off', atypical offence with little likelihood of reoffending because:
   - Previous convictions were all in his youth, his middle years having been trouble-free.
   - His barrister recommended plea bargaining for a lesser charge, but he insisted on pleading guilty to avoid his wife having to give evidence, thus showing real remorse.
   - He now shows concern about the effects of his behaviour on the children and has negotiated with his wife to see them in the presence of relatives to reduce their distress.
   - He now accepts that his marriage is over.
   - He has begun anger management and alcohol education programmes in prison, where he is reported to be cooperative.

   (Sources of information: the offender and prison staff.)

3. This man is likely to reoffend in particular circumstances because:
   - It is easy to be remorseful and reformed in prison where there is no access to alcohol.
   - He is likely to 'coast' through his sentence.
   - He remains angry about his wife's new, much younger man.
   - He is unrealistic about how he will avoid arguments in the future.
   - There are potential problems over his accommodation on release from prison because housing away from his wife will remove him from sources of support, such as relatives and friends, and he resents losing his own home.

- Anger management and alcohol education programmes are untested in real-life situations.

(Sources of information: the prison staff and probation officer.)

No one explanation was decided upon as the most likely 'truth' at the risk assessment meeting, but the ability of the probation officer to propose multiple explanations rather than having to defend a single one meant that the risk assessment meeting members could engage in a helpful discussion. They decided that they needed to know:

- What additional data were needed to check possible explanations; for example, interviewing his wife and children on their own to find out what their needs, wishes and concerns were and making arrangements for this to be discussed at a further meeting.
- What resources would be needed to reduce the potential for reoffending; for example, what support relatives could realistically offer this man, what programmes needed to be established to continue and monitor the anger management and alcohol education courses begun in prison, what housing and employment facilities were available in the neighbourhood where the man would live on release from prison and how the marital property could be harmoniously divided.

The main advantage of the probation officer being able to hold more than one explanation meant that she could focus on all three areas of assessment – risk, resources and needs – and thus was able to develop a management plan appropriate for all the people involved, which was well resourced, with tangible outcomes and capable of being monitored.

In conclusion, we are arguing unashamedly for the making of high-quality assessment. This entails demanding, thoughtful work rooted in clear theory and acknowledges useful assessment to be a complex ongoing process. It would be highly understandable if social workers, faced with excessive workloads and many conflicting demands, regarded our framework as unrealistic, but the need in their case is for adequate resources in terms of staff and for supervisory support, rather than for short-cuts or shallow work that can so easily backfire or make matters worse.

Before outlining the assessment implications of the various theories informing social workers' understanding of the nature of people, in the following chapter we discuss how those theories can be made more explicit so that an improved decision about what theory will be used can be made.



Summary

- Despite helpful government guidance on outcomes, when measured, especially in terms of service user satisfaction, assessment outcomes are largely unsatisfactory.

- Assessment is usually a one-off event with little evidence of re-evaluation.
- Assessing social workers seek to confirm rather than disconfirm their initial hypotheses.
- Assessing social workers often 'shape' data to fit their favourite theoretical models.
- Where risk is a factor, this predominates in assessments to the exclusion of need.
- A social worker's initial assessment is the key determinant to future action and outcomes. Social workers tend to use a questioning, procedural or exchange model of assessment depending upon whether risks, resource allocation or needs are the main factors.
- It is important to see assessment as a staged process and to remain reflexive throughout.



Further learning activity

- In a group, agree what would be appropriate key performance indicators for an assessment of a chosen service user group.



Further reading

Brown, L., Moore, S. and Turney, D. (2011) *Analytical and Critical Thinking in Assessment – Pilot Action Pack*. Dartington: Research in Practice.

D'Cruz, H., Gillingham, P. and Melendes, S. (2007) 'Reflexivity, its meaning and relevance for social work: a critical review of the literature', *British Journal of Social Work*, 37: 73–90.

Featherstone, B., Gupta, A. and Morris, K. (2017) 'Bringing back the social: the way forward for children's social work?', *Journal of Children's Services*, 12(2–3): 190–6.

Morris, K., Featherstone, B., Hill, K. and Ward, M. (2018) *Stepping Up, Stepping Down: Family Experiences of Multiple Service Use*. London: FRG/Lankelly Chase.

Platt D. (2011) 'Assessments of children and families: learning and teaching the skills of analysis', *Social Work Education*, 30(2): 157–69.

4 SELECTING A MAP

What this chapter is about

We have outlined the issues and the process of making assessments, and we have addressed data collection. Before considering in detail the theoretical maps that guide social workers' *analyses* of problematic situations, we will first explore the array of social work knowledge with a view to improving how we *weight* data (stage 3 of the process) and then decide which map(s) to select for the purposes of *analysis* (stage 4 of the process).

We aim to provide a way through the thicket of concepts and theories of which social workers become aware in seeking helpful explanations for the nature of people and society and to locate some signposts. We identify the ideas that will be most useful in making judgements about data and map selection and address how theoretical maps and data collection are not entirely separate. Additionally, we look at the debate about finding the truth.

Main points

- The range and variety of theory.
- Competing theories.
- False certainty and developing hypotheses.
- Uncertainty and open-mindedness.
- Map selection – 'fit' and 'location of problem'.
- How theory and data spiral around each other.
- Introduction to constructionist ideas.
- Naming the maps.

The theory thicket

Social workers are introduced to, and familiar with, a wide range of theory from the sociological (for an introduction, see Llewellyn *et al.*, 2014; Haralambos and Holborn, 2013) to the psychological (for an introduction, see Gross, 2015; O'Brien, 2016). There exists a plethora of research findings concerning specific aspects of people's lives, including psychological research findings relating to such aspects as attachment and loss (Bowlby, 1982; Rutter, 1981; Murray Parkes, 1986; Howe, 1995, 2013); stages of human development (Hobart and Frankel, 2004; Green, 2010); personality development theories (Schaffer, 1998); the hierarchy of human needs (Maslow, 1954); intellectual development (Piaget, 1977) and moral development (Kohlberg, 1968). Sociology offers theoretical insights into social strata, power and oppression (Jones, 2003; Payne, G., 2006a), while social psychology looks at, for example, groups, decision-making and stereotyping (Ingleby, 2006). So the question the reader will probably ask is 'How do all these fit together?'

To answer this, we take the reader back to stage 3 of our initial overall framework – weighing the data (discussed in the last section of Chapter 3, 'The stages of assessment'). It is at this stage in the assessment process that the social worker makes judgements and evaluations on how well service users are doing in their particular circumstances. Are their strengths sufficient or are their limitations too great? Do their capacities and resources seem to be sufficient for coping? How does the difficulty or the particular situation compare with the norm? How much does it deviate from the culturally acceptable, the legal or the affordable? Are the risks acceptable? In other words, is there a problem? The making of these judgements is informed by a background knowledge of all the above theories, is also usually assisted by agency guidelines and procedures, and is underpinned by core social work values and skills, even though these are not often made explicit (for an overview, see Trevithick, 2012; Taylor and Whittaker, 2018).

Agency practice will vary according to whether the dominant purpose of the work is the control of deviance, the empowerment of needy and oppressed people, or ensuring people's quality of life and safety. Yet, how any worker uses theory is a matter of great uncertainty, which we hear most commonly expressed via metaphors such as 'once you learn to ride a bicycle, you do it without thinking'. It seems to us that in weighing up the gravity or need of a case, social workers' judgement is informed, and their beliefs bolstered, by the above-mentioned core theory. Most social workers would say that this is useful and that they are using more than mere common sense.

The very existence of alternative and often-competing theories of human behaviour and human problems does add considerable complexity to the task, but we hope in this chapter to provide some assistance in explicit theory selection. It is not, however, the intention of this book to elaborate on all these areas of theory. We simply point to them as informing social work

activity and show some key sources where they can be studied. They do connect, however, with the maps in that preference for a particular map will lead to more use of, or reliance on, particular aspects of the core theories of psychology, human development and sociology. One theory will fit better than another theory with individual social workers' views of people and difficulties and with ideas on 'the nature of people' implicit in any one chosen map.

THINKING POINT

Consider a new method/technique you have just learned about.

- What are the theoretical underpinnings?
- How does this fit with your existing theories about the nature of people?
- How does it clash with your theories about the nature of people?

We wish to emphasize that much of the theory can be used oppressively when social workers use it as if it were *the truth* for particular service user situations. Most of it is culturally biased and presented as more 'certain' than it really is. For example, we rightly hesitate to describe any family as normal or abnormal, healthy or unhealthy, although we do need to have some idea of which families need help and which do not. Theories help us to develop *informed* opinions when they increase our understanding of the likely relationships between events in people's lives, the impact of personal history and social background and present needs and behaviours and when they add to our awareness of the sources of distress, be they external, such as oppression, or internal, such as guilt. They can help us to understand the values implicit in policies, human motivation and the importance to people of their roles in life and their expectations.

The trouble with certainty

We would like to think that theories can usefully help us to consider how some solutions can make matters worse, how outcomes are often so uncertain that it is only at the end of our involvement that they can be verified, how all assessments are essentially tentative and how uncertainty can be positive.

No assessment should be once and for all – it is a continuing process that is improved as intervention proceeds. It is also revised when work is formally reviewed and needs to be reconsidered when termination is being planned. It remains in focus as effectiveness is evaluated after the work has finished. However, it is never to be believed in to the exclusion of other possibilities. Hence, we say that rather than seeking to prove hypotheses, we seek to

improve them – and proof will come only when the work is evaluated. Ideally, we need to develop competing hypotheses and look for evidence to *disprove* them because along with uncertainty comes hope for change, or at least such an approach would reduce the risk of grave inaccuracy. Overreliance on theory conflicts with what Pozatek (1994, p. 397) calls the *uncertainty principle* because the very act of observing changes what is being observed. This should prompt us to ask how we can tell that what we see is what was there before we saw it. Without realizing this difficulty, workers can disseminate information and 'initiate and maintain a pathologizing discourse' (Pozatek, 1994, p. 398) that is oppressive. By way of contrast, the constructionist approach is to work with service users in a way that is respectful of the unique complexity of each person's life and his/her understanding of it. This shift in perspective is necessary to 'account for the unpredictability and randomness that are part of everyday life' (Pozatek, 1994, p. 398) in any particular culture. Assessments by professionals all too often get accorded the status of truth and, if unchallenged, the resulting beliefs become accepted as true.



PRACTICE EXAMPLE

Following the removal of children, Roxanne's social worker, Mary, has undertaken a comprehensive assessment, concluding that Roxanne has resolved many of her difficulties but remains vulnerable because of her lack of social support. Mary has also commissioned a psychological assessment. This assessment concludes as follows:

> The results indicate that Roxanne has a poor self-image, seeing herself as being of little value, inadequate and feeling a sense of hopelessness. There is a marked lack of self-confidence and a belief that she is not capable of doing things on her own. In essence there is a lack of a strong feeling of identity...Although her history was not discussed in detail, it is my view that her childhood experiences have played a significant role in the development of this personality style. There is an urgent need for her to address this area of functioning via extended counselling.

Roxanne was greatly distressed by the psychological findings: 'That's not me. He's twisted my personality. I couldn't answer the questions so I answered in the middle. He didn't discuss his opinions at all so I had no chance to disagree. It's so final, his word goes, like it or lump it. The Guardian ad Litem is going with that report, so Mary's panicking now. It's turned things round, and it's so late. I've no chance of proving I don't need that work'.

As this example shows, this not only is oppressive to service users but also limits what social workers think can happen. Pozatek (1994) reported seeing many interventions that were unhelpful to service users that involved a high degree of worker certainty. Understanding people's experience is as important as understanding their behaviour. This requires a collaborative/partnership approach to interpreting meaning, an awareness of the power of the prevailing discourse, a willingness to co-construct shared understandings of situations by dialogue with service users, and adopting a stance of uncertainty that pushes us to try harder to grasp service user experience. Assessments have to be more like qualitative than quantitative studies and be 'making sense' activities rather than ones clinging to naïve realist epistemologies. Influenced by postmodern perspectives, we believe that no single theory can fully tell the truth and that there is anyway a plurality of truths. Truth can only be interpreted and certainty is illusory. We like the expression *working truths.*

So we take an interpretative view, committed to understanding the meanings that service users use to make sense of their lives, meanings that are constructed by the language used in talking about life. Although we do acknowledge the existence of reality that we can bump into, we maintain that assessments never fully reproduce it. What we see and hear is evidence or data, but we need reflexive checking of our assumptions and our plans for action in coming to an understanding of the *meaning* of the data. Therefore, while we need to be aware of what is known in the social sciences and use theory to check our own prejudices as we make the initial judgement in stage 3 of an assessment, we need to welcome uncertainty in work where 'the perturbing agent can only serve to trigger an effect: it is the living being [the service user] who determines the outcome of the interaction' (Maturana and Varela, 1987, cited in Pozatek, 1994, p. 397). What separates the creative social worker from the mere technician is the capacity to shift from one perspective to another. This demands that we can make our minds up about what to do but remain open-minded. It will be clear to the reader that we are attracted to social constructionism in the way in which we view social and psychological theories; for an introduction to this approach, we recommend Gergen (2015), Witkin (2011), Burr (2003) and Parton and O'Byrne (2000).

THINKING POINT

Ten-year-old Stephen moves about the classroom a lot, talks loudly and is fidgety. He has been diagnosed with ADHD. He tells you that one of the reasons he is fidgety is that his teacher talks too fast and gives him mean looks.

- What influence will the clash between professional and service user theory and diagnosis have on you?

(Source: Adapted from Saleebey, 2013b, p. 37.)

Map selection

Stage 4 of the assessment framework involves analysis of the data, and this requires an application of one or more of the theoretical maps (derived from methods of intervention) in order to gain a useful depth of understanding that will guide plans for intervention. In our experience, many assessment reports simply describe problems from various subjective perspectives and then give a common-sense summary of the situation, perhaps adding some suggestions for what should be done. When we ask workers how they arrived at their recommendation, they may say that this is what they always do in these cases or that's the way it is done in the particular agency. When asked whether other social workers might see the situation differently, they readily accept that they may well do so. The idea of selecting a theory to provide a particular analysis or explanation of how things have become as they are, or how they might be changed, is felt to be only adding to the workers' difficulties and a rather academic exercise in any case, but it is crucial that our theoretical models are made explicit if we aim to practice anti-oppressively. We need to be aware also of the consequences of using a particular map, with its underpinning philosophy, as this may not accord with service user experiences.



THINKING POINT

- Read an assessment.
- Which theory underpins this assessment?
- Does it lead logically to the interventions proposed?

There are many 'maps' from which to choose but none of the resulting analytic descriptions can reproduce reality; they can only propose helpful re-understandings:

> It is now widely accepted that any statement that postulates meaning is interpretive – that these statements are the outcome of an enquiry that is determined by our maps or analogies or, as Goffman puts it, by 'our interpretive frameworks'. (White and Epston, 1990, p. 5)

Fit

In considering the factors that influence theory selection in social work practice, we have the impression that *fit* (in the sense that a metaphor can fit a situation) with the original data or type of problem is the greatest influence in theory selection. For example, family therapy ideas fit problems of family relationships, parenting problems fit with notions of skills training,

a task-centred approach has particular ways of looking at interpersonal interactions, and behavioural problems fit with the behaviour modification approach. However, substance abuse could fit equally with a behavioural approach or with a solution-focused approach, and affective disorders such as depression fit with a cognitive analysis of difficulties or psychodynamic interpretations. We need to arrive at fit not only between data and analytic maps but also between our analyses *and those of service users themselves* – except when these are clearly in conflict with the needs or rights of others. The existence of adequate fit between original data and intervention should not, however, be seen as necessarily prescriptive. In assessments of need or risk, notions about capacity for self-care fit well in some situations, such as an older person living alone, but less well in situations such as a parent struggling to manage a child's temper tantrums. At the end of each of the following 'map' chapters, we will suggest some advantages and disadvantages in terms of outcomes that might be associated with that map and therefore possibly with its use in certain situations.

Perhaps the second-greatest influence on assessment consists of the actual services that are available and the criteria for suitability of these, even when these lead only to fitting people into the best (least bad) alternative available (Wright *et al.*, 1994). The interventions that the worker can personally deliver and the worker's preferred explanation for problems influence theory selection. As the reader will discover, some maps claim to be useful for most situations, and most social workers will feel that they do not need to draw on all five maps.

Locating the problem

An alternative way of selecting the most useful map would include the following features. Having engaged with a potential service user and begun to establish trust, thus generating a flow of information or data to which one has listened attentively, one could begin to ask 'Where is the problem/need/solution mainly located, outside the service user, within the service user, or between the user and others?' In other words, is it extrapersonal, intrapersonal or interpersonal? Frequently, a person's need/problem/solution is perceived by the individual or the family as being *both* internal and external.

Where the problem or solution is considered to be mainly outside the service user, it is for the most part not the service user who is the main target for change but the social system. Then it may be a matter of advocacy, or a needs and risks assessment and a survey of appropriate resources, or possible systems analysis as a preparation for systemic change.

If it is felt to be inside the person, the assessing social worker needs to ask whether it consists of a habit, in which case behavioural ideas may fit best. If it is a feeling, a psychodynamic approach or a cognitive approach might be considered, while cognitive theory strongly suggests itself for a self-defeating pattern of thinking. If it is most likely to be found between the person and others, task-centred theory, narrative ideas or cognitive theories may help.

Matching theories to types of problem is difficult. This difficulty arises from the fact that more than one theoretical approach may be helpful in any one case and various theories can tackle some problems equally well, depending on the skills of the worker. For example, if a service user is depressed, psychodynamic theory may provide useful insights, but cognitive theory also has its own way of helping with this problem, claiming that feeling is the result of dysfunctional thinking. If the cause of the depression is interpersonal, then solution-focused or narrative ideas could be indicated, whereas if the cause is external, then tackling oppression and finding resources will be more important. Also, social workers' own preferences and abilities have to be taken into account as long as they can show that they are effective in achieving service user satisfaction. Some social workers and writers claim that one method of assessment and intervention can suit all situations, an example being de Shazer (1993), who suggests that there are no contraindications for solution-focused work (see Milner and Myers, 2017, for a discussion of how solution-focused ideas are applied to a range of social work and social care situations).

Of course, various ways of working may take a longer or shorter time, and since our premise is that assessment is more helpful if it matches the intended intervention, busy workers will favour ideas from brief therapy. We feel that there is little point in doing a thorough Freudian analysis if there is neither the time nor the expertise to carry out the related psychoanalytic intervention. Cost will be a further factor to consider, remembering that quickest and cheapest is not necessarily the best.

In some situations, the theory will immediately suggest itself because the intervention will be ready-made. For example, if the problem is one of bedwetting, social workers may well suggest a reward system such as a star chart, or a warning bell, both being based on behaviourist theory. So too is skills training for, perhaps, a man with underdeveloped fathering skills and assertion training for those who have not learned to assert their needs appropriately and who may be either too aggressive or too passive. However, we cannot stress too strongly that assessors need always to look at the extrapersonal and the interpersonal before focusing on the intrapersonal because power is an ever-present issue. It is extremely rare in any case for any problem to be entirely intrapersonal; people may be *in* the problem but they rarely *are* the problem.

In practice, the selection of a theoretical framework is usually not a clear-cut matter. Finding the *best fit* will, especially for new social workers, often entail consideration of more than one map and trying them for fit and usefulness, rather like finding which *metaphor* fits a particular situation best. In this process, one would be looking not only at aspects that fit well but also at aspects that clash or misfit and then weighing up the positives and the negatives. By positives, we mean those aspects of theory that shed light on the difficulty and how it might have started and, more importantly, on how it is maintained in existence and what might be helpful in its resolution.

By adding together these positives and allowing for any negatives, social workers can compare different approaches for fit and usefulness. There is no reason why the service user should not be included in this process.

The spiral of data, theory and analysis

We now wish to address another aspect that can be confusing to assessing social workers: the overlap between theoretical analysis and data collection. This comes about because the particular theoretical approach that a social worker implicitly holds, or selects, influences the questions asked when reaching for depth of understanding. Furman and Ahola (1992) maintain that it is not the truth of a theory as established by research or some value system that matters but the usefulness of the questions that flow from it. They demonstrate this by using a totally fictitious theory and showing how it can lead to a useful analysis. The social worker begins by saying something like this:

> Come with me on an imaginary interview. This interview will take place in a dark, damp cave outside of town where lives a gremlin called 'The Jaahak', whose sole purpose in life is to get people to have problems like yours. Any steps to change these problems upset him very much, because his whole life is dedicated to making people suffer these problems, in your case substance misuse. Our job is to defeat The Jaahak and our first step is to work out what he likes you to do and what he hates to see you doing.

So, in this interview, the theory being used to explain the problem is that such problems are caused by a gremlin called The Jaahak. This being the case, the questions naturally include him, leading to the collection new data that are linked to the theory – data about what The Jaahak likes and dislikes people to do. The questions could seek out a list of these likes and dislikes; for example, in the above scenario, the service user discovers that The Jaahak likes him to:

- Associate with other users.
- Not bother about getting a job.
- Sleep during the day and hang out at night.
- Steal money to feed the habit.
- Avoid treatment.
- Ignore warning literature.
- Squat.
- Be anti-police.
- Not talk to the family about the drugs.

As the service user completes this list, s/he could be asked whether it includes many of the things currently done. Then he could be asked to begin a list of dislikes The Jaahak may have, such as:

- Returning home.
- Looking for a job.
- Discussing the problem with the family.
- Visiting a counselling service.
- Sleeping at night.

Or anything else The Jaahak would really hate, for example:

- Reading about drugs.
- Trying to change his/her friends.

We could ask 'Which of these things could you start practising in order to begin to worry The Jaahak?'

Note that The Jaahak's likes and dislikes include both *interpersonal* and *extrapersonal* factors. It would not be difficult to include *intrapersonal* factors too.

These questions, driven by this fictitious map, can lead to a helpful analysis that helps the service user see what might be done to start developing a solution for the difficulty. The service user may begin to see that many of the behaviours now engaged in are ensuring the continuance of the problem, or at least are helping to maintain it, and make its resolution less likely. However, our purpose in presenting this 'theory' is to show how the theory shapes the questioning, which, in turn, leads to sets of data being produced because our very questions construct their own answers: 'New narratives yield new vocabulary, syntax and meaning in our accounts [and] they define what constitute the data of these accounts' (Bruner, 1986, p. 143).

THEORY INTO PRACTICE

Amy and Ali have had their children removed to foster care following a series of drunken fights in front of the children. At a meeting to consider what work needs to be undertaken before the children can return home, the social worker says that she wants the parents to understand the impact of their behaviour on the emotional well-being of the children and for Ali to accept responsibility for his violence to Amy. Amy insists that she started all the fights but that they are fine now she has stopped drinking. The social worker does not accept this and presses Ali further to take responsibility for his behaviour.

- What theory underpins the social worker's assumptions about the causes of domestic violence?
- How would Amy and Ali demonstrate that they understand the impact of their behaviour on the emotional well-being of the children?
- How could this be measured?

In beginning an assessment, therefore, after having engaged with the service user, it is a matter of collecting initial data by listening to the stories of the potential service users and others. These data will point to a possible preferred theory in the mind of the worker and the resulting questions will provide their own data (service users' answers or information). This in turn will lead to an explanation of this service user's particular situation, the explicit use of more than one theory clearly being an important safeguard against bias. Data collection does not stop dead at the end of a checklist so that inference-making can begin with the use of a theory; rather, these aspects spiral around each other as the theory is drawn on to generate new data of its own. This will be true of any theory that may be selected.

Interventions follow from the assessment, which is based on the data, including needs, risks and resources, and on the inferences made. This is not the same as the methods-led assessments referred to in Chapter 3, nor is it the same as jumping to conclusions too soon and making the data fit one's theory. As we stressed in Chapter 3, social workers should have more than one hypothesis, and both hypotheses and questions are generated by theory. Because we cannot empty our heads, there is always some theory. Thompson (2016) discusses 'the fallacy of theoryless practice' and shows how complex actions cannot be divorced from thought. He is referring not just to 'book theory' but also to the informal theory that underlies people's explanations of events. It is only when we acknowledge what ideas influence our actions that we are in a position to question them. Without such reflection, we risk becoming dogmatic. Because social workers ought to know why they are asking particular questions, they need to know and make explicit what theory is driving their assessment questions.

THINKING POINT

- Read an assessment you have made.
- How did you decide what questions to ask?
- What theory/working hypothesis guided you to these particular questions?

Finding the truth – the road to constructionism

By now, the reader must be wondering how we can be placing equal value on different theories or even suggesting that a fictitious theory might be useful. Surely, the truth about a situation is what counts? We do believe that there is such a thing as *the* truth about a situation, certainly in the collection of accurate data or the description of service users and the resources available to assist with their needs. However, we also believe that there are many, and often conflicting, truths about any one subject's situation. Since an analysis is a 'making sense' of a set of facts and it is possible to construct any number of accounts, we would argue that the most truthful analysis is the one that is the most *helpful*; the one that leads to the most useful understanding and to an intervention that achieves the service user's goals is the one that has the most utilitarian truth.

THEORY INTO PRACTICE

Sixteen-year-old Kyle's social workers view his physically abusive behaviour towards his grandparents as evidence that he has unresolved issues to do with his witnessing his father stabbing his mother to death six years previously. Kyle explains that he gets angry when his grandparents don't allow him to have an opinion. He adds that he copes with his mother's death by not thinking about it.

- **Which explanation of Kyle's behaviour has the most utilitarian truth?**

In the current state of the social sciences, it is not possible to prove that any helpful analysis is more or less true than another, and we know of no one who expects that it will ever be possible to reach one analysis universally accepted as the most true. Neither is it likely that we will be able to reach a deeper level of meaning beneath surface appearances that will rule out all other meanings. For constructionism, it is unlikely in social work that there will be one version of events that is true in the sense of making all others false. This can be attacked as leading to a relativism that puts the very premise of constructionism in doubt (Burr, 2003), but its strength is that, if accounts can be said to be neither true nor false, meaning can easily be mobilized in the social world in the interest of particular disadvantaged groups. We know that the powerful are skilled at using discourses ideologically and politically in their own interest.

Positivists felt that experts could acquire the necessary knowledge to explain and correct the world, to make continual progress and to know when they had found the truth of what was really the matter. However, in this age of postmodernism, the subjective meanings of the individuals who

are experiencing difficulties are being seen as central, and their theories (accounts of their world view) are being seen as mattering a great deal. Their attributions and explanations are part of the reality and even create that reality. Because there is scepticism that we can locate the truth, what matters is the currently operating 'created truth' of this person and how a thematic map might help us to co-construct with the person a more helpful and empowering account. It is interesting that, later in his life, Freud shifted the emphasis from historical truth to narrative truth. Essentialists feel that truth is something external to the person and something the person can regard objectively, whereas constructionists see it as essentially something that is created by the ideas, thoughts, constructs, beliefs, communications, words and language of the knower. We *author* our lives, and if they are unsatisfactory, we can *re-author* them. Language does not simply represent reality; it makes it.

This approach, that one story is as true as another, can be attacked as an exaggeration. After all, a cat is not a dog. There has to be some fit or correspondence between external reality and what we construe. Except when we are deluded, we can usually tell the difference between fact and fantasy. In our daily lives, we rely on those ideas that are 'object-adequate' (Pocock, 1995, p. 161) that fit with the hard realities which we bump into daily. Some stories are more testable than others, and some stories come to dominate our understanding from time to time. Pocock (1995) takes the view that we can have more confidence in some stories, so it is a matter of looking for the better story. A most useful theory represents the best story that can be written from a particular perspective to make sense of the uncertainties of life. Indeed, several stories can coexist, offering different layers of perspective. What we need to locate is the *pragmatic truth* (Pocock, 1995, p. 160), which will be the most useful in facilitating change in any particular situation as long as the outcome is both ethically sound and useful. It is, therefore, important to hold to uncertainty, to develop more than one hypothesis and to compare alternative and competing understandings for usefulness.

In another sense, a theory can be seen as a story's plot, but we want to keep to the notion of map in this book. We hold to the postmodernist view and the belief that the narrative can create the reality in human difficulties, so substitution of the term map is meant in the narrative sense, as a plot for a story or as an analogy that makes sense of a situation and gives direction. In social work, the situation is usually a stuck one, where life has become like one episode of a miserable soap opera repeated over and over again. The best map is the one that fits that current situation best and is the most useful in facilitating progress – the most pragmatically true and the most positive and empowering for the service user.

We maintain that social work's search for one cohesive theory is misplaced. Social workers need a selection of practice principles and values, coupled with a range of theoretical models and methods, as a foundation from which they can respond creatively to the infinite range of situations

they will meet. This creativity will enable them to be thinking, reflecting, responsive professionals. In the words of Milton Erickson:

> Each person is a unique individual. Hence [work] should be formulated to meet the uniqueness of the individual's needs rather than tailoring the person to fit the Procrustean bed of a hypothetical theory of human behavior. (Erickson, cited in Zeig, 1985, p. 8)

We must avoid being like Blaug's (1995) carpenter who, possessing only a hammer, tended to see every problem as a nail. Each theoretical approach has its own usefulness or domain in which it is helpful in some particular way. No one map has been proven to be more effective than another in all situations, nor is it likely that such a map will be found. Many writers (see, for example, Pinsof, 1994) maintain that it is, therefore, a matter of linking together more than one fitting map to maximize usefulness and reduce deficit. Pocock (1995) supports this pluralist approach, which gives the worker more positions from which to be helpful by selecting 'a highly congruent better fitting set of ideas' (p. 162).

PRACTICE EXAMPLE

Elsie, age 11, was having severe tantrums over contact with her mother, who, according to the father, had walked out and left them all. This father was distressed and angry, condemning his wife in the child's hearing. He repeatedly said of the child that she was 'disturbed' and 'It will take years to get her back to normal'. The mother was seeking contact with the child, but the child was refusing to cooperate. We worked with the couple, drawing on a divorce mediation map, and the father was able to agree that the child should be told that her mother had not left her but that her mother and father would be living in two houses in future, and they both still loved her and would always be her only parents, and her father now wanted her to see her mother. To the father, we said, 'Perhaps this child is not disturbed, perhaps she is playing a game, the game of being on her father's side and, as soon as she knows that seeing her mother is not disloyalty to her father, she may recover very quickly'. When they were seen a week later, the child was staying with her mother during the agreed times without difficulty. In this case, we had recounted a different plot from that developed by the family, using our knowledge of separating families and of mediation to develop a story that altered the meaning of the components of the problem and helped to bring about change.

Naming the maps

Suppose one were travelling from a small town in Scotland to a village on the south coast of England. One could buy various maps that might be useful depending on one's mode of transport, on one's needs for the journey or on how well developed were the roads or ways. Assessing a potential service user can feel like entering uncharted (or variously charted) territory as the worker searches for ways by which to *arrive* at a conclusion. In the following chapters, we will be considering five theoretical approaches, which we have called maps of various kinds. We use the map metaphor derived from Bateson (1977) and subsequently developed by several writers in the family therapy field and by solution-focused writers such as Durrant (1993). This metaphor appeals to us because it helps to deal with the issue of truth.

Our traveller from Scotland has quite a choice of maps. She could access a GPS or satellite navigation system that can pinpoint her position and allow her to key in her destination and preferred route. On her Sat Nav, the speaker can give her directions and she can perhaps change the voice depending on her mood, requiring little concentration – until it directs her to a dead end. She could get a motorway map, which would show junctions and service stations. As she passes each of these, she will know how far she has travelled, whether it is in the right direction and what else she has to do to arrive at her destination. However, she may need a detailed road map to help her find her way when she is not on the motorway. If she wishes to walk, say to raise funds for a charity, she may prefer to take minor roads and footpaths, in which case another kind of map, such as an Ordnance Survey map, showing hills and valleys, might be more helpful to her. Likewise, if she were to travel by boat, she would need a map of coastal waters. Perhaps maps also need to be understood by the person being met, or else the service user might not be waiting at the harbour! Maps should ideally have meaning and helpfulness for both parties and be in a language that both use.

Each of these maps could claim to be a map of Britain, and they all are true in what they represent. But none of them is truly Britain; the map is not the territory. On the other hand, if we consider the domain of *the meaning of experience*, we could say the map is the territory – that real meaning is simply that which we construct and narrate. We regard theories of human situations as maps to the understanding of problems, all different, all offering a different construction, yet all potentially useful and equally true. It is crucial that, when faced with the often-pressing needs of service users, we avoid taking the naïve realist view and that we are reflexive about the effects of the lenses we use. What matters is what gets the best outcome for all concerned.

In Chapter 5, we take a broad view of wider systems that affect people's lives, so the first map is named a Satellite Map which considers not only these systems but also what people bring to them. Because Freudian ideas relate mainly to getting below the surface of the person and their feelings, we have named Chapter 6 'A Map of the Ocean'. On the other hand,

cognitive-behavioural work focuses on observable conduct and on the ups and downs of action, so in Chapter 7 we have named it 'An Ordnance Survey Map'. In Chapter 8, we have labelled task-centred work a 'Handy Tourist Map' for several reasons: it can be popular with busy workers, offers relatively brief ways of working, is easily explained to service users, and is an easily accessible guide to assessment that has a wide application. Chapter 9 presents the Explorer's Map, which is interested in people's strengths, futures, possibilities for solutions and new narratives, and, following a focus in Chapters 10 and 11 on specific practice areas, Chapter 12 considers a map of the Universe and spiritual aspects to people's lives.

It will be clear that, at least in some instances, one map does not rule out another. Rather, they can complement each other, adding a further layer of understanding and providing further indicators towards possible interventions to bring about change.

We hope in particular to show that several maps can apply in helping in any one situation and, to some extent, the choice that works best for one worker may be different from that which works best for another. In our view, social workers and service users should be encouraged to experiment and thus eventually devise their own most useful blend of ideas, although that cannot work if we seek to combine ideas that are not compatible. The important point is that professionals ought constantly to review their effectiveness, seek out ways of increasing usefulness to users, and explain their maps to service users. In this way, their array of maps can evolve over time in an atmosphere of research and evaluation, drawing especially on user feedback, but never claiming to have found the truth. This involves constantly checking for the advantages and limitations of each map and for ways of making them more useful to the service users by helping to generate really helpful analyses of their difficulties and their solutions.

Finally, it may be helpful to look on the various maps (or method theories) as differing *metaphors* for the same reality as well as different ways of telling the story.



Summary

- In developing a deeper *understanding* of difficulties, with a view to deciding on intervention, social workers can draw on a range of theoretical maps, based on the theories from which methods are derived.
- Differing hypotheses result from viewing situations with the aid of theoretic maps. This is healthy since no one map can claim to lead to a single truth and because forming alternative understandings safeguards against bias.
- Pragmatic truth (that is, the interpretation which is most helpful to both social workers and service users in developing solutions), is the most

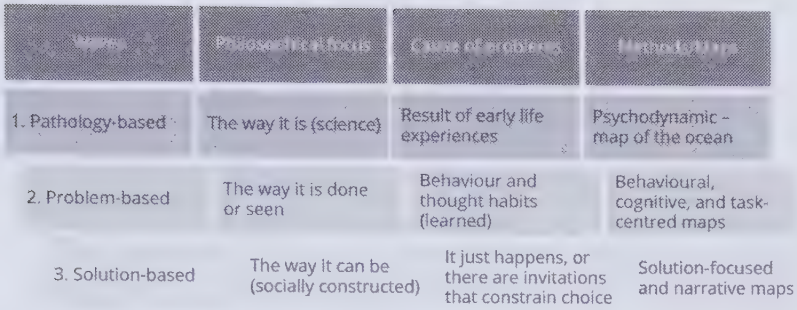

Figure 4.1 Waves and maps

desirable, provided the work is firmly rooted in the values of respect and anti-oppressive practice.

- Social workers need more than one map or tool in order to avoid being likened to a carpenter who has only a hammer.
- Having more than one map helps us to retain uncertainty and open-mindedness, which is the beginning of hopefulness.
- Maps have been developed in three 'waves' since the middle of the twentieth century (see Figure 4.1).

Further learning activity

- Using your tablet or phone, research the main news story of the day and contrast how it is represented in the different news media.

Further reading

Gergen, K. J. (2015) *An Invitation to Social Construction*, 3rd edition. London: Sage.

Witkin, S. L. (ed.) (2011) *Social Construction and Social Work Practice: Interpretations and Innovations*. New York: Columbia University Press.

Witkin, S. L. (2017) *Transforming Social Work: Social Constructionist Reflections on Contemporary and Enduring Issues*. London: Red Globe Press.

5 A SATELLITE MAP: SYSTEMS APPROACHES

What this chapter is about

Here we provide an introduction to systems thinking as it might be applied in social work. We draw on three particular systems approaches, beginning with Bronfenbrenner's (1979–2006) ecological systems theory, then Pincus and Minahan's (1973) systems approach to planning in social work practice and, thirdly, systemic family work.

By 'systemic', we mean the quality of being part of an organized body/entity which is greater than the sum of its parts and these parts interact in a tension that seeks to maintain stability while dealing with change that is necessary for survival. Resistance is the first reaction to change. Natural systems survive by using their own energy and since this is limited they naturally die in time (*entropy*) unless they get an input of energy from outside. Social systems can develop their own energy for survival, known as *synergy*, through family relationships, for example. A social system that lacked sufficient synergy would be in trouble unless it drew energy from others. As synergy counteracts entropy, it is sometimes called *negentropy*.

In this chapter, therefore, the term 'system' is used to set out how individuals are affected by the environments of systems such as family, school, neighbourhood, places of work, agencies, culture, laws, ideologies and values. Anderson *et al.* (1999) go so far as to suggest that systems thinking integrates holistically the continuum from atoms to the cosmos. We will attempt to look first at the human ecosystem (collection of systems), highlighting the impact of various systems on human development and functioning, then at the value of focusing on social work's own basic systems and, thirdly, at systems ideas as they relate to the functioning of families.

Main points

- An outline of the wide range of systems, from a child's immediate carers to the general 'macrosystem'.
- Discussion of Pincus and Minahan's systemic approach and an explanation of its use in the social work profession.
- An introduction to Family Systems ideas and their usefulness in looking at, and addressing, family issues.
- Reflection on the benefits and criticisms of systems thinking in practice.

Wider theoretical perspectives

1. ***Bronfenbrenner's Ecological Systems Theories***

In Bronfenbrenner's theory, we zoom out, as if using Google Earth, to take the widest possible view of the systems affecting our lives. Drawing on his work (1979, 2005, 2006), the systems affecting our lives, especially their development, can be thought of as ever-widening circles as shown in Figure 5.1.

Each of the systems interacts with, affects and influences the others.

At the centre is the child/person, with individual gender, age, health and innate characteristics and abilities.

1. **The child** has access to technology such as television, iPhones, iPads, the internet etc., making up a system which had been named the **Techno subsystem**, an extension of the self in that through it the person can be in instant contact with other systems. This subsystem creates a cyber life which is having a considerable effect on parent–child interactions. The technology penetrates the child–parent boundary, giving even very young children access to wider systems and other cultures and giving those systems access to the child. Here change is rapid; we now have, for example, the Amazon (not the river) Ecosystem which recruits even at primary-school age.

2. The child is surrounded by the **Microsystem** of family (which is a child's venue for initial learning about life and the world, for developing mutuality with significant others and for trust building), peers, school, church, with which s/he has direct contact – the child's immediate environment of people and places.

3. Next is the **Mesosystem**, which is the overlap or connections between the parts of the Microsystem (e.g. parent–teacher groups and local politics).

4. The **Exosystem** consists of the indirect environments (e.g. issues at a parent's place of work could affect the individual child who has no direct contact with the workplace).

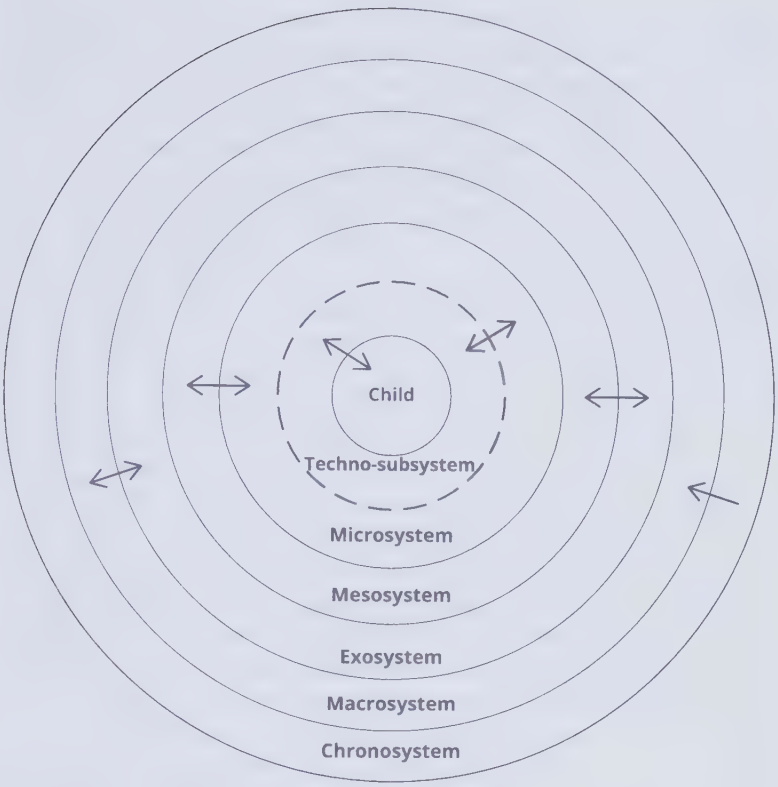

Figure 5.1 Ecological systems

5. The **Macrosystem** includes national and international agencies, social ideologies, cultural values, laws, politics, attitudes, beliefs, war, poverty, migration, globalization, homelessness and pandemics. It has effects that cascade throughout the other layers.
6. Lastly, all the above are seen as sitting on the **Chronosystem**, which is the impact on all the systems of transitions or change over *time* or in one's lifetime. We can think of it as, for example, producing the technosystem more recently, which is leading to a sense of progress where the possibilities of the human race are more and more fully realized, as our visions of the world and our capacity to take common action are transformed. Like all developments in the world and its systems, life always has to become different in order for it to remain itself.

The notion of 'boundaries' between the systems does not stop us from crossing them – they are not razor-wire barriers. Potentially, we have some access to all of these subsystems, giving us more social knowledge and many

possibilities for thinking about the problems social workers face. Each system has its own values and rules and interacts with the systems at either side of it, causing effects which travel both ways between the macro and the personal. As Bronfenbrenner saw it, failings in the microsystem, for example, cannot be replaced or compensated by other systems. He held that the impact of our primary relationships and family support last a lifetime and therefore supporting families in their parenting tasks should be the prime object of services such as social work. Teachers too can play a key role in informing parents about a child's developmental needs as well as educational needs. Work environments also need to be sensitive to the impact of work on families and seek to avoid conflict, while governments need to develop policies that support families in raising children.

Jordan (2013, pp. 242–3) argues that even when social workers cannot directly influence law and social policy, they are likely to be complicit in social injustice, unfairness and neglect unless they develop an awareness of current debates and issues and the wider significance of their practice. It is easy to feel powerless in influencing the macrosystem but we must not underestimate our ability to make an impact by the use of our own technosystem and the media generally. Technology and science are rapidly changing all of the systems in our biosphere. Ecosystemic ideas enable us to consider how the problems of people living in unsafe, exploited and disadvantaged communities can be addressed by supporting individuals and local leaders in reaching out to the macrosystem, engaging with policymakers and politicians. Bronfenbrenner prompts us to make connections with our social science and social policy studies when seeking to work out what changes are required to enable communities and families to experience less injustice and discrimination, and also to consider how our professional bodies might be able to have a greater influence on behalf of the disadvantaged. Without crossing systems' boundaries, we will be like ambulance workers with only enough time to do emergency or short-term work and no time to do preventative or corrective work like that shown in the practice example below.

THEORY INTO PRACTICE

Imagine that you are working with a travellers' community or with a group of asylum-seekers. Give the group a name and consider the following:

- **How could you draw on ecosystemic ideas to ensure you do not add to the oppression or stereotyping of the group?**
- **Other than doing your statutory duties, what conversations could you have so as to increase systemic awareness and to promote some measure of empowerment?**

The original ecological system framework had only four subsystems; the chronosystem was added later and the technosystem is a relatively recent addition. New technology, in the form of communication and entertainment devices such as iPhones and iPads (which did not exist in Bronfenbrenner's time), can be seen as getting between parents and children, so much so that these devices have been labelled by many parents as 'the iNanny' – a formidable being who brings some advantages but also some serious disadvantages. 'S/he' has great power and is often much loved, certainly desired, by parents and children alike. But parents can also be jealous of 'him/her' and if a child spends too much time with 'him/her', serious conflict can occur.

The benefits of these devices and social media include giving children a window to a larger experience, to a network of friends and their views on Facebook and Twitter. Car journeys with children have become less fraught and parents are given space to read weekend newspapers (or to access them online). School-work projects have become more interesting, with parents being able to join in. However, the disadvantages are a cause for concern to many, who feel that leisure time is being shaped increasingly by tablets, that these cause children to waste time as the technology 'infiltrates families on an unprecedented scale' (Emma Cook, in *The Guardian*, 27 April 2013). They can greatly restrict time for reading and interacting face to face. Thynne (2013) fears that the cyber systems are 'rewiring' children's and adults' brains. She quotes Nicholas Carr as claiming that they cause a 'loss of concentration and focus, division of attention and fragmentation of our thoughts', making reading harder and destroying 'the linear, literary mind'. Palmer (2013) argues that the iNanny needs to be avoided as much as possible because 'allowing electronic strangers into a child's bedroom before the mid-teens is an extremely bad idea' and parents should be supported in making bedrooms a technology-free zone. Thynne (2013) quotes Keith Topping, who studied the reading habits of 300,000 children, as finding that increasing numbers of 13- and 14-year-olds are opting for books with a primary school reading age. The reading that develops key life skills such as having the empathy to place one's self imaginatively in another's mind and the ability to sustain deep concentration, to write or to simply think is diminishing.

Bronfenbrenner also developed the Process-Person-Context-Time (PPCT) model. This addresses the increasingly complex process of reciprocal interactions between persons, objects and symbols in the environment, some more immediate or proximal, others more remote. It is by engaging in interactions that we make sense of the world and understand our place in it. Human development involves interaction with a variety of people, groups, roles and ever-widening systems. The person brings much to the process in the form of personal characteristics, qualities, mental and emotional resources, such as resilience and skills, as well as social resources like access to life's essentials and to educational opportunities. S/he brings a particular

force in the form of temperament, motivation, drive and persistence, all of which affect individuals' roles in changing their context in various ways. All these aspects of the PPCT model are seen in terms of relative consistency and change over time. Walker's (2007) superb article 'The Story of Matthew' is an excellent demonstration of the application in practice of the interactions between environmental and individual factors as set out by Bronfenbrenner. Social workers are invited to be aware of systemic influences when assessing problems and especially to collaborate with other services who deal with individuals or families and to look for strengths in the various systems that could support people (older people or those with mental health difficulties, for example), as well as identifying stresses caused by systems, large and small, that affect people's lives.

Gitterman and Germain (2008) also offer an ecological perspective (known as the ecosocial model) to systems thinking in social work practice, broadening the focus from the individual to social and environmental influences, and the interactions between these, focusing on an integrated whole that is greater than the sum of its parts. Their number one value is protecting life, which includes mobilizing community resources and influencing policy. They deal more closely with the professional function in relation to life stresses, placing the social worker at the centre, surrounded by demands and pressures from difficult life events or transitions, as well as dysfunctional families, groups and communities. Their *life model* also sees the social worker as drawing on and developing resources within individuals, families, communities and governments, the intention being to raise awareness of the place of social work in the great scheme of things as well as the influences and pressures of all involved. Where there is a failure to cope with life, there is an emphasis on gaining some *fit* between needs and resources, seeking to change some aspects of a person's internal resources (for example, competence, self-concept and relatedness) as well as addressing obstacles to the use of external resources. These obstacles may include, for example, exploitative power, habitat, one's unique life course or social events affecting families and communities. Payne (2005) discusses this model/approach much more fully.

Implications for assessment

Knowledge of systems helps us to take a broad view of context and to take it into account in practice. For instance, what can families do about the influence of technosystems? Should parents monitor and impose rules? Cook (2013) quotes Luckin (2011) as suggesting that the future should be embraced rather than driven underground and that the most successful approach is when parents are open to what iPhones, iPads and the Web offer to their children, find out how it works and understand what is good and bad. She finds that techno devices alone will not offer much that is positive. They have to be part of a united family effort of working out how to embrace

them and turn them to the best advantage. While it is never too early to set boundaries, such as time limits on usage, there is insufficient research to indicate what the limits should be. Some suggest that if a child's behaviour is adversely affected parents should consider banning all use. Others argue that, well before puberty, children will find access to the 'net' no matter what parents do earlier. The process can be compared to dealing with food. Balance is the key – left to their own choices, children would eat chocolate all day but no sensible parent would allow that. Children need a balance of fun online and interaction offline. It is being argued that it is best if learning the skills of socialising and interacting starts offline.

Applying ecosystemic ideas to assessment, the process starts with organizing data to reveal significant patterns, especially as regards *life stresses,* and then moves on to analyzing and synthesizing data so as to draw inferences about *strengths and limitations* of people, their *expectations* (particularly of the agency), external resources and deficits and *the level of fit* between person and the larger systems/environment. Service user participation in the process is seen as essential, as is their collaboration in the prioritizing of what issues need immediate action, what can be set aside for now and what can be ignored. In this approach, the focus is not only on the person but on the-person-in-the-situation/environment, with particular attention to stresses and stressors. In ending an involvement, this model assesses the factors that led to ending, the appropriateness of the methods used and the timescale, as well as changes in the service user–worker relationship. It addresses any negative feelings about ending and acknowledges any sadness, pleasure or release experienced by either party.

It has long been recognized that social work is more than assessing and dealing with individuals who present problems. Government guidance on assessment, the Framework for the Assessment of Children in Need and their Families (2000), the Common Assessment Framework (2005) and *Working Together to Safeguard Children* (2018) all stress the value of having a wider focus than seeing all problems as deriving from individual weakness, so various aspects of people's environments such as the wider family, housing, employment, income, community resources and technology are identified for consideration. Seeing how we all influence each other, especially in the high stress levels of many lives and the stressful atmosphere caused by lack of respect and care, and limited income support, helps us to keep a holistic and less blaming perspective. This is not to say that all responsibility for behaviour is removed from individuals.

Although never designed to address the specifics of particular interventions, systemic ideas have led to the development of the *person-in-the-situation* approach and to keeping social work 'social'. It helps us to think of wholes rather than just parts of lives or of situations. It has provided the insights of terms such as boundaries, entropy and synergy as well as ways of analyzing complex human situations.

THEORY INTO PRACTICE

We have filled out some detail of how the techno subsystem operates. We invite you now to spend some time reflecting, perhaps in a group, on how the other Bronfenbrenner systems (the macrosystem, for example) operate in practice to affect people's lives for better or for worse.

- Take each system in turn and consider what control people can have of them.
- How does Bronfenbrenner's theory help us to understand the situation of those minority ethnic groups experiencing social disadvantage?

Critical comment

The ecosystems approach is criticized for being over-inclusive and promising more than it can deliver. Some have accused it of viewing children as objects and of not recognising sufficiently that children's constructions of family and life generally are more complex than the theory suggests. Some have felt it misses the tension in families between control and self-realization in child–adult relationships, failing to consider how children can change culture and failing to acknowledge that there is no common understanding of 'normal'. It is also accused, like many models, of overlooking rights. The *life model* of Germain may deal with issues of class and cultural differences better, though, like many models, it is vague in addressing the problems of minorities and weak in its concern about oppressive social dynamics.

Outcomes

Apart from the benefits discussed above, it is difficult to research ecosystemic approaches, because while they contribute to a systemic way of thinking, a mindset, they (apart from Family Systems theory) are very broad and not really designed to lead to particular interventions. However, a study by Hollomotz (2009) found that, in dealing with the risk of sexual violence to people with learning difficulties, the ecosystemic model was useful in assessing the impact interactions between individuals and the social environment have on a person's learning and development opportunities that have potential to increase self-defence skills.

2. ***Pincus and Minahan's systems theory***

Social work is a multifaceted activity and it is not easy to be clear about where we start on any particular day, about whom to see and for what purpose or gain. The Pincus and Minahan systems model was designed to map

out this complex territory, to give direction, to be our 'Sat Nav'. It does not focus on the specifics of interventions or assessments as the maps in the following chapters do. It does, however, take you to the right door, if not into the house. In social work literature, this is probably the best-known systems theory. It certainly was dominant in the last quarter of the last century. In some countries, it almost dropped out of sight from about 2000, but it is our understanding that it is now regaining interest, particularly for the way it distinguishes between certain service users and for its contribution to networking and interagency cooperation thinking, something for which most child death enquiries have been crying out. Like other systems theories, it has its own set of terms and specific meanings.

In the Pincus and Minahan approach, the emphasis is on seeing social workers as *agents of change* in individuals, families, services and networks, inviting and persuading them to act in helping and protecting others. Action can mean agreeing to do something, doing it, saying something useful or helping someone else to do it – any participation in a change effort. The approach of this system includes clarifying who is a service user and what we call those who refuse to permit or accept service. The terms 'client' (i.e. a willing service user) and 'target' (i.e. an as yet unwilling or undecided service user) are employed. Currently, these terms are not popular in some services, but we have been unable to find generally agreed terms to replace them. In addition, the distinction made by these terms leads us to consider what we are doing in terms of skills and values when we meet one group or another. Value principles may apply one way in meetings with willing service users and a different way in meetings with unwilling targets such as a powerful and ruthless landlord (to take an extreme example). Here, invitation and persuasion of various sorts may replace empowerment and self-determination. The approach is transparent about the different relationships we may have in counselling, in protection work and in advocacy. It does presume, however, that the major social work values of respect, caring, listening and anti-oppressive practice apply even where the work involves persuasion, influencing and inviting 'targets of change' into the action system and the client system.

For the sake of historical accuracy and clarity, we will use the terms 'client' and 'target' as Pincus and Minahan defined them. Their system theory suggests that people in difficulty generally turn to one of these three networks or resources:

1. *Informal/natural networks* such as families, friends, bartenders, co-workers and many more who may provide support, advice, loans, and baby-sitting.
2. *Formal membership networks* such as trade unions, recreational clubs, support groups and tenant associations who may offer more specialised help.
3. *Public/societal networks* such as housing organisations, the health service, social care services, courts, schools, income maintenance services and even international aid agencies and non-governmental organizations (NGOs).

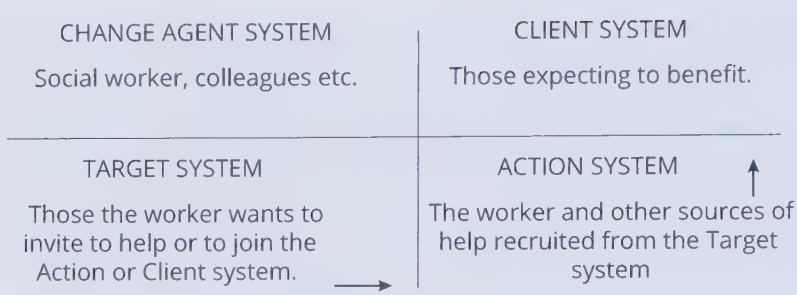

Figure 5.2 The Pincus and Minahan system

Usually, it is only when these services fail in some way or are not mobilized, or there is a breakdown in communication, that a referral is made to a social worker.

The Pincus and Minahan map is set out as four interconnected systems that can be shown in a diagram (Figure 5.2).

The change agent system

This system includes the social worker, supervisor, colleagues, care assistants, and residential workers. The social worker is the central agent of change, seeking to influence the Target system as well as helping the Client system and discovering who inhabits these systems. S/he assesses who is willing in the Change agent system to join the effort in some way or who would be most useful to the change effort. Some will be part of her/his team, some may run facilities that may be needed, others will have resources to offer. This means s/he is never alone and has a system that can empower him/her as required, perhaps by co-working a particularly difficult situation such as a disaster, where the main role is one of empowerment, mobilizing resources (including those of victims) and building and maintaining action systems to meet need. S/he has the power of a system to call upon and to bring to bear on situations.

The client system

In Pincus and Minahan's terms, a client is defined very specifically as a person, family or group who requests, engages and sanctions service for themselves and who expects to benefit and enters into a working agreement with the worker. This definition makes it difficult where the main beneficiary might be a young child or a person lacking mental capacity. In this case, the client might be a carer, or the community, or the state. Service users who refuse service are not in the Client system – they may be in the Target system in the hope that they can be invited into the Client system. We feel that, in

a sense, everyone is a client for something, though not yet for the service being offered at this point. It is a person's right to decide what they want to change or not change but not to block essential service to others. There may be some other aspect of the situation where they would like something to be different and addressing this might be an appropriate social worker response. No one, apart from those legally 'sectioned', should be forced to be a client in terms of this system, and resistance is not to be interpreted negatively; rather, options are to be clearly outlined and if possible discussed. Powerlessness has to be respected and not exploited, as we seek to secure consent by ethical persuasion and by building trust in a non-oppressive way. This is well demonstrated by Dominelli's (2015) report on disaster work.

The target system

Some may recoil from the term 'target', but it is not meant in an aggressive way; it has nothing to do with guns or arrows or performance targets in management. It is similar to canvassing or sending invitations to a particular group. The Target (of change) system, within this systems approach, is made up of those the social worker wants to invite to become engaged in the change effort. Usually, in collaboration with the Client system with whom there are agreed goals, the social worker assesses who might help or who might eventually join the Client system, such as neglectful parents who have not yet been engaged and who might benefit the change effort as well as themselves. Some might be in the Client system for one matter and in the Target system for another. Potential helpers may be other family members, relatives, voluntary groups, a teacher or people in the Change agency. In the Pincus and Minahan approach, the Client system is never the only system where change is required; it is required, in particular, in the Target system, be it with resource managers, workers in other services, teachers, landlords, policymakers or politicians.

The action system

This system is made up of the social worker and all those who have been recruited from various resource systems, along with anyone who works alongside, with or for the social worker, especially workers from other agencies: educational, health, support groups and the police, all who wish to contribute to the change effort. Some of these may be part of the Client system, such as the partner of a person with a substance abuse problem. The social worker's main role here is to maintain this system for as long as it is needed. In practice, a social worker may be maintaining several Action systems of various sizes and various levels of commitment. It may sometimes be felt that this is not worth the effort and it might be more simple to do it all oneself, so it is important to select Action system members carefully and ideally only those who will do some work. This saves the worker from burnout

and carrying too much personal responsibility, and a good Action system can almost run itself. It certainly can deliver a better and faster service than a solitary worker. Sometimes, the Action system is virtually already operating (for example, where there is a constructive extended family). The image of the social worker using this system to guide, organize and monitor practice becomes akin to case manager, but one who is fully involved in promoting good service for individuals and families without referring many of them to specialist organizations.

Implications for assessment

We will explore this heading through an example of the Pincus and Minahan system being used in practice.

PRACTICE EXAMPLE

Jo is an education social worker employed by the local authority. She deals with school issues affecting children and families, attendance and behaviour problems that children and families pose for schools and also difficulties that school life poses for children and families. Sally, age 9, attends Grande Road School, where Miss Blyth is responsible for the pastoral needs of pupils. She makes a referral to Jo's department, where a supervisor (whose special interest is children with divorced parents) allocates the work to Jo. The referral states that Sally is not attending school regularly, that she is often late with her work and that she appears to be rather unhappy. Her absences seem to coincide with history and geography lessons taught by Miss Adams. It is thought that the family are poor, the parents are divorced and Sally has only one friend as far as is known.

Jo meets Sally and elicits her story. She does not like Miss Adams, because she asks her questions that she cannot answer and makes her feel embarrassed. Sally agrees that she could do better at school if she could attend regularly. Turning to her family, Sally is worried that her mother seems to be unhappy, so she sometimes stays at home when Mum is not very well. She likes her Dad but not his new partner, so she does not enjoy visits to him. She wishes that Mum could be less unhappy. Sally agrees to meet Jo again and that Jo can meet her Mum and Miss Adams.

Jo meets Mum and confirms that Mum has not coped well with the divorce which, she feels, 'destroyed everything' for her. She is concerned about Sally's education and welfare but she gets 'so low' that she sometimes needs Sally to stay with her during the day. Mum has been prescribed some medication but she does not take it regularly.

Jo next meets Miss Adams, who has many responsibilities in the school and is 'very busy'. She does not know Sally very well because this is the first year she has worked with her and she is often absent. She has noticed that Sally sometimes does not seem to be paying attention and so she asks her a question to engage her. When Jo mentions problems at home, Miss Adams is rather defensive and agrees only to keep an eye on Sally and to meet Jo again in two weeks' time.

Jo now has some useful preliminary data which she records to aid assessment/analysis:

Change agent system	Client system
Jo Supervisor – interest in effects of divorce	Sally – permits involvement Mum – wants to help Sally Miss Blyth – ditto
Target system	**Action system**
Sally – Jo wants her to go to school Mum – Jo wants her to send Sally to school Dad – might help to influence Sally Miss Adams – ditto Miss Blyth – ditto	Jo

Jo sees how important it is to build up the Action system by recruiting the five people in the Target system to become involved. Miss Adams might be invited to try other ways to engage Sally; Miss Blyth might greet Sally or get someone to do so, making Sally feel more welcome; Mum can be encouraged to address her low feelings and see her GP again; Jo can invite Dad to be more supportive in whatever way he feels he can.

We realize that this will be perceived as too simple and obvious an example but we have employed it for clarity (and brevity) so that readers can see that the approach is not as difficult as the language of systems theories may suggest.

In caring for older adults, several needs might be identified and several services may be involved: supports, domiciliary and medical care, Occupational Therapy, sanitary help etc. It is useful (and not difficult) at the assessment stage to list those in the four systems. The list in the Target system will be lengthy, their involvement will need to be coordinated by the key worker and as Targets are recruited to the Action system the movement of individuals to that system can be shown and monitored.

THEORY INTO PRACTICE

- Thinking about a situation you are aware of, take a page of paper, place a large cross in the centre and start filling in the four quarters with names, as shown in the example above. Put the date at the top of the page.
- When you review progress, start a new page, date it and fill in the squares showing who is now in which system (square) following your efforts so far.

Advantages

This model, which Pincus and Minahan themselves described as 'integrated', can build an assessment of the broad territory of a problem and how to organize the workers' approach. Harassed workers burdened by intensive interpersonal work can be enabled to stand back and consider the wider picture and realize that it is not just people who are problematic – some 'environmental manipulation' can pay off in addressing problems. It invites the worker to look *around* the problem and not only *into* it, to ask why workers are involved, who else is involved and to what benefit. In this way, it prompts an awareness of contexts and environments. It places an emphasis on processes and at how systems are interacting. It invites people to be better colleagues of other services and so improve interagency collaboration, the lack of which is constantly lamented. The basic questions of who is to be defined as a member of the Target system and of the action system is a helpful step in considering the *social* aspect of the work apart from the psychological content of assessments or interventions.

Critical comment

This approach has been criticized for assuming that society is teaming with helpers and resources, formal and informal, that are ready to help, but some of the targeting work can be a waste of time. The Marxist criticism is that systems theory does not take into account the incompatibilities of capitalism and class power with caring and how these hinder social integration.

3. ***Family Systems theory***

In presenting this third system, we go through the front door, zooming in to seeing the family as a central human system, containing various subsystems but also surrounded by a set of larger social systems which, taken together, comprise the family's supra-system. 'Family' can be defined in many ways and it can look quite different in different cultures. We do not define it on the basis of marriage or ownership of property or as a 'nuclear' family in its own

'castle'. For the purpose of this chapter, we define it as a group of people, related by blood or by sharing a home, who see themselves as, or hope to be, ongoing mutual supports, generally relating more closely to one another than to others. We do not define what is normal in the wide spectrum of families, other than there usually needs to be a tolerable fit between what members seek, receive and give to one another and also some fit between their norms and values and those of the network and culture to which they belong.

When a worker meets the household, the focus is on understanding the dynamics of the group/system rather than primarily on individuals, but of course if a worker identifies a special need in an individual, that need would be addressed while still keeping the whole system in mind. A Family Systems approach is interested in the transactions that develop from the life experiences of such a group, using systemic ideas such as boundaries, subsystems and roles to understand difficulties. We are clear about the importance of being aware of issues of power, dependency and the possibility of exploitation. In this regard, we see this approach as a means of assessing and assisting families who wish to deal with some problem, stress or unhappiness in the household and who accept this approach when it is explained to them, but definitely not as a means of establishing whether abuse is occurring or might occur or is suspected. Such concerns and investigations must be dealt with through the appropriate protection protocols. Safety therefore remains the primary issue.

We offer the following diagram of a family with two adults (shown as persons 1 and 2) and their two children (shown as persons 3 and 4) (Figure 5.3).

The arrows show interactions or communications between persons, between subsystems and with various systems that form the supra-system. They show that even in a small family there are many interactions with much potential for support and equally much potential for stress, distress, hostility and so on. In addition, many families have numerous contacts with relatives and significant others, some of whom may reside with the family and play significant roles there (grandparents, for example).

Seen as a system, the family will be found to have most of the attributes of systems generally, namely *the whole* is greater than the parts and each part affects the others. There are *stages* of development, *boundaries* between subsystems and between the family and the supra-system and various *transitions* over time. *Changes* in one subsystem have reverberations in the others, particularly changes at transitions, and these are most important as we shall show. In family-system thinking, behaviours are seen as residing *between* individuals – as interpersonal processes – or as happening *between* the family and the environment around it. *Rules* develop to regulate interactions, roles and the preservation of stability – *homeostasis*, the processes by which systems maintain themselves in a steady state while allowing some change. As in all systems, there is a natural *resistance* to change, which is felt to be threatening. *Causation* within systems is seen as circular rather than linear. We will now look more closely at the significance of each of these characteristics (shown here in italics) as they relate to families.

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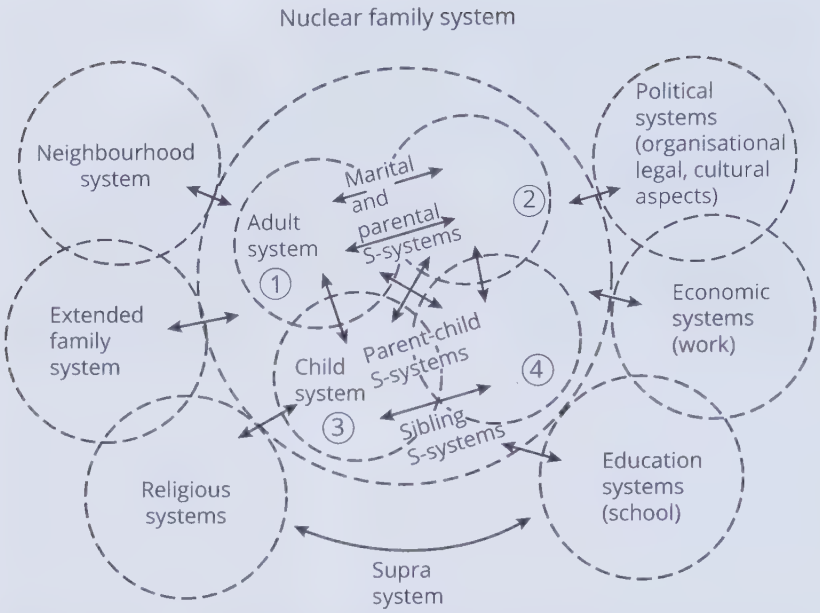

Figure 5.3 A Family System, Masson and O'Byrne, 1984 (This figure was published in Applying Family Therapy, Masson, H. and O'Byrne, P. (1984), p. 4. Copyright Elsevier Ltd)

Stages of family development

Writers in family therapy and in social work have produced various lists of stages in the family life cycle (Carter and McGoldrick 1980, Schertz 1970 and Carr 2012, to name but a few). They all start at different points, but we will go with Carr's list:

- Leaving home.
- Forming a couple.
- Family with young children.
- Family with adolescents.
- Launching the children.
- Parents in middle age.
- Parents nearing end of life.

Each stage has its own functions, tasks, potential for fulfilment, demands, stresses, adjustments and alignment of relationships. The arrival of a child brings new functions and roles, in time child–parent relationships shift, parenting roles have to be balanced with marital roles and gradually children develop more autonomy and adolescents prepare to move out of the family

home, leaving parents to readjust to life in the 'empty nest'. Of course, family systems vary greatly in their make-up, their reasons for being together, their beliefs, environmental circumstances, ethnicity and culture (see, for example, Burnham, 1986). Probably no two families have ever performed the same or followed the smooth path suggested by the list of stages. Separations, divorce, accidents, deaths, unemployment and many other events can involve massive adjustments. Family life for some is paradise, for others hell.

Transitions

Time and events force families to make transitions from one stage to the next, with new functions and rules. Linked to the tendency of all systems to resist change, these transition points usually become 'stress points' (Scherz, 1970) out of which can come constructive resolution, regression or chronic problems. Many families in difficulty are experiencing what can be considered the normal difficulties of transition points and the changes associated with them.

Change

The most important aspect of the difficulties associated with changes is how they are handled. They need to be accepted and seen as an inevitable outcome of everyday difficulties, involving adaptations, rather than the end of a family's happiness. If a family has utopian expectations of life, what are normal difficulties can become serious problems resulting in impasses or crises. Some people mishandle change by denying that it is happening, others panic, seeing changes as more serious than they are, others try to prevent transitional changes. These actions can lead to unhelpful feedback loops and, in any case, such problems can very well be attempts by the system to maintain a steady state, the prevailing homeostatic balance of family relationships (Burnham, 1986).

THEORY INTO PRACTICE

Bob and Sarah pride themselves in having 'always lived for their children' but they have been worried about their eldest daughter showing signs of wanting to launch herself, such as staying later at friends. Sarah fears that this will be the end of a special relationship. Bob agrees and they both attempt, with partial success, to keep their daughter as a child in various ways. However, they also react to her being childish at times in not taking more responsibility for herself.

This leads to arguments that distress the two younger children, and now the parents complain that the daughter is making all their lives a misery.

- **Who is responsible for this?**

Causation

Faced with such situations, we need to be aware of our own linear thinking, seeing X as simply caused by Y. In systems, because causation is frequently circular (X causes Y to cause X to upset Z, for example), social workers can use 'circular questions' to unravel such tangles. Looking at someone's misbehaviour, we can ask ourselves who is causing who to cause this problem? Because we have a system involved, we need to expect that behaviours are interactional relationships, problems *between* people or subsystems, each of whom affects the other in a circular manner.

This makes the understanding of particular problems quite difficult. Prolonged boundary problems can lead to 'scapegoating' as one subsystem uses a member of another subsystem to diffuse its problem. For example, parents with a relationship problem, which they are unable to acknowledge or address, could use a 'disturbed child' to take the focus away from themselves.

PRACTICE EXAMPLE

Shannon's behaviour at home and at school was difficult and demanding. She has been placed on a criminal court order for assaulting another child and for theft. When her worker visited the home, she found that not only did the parents disagree on matters of discipline, but they also undermined each other's attempts to manage family affairs and implicitly allowed Shannon to take control in destructive ways through the cracks in their marital and parental subsystem functioning. As the 'cracks' became more apparent in discussion, Shannon's father felt quite threatened and made attempts to end the work, but patient-concerned persistence enabled the worker to stay engaged and after a few more meetings complaints about Shannon ended. When the worker next met Shannon, she was much calmer about her life, although she seemed to be slightly irritated by being no longer 'centre stage'.

Boundaries

Boundaries between individuals and between the subsystems are considered for their rigidity or impermeability and for their openness or permeability. In the diagram, they are drawn with broken lines, hinting that some permeability is common/normal/desirable to allow contacts/exchanges and the usual ebb and flow of life and adaptation to change. However, if boundaries are too open, a system can be overwhelmed by sense impressions, resulting in a lack of clarity of identity sense. Open intra-family boundaries curtail individual's psychological and physical space or privacy. People begin to think

they know what others are thinking and feeling, and others begin to doubt where they end and others begin. They become unsure of their own wishes and responses, and communications become confusing or distorted. Where boundaries with other systems are too open, a home can be flooded by visitors who 'make themselves at home', sometimes for days, and get involved in personal of family issues in an intrusive and unhelpful way, sitting in on every discussion even when the social worker calls.

On the other hand, where boundaries are too rigid, we get stability at the expense of defensiveness, as well as impaired growth, development and creativity. The family may be cut off from necessary involvement with services or other healthy influences. Rigid boundaries between individuals can lead to a lack of empathy or of the ability to see life events from others' perspectives. Adapting to changing circumstances can also be impaired. Sharing of feelings, wants or ideas can be threatened. Some writers say that in extreme situations there can be an increased risk of mental illness and abuse. Such overly integrated families are at one end of a wide spectrum, while those at the other end seek to flee from involvement with each other. At the extremes, families may be enmeshed, in too rigid boundaries that limit autonomy, or disengaged, in too open boundaries that lack support for needy members; most families, however, exhibit a measure of both aspects in different subsystems at different stages without serious problems.

A common source of problems lies in boundary breaches between the family system and grandparents. Grandparents may see the children almost as their property or they may undermine the rules set by parents concerning discipline. They may dislike the partner of their son or daughter, thereby affecting the parental subsystem and cutting across the family hierarchy.

Rules

We think of rules in two ways, firstly as imposed or agreed understandings that regulate the game of family living (bedtimes, for example). Such rules are usually explicit and openly acknowledged and sometimes broken with certain consequences. Rules can become 'set in stone' or seen as such (i.e. unchangeable).

We will see later that rules management is a key part of parenting. But here we want to address the other meaning of 'rules' (i.e. what happens 'as a rule'). These rules are similar to expectations and 'shoulds' – 'we should be enjoying things together'. They characterize and regularize interactions. But all rules need to respond to transitions, to the passing of time and to changes in the general culture.

Roles and tasks

The subsystems within a family have their own roles and tasks, and agreements about these are worked out by trial and error 'for a combination of

reasons, including obligation, necessity, pleasure, and usefulness at any particular time in a family's development' (Burnham, 1986, p. 24). Apart from caring and supporting each other, *parenting* is probably the most significant and demanding task. Holland (2010) says that the parenting tasks, commonly agreed as necessary for the benefit of all children, are *basic physical care, affection and security, guidance and control,* the *stimulation* of innate potential, facilitating appropriate responsibility and independence and self-awareness (i.e. a sense of identity, of social acceptance and of personal history). Others would add in meeting care needs, guiding and supporting development, *protecting*, helping to deal with racism, acting as advocates, *developing emotional bonds*, provision of a secure base, *providing stability,* providing models with whom to identify, teaching to cope with stress without aggression or illness, providing good quality discipline and good communication networks (internal and external). [The factors in italics are included in the 2013 government document *Working Together to Safeguard Children.*]

We suggest that parental subsystems must take responsibility for their own boundaries, balancing the degree of permeability for the benefit of all, tackling the socialization of children in ways that are flexible enough to accommodate the changing needs of children as they grow up. Parents have to work out how to protect, control, guide and assist their children to independence.

Meanwhile, in sibling subsystems, children's tasks include learning to relate to peers as well as to parents, learning how to share and cooperate, bargain and negotiate with each other. For this to happen, children need some 'space' to work things out. To say that family roles are designed to provide a level of devotion where each is sensitive to the others' needs and to tenderly care for the other without reward is probably utopian. Such devotion may sometimes happen, but a more realistic style might be positive reciprocity, fair shares and give-and-take. Unfortunately, in many troubled families, we find negative reciprocity, a tit-for-tat of insults or injury. But it is problems with the parenting tasks that bring many families to the attention of social workers.

In the following practice example, one could describe the problem situation as a serious decline in synergy, particularly in the parental subsystem. Without the energy provided by the workers, entropy may not have been far off and would probably have led to burnout.

Implications for assessment

We will address this heading through an example of Family Systems Theory in practice, in which there is a series of reflective assessments/re-assessments as the work progresses (Figure 5.4).

As the above genogram shows, Ann and Joe live with Ann's three children by a previous relationship. (The // marks show that Ann obtained residence in the divorce settlement.) Social workers became involved when Ann and

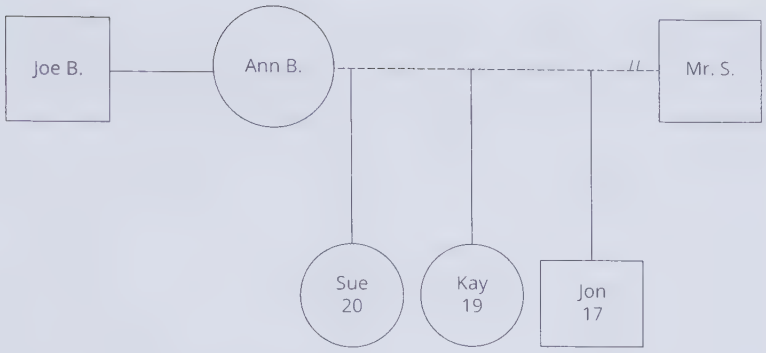

Figure 5.4 The Brown family

Joe sought help with dealing with Jon's disturbing behaviour. They could not cope with his abusive manner, temper and angry rows. He would get into a bad mood several times a week and become 'sour', bossy and looking for 'aggro'. They felt he was most cantankerous, refusing to help with domestic chores, work they felt should be shared as the whole family had jobs to go to. They felt powerless to improve matters and now Ann had developed 'nerve problems' and her hair had started falling out. Still, she did most of the shopping and cooking. She had said Jon was 'wearing her out'.

For convenience, we will refer to Ann and Joe as 'the parents' and the three siblings as 'the children'. The comments in square brackets are ideas on which the workers were reflecting during the work. What follows is a summary of the parts of the example that show systemic ideas being used.

PRACTICE EXAMPLE

At the first family meeting with the whole family, with a pair of workers, Ann spoke of the problems mentioned above and of their unhappiness, bitterness and rows. She and Joe often worked late and expected the 'children' to do their share in the home, to help with food preparation, washing up, keeping the home tidy, especially putting their laundry away. She was the only one who put things into the clothes basket. When they ask Jon to help, he says "you do it" and, to make peace, Joe ends up doing it, which upsets Ann even more. [Some circular causality may be happening here?]

Meanwhile, the girls sometimes supported Ann and sometimes they were on Jon's side. [Playing one off against the other?] They and Jon had aggressive rows at times, using insulting words like 'bad' or 'mental'. They accused him of hitting them when he lost his temper

and that he never washes up, so that Joe 'had' to do it. This upsets Ann even more. They were also disrespectful towards Joe, who was a quiet person who did his best to look after the chores. He said he just wanted to be a father to them but it seemed that he did not demand a reasonable sharing of responsibility from them, while still hoping they would be more adult.

Any tentative suggestions made by the workers, about obvious ways forward, were rejected by the family as a waste of time. [Normal resistance to change?] Then Kay commented that she was thinking of going to live with her boyfriend anyway. [Would this raise *'leaving home'* issues? Jay Hayley (1997) linked leaving home, which could be a positive, supported, leaving or a negative (forced) one that could lead to emotional disturbances in the family as a whole. Even positive leavings can upset parents as they face 'the empty nest' life. Leaving home is also an important transition – 'launching the children'.]

Having explored the family problems and some history, the workers ended the session by distributing their usual questionnaires, as a 'home-work' task, to be completed for the next meeting in two weeks.

At the second meeting, only Jon had completed his questionnaire, which he handed to the workers, who said they would study it and return it next time. The others made various excuses. [An example of systemic resistance?] The workers went with the family mood, suggesting that they may prefer a more interesting way of looking at their situation, and offered pens and paper on which they could draw the family – to show how they were with each other. The workers offered them an example, using people's initials and placing them on the paper to show closeness, distance, who was central to the group and who was out in the cold, who was high up and who was low down.

There were some minor protests which the workers dealt with by employing calm optimism. [Such friendly encouragement, help and optimism, as and when required, could be described as an injection of negentropy.] When the drawings were finished, names were placed on top and they were passed around. Some were liked, some were a cause for laughter and some were upsetting. But there was a lively cooperative debate. The family members came to realize that they each had a different perception of reality and they were all equally valid. For example, the parents had placed Jon low and themselves out to the side; the sisters had put Jon high up but also out to the side; Jon had put himself fairly low and Joe out to the side; Ann had placed herself and Joe roughly in the centre, with herself lower but larger. The discussion became quieter and more serious, they were

more attentive to each other. In general, the workers felt there were hints of a weak paternal alliance. Members were invited to reflect on each other's views and if possible on how they would like things to be different. The atmosphere was more relaxed, perhaps warmer. They were then prompted to think about what the family did for fun – most felt "very little". Joe and Ann had not been out together for ages [Too enmeshed in the sibling subsystem?], so the workers asked them to go out more, as an experiment, leaving the washing-up and trusting the others to adjust in their own way, perhaps agreeing on a rota for certain tasks or taking turns in some other way. [Spending time without the 'children' could help their parental alliance as well as the boundary between it and the sibling subsystem.]

The workers ended the meeting with the promise of using more interesting ways still next time to help them make progress.

At the third meeting, the workers asked how the previous two weeks were and they learned that there had only been minor shouting matches and no violence. The parents seemed pleased – they had no complaints. They had gone out for a drink and a meal and had found the house quiet on their return to it. The washing-up was done but not yet dried. So the workers invited them to take part in a family sculpt. They explained and demonstrated how this could be done and asked for a volunteer who would place the others in positions and poses to show how the 'sculptor' sees the family. Once again, it was Jon who volunteered. [It is always amazing that the so-called 'trouble maker' often becomes the most helpful/constructive member, perhaps because they have more to gain or they are hurting the most?] He put Ann and Joe on chairs in the middle of the room with the two sisters standing in front of them and himself next to Sue but a little way off. The workers asked them to freeze this pose and think of how it felt. Then it was discussed. The general feeling was that it was well done but it did not feel very happy – no smiles. As was usual for the workers, they suggested that another sculpt could be done differently – this time it was to show how they would wish life to be in the family. They happily made a few attempts at this, with light-hearted banter and some laughter, showing more unity in various ways. In the discussion, they agreed that this would not be too difficult to put into practice.

As was the workers' practice, they arranged a final visit to the parents to further reinforce their status, separate from the sibling subsystem. When the referring social worker next met the parents, they were found to be still satisfied with the state of family relationships. They felt confident that they could cope with ups and downs.

THEORY INTO PRACTICE

- **Look again at the theory behind the Family Systems approach and then consider how it was used to understand and work with the difficulties in the Brown family.**
- **If you are aware of a family with systemic problems, consider how you might get support in offering help.**

Advantages

When used with an awareness of the potential abuse of power, the theory and tools of the Family Systems approach, genograms, sculpts, role-play, unravelling family chores, fair shares and the allocation of tasks, seeing family subsystems and individuals if necessary, can provide an understanding of family dynamics that can be empowering for workers and families. The process can assist in assessing problems and in assessing whether a family or its members have the potential to change when provided with a context for change by workers who can engage them firmly and cordially and not be put off by resistance. It can support parents who feel powerless at the interactional level in parenting. It is useful in helping parents to understand the distinction between their linear physical power and their interactional helplessness. While systems-thinking views 'cause' as circular, the linear cause of abuse/harm has to be kept in mind. One can feel powerless at the circular/interactional level and be powerful at the linear level – this is seen as a potentially dangerous combination. People are not responsible for their feelings but fully responsible for abusive actions. The approach helps in understand processes such as scapegoating and the enmeshment of subsystems. It offers ways of shoring up permeable boundaries and weak spousal or parental alliances.

We have found that Family Systems theory helps to gain better participation by children and young people in effecting change, and we have been pleasantly surprised at how often the identified 'problem child', or scapegoat, can become the most helpful family member. The Social Care Institute of excellence has asked workers to ensure participation by children and their families in change efforts. However, the Family Systems approach, also known as Family Therapy, is an approach that requires training, if not in qualifying courses perhaps in post-qualifying courses or by attending the special short courses that are available.

The work done in the above example can be described as one form of family therapy, not that the workers were Family Therapists but social workers *applying* family systems ideas for a therapeutic outcome. There are many models of Family Therapy and here we drew on ideas in the strategic model and partly on the structural model. For simplification, we describe the work with the Brown family as task-centred as no structured data collection is used other

than eliciting various members' views, asking what is wanted, what are the obstacles and whether or not we can help the family to have a go at doing something different that could make a difference, as we keep the above systemic 'map' in mind, and then discussing the results of attempting tasks by the family. For a useful introduction to other family therapy models, see Walker and Akister (2004), who also present an account of the Family Assessment Model (FAM) published by the Department of Health and written by Bentovin and Bingley Hall (2001). This is a complex problem-focused questionnaire, based on the earlier McMaster model; Walker and Akister offer a shorter, neater version of the McMaster Structured Interview Schedule asking about problem-solving, communication, affective responsiveness, affective involvement, behaviour control and roles (i.e. providing resources, personal development, management of the system, nurturing and supporting).

Few, if any, dispute that families are 'systems' and the case study above shows systems-ideas being used to understand and to intervene in their dynamics.

Critical comments

Family Systems theory also has its critics. Some centres for family therapy have been criticized for ignoring the social context of families and looking only at dysfunction within the family. They seemed to forget that families live in communities, in districts, in states. Class too seemed to be ignored as was the availability (or not) of services. That would be less likely if there were a greater awareness of the significance of the larger systems of Bronfenbrenner.

Earlier family therapy made little mention of the abuse of male power or the powerlessness of many women and the blame attached to them for 'failing to protect'. At the present time, and for some years, these failings are being addressed. It is now recognized that the powerless need to be empowered, helped to understand false blame and be informed of the range of options for responding to it. We must challenge any assumption that it is women who need to change and that men cannot. Where abuse had occurred, some Family Systems theorists seemed to suggest that it was the family (rather than the individual abuser) who was abusive and therefore responsible. We say responsibility for abuse should not be routinely spread – one should not ignore *who* did it.

In the USA, there have been serious concerns expressed by senior practitioners that in some private services badly trained workers have simply offered affirmation or tacit approval of people who showed abusive behaviour towards others. Some workers seemed to affirm abuse as being always 'okay' or offered interpretations to lower guilt, which would serve to put further victims at risk. This has been condemned in the strongest possible terms by the professional association who say abusive or dangerous actions (or both) must be responded to by taking action to protect the vulnerable. Value conflicts need to be understood and challenged and the values of the

profession clearly expressed. In this regard, no worker should promise total confidentiality and should explain that knowledge of criminal abuse must be shared with the police.

It has also been felt that some centres seemed to work only with whole family groups to the neglect of individuals' particular needs. Attention to such needs could still be given with a systemic mindset, having the whole group in mind while meeting with individuals.

Outcomes

There has been little scientific research of family work by social workers, but in clinical settings it has established itself as a reliable approach. However, the following findings are of interest: Markus *et al.* (1990) did an analysis of 19 studies of Family Systems interventions and found that the typical service user had a better outcome than 76 per cent of people who had alternative types of help. In addition, the benefits continue to improve further during the first year after the intervention, although the authors concluded that benefits may start to decline after 18 months. In 2004, Goldenberg and Goldenberg also reported positive outcomes.

More convincing is Carr's (2016) review, where he poses four questions: Does systemic therapy work? What sort of systemic therapy works for specific problems? What processes occur in effective systemic therapy? Is systemic therapy cost-effective? He analyzed several meta-analyses, systematic literature reviews and randomized controlled trials of systemic interventions. He found that the evidence relating to children's problems and also that relating to adult problems supported the effectiveness of systemic family work. He recommended using the Family Systems approach to deal with those who have problems with eating, sleeping attachment, physical abuse, sexual abuse, attention deficit hyperactivity disorder (ADHD), drug usage, anxiety, depression, grief and attempted suicide, as well as problems with children's behaviour and a wide range of psychosexual problems. In looking at what processes made this approach effective, Carr (p. 44) identified five parts: (1) planning (alone or with a team or supervisor); (2) meeting with clients; (3) taking a break from the meeting with clients to review progress and plan an end-of-session intervention; (4) reconvening the meeting with clients to provide feedback and an end-of-session intervention; and (5) reviewing the session (alone or with a team or a supervisor). Being focused on the main presenting problem was effective, rather than seeking broader goals, and making a good initial engagement with the family provided a solid base for progress. Carr (p. 39) said that the evidence indicates that two out of three cases improve with systemic therapy. In comparison, only one out of three cases improves without systemic therapy because of the passage of time. A further critical finding is that about one in 10 cases deteriorates with systemic therapy. Carr *et al.* (2017) found that an evaluated Parents Plus programme that took a systemic, solution-focused group work approach to working with families

where children had behavioural and emotional difficulties was very effective in managing these problems.

In this chapter, we have looked at only three systems approaches. There are several others, although some might be better described as organizational frameworks. The approach proposed by Goodman and Trowler (2012b) is an example. Briefly, this 'Hackney model' is based partly on ideas from the McKinsey school of management and its '7S' framework for any organization. The approach says there are three hard aspects (strategy, structure and systems) and four soft aspects (shared values, skills, staff and style) that need to be aligned and mutually reinforcing.

Shared values are considered to be central, and the whole family, the workers and all those involved can be invited to join in finding solutions. The professionals are not seen as having all the answers. The views of the family are privileged, and the authority for decisions taken is brought as close to the family as possible.

Units are made up of five people: a consultant social worker (who is expected to identify what s/he does not know and to find out from those who do know, such as a psychologist), a social worker, a children's practitioner, a family therapist/clinical practitioner and a unit coordinator who deals with all administration. It is said that being proactive, energized, interested and focused on change gives families the best chance of staying together and keeping children safe. They use a relational frame in making assessments, and rather than fixing on individuals, they give space to a contextual and relational understanding (Pendry, 2012). While being more costly than the typical social work team, they claim to save considerable sums because fewer children are removed from families. Minuchin (1974) would applaud this as avoiding the 'dismembering' of families and other negative consequences of quick solutions. There may also be less referring out to other services.

This 7S-based approach also has critics. There are doubts as to whether the model is a good fit for social work which is not a business. Some feel that it does not focus sufficiently on individual problems and on the large resources some families need for support and safety. The evidence, however, is encouraging, with the evaluation of the introduction of this model in five local authorities by Bostock *et al.* (2017) identifying a better quality of practice than normal and higher levels of satisfaction by families. Families appreciated being involved and having their strengths and solutions valued. The practice of having systemic discussions about the families by workers who were selected and trained in this approach was valued, and the initial outcomes were encouraging though limited.

We would repeat that it is dangerous to say that all problems are purely environmental or systemic, minimizing personal responsibility. Even in harsh social circumstances, people with 'mental capacity' are still accountable for what they decide to do. The environment may be a powerful temptation, or invitation, to make a negative response, but invitations do not mean that one has to do it – so long as one has mental capacity, one has a choice.



Summary

- An understanding of the dynamics of systems is helpful in examining any complex situation and in understanding why dealing with it may be demanding.
- Eco-systemic theory enables us to take a holistic view and to understand the multiple sources of stresses as well as resources. It enables workers to consider wider causes of difficulties and to see the person-in-the-situation as the service user, not just the problematic person.
- The Pincus and Minahan systems approach enables social workers to keep a 'social' perspective when seeking to help individuals or families, to focus on mobilizing others to take action so that the worker does not have to do everything and suffer burnout.
- Systemic family work, which tends to be taken over by private clinics, is available to social workers with proper training. It provides ways of thinking systemically in families and of empowering their drive to cope and survive. The pressures on families can be great, especially in a climate of financial restraint and the expectations of children.
- The tools of family therapy can improve communication, help achieve negotiated fairness, untangle enmeshments, strengthen fragile boundaries and deal with destructive behaviour.



Further learning activities

- How do the various systems theories assist you in understanding the dynamics of your social work seminar or work group?



Further reading

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6 A MAP OF THE OCEAN: PSYCHODYNAMIC APPROACHES

What this chapter is about

In this chapter, we will be considering various ideas associated with the psychoanalytical approach to understanding the nature of people. We are selective in our sources, limiting ourselves to the work of Erikson (1948, 1977), Hollis (1964), Berne (1978) and Bowlby (1982, 1988), who have built on and developed Freudian theories in ways which have proven particularly attractive in social work. Our description of the theory will reflect a synthesis of many people's ideas and insights, their terms and their language.

Main points

- Wider theoretical issues: psychodynamic social work, ego psychology and transactional analysis.
- Implications of psychodynamic theory for assessments.
- Practice theory: attachment theory.
- Implications of attachment theory for assessments.
- Critical comments on the difficulties of using this theory and on the expression of feelings.
- Outcomes of this approach and of research into it.

Introduction

Social work theory can be said to have emerged in three main waves. The earliest of these was rooted in the ideas of Freud (for example, 1937) and his successors; it was a medical model and therefore was pathology-based. Subsequent waves have been described as characterized by problem-solving and by solution-building, and we will address them in subsequent map

chapters. Despite its medical origins and purely psychological theory, the psychodynamic map remains the most used in social work with children. We have, however, stressed that since external problems become internal and the internal affects the external, looking at nothing other than psychological aspects is as inadequate as looking at nothing other than social aspects; we need to consider both. Also, the ideas in this and the next four chapters all need to be used alongside the climatic ideas outlined in Chapter 2.

Wider theoretical perspectives

Psychodynamic social work developed from Freudian theory, particularly *psychic determinism*: viewing our actions as determined by inner forces that develop in early childhood. It places great store on a person's early childhood and on early parental relationships, the past influencing the present. Some Freudians go so far as to say it can even be tyrannical in its influence. Therefore, this approach can have a feel of digging down deep as an archaeologist would, but, more so, it can have a feel of descending into the unconscious as if exploring in a submarine. Our chapter title comes from a comment by Hall (1954, p. 2) that the id is 'oceanic' in that it contains everything and recognizes nothing outside of itself; if there is too much rough weather, it can turn nasty. We begin with a simplified diagrammatic presentation of the core ideas in this exploratory map (Figure 6.1). Bear in mind, however, that we are not discussing physical parts of a person but mental constructs that seek to explain people's functioning: '[T]he relationship between conscious and unconscious functions within the psyche can be more fully understood and appreciated if they can be seen as much as metaphors as literal statements' (Jacobs, 1999, p. 9).

Although the id might not be capable of recognizing anything outside itself, Freud certainly did recognize the outside world and its impact on the ego, so we have shown the world of reality on our version of this map and,

The Mind		**The World**
Unconscious	Conscious	(Other people and the environment)
The Superego ('Parent')	The Ego ('Adult')	Reality
The Id ('Child')		

Figure 6.1 Mind and world

as we shall show later, a large area of the map will deal with the interaction of the ego with reality.

Freud's earliest distinction was that between the conscious and unconscious mind, considering the latter as the greater part, consciousness being only the tip of the iceberg above the surface. In the 1920s, Freud developed the notions of ego, superego and id. While a large part of the ego, although by no means all of it, can be conscious, the vast majority of the superego and probably all of the id are unconscious. Freud also identified the *pre-conscious* as that part of the unconscious that we can readily recall, that is just under the surface.

The superego develops through a process of internalization. The child internalizes the values, rules, prohibitions and wishes of the parent and of authority figures, but the process is one that magnifies these rules and records them in the raw, without editing, and laden with amplified feelings. So it is not just what a parent says to a child but all the emotion, perhaps terror, that was felt at being blamed, abandoned or hurt in various ways: the small child who breaks a cup can feel that s/he has destroyed everything. Admonitions and rules go straight into memory, carrying the weight of total truth, never to be erased from the tape. The research of Penfield (1952) and the work of Berne (1964) have helped to shape this view of the superego, and Berne (1964) later referred to it as the Parent (using a capital P to indicate that this is an internalized parent) part of the person, the part that tells and teaches. Even though the telling is long lost from consciousness, the recording remains active in the unconscious, shouting loudly.

The superego may be restrictive or permissive (Caplan, 1961). People riddled with guilt can be said to have an overrestrictive superego, and people with too little guilt an overpermissive or weak superego. Those with no internal rules, no conscience about hurting others, are labelled sociopaths (commonly called psychopaths). Caplan (1961) talks of the superego as the condemning and prohibiting part of the mind that says 'Do not...' or 'I must not...' and distinguishes this from the ego-ideal, which says (of a desirable act) 'So as not to let myself down, I ought to do it because that would fit my ideal me'. So, some people's conscience tells them they have to strive for great heights of achievement and set themselves high standards, be thrifty, and so on. On the other hand, too rigid and dominating a superego could create difficulties by way of excessive guilt, leading to neurotic effects such as depression, phobias, obsessions, compulsions, neurotic anxiety and moral anxiety or shame. Reality anxiety (Hall, 1954), however, is seen as an ego reaction to the threat of loss.

The id is that aspect of the person which is primitive, the animal drive: it is the Child (again with a capital C in Berne's terms), full of feelings, capable of rage, operating on instinctual drives and urges, hungry to fill any voids that are felt. Like the superego, according to Harris (1970), the id is also shaped by early recordings of feelings of blame, fear and abandonment. Even those with a happy childhood will record Not OK feelings that can loom

larger than all the OK feelings. We can all be said to have a Not OK Child in us. The child who feels unloved may seek to fill a sense of void by theft, sometimes impulsively, as in kleptomania. The id also feels hurt by rejection or oppression.

Berne (1978) distinguishes between two main id drives – *libido*, which is sexual impulse, desire and attraction, and *mortido*, which is the killing instinct, hating, attacking and hitting out violently. He suggests some people are more prone to one rather than the other, although these are close relatives born of the need to propagate and survive. They explain something of what some people are looking for, so the id is described as being governed by the *pleasure principle*; the lack of sufficient pleasure leaves it hurting, demanding and wanting irrationally, sometimes leading to a chaotic life of acting out, living for kicks or sending out cries for help, such as the abused person who shoplifts to attract attention to his/her plight, behaving in a way that could be interpreted as asking to be caught.

The third area is the *ego*, the I and Me, the self. Berne labelled this as the Adult (with a capital A) part of the mind, which thinks, decides, plans and relates to the world of reality. It is governed by the *reality principle*, exploring and testing, born of curiosity.

The ego is placed between the superego and the id in Figure 6.1 because it acts as a referee between them, struggling to keep a balance between the gratification of needs and impulses and the sacrifice of this gratification to the demands of reality. This is what psychodynamic means – an interaction and tension between (a) the id drives; (b) the superego, with its possibly guilt-ridden prohibitions; and (c) a tension between inner needs and outer realities, in an attempt to keep a balanced ego.

Defences

The ego lives under great pressure from three sides: the id, the superego and real threats in the world. Anna Freud (1936, 1968) itemized various mechanisms of defence used by the ego to help it cope with the instinctual drives of the id and, to a lesser extent, with the condemnations of the superego and the demands of reality: '[T]he infantile ego experiences the onslaught of instinctual and external stimuli at the same time; if it wishes to preserve its existence it must defend itself on both sides simultaneously' (Anna Freud, 1936, p. 191). She listed denial, repression, reaction formation, intellectualization, displacement and sublimation as the main defences. Repression gets rid of instinctual derivatives, just as external stimuli are abolished by denial. Reaction formation secures the ego against the return of the repressed impulses, while by fantasies, in which reality is reversed, denial sustains it against attack from outside. The ego uses sublimation to direct instinctual impulses from their sexual goals to higher aims, and reaction formation is the ego further draining itself of the capacity for reversal (p. 190). The existence

of neurotic symptoms itself indicates that the ego has been overpowered and some plan of defence has miscarried (p. 193).

Post-Freudians have added to Anna Freud's defences, up to 44 such defences being mentioned in the literature. For example, Bibring *et al.* (1961) suggests that there are dual aspects of defences: first, warding off anxiety in relation to unconscious conflict and, second, actively supporting adaptive functions of maturation, growth and mastery of the drives. They list 39 defences, 2 of which have 2 subdivisions and 1 of which has 4 subdivisions. These include asceticism, clowning, compliance, depersonalization, eating or drinking, falling ill, identification, reutilization and whistling in the dark. Most people use several of these, at least from time to time, and they can be helpful, or not, depending on the degree of usage and the particular circumstances. It is important to remember, however, that defences can be helpful or unhelpful, particularly in a crisis when the ego is under great stress. For example, intellectualization might helpfully involve making lists of tasks or thinking through the traumatic event. On the other hand, defences can be unhelpful when they lead to ongoing denial of loss or projection of cause onto others. We sometimes think that projection is the curse of contemporary life where there seems to be a growing tendency towards not accepting personal responsibility. Part of the task of assessment in psychodynamic social work is to decide which defences are being used and whether they are a help or a hindrance and, if the latter, to consider how they can best be confronted.

In translating psychodynamic ideas into social work practice, Coulshed and Orme (2012) wrote that, in assessing people, we need to see whether the ego can tolerate self-scrutiny without becoming too anxious. In cases in which such scrutiny does not promise for change, we need to ask ourselves what level of support is needed to help the person cope with external pressures. Coulshed and Orme suggest that indications of such lack of promise might be anxiety, dependence, low intellectual capacity and distrust. They warn against laying bare repressed feelings, or offering interpretations to that end, if the ego thereby risks being overwhelmed. An immature, weak ego needs defences to be strengthened rather than torn down; ego supporting is to be preferred to ego modifying in such cases.

Wasserman (1974) points out that it takes a strong ego to be able to mourn, suffer, verbalize anger and even be depressed. So the absence of depression in some situations, while it might appear to be adaptive, might in fact be due to an overdefended ego and therefore be maladaptive. In psychodynamic assessments, social workers look not only at behaviour but also at the situation and consider the stresses that may be operating, the degree to which the ego is pressed upon and the stresses with which the ego can or cannot cope. So, ego functioning is influenced not only by internal pressures from the superego and the id but very much also by external stimuli. Social, cultural and economic factors, injustice and oppression do not remain outside the person: they become internalized. Since practice is often concerned

with efforts to influence adaptive capacities, assessments are more likely to be useful if they focus on the interface of the ego with the world: how the ego is learning, controlling and balancing with self-reliance and pride. This will mean that a social worker will not be concerned about intensive psychoanalytic techniques of free association, the recovery of the repressed, or the interpretation of dreams and breaking through resistance. Rather than taking a blank-screen approach, she will offer a relationship, listening and reflecting with the service user, joining the resistance (Strean, 1968), so that they can get going with the problem-solving that needs to be done. This does not in every case require the reliving of past traumas.

PRACTICE EXAMPLE

Thirteen-year-old Emily was receiving weekly psychotherapy sessions to explore her experiences of being sexually abused, as a means of helping her understand her current physical and sexual abuse of peers. She protested that she did not want to talk about her own sexual abuse and, when this was ignored, she became silent. When this too was ignored, she began protesting more aggressively: writing 'slag' instead of doing the prescribed artwork; telling her therapist that she was useless; and playing up in the car going home with her foster carer. The therapist saw this behaviour as evidence that she was engaging with therapy. Emily saw it as due to their refusal to listen to her protests.

Ego functions

We would now like to consider the *functions* of ego, another area that can offer useful possibilities for assessment, particularly of the strength of the ego. It is the function of the ego to provide stability, equilibrium and predictability in such a way that, once we get to know someone, we can say that in certain circumstances s/he is liable to react in a certain way that is true to character. This makes for sound relationships. Bowlby (1982) explains this in terms of the child making stable internal representations that will depend upon attachment styles developed in infancy but persisting into adult ways of relating. (Note that the prediction of others' behaviour that makes people feel in control of social situations is explained in different ways in the psychological literature. See, for example, the discussion on attribution theory in Chapter 2.) The ego also manages cognitions, perceptions, planning and problem-solving. It makes judgements and decisions, adapts to reality and controls impulses (for example, not hitting out at someone being offensive who is bigger than oneself!). The ego is responsible for personal growth, coping with stress, using skills and tolerating frustration, loss, pain and sadness.

It is the ego that neutralizes pressures from the superego and urges from the id. It produces self-assertion and the ability to verbalize feelings rather than act them out and finally directs our striving and our attempts to achieve and to care. To do all this, the ego needs to be flexible, adaptable, resilient, reality-based, stable in the face of pressure and tolerant of anxiety and loss.

The ego, therefore, has a massive task to perform, which can make it feel overwhelmed and in need of defences. We all need some defences at times, but many service users may particularly need us to strengthen or support their egos, not by breaking through defences with interpretations but by respecting and working with defences, acknowledging the threats they face and discussing the implications and confusion of their ambivalent feelings, or considering their unfinished emotional business, providing support perhaps through a corrective relationship that provides an emotional re-education, so that the service user can move on to be an independent, coping person. But this can be slow work.

The term coping, however, has particular connotations for feminist writers who read it as putting up a front of coping by splitting off unwanted feelings, getting on with life without a fuss. Women often have no other choice; they dread failing to cope and are likely to suffer serious consequences if they do. For example, women tolerate much domestic violence rather than risk losing their children and put up with accusations that they have failed as mothers to protect their children (Kelly, 1994; Scourfield, 2003). Worse still, a black woman is stereotyped as being expected to cope with 'all kinds of hardship and material and emotional deprivation, as though she had no feelings or needs at all' (Lawrence, 1992; hooks, 1991, 1993). Thus, we need to consider how reality is structurally more difficult for some people because of the oppressions of society, sexism and racism and other forms of discrimination:

> Following the early work of Richmond, psychosocial casework does promote indirect or environmental interventions as well as direct clinical work, but even today it retains a narrow understanding of what constitutes 'the environment', resulting in social interventions which usually seek little more than to mobilise or modify existing community resources. (Barber, 1991, pp. 16–17)

The terms independence and separation, so central in psychodynamic explanations of healthy personality development, have difficult connotations in that, because society is fundamentally patriarchal, women are more likely to have feelings of vulnerability, weakness, helplessness and dependency (Miller, 1973) or, on the other hand, to have learned from their mothers that they must orientate themselves 'towards meeting the needs of others' and 'to be a carer and not to expect to be cared for' (Lawrence, 1992). For an alternative view of ego development, see Mead (1934).

Transactional analysis

Harris (1970), and later Berne (1978), developed the idea of transactional analysis (TA) in order to look at the relationship between any two people, not just parents and their children. They describe the transactions as taking place between the Parent, or the Adult or the Child of one person and the Parent, or the Adult or the Child of another. Hayes (2000) states that the main concept in TA is that of ego-states, Jacobs (1999) says that the model describes the related behaviours, thoughts and feelings that are manifested in one's personality and that have both internal and external functions, whereas Steward and Joines (1999) stress how the interacting states are constantly overriding each other in positive and negative ways. This is shown diagrammatically in Figure 6.2.

If person A is being irresponsible, sulky or childish, this behaviour is likely to provoke the Parent of person B. This transaction is shown by the line x, and y is a complementary reaction from B; it is expected and appropriate. Other obviously complementary interactions are Parent–Parent, Adult–Adult and Child–Child. However, if the transactions are crossed, there can be trouble if, for example, A's Adult addresses B's Adult but B's response is from B's Parent (telling A off, perhaps), as shown by lines p and q.

For Berne (1978), the transaction, the *unit of social intercourse*, is the key unit of study. Transactions will vary, depending for example, on whether the service user is relating to her social worker, to a partner, to a friend or to her own children. In some situations, she may find that she may need to be helped to practise using her reasonable, reasoning, grown-up Adult more. If practice makes no difference, she may need to be encouraged to get in touch with feelings from the past which, because they are currently out of consciousness, are dominant in certain circumstances. Events and people in our lives can hook our Parent or our Child, which can appear to take over for a

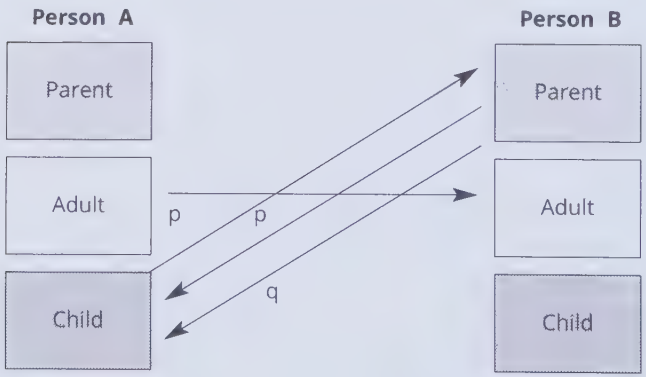


Figure 6.2 Parent–Adult–Child

while. This often operates in situations of conflict. Berne further developed notions of *life scripts*, laid down in childhood and often followed later.

Parent–Adult–Child *contamination* is another interesting idea from Harris (1970). Parent contamination (of the Adult) is when the Adult is holding to unreasonable, taught ideas, such as a strong prejudice against a certain group. This may be accompanied by a *blocked-off* Child, making it difficult for the person to play or have fun. Child contamination of the Adult is when feelings from the Child are being inappropriately externalized/exhibited in the Adult (for example, as delusions). This may be accompanied by a blocked-off Parent, leaving a risk of a weakened conscience, a low sense of guilt or responsibility, and a lack of social control, remorse or embarrassment.

Harris (1970) further expands the Parent–Adult–Child metaphor to describe a manic person as one whose Parent is applauding the Child and a depressed person as one whose Parent is beating on the Child (p. 105). In both of these, there is Parent–Child contamination, and Harris suggests that such people are probably brought up 'under the shadow of great inconsistency' (p. 105). It may help here to recap and show an ego gram of a particular service user, Miss O, age 70, based on the work of Berne (1978) (Figure 6.3).

This can be seen as a graph of the 'family within' Miss O, who had become quite depressed when relatives were 'nasty' towards her because she would not give them a loan. It is based on conversations with her, listening to her memories of her responsibilities as the eldest child, her impressions of her parents as strict and stern, and her assessment of herself as being afraid to have fun but planning little deceptions to help her cope. Her Parent (the capital indicates that this is the internalized version of a real parent) is therefore represented as highly critical and not very nurturing. What nurturing there is more rescuing than encouraging. Her Child, on the other hand, is not very free, being fearful of the critical Parent. It is, however, fairly well

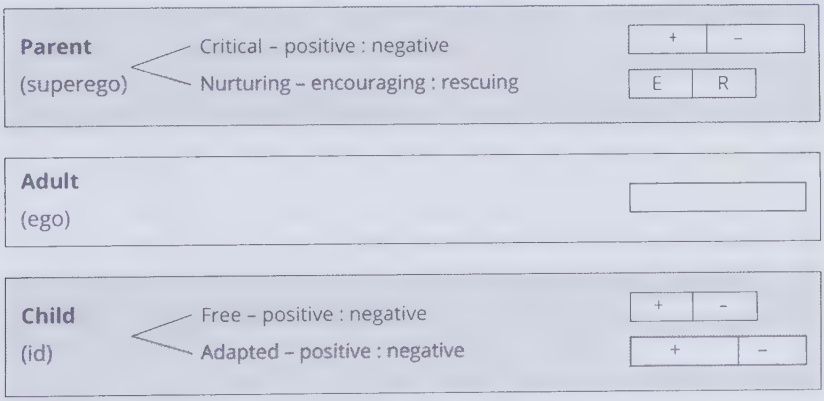


Figure 6.3 Ego gram

adapted, meaning that it has found a good deal of (possibly naughty) ways of making do. Meanwhile, her Adult (ego) is reasonably strong, but she still has some growing to do. The critical Parent and the adapted Child are both difficult to manage. Much depends on what level of stress is caused by the world, especially the world of relationships. If this proves to be too bleak and stormy a place, this ego will need quite a lot of support and luck.

Bright (2015, pp. 187–92) contains useful exercises on recognizing ego states and transactions, and Widdowson (2015) provides good examples of how TA can be applied to the treatment of depression.

Implications of a psychodynamic approach for assessment

Whatever criticisms exist of this approach (and there are many, as we will shortly discuss), it remains a useful way of attempting to understand seemingly irrational behaviour. This is pertinent when service users' difficulties appear to reside inside themselves rather than at the interface of the service user and structural inequalities. The notion of defence mechanisms can be a useful consideration in the assessment of people who have difficulty expressing their emotions, and TA provides a simple and accessible way of looking at people's interpersonal relationships. It acknowledges the influence of past events and helps to create a healthy suspicion about surface behaviour.

Insight can empower people to understand what is going on within themselves and between themselves and the outside world. Despite the assumption that psychosocial work is lengthy, it is possible to use the approach briefly in the course of assessment.

PRACTICE EXAMPLE

The father of a boy who was not doing well at school was 'in a state', trying to cope with his anger at the teachers while trying to maintain his son's enthusiasm for education. The social worker asked the father whether he had been keen on education when he was at school. He said he had not, and he had a very negative experience of teachers. When it was suggested that perhaps he was still addressing his own past school issues rather than his son's, this insight helped him to rehearse his meeting with the school so that when it took place he was better able to focus on his son's situation, behaviour and needs in a rational and helpful manner.

Supporters of this model suggest that it is useful for situations in which long-term work with a neurotic person is indicated. Cases of compulsions, hysteria, excessive dependence and people unable to face an emotion (loss, for example) may also fit this approach. One needs to understand the process of

transference in order to keep the therapeutic relationship reality focused. Although transference is not strictly a defence, more an example of the past manifesting itself in the present, it is a process that takes place when a person transfers feelings relating to one person (for example, a parent), onto the social worker. Thus, the social worker needs to consider whether the service user is really referring to the social worker or perhaps to some early parental figure.

This approach has also influenced a listening, accepting attitude in social workers which avoids overdirectiveness and can be useful in informing the earliest stages of assessment: deciding on the interview format and helping to focus on specific parts of the analysis. All maps lead to a set of questions that can be considered by an assessor. This map suggests the following questions, but rather than developing an interrogation, they ought to be considered as directing a conversation, using the values of exchange and narrative, so that the answers to them emerge:

- Which developmental stage is reflected in the behaviour?
- Is the superego (conscience) overly rigid or overly permissive?
- Is there anxiety? How severe is it? What indirect support might be helpful?
- How dependent or independent is the person?
- Are there signs of ego breakdown?
- What ego defence mechanisms are being employed, or are implicit, in the person's behaviour?
- Which ego defences need supporting or strengthening?
- Or are they strong enough to allow some insight work?
- What threat is the person experiencing? External (social) or internal (psychological)?
- What ambivalences are present?
- Are there some repetitive themes?
- Have there been past unsatisfactory relationships that need a corrective relationship?
- Which ego coping functions are working or not working for this person?
- What are transactions with others like?
- What contamination is there?
- Does the person know what they should do and yet repeatedly not do it?
- Has the person had a figure with whom they have been able to identify?
- Have I considered the gender difference implications, especially in terms of coping and independence?

Attachment theory

Psychodynamic theory sees people as developing in a sequence of stages, each one dependent upon the successful negotiation of the earlier one for its own success. Freud's interest in the early stages of child development, particularly sexual development, was extended across the life span by Erikson (1948, 1977), whereas Klein's object relations theory (1988) and Bowlby's attachment theory (1963, 1979, 1982) focused more on the social and emotional interactions of this period. We focus here on attachment theory as it is used more frequently in assessment than are the theories of Klein and Erikson.

Bowlby agrees with one of Klein's main hypotheses, that childhood experiences of mourning link to ways of responding to loss in later life, but considers that the vulnerable period extends over a number of years of childhood and that the significant object is the mother (and sometimes the father) rather than the breast. The primary loss of a parent gives rise not only to separation anxiety but also to processes of mourning in which aggression plays a major part. Attachment theory also claims predictive power, making it a useful theory for those who have to assess risk. Whereas psychoanalytic theory and practice (particularly the work of Goldstein *et al.*, 1973, 1979, 1985) influenced the emphasis on the welfare of the child in the Children Act 1989 and, at the same time, in court decision-making (Mr Justice Thorpe, 1997), attachment theory has been particularly influential in shaping subsequent child protection policy and practice to the extent that it became the official discourse of child protection work, *the* way of talking about it. It has also been invoked as an explanation for dysfunctional behaviour in all forms of interpersonal violence: marital disharmony (Weiss, 1982, 1991), poor relationships between elderly parents and their children (Cicirelli, 1991; Yan and Tang, 2003), dysfunctional family systems (Byng-Hall, 1985; Marvin and Stewart, 1990), adult bullying (Randall, 1997), physical and mental health (Allen and Fonagy, 2006; Danquah and Berry, 2014; Peitromonaco *et al.*, 2015), aged care (Karantzas and Simpson, 2015), and stress (Diamond, 2015).

Attachment theory is an ethological theory of interpersonal relationships that emphasizes the evolutionary significance of intimate relationships, also referred to by Bowlby as *affectional bonds*, particularly those in early childhood. Bowlby believed that people possess an inborn need for close attachments to significant others which serve a survival function. Throughout childhood and adolescence, people develop expectations regarding the availability, or otherwise, of attachments through specific attachments in the first instance (usually the mother but sometimes the father) and then through multiple attachment relationships. Each relationship builds on the previous one and contributes to the construction of what Bowlby called the *internal working model*, a characteristic way of thinking about and responding to others in relationships. As the person matures, these models become more stable and part of the personality, serving as an interpreter for new information

regarding attachment relationships and thus influencing behaviour. Attachment patterns not only persist but also self-perpetuate; for example, a securely attached child is happier and more rewarding to care for than an anxious ambivalent child, who is apt to be clingy and whiny, or an anxious avoidant child, who will be distant and prone to bully other children (Bowlby, 1988).

The terms *secure, anxious* and *anxious attachment style* derive from the research findings of Ainsworth and colleagues (Ainsworth *et al.*, 1978; Bretherton and Waters, 1985), who researched mother–toddler relationship styles by means of a 20-minute miniature drama known as a 'strange situation'. They observed toddlers' behaviour in a sequence of three situations. First, the toddler was left with the mother in a small room with toys. The mother was then joined by an unfamiliar woman who played with the toddler while the mother briefly left the room. A second separation ensued, during which the toddler was left alone before the mother finally returned. The researchers were interested in the reunion behaviour between the mother and toddler.

They found that the toddlers exhibited three basic relationship patterns. These were those with non-expressive, indifferent or hostile relationships, in which the toddlers devised a strategy whereby maximum closeness to the mother was obtained without fear of rebuff; those with strong, positive feelings towards the mother, where the toddler looked for the mother but played freely; and those with markedly ambivalent relationships, characterized by the toddler being clingy and angry. The researchers labelled these reactions as types A, B and C; type C was later subdivided into two related types (for an overview, see Bretherton, 1992). Type B was the normative response among the white, middle-class sample. Although the researchers reported that they did not impute that any one type of response was better than another, these attachments styles soon developed labels which imply healthy or unhealthy psychological development. Type A became known as *insecure-avoidant*; type B *secure*; type C was subdivided into *anxious-ambivalent* and *anxious-disorganized*. Although similar research in Germany found that type A relationship styles were the dominant pattern (Grossman *et al.*, 1985), and type C more frequent than anticipated in Israeli kibbutzim (Sagi *et al.*, 1985) and Japan (Myake *et al.*, 1985), secure attachment style has been translated into the desirable style.

Ainsworth *et al.* (1978) found that the toddlers' behaviour in the *strange situation* could be explained by the behaviour of their mothers. For example, secure children had mothers who were sensitive to their emotional signals, whereas insecure children had mothers who could be observed to be insensitive, rejecting or unpredictable. This does not mean, says Bowlby, that mothers should be blamed for treating their children in a way that is a major cause of mental ill health: '[T]he misguided behaviour of parents is no more than the product of their own difficult and unhappy childhood' (Bowlby, 1988, p. 145); this is seen as pointing to an intergenerational effect. Main and colleagues (Main and Weston, 1981; Main *et al.*, 1985) found a strong

correlation between how a mother describes her relationships with her parents during her childhood and the pattern of attachment her child now has with her. Her interviews have been developed into an 'adult attachment interview', in which a person is invited to talk openly and at length about childhood experiences and memories that may be quite painful, and then analyzed for style and manner in which the story is told rather than content (see also Hesse, 1999; Crittenden and Landini, 2011). Whereas the mother of a secure child is able to talk freely and with feeling about her childhood, the mother of an insecure child is not. Four types of attachment style were identified, which are similar to the categories used in the strange situation research:

- *Secure-autonomous.* The mother's story is coherent, consistent and objective. She is able to collaborate with the interviewer.
- *Dismissing.* The story is not coherent. Although she claims in a generalized, matter-of-fact way that she had a happy childhood, she has no supporting detail and may say that she can remember nothing of her childhood.
- *Preoccupied.* The story is incoherent and will describe an unhappy relationship with her mother about which she is still clearly disturbed.
- *Unresolved disorganized.* This is similar to dismissing or preoccupied styles but may include long silences or overtly erroneous statements.

Main also identified an exceptional category of mothers: those who had unhappy experiences but had incorporated these with happy ones and had securely attached children. She hypothesized that these women seemed to have come to terms with their experiences.

Advances in the understanding of how the brain grows and develops further explain the significance of parental responses to their infants. Poorly attuned parenting affects several different and interlinked aspects of brain development which, in turn, affects how infants learn to regulate stress (Brown and Ward, 2012). Gerhardt (2015) argues that negative emotions can actually prevent the baby's brain from developing because these emotions lead to the production of cortisol, which stops the development of endorphins and dopamine, thus preventing glucose from being manufactured. This neuroscientific turn is becoming increasingly common in children's social work practices. However, as Wastell and White (2012) caution, claims about the way a child's brain is affected by trauma and abuse are often unsupported by the current state of the evidence, with much more organic plasticity and potential for resilience than is acknowledged by those who seek to promote biologically determinist arguments.

Bowlby (1979) makes the important point that because affectional bonds, such as those between mother and child or husband and wife, are subjective states of strong emotion, the threat of loss arouses (separation) anxiety, which in turn arouses anger in various degrees. It is the situation that signals an *increase* of risk that creates a fear response, he says; therefore, threats of abandonment are terrifying. These threats create intense anxiety, and they also arouse anger, often also to an intense degree. For Bowlby, anxiety and anger as responses to the risk of loss go hand in hand; thus, attachment theory explains all interpersonal violence.

THEORY INTO PRACTICE

Emma and Aktar's children (7-year-old Mark and 3-year-old Mohammed) have been made the subject of a care order following the discovery that Aktar had beaten Emma badly after drunken rows. Specialist psychological assessment of the children indicates that Mark has an idealized, anxious attachment to Emma, an avoidant attachment to his father, and a distant one to Mohammed. It also suggests that Emma is significantly depressed and suffering low self-esteem related to her early experiences of physical and emotional abuse at the hands of her mother. The foster carers report that the boys get on extremely well with each other and look forward to their parents' visits. During your assessment interview, Emma talks freely about her unhappy childhood experiences. Aktar talks about a happy childhood and continuing close relationships with his family.

- **In what way does attachment theory help you to understand the relational dynamics of this family?**

How attachment theory informs assessment

Attachment theory has much to say about what constitutes positive parenting and so has particular relevance for safeguarding, family support, and preventive services (Howe, 2013). The link between the attachment patterns of children and adults who are violent or neglectful and their parents is the subject of research aimed at predicting which specific attachment patterns are the most likely to precipitate people to behave violently or neglectfully to their children, partners and peers. Parents who abuse their children have been demonstrated to have experienced poor childhood experiences themselves (for an overview, see Howe, 1995), although there is some disagreement over which parental attachment pattern is the more damaging for children. Crittenden (1999) and Finkelhor (1983) suggest that anxious-ambivalent and anxious-disturbed attachment patterns, which lead to emotional abuse and neglect, have more serious consequences for children than an avoidant

attachment style, which leads to physical abuse. Browne and Hamilton (1998), however, found that a smaller percentage of their respondents who reported emotional maltreatment was violent compared with those who reported either physical or sexual maltreatment. Bowlby also highlights the damaging effect of physical abuse, citing research that shows physically abused children were not only more likely to assault other children but also notable for a 'particularly disagreeable type of aggression, termed "harassment"...malicious behaviour that appears to have the sole intent of making the victim show distress' (1988, p. 91).

A link between poor childhood experiences and men assaulting their partners has also been a recurring finding in the research into violence and attachment style; a particularly large study (8629 participants) found correlations between adult violence and childhood physical or sexual abuse or witnessing domestic violence (Whitfield *et al.*, 2003). Hazan and Shaver (1987) add to Bowlby's analysis of male violence; they found that men with avoidant attachment styles had relationships that were characterized by fear and extreme jealousy, and anxious-ambivalent individuals' relationships were characterized by emotional highs and lows, accompanied by obsessive thoughts concerning the other and a strong desire for union with others. Later research (Bartholomew and Horowitz, 1991) reconceptualized avoidant attachment styles in adulthood as dismissing and fearful, the latter category being significantly related to measures of anger, jealousy and verbal abuse, which Dutton *et al.* (1994) describe as an angry attachment style. They found that couples with different attachment styles may actually antagonize each other, escalating aggression with violence. Kesner and McKenry's (1998) research adds detail to this finding: they found not only that attachment factors are unique predictors of male violence towards a female partner but that these partners were more likely to have insecure adult attachment styles. With refinements to the adult attachment interview, more distinctions have been made about the form violence may take: *dismissing husbands* have been found to be the most controlling and distancing, their violence being related to instrumental violence to assert their authority and control; *preoccupied husbands* tended to precipitate violence only when their partners threatened withdrawal, their emotional and physical violence being related to expressive violence in response to abandonment fears (Babcock *et al.*, 2000). Attachment patterns are also predictive of elder abuse; these links between poor childhood experiences and poor relationships between elderly parents and their children were established by Cicirelli (1991). The Adverse Childhood Experiences (ACEs) studies identify 10 factors that increase vulnerability to adult problems:

1. Sexual abuse before age 18.
2. Emotional abuse by parent/loved one.
3. Physical abuse by parent/loved one.
4. Emotional neglect by parent/loved one.

5. Physical neglect by parent/loved one.
6. Loss/abandonment of or by a parent.
7. Witnessed abuse in the household.
8. Drug/alcohol in the household.
9. Mental illness in the household.
10. Loved one incarcerated.

Compared with people with no ACEs, those with a score of 4 or more were found to be:

2 times more likely to currently binge drink and have a poor diet
3 times more likely to be a current smoker
5 times more likely to have had sex while under 16 years old
6 times more likely to have had or caused an unplanned teenage pregnancy
7 times more likely to have been involved in violence in the last year
11 times more likely to have used heroin/crack or been incarcerated

(see, for example, Bellis *et al.*, 2014).

Sound assessments logically lead to appropriate interventions, in this case *Attachment Therapy*. Building on the work of Fahlberg (1988a), Fonagy (2001) and Kennedy (1997), attachment-based interventions have been developed to promote sensitive parenting (Schofield and Beek, 2006; Juffer, 2008; Crittenden, 2008). Pearce (2009) describes this as experiential, with children offered sustained, consistent and intense experiences of structure, direction, guidance, deep understanding of their inner world and emotional connectedness. Fear (2017) describes this as *learned security* through the experience of enjoying a secure base provided by the therapist so that the person can then transfer their learning to relationships with significant others. Attachment therapy can be used with adults too, increasing people's capacity for compassion (Shaver *et al.*, 2016), resilience and caregiving (Mikulincer and Shaver, 2017).

Caution in applying attachment theories

A word of caution is necessary. The Babcock *et al.* study (2000) makes an important point that although 74 per cent of the violent husbands (out of a sample size of only 23) were likely to be classified into one of the insecure categories on the adult attachment interview, 6 violent husbands were classified as secure (26 per cent). As the authors comment:

> Clearly not all men who engage in repeated physical aggression against their wives have attachment patterns that differ from other men. It is likely that there are many different pathways to

> becoming maritally violent and a route involving insecure attachments and dysregulated affect is *only one* of them. (Babcock *et al.*, 2000, our emphasis)

The reader also needs to bear in mind that the correlation between abusive parents and insecure attachment style is not the only correlation revealed. For example, the abusing mothers in the Crittenden study (1988) were also those who had the least education, were likely to be unsupported by either partner or extended family and contained the largest number of women with learning difficulties. Crittenden (1999) argues that these disadvantages were a result of their own childhood experiences resulting in them having severe difficulties in sustaining interpersonal relationships. Equally, Fraiberg (1980) suggests that insecure attachments are detrimental to cognitive functioning, but it is dangerous to dismiss the effects of hardship on effective parenting (see, for example, Howe, 1995). The enormous influence that parents exert over their children's brain development, especially during the rapid growth of the early years, is not simply related to the child's emotional brain development but physical too as, for example, the effects of maternal drinking on foetal alcohol syndrome. Of course, it is not unlikely that two are linked; a mother who drinks to excess not only is affecting her child in utero but will be frequently physically and mentally unavailable.

Belsky and Nezworski (1998) maintain that although the association between poor-quality, insecure relationships in childhood and later social and behavioural difficulties is not inevitable, it is probabilistic. But by no means do all parents with poor childhood experiences go on to become abusing parents. Children actively adapt to their experiences and environment by discovery, inventing and reinventing attachment strategies (Crittenden and Landini, 2011) and need only one supportive figure in their lives to become resilient. This figure could be a neighbour, sibling, teacher or relative. Our experience of working with adults who have been sexually abused as children is that they are incensed when their abusers claim their own childhood abuse as a mitigating factor.



THINKING POINT

1. Read either
   D. Shemmings (2018) 'Why Social Workers shouldn't use "Attachment" in their records and reports'.
   Or judgement GM v Carmarthenshire County Council & Anor [2018] EWFC 36 (6 June 2018).
2. Read an assessment report prepared for court proceedings.
3. In what way could this report be criticized by the judge?

Critical comment

A practical difficulty in using psychodynamic theory as a base for assessment is that the theory is top-heavy in content (Butt, 2003); that is, it provides an explanation for the causes of relationship difficulties but it is less successful in developing interventions that are effective in terms of either costs or user-friendliness. Psychodynamic social work interventions have been demonstrated to be consistently unpopular with adults who are violent (see, for example, Mayer and Timms, 1970; Davies, 1999; Scourfield, 2003; Milner, 2004, 2008a), mainly because service users become frustrated with a focus on the past when they locate their concerns in the present. Gallwey acknowledges, for instance, that when parents lose a child following a child protection assessment, 'it may well be that they become paranoid and persecutory and it can be very unfair to pick up the projection and suggest that these are necessarily long-term psychological problems' (1997, p. 139). Neither is denial necessarily a psychological response; people often have sound social reasons (loss of a job, friends, family) for denying responsibility for many problem behaviours (Turnell and Essex, 2006; Milner and Myers 2007). And it is important to bear in mind that *resistance* does not necessarily prove what is being resisted. It can simply be resistance.

Despite this, psychodynamic hypotheses have become part and parcel of folk psychology. Butt (2003) makes the point that psychological expertise and therapeutic potency have become magnified with theories being selectively raided for those components that seem to explain the phenomena under scrutiny: 'The lesson that seems to have been taken from a century of therapy, rightly or wrongly, is that emotions are better out than in' (p. 164). This echoes only part of Bowlby's claim about effective therapy: 'that a patient not only talks about his memories, his ideas and dreams, his hopes and desires, but also *expresses his feelings*' (1988, p. 156, our emphasis). Storr (1966) cautioned that expressing feelings is only one valuable feature of the psychoanalytic process, that many people do *not* show an improvement as a result of expressing feelings. Encouraging people who are violent to express their feelings is positively dangerous as catharsis (and, by implication, uncovering work) actually makes people more aggressive (Bushman *et al.*, 1999). As we saw in the case example of Emily (earlier in this chapter), sadly, this sometimes is interpreted as evidence that the uncovering therapy is working.

It is also worth noting that how people express their feelings varies from culture to culture and age to age. As Butt (2003) points out, being 'in touch with one's feelings' is a relatively recent construction in the United Kingdom. Storr (1966, p. 66) states that the idea of cure in psychoanalysis raises fundamental problems of philosophy, such as what constitutes human happiness and what sort of person one should be. This argument has been taken up by feminist psychotherapists, who redefine relational bonds in terms of mutuality between mothers and daughters (Jordan, 1997) and view dependency as

being able to count on the help of others rather than a pathological state (Stiver, 1991).

The second main working hypothesis that has emerged from attachment theory – that the past inevitably influences the present and the future and may need to be modified (see, for example, Howe, 1995, p. 190) – has become axiomatic in a wide range of professional interventions, despite its not being particularly well supported by the literature (see, for example, Dogra *et al.*, 2002) or by prominent psychoanalysts. As Rycroft (1966) commented, the idea that children should be treated lovingly and humanely does not require any psychological backing; loving is not an activity that can be easily engaged in on mere advice, since its essence is sincerity and spontaneity; and much of the trauma and suffering endured by children is inevitable (p. 16). In the same volume, Gorer (1966, p. 32) argues that psychologically tinged explanations are invoked for failures, not for successes, so the research base of attachment theory is necessarily skewed.

A further concern is the potential to be overdeterministic when exploring experiences, viewing these as inevitably leading to entrenched future problems. The notion that the 'First Three Years' determine the adult has gained ground through campaigning and interest groups, yet the evidence base for this is weak and contested within child development (Macvarish *et al.*, 2014). The 'ACE' approach has also been heavily criticized on several grounds. First, there is a claim that these negative experiences become embedded in the brain and body through stress and neuro-chemical responses. This claim is not supported by strong evidence and is overdeterministic, ignoring the capability of people to make sense of events in different ways. The ACE approach views people as being subjected to events, rather than interpreting them, thus reducing their agency (Edwards *et al.*, 2015). A further issue is that many of the adverse events are actually very common, which pathologizes large swathes of the population. They are also imprecisely drawn and tell us nothing about the severity, frequency and local impact of these categories. How do we make sense of 'alcohol use in the household', for example? Or 'Mental Illness'? This approach also individualizes problems and ignores broader harms such as poverty, poor housing and other social and environmental factors (White and Wastell, 2016).

Outcomes

Most meta-studies of social work outcomes place psychodynamic and psychosocial work as the least effective approaches to practice (see, for example, Thyer's comprehensive review of outcomes (1998, 2002)). Research into this approach is troublesome in any case since the approach places more emphasis on process rather than on results. A study by Hilsenroth *et al.* (2001) showed that, after nine sessions, while 59 per cent of service users felt some improvement in subjective well-being, only 25 per cent showed reliable

improvement in symptomatic distress as measured on the GARF (the Global Assessment of Relational Functioning scale used by psychologists). They report that some rapid improvement happens early in the process and is followed by a negatively accelerating positive growth curve – improvement diminishes as the number of sessions increase. It took six months to a year to get 75 per cent improvement. In the early phase, the subjective experience of well-being precipitated a reduction of symptoms.



Summary

- We have explained briefly the ideas of Freud and the post-Freudians, with some emphasis on 'defences' and ego-psychology.
- The main functions of the ego have been outlined, and the application of ego strengths in assessment explained.
- TA (transactional analysis), a popular version of Freudianism, has been presented, as has its application in assessment.
- Attachment theories were described and discussed, with notes of caution about their application.
- Outcomes were briefly mentioned, showing that this approach usually requires a great deal of time if good outcomes are to be achieved, although brief versions can be used during assessment.



THEORY INTO PRACTICE

Twenty-nine-year-old Samantha divorced her violent husband after finding out that he had been unfaithful to her. School has reported major concerns about her care of her two boys (6-year-old Luke and 5-year-old Jaiden). Both boys have special learning needs requiring one-to-one teaching support for their behaviour. The boys are invariably late for school and sometimes are absent for days at a time. Jaiden has told his support worker in school that 'mummy drinks and doesn't wake up to take them to school'. Samantha also leaves the boys with her mother at weekends. Her mother finds the boys difficult to handle and also says she has had 'nothing but violent men in her life'. Samantha complains that she cannot control the boys at all and responds to their behaviour by withdrawing emotionally.

- **Using attachment theory as a base for your initial hypothesis about the relational dynamics of this family, what interventions would such an assessment imply?**



Further learning activity

- In a group, discuss how attachment theory can be used in your social work assessment with adult service users.



Further reading

Bowlby, J. (1988) *A Secure Base: Clinical Implications of Attachment Theory*. London: Routledge.

Fear, R. H. (2017) *Attachment Theory: Working Towards Learned Security*. London: Karnac books.

Gillies, V., Edwards, R. and Horsley, N. (2017) *Challenging the Politics of Early Intervention: Who's 'Saving' Children and Why*. Bristol: Policy Press.

Howe, D. (2013) 'Attachment theory'. In M. Gray and S. A. Webb (eds), *Social Work Theories and Methods*, 2nd edition. London: Sage.

Macvarish, J. (2016) *Neuroparenting: The Expert Invasion of Family Life*. London: Palgrave Macmillan.

Mikulincer, M. and Shaver, P. R. (2017) *Attachment in Adulthood, Second Edition: Structure, Dynamics and Change*. New York, London: Guilford Press.

Simpson, J. A. and Rhodes, W. S. (eds) (2015) *Attachment Theory and Research. New Directions and Emerging Themes*. New York, London: Guilford Press.

7 AN ORDNANCE SURVEY MAP: BEHAVIOURAL APPROACHES

What this chapter is about

As with psychodynamic social work, the application of behavioural theory to social work was taken initially from clinical psychology and then adapted to a wide range of social work situations. We will identify three waves of theory and therapy that have developed firstly from traditional behaviour therapy based on the work of Pavlov (1960), Skinner (1958) and Bandura (1969, 1977). The second wave of cognitive behaviour therapy uses theories of cognitive models of disorders and behaviour and social learning principles to develop a cognitive behaviour modification based on the work of Beck (1967), Ellis (1962), Seligman (1992), Linehan (1993), Ward and Mann (2004), Ward *et al.* (2007), Ryle (1990, 1997) and Fonagy and Target (2006). The third wave of cognitive behaviour therapy is multimodal, incorporating elements from psychoanalysis, evolutionary, social, developmental and Buddhist psychology based on the work of Segal *et al.* (2002), Hayes *et al.* (2007) and Gilbert (2009).

The cognitive part of the map looks at how habitual ways of thinking can be considered as habitual behaviour, with an emphasis on how unhelpful thinking can be replaced by learning and practising more helpful thinking and on how these ideas develop useful assessments that can accommodate both quantitative and qualitative aspects of change.

Main points

- Wider theoretical perspectives:
  - Wave 1 – respondent and operant conditioning, social learning theory
  - Wave 2 – Rational Emotive Therapy, Cognitive behavioural therapy, Learned Helplessness, the Good Lives model and Cognitive Analytic Therapy
  - Wave 3 – Acceptance Commitment Therapy, Mindfulness, Compassion-Focused Therapy.

- Implications of these theories for assessments.
- Critical comments on the psychological reductionism, values and assumptions of these theories.
- Outcomes of this approach in working and research findings.

Introduction

We now turn to the first of the second-wave (problem-based) chapters, where problematic behaviour and thinking are seen as learned. This takes a less essentialist psychological perspective than the psychodynamic approach in that there is less a sense of a given reality within people and more a sense that people learn to be what they are. Therefore, they can learn to be different and behavioural disorders can be changed through the application of learning theory principles. Behavioural social work emphasizes the assessment process on the grounds that, without a behaviour baseline, intervention cannot be judged (Barber, 1991). This involves a detailed examination of specific behaviours to establish how they have been acquired and maintained as habitual ways or paths that people walk, day in, day out, step by step, so we describe this map as an Ordnance Survey map.

Wider theoretical perspectives

Wave 1: Traditional behaviour modification

Traditional behavioural practice is based on three types of learning: respondent conditioning, operant conditioning and social learning theory. We will address these in turn.

Respondent (classical) conditioning

We first consider *respondent* (classical) conditioning, which is based mainly on the work of Ivan Pavlov, a Russian physiologist working in 1911. Any basic text in psychology will tell the story of how Pavlov conditioned dogs to salivate at the sound of a bell by associating the sound of the bell with the arrival of food. This was described in the language of experimental psychology: the bell being said to be a stimulus (S) and salivation a response (R). This is known as classical conditioning, with a stimulus always preceding a response:

$$S \rightarrow R$$

Responses not only are learned but also can be unlearned or become extinguished; for example, if food did not follow the stimulus of a bell, Pavlov's dogs ceased to salivate after a while. Probably the most common application

in clinical psychology of respondent learning is in dealing with phobias. Here, the assessment involves the development of a hierarchy of responses to the feared object before the sufferer is gradually helped to relax and is then presented with the item at the bottom of the hierarchy. More greatly feared items are not presented until each step has been successfully achieved. This process is called *systematic desensitization*. In other words, the person's reflex responses to the fear, such as increased heart rate, are gradually removed. The S-R sequence of learning, however, explains only a narrow range of learning opportunities that involve reflex actions.

Operant conditioning

Operant conditioning explains a more extensive form of learning. It has a very wide application in addressing a range of human behaviours in which reflex actions are not necessarily present. This part of the theory also derives from animal experiments. For example, Skinner (1953) demonstrated how pigeons could learn to peck at a set of levers to obtain corn. The reward of food followed their effort, reinforcing the behaviour. In operant conditioning, it is the person's actions that operate on the environment; any one act is still labelled a response (R) and the consequence a stimulus (S), even though in operant conditioning responses precede stimuli. The stimulus then elicits a stronger response (R2):

$$R \rightarrow S \rightarrow R2$$

This clumsy use of jargon terms may seem confusing, but as Hudson and Macdonald say:

> [D]o not be exercised over it, simply think of them as different animals, having a familiar meaning in the respondent paradigm (stimulus eliciting response) and an unfamiliar one in the operant paradigm (the association of a behaviour with a consequence). (1986, p. 28)

Operant conditioning is often referred to as the ABC approach. A stands for Antecedents, which cue in the start of the behaviour; B stands for the Behaviour itself; and C stands for the Consequence, which reinforces. Stuart (1974) gives considerable attention to antecedents as a key focus for intervention. He distinguishes between three types of antecedent:

1. *Material and competence antecedents*. These are the tools and skills without which the behaviour cannot occur. For example, a student needs ability, books and other materials.
2. *Instructional antecedents*. These are rules, requests and expectations, not always explicit, set by others. For example, parents often unfairly criticize

children for not doing what they were not asked to do, saying they should have known it was expected.

3. *Potentiating antecedents.* These consist of a set up in which the rewarding impact of the consequence is increased. This can happen in three ways:
   - By restricting the consequence so that it follows only when the desired behaviour has happened (for example, no television viewing until after an assignment has been completed).
   - By providing a sample of the consequence for a person who has never experienced it (for example, the excitement of using a Fitbit).
   - By offering a person a choice of consequences from a menu of options (for example, going out for a burger or playing pool).

In assessing problematic behaviour, therefore, it is essential to begin by examining its antecedents and considering how their effect could be either increased or reduced. The behaviour itself (B) must also be mapped out in detail. Sheldon (1982) says that a behavioural assessment takes place independently of the definitions and labels that others place on problems. For example, a behavioural assessment would not state that a person is deluded; rather, it would state precisely what behaviours were involved.

The consequences of behaviour (C) in operant conditioning strengthen or weaken subsequent behaviour. Rewarding consequences, or reinforcers, make it more likely that a behaviour will occur. Positive reinforcers strengthen (reward) behaviour by gaining/giving a wanted/positive consequence (for example, money); whereas negative reinforcers strengthen (reward) behaviour by removing an unwanted/negative consequence (for example, pain). The unwanted consequence may be present (for example, a twisted arm), in which case the required behaviour enables the subject to escape the pain; or it may be threatened (for example, 'You will be grounded unless you behave well from now until 3.00 p.m.'), in which case the subject avoids the unpleasant consequence by behaving well for that period.

Confusion, however, is common here. Because avoiding threatened sanctions is a negative reinforcer, we are apt to think punishment is the same as negative reinforcement. While punishment is usually unwanted or aversive, it does not necessarily remove or reduce behaviour; often, it encourages endurance or the avoidance of being observed in the behaviour. This adds to the confusion in that punishment can be said to be either positive (giving unwanted pain) or negative (taking away a want, such as money). Figure 7.1 may help to clarify matters.

There are no absolute examples of positive and negative reinforcers because what is perceived by one person as negative or bad may be considered by another as desirable, and vice versa. Something unpleasant or painful would probably be considered negative by most people, but others may enjoy it or see it as a proof of macho strength, for example. Thus, the terms positive and negative (like good and bad) must always be seen *as perceived by*

A REWARD (that is wanted/liked) **strengthens** the behaviour that precedes it. This REINFORCEMENT is said to be		An ADVERSIVE consequence (that is disliked) **weakens** the behaviour that precedes it. This PUNISHMENT is said to be	
POSITIVE when gaining a positive, e.g., a sweet	NEGATIVE when avoiding or ending a negative, e.g., not getting caught or ending a pain	POSITIVE when getting a negative, e.g., pain or a shout	NEGATIVE when losing a positive, e.g., being fined

Behaviour is also weakened by the absence of reinforcers or by weakening the link between stimulus and response (as in satiation).

Figure 7.1 Reinforcement and punishment

the service user. A vital part of a behavioural assessment, therefore, is establishing what is or is not rewarding for the particular service user: 'It is a good general rule that the "customer knows best"' (Sheldon, 1982, p. 113). When making behavioural assessments, social workers can expect to find both positive and negative reinforcements operating with unwanted behaviour being reinforced. They may be part of this learning process. For example, the social worker who rushes round to the foster home each time a child exhibits unwanted behaviour and never visits at times when the behaviour is acceptable may be unconsciously reinforcing unwanted behaviour.

Reinforcement is more effective the nearer in time it is to the behaviour and when it is consistent, although there are different schedules of reinforcement (for example, continuous or intermittent). Intermittent reinforcements have a more lasting effect on behaviour. Schedules of intermittent reinforcement may be *fixed ratio*, like pay for piecework, or *fixed interval*, like a weekly wage. There are also variable ratios in which the number of performances of the behaviour is varied before the reward is given, and variable intervals where the time between rewards is varied. These variable schedules provide the most lasting effects on behaviour.

THEORY INTO PRACTICE

Julie has two children, ages 8 and 10 years. A neighbour has reported much shouting in the home and the children crying a lot and being distressed. Her husband works long hours and gets upset with her when faced with repeated complaints about the children and how they pay no attention to her requests, even when she shouts at them. They occasionally respond by crying and shouting back at her, each making allegations about the other.

When the social worker visited, she asked Julie for more detail about how she attempts to manage the children's behaviour. Julie explained that because the children don't seem to take her seriously, she loses her temper and threatens them with dire consequences when their father gets home. She has even told them that he will 'bl...y kill them this time', and 'Now you've done it – he will flog the living daylights out of you'. This makes them cry and 'they start hating each other more than ever'. She says she can't understand what is happening to them as both she and her husband are really quiet and pleasant people. Her husband has never, and would never, hit any of them.

- What sorts of conditioning or learning are taking place in this family?
- What type of behavioural intervention might help them?

Social learning theory

The third type of traditional behaviourism is based on Bandura's (1977) social learning theory, or vicarious learning (modelling). Very briefly, the theory says that we learn by observing and imitating others. We observe, we think about what we see or experience and we copy what the *model* has done. These models give advance information about the likely consequences of behaviour, and social learning theorists claim that this is a more efficient way of learning than is classical or operant conditioning. Here, learning is further facilitated if the observer sees the model's behaviour being rewarded, if the model is reasonably like the observer (which aids identification), if the model is popular or of high status, such as a professional sportsperson or a television personality (the wannabe syndrome), and if the observer can practise the behaviour immediately and gain reinforcement.

Implications for assessment

In using the traditional part of this Ordnance Survey map, assessment begins after a 'get to know you' phase, with a detailed description of the target behaviour(s) or required behaviour(s) in precise terms. This requires the direct observation of current behaviour, by the social worker, the service user or a third party, who counts the frequency of certain behaviours in certain circumstances, listing antecedents, behaviours and consequences. A log may be useful here, such as that suggested by Schwartz and Goldiamond (1975), as adapted in Figure 7.2.

The behaviour modification approach promotes several techniques that are useful for reducing unwanted behaviour and strengthening wanted

Time	Activity	Where?	Who was there?	What you wanted?	What happened?
7.00					
8.00					
9.00					
10.00					
11.00					
and so on until bedtime					

Figure 7.2 Record of behaviour

behaviour. Social workers may wish to check through a list of these ideas and consider which might be the most effective for the removal of a particular problem. In general, operant techniques are appropriate for operant behaviour problems and respondent techniques for respondent problems (Fisher and Goceros, 1975).

Persistence with behaviour despite distressing consequences suggests that such behaviour might be the result of limited-choice alternatives, given the history and circumstances of the person involved. The task is, therefore, to help construct new ways of producing positive consequences that might be accompanied by less distress.

- A traditional behavioural assessment would attempt to establish a baseline of behaviour by using points in the following sequence:

  1. Decide on the goals with the service user in strict behavioural terms; that is, those which are not only clear to the service user but also capable of measurement.
  2. Where, when and how often is the new behaviour required?
  3. How would the service user measure success?
  4. What will other people notice about the behaviour when this happens? This could be at home, at work or at leisure.
  5. How will this differ from what is happening now?
  6. What areas of life will be changed for the better?
  7. Has there been any condition under which the problem was not a problem?

- Next, a *baseline* is set for the current behaviours (wanted and/or unwanted), showing how often they occur, hourly or daily, over a period of a week or two. Then decide whether the problem is one of an excess of unwanted behaviour or the lack of wanted behaviour, using the following questions:

1. What behaviours are in excess and what behaviours deficient?
2. What behaviours need to be increased or decreased?
3. What behaviours are occurring in the wrong place and at the wrong time?
4. If it is a matter of removing unwanted behaviour, how is it being maintained or reinforced?
5. Is the consequence one of positive reinforcement or negative reinforcement?
6. Can these reinforcers be removed?
7. What alternative behaviour could be put in its place? This needs to be carefully considered because behavioural change techniques have been shown to have more power in strengthening than weakening responses, so 'no deceleration technique should ever be used unless alternative behaviours are positively reinforced' (Stuart, 1974, p. 411).
8. What are the antecedents or cues:
   - Material/competency?
   - Instructional antecedents?
   - Potentiating antecedents?
9. If the behaviour is acquired by modelling, can contact with the model be discontinued?
10. If it is a matter of needing to develop wanted behaviour, ascertain:
    - What new behaviour could be desirable.
    - What antecedents are missing and need to be put in place.
    - What is considered by the client to be rewarding.
    - What reinforcers are available or could be gained.
    - Because reinforcers need to be administered immediately and consistently, who would be available to do this.
    - Whether the new behaviour could be acquired by modelling; and if so, whether an appropriate model is available.
11. If it is a matter of strengthening current behaviour, check out:
    - What the antecedents are.
    - What the consequences are.
    - How more rewarding consequences can be achieved and by whom.
    - What schedule or reinforcement would be the most efficient.

The answers to these questions should be used to build up a baseline.

PRACTICE EXAMPLE

A student has a problem with doing college assignments on time.

Next goal: Wants to get next essay finished on time.

- This requires a considerable amount of reading and note-taking.
- If he read a chapter an evening and made notes on it, he could be better prepared.
- This could be done in the bedroom, away from distractions.
- A daily log of chapters read could be kept.
- This will be better than wasting time watching television.
- Change is needed now because of college deadlines.
- Unless dealt with, the problem will continue until the course is passed – or failed.

The student's difficulty could be seen as an excess of unwanted behaviour (watching TV) or as a deficit of wanted behaviour (study). Because it is easier to strengthen weak behaviour, he decided to look for ways to strengthen studying, choosing the bedroom as the best location for study.

The consequences (in the longer term) of more effective studying are passing the course and avoiding the embarrassment of failing. Since negative reinforcement is more powerful, the student asks his partner to remind him of this consequence. There is also something (a certain crunchy chocolate confection) that he finds very rewarding, so his partner acquires some of this and shares it when a chapter has been read. The rewards of watching TV cannot easily be removed, and this is a further reason for concentrating on rewarding the study behaviour. However, modelling can be assisted by the partner also reading instead of watching TV at study time. The emphasis, in the short term, is on the pleasant consequences of having the chocolate following a period of study. The student knows that this work will avoid dreaded failure in the long term. He drew up the baseline and progress record (x = reading for 1 hour) shown in Figure 7.3.

In the previous case example, Julie did not realize that making threats which are not carried out is a strong reinforcement of the behaviour that preceded the threat. The children escape the threat each time and the bigger the threat the stronger the reinforcement. This negative reinforcement can be stronger than positive reinforcement. The social worker asked her to:

- make only those threats that she was certain she could carry out.
- plan in advance her sanctions for bad behaviour, calmly tell the children what the consequences will be and impose them as soon as they misbehave.

- try to catch the children being pleasant and reward this behaviour as often as possible for a few weeks.

Julie shared these suggestions with her husband and, despite some slip-ups, they achieved a reasonable measure of peace and began to have more fun together. This outcome had a major impact on the assessment of Julie and her family.

In conclusion, traditional behaviour therapy is focused on directly changing problematic emotions and behaviours through counter-conditioning negative emotions or the reinforcement of more appropriate behaviours.

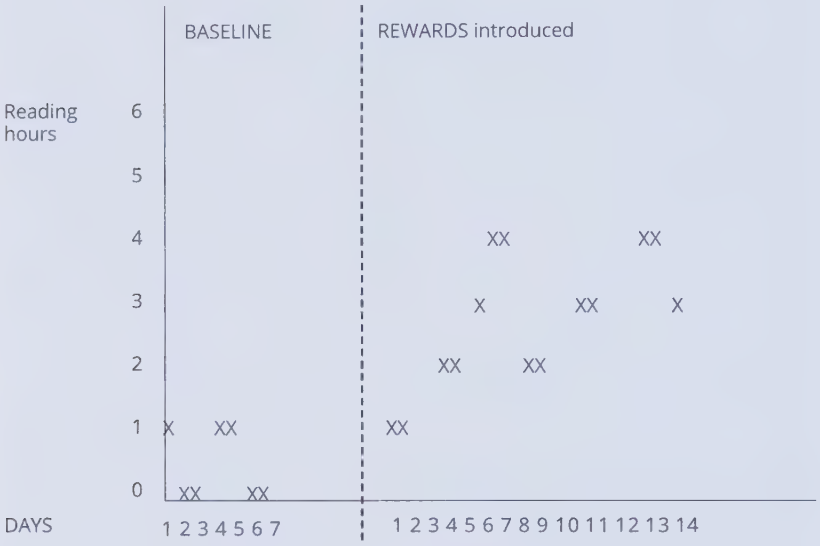


Figure 7.3 Behavioural baseline and response to rewards

Wave 2. Cognitive-behavioural theory

The cognitive dimension of behavioural approaches looks at thoughts as if they were behaviours where unhelpful habits may be learned. This has been the most widely used of all therapeutic interventions. It suggests that behaviour is mediated through thought processes just as much as through a series of responses to stimuli. As Cigno (1998) explains, the focus is therefore on current causes, here and now, on the basis that people are not just responding to stimuli but also *interpreting and construing* them in various ways that maintain problematic behaviours and states such as depression (for example, through self-blaming). This is particularly relevant to social work, which seeks to individualize service user behaviour but does not always find this easy; insight does not necessarily change behaviour, nor does traditional behaviour modification always prove effective. Indeed, although the latter seems scientific, logical and accessible,

each human situation contains so many variables that even Skinner commented in his novel *Walden Two* that predicting behaviour is rather like making a weather forecast. On the other hand, as the term implies, the cognitive dimension considers 'how behaviour is guided by the perceptions and analysis of what we see' and how 'irrational thoughts or disturbances in perception lead us to process our view of the world incorrectly' (Sheldon, 1995, pp. 184–5).

Within this cognitive model, there are numerous variations, but we will confine ourselves in this brief outline to five categories, as follows:

- Rational Emotive Behaviour Therapy (sometimes known as REBT), based on the ideas of Ellis (1962, 2006).
- Cognitive Behaviour Therapy (commonly known as CBT), based on Beck and Beck (2005) and Beck and Tomkin (1989).
- Learned Helplessness, based on the ideas of Seligman (1992).
- The Good Lives model (GLM), based on the work of Ward and others (2004, 2007).
- Cognitive Analytical Therapy, based on the ideas of Ryle (1990).

The work of Ellis has been further developed by Dryden and Yankma (1993) and by Ellis and Dryden (2007). The work of Beck and of Ellis has been further developed by Burns (1999).

A cognitive approach had been implicit in the ego psychology of the 1940s, but Ellis and Beck redefined *emotions* as clearly cognitive in essence, Ellis (1962) describing them as *a strongly evaluative kind of thinking resulting from what he termed self-talk, internalized sentences and self-verbalization* (Ellis had built his ideas partly on the work of Adler, who had parted company with Freud on cognitive issues) – all aspects that could be un-learned. Emotion, in this approach, 'is a feeling a person experiences after estimating [in an unreasonably negative way] what an event *means* to him' (Werner, 1970, p. 254, our parenthesis), inferring that people must be confronted with the disparities between their perception and reality and be offered alternatives to inaccurate perception, as the discrepancies between stated goals and actual behaviour are being addressed. Behaviour is shaped neither by unconscious inner drives nor by externally conditioned habits but by a third force, cognition: the self-determination of the individual who uses both internal forces and the external environment. 'Action is not completed unless conscious thought processes support it' (Werner, 1970, p. 252).

Werner saw choosing goals, evaluating events and self, and solving problems as the three conscious cognitive processes intimately associated with personality development. For Werner, change in the three elements just listed results in changes in personality. For example, a person whose personality is characterized by withdrawn behaviour is not necessarily seen as fixated at one stage of development. Instead, this is seen as probably due to frequent failure to attain desired goals, and a personality change can be

effected if that person experiences success in goal achievement. In assessment work, this leads to asking questions about perceptions of goals, of expectations, of self and of difficulties (in general about one's private logic).

In the case of the student mentioned earlier, these questions discovered that, while his goals were constructive and realistic, there is a possible opponent factor in that his children did not understand or agree with them; the family atmosphere was rather indulgent but also reasonably competitive. A private logic of 'Do I really have to be so hard on myself?' operated, and there were early recollections of being sent to the bedroom as a punishment, so there is quite a mix of emotions and perceptions, the clarification of which was helpful, both as an understanding of the difficulty and as providing signposts towards change.

In this approach, behavioural change involves recognizing thought patterns and practising new ones (see, for example, Milner and Myers, 2007, chapter 4). In recognizing the role of cognition, it is a move on from traditional behaviour modification practice. It also underpins work such as assertion training and skills training in general.

Rational Emotive Behaviour Therapy (REBT)

Ellis (1962) was interested primarily in anxiety and depression and how these states were caused or maintained by thoughts. He developed an *ABC alternative* to that of operant conditioning. For Ellis, A is the Activating event, such as loss of employment; B is the Beliefs one has about that event, such as 'My whole life is ruined'; and C is the emotional Consequence. For Ellis, those consequences are mostly feelings of depression. He suggests that cognitive processes (especially negative interpretations or high expectations), rather than simple reinforcements, influence behaviour, with people usually blaming the Activating event for the Consequential emotion. Ellis seeks to *break this A–C connection* and show the service user that the emotion follows from the Beliefs (B) about the event rather than from the event itself (A). This explains why different people react differently to the same event. Ellis would say that A–C thinking is a distortion and needs to be replaced by B–C thinking. It is *what we make of events* that leads to problems.

Ellis (1962) outlined a set of *irrational beliefs*, the most common being that people oppress themselves by believing they *must* do, or have, or achieve certain things. He coined the word *musterbation* to challenge this process in the application of cognitive therapy. For him, *musts* and *shoulds* were irrational demands of self and others that lay behind many difficulties. He wrote that the main dysfunctional musts were 'I must do well', 'You must treat me well' and 'Life must be easy', whereas the reality is that we are all imperfect, we are all capable of 'acting like jerks'. So we need to ease up on ourselves and others and get away from slogans like 'Good enough is not enough'. He also coined the word *awfulizing*, the process whereby merely unpleasant or uncomfortable experiences are described as awful, horrendous: 'It has totally

ruined my life – things will never be the same again', that is, it is worse than 100 per cent bad. For example, when the bus is late, some people will refer to this as terrible or disgusting. Burns (1999) has added to the following list of common damaging distortions:

- *All-or-nothing thinking*: what is short of perfect is a total failure.
- *Overgeneralization*: a single failure is a never-ending pattern of failure.
- *Mental filter*: selecting and dwelling only on the negatives.
- *Disqualifying positives*: rejecting them as not counting.
- *Jumping to conclusions*: making negative judgements on little evidence and also mind-reading that ascribes negative rather than positive intent.
- *Magnification/minimization*: exaggerating one's faults or another's strengths or shrinking one's own strengths (also known as reversed binocular vision).
- *Emotional reasoning*: 'I feel it, so it must be true'.
- *Should statements*: by which one whips and punishes oneself before one can be expected to do something. Additionally, *should statements* directed at others lead to anger and frustration.
- *Labelling/mislabelling*: 'I am a loser,' 'He is a dirty rat'.
- *Personalization*: seeing oneself as the cause of negative events.

In REBT, Ellis (1962) takes a prescriptive approach, strongly debating with, confronting and challenging people to correct their distortions and replace them with more rational reasoning. Such rational reasoning is supported by (behavioural) rewards in the first instance until the service user achieves the self-rewarding effect of attaining an agreed goal.

Cognitive behavioural therapy

Beck (1993, 2005) has a more gentle style that leads people to reconsider their beliefs and is, perhaps, more rigorous in the assessment stage of therapy. He developed a system of identifying negative automatic thoughts (for example, 'I can't make real friends', 'I'm stupid', 'I always say the wrong thing', 'Everyone knows how disorganized I am', 'I'm no good'). So Beck used to set about *cognitive restructuring* – examining how a service user is interpreting a situation, perhaps employing cognitive distortions that lead to miserable emotional states, and then replacing this thinking with more reasonable interpretations. Burns (1999) suggests the keeping of a daily log to identify the details of both the behaviour and the accompanying cognitive processes, which might look something like Figure 7.4.

An automatic thought will usually be a form of self-criticism, whereas a rational response will be a self-defence or a rebuttal of an automatic thought.

Date/ time	Situation	Emotion	Automatic thought	Rational alternative thought	Outcome

Figure 7.4 Response record

For example, parents experiencing problems with their children may catch themselves thinking 'Where did I go wrong?', whereas a more rational response might be 'I am not a bad parent; I do try; I cannot control all that goes on in my children's lives'.

Keeping an assessment record such as that shown above becomes the therapy in that the service user comes to appreciate the improved emotional and relational outcomes of more rational responses. Burns (1999) provides a selection of checklists and self-evaluation instruments that a service user could complete. These facilitate data collection and diagnostic analysis because they include many of the assessment questions a social worker needs to consider.

Cognitive approaches have their own specialized therapeutic offshoots, such as the Institute for Rational-Emotive Therapy, which suggests that service users list irrational beliefs, then dispute them, before putting *effective rational beliefs* in their place (see, for example, Dryden and Mytton, 1999). An example of an irrational belief is 'I can't stand it when he...' or 'I can't stand it when I do not have the drug', an effective rational alternative being 'It's unpleasant and uncomfortable, but I can stand it'. Equally, the irrational belief 'I cannot be happy unless I have someone to love me' could be replaced by a rational response such as 'As an independent person I can love myself, so I can always be loved, and this will make me more attractive to others'. Yapko (1988) suggests some further examples of distorted thinking that may lead to depression: 'It's me'; 'It will always be this way and it affects everything I do'; 'It can only be this way'; 'Life always has been bad, therefore it will always be bad'; 'The whole thing is ruined'.

Implications for assessment

This approach leads to the following questions during the assessment phase:

- What cognitive distortions can be heard in the client's story?
- What automatic thoughts enter the mind when things are not right?
- How is the person putting him/herself down?

- How can these irrational beliefs be disputed?
- How can rational beliefs be developed?

Social workers can design their own assessment instrument to fit with the language and situation of the service user. We have seen some interesting examples of this:

PRACTICE EXAMPLE

Kath had three failed relationships, the first with a man who beat her and the other two with men who humiliated her and emotionally abused her in various other ways. She has two children, both of whom insult her and have little respect for her. The younger child has come to the attention of the social care team with reports that he is out of control.

Kath says she thinks that it's true what they say to her: 'They can't all be wrong' and 'It must be true that I am no good as a mother'.

The social worker asked Kath to catch herself thinking negative thoughts about herself and said: 'Because these are *not true*, replace them with true thoughts in column 3'. She gave Kath some examples and ensured that she understood the exercise. Kath agreed to do this for a week.

Table 7.1 is the *self-esteem table* that was designed during the session.

Table 7.1 Self-esteem table

Negative thought that arose	Score negative feeling. (Score out of 10: 0 = very bad, 10 = very good)	Positive (TRUE) thoughts you replaced them with	How did that feel? (Score out of 10 0 = very bad, 10 = very good)
1.			
2.			

Learned helplessness

Cognitive theorists are also interested in the concept of *learned helplessness* (Seligman, 1992). This is a state that results from repeated exposure to unpleasant events that are beyond the control of the individual so that whatever a person does has no predictable effect one way or another. An example of this is a woman who sometimes gets battered when she does something and sometimes gets battered when she does not do the same thing. This information about the lack of connection between effort and outcome grows

PRACTICE EXAMPLE

A different log was used for Sam.

Sam had acquired a police record for assaults on family members and their friends. He said he feels provoked on these occasions and feels that he cannot control the urge to hit those who annoy him. He becomes verbally abusive and sometimes, as others become verbally abusive to him, he 'loses it'.

The social worker invited him to practise replacing feelings with *thoughts* for a week and record the results. The *anger log* shown in Table 7.2 was designed for him.

Table 7.2 Anger log

Situations when I FELT provoked to be annoyed or angry	THOUGHTS I used to gain control of my words and actions	My success (Score out of 10)

into an expectation or belief that responding to one's situation is futile, that all future efforts will fail in the same way and that it will always be so.

The key features of learned helplessness, lack of energy, negative mood, self-condemnation and withdrawal are similar to those of depression, so Sheldon (1995) maintains that depressive and anxious people attribute success to good luck or the task being easy, while attributing failure to lack of effort or poor ability, adding that irresponsible people do the opposite. This means that even when action could be taken, a person who has learned helplessness is unlikely to try anything and it is important not to label this as unmotivated or lazy. Barber (1991) describes this as a psychology of powerlessness, which explains the passivity of many recipients of social work services – single mothers on income support, disabled persons dependent on others, victims of child abuse and domestic violence.

THEORY INTO PRACTICE

A social worker arrived at a home to find a woman being beaten violently by her husband. She hurried the woman and her four children into her car but was amazed at the woman's behaviour. This woman had become so accustomed to the futility of any action on

her part during violent episodes that she sat perfectly still in the car, apparently calm, while her husband beat the car with a spade.

- What are the main features of learned helplessness?
- If she has a good day, will this end the helplessness? Why/why not?
- To what is she likely to attribute good days? Of what is she likely to see them as proof?

Implications for assessment

Learned helplessness highlights the need for social workers to combine psychological and sociological factors – not only to attend to external resources but also to mobilize internal resources, considering the dispositional factors within each person. Additionally, it may be more immediately helpful and empowering for the service user in the short term if accessible dispositional factors are changed while situational factors are addressed as part of a long-term strategy. It is important to bear in mind that attributions are not just the product of an individual's mind but are also influenced by culture. When internal attributions are addressed, the service user may then be empowered to make more appropriate external attributions. In assessing learned helplessness, Barber (1991) suggests using the following questions:

- How long have things been bad?
- What efforts have you made to change things?
- How much success have you had?
- How much good times have you had compared with bad times?
- What do you put your good times down to?
- What do you put your bad times down to?
- If attributed to internal causes, do you put it down to effort or ability? (Effort is easily improved.)
- If attributed to external causes, do you put it down to luck or task difficulty? (Real luck is totally outside our control but, since there is an element of one making one's luck by planning and effort, some so-called luck can be self-made.)

The good lives model

This model has been developed in the decade beginning 2000, mainly for work with offending behaviours – see, for example, Ward (2002), Ward and Stewart (2003), Ward and Mann (2004), Ward *et al.* (2007). As with all developments, it has drawn on other approaches that we outline in this book and has been applied mainly to violent behaviour, criminal activity and sexual abuse. Its main contribution is the way in which it applies positive psychology (the study of human happiness and mental well-being) to problematic behaviour. It also provides a different orientation between worker and service user. The following assumptions underpin the approach:

Human well-being requires the achievement of eight *primary goods*:

- LIFE – optimal functioning physically, sexually, mentally and socially
- KNOWLEDGE
- EXCELLENCE – a level of mastery/agency at play and work (autonomy and self-directedness)
- INNER PEACE – free of turmoil, stress and conflict
- RELATEDNESS/FRIENDSHIP – belonging, being intimate, family and community
- SPIRITUALITY – in the broad sense of finding meaning and purpose in life
- HAPPINESS
- CREATIVITY

This list of primary goods does not claim to be exhaustive and others may wish to subdivide some of the items. A primary good is something sought (not necessarily consciously) as an end in itself, whereas secondary goods are sought as a means to a primary good. The primary goods are the foundation of human well-being and of a clear sense of identity and therefore are in the best interest of the individual and the community.

The theory suggests that all human behaviour is in the pursuit of these goods and, in a sense therefore, can be said to be for a good purpose. What we all hope to achieve is a Good Life – one that optimizes our sense of well-being. The problem is that some people want to gain goods by the direct route (short-cuts) like theft or sexual assault – routes that are usually dangerous to another person or that infringe their rights. While the pursuit of primary goods is to be supported, the *means* have to be socially acceptable, and unacceptable, disrespectful and unsafe means are to be challenged, especially *the beliefs and ideas that support offending behaviour* (as we do in other

cognitive approaches). The pursuit of self-interest is supported so long as it is done in a satisfying way for all concerned.

The challenges to beliefs and means, however, are not confrontational, for the style of the approach is *supportive of the person*, looking at their strengths and abilities, examining in some detail how they go about achieving other primary goods. So a holistic view is sought, strengths are mobilized and built on and the pursuit of a good life is encouraged throughout. Negative language is avoided as much as possible – words such as distortion, irrational and deviant are replaced with change of life, new approach, self-management, intimacy-building and healthy functioning.

The focus on the service user's best interests and good intentions means that it is easier to avoid moral condemnation of the *person*, because it is undesirable/harmful *means* rather than intentions that are being challenged, and so an empathic working relationship is maintained. It is claimed that this accounts for greater motivation on the part of service users and more persistence with the work. The past and its meaning are explored to understand its influence and the obstacles it placed in the person's way.

Implications for assessment

In this approach, assessment starts with the present situation but soon broadens out to look at the person's pursuit of primary goods as a whole. It establishes:

- What is important to the person, what their priorities are for the attainment of well-being.
- What lacks or influences tempted them to take the unsatisfactory direct routes or short-cuts?

Risk to others, need and responsibility are explored as the service user is invited to draw his/her own conclusions during a joint investigative conversation. Strengths and life achievements are underlined. How can the person become more fulfilled? What goals would promote this? In this process, it is recommended that workers avoid using a list of the primary goods to be taken in turn as in a questionnaire. Such a form-filling approach is considered to cause the person to feel they are doing a test, whereas the aim is to get them to examine themselves. The intentions and rationale of the worker are to be transparent, namely to work out how to get the person to achieve a fulfilling life, as this is seen as the best safeguard for the future. The link between the offending behaviour and a specific good is examined, as are the details of daily living and how this might be relating to other goods as a picture of the person's relationships and environment emerges and in particular how they see themselves *vis-à-vis* various primary and secondary goods:

- What is important to them and how do they go about getting it?
- What else do they hope to achieve in the future? Are there cognitive processes that need to be changed?

- Is there an overarching good or value that sums up the person?
- Could that be a focus to begin with? Where to start? Tasks? A plan?

Cognitive Analytic Therapy

Cognitive Analytic Therapy (CAT) was developed by Ryle (1990) for work with people with complex mental health problems. It uses theory and practice from both cognitive and psychoanalytic approaches to examine a person's past and the patterns of behaviour and thinking that were developed as a child as a means to survive and cope. Though necessary at the time, these are now causing them to think, feel and act in ways which stop them from functioning well. The structure of the therapy obliges the worker to explain what they are thinking and co-operate with the service user to modify and refine these suggestions into a 'formulation', a working map which becomes a focus to guide the remainder of the work.

In the assessment phase, the worker and person map out the issues and patterns, the way the person has tried to deal with them and what they want to change. This is expected to take four sessions, at the end of which the worker reads out a Reformulation in the form of a letter. This is a synthesis and re-authoring of all the person has shared about the past – their challenges, how they previously tried to cope, their strengths and their goals.

CAT was designed as a structured 16-session model with the following stages:

- An initial session to agree to work together. The process (below) is described so that the service user knows what to expect. The work will demand commitment on both sides so the therapist will go further only if the person is ready for it.
- Sessions 1–4: Assessment phase. The worker gathers information and tests emerging ideas by sharing them. A questionnaire is used which the person can take away to fill in. The questionnaire is asking 'What have you noticed?' It also introduces useful terminology such as 'traps, dilemmas and snags' for unhelpful thinking and 'states' for a range of emotion/body states. The person is encouraged to change the terms used to name things, substituting their own terms where possible. The naming of the particular emotional states and behavioural patterns is a collaborative investigation (Kelly, 1955).
- Session 5: In the session, the worker reads out a two-page draft letter (the Reformulation letter) outlining what he/she thinks is happening in the person's life. This letter is carefully constructed. It validates the person's 'chronically endured pain' (Mann and Goldman, 1982) and their various strategies for enduring it. The reading of the letter has a big impact as it is unlikely anyone will have taken the time to understand their story in such detail before. The service user is asked to comment on the letter, with a view to making it more accurate to their experience.

- Session 6: The worker reads out the amended Reformulation. This outlines up to four 'Target Problem Procedures' (TPPs). These are patterns which combine cognitive elements (e.g. either/or thinking) and emotional states. The TPPs become reference points for future sessions. Homework (observation tasks at first) is based on these.
- Session 7: The worker shares a draft diagram of the Reformulation (the Sequential Diagrammatic Reformulation, SDR). This is drawn as a map, showing the patterns as loops of limiting thoughts, feelings, beliefs and behaviour. The service user comments on this.
- Session 8: The worker shares the amended SDR. This provides a visual reference point for future work and helps both worker and service user find their bearings during subsequent 're-enactments' of the patterns, both in and out of the therapy room. Sometimes, these are alarming to both worker and service user, so a pre-agreed and mutually negotiated map is helpful in allowing them to repair any ruptures in the therapeutic relationship.
- Sessions 9–14: Working through the TPPs as they occur in daily life. Re-enactments offer the chance for the person to have real-life practice at modifying their responses with the help of the worker. The service user's skills at noticing and revising the TPPs are logged. In this phase, other therapy practices can be used, depending on preference of service user and worker – art therapy, narrative, mindfulness, etc. As the sessions progress, exits to the TPPs which have been discovered by the service user are logged.
- Session 15: Service user and worker read Goodbye letters to each other. These outline what has been learned and put into words what the therapy has meant. The person's success at noticing TPPs, revising them, and finding exits from them is celebrated. The final few sessions, and the reading of the Goodbye letters, offer opportunities for issues of loss to be named and explored. As in psychodynamic brief therapy (Malan, 1963), one of the main aims is to experience that loss, though painful, can be survived.
- Session 16: Final meeting.
- Follow-up session after about 3 months. Knowing there will be a follow-up meeting keeps the focus of the work alive in the person's life. They will likely keep working on the TPPs because they know that the worker cares and will want to know how they got on.

Implications for assessment

A CAT assessment is a collaboration between worker and service user. By making the process of assessment both explicit and transparent, CAT enables the task of assessment to become a project shared by co-investigators. The assessment uses the person's own words. The service user is involved in

defining the issues and in setting their own goals. The use of co-created therapeutic documents has many benefits:

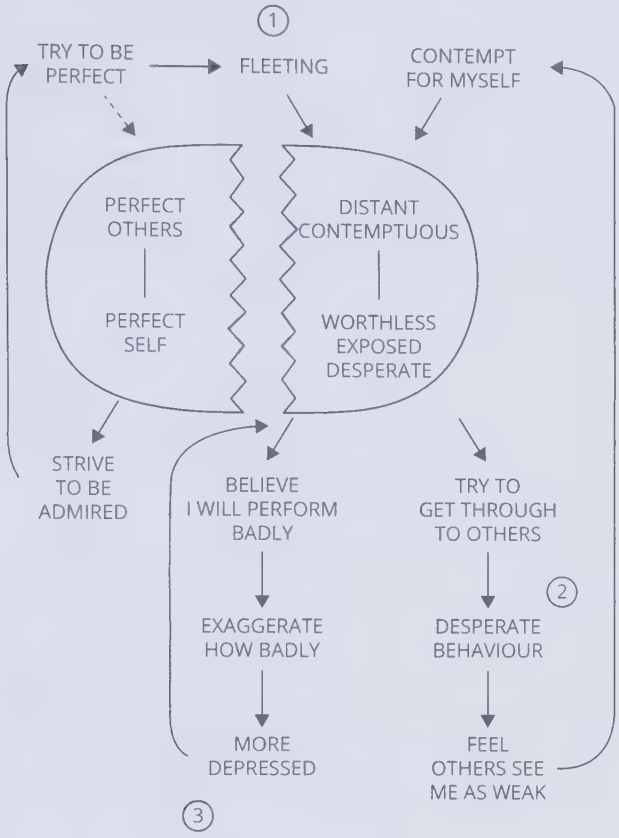
- It provides a third focus point, thus reducing the way therapy can be experienced as a threateningly intense one-to-one encounter.
- It forces the worker to share their thoughts; this means that hypotheses are made available to be revised and improved in the relationship, rather than sitting in the worker's head untested.
- The ceremony of reading documents adds to the sense of intensity that is helpful for therapeutic change.

The assessment produces realistic targets for change (TPPs). These are understood as arising from the service user's history and from their attempts to cope with the challenges of their life. They encompass felt states of body/emotion as well as patterns thought and behaviour. As a result, they make sense to the service user and enlist their enthusiasm to make changes. The therapist is communicating their confidence that the service user can make these changes.

The structure of CAT provides security for both worker and service user. The context of a clear structure allows the power of the documents to be experienced as helpful. The documents are also used in supervision where their clarity offers opportunities for accurate input by the supervisor. Re-enactments will involve transference and counter-transference, so supervision is essential. By experiencing a caring relationship, the service user can experience self-awareness which allows them to make different choices. These can be tried and tested in a safe environment.

PRACTICE EXAMPLE

Sajid was experiencing recurring depression. In the assessment, he described how, if he was not involved in new plans and new beginnings, feelings of worthlessness and anger would build up to unbearable levels. The struggle to manage the intolerable pain of this would exhaust him. This resulted in debilitating bouts of depression, which reinforced his feelings of low self-worth. His Reformulation and SDR highlighted three TPPs: (1) swings in self-esteem (feeling as if he has to be either perfect or worthless), (2) outbursts of emotion (trying to pierce the distance between him and others with unreasonable and demanding behaviour), (3) depressed thinking (feeling worthless, expecting to perform badly, exaggerating how badly he performed, thus proving his lack of worth).



Because Sajid's SDR showed the steps of these patterns, it offered rich opportunities for observation, experiment and revision. Sajid discovered and practised many exits during the therapy. Examples, relating to each TPP, were (1) realistic appraisal of the significance of events, (2) using humour to diffuse and share his feelings, (3) confiding in a friend.

Summary

In conclusion, the traditional behavioural approach can be used on its own, as can the cognitive dimension; added together, however, they provide a more powerful analysis of a wide range of troubled situations, examining what precedes and follows behaviour environmentally, and also what thoughts and resultant feelings precede, accompany and follow from the behaviour, giving clear indications of which interventions are most likely to be helpful. In the cognitive approaches, the assessment process begins by assessing the consequent emotional problem (C) – how problematic it is it?

Does the service user want to change it? What goal can be agreed? What are the activating events (A)? How does the person perceive the activating events – what beliefs are held about them (B)? Having taught the B–C connection, B is assessed for rationality/helpfulness or the opposite. In the Good Lives approach, the support of the pursuit of primary goods is key, along with an examination of the means of attaining them. Cognitive analytical therapy's utilization of psychoanalytic ideas reflects the way theory and therapy are moving to accommodate people with complex mental health issues that are reflected in third-wave cognitive therapies. The focus, however, as in other therapies in the second wave, is on directly changing the frequency or content of the thoughts, particularly irrational ones.

Critical comment

Cognitive approaches have considerable appeal for social workers because they offer a systematic, scientific approach that makes it possible to structure the work: 'The objective is spelt out clearly, the method predefined, and the end product always measurable' (Davies, 1981, p. 54). The initial stages of assessment are given prominence in this approach, and the production of behaviour baselines aids data display. Additionally, a strict behavioural approach has the advantage of going some way towards meeting the values of social work in that service user participation is encouraged, labelling discouraged and accountability made evident. Sheldon (1982) argues that a behavioural assessment has the advantage over other approaches of not squeezing out the service user's story or shaping the evidence to fit a favourite theory, so this careful attention to detail is particularly useful in 'blowing up' aspects of service user situations so that all variables can be explored. When the ideas about learned helplessness are taken on board, this has the potential to bridge the gap between psychological and sociological explanations of behaviour and maintain the focus on social as well as individual factors. O'Hagan and Dillenburger (1995) maintain that a functional behavioural approach offers a thorough, non-abusive approach to childcare work.

However, despite the claims of behavioural social workers that the approach is value-free and service user-friendly, it remains in practice largely psychologically reductionist and often prescriptive. Although the cognitive-behavioural approach can improve people's responses to inequality, it is no substitute for addressing social problems. In residential work, for example, usually it is only the immediate environment of the service user that is examined; even with behavioural group-work, it tends to yield little more in the way of solutions than the establishment of token economy regimes. Whatever the value of these, they do not take into account the realities of, for example, children's experiences in residential care where homes are understaffed, underfunded and, in some cases, abusive.

Also, the approach is not as value-free as it claims. For example, Ellis's (1962, 2006) rational therapy is really about appropriate white, masculine

assertiveness. It would be difficult to challenge many women's irrational beliefs as they may well be embedded in the rational context of patriarchal relations. Renzetti (1992), for example, suggests that many lesbian women remain in violent relationships because of *learned optimism*.

The scientific nature of traditional behavioural assessment rests on modernist assumptions about certainty and, in practice, assessments need to include the cognitive aspects. Even then, there often appears to be a tendency to go for a rushed solution after a limited assessment; see, for example, the modified and limited use of social skills training in group work. One is left with the same basic criticism we made of psychodynamic approaches: it is usually easier to bend the theory so that the assessment suggests an intervention that changes how an individual accommodates their lot, rather than actually look at whether that 'lot' should be changed. This is, of course, the perennial problem of social work, as it always seems easier to change an individual than challenge the status quo.

Outcomes

Research into the outcomes of behavioural social work (Sheldon, 1995) suggests that a combination of traditional behavioural approaches and cognitive approaches produces better results, and the cognitive dimension is being increasingly applied to a wider range of problems. Vennard *et al.* (1997) found that the use of cognitive-behavioural work was more effective than psychosocial approaches for reducing antisocial behaviour in both adults and juvenile offenders, and Buchanan (1999) found it the single most effective (problem-focused) approach for children with emotional behavioural problems, as did Kazdin (1997). Concerning work with children, Sutton (2000, p. 4) concludes that

> [T]here is abundant evidence that when practitioners develop a warm, empathic and respectful therapeutic alliance with family members and can help them to employ principles and concepts drawn from cognitive-behavioural theory, they have been able to help thousands of children with a variety of problems.

However, even though other studies found that cognitive-behavioural work produces the most positive outcomes, the meta-analysis by Gorey *et al.* (1998) did not find evidence to support this and it probably has not been compared with constructionist approaches.

The Department of Health (2001a) *Evidence-Based Clinical Practice Guidelines* consider CBT to be well supported by the Cochrane-registered reviews (the Cochrane Library, Oxford) and other high-quality reviews from 1990 to 1998. It is reported to have the best record of effectiveness in the treatment of depressive disorders. McLeod (1998) comments that 'the effectiveness of cognitive behavioural therapy for a wide range of conditions is

amply confirmed in the research literature' (p. 80). However, Mair (2004) argues that it is wise to treat any early apparent successes with caution given the incrementally disappointing reconviction rate indicators that have emerged over time.

This caution has been confirmed by Mews *et al.*'s (2017) extensive review of the Core Sex Offender Treatment Programme (SOTP). The SOTP was the main accredited cognitive-behavioural treatment programme for men who were in prison for sex offences. It has been developed over many years by experts in CBT and been subject to rigorous application through the training of staff and the use of manuals and quality assurance of delivery. In many ways, this programme was a flagship for applied CBT with offending behaviours. The study tracked 2562 sex offenders who had completed the SOTP and matched them with 13,209 sex offenders who had not had the SOTP, and a follow-up was an average of 8.2 years. Disappointingly for the proponents of cognitive-behavioural approaches, there were similar reoffending rates between the two groups (although contrary to popular belief, the rate was low in comparison with other offences), with the exception that:

> More treated sex offenders committed at least one sexual reoffence ... during the follow-up period when compared with the matched comparison offenders (10.0% compared with 8.0%).
>
> More treated sex offenders committed at least one child image reoffence during the follow-up period when compared with the matched comparison offenders (4.4% compared with 2.9%).
>
> (Mews *et al.*, 2017, p. 3)

Unfortunately, in this study, the SOTP seemed to increase the likelihood of reoffending. What works better seems to be community-based supervision where support can be offered to increase desistance by helping overcome problems such as family problems and employment (Cowburn and Myers, 2016).

Wave 3. Multimodal Cognitive Behavioural Therapies

The third wave of cognitive therapy developed from workers finding that second-wave therapies did not work particularly well for people with complex mental health issues. This third wave is multimodal, incorporating elements of psychoanalysis – most particularly, attachment theory and ideas from Gestalt Therapy – but also ideas from evolutionary, social, developmental and Buddhist psychology so that service users can develop broader, more flexible and effective emotional and behavioural ways of being. These therapies include Dialectical Behaviour Therapy, Functional Analytic Psychotherapy, Acceptance and Commitment Therapy,

Mindfulness-based Meditation, and Compassion-Focused Therapy. We outline the last three below.

Mindfulness and Mindful Meditation

Mindfulness and mindfulness meditation have their origins in Buddhist meditation but became popular in the West following the work of Kabat-Zinn (1990, 2013) on how to cope with stress, pain and illness. Mindfulness is a way of approaching and tuning in to the present on a moment-by-moment basis rather than withdrawing or escaping from it. It allows the person to connect with the observing self: the part that is aware of but separate from their thinking self. Mindfulness techniques can also help people increase awareness of their senses as well as their thoughts and emotions. Segal *et al.* (2002) build on the work of Kabat-Zinn, with mindfulness exercises that focus on being consciously aware of here-and-now experiences but not attaching meaning to them or reacting to them. This decentring process is said to help the person disengage from self-criticism, ruminating thoughts and dysphonic mood. A classic mindfulness instruction is 'Notice every sensation of your breathing. Every time your mind wanders, bring it patiently back to noticing the breath. Do this again and again, with immense kindness. Try it and see how you get on'.

Negotiating the boundary of personal space in a mindfulness exercise is complex – a simple formula won't work for all. Thus, it is important to use graded experiences of mindfulness, staying directly attuned to moment-to-moment service user experience. It is also important to be prepared to incorporate the unexpected, as the practice example below illustrates.

PRACTICE EXAMPLE

The worker asked Claire whether she would like to experiment with using mindfulness in a five-minute exercise. The worker explained the purpose of the exercise as being to establish a safe reference point in her own body. He outlined his hope that coming back to this reference point would give Claire a refuge when faced by difficult experiences that she was having through the week. He expected this skill would take practice and he wanted to give Claire an example of how she could begin. Claire agreed.

The worker suggested that Claire relax in an upright sitting position, with her feet flat on the floor, and her hands relaxed on her thighs. She could close her eyes, or keep them open, as she wished. Not wanting to give Claire the impression that she was being watched, the worker closed his eyes and began to run through some instructions:

'Bring your awareness into your body. [pause] Become aware of your breathing. [pause] Feel the chair supporting you. [pause] Feel the soles of your feet being supported by the floor. [pause] ...' etc.

The worker continued smoothly through the exercise to the end.

After the exercise, Claire said that from 'Feel the soles of your feet being supported by the floor' she had felt the floor moving and buckling beneath her. She had a flashback to the trauma of being in an earthquake. Neither Claire nor the worker had anticipated this outcome and the worker had been completely unaware of it as it was happening.

In this case, it was possible for Claire to talk through what had happened and the incident provided useful material.

Mindfulness meditation can be offered as a stand-alone course. It is also a central technique of third-wave therapies.

Acceptance and Commitment Therapy

Acceptance and Commitment Therapy differs from CBT in that rather than teaching people how to control their thoughts, it teaches people to notice, accept and embrace their thoughts, feelings, sensations and memories (Hayes and Smith, 2005; Hayes *et al.*, 2007). In other words, to develop mindfulness skills so that painful thoughts and feelings can be dealt with effectively and to clarify what is truly important and meaningful to each person.

At the core of Acceptance Commitment Therapy is the notion that psychological suffering is caused by avoiding and evaluating experiences. People faced with a stressful situation that cannot be controlled can become stuck in one place for quite a long time, making them feel overwhelmed and helpless. This is characterized by an acronym FEAR:

- **F**usion with one's thoughts
- **E**valuation of one's experiences
- **A**voidance of these experiences
- **R**eason giving of one's behaviour

A healthy alternative is ACT:

- **A**ccept one's reactions and be present.
- **C**hoose a valued direction.
- **T**ake action.

ACT aims to change the relationship between the person and their thoughts. This is achieved by:

- Cognitive defusion: distancing from, and letting go of, unhelpful thoughts, beliefs and memories.
- Acceptance: making room for painful feelings, urges and sensations, allowing them to come and go without struggle.
- Contact with the present moment so that the person can engage fully with the here-and-now experience, with an attitude of openness and curiosity.
- Values: discovering what is important to one's true self.
- Committed action: set goals according to one's values and act on them.

So, for example, a person suffering from anxiety would be encouraged to experience that anxiety fully rather than withdrawing from it and observe the self in a non-judgemental way. Although it sounds counter-intuitive, fully realizing the experience of anxiety enables anxious people to realize that the anxiety they experience is merely a reaction to perceived threats, enabling them to choose a valued direction and take action towards it. It can be seen from this that ACT is more than an acronym.

ACT's emphasis on discovering values that will direct action are the ones that resonate for the person, not what they think they 'should' have. The worker will guide the person through any fears or resistance they may have to discovering their own values and help them deal with any childhood memories or emotions that are stirred up in the process of looking at real values.

Compassion-Focused Therapy

Gilbert (2009, 2010) noticed that many people with complex mental health challenges with high shame and self-criticism didn't improve with the cognitive therapies (see, for example, Beck *et al.*, 1979, Linehan, 1993, and Fonagy and Target, 2006). Understanding their negative thoughts and behaviours didn't make them feel any better as it didn't acknowledge the fears people may have of giving up their current way of reasoning (Mukulincer and Shaver, 2007). Instead, posited Gilbert, they needed to be able to soothe themselves and experience inner peace. A key concern of Compassion-Focused Therapy is the use of compassionate mind training to help people who experience high shame and self-criticism to develop and work with experiences of inner warmth, safeness and soothing via compassion and self-compassion. The three components of self-compassion being:

i) Mindfulness

ii) Kindness towards oneself as opposed to self-judgement

iii) Feeling part of a common humanity as opposed to isolation (Neff *et al.*, 2007).

Compassionate mind training also has three components:

i) The worker uses the skills and expresses the attributes of compassion.

ii) The person experiences their interaction with the worker as one that is de-shaming, compassionate and safe.

iii) The worker helps the person to develop compassionate skills and attributes.

It is considered useful not only with people with deep feelings of shame and an unrelenting inner critic but also with people who:

- Have been emotionally or physically abused, including neglect and bullying.
- Are unable to be kind to themselves.
- Have difficulty in believing the world is a safe place.
- Have anxiety and panic attacks due to feeling life is threatening.
- Find it hard to trust in others.

In conclusion, third-wave behavioural therapies focus on content and functions of psychological phenomena rather than their form. Instead, they are designed to work at a meta-level by helping people to change the functions of their thoughts and their relationship to events. Through changing how people observe and process thoughts, they are also changing their degree of influence in their lives:

> Compassion Focused Therapy adopts the philosophy that our understanding of psychological and neuro-physiological processes is developing at such a rapid pace that we are now moving beyond 'school of psychotherapy' towards a more integrated, biophysical science of psychotherapy. (Gilbert, 2009)

Implications for assessment

Third-wave behavioural therapies are practiced mainly in health settings in situations of anxiety, depression, post-traumatic stress syndrome and pain relief. It can be as brief as 30 minutes so has obvious advantages for hospital social workers who will find that simplified skills of mindfulness are straightforward. Acceptance Commitment Therapy has been used in life coaching situations so may be appropriate in social work supervision when considering how to deal with the many stressful practice situations.

As with second-wave cognitive therapies, it starts with the present situation but broadens out to look at physical experiences as well as thoughts, looking particularly at dysfunctional attachment styles. The worker is the expert in deciding on the nature of the problem, modelling and actively teaching service users ways of achieving these behaviours. As such, it is more prescriptive than collaborative.

Critical comment

Third-wave cognitive therapies borrow heavily from other therapeutic approaches, claiming to be integrated, biophysical science. Selecting the most appropriate ideas and techniques for therapy is sensible, but it requires a sound knowledge of how theory works. McLeod (1998) suggests that whilst there is no problem with therapists using lower-level constructs that carry little in the way of theoretical baggage, higher-level theoretical constructs and concepts cannot be taken out of their parent model. For example, it is not theoretically coherent to take attachment theory out of its psychoanalytic context and ignore the central tenets: a solid belief in catharsis, in stages of development, in resistance, in transference and in countertransference. Whilst it might seem reasonable to import a technique that has proven successful in some context and therapeutic model, 'One should bear in mind that any given technique, developed in a particular context and under different theoretical premises is probably transformed into a different technique when used under different circumstances' (Lazarus and Messer, 1991). Mikulincer and Shaver (2017) argue that attachment working models cannot be equated with social cognition models because:

> ... they evolve not only from simple memories of actual experiences but also from dynamic processes of goal pursuit, emotion regulation, and psychological defenses involved with wishes for proximity and security, and fears of separation and helplessness. (p. 45)

Carrington (2013) cautions against the unintentional misappropriation of spiritual knowledge, theory and practice so, for example, the tokenism accorded to Buddhism in ACT could mean 'taking a form of meditation and using it outside paradigmatic guides, changes its intended purpose and outcomes' (p. 29). Lindhal *et al.* (2017) argue that 'the focus on positive health-related benefits [of meditation] represents only a narrow selection of possible effects that have been acknowledged within Buddhist tradition both past and present'. For example, Buddhist traditions also acknowledge periods of challenge or difficulty associated with the practice of meditation. In Tibetan Buddhist traditions, the term *nyams* refers to a wide range of 'meditation experiences' – from bliss and visions to intense body pain, physiological disorders, paranoia, sadness, anger and fear - which can be a source of challenge

or difficulty for the meditation practitioner. Farias and Wilholme's review of the research (2015) shows that personal change effected by meditative and mindfulness practices can vary widely from one individual to another and that peace and compassion may not always be the end result. Zen traditions have also long acknowledged the possibility for certain practice approaches to lead to a prolonged illness-like condition known as 'Zen sickness' or 'meditation sickness'. For example, Clark (2017) reports having a full-blown panic attack whilst meditating. Lindhal *et al.* suggest that the privileging of *experiences* as central to meditation may in some cases more reflect modern sensibilities rather than Buddhist concerns throughout the ages:

> Buddhist-derived meditation practices are often presented in the West in terms of their non-religious health-related outcomes with little to no attention given to the possibility of the broader range of effects suggested by traditional Buddhist sources. (2017)

It is probably more accurate to describe third-wave therapies as eclectic rather than integrated, utilizing non-model-specific relationship factors such as a supportive relationship, a rationale whereby service users can make sense of their problems and the participation in healing rituals. (For an overview of eclecticism and integration, see Milner and O'Byrne, 2004, Chapter 10.)

Outcomes

Mindfulness-based cognitive therapy has been found to be effective in reducing depressive and anxiety symptoms in people with mild to moderate depression (Potts *et al.*, 2014). Combining mindfulness with acceptance-based interventions is associated with robust and substantial reduction in symptoms of anxiety and co-morbid depressive symptoms (Vollestad *et al.*, 2012), although the authors of this study caution against presuming a causal connection. Macbeth and Gumley's (2012) meta-analysis found compassion to be an important explanatory variable in understanding mental health and resilience. Higher levels of compassion were associated with lower levels of mental health. High levels of self-compassion developed well-being, reduced anxiety and stress and increased resilience to stress. Van Damm *et al.* (2011) equally found self-compassion to be effective as a way of directing behaviour to deal with threats and resolve conflict.

There are few studies into the unwanted effects of meditation-related experiences, which Lindhal *et al.* (2017) found to be typically underreported, 'particularly experiences that are described as challenging, difficult, distressing, functionally impairing, and/or requiring additional support'. Rockliff *et al.* (2008) report that some people find compassion-focused imagery physiologically stressful. Gilbert (2009) suggests that such people will be the most difficult to help develop self-compassion. He speculates that they may

benefit once their fears and resistances are worked through, although he acknowledges that there is no research evidence for this.

Ruiz (2010) concludes that although the comparison research for cognitive therapy and Acceptance Commitment Therapy is in its beginning, the available empirical evidence is promising. However, Herbert and Forman (2013) conclude that the latter 'cannot yet make strong claims that its unique and theory-driven intervention components are active ingredients in its effects'. Macbeth and Gumley (2012) call for more research to develop an evidence base for compassion in psychopathology, primarily in depression, anxiety and stress. Lindhal *et al.* (2017) call for more research into the range of possible – or likely – effects of meditation-related practices. As the evidence base has developed, there are indicators that ACT may have a more limited effect than previously thought. For example, Van Der Gucht *et al.* (2017), in their large sample randomized control trial about the introduction of ACT in schools, found no identifiable impact at all on the children.



Summary

- Behavioural approaches offer a detailed and thorough method for the analysis of problems, suggesting useful techniques to aid assessment.
- These approaches are most effective in developing strategies to *strengthen* behaviour.
- Despite the advantage of rigour in the assessment of behavioural problems, the traditional behaviourist approach is little used by social workers.
- Cognitive-behavioural approaches, in that they emphasize the role of thought processes in behaviour, offer a more acceptable approach to assessment and intervention for many social workers because they help them to understand the emotional component of behaviour difficulties.
- The emphasis on learned helplessness gives behavioural approaches the potential to deal with anti-oppressive practice issues, and Barber's questions can be useful in analyzing helplessness and in starting empowerment and increasing self-confidence.
- The Good Lives model combines behavioural therapy with an empathic working relationship and a holistic approach to the person with the problem.
- Cognitive Analytic Therapy combines behavioural therapy with psychanalytic approaches in a structured, collaborative way.
- Third-wave cognitive therapies such as Mindfulness-based Meditation, Acceptance and Commitment Therapy and Compassion-Focused Therapy focus not so much on distorted thinking as on changing the relationship between the person and their thoughts.



Further learning activities

- What are the key differences between the various cognitive approaches?
- How might these differences affect the service user?
- How might these differences affect social work practice?



Further reading

Hoffman, S. G. (2011) *An Introduction to Modern CBT. Psychological Solutions to Mental health Problems.* Chichester: Wiley-Blackwell.

Kelly, G. A. (1955). *The Psychology of Personal Constructs.* New York: Norton.

Malan, D. H. (1963). *A Study of Brief Psychotherapy.* London: Tavistock.

Mann, J. and Goldman, R. (1982). *A Casebook in Time-limited Psychotherapy.* New York: McGraw-Hill.

Prochaska, J. O. and Norcross, J. C. (2014*) Systems of Psychotherapy: a Trans-theoretical Analysis.* Stamford, CT: Cengage Learning, pp. 310–12.

8 A HANDY TOURIST MAP: THE TASK-CENTRED APPROACH

What this chapter is about

The map presented in this chapter is also from the second wave of social work theory. It too is problem-focused, having much in common with the cognitive element in the previous map, but it moves further towards social constructionism and also towards acknowledging and dealing with external social factors in human difficulties.

This chapter addresses the task-centred approach to social work assessment and intervention – probably the most used approach of the past 20 years after psychosocial casework. This theoretical map differs from those in preceding chapters in that, while it is implicitly behaviourist and cognitivist, it did not originate in clinical psychology but is based on research into social work practice and written specifically for social workers. We refer to it as a handy tourist map because it involves no elaborate or complex theory, its principles could fit on a folded card and social workers use many of its elements, perhaps without naming them, as a guide to where they need to get to in much of their work.

Main points

- Wider theoretical issues: assumptions about problem classification and causation.
- Techniques: goal setting, from wants to goals, task selection.
- Implications for assessment: task review, assessment questions, obstacles.
- Critical comments on the usefulness of this approach and on task selection and performance.
- Outcomes of research studies of this approach and on its social dimension.

Wider theoretical issues

The task-centred approach arose from disenchantment in the 1960s with the existing open-ended and long-term ways of working. William J. Reid's dissertation published by Columbia University in 1963 was the first statement of the ideas, which were subsequently developed by Reid and Shyne (1969), Reid and Epstein (1972), Reid (1978) and Epstein (1988). The main British publications are those of Doel and Marsh (1992) and Marsh and Doel (2005). Most texts on social work interventions now include the task-centred approach (see, for example, Coulshed and Orme, 2012; McColgan, 2013).

There are certain assumptions underlying this approach, many of them drawn from the (cognitive) philosophical writings of Goldman (1970) and from the crisis intervention ideas of Parad (1965). Briefly these are:

- The usual and best way to get what you want is to take action.
- Action is guided by beliefs about the world and self, and these are the basis for plans of action.
- Many psychosocial problems reflect only a temporary breakdown in coping.
- Time limits help to motivate service users before the edge of discomfort becomes blunted with time.
- One positive problem-solving experience improves one's ability to cope with the next difficulty.
- 'Normal life consists of one damn thing after another', said Dorothy L. Sayers's character Lord Peter Wimsey. Difficulties are mostly normal; they become problems only when they become 'the same damn thing over and over' (O'Hanlon, 1995) as a person becomes stuck.
- We are what we do, and feelings flow from behaviour.
- Feelings can be viewed as beliefs about wants.

The approach is mainly cognitive in that emotions become translated into beliefs, as we shall see when we address causation, and people's capacity to think is utilized to solve their problems. It concentrates mainly on 'exposed problems' (Payne, 2005, p. 100), which it classifies in defined categories, although, as Payne mentions, emotional problems can be helped by success in performing tasks. It is suitable for a very broad range of problems, even problems in care management and service systems (Ford and Postle, 2000). It is concerned mainly with problems that can be solved by tasks performed by the service user and the social worker. It sees

the worker in a collaborative role with the service user, puzzling out together what to do.

Problem classification

Reid (1978) classifies problems into eight types:

1. *Interpersonal conflict*: interactions with others are presenting difficulties: 'We don't get along'. The problem is in a relationship, be it marital, parental, school or work conflict.
2. *Dissatisfaction with social relationships*: 'I am not assertive; I get picked on'. The problem here is more general, within the individual rather than between them and others.
3. *Problems with formal organizations*, such as housing, schools, hospitals and state benefits systems.
4. *Difficulty in role performance*, such as parent, spouse, worker or student.
5. *Problems with decisions*.
6. *Reactive emotional distress*, such as depression or anxiety resulting from a situation.
7. *Inadequate resources*, such as money, food, work or housing.
8. *Others*, not included in the above, such as behavioural problems associated with addictive or compulsive patterns, substance abuse, crime and gambling.

In the assessment stage of task-centred work, it is also important to seek out how various problems are *interconnected*. This can arise in two ways. First, actual problems in different categories can be interconnected, such as drinking, unemployment and lack of money. Having identified these connections, the potential service user together with the social worker can consider which would be the most useful to tackle first – as, in dealing with that problem, other problems may take care of themselves. The second way in which interconnectedness can arise is in the problems of different people (for example, two parents where the problem of one is maintaining the problem of the other in each of their cases). We find that service users find it helpful to be given a scale, setting out the eight types in a way such that they can write in the problems and score them at the beginning of work and again at the end (Figure 8.1).

Problem type(s)	*Nil*	*Low*	*Some*	*A lot*	*Serious*
Interpersonal: [Add some detail]					
Social relations:					
Formal organizations:					
Roles:					
Decisions:					
Emotional distress:					
Resources:					
Others:					

Figure 8.1 Problem scale

Problem causation

Next, there is an analysis of the *cause(s)* of the problem. This is where there is a major shift of thinking from earlier approaches to assessment in social work. In this approach, there is no question of seeking out the original cause of a problem. Even where a prior event (for example, a loss) is recognized as starting the problem, it is what the service user is making of that loss here and now that matters. The event cannot be changed, but the person can be helped to grieve, to accept the reality and to plan a new life without the lost person or status. Of problems, it is said that they simply happen. Rather than searching for complex, original causes, the assessing social worker looks for *obstacles* that are contributing to *maintaining* the problem in existence by preventing its resolution. It is those *causes of the problem continuing to be* that really matter. The removal of these obstacles will allow the change to happen. The focus, therefore, is mainly on the here and now, with perhaps some attention to the recent past, because irrespective of the original cause that started the problem off, the cause that counts is the cause that is blocking the resolution of the problem in the present. These are current things that the service user and worker can do something about – we can do nothing about changing history. It is important in this approach not to interpret service users' behaviour or explain it in terms of irrational behaviour, resistance or defence mechanisms. Doel and Marsh (1992) refer to this as 'shooting the reflective parrot' that sits on the shoulders of many social workers trained in essentially psychosocial approaches.

In a task-centred assessment, cause equals *obstacle* preventing the problem from being moved. There are four main obstacles:

1. *The social system.* This could be the family, extended family, community, formal or informal networks, or society at large (as in the case of many

oppressions). Here, the task-centred approach is clearly saying that the cause of problems can be outside the individual. Where that is the case, to see it anywhere else would be to pathologize the service user unjustly. However, obstacles are frequently complex and can include both internal and external elements.

2. *Beliefs or constructs* about the world, life, self and the problem. Beliefs can be factual or evaluative, and their accuracy or consistency can be challenged.

3. *Emotions*, which are translated into beliefs about wants. For example, 'What I want is lost or unobtainable' = depression; 'What I want is wrong' = guilt. Moving feelings to an explicit cognitive level makes them easier to deal with since the underlying beliefs can be disputed. For example, a person feeling guilty about being sexually abused can be helped to see that it was not they who initiated the behaviour.

4. *Attempted solutions*, or actions being taken, that are making matters worse. There are three main types of attempted solution that can become obstacles:

    - Seeking utopian goals, or aiming too high, such as wanting children to be angels.
    - Trying too hard to do what can only be spontaneous (for example, trying to get to sleep or trying to get a stepchild to love you).
    - Seeking to change attitudes when the service user could settle for behaviour or wanting someone to want something they do not want.

Examples of these attempted solutions include challenging children for stomping upstairs because they do not think they should have to go to bed so early or complaining that a child is not enthusiastic about going to school. In both cases, not settling for the behaviour concerning going to bed and to school will turn a minor difficulty into a problem. If the child's attitude were simply ignored, there would be a better chance that it would go away. Tasks can be designed to undo these unhelpful attempted solutions.

From wants to goals

Problems are defined by Reid (1978) as unmet or unsatisfied wants as perceived by the service user. These perceptions may often be unclear but, more importantly, an unmet want is often attributed to the potential service user by someone else. For example, person A may say 'My partner B has a drink problem – he needs to control his drinking'. This is the attribution of a problem by person A (the referrer) to person B. A is seeking help for B, so A's want/problem is really 'I have a problem with my drinking partner'. That is the only *acknowledged problem* so far. B has not acknowledged any want; he

is not an applicant, and it is mainly service users who are applicants in some way that concern us in the detailed use of this map.

Of course, in statutory agencies especially, many of the people we work with are referrals rather than applicants. They are the unwilling people whom courts, child protection panels, schools, parents and families refer to us. These people may say they have no unmet want with which they wish us to help. In these situations, task-centred work does not move forward unless, and until, some want is acknowledged, even if it is only 'I want you off my back'. Unwilling referrals can be engaged by exploring how it is that others see them as having problems or as being problems, how the situation is affecting them, whether there is something they would like to see changed, and whether there is something they could do that would free them from interference in their lives. When they acknowledge some such want, they become applicants. In this approach, therefore, the first step in assessment is to establish whether this person has any want (that is, 'Is there anything you want to change?', 'Do you want my help in achieving it?'). Some people see themselves as confirmed failures in life and may not believe that any help will make a difference. They may need to consider the questions 'If effective help was available, what would you like it to tackle?' and 'Are any of the attributed problems real problems for you in any way?'

PRACTICE STUDY: THEORY INTO PRACTICE

Fourteen-year-old Dean has been living in a residential care home for young men since it was discovered that he had sexually assaulted the 8-year-old friend of his sister. He refuses to go to school as he is afraid of reprisals from the girl's older brothers. Care staff complain that he is bullied by the other lads and spends much of his time in the home on his PlayStation. He also raids the fridge at night and has put on a great deal of weight.

Dean refuses to talk about his offence, except to say that he will never do anything like that again. He wants to return home to his mother and two younger sisters.

He currently visits them for two hours each week and these visits are supervised. The supervisor has no concerns about Dean's behaviour on these visits, but she has expressed concerns about his mother often smelling of drink. His mother denies drinking excessively, saying she has only the occasional drink when she gets upset at local youths throwing things into the garden and chanting 'Nonce house!' She would like to move but is in arrears with her rent.

- **Using the problem scale (Figure 8.1), list the problems and wants for everyone in this situation. How might the wants translate into goals?**

This approach takes nothing for granted and asks the most basic and obvious questions, respecting potential service users' states, seeking to start where they are and looking at life through their perception of it. Epstein (1988) describes this phase as the *start up*, in which the worker establishes whether there are acknowledged wants in the mind of those referred for help – she referred to them as *up-front problems.*

The next step focuses on wants, to firm up goals, assessing whether they are specific and achievable and, if so, in how much time, particularly how short a time. This consideration of time-limited work is seen as crucial for motivation and clearly fits well with the current requirements. Many potential service users will have more than one want; these are prioritized at the assessment stage, and usually no more than three are targeted. Once agreed, these problems become the basis of the goals of the work. Where, when and with whom these problems arise are explored, as are the consequences of behaviours, the meaning the problem has for the person and for significant others, and also the social context. These considerations arise in clarifying *goals* at this point:

- What needs to be done or changed?
- What constraints make this difficult?
- What tasks will be required of the service user and/or the worker, mainly the service user, in order to begin to improve matters?
- How long will it take? Discussing and agreeing time limits appear to greatly heighten motivation. We suggest that, when in doubt about length, err on the side of brevity.

We also recommend the Want Sheet (Figure 8.2) designed by Masson and O'Byrne (1984), which is particularly useful where two or more people are involved, as in family conflicts. Instruments such as these help people to clarify wants or, often more importantly, to express wants. The vagueness arising from an inability to explain, clarify and express wants is often a further problem compounding the original problems.

NAME	*What I want from them*	*My chances of getting it*	*What they want from me*	*Their chances of getting it from me*
Dad				
Mum				
Rebecca				
Paul				

Figure 8.2 Want Sheet

PRACTICE STUDY: THEORY INTO PRACTICE

Samantha is asking for help in dealing with her 15-year-old daughter, Rebecca. Rebecca gave her no cause for concern until her dad left the home after discovering that Samantha had been having an affair with a woman she met at work. He now lives with a new partner in the next town. Samantha reports that Rebecca has 'got in with the wrong crowd' and is staying out until all hours. She thinks she is taking drugs, and is concerned that Rebecca has also started cutting herself. Rebecca says that she cut herself only once or twice and this was only as a result of a craze for cutting at school. She doesn't see why she shouldn't stay out late with her friends as she can still get up for school. The conflict between Samantha and Rebecca has escalated to the point where they have 'screaming matches' every day. Samantha is also concerned about the effect of this on her younger son, Paul.

- **Complete the Want Sheet in Figure 8.2 for this family.**

Goal clarification at the assessment stage is in itself also a major part of helping. The social worker will want to help or coach service users in taking action to deal with the problem themselves. The service user, rather than the social worker, being the main agent of change in this approach, clarity and agreement are vital at this point. Each member of a family or group can be asked to complete a Want Sheet and then share them with one another, giving them an opportunity to challenge misconceptions about each other's expectations within the group. Such exchanges can give valuable information about the potential of the group for sorting out its problems through its own action. The approach therefore is essentially an empowering one with the social worker serving/servicing the user(s).

The meeting of a want is equivalent to reaching a goal. Every social work text will stress the need for clearly defined realistic goals that are salient to the service user; however, there may be a tendency among some social workers to busy themselves with tasks and miss out on the work of identifying goals, which in turn makes evaluation difficult. The task-centred approach sees the clarification of wants/goals as a crucial step in the assessment and helping processes.

Task selection

The next step is task selection, working out with the potential service user which tasks could be attempted to bring about change. A wide range of tasks is usually developed and these are discussed, the social worker and potential

service user collaboratively assessing which would be the most useful, which are within the potential service user's repertoire and, if they are not immediately capable of being done, how much help, coaching and rehearsal the potential service user would need in order to be able to do them. If outside resources are needed, the assessment needs to consider what are they and who should get them.

In this step of the assessment process, decisions are made jointly with the potential service user, discussing the task options available and considering:

- The potential benefits of each.
- The work involved in carrying them out.
- Any factors that may make a task difficult.

The following are some of the options available in selecting tasks:

1. *Exploratory tasks.* These further examine the problem or challenge factual beliefs. A parent may say, 'My son is always disobedient', so the task could be to count up the occasions when he obeys or disobeys over the next week and set out to catch him being obedient as much as possible or at least once.
2. *Interventive tasks.* These are used to make a change or move towards solving the difficulty or meeting the want, such as parents going out together more. Attempting such intervention by way of experiment provides valuable evidence for the assessment.
3. Tasks can be *simple* (one action) or *complex* (several actions or parts). However, simple tasks are preferred in this approach.
4. *Single* (done by one individual) *or reciprocal* (someone does something and another person reciprocates) *tasks.*
5. *Physical or mental tasks.* It is recommended that mental tasks be made as physical as possible (for example, by making lists of one's ideas or observations).
6. *Incremental tasks*, beginning with small steps and then increasing in difficulty as the service user gains in confidence and skill.
7. *Pretend tasks*, such as pretending that something has changed (for example, a depression having lifted), noting the difference or seeing if someone else notices anything different.
8. *Reversal tasks.* These entail doing the opposite of what the service user has been doing to tackle the problem. These are especially recommended where the attempted solution is the main cause of the problem being stuck.
9. *Paradoxical tasks.* These may be considered where straightforward tasks have failed and where they can be preceded by a positive reframe of the

problem. These ask the service user to not change or to make the problem worse, and, unlike any of the above tasks which are negotiated with the service user and which hope for compliance, these are not negotiated or discussed. The hope is for refusal, the intention here being that the service user will recoil from the injunction and thereby change.

We then consider:

- What practice, rehearsal or guidance may be needed.
- The overall plan for carrying out the task.
- How and when progress will be reviewed.

THINKING POINT

Referring to this list, which sort of tasks might you use in the early stages of your assessment of Samantha and her family above?

Whichever tasks are chosen, they work better when a brief *time limit* is set. Reid (1992) found that goals and tasks without time limits were less effective; he suggests that when longer work is required it be broken down into short periods for task work towards specific goals.

Other approaches use different tasks to promote change: in systemic family work such as that demonstrated by the Brown family in Chapter 5; in the solution-focused approach where the philosophy leads to the use of specific tasks – see Chapter 9.

Implications for assessment

Task review

When reviewed, tasks provide useful information/evidence, not only about the problem but also about the most helpful way of addressing it, about the motivation and capacity of the service user and about the likely time and effort that will be required. The final step, therefore, is task review. If the tasks are carried out and some progress is found, the assessment is well on its way to completion; we already know what needs to be done – it is only a matter of estimating how long it will take to complete. If, however, the tasks are not done or they have made no difference, we know that further analyses and changes are required. If the tasks are completed but ineffective, this is valuable information that will increase the likelihood that more effective tasks can be and will be designed. So the step of task selection is retaken.

The task review will not only seek to discover any reasons for tasks not being carried out but also include supportive discussion, especially of any beliefs and anxieties that may be impeding progress. This is followed by the

planning of more appropriate tasks or rehearsals for their performance. (The questions listed under Stage 7 below will apply.)

Assessment questions relating to the six stages of the process:

Stage 1. Meeting the service user

- Is this case a matter of a referral or an application?
- Is the service user's want attributed or acknowledged?
- If attributed but not acknowledged, is there anything else wanted?
- If mandated by court to cooperate with the service, how does s/he want to proceed? What are his/her own wants?
- To sum up, do we have an applicant for anything? Do we have a service *user*?

Stage 2. Exploring the wants (unsatisfied want = problem)

- If referred, what is wanted by the referrers?
- Does the service user want this? Or is that a problem for the service user?
- What does the service user want to do about it?
- Does the service user want help to do that?
- What are the applicant's own wants?

Then analysis of 'cause':

- How is the problem maintained: by beliefs, emotions, the social system or attempted solutions?
- What are service user's beliefs about the situation and about the want? Are the beliefs accurate? Consistent?
- If the *cause* is an attempted solution, is it seeking utopian goals, trying too hard or seeking attitudinal change?

Stage 3. Problem classification

- How can the problem(s) be classified? (What type of problem/s?)
- Which, and how many, of the eight types are involved? How serious is each one? How frequent?
- Is there any interconnectedness between problems?
- What meaning does the problem have for those concerned?

Stage 4. Agreeing a goal or goals

- Is the want/goal specific?
- Is the goal achievable?
- What constraints make change difficult?

- What needs to change, for the goal to be reached?
- How long will it take to reach the goal?

Stage 5. Agreeing a task or tasks

- What tasks will be required to make the necessary change?
- Will the service user be able to carry them out?
- What task/s will the social worker or others carry out?

Stage 6. Task implementation

- What help or rehearsal will be needed to prepare for task implementation?
- What other resources will be needed?
- When will the work be reviewed?

Stage 7. Task review

If tasks are not done:

- Has the service user a clear enough understanding of the task and its relevance?
- Has the service user any adverse beliefs, such as thinking that the task has little value or that doing it will be frightening? Has s/he the necessary self-confidence to perform the tasks?
- Does the service user have the necessary skill to perform the task completely and consistently? If not, how can this be acquired?
- Does the service user have the necessary concrete resources to carry out the task? These may be money, accommodation or the support of friends.
- Are there reinforcements necessary to encourage the service user in the persistent carrying out of the tasks? If so, from whom could they come?
- Are the social worker's attitudes affecting the service user's performance? Does the service user's forgetfulness or anxiety annoy the social worker, or do his/her behaviours or attitudes make the social worker feel contemptuous in any way?

On first reading, these questions may seem to be too obvious and simplistic but that is really their strength. It is all too easy to make assumptions and end up putting words into the mouths of service users; it is good practice to take nothing for granted and to ask all the fundamental questions necessary. Even where the nature of the problem is clear and specific, we still need to learn from service users how best to help them proceed in small steps towards their goals. Encouragement over small achievements and seeing them as a cause for optimism are vital elements in the coaching process. Small successes improve motivation to progress further.

PRACTICE STUDY: THEORY INTO PRACTICE

The K family: a social services department received a complaint from neighbours that they could hear shouting, and what seemed like a child being hit, coming from the K family's house.

The visiting social worker explained who she was and the purpose of the visit, making use of good engagement skills to gain access to the home despite some early hostility and fearfulness on the part of the Ks. The couple had been together for three years and there were two children, Sarah (age 12) and Jason (age 3). Sarah was Mrs K's child from an earlier relationship, and Mrs K had lived alone with Sarah for several years. She had a low-paid, part-time job and struggled to pay her way, accumulating £4500 in debts. Mr K had not been aware of the debts until about 18 months previously when a court letter arrived. He had felt very angry and had started to drink more than usual, often on his own. He also had back trouble and had been unemployed for the past six months, which was getting him down. Mrs K also said she felt a bit depressed and that everything seemed to be falling apart. They agreed that there had been loud arguments; he was angry over the debts and she would respond that his drinking and attitude were making things worse. Over the past 18 months, they seemed to talk only when they rowed; he had hit her once (a 'slap on the face') and he had lost his patience with Sarah. They both said he had not hit Sarah but he had frightened her and made her cry. At one point, he had briefly left the family, returning for Jason's sake.

- **Sum up the wants of each person and identify which are acknowledged.**

Given these data, the worker was able to establish that Mrs K wanted to be less depressed and more able to deal with the debts (her two main *acknowledged wants*), and she felt that Mr K should help her more in the home instead of just shouting about things. Mr K wanted his wife to be honest over the debts and to be more firm in dealing with Sarah (two *attributed problems*), but he did acknowledge that he needed to watch his temper in order to avoid hitting anyone in the family. Both Mr and Mrs K, however, expressed feelings of hopelessness about the future in that debt, unemployment and health problems were seriously frustrating and heightening the risk of abuse and family break-up. This led to a vague acknowledgement that they needed some help or guidance of some sort. At this stage of the assessment, they could be said to have a mixture of attributed and acknowledged problems, some vague goals and many constraints. The social worker next showed them a problem scale and, talking them through it, asked them to enter their problems and use ticks to show how serious they considered the

Problem type(s)	*Nil*	*Low*	*Some*	*A lot*	*Serious*
Interpersonal:				X	
Aggressive arguments					
Social relations:					X
Few friends					
Formal organizations:		X			
Courts					
Roles:				X	
Budgeting					
Decisions:	X				
Emotional distress:			X		
Feeling depressed					
Resources:			X		
Debts. No job					
Others: *Drinking*		X			
Backache				X	

Figure 8.3 Completed problem sheet

issues to be. With some encouragement and advice, they produced the sheet shown in Figure 8.3.

This exercise helped to set out the situation in a non-blaming way so that, for example, Mr K was able to accept that drinking was at least a minor problem. The completion of the scale led to some discussion on the *interconnectedness* of the problems. Did the fighting make the depression worse? Did this affect their ability to tackle the debts better? Did the drinking make the rows and the debts worse, or were they causing it? Where would the most effective starting point be? At this point, they were not ready yet to face up to the problems of their relationship, their inability to talk things out or their lack of social life. They were, however, clearer that something needed to be done, and they were willing to have the worker see them again to plan some action together.

Before leaving, the worker left two copies of the Want Sheet with them and suggested the *task* of completing their sheets separately and privately, then sharing them for discussion one evening when the children were in bed. A second visit was arranged for a week later.

As she departed, the worker began to consider what obstacles might be blocking this couple from satisfactory functioning:

THINKING POINT

Pause here and consider what obstacles might be maintaining the problems of Mr and Mrs K.

Obstacles to problem-solving

1. *Beliefs.* As she had listened to their accounts, she had a sense that they believed they were each being blamed by the other, that they were caught forever in growing debt and that they had lost any real hope of financial coping or of happiness. Mr K seemed to think that his back was permanently damaged, but he had not continued with medical checkups. The social worker could gently discuss and question these beliefs with the family.

2. *Emotions.* The belief in the loss of prospects could explain the depression. Mrs K was also isolated in that there was little communication with Mr K, so she might have been feeling unloved and alone. This depression and sense of isolation could be addressed by examining the underlying beliefs.

3. *The social system.* Reduced welfare benefits and a shortage of employment were affecting the family, as was the lack of nursery school places in the area. It may be possible to act as advocate concerning these issues.

4. *Attempted solutions.* How had they gone about the debt issue? Was Mr K's drinking an attempted solution? There was no evidence of utopian thinking in the session. It would be useful to check what efforts, if any, Mr K had made to respond to his wife's depression. Attempts like 'Cheer up!' tend to make the other person feel worse. These questions could be explored at the next meeting, and tasks could be negotiated to help counter any such attempted solutions.

In the next session, the social worker planned to use these questions to obtain a more in-depth assessment of their situation and review the task with them. By the end of the second meeting, they were clearly saying they wanted help in improving their relationship in terms of talking with each other and their children. Using incremental steps, Mr K decided he would visit his doctor about his back and both parents would attend debt counselling. Additionally, they agreed to spend 15 minutes talking, at least two nights a week, without the television on and when the children were in bed. This constitutes three simple tasks that would be monitored over four more sessions with the social worker, who by now was well placed to write a report on this family and the likely prospects of their being able to care safely for their children. The review element of the task-centred approach would provide further assessment should the tasks not be done or should they fail to bring about the service users' desired changes.

Critical comment

Reid (1978) suggests that this approach is suitable for any specific, acknowledged psychosocial problem that is capable, with some help, of resolution by the service user's own action. It can serve 'as a basic approach for the majority of clients served by social workers' (p. 98). Used in full, as the sole method, its range is narrower than if it is used along with other approaches. For example, as well as engaging in tasks, victims of trauma and people in grief may need to talk at length to an understanding listener who can facilitate their self-expression. Given some creativity in developing appropriate tasks, this approach is suitable, therefore, for most potential service users who are capable of rational discussion, perhaps with the exception of those with existential problems, seeking for meaning and identity. These need time for a lengthy, 'searching and free-ranging self examination' (ibid., p. 99).

Various texts criticizing the relevance of Eurocentric approaches to social work with black service users and their families (see, for example, Logan *et al.*, 1990; Devore and Schlesinger, 1991) find task-centred approaches less problematic than those in the maps described earlier. Logan *et al.* (1990) maintain that this is because the task-centred approach acknowledges the person–environment interaction and the place or impact of the social system on the personal. It also respects the beliefs, values and perceptions of the service users and listens to their definitions of their problems and their concerns. In this approach, the problem is always the *problem as defined by the service user.*

This approach also encourages service users to select the problem they want to work on and engages them in task selection and review. Logan *et al.* (1990) found that minority ethnic groups preferred this level of personal responsibility as well as the action orientation of the task-centred approach. They add, however, that white workers need to concentrate on keeping a *strength focus*, assuming the existence of community and cultural strengths and seeking to locate them. The task review is clearly vital for checking cultural appropriateness and whether different world views are being overlooked. Issues such as language differences also need to be addressed. Staying with specifics reassures members of some minority ethnic groups who may feel threatened when a lack of specificity by social workers suggests that they are attempting to take over the person's whole life. Last, it clearly helps to develop service users' confidence in social workers if the latter show themselves willing to carry out their share of tasks, especially if they show themselves to be assertive brokers of services, actively helping to remove environmental barriers, locating information and conferring with other agencies and with those the service user considers relevant, such as community leaders and also helping with resources. And, just as they review the efforts of the service user, social workers ought to review their own performance of tasks, what they have and have not done, and the reasons why. This accountability is assisted by the clear data display developed in the assessment process. In this way, the approach can be seen to be truly collaborative, empowering and taking into account the social dimension.

PRACTICE STUDY: THEORY INTO PRACTICE

Mick is a 50-year-old kitchen fitter employed by his local council. He has been off work with depression since being disciplined for racially abusing a colleague. His GP considers him fit for work, but Mick stormed out of the consulting room when he was refused a sick note and verbally abused surgery staff. He later attempted to hang himself but is now recovering well in hospital. At initial interview, he tells you that he doesn't want to go back to either his home or his job as he only gets harassment at both places; he lives with his elderly mother in a terraced house in an area where most residents are recent immigrants and he is 'bothered' by gangs of youths. At work, he is on the receiving end of taunts about being a single man, with the implication that he's gay.

- **What tasks might you expect Mick to undertake, and which would be your responsibility?**

It will be clear that, because this approach prefers to assess *during* intervention rather than before it, time and care must still be spent in carrying out a useful assessment. However, because tasks will have been tried out, much more realistic practical information will be available than if the assessment and intervention processes were carried out separately. In a period of three weeks or so, a considerable number of trials/experimental tasks can be completed, provided these are started at the end of the first meeting without waiting to plan the perfect action. In this way, service users have an opportunity to demonstrate their capacities as well as their needs and, together with the worker, gain a useful understanding of what is maintaining the problematic situation and what might be a helpful way of dealing with it. It is also our experience that this collaborative style, with its focus on actions rather than feelings, sets the scene for the mutual bridging of difference gaps in an unthreatening way. The tasks are set to attack the problem and they, and not the person as such, are the focus.

In our view, there are few disadvantages to this approach if it is used rigorously, although its capacity for empowerment perhaps needs to be more explicit. In the case example of the K family, the children are not directly empowered or involved; children should be heard and their views taken into account. Some social workers, believing the approach to be value-free and intrinsically non-oppressive, take this as read and make no further efforts to address issues of empowerment and anti-oppressive practice. The coaching role of the worker could be open to abuse, perhaps encouraging an overworked social worker to be overly directive. Like all other approaches, it needs to be accompanied by the values of anti-oppressive practice set out in Chapter 2. Additionally, the emphasis on simple tasks may give rise to concrete solutions that can obscure the advocacy role mentioned earlier.

Although, in theory, the approach should be ideal for group and community work, there are few examples of this happening. It may be that, like the approaches already discussed, it lends itself most easily to individual and family problems.

Outcomes

After years of research, Reid and Epstein (1972) published several results showing a high degree of progress within limited timescales; for example, in a study of social work with children in their last year at school, 80 per cent of the children reported that their overall situation had changed for the better, with 20 per cent reporting no change. However, when independent assessors studied the files, they reported evidence of improvement in only 21 per cent of cases, although in the opinion of other people involved with the children ('collaterals'), there was improvement in 60 per cent of the cases. Reid and Epstein provide examples of work with families, where 72 per cent reported improvement in the main problem and 56 per cent said the problem was either better or no longer present; 45 per cent felt a lot better.

Since then, there have been many evaluation studies of varying degrees of rigour (for a fuller discussion, see Fortune and Reid, 2011). These studies show that there is reasonable support for the effectiveness of the task-centred approach in alleviating problems of living and modest evidence of wider effects, such as improved coping. The longer-term impact of the approach requires further study, there being only four studies that followed people up for longer periods. These found that whilst improvement persisted there were no changes in social problems, such as practical problems with employment and housing. Thus, we might expect the K family discussed earlier to be coping better with their difficulties but probably still impoverished.



Summary

- Task-centred work involves a six-stage process, in which problems are viewed as temporary breakdowns in coping with unmet wants.
- It sees the 'causes' of problems as those *obstacles* that prevent resolution (that is, in the four obstacles that maintain problems, namely beliefs, emotions, attempted solutions and the social system).
- It offers a unique problem classification and problem clarification process.
- Goals are reached by taking action, by performing tasks, and coaching in task selection and task preparation is central to the helping process.

- Time limits and task reviews aid motivation and promote optimism and empowerment.
- A sound assessment is best made after task analysis and task experimentation. The more time there is for this, the better.



Further learning activities

- Discuss the various ways in which the task-centred approach differs from cognitive-behavioural approaches.
- Using the case of Dean mentioned earlier in this chapter, what difference would this make to how you might approach the assessment?



Further reading

Doel, M. and Marsh, P. (1992) *Task-Centred Social Work*. Aldershot: Ashgate.

Fortune, A. and Reid, W.J. (2011) 'Task centered social work'. In F. J. Turner (ed.), *Social Work Treatment*, 5th edition. New York: Oxford University Press.

Marsh, P. and Doel, M. (2005) *The Task Centred Book (Social Work Skills)*. Abingdon: Routledge.

Reid, W. J. (1978) *The Task-Centred System*. New York: Columbia University Press.

9 AN EXPLORER MAP: STRENGTHS-BASED APPROACHES

What this chapter is about

This chapter presents theoretical maps which belong to the third wave of social work theory. The knowledge bases in previous map chapters were about pathology and the nature of problems. The knowledge bases in this chapter are about solutions and the nature of human resilience, creativity and growth. Thus, strengths-based and constructivist approaches are more interested in service users' futures than their pasts, in potential rather than pathology. Through the exploration of unused or underdeveloped strengths and resources, service users are helped to develop alternative stories of their lives, focusing on possibilities rather than failures.

Main points

- Wider theoretical issues: resilience, effectiveness, social constructionism, philosophical assumptions.
- Implications of strengths-based practice for assessments.
- Practice techniques: possibility questions, goal setting, externalizing the problem, tasks and feedback.
- Meeting agency requirements and service user needs.
- Critical comments.
- Outcomes.
- Summary.

Wider theoretical perspectives

The central characteristic of strengths-based approaches is optimism about people's willingness and ability to change their lives for the better, a belief that they prefer to be responsible, recognized and respected members of society (Saleebey, 2013a, 2013b, p. 13). In order to prevent creating dependency

and despondency, the work is more effective where it is brief (Walsh, 2010) and focuses on what Kristhardt (2013) calls social outcomes rather than social services. This means that needs are viewed not from the providers' perspectives but from those of the service users, respecting their knowledge about their needs and possible solutions. This does not mean that anything goes; rather, it is about assessing service users for their skills, abilities and resources and assisting them in making responsible decisions and choices. Thus, the theoretical underpinning of strengths-based approaches is the social constructionism that has been identified by Burr (2003) as a critical stance towards taken-for-granted 'scientific' knowledge on the grounds that social 'facts' change over time and in different cultural contexts. These knowledges may be helpful to some groups of people but positively oppressive to other groups. Thus, it embraces one-half of the evidence-based practice development, effectiveness, remaining cautious about the evidence-based practice which makes generalizations about the nature of people. It is deeply sceptical about the ability of the grand modernist theories and explanations to deliver truth; holding to a plurality of truths, including those contained in the 'local' theories of service users. Therefore, it avoids any form of diagnostic labelling and sees professional categorization of people as dis-empowering. For example, the Finnish psychiatrists Furman and Ahola (1992) reframe depression as *latent joy* and borderline personality disorder as a *search for a new direction in life*. When working with children, the narrative therapists Marsten and Epston (2017) replace psychiatric labels with local and whimsical descriptions.

THINKING POINT

List three advantages and three disadvantages for a 7-year-old boy and his family of being diagnosed as on the autistic spectrum.

Resilience model

In the strengths-based approach, resilience is defined as the ability to adapt successfully in the face of adversity (Anderson, 2013). Resilience is a capacity that we all have and can be tapped into to make a positive and powerful contribution to the lives of service users: 'all individuals, regardless of how debilitated or hopeless can dig deep enough to find and summons strengths in themselves that they may never have tapped before or thought existed' (Bernard and Truebridge, 2013, p. 205). For example, Victor Frankl (1984) wrote of his time in a concentration camp and of experiences such as being half-starved, hardly able to stand up and on a forced march in the snow. Men were falling, being beaten and left to die, yet in spite of such hardship he was able to find the determination to continue by picturing life after the war, sitting under a tree enjoying jokes and ideas with students on a warm day, and telling them how their image helped him to survive. He wrote that no

matter what one's hardships or losses, no one can take away one's freedom to choose one's attitude or one's own way.

The emphasis in this model is on the skills and characteristics that make some people more resilient than others (Reivich and Shatte, 2003; Selekman, 2002, 2007). Some people cope with setbacks very well, whether they are small ones, such as not being picked for the football team, or big ones, such as living in a home where there is domestic violence. Their resilience helps them pick themselves up and get on with life. A growing body of research and practice shows that most people overcome serious adversity; particularly demanding and stressful experiences do not lead inevitably to vulnerability, failure to adapt and psychopathology (for an overview, see Saleebey, 2013a, 2013b). Others don't cope as well; they get stuck, see life as very unfair, and sometimes become depressed or begin harming themselves or others. The difference between these two groups of people is not the severity of their problems; it is the ability to get a good outcome in the face of adversity. Even where children are living in poverty, where their parents are resilient, so are the children. Research on resilience has argued for a shift in our attention from the traditional focus on an individual's deficits to engaging individuals in the identification of strengths within times of difficulties (see, for example, Luthar *et al.*, 2000; Edwards and Pedrotti, 2004). Saleebey (2013a, 2013b) maintains that all environments, however bleak, have resources that can be used to develop resilience skills.

Having a sense of humour is probably the most important resilience skill but as it can't be learned, learnable resilience skills form the focus of resilience approaches. These include the following:

- Emotional awareness – the ability to identify what you are feeling and, when necessary, the ability to control your feelings.
- Impulse control – the ability to tolerate ambiguity so that you don't rush to make decisions but instead look at things thoughtfully.
- Optimism that is wedded to reality in that you don't simply look on the bright side all the time. Instead, an optimistic explanatory style helps you think about adverse experiences in a constructive way (i.e. it's a temporary setback).
- Possess the ability to look at problems from many perspectives.
- The ability to read and understand emotions is a social competence that provides social support. Resilient people don't necessarily go it alone; they know when to ask for help and where to go for that help.
- Self-efficacy. Confidence in your own ability to solve problems, knowing your strengths and weaknesses, and relying on the former to cope.
- Reaching out, being prepared to take appropriate risk, is also a characteristic of resilience. This means having a willingness to try things and considering failure as a part of life.

Although most people have a self-righting tendency, this tendency needs to be supported by internal and external factors as resilience is dependent on the interaction of factors at all levels of life:

- *Having a support network of family, friends and teachers* is an important component of resilience: 'many of life's major resiliences are acquired in the context of close relationships, particularly parent–child and peer relationships' (Howe, 2008, p. 107; see also Brown and Ward, 2012, p. 22).

Although resilience is learned mostly in a family environment that is low in criticism and high in praise, somewhat surprisingly, children lacking these basics develop resilience where they have support in at least one aspect of a possible network. Gilligan (2002, 2007) comments that only one committed adult and/or a good school experience is a source of resilience for children. Equally, friends are very important for people who have little support at home or work.

- *Confidence that they can face new and challenging situations.* This confidence develops from previous successes that remind people of how they have overcome adversity in the past.
- *Having a sense of purpose and future.* Having ambitions, goals, a desire for achievement and motivation helps people believe that things will be better in the future.
- *Socially competent people* who are friendly and have a sense of humour also have resilience because they are active and adaptable as well as having supportive friends.
- *Problem-solving skills* are also a key characteristic as then the person can reflect on problems, using flexibility and willingness to attempt alternative solutions.
- *Autonomy.* Resilient people have a sense of their own identity and an ability to exert some control over their own environment. Interestingly, some children in dysfunctional families separate themselves psychologically from their families and this resilience is a safeguarding factor.
- *Attitudes* are also important as people who can stay involved rather than withdrawing are more likely to be able to keep trying to influence events rather than give up. They also learn that stress is a challenge to be faced rather than bemoan their fate. This involves seeing themselves accurately so that they can distinguish between problems that are their own fault, take responsibility to try to correct the behaviour, and still feel worthwhile when problems are not their fault (Selekman, 2007). These characteristics are not static; resilience is a process in which 'capacities, knowledge, insight and virtues [are] derived through meeting the demands and challenges of one's world, however chastening' (Saleebey,

2013a, 2013b, p. 15). The characteristics of resilience add up to what has been called social capital: 'Social relationships and a sense of emotional connectedness with others appear to bring great social benefits' (Howe, 2008, p. 178). Lack of connectedness, or membership in Saleebey's terms (2013a, 2013b, p. 13), results in people feeling alienated, facing marginalization and oppression on a daily basis. But this does not mean that they do not have strengths which can be utilized. Increasing a person's resources to cope with negative events builds resilience (Shastri, 2013).

PRACTICE EXAMPLE

Thelma has recently left her husband after years of physical and emotional abuse but is now facing a number of legal battles over her divorce, contact with her daughter, and compensation for her husband selling her house and furniture behind her back. She is also struggling with the fact that he is pleading with her to take him back (she still has some feelings for him) and the financial pressures of living in a rented house she can't afford. She says that she can see no future for herself now that she is getting older and feels like giving up.

When asked how she keeps going even though she feels like giving up, Thelma says she still takes care of her appearance, walks the dog each day, and helps relatives. Although she can see no joy at the moment, she can remember times when she was joyful. She keeps going because she has hope and reminds herself of this by having red roses in the house.

Narrative model

The approach is more overtly political, cultural and social than other strengths approaches in that it is concerned about the oppressive effects of dominant narratives on people's understanding of the validity of their ways of living (White, 1993, 1995a, 1996; White and Epston, 1990; and Epston, 1998; Payne, 2006a, 2006b; Baldwin, 2013). White (1995a) argues that there isn't a single story of life which is free of ambiguity and contradiction and that can handle all the contingencies of life. These ambiguities, contradictions and contingencies stretch our meaning-making resources, especially when there are dominant cultural stories about particular sorts of behaviour. These stories tend to concentrate on identifying the behaviours seen as desirable by the most powerful groups of people; thus, people whose behaviour does not conform to this become storied as deficient in some way. White refers to this as being entered into a story, a story which people come to

believe about themselves and one which the professional may unconsciously perpetuate:

> Labels always bespeak the reality of an outsider, they collectivize and abstract real experience, and make the client's own experience and stories seem alien and contrived. We must use labels judiciously if at all with a profound respect for their distortions and limitations. (Saleebey, 2013b, p. 269)

In narrative assessments, the problem is first deconstructed. This takes the form of searching for *unique outcomes* or *sparkling moments* (Bird, 2000) – times when a person actively resisted the influence of the problem, a contradiction to the dominant story, or *plot* in Epston's terms (1998, p. 11). Deconstructing the problem is done by reflecting with people how they came to be recruited into a *problem-saturated story* in which they are often vilified (Augusta-Scott, 2007). This includes discussing that story in a way that separates the problem from the person, developing a sense of alienation between the person and the problem. This *externalizing* conversation is helped by asking questions that establish the influence of the problem on the person, and their influence on it. This can be seen as discussing the person's relationship *with* the problem. Separating the person from the problem enables the service user and the professional to work together to remove the problem. Narrative approaches to work with children encourage playfulness, enlisting young people's imagination to discover their values and preferred visions for their lives (Marsten and Epston, 2016; Vetere and Dowling, 2016). Narrative approaches have also been linked with the neuro-scientific knowledge to improve an understanding of emotional expression (Zimmerman, 2017).

White (1996) states very clearly that while the alternative narrative offered may be seen as part of radical constructionism, he does not accept that anything goes simply by giving it a new name. Because narrative is constitutive of people's lives, shaping and structuring them, we must be accountable to those we seek or assess or help. Not all stories are equally good in their effects. Payne (2006a, 2006b) discusses the implications for workers of deconstructing their own stories. While he acknowledges that racism and patriarchy are cultural beliefs rejected by most of us, he reminds us of the need for constant vigilance against the more subtle manifestations of these stories (for example, the way sexism may be demonstrated through verbal tone and the dominance of conversations). Jenkins (1990) refers to this as the danger of acting from a position of self-righteousness and moral superiority. In narrative assessments, therefore, critical self-monitoring and regular checking out with other people are essential.

PRACTICE EXAMPLE

Although Geoff feels that he is not likely to harm a child after having counselling for his childhood experiences of physical abuse, has successfully completed an anger management course, and stopped using cocaine, he tells his social worker that his previous counsellor had told him that it would take a long time for him to come to terms with the pain of his previous experiences of physical abuse. He is, however, being assessed for his dangerousness towards his partner (he has hit her several times) and his child (as a teenager, he sexually abused his sister). This psychological story is unhelpful in that it provides him with an excuse for his behaviour and also maintains him as a victim of circumstances, thus limiting his ability and willingness to take responsibility for his behaviour.

Solution-focused model

Constructionist writers such as Baudrillard (1983) and Rorty (1979) and others challenged structuralism and the positivist link between theory and practice, especially in psycho-social thinking, while Wittgenstein (1963) argued for an understanding of language that sees it as central to understanding the nature of truth. For him, truth is the product of language, not 'reality'. Constructionism is sceptical about the 'iceberg approach' of the structuralists (looking beneath the surface, seeking the answer to 'why'.) Burr (1995) writes that we need to question the 'taken-for-granted' ways of understanding the world and to problematize the 'obvious' and the 'real'. She sees knowledge as created between people and the talking that happens when they communicate. We make and remake our 'worlds' by talking.

Learning exercise

1. Re-read the sections on 'the trouble with certainty' and 'finding the truth' in Chapter 4.
2. Choose a service user with whom you are working and rethink any 'certainties' that have crept into the assessment – whether by you or other professionals. Are there other ways of describing the service user's situation?

At its simplest, its practitioners hold an unwavering belief in the capacity of service users to discover their own, workable solutions to their problems. Examining in great detail 'what worked', de Shazer's mental health team perfected a set of economical techniques that form the foundation of the

approach (de Shazer *et al.*, 1986; de Shazer, 1988, 1991, 1994). Many of the techniques will be familiar to social workers adopting different approaches but solution-focused workers use them to explore service users' futures, not to understand past events.

Rather, it takes a not-knowing stance towards people's problems, preferring to remain curious about people's stories and views, about their strengths and potential, about occasions when the problem was less, and about how that happened – curious about the seeds of solution. Rather than seeking to understand (based on some grand theory), it seeks merely more helpful 'misunderstandings'. There is a preoccupation with difference, with what was different when things were better and what needs to be different for them to be better again. It utilizes each problem-free aspect of the person and engages in problem-free talk, engaging the person, rather than the problem. Indeed, it sees the problem as outside the person, or perhaps, as Thompson (2006) says, the person is *in* the problem. The person is not the problem, the *problem* is the problem. The social worker joins the person *against* the problem and thereby gets a different story. Therefore, this approach seeks not to be pathology-based and thus its assessments are not based on identifying deficits. This is particularly so in the assessment of dangerousness, solution-focused workers finding it easier to assess safety, which is measurable, rather than risk, which resists quantification; in other words, it is easier to assess the presence or start of something, safety, than it is to assess the absence or cessation of something, risk. Where it is not possible to identify safety, there is dangerousness and the need for protection.

This solution-focused approach seeks to find the seeds of solution in a service user's current repertoire, seeking those occasions or *exceptions*, however small or rare, when the problem is less acute in order to identify when and how that person is doing or thinking something different that alleviates the problem. This involves listening carefully to, and then utilizing, what the person brings to the encounter, focusing on problem-free moments, constructing an envisaged future when the problem is no longer there, and getting a very detailed description from the service user of what will be different then and whether any of that is already beginning to happen. Troubles are seen as social constructions; they are talked into existence by service users and professionals and they can be talked out of existence when they are described in new ways (Miller, 1997). It is talking, the particular use of language, that constructs lives. Central to this constructionist practice is asking service users to imagine what their lives **will** be like **when** their troubles have ended, and what they will be doing differently, interacting with others in their everyday living, where 'thinking makes it so', for language develops our perceptions and makes change happen. Thinking about life does not merely describe it but creates it. Troubles are seen as social constructions; they are talked into existence and they can be talked out of existence when they are

described in new ways (Miller, 1997). Constructive talking can reconstruct lives; even where a person has a chronic and debilitating illness, how it is talked about can make a difference to how it is experienced (Burns, 2016). Constructionists have moved from a structurally fixed world of ideas into a socially constructed one where solution-focused practices and philosophy about troubles have opened new ways of thinking and responding. Words **do** things, so we will be discussing some very specific words, questions and conversations. This philosophy is set out more fully in Parton and O'Byrne (2000) and Milner and O'Byrne (2002a).

THEORY INTO PRACTICE

Helen's aftercare worker put a lot of effort into preparing her for independent living after many years in a children's home but found, two years on, that Helen was depressed, tearful, unable to leave her flat unaccompanied, spending most of the day watching television or telephoning her worker and relatives with long tales of her misery, developing an eating disorder, and on poor terms with her natural father and brother, and making heavy demands on the worker's time. Intensive psychodynamic-based work on helping Helen to come to terms with the effects of her abusive past on her current functioning and behaviourally based work on her fears of going out alone failed to effect any improvement. Taking a solution-focused approach, the worker discovered that Helen was free from sad and intrusive thoughts when she watched television programmes about the archaeology of Roman Britain. Helen became animated when discussing her one interest and talked about her preferred future as an archaeologist. Rather than dismissing this as utopian thinking, the social worker built on this exception. Helen began to read books about Roman history and then had to get on better terms with her father and brother as she wanted a lift to visit local museums to further her interest. She bought a book on Roman cookery during one such visit and tried out some of the recipes at home, thus developing a solution to her eating problems. Her 'depression' lifted considerably and three months later she had applied for, and been accepted on, a distance-learning module of a university degree in Roman archaeology; applied for a grant to pay for her studies; approached a charity for assistance with buying a computer; and paid off her debts so that she could change her telephone system to enable her to access the internet for her studies. In order to complete her module, she will have to attend a residential study weekend at a Roman site, so she will soon have to find her solution to her inability to leave the flat alone. Her aftercare worker is feeling better too as the work has become much more interesting for her.

Although distinct in how interventions are devised, the models share many similarities, particularly how existing strengths can be utilized and developed to facilitate change through collaborative relationships. All three models emphasize the crippling effects of labelling which may hide people's capacities; thus, it is important that an assessment starts from an assumption that social workers do not know the upper limits of a person's capacity to grow and change. This means that service user aspirations should be taken seriously; even where they seem unrealistic, they provide a useful starting point for the assessment process. The techniques of each model are described differently but here, again, there are similarities; for example, the *sparkling moments/unique outcomes* of the Narrative model are not dissimilar to the *exception finding* in the Solution-Focused model and the *strengths finding questions* of the Resilience model. All the models use challenge delicately, respectfully and supportively. In applying these models to assessment processes, risk is not ignored but as it is difficult to quantify, strengths are assessed for their potential to develop measurable protective factors so that safety can be assessed.

Assumptions

Myers (2007a, 2007b) provides the following list of key assumptions as an aid to practice.

Assumptions about problems

- The problem is the problem; the service user is not the problem
- Problems do not necessarily indicate a personal deficit.
- Problems happen in interactions between people rather than inside them.
- Problems are not always present; exceptions occur.
- Complicated problems do not always require a complicated solution.

Assumptions about the past

- Events just happen: exploring the past leads to blame whereas the goal is to develop responsibility for the future.
- Exploring a problem-free future avoids having to dwell on or understand the past.
- A diagnosis does not have to determine the future.

Assumptions about change

- Change always happens; nothing stays the same.
- What may appear to be small changes can be hugely significant.
- Change can be constructed through talk.

Assumptions about talking

- Hearing what the service user has to say is important.
- Take a not-knowing stance that reduces premature and imposed worker judgement.
- Stay on the surface of conversations rather than looking beneath; any search for meaning is likely to be the worker's interpretation.
- People experience and make sense of their world in different ways; their reality may not be yours.

Assumptions about solutions

- Identify what is going right rather than what is going wrong.
- Service users have the solutions to the problems; assist them in finding these.
- Solutions generated by the service user are more likely to be meaningful, achievable and successful.
- Imposing what works for others does not always work for the individual; seek what works for them.
- Increasing service user choices will enable behaviour change.
- Goals need to be meaningful for the service user in order to be successful, but they also need to be legal and moral.

Implications of strengths-based approaches for assessment

Taking a strengths-based approach to social work means everything you do is predicated on helping discover and develop people's strengths and resources to help them achieve their goals, realize their dreams, and become independent of welfare services so that they and their families have better futures. Although the strengths-based practitioner is not particularly interested in pathology, victimization, etc., service users' painful experiences and current struggles are not ignored; it is perfectly possible to have one foot in acknowledgement and one foot in future hopes. This means that tick box questions focusing on entitlement to a particular service, while useful to the agency perhaps, are not appropriate or considered useful in using these models – unless that is the service user's expressed choice. Neither are questions predicated on professional knowledges appropriate as these narrow the conversation. For example, questions based on theories of domestic violence predicated on the abuse of male power effectively silence men and women for whom their reality is more complex (Milner, 2004). Rather, questions are exploratory with a subsequent question not being formulated until the answer to the first question has been heard. In this way, the worker is never

ahead of the service user and not in danger of closing the conversation down. The worker's questions express a genuine curiosity about how the service user has achieved past successes leading to a formulation for solutions.

Government guidance on assessment frequently advocates a strengths dimension; for example, the document *Working Together* says 'High quality assessments … build on strengths as well as identifying difficulties' (2013, 1:32). But there is much more to discovering strengths than simply asking a person about them and then listing them. A list of strengths in no way corresponds to a list of difficulties; and strengths, in themselves, mean little. Certainly, they do not equate to safety in situations where a family member is vulnerable to harm (Kelly, 1996). It is how they can be used to build solutions and safety that is central to a strengths-based assessment. Look again at the questions Thelma was asked. Having listened to the problem and the feeling of 'having no future', rather than lingering unduly on how bad things are for her, the social worker asks about what is not so bad – what seed of a solution might be present. Notice how it brings out a very different person with different possibilities for the future.

In partnership, both the service user and the social worker build a picture of a possible future without the problem or with the problem lessened. Talk (language) is seen as powerful enough to construct life; talk of life with the problem constructs a problem-laden life; talk of life without the problem constructs a problem-free life. Talking in detail of what will be happening, what people will be saying, what effect this will have on relationships, and so on, provides the experience of a glimpse of that life; that life then becomes a possibility and the person experiences a sense of personal agency in setting out to construct it. The new story can even include a changed or different self, especially an accountable self. Ferguson (2003, 2004) refers to this as creative reflexivity in which service users have new opportunities to shape their lives. Assessments that fix people's identities, conflating the person and the problem, are avoided as new possibilities become visible. From this assessment process, messages and tasks emerge for the service user to consider between sessions.

The Department for Health (2017a, pp. 12/13) report on a roundtable discussion about strengths-based practice with adults, led by the Chief Social Worker for Adults, identified the key features of such an approach. It:

- is rights-based and person-centred;
- has a clear ethical and values-based position;
- works in a place-based way;
- recognizes the limits of institutional work and takes an interdisciplinary, holistic view, seeing people as resourceful and resilient in the face of adversity;
- acknowledges that people are a lot more than their care needs, are experts in their own lives and take the lead in their own care;
- acknowledges that notions of community are subjective – for some, family; others, online or local neighbourhood;

- reframes the narrative and tells the 'good' stories about what people have done, what they do every day and what they have achieved – '*we are all amazing people*';
- draws upon a person's resources, abilities, skills and connects with their social networks and communities – whether actual or digital;
- uses explicit methods to identify strengths and assets – both soft assets (personal interests, skills, relationships) and hard assets (finances, housing, health) are goal-orientated and outcomes-focused;
- is collaborative and based on reflective conversation, encouraging the person to make sense of where they are and making meaningful choices;
- is respectful – does not make assumptions, is non-judgemental, and is hope-inducing!

The report explicitly endorses this approach and provides a range of practice examples, many of which have appeared in the several editions of this book. We welcome the report as a recognition of the mainstreaming of strengths-based practices.

This approach thus has a view of assessment different from most others. Rather than assuming that information about a problem will help to find its solution, the assumption is that we can understand a solution without necessarily knowing a great deal about the problem. Searching for an understanding of a problem usually leads to a laundry list of deficits or negatives, whereas this approach says that what is needed is a list of positive strengths and *exceptions* to the problem. Lists of deficits often risk overwhelming both the service user and the social worker, engendering hopelessness and a tendency on the part of the social worker to use such expressions as 'unmotivated', 'resistant' or 'not ready to change'. In strengths-based assessments, 'resistance' is regarded as an inability on the part of the worker to recognise the service user's 'unique way of cooperating' and an indication that more careful listening needs to happen. For example, Iveson (1990) says that when people repeatedly shout about their complaints or complain in other ways we find difficult to hear, they are invariably people who are not being heard. To hear them, we must accept their language as rational and meaningful, even when it appears irrational, unreasonable or perverse.

Repeated complaints are especially likely to happen in child protection assessments when neither parents nor social workers feel they are listened to:

> Parents stuck in protracted disputes tend to repeatedly tell the same story in the same particular way. This is unproductive and unsatisfying as it makes the parents feel a sense of disputation and powerless. It is important to listen to the parents' story in a way that does not feed the frustration of the denial dispute. (Turnell and Essex, 2006, p. 55)

Saleebey suggests that the frequent talk about manipulative and resistant service users in agencies may well stem from social workers' attempts to prevent being fooled or lied to by cunning service users so:

> ... we must consider the possibility that avoiding the truth may be a function of the manner in which the professional pursues and/or asserts the truth. The professional's knowledge, information, and perspective are privileged and carry institutional and legal weight. The client's do not. (2013a, 2013b, p. 17)

Practice techniques

The main technique in undertaking a strengths-based assessment is the formulation of appropriate questions. The best-known solution-focused question is the *miracle question* which is helpful in developing goals with people who are not sure what their goals are or who find it difficult to believe in a better future:

> Suppose tonight, while you are asleep, a miracle happened and the problems you have today are gone in a flash, but because you were asleep you don't know this has happened. What would be the first difference you would notice in the morning?

This is followed by gentle prompts about new behaviours, new attitudes and new relationships, followed by 'Is any little bit of this happening already, sometimes?' So the miracle question helps to get a picture of the future without the problem, and the follow-up searches out small exceptions to the problem. When these are found, the key question then is 'How did you do that?' This is not only a compliment but it presupposes personal agency and builds up possibilities of repeating what they are able to do at least once. With some small exceptions, a minimum of motivation and a little imagination, when we use constructive questions the possibilities are boundless and the potential service user can get ready for change without analyzing the problem – they can 'describe what they want without having to concern themselves with the problem and without traditional assumptions that the solution has to be connected with understanding or eliminating the problem' (de Shazer, 1994, p. 273).

Although the miracle question is a key element of solution-focused practice in the USA, many UK practitioners find it too formulaic (Walsh, 2010). Brief (www.brieftherapy.org.uk) has found that asking a service user what their best hopes are works as well as the miracle question. Macdonald (2007, p. 14) provides a list of key questions for goal setting:

- What will it be like when the problem is solved?
- What will you be doing instead?

- When that happens, what difference will it make?
- How will others know that things are better?
- Who will notice first? And then who?
- What else will be different?
- What else?
- What else?

Scaled questions are used in a particular way in this approach. These questions can be directed at service users' estimations of the severity of their difficulty, at their level of confidence about reaching their goal or at their willingness to work hard to make progress. A scaled question is usually put like this: 'Suppose we had a scale of 0 to 10, with 0 being the "pits" and 10 being "there is no problem", where would you put yourself on that scale?' This scale is set up 'in such a way that all numbers are on the solution side' (de Shazer, 1994, p. 104), but it is impossible to be sure about what any number really means, even for the service user. They and we know that 5 is better than 4 and less good than 6, so answers provide a way of grading progress – or its lack – for both social worker and service user. But, more importantly, scaled questions and their answers help to make concrete what is not concrete, making it easy to describe what is hard to describe.

Numbers get their meaning from the scale to which they belong; they are content-free in so far as only the subject has any idea what they mean. But when we ask 'How will life be different when you move from 5 to 6?' and 'What will important people in your life notice that is different?', these future-orientated questions help the service user to begin constructing progressive change. Scaled questions also make it much easier for a service user to talk about behaviour which either embarrasses them or reminds them of failure and censure.

PRACTICE EXAMPLE

Fourteen-year-old Jade had been told at every school exclusion meeting that her aggressive behaviour was unacceptable, to which she reacted in a sullen manner, but she could describe her efforts to control her temper through scaling:

> **'I've only got to four or five (she had hoped to get to six during the summer holidays) and I'm worried it'll go down to one or two when I start back at school. But it's better than it was. I was minus five at middle school!'**

In discussions of a problem such as depression, scaled questions help us to get away from the idea that one is either depressed or not, as if depression had an on–off switch. Suppose a worker asked, 'So if 0 is how depressed you were when you asked for help and 10 is when you will be unaware of any depressing feelings, where are you now?', any reply above 0 would indicate that the depression was less bothersome now and that things are already moving towards the goal (de Shazer, 1994). Clearly, these questions have nothing to do with why the problem is happening. They are about goals, where people are positioned in their situations and what the service user is doing that is different when there is less of a problem or no problem. They are about 'putting difference to work' (de Shazer, 1991): the questions explore what is different when the problem is not happening.

A distinction can be made between problems and unhappy situations. Problems relate to patterns of behaviour, attitudes, beliefs and moods; unhappy situations relate to losses (for example, loss of work, of a person or of a resource) and to environmental events (for example, the weather). While there are solutions to problems, many unhappy situations have to be coped with. In their case, coping questions are important, such as 'How do you manage to get by?', 'Are there times when you can cope better?', 'What helps?'.

The many different sorts of useful assessment questions include the following:

Pre-session change questions

- Has anything different happened since you made the appointment/were referred for assistance?
- What has been going well in your life since you made the appointment/were referred for assistance?

Survival questions

- Given all the difficulties you have had, how have you managed to survive?
- What is the hardest thing you have ever done?
- Tell me about the times you can cope despite this feeling?
- How did you do it?
- What have you learned about yourself during these difficulties?
- [Having identified skills and capacities], can we use any of this in your current difficulties?

Support questions

- In times of difficulty, who or what has been helpful?[1]
- Who could help you do [the exception] more?

1 Some children name pets or invisible friends and families as sources of support in times of difficulty (for more information, see Milner and Bateman (2011).

- How did you find this person/people?
- What do you think it is about you that got them to respond to you?
- Do you think you can rely on them for help in your current difficulty? Have you met anyone who has had similar experiences in their life?
- Have you been able to help or support other people who have had similar experiences in their life? How have you done it?
- What have you done to them that may have been helpful for them?
- What have you said to them that may have been useful to them?
- In the future, when you feel that you have fully recovered, would you want to help other people who have had similar experiences in their life?
- What would you want to say to them?
- How would you want to help them?

Exception questions

- Tell me about the times you are not … ?
- Tell me about the times you are less … ?
- When you feel like that, and you don't do it, what do you do instead?
- How did you do that?
- What will it be like when [the exception] is happening more?
- Who will notice when [the exception] is happening more?

Possibility questions

- What are your best hopes?
- What sort of person do you want to be?
- What can you see yourself doing differently when you are that person?
- What will people notice differently about you when you are that person?[2]
- How might they respond differently to you?
- How do you think this will be helpful to you?
- How will you know that you don't need any help anymore?
- How will I know that you don't need any help anymore?

Esteem questions

- When things are going well in your life, what is different?

2 This is a useful question to ask in safeguarding situations to begin a discussion about how family and professional goals can come together.

- If 100 is the best person you could be, how many points would you give yourself today?
- On a scale of 1–10, how satisfied are you with that score?
- If you were a point higher, what would you be doing differently?
- What things have you done that have made you proud?
- What things have you done that made your family/friends proud?
- How did you do that?

Perspective questions

- What do you make of your current situation?
- What is your theory about this?
- How do you explain this to other people?
- What effect has [the problem] had on your family/friends/work?
- Does it suit you to have this problem in your life?
- How has [the problem] changed things for your family/friends/work?
- What effect do you have on the life of the problem?
- What would be helpful for you right now? Has the experience affected you in some way positively as a person?
- Has it perhaps made you in some way wiser, more compassionate or more spiritual as a person?
- Has someone else noticed such changes in you? What would they say if I asked them the same question?
- Have you felt that your experience has lead you to feel closer to other people or that it has become easier for you to understand other people?

Change questions

- Given a choice between life with the problem and life free of the problem, which do you choose?
- What are your ideas about how things in your life might change?
- What can you do to stop things getting worse?
- If 10 is you know what you want and what to do, and 1 is the opposite, where are you on this scale?
- Most problems have advantages as well as disadvantages. How can you keep the advantages at the same time as getting rid of the disadvantages?

(adapted from Saleebey, 2013a, 2013b & Furman, 2018)

Externalizing

This is a narrative model technique which is especially useful for situations where service users find it very difficult to talk about their difficulties. *Externalizing conversations* aim to separate the person from the problem. This is an effective way of identifying unique outcomes (White and Epston, 1990, p. 95). These unique outcomes include not only when the service user actively resisted the influence of the problem but also ways in which they subverted it, endured it or delayed its effects. In order to encourage a service user to have a different relationship with both the problem and the narrative that supports it, early on in the assessment, the problem is spoken of as an external enemy oppressing the person. This aids the non-pathologizing of the service user; it is the problem that is the problem. Externalizing conversations help the service user to stand back from the problem and recover a sense of self-agency as they separate themselves from their own subjugation and begin to resist the influences that recruited them or that invited the problem into their lives.

To aid separation of person and problem, it helps to give the problem a name as soon as possible, using the service user's own narrative metaphors. Often, the service user can suggest a richly descriptive name for the problem; for example, we have experienced 'temper' named as Total Upset, Fiery Red Bomb, Black Cloud and Raging Bull. Equally common is a more anonymous naming, such as 'It'. In naming the problem, service users then find it easier to describe the influence of the problem on their lives.

PRACTICE EXAMPLE

Zaffir was so crippled with anxiety following an unprovoked assault on the street that he was unable to go to school. The assessing social worker's initial name for the problem was thus 'anxious non-school attendance' or 'school phobia'. Zaffir talked at length about his anxieties about the possibility of a further assault but, once he had named these anxieties as *Sad Fear*, he was able to recognize the influence of *Sad Fear* on all aspects of his life. It was making him tearful, stopping him eating or keeping himself smart, and ruining his hopes of getting an education. He did not want to keep *Sad Fear* in his life, and the one unique outcome he could identify was when he had 'talked back' to a voice in his head that told him to be 'more scared'. Through this externalizing conversation, he was able to extend his unique outcomes by telling the voice to go away if it couldn't come up with something new to say or swear at it in Punjabi. Thus, there was no need to assess possible depths of anxiety or re-label him as suffering from post-traumatic stress disorder.

Externalizing conversations are particularly useful in the assessment of service users who hear voices. Instead of assessing for the possible presence of auditory hallucinations or delusions, the social worker interrogates 'voices' as unhelpful beliefs which can be resisted or subverted. White (1995a) suggests that it is helpful to question the purposes and motives of the 'voices':

- Are these voices *for* you having an opinion or are they *against* you?
- These voices throw you into confusion. Whose interests are best served by this confusion?
- What is it like for the voices to have to listen to your thoughts for a change?
- (And later), what is like for them to know that you are developing a disrespect and mistrust of them?

For a more comprehensive questionnaire on 'voices', see Romme and Escher (2000). Similarly, Jacob (2001, p. 70) provides a set of cartoons depicting 'Monster Bashing Methods' for thoughts and beliefs underpinning eating difficulties.

Tasks

Having listed concerns, agreed goals and discovered strengths and exceptions, the assessment process then moves to the next phase – what to do about the problem. The strengths-based practitioner is not prescriptive, but a set of tasks is devised to utilize the strengths identified. These are developed with the service user, who is invited to have a go or experiment with them and keep a track of any difference that is made. The invitation is a permissive one in that service users can change the task or do something else that occurs to them that might be more useful. Unlike cognitive-behavioural approaches, there is no expectation that the task will be done or have a specific effect; they are merely ways of enabling the service user to note changes that are beneficial (for fuller details, see Milner and O'Byrne, 2002a, 2002b). In many instances, service users report back that they had a 'better idea'.

Where a situation is vague, a *formula* (or standard) first session (F1) task is given, asking service users to list all those things that are happening in their life that they want to continue to happen. By listing what does *not* need to change, this exercise helps the clarification of appropriate goals. Sometimes, people are so overwhelmed by their problems that they say they want to change everything and, here, it is useful to ask them to 'take a step in a direction that will be good for them'. This helps them take a step towards taking responsibility for their futures and, thus, a step away from victimhood.

When a service user is unable to recall an exception, a *pretend* task is suggested; for example, pretending to be not depressed one half of the week and noticing what is different or what other people see is different. This helps to develop and identify possible exceptions that make a difference to the problem.

Where exceptions are spontaneous or the result of other people's efforts (that is, not deliberate on the service user's part or seen as outside their control), service users can be asked to *predict* when spontaneous exceptions are going to happen. For example, a service user who compulsively steals could be asked to predict days when the urge to steal will or will not come. It has been found that service users can improve their ability to predict this correctly with practice and, of course, when they can get a high proportion of predictions correct, the question is 'Are the exceptions really spontaneous, or do you have some control?'

Where there are clear exceptions, the person is asked how they did them and can they do more of them.

Feedback

Strengths-based practice recognizes the importance of constructing helpful feedback for people at the end of sessions in order to build solutions. De Jong and Berg (2002, p. 128) identify three main aims of feedback:

- To assist in the development of clear goals.
- To focus people on the exceptions that are related to the goals.
- To encourage people to notice what they and others may be doing to make the exceptions happen.

Verbal feedback is given at the end of each meeting; however, we find it useful to follow this up with written feedback so that the service user has a record of progress – or lack of it – on which to reflect. Written feedback is also important in terms of transparency and accountability; service users are concerned about what is written down about them. Strengths-based work lends itself to being entirely open with the service user as there is no hidden agenda behind the questioning of the workers; they are eliciting information from the person and seeking their meanings rather than analyzing it from a professional perspective. In this sense, it is relatively easy to explain to people how you work, emphasizing that they are the person who knows themselves the best, that everyone has the capacity to change and the strengths to achieve this, and that your role is to work with them to help deal with the problem. This contrasts with some other approaches where the worker is looking for hidden meanings and it can be difficult to explain the theory behind such interventions.

To help people identify their progress and how they did it, the written feedback is formatted in four sections: problem description, exceptions (what has been done), solutions (how it was done) and tasks/next steps. The example below shows how feedback is constructed in this way and uses the service user's own words. Feedback notes are not only for service users; they constitute an accurate agency record of each session. Some social workers find the use of the service user's words unprofessional but to re-author these words would be against the basic assumptions of the approach: honouring the service user's knowledge, accuracy, and transparency.

THEORY INTO PRACTICE

Session notes

Name: Denzil **Date:** 3rd January

Problem

Denzil is excluded from school at the moment because of his behaviour and attitude. He was re-admitted last week but didn't make enough effort. Now he is ready to change. He would like to be able to understand why he's running away and behaving in an odd manner so that he can choose a different option and get out of the state of mind that makes him want to run away or take something.

When he's got out of this state of mind, he will able to control himself more, not let his emotions take over, and think about things. His friends won't notice much different about him when this happens but others will. His teachers will notice that he is talking to them politely, getting on with his work and not talking to others in class. His mum will notice that he does things at either the first or second time of asking and he will be happier because then she'll want to sit down with him and talk about what he's been doing all day. His friends in school will notice that he's not talking to them, not messing about in class and not being sent out or in detention so much. He will be ignoring them when they talk to him in class.

When all this happens, he will be staying in school, getting on with his work, and getting good grades in his SATs so that he can be a lawyer or a psychiatrist when he's grown up.

Progress

1. Denzil can be quiet in class and get on with his work. He did this in art when he was drawing masks (this work is brilliant).
2. He can do being polite to teachers.
3. He can be responsible, like when he looks after his mum's best friend's sons and when he's form rep.
4. Denzil can take criticism without getting annoyed.
5. Sometimes Denzil can control his state of mind and avoid trouble, like the time he found a fiver on the floor and thought 'wow, I can do a lot with that', but he turned round and walked away from temptation.
6. Denzil can think quickly and control situations that are moving fast and need control and care – like his free running.

Solutions

1. Denzil was quiet in class and got on with drawing the masks because he controlled his excited state of mind. He set himself a goal and got there by talking and laughing – but not too much – with a friend who can talk and work at the same time. He also concentrated a lot; he drew the word 'mask' four times to get it just right.
2. It's easy for Denzil to be polite to teachers because he is a polite person – only sometimes he forgets to be polite to teachers he doesn't like or respect.
3. He does responsibility mostly when he's interested and is controlling his state of mind. It's easy when he's not getting all excited and looking for a buzz.
4. Denzil can take criticism because he listens to people and takes what they are saying on board.
5. He controlled his state of mind when he saw the fiver by thinking that it would cause stress for his sister and get him into trouble. He controlled the excitement and felt good after he had walked away. He knew how to do this because he has worked out that it is no use taking advice on how to control his state of mind at stage two (when he's in the middle of it). It's more helpful to control it at stage one (when it's about to start). Then he can walk away or resolve the issue before it gets to stage two.
6. Denzil can do free running without getting hurt by planning three or four steps ahead and then using his energy and just going for it.

Tasks

1. Denzil will go to school with his mum and tell them most of his plan for handling his state of mind, getting on with his work, and his determination to do this (this is at eight and a half out of ten). His plan is use his skills in free running; he will plan three or four steps ahead and then just do it so that he can walk away from the excitement factor which he knows means he is at stage one of the state of mind that gets him into trouble.
2. He won't tell anyone about his plans for handling Miss B. She always shouts, never has a good word, and has a nasty attitude. He will be extra polite to her and this will probably really annoy her because she thinks that Denzil is an easy target for her bad temper.
3. Doing his plan for school will take a lot of energy so he will go more gradually at changing his attitude and behaviour at home. On

Wednesdays (his hardest day), he will come home from school and do his jobs around the house. If he's late from school, he will do some jobs when he arrives and the others later. He will surprise his mum and sister by doing the hoovering, tidying, kitchen, whatever. They won't know what day he's going to be doing these things.

Meeting agency requirements and service user needs

There are many situations where service user and social worker goals differ, especially where there is obvious vulnerability. For example, Hawkes *et al.* (1998) give good examples of how people who have been diagnosed with mental illnesses, particularly psychosis, are routinely dismissed as not having the capacity to make rational decisions or choices, therefore becoming subjected to interventions that reduce opportunities for collaborative work. They give the example of someone hearing voices who has a goal of becoming the next England football manager, which may on the face of it seem part of a complex of irrational belief systems. They make the point that this diagnosis is irrelevant to a great extent, as the steps needed to become the England manager require concrete actions about going to football training, taking his medication to assist him to worry less and making his bed to get on better with his mother, all actions that are helpful for him generally and over which he can have some control.

Equally, practitioners may worry that a person's goal may be life-threatening; for example, someone with an eating difficulty may have a goal to lose even more weight or a severely depressed person may be contemplating suicide (we discuss these particular problems in more detail in Chapter 11). Strengths-based social work manages tensions between care and control, individual and social needs, risks and safety by clarifying partnership without neglecting responsibility taking. An important element in this process is the provision of feedback to service users so that they are clear what the concerns are, what they need to do about them, and what a successful outcome will look like. We address strengths-based safety work more fully in Chapter 10 but here an example of a strengths-based assessment feedback in a safeguarding situation is illustrated.

THEORY INTO PRACTICE

Initial safety plan for Dale, Bradley (age 7) and Kaiden (age 4).

Concerns

1. **Dale has a history of hitting people when frustrated and/or under the influence of drink/drugs.**
2. **Bradley and Kaiden have witnessed dad and mum fighting.**

3. Dale doesn't recognise that Bradley's disruptive behaviour at school may reflect his behaviour at home.
4. Both children have shown fear of Dale at times.
5. He isn't always honest with Social Care, so they doubt his assurances that his relationship with Sharon is truly over.
6. He can become frustrated when meeting with social workers and they tend to visit him in twos for their own safety and so that things do not blow up in front of the children.
7. He has been disrespectful to the female social worker.
8. He has been drunk when collecting the children from school.

Goals

1. Dale wants the children to live with him and wants Social Care out of his life.
2. The children want their parents to live together without arguing and fighting. Alternatively, they want some form of contact with their mum.
3. Social Care want Dale to be able to work in partnership with them so that they feel confident about his care of the children. When he is doing this, he will:
   - be sober when with the children
   - be extending his parenting skills so that he can find ways of handling any difficulties the children present in a way that ensures they are not fearful
   - control his temper so that he is not angry in front of the children
   - encourage the children to speak openly about any worries they have
   - talk quietly, calmly and respectfully with Social Care
   - accept that he may make mistakes and be able to own up to these and learn from them
   - be honest and open with Social Care, recognising that openness about difficulties will not necessarily mean that the children will be removed. Rather, they are difficulties to be resolved.
   - be respectful to women

Social Care will be confident to close the case when:

1. Dale's practical care of the children continues to be of a high standard.
2. He understands the children's emotional needs, can control his anger and be a good role model for the children.
3. Demonstrate over time that his separation from Sharon is complete so that contact between mum and the children can take place without the need for Social Care supervision. [Alternatively, should the parents wish to live together again, they can accept that the children will need to be removed whilst they undertake work on developing more peaceful ways of being together.]
4. Dale is respectful of women and this is reflected in how Bradley treats women teachers at school.

Timescale

Dale will have up to four months to work with his counsellor to demonstrate that he can meet these goals, and progress will be reviewed every six weeks.

Critical comment

Criticisms of strengths-based approaches in the UK (see, for example, Walsh, 2010, pp. 28–36) and in the USA (see, for example, Saleebey, 2013a, 2013b, pp. 283–95) include the following:

Concerns about assumptions that strengths-based approaches can resolve all difficulties. There are various parts to this criticism; for example, it can relate to the fact that the approach ignores evil, other than it is best not to make this assumption about a person first. Equally, it can refer to the hideous reality of some people's lives. Evidence of coping does not equate with resilience; for example, children may seem to be coping with parental drinking but this does not necessarily mean that they are resilient enough to continue coping without help (Adamson and Templeton, 2012). Frankenberg *et al.* (2013) found that education was a factor in resilience to a natural disaster; those with good educational experiences were more resilient than those with poor educational experiences. Evans and Reid (2014) criticize the resilience discourse in that it puts the onus of disaster responses on individual rather than publicly coordinated efforts. They argue that promoting resilience draws attention away from governmental responsibility and towards localized, laissez-faire responses.

The narrative approach has the better track record here, having been used with whole communities (for example, community group work with aboriginal people tackling problems of diabetes that are partly a result of poverty;

group work with HIV in Malawi villages, collective narrative practice with rape victims in the Chinese society of Hong Kong). (For more details, see Dulwich Centre Newsletters, www.dulwichcentre.com.au.).

Exaggerated claims for its effectiveness and a lack of rigorous scientific studies. The Narrative model has been most criticized for the lack of research material to support its claims (Etchison and Kleist, 2000). For example, the contributors to the Burack-Weiss *et al.* (2017) account of narrative social work practice cite narrative competence and narrative humility as external validation of the model. As O'Byrne (2017) points out, this is a validation of process only, not outcomes.

Dangers that service users may not be offered longer-term support and interventions. This seems to arise from a misunderstanding of use of the term 'brief therapy'. Most change takes place in the first few sessions with a person but this will take longer where a person is not yet ready for change. Being brief means being minimally intrusive; a person may not need many sessions with their worker but they may be spaced over a lengthy time which is dictated by the nature of the problem and the time required to do the solution. Similarly, many people will be able to manage their own care once their own resources have been identified and their ability to make choices validated but will request occasional feedback on their efforts.

Ethical problems that can arise if concepts of neutrality and pragmatism are taken too far without sufficient attention being paid to issues of influence and power. Criticisms have centred on particular oppressions such as gender (Dermer *et al.*, 1998) and on the overarching oppression of presuming what healthy, well-functioning personality should be (Fook, 2000). Gender differences are discussed in several texts (Berg and Reuss, 1998; Dolan, 1998a; Milner, 2001). Lipchik and Kubicki (1996), writing about working with people who are violent, suggest that rather than remain neutral, the worker raises gender as a possible issue. However, where the service user does not find this a helpful part of the conversation, the issue is not pursued. This would apply to any type of oppression the worker thought was a possible issue for discussion. Anderson (2013) makes the point that problem-based models which view the person as a problem or diagnostic category strip the context of oppression from their practice.

The risks associated with a simplistic application of positive psychology. This has been referred to as a smiley-face attitude put upon the devastating experience of people (Ehrenrich, 2009), a preoccupation with 'surface' rather than 'depth' (Howe, 1995), and being 'solution-forced' rather than 'solution-focused' (O'Connell, 2001). We would agree that seeking solutions relentlessly when someone is expressing grief or pain at events that have severely impacted on their emotional well-being is not helpful in developing a collaborative relationship; nonetheless, the validation can be expressed in such a way as to sow the seeds of exception, self-agency and change (see, for example, Lipchik and Turnell, 1999; Lipchik, 2002).

Our criticisms are not with the models but the way they are practised. Walsh (2010) found that social workers tended to adapt the model, using it in conjunction with other models. This has the capacity to be creative and develop the model further, but if the ethical and philosophical tenets are ignored, any one or all of the criticisms listed above would become fair comment.

Outcomes

Strengths-based approaches have been evaluated more extensively than problem-based approaches, especially the solution-focused model. Macdonald (2011) outlines the various studies, concluding that the effects are as good or better than any other known methods and also longer-lasting. An interesting aspect of these studies is that they show no difference according to service user group, ethnicity, age or gender. The approach has been shown to be helpful with anorexia, violence, drug abuse and mental health problems, regardless of learning ability. A five-year follow-up study of a solution-focused community pain programme showed the approach resulted in higher levels of psychological well-being and improvement in managing pain severity (Simms and Barker, 2018). There is increasing evidence of its effectiveness across cultures; see, for example, Cui *et al.* (2008), Panayotov *et al.* (2012) and Hogan *et al.* (2016). The main study of the effectiveness of resilience approaches is by Rapp and Goscha (2006).

Research into narrative approaches is in its infancy, yet Gorey *et al.* (1998) found that where there is a 'mutual client–worker strategizing' to change an external target 'the prevalence of moderate to large interventive effects may be fivefold greater' compared with cognitive-behavioural approaches. They found that when the problem is defined as transcending the individual, 'that is the problem does not reside "under the person's skin"' the work is very effective' (p. 274). They add that practice based on oppression theories has 'possible greater effectiveness' compared with traditional problem-solving approaches (for example, in work with survivors of abuse). We are also aware of the work of Fisher *et al.* (1998) in studying the externalization of problems in work with compulsive adolescents. They made the problem 'the enemy' and found that eleven of fifteen participants who provided follow-up data showed significant improvement following a seven-week programme. There are also numerous qualitative research articles on narrative approaches listed on www.dulwichcentre.au.



Summary

- The strengths-based perspective in social work practice is grounded in resilience research (Saleebey, 2013a, 2013b); effectiveness research (de Shazer *et al.*, 1986); and social constructionism that illustrates the ambiguities of life stories (White, 1995a).

- This practice requires skills in listening and assisting people to find their own solutions to problems, which are then more likely to be achievable and sustainable.
- Strengths-based assessments are also opportunities for transformative interventions.
- Strengths-based approaches are helpful in the development of thorough and comprehensive safety plans.



Further learning activities

- What are the key differences between the strengths-based approach and problem-based approaches?
- How might these differences affect service users?
- How might these differences affect social work practice?



Further reading

Department of Health (2017a) the *Strengths-based Social Work Practice with Adults: Roundtable Report.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/652773/Strengths-based_social_work_practice_with_adults.pdf.

Marsten, D. and Epston, D. (2016) *Narrative Therapy in Wonderland. Connecting with Children's Imaginative Know-How*. New York and London: W. W. Norton.

Milner, J. and Myers, S. (2017) *Using Solution Focused Practice with Adults in Health and Social Care.* London: Jessica Kingsley Publishing.

Myers, S. (2007) *Theory into Practice. Solution Focused Approaches.* Lyme Regis: Russell House Publishing.

Parton, N. and O'Byrne, P. (2000) *Constructive Social Work*. London: Red Globe Press

Saleebey, D. (2013) *The Strengths Perspective in Social Work*. London: Pearson. (International sixth edition).

10 ASSESSMENT IN CHILDREN'S SERVICES

What this chapter is about

This chapter outlines briefly the statutory context for the assessment of children and the values and principles underpinning it. It describes the theoretical and research evidence on the aetiology and maintenance of child abuse commonly used by social workers in making assessments, illustrating the lopsided nature of this research. The problems accruing from attempts to eliminate risk are discussed, and a safety-focused assessment approach is presented. Then the evidence of good practice in the assessment of need is presented and outcomes for children are discussed. The chapter concludes with suggestions as to the ways in which the wishes and needs of children can be assessed and good working relationships with parents and colleagues promoted. The learning exercises in this, and the following chapter, are intended to complement student placement and work experiences.

Main points

- The statutory framework.
- Types of assessments and processes.
- Values and principles.
- Theoretical and research evidence in the aetiology and maintenance of child abuse.
- Assessing risk, problems with the research evidence.
- Signs of safety.
- Assessment of need.
- Assessing the wishes and needs of children.
- Critical comments on the lack of attention to people's competence/strengths and on the difficulties of group decision-making.
- Difficulties in intra- and inter-agency decision-making.

Introduction

Assessment in children's work takes different forms, depending mostly on whether it is a case of unmet need, of protection from harm, or of adoption. In all these categories, the work is driven by law and government guidance, which in turn is driven by failures in the system that have led to tragic deaths. Reports investigating the unfortunate tragedies made several recommendations that are now enshrined in the law and in a tide of government frameworks, checklists, forms and definitions of terms. These not only vary between the four nations; for example, Northern Ireland published very detailed thresholds for safeguarding (UNOCINI, 2011) whereas Scotland's 2010 guidance set out core principles and a framework for standards, supported by a Practice Model within the Getting it Right for Children programme. Following the dispensations granted to each English local authority by the Department for Education (DfE), children's services and local authorities added policies and principles and produced protocols and procedures of their own which were intended to lead to more flexible assessment processes (Munro and Lushey, 2012). The result is that it is difficult to discuss the subject adequately in one chapter, and student social workers need to spend time familiarizing themselves with local practice and documentation.

Much of this chapter is about the legal context, processes, assessment forms and so forth, so we remind the reader that the ideas in the 'maps' chapters, Chapters 5 to 9, about ways of helping people to be self-determining, take responsibility for their actions and words, take child safety seriously, mobilize their own resources (internal and external), be creative and engage with professionals, are to be drawn on if assessment is not to be separated from intervention. The response of a person to such help is a key element in any assessment.

The reader may also wish to refer back to the section on the legal context in Chapter 1.

The statutory framework

The essential bedrock of the law in this area is the Children Act 1989, in which Section 17 deals with children in need and Section 47 deals with children at risk of significant harm. Following its passing, further tragedies, often blamed on the failure of agencies to share information that had it been known more widely could have prevented the deaths, led to further official guidance and eventually this led to the Protection of Children Act 1999, which was followed closely by the *Framework for the Assessment of Children in Need and their Families* (2000). The Assessment Framework was issued to address increasing government concerns about poor assessment practice in children's social care and to promote a more broadly based approach to assessment of need and the provision of services, the idea being that better assessment leads to better services. (For a fuller discussion see ward and Rose, 2002; Cleaver and Walker, 2004; McAuley *et al.*, 2006).

This framework required that information should be organized according to three 'dimensions' (sometimes known as 'domains'). These are the child's developmental needs, parenting capacity and environmental factors. Each dimension included a list of aspects (or sub-dimensions) to be considered, and an assessment recording form was devised setting out questions or prompts relating to each aspect (for example, health, emotional development, relationships, self-care, safety of the child; the parent or carer's ability to provide basic care, emotional warmth, stimulation, guidance and boundaries; and for the environment, family history, housing, employment, income and community resources). Notes were made of any help offered and of the responses to that help, and social workers were asked to engage in analysis, judgement and decision-making as they summed up the information.

Then the Climbié tragedy occurred with a report published in 2003, which again stressed interagency work and new accountability structures. This led to the *Every Child Matters* government documents for England and Wales (HM Government, 2004), with an agenda on children's rights to be healthy, safe, able to enjoy and achieve, make a positive contribution and gain economic well-being. The Children Act 2004 followed, enshrining these outcomes in law. The Scottish Parliament published *Getting It Right for Every Child* (GIRFEC) in 2004. Section 10 of the 2004 Children Act required local authorities to make arrangements to promote interagency cooperation with a view to improving children's well-being, which included protection from significant harm and neglect. Section 11 required services to ensure that their work safeguarded and promoted the welfare of children in need. 'In need' was defined as 'likely to suffer significant impairment of health or development without services'. Section 12 required that databases be set up nationally. Section 11 also set up Local Safeguarding Children Boards (LSCBs) which produced their own principles and guidance, much of it rehashing earlier guidance but stressing interagency work still further, as well as cooperation with parents and other carers and especially emphasizing the need to be child-focused and to take into account what children have to say.

At the same time, the *Common Assessment Framework* (CAF) for children and young persons was devised and published in 2005, to be used nationwide by the end of 2008. In Scotland, the document was called the *Integrated Assessment Framework*, and in Wales the *Unified Assessment Framework*. The former explicitly stated that the principles of the assessment should include the following:

- Collaborating – working *with* the family to find solutions – they will often know better than the worker.
- A focus on the child's and family's *strengths* [original emphasis] as well as needs and these strengths should be recorded. (DfES, 2006, para. 4.8)

The CAF improved the earlier framework (DoH, 2000a) by revising the dimensions and their headings, making it available for all agencies dealing with children and capable of being shared more easily so that service users would not be asked for the same data again and again. This framework, however, was not considered sufficient for cases where there was reason to suspect significant harm or severe neglect; for such cases, a Section 47 investigation is needed and the headings of the 2000 framework form part of that. The 2000 framework had spoken of some families needing specific services to assist them in achieving a child's outcomes in terms of health and development (for example, if they required help with particular stress factors).

THEORY INTO PRACTICE

Peter (12 years), Laura (9 years) and Michael (7 years) live with their mother, Sharon, and have contact with their father, Doug, for full weekends every other week, alternating with Saturday visits. Following Doug's complaints about the effects of Sharon's drinking on the children's well being and her counterclaims that his concerns are malicious attempts to control her as he did through a violent marriage, Social Care have investigated twice in two years. On both occasions, the case was quickly closed. Recently, the two younger children confirmed Sharon's drinking; their wishes are to continue living with mum and seeing dad at weekends but for the drinking to stop. Peter is supportive of his mum, saying she only gets 'happy drunk sometimes'. Sharon has difficulty disciplining Peter, who roams the district and comes in late. Although pleasant and polite with adults, he tends to dominate his brother and sister. The investigating social worker does not consider there to be sufficient grounds to institute a Section 47 investigation and is recommending that the children remain with Sharon but that be referred to a voluntary agency which supports the children of parents with drink problems.

- **To what extent do you consider the children's needs and wishes to have been met?**

By 2007, the government project *Every Parent Matters* had published further documents, looking at interagency support and help for families as well as how *all* children could have ensured outcomes. An overall plan for children's services became clearer, and the relationship between the 2000

The continuum of needs and services.

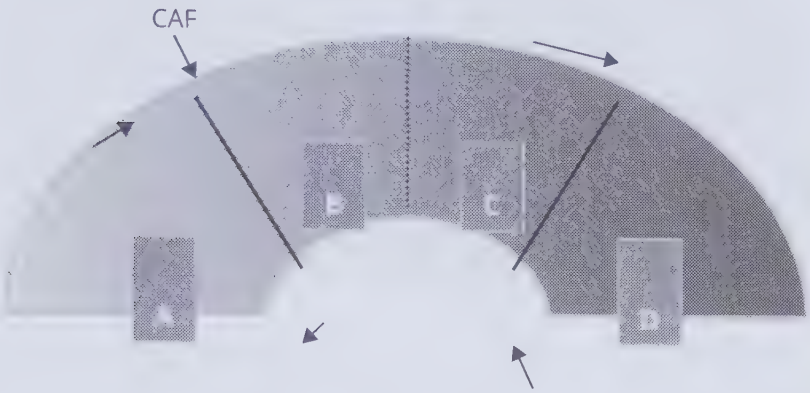


Figure 10.1 Windscreen diagram (adapted from Common Assessment Framework for Children and Young Persons – A Manager's Guide, 2006. London: DfES)

Framework and the new CAF was spelt out, and a continuum of needs and services, at four levels (A–D), was introduced (see Figure 10.1.)

A. *Children with no additional needs.* This is the level of service for the majority of children. The majority have good enough parents and need only the general services, a local doctor, a dentist, a school, and so on. There is no lead professional.

B. *Children with additional needs, when a single professional is involved.* Targeted support. At this level, a CAF may be started (see note below). This work could be in any agency such as a school with a mentor service or health visitor services. Ideally, an intervention plan should be started and reviewed at set periods.

C. *Children with additional needs, with integrated targeted support and a lead professional.* A CAF would certainly be completed here, if not already started, as well as an intervention plan, and planned reviews. B and C services would cover much of the work with any child 'in need' but not investigations where a child was considered to be at risk of significant harm.

D. *Children with complex needs (especially safety), with integrated support and detailed enquiries by a statutory or specialist service.* In this area, the 2000 Framework is used and Section 17 or Section 47 enquiries are carried out by child protection teams. The work may conclude with a CAF assessment if the work is referred back to level C.

THINKING POINT

- Choose a family you are aware of and identify the needs and risk factors.
- Locate the children on the continuum.
- What needs to be done to move them back towards A?
- Access your Local Safeguarding Children Board website and find their published statement of thresholds (as required by WTSC, 2018) or the Northern Ireland statement of thresholds (UNOCINI, 2011).
- How does this inform the location of your family on the continuum?

The CAF covered the topics of the 2000 Framework minus the risk investigation/Section 47 enquiry work. Levels B, C and D involve services *sharing information* with each other in various ways. Cases may move back or forward on the continuum as they are reassessed, with managers monitoring whether cases drifted at an inappropriate level. Many referrals came in at level D and about half were moved back to a lower level where needs were not particularly complex or there was no serious risk to the child. Various services have differing threshold criteria for the four levels and these should be clearly outlined and shared.

The death of Peter Connelly (Baby P) in 2007 generated another wave of anxiety and concern about children's social work, and the subsequent report by Lord Laming (2009) identified continuing difficulties with child protective systems and practices. The appointment of Professor Eileen Munro by the incoming Coalition Government led to her report of 2011 and the *Working Together to Safeguard Children* (WTSC) 2013 guidance. This guidance developed the suggestions contained within the Munro report to change aspects of practice, including the timescales for taking action. Although the 2013 guidance technically replaced the 2000 Assessment Framework, it retained the structure and domains for assessments that had become familiar practice.

The Munro report recommended the relaxation of some of the more bureaucratic practices that had developed and that were compromising the quality of assessments. Social workers found themselves driven by organizational needs to meet tight deadlines rather than always conduct a thorough assessment (Broadhurst *et al.*, 2010; Horwath, 2011) and engage with electronic recording systems that were not fit for purpose (White *et al.*, 2010). A (re)focus on professional judgement and more flexibility in responding to the complex situations faced by families was suggested, enabling social workers to tailor their actions more to the specific family circumstances than to the rigid bureaucratic frameworks.

The Children and Families Act 2014 and Children and Social Work Act 2017 continued these changes in England, including the latter abolishing the LSCBs to be replaced by collaborative arrangements that meet local

needs. The WTSC guidance 2018 outlines the current interpretation of the legislation. Local authorities have increasingly developed their own assessment protocols and approaches, with a focus on 'Early Help' to address emerging problems. The CAF is still used by many agencies, but there are other models and language used that reflect the different local developments, so, for example, Leeds Children's Services changed their language from CAF to Early Help Assessment (https://www.leedslscb.org.uk/Practitioners/Local-protocols/Early-help-intro/Early-Help-Assessments).

In Wales the relevant legislation is Ss 21 and 24 of the Social Services and Well-Being (Wales) Act and the guidance is to be found in 'Working Together to Safeguard People Vol. 5' (Welsh Government, 2018). In Northern Ireland, the relevant policy guidance is to be found in the 'Cooperating to Safeguard Children and Young People in Northern Ireland' (Department of Health, 2017b). In Scotland, the 'National Guidance for Child Protection in Scotland' (Scottish Government, 2014) outlines the requirement of the Children and Young People (Scotland) Act 2014.

We will now outline the key elements of a child protection assessment.

Types of assessments and processes in child protection (Table 10.1)

Table 10.1 Some of the terms and initials used in child protection

Section 17	Section 17 of the Children Act 1989 referring to children in need.
Section 47	Section 47 of the Children Act 1989, referring to children at risk.
CAF	Common Assessment Framework.
CP	Child protection.
Failure to thrive	The rate of growth is significantly below normal because of inadequate nutrition and/or emotional harm. It usually applies to the first three years.
Framework (2000)	The Framework for the Assessment of Children in Need and Their Families (2000).
Harm	'Significant harm' which is any physical, sexual or emotional abuse, neglect or injury, or impairment suffered from seeing or hearing the ill treatment of another, that is sufficiently serious to adversely affect progress or the enjoyment of life. There are no absolute criteria – it can result from a single event or an accumulation of events.
In need	Unlikely to attain a reasonable standard of health or development without the provision of services.

Table 10.1 (Continued)

Suspect	'To have reasonable cause to suspect'. Having a sensible reason for thinking that a child may be at risk of being damaged or not protected by an adult who should be ensuring safety and well-being. This criterion is lower than 'beyond reasonable doubt' (as in criminal cases) or 'the balance of probability' (as in civil proceedings) or having a reasonable belief that something is true.

Referrals

A case starts when a referral is received expressing concern about the safety or welfare of a child:

- More detail may be sought from the referrer.
- Is the information direct or third-hand?
- Is there maltreatment?
- Who else knows?
- What are the name and location of child?
- Any family details?

Records are checked. If these show an existing assessment, this is updated. Other agencies may be contacted, including the police. Within one working day of receipt of the referral, a decision should be made about the type of response to make (in discussion with a manager) and the social worker should acknowledge the receipt of the referral with the referrer. Based on an assessment of the information (the nature of the concern, how it arose, what the needs seem to be, whether risk of harm is suggested and whether urgent action could be needed), a decision is made whether the child requires immediate protection; is a child in need requiring a Section 17 assessment; is suffering or likely to suffer significant harm requiring a Section 47 assessment; any services that may be required by the family and any more specialist assessments to aid decision-making by the local authority. The child and family should be informed of any action resulting from the decision and if it is necessary for social workers to see the child, then this should be done as soon as possible. The Children Act 1989 Section 27 places a duty on other statutory authorities such as health and housing to cooperate with any investigation or requests for information about the child and family.

Sharing information

How and when to share information about the family have become complicated with concerns about data protection. The DfE (2018) in England has

produced guidance on this, including clarifying any concerns social workers may have about confidentiality. In brief, the protection of children does provide the justification for sharing sensitive information between agencies and the DfE provides detail on how this should be done. Misconceptions about the Human Rights Act 1998, the Data Protection Act 1998 and the legal status of consent should not get in the way of effective sharing of important information.

Immediate protection

Where protective action is thought to be necessary at any point to ensure the urgent safety of a child, legal powers should be used immediately. To do this, an immediate strategy discussion is held, involving the local authority, the police and any other agency dealing with the matter. There may be situations where, for example, the police have urgently to remove a child that is being harmed (Section 46 Children Act 1989) but such action should be rarely used. Wherever possible, and here legal advice is crucial, an application to court for an Emergency Protection Order (Sections 44 and 46 Children Act 1989) should be made. The removal of a child from home without a court order should be exceptional, and the child should be seen to determine how best to protect them. Agencies that have statutory powers of child protection include the police, the local authority and the National Society for the Prevention of Cruelty to Children (NSPCC).

The Children and Family Court Advisory and Support Service (CAFCASS) has its own flowcharts and processes for protecting children for whom the courts are making decisions.

Beginning the assessment

The WTSC 2018 guidance requires the assessment to be completed within 45 days of initial referral, and any extension of this needs to be discussed with the family and other practitioners and the reasons for this recorded. The exact length of time depends on the issues identified, but there is a presumption that the assessment will be timely and appropriate to the levels of risk and need. As specific needs emerge during the assessment, social workers are encouraged to refer to or commission services prior to the full completion of the work. This is intended to avoid any delays in addressing the needs of children and families.

The work may involve the following:

- Consulting again with the referrer.
- Consulting other agencies who know the child or the family.
- Checking records.
- Interviewing the parents and the child.
- Ascertaining the child's wishes.

- Visiting the home.
- Taking some family history and listening to the various accounts and explanations given.
- Checking for strengths and resources.

It involves assessing the seriousness of the concern, its duration and repetition, the vulnerability of the child, the family context and interactions as well as any risk factors such as mental illness, misuse of drugs and/or domestic violence. If there is no reason to suspect risk of harm or need for support, then feedback is sent to the referrer, although it might be useful to assist the family to access universal services where appropriate. If there is no concern about harm but there is unmet need, there is a team discussion about what help/support is required. More assessment may be needed for this and services may be put in and reviewed.

There is specific guidance to assist the assessment where children have links with a foreign country (e.g. a foreign national, dual nationality, foreign parents) and it would be helpful to liaise with agencies there (DfE, 2014).

The strategy discussion/meeting

If there is reasonable cause to suspect during the assessment that the child is suffering or is likely to suffer significant harm, then a strategy discussion should take place between the relevant agencies to determine the risk and agree actions to respond to this. This should include the social worker and their manager, school, health services and/or the referring agency. The strategy discussion should focus on sharing information, considering the process of any criminal investigation and whether a Section 47 assessment needs to be undertaken. If it is agreed that a Section 47 is appropriate, then it needs to be clear what further information is needed and how this will be gained, whether legal action is required and, if so, what type, and whether any direct intervention is needed immediately to support the child.

Section 47 enquiry

If a Section 47 enquiry is agreed, the social worker will lead this assessment with the support and cooperation of other relevant professionals. The purpose of the assessment is to:

- carry out enquiries in a way that minimizes distress for the child and family;
- see the child who is the subject of concern to ascertain their wishes and feelings; assess their understanding of their situation; assess their relationships and circumstances more broadly;
- interview parents and/or caregivers and determine the wider social and environmental factors that might impact on them and their child;

- systematically gather information about the child's and family's history;
- analyze the findings of the assessment and evidence about what interventions are likely to be most effective with other relevant professionals to determine the child's needs and the level of risk of harm faced by the child to inform what help should be provided and act to provide that help.

The enquiry focuses on the information most important in relation to the risk of harm and, if it finds that concerns about risk of harm are substantiated and the child is continuing to be at risk, a Child Protection Conference has to be convened within 15 working days of the strategy meeting that initiated the Section 47 enquiry.

The initial Child Protection Conference

This has to meet within 15 working days of the last strategy discussion. The purpose of the conference is to bring together and analyze, in an interagency setting, all relevant information and plan how best to safeguard and promote the welfare of the child. It is the responsibility of the conference to make recommendations on how agencies work together to safeguard the child in future. The conference receives a report from the social worker which has analyzed the information generated by the assessment and makes recommendations for action. Social workers should be supported by their manager throughout this process. This report should usually have been discussed with the child and family prior to the conference; however, this may not be appropriate in some cases. The conference makes one of two decisions:

- Concerns about harm are not substantiated but the child is in need of a plan for ensuring future welfare. This can include further assessments and service provision.
- There is risk of harm and the child will be subject of a child protection plan (formerly known as 'placed on the Child Protection Register') and a key worker named who will arrange a 'core group meeting' within 10 working days. The child is now known as 'a child subject to a child protection plan'.

The core group

This group, made up of the main interagency staff involved in the case and with a registered social worker as the lead professional, puts into action the recommendations of the Child Protection Conference. It meets within ten working days of the conference. The purpose of the core group is to:

- develop the outline child protection plan, based on assessment findings, and set out what needs to change, by how much, and by when in order for the child to be safe and have their needs met;

- decide what steps need to be taken, and by whom, to complete the in-depth assessment to inform decisions about the child's safety and welfare; and
- implement the child protection plan and take joint responsibility for carrying out the agreed tasks, monitoring progress and outcomes, and refining the plan as needed.

The lead professional draws up a plan for, or implements, any interventions that are needed and holds the first child protection review conference within three months of the initial conference, and further reviews up to but no longer than six months, with a revised plan if necessary. If the plan is not working and there are still some serious concerns, this should be raised in the review conference and consideration be given to legal action to protect the child.

Values and principles

The WTSC 2018 (pp. 26–7) guidance provides a list of principles for producing high-quality assessments. They should:

- Be child-centred. Where there is a conflict of interest, decisions should be made in the child's best interests; be rooted in child development; and informed by evidence.
- Be focused on action and outcomes for children.
- Be holistic in approach, addressing the child's needs within their family and wider community.
- Ensure equality of opportunity.
- Involve children, ensuring that their voice is heard.
- Involve families.
- Identify risks to the safety and welfare of children.
- Build on strengths as well as identifying difficulties.
- Be integrated in approach.
- Be a continuing process, not an event.
- Lead to action, including the provision of services.
- Review the services provided on an ongoing basis.
- Be transparent and open to change.

In addition to these, we consider that it is important to:

- Allow enough time for people to absorb the professionals' concerns and the processes involved.
- Offer confidentiality but with the limitation that information will be passed on if this is necessary for the child's safety.

- Use appropriate language in engaging with people.
- Work in partnership with parents and carers and children.
- Enable maximum participation by the entire family.
- Listen and endeavour to understand people's concerns.
- Respect the dignity of all people and their need for privacy.
- Ensure people know their rights and responsibilities concerning participation and cooperation.
- Keep an open mind and an attitude of uncertainty.
- Acknowledge errors and misunderstandings as well as possible bias.
- Base the assessment on sound evidence – what is seen and what people say.
- Keep recordings up to date.

Theoretical and research evidence on the aetiology and maintenance of child abuse

Social workers are asked to make judgements about what is good enough for meeting children's safety and well-being. This involves assessing parents' capacity to parent and also to evaluate a child's development, using the subheadings of the three 'dimensions' in the 2000 framework. The framework encouraged the use of various scales and checklists (for example, the work of Cox and Bentovin (2000), Caldwell and Bradley (1984) and Bentovim and Bingley Miller (2001)) for the gathering of information and for thinking about what is good enough parenting and good enough care. Hepworth *et al.* (2002) developed a list of factors to be considered, information about these being obtained through verbal report, observation and worker self-awareness. The factors they listed are manifestations of the problem, severity, strengths and obstacles, interactions, unmet need and wants, developmental stages, the meanings people ascribe to events, behaviour (frequency and duration), substance abuse, emotional reactions to the problem, coping efforts, skills needed, cultural, societal and class factors and the external resources needed, cognitive/perceptual functioning (reality testing, values, judgement, misconceptions), emotional control, family boundaries, power structure, decision-making processes, expression of feeling, goals, communication, roles, strengths, and problem-solving. But these are only headings, prompts or a checklist – they do not tell us what is good enough.

Jones (2000) comments that it is not possible to ascribe a numerical value to aspects of parenting and that parenting capacity can be understood only in the context in which it operates. We can, however, draw on what it would be reasonable to expect of parental care to a similar child in a similar situation. There is extensive literature about parenting capacity; see, for example, Jones (2000) and Cleaver *et al.* (1999).

When considering whether parents who have maltreated a child have made progress in their parenting, Silvester *et al.* (1995) have indicated signs that suggest a poor outcome:

- Not fully acknowledging responsibility for the child's state.
- The child is blamed.
- The child's needs are not recognized and parents' needs are put first.
- Frequently showing lack of concern about problems such as alcohol misuse or mental illness.
- Relationships within the family or between family and professionals remain at the breaking point.

Jones (1998) reported on research findings that indicated the features associated with good outcomes:

- The children did not have residual disability, developmental delay or special educational needs.
- The children had been subjected to less severe abuse or neglect.
- The children had the benefit of corrective relationships with peers or a supportive adult.
- The children had developed appropriate attributions about the treatment they had received.
- There was cooperation with the helping agencies and professionals.
- There was engagement in therapeutic work
- The psychological component of the abuse was amenable to change.

Silvester *et al.* (1995) found that the family's capacity to change remained uncertain where:

- It was not clear the parents were taking responsibility for the abuse.
- It was unclear whether the parents put their own needs first.
- Parent–child attachments were ambivalent or anxious.
- Family patterns were inflexible.
- Relationships with professionals were ambivalent.

Such families should, however, be given help and the best chance to make the necessary changes so long as the child does not have to wait too long, depending on their particular age and development. Following the Adoption and Children Act 2002, parallel planning for both rehabilitation and adoption was encouraged to prevent delay and drift for looked-after children (Wigfall *et al.*, 2006).

The ability to set clear and firm limits for a child is stressed in the literature, as children need the security of firm boundaries as well as warmth and encouragement. This is becoming a difficult area to assess as children gain increasing freedom in many families where parents cannot or do not wish to say 'No' and children can be said to be burdened with more choices and power than is appropriate. The Winnicott (1964) term 'good enough parenting' suggests that if parents do the following, especially in the first five years of a child's life, while they may not be super parents (if such is possible or desirable), they are good enough:

- They attend to the basics – physical care, nutrition and protection.
- They attend to emotional needs by unconditionally and consistently showing love, care and commitment.
- They set reasonable limits.
- They facilitate overall development with:
  - A high level of warmth and constructive criticism and a low level of negative criticism.
  - A high level of time spent with the child and child-focused activities.
  - A high level of communication.
  - Good parental cooperation, showing unity and enjoyment of each other and the children.

Assessing risk: problems with the research evidence

Child protection work is strongly underpinned by discourses (theories, research evidence, policies and protocols) of risk assessment and management which have led to risk assessment tools being relied on, often uncritically, to assist in what is actually a complicated and uncertain area of work. Stanley (2005, 2006, 2007) argues that risk assessment has developed to manage incidents rather than to address families' needs. He identifies three risk periods:

- A growing anxiety towards children in the 1970s where risk was used to identify those children at risk and those not at risk (see, for example, Parton *et al.*, 1997; Parton 1998).
- This was followed by a period where risk assessment tools and risk management policies were developed to define degrees of risk (see, for example, Kemshall, 2002; Myers, 2007a).
- Then a period of legitimacy emerged, where discourses of risk were drawn on to legitimize assessment decisions. Bessant (2004) refers to this as a 'science of risk'. Here, risk is seen as something that can be located and

> resolved; thus, evidence and certainty are privileged and ambiguity and uncertainty are expected to be managed through risk assessment procedures: 'if the tool predicts violence and this occurs, then the organization is defended; if the tool has been followed and an unexpected outcome occurs, then it is at fault and requires further development' (Milner and Myers, 2007, pp. 28–9). Webb (2006) suggests that social workers use these risk discourses to make 'risk claims' to argue for or against a particular decision (p. 154).

The difficulty with such certainty is that both actuarial and clinical assessments of risk have only modest predictive accuracy (Barlow and Scott, 2010; Daniel *et al.*, 2009). For example, the AIM (Assessment, Intervention, Moving on) model for children who have sexually harmful behaviour consists of a series of factors or characteristics – based on research evidence and clinical consensus – that are categorized as either concerns or strengths. These factors are allocated a high, medium or low numerical value. These are plotted on a grid to indicate the level of risk of the person being harmful in the future. The grid has two axes: high-concern–low-concern and high-strength–low-strength; thus, a young person with high concerns and low strengths would be considered as needing intensive interventions. Although it appears to be 'scientific', there are problems with the model. There is no agreed definition of what constitutes sexually harmful behaviour; a key study informing the model (Skuse *et al.*, 1998) consisted of only eleven boys. This study was designed to explore recidivism, and three factors are prioritized as warranting a high-concern categorization regardless of other considerations (for a fuller, discussion, see Myers, 2007a). Not the least of the problems with this model is what interventions are indicated when the assessment reveals both high concerns and strengths.

A major problem with risk assessment tools is that the research evidence is skewed towards the aetiology and maintenance of abuse, and little is known about what constitutes safety. Thus, practitioners tend to focus their assessments on a search for what the research indicates is risky behaviour at the expense of other domains in the assessment framework, particularly the impact of family and environmental factors (Jack and Gill, 2003; Cleaver and Walker, 2004; Caldwell, 2010; Bateman and Milner, 2015). Risk assessment defies accurate quantification so social workers can never be sure that risky behaviours have ceased, although they are preoccupied with risk elimination. This, say Turnell and Essex (2006), leads them to adopt a one-position response, such as insisting that a mother leaves her husband or a teenage daughter is not allowed to live at home. As families rarely agree with this one-position response, such assessments are unlikely to lead to constructive planning and interventions. We have noted that social workers have a tendency to institute yet another assessment in these situations, involving families in protracted, and often intrusive, questioning about their past behaviours. Where the children are young, there is often a hidden

one-position response – bolstered by the need not to delay permanency. Parallel planning often disguises intent to adopt – the ultimate risk elimination strategy. This is frustrating and distressing for parents who believe that rehabilitation is a genuine option.

Second, much of the research does not acknowledge its own limitations. For example, a persistent recommendation from the research into good outcomes mentioned above is that parents fully acknowledging responsibility for the abuse is a key factor. This is not actually the case; for example, there is no evidence that denial of responsibility has any effect on recidivism in cases of sexual abuse (Hanson and Bussiere, 1998; Hanson, 2004; Christodoulides *et al.*, 2005; Cooper 2005; Craig *et al.*, 2005; Henning *et al.*, 2005). Neither does denial influence recidivism in cases of physical abuse; as Turnell and Essex (2006) point out:

> There are very few benefits to be accrued by an alleged perpetrator in admitting abusing a child. A person who takes responsibility for seriously abusing a child may garner a clearer conscience but they may also very likely face criminal charges, job loss, exclusion from family and community, as well as other major negative repercussions. This highlights the inappropriateness and injustice of framing denial solely as an individual psychological distortion of an evident truth, when there are so many strong and interactional pressures that make denial a compelling response. (p. 29)

THINKING POINT

Reflect on a family you are working with where concerns are consistently denied by the parents.

1. What are the possible reasons for the family taking this standpoint?
2. What could you say to this family that would demonstrate that you respect their position whilst continuing to ensure the safety of the children?

It is entirely possible that the research finding about accepting responsibility being associated with good outcomes is an artefact of the way in which social workers frame outcomes in the first place; Stanley (2005) found that social workers were more likely to leave children at home when their parents acknowledged the concerns and 'came on board'. However, there is a great deal of difference between social workers and families sharing the same perspective – what Platt (2007) refers to as congruence – and cooperation, the extent to which a social worker perceives family

members to be compliant. Cleaver and Freeman (1995) found that parents rarely shared the same perspectives as social workers at the beginning of a case; indeed, family members tended not to share the same perspectives between themselves. Where there were good outcomes, the families' and professionals' perspectives came together gradually – not as the result of families accepting the social workers' account but by extreme sensitivity, tolerance and awareness at the point of confrontation by the assessing social worker (p. 89).

PRACTICE EXAMPLE

Eight-year-old Jonathon was placed with foster parents when he was two years old. It is strongly suspected that his mother physically abused him but she has consistently denied this. She has been permitted monthly two-hourly contact with Jonathon and has not missed a contact in six years. Jonathon is happy in his foster placement but has recently expressed a wish to see his mother more regularly. She has asked for more contact several times and is now applying for his care order to be revoked.

The social worker is opposing this on the grounds that mum has never admitted harming Jonathon and that this means that he cannot be safe with her or that she can 'move on' until she admits responsibility for the earlier abuse.

Third, social workers do not always use the research evidence well. As we have discussed in Chapter 1, there are several organizational reasons for this, but it does result in the formation of working hypotheses about families that are based on the selective use of research findings (Scourfield, 2003; Spratt, 2015). These are dangerous when they gain the status of a mantra; for example, the research into the deleterious effects of domestic violence on children has become a reason to remove children, whatever the circumstances of the violence (Milner, 2004). Other commonly held working assumptions include the 'fact' of male abuse of power in all domestic violence (this ignores female-on-male and female-on-female violence); the inherent recidivism of sex offenders (see above); that previous behaviour is the best indicator of future behaviour; and the primacy accorded to secure attachments (see Chapter 6). These are all powerful working hypotheses that influence assessments. Other well-identified risk indicators such as the effects on children of parental mental illness and substance misuse (Cleaver, 2002; Falkov, 2002; Smith, 2004) have figured less prominently in child protection discourses, although there is evidence that this is changing (e.g. Forrester and Harwin, 2008; D.H., 2010; NSPCC, 2015).

THINKING POINT

Following concerns about her mother's substance misuse and her neglect of her daughter, 4-year-old Casey has been with foster parents for eight weeks. During this time, her mother has maintained regular contact with Casey. You are concerned that Casey not wait too long for a decision to be made about her permanent placement.

- What working hypotheses about family reunification inform your preliminary planning?
- Read Biehal (2007) 'Reuniting children with their families: reconsidering the evidence on timing, contact, and outcomes', *British Journal of Social Work*, 37: 807–23.
- Does the evidence support your hypotheses?

Fourth, the need to make an 'at risk' or 'not at risk' claim leads social workers to depend heavily on 'expert' assessments. Stanley (2007) notes that these are used to legitimize social workers' preferred decisions, despite the fact that they mask important ideas about the way risk is constructed differently by psychologists and social workers. The former are even more likely than social workers to depend upon a barrage of risk assessment tests despite their poor predictive power. These reports are immensely powerful documents in that they determine blameworthiness and creditworthiness and remain durable across time and space (Taylor and White, 2000). They may well have been prepared after only one session of fixed questions with the parents (the exchange model does not figure highly in these sorts of assessments), yet these psychological assessments will override any social factors which may well be relevant; for instance, a report may indicate medium risk yet ignore evidence of high need. They also encourage certainty where certainty is unknown. For instance, one man complained after a psychologist told him that his was 'the typical profile we would expect of a sex offender'. The man complained that he had merely answered a set of predetermined questions about stress responses, drinking and so on, to which the possible responses were 'very much, sometimes, not at all' and that he had replied 'sometimes' to all the questions. Such a question format is not only highly 'unscientific' but also dangerous in that the person who is deciding on the questions is framing the subject as a sex offender on predetermined but spurious criteria – as the meta-analyses demonstrate, owing to the heterogeneous nature of this group of offenders, there is no current consistent profile of the sex offender (Craig *et al.*, 2005). The Children and Families Act (2014) limits the use of expert evidence in family proceedings.

Assessment of need

The tendency of social workers to overemphasize the psychological dimensions has distorted assessments, particularly, as we noted above, the neglect of the impact of environmental factors on the lives of children. However, there is evidence that the CAF did encourage more parental participation. Cleaver and Walker (2004) found that three quarters of parents in their study felt involved in the assessment: social workers had explained why the assessment was being carried out, how it would be done, and what it would entail. They felt less satisfied with the care plan, however, except where they had a shared perspective with the social worker about the difficulties and had been involved in the choice and development of the plan. Millar and Corby's study (2007) confirms that the Framework's format has improved communication in the ways parents are involved. Particularly relevant to feeling involved in the assessment was being given copies of the assessment decision and plan:

> Parents liked to know what was being said about them, and valued the chance to make comments that were recorded and openly discussed. We suggest that the format of the framework helped to produce this transparency of approach, *encouraging explicitness about social workers' concerns and a dialogue about them.* (Millar and Corby, 2007, our emphasis)

However, the improved communication between parents and social workers was found mainly in families where there was less extreme conflict over perspectives – those with disabled children or complex caring problems. It seems that the framework has more effect in improving communication in assessments of need than risk (see also Tunstill and Aldgate, 2000). Gladstone *et al.* (2014) argue that it is not sufficient that one party thinks participation is going on as parents' experiences of child protection decision-making are categorically different from the ambitions of child protection practitioners. Although a child-centric orientation is emerging, it is far from established: '...although the legislative requirements and the ambitions of front line workers hold parents' involvement to be centrally important, the existing research ... highlights many shortcomings in achieving this' (Berrick *et al.*, 2016). Being focused on the child is not the same as 'just being there for the child' – children are members of families and need to be viewed in that context, with a presumption that they are best cared for by their families with appropriate support (Featherstone *et al.*, 2018).

A preoccupation with parental disguised compliance may well contribute to failure to establish full parental participation in child protection assessments. Whilst it is sensible to be aware that some parents will have much to hide, many parents and their children may well just not agree with the care plan and it is unfair to label them as non-compliant when they may be afraid

to question elements of the care plan. Whittaker and Havard found that although defensive practice is common it not necessarily a deliberate process 'but "part of the culture" of an agency or something picked up from other practitioners without questioning' (2016). Wilkins would like defensive practice questioned. He is concerned that disguised compliance is used as a 'catch-all' term in relation to almost any signs of resistance or even just ambivalence on the part of parents. He argues that it is often the plan with which parents do not want to comply rather than them being intrinsically non-compliant people. In which case he asks – 'what could the social worker be doing that might be increasing resistance?' (2017). Turnell and Edwards (1999) suggest using scaled questions in these situations, such as:

- If 0 means you can't be bothered and 10 means you will do anything to keep your family together, where are you on this scale? [willingness]
- If 10 means you are completely confident that you can work with the care plan and 0 means you have no confidence in it at all, where are you on this scale? [confidence]
- If 10 means you know exactly what to do for us to close the case and 0 is you have no idea where to start, where are you on this scale? [capacity]

You would then ask more questions about the lowest score of the three (for suggestions about follow-up questions, see Chapter 9).

THEORY INTO PRACTICE

Daniel has served a short prison sentence for sexual intercourse with a 15-year-old girl. He desperately wants to have contact with his two young children but rated himself at only 6 on the 'willingness' scale because 'I'll do anything it takes, but when I get depressed, I sneak about and avoid the situation'.

- **Devise five follow-up questions that are aimed at helping him handle his depression better and increase his motivation. (adapted from Milner, 2008a)**

Boddy *et al.* (2006) identified the elements of successful assessments of families in need where children had either complex disabilities or complex needs. These assessments were genuinely collaborative and the active participation of parents in the process shifted the emphasis from 'services' to 'solutions' by:

- Using accessible language.
- Explaining the assessment process and discussing this with parents before asking any checklist questions.

- Conducting the assessment in either the home or a familiar community building.
- Sharing information with parents.

Other elements included having confidence in the lead professional and developing 'joined-up working' from bottom-up initiatives rather than depending on strategic-level decisions.

In addition, Turney *et al.* (2011, p. 14) found that the barriers to achieving a quality assessment of need included the following:

- Personal – including whether or not the practitioner is competent, has the appropriate knowledge and confidence to carry out the required tasks, and has the scope to do so within their individual caseload.
- Interpersonal/relational – including the range of activities involved in communicating with children and young people, parents, and other professionals.
- Systems issues – including increasing dependence on complex and sometimes unreliable or unwieldy IT systems and the sense of lack of time for face-to-face work as a result of time spent inputting data.
- Organizational constraints – including the organizational culture (for example, whether there is a commitment to reflection and learning, management of workloads and so on) – and the level of available resources. The outcomes of assessments often depend on there being adequate resources to implement plans.

Mellon challenges systems issues and organizational constraints:

> If social workers don't have the courage to challenge a culture that puts human relations at the bottom of the pile, they have no moral authority to demand of parents what they can't deliver for themselves. If work is causing moral distress, then professional ethics demand that this is challenged. (2017)

As Brandon *et al.* (2007) found, where parents are not part of the assessment and not in agreement with the resulting plan, they will be reluctant to accept the help offered. This is an expensive waste of time and resources, which leads only to reassessment. While all assessments should be fluid and ongoing to meet changing circumstances, they are rarely successful without the full participation of parents. As families in need tend to have lower priority than families at risk, it is important for social workers to consider how to assess unmet need in their communities as well as individual families. It is not uncommon for specific groups of potential service user needs to be researched and assessed in a participatory way by voluntary agencies (the Barnardo's project (Rotherham) on assessing the needs of asylum-seekers'

children is a good example of this), but we suspect that in areas of high deprivation, whole communities of children's needs are unmet. Dealing with the more acute incidents that arise under child protection assessments is complex as it is not uncommon for parents' high unmet needs to skew the assessment.

PRACTICE EXAMPLE

Hayley's three children – Kaylee (7), Charlie (4) and Liam (2) – were made the subject of a Care Order after Hayley's sister, Emma, informed Social Care that the children were being neglected. Hayley was estranged from her family following their disapproval of her much older boyfriend, who had a drink problem. The psychological report revealed that Hayley had the cognitive age of an eight-year-old. The social work report revealed that Charlie and Kaylee had ambivalent attachments to their mother.

The children were placed with Hayley's parents with Hayley having contact with her children at her parents' home. With an improving relationship with her family came the realization that Hayley had high unmet needs: her next-door neighbours were verbally and physically abusing her (at one point, they put burning material through her letter box); her boyfriend was of little support, but she maintained this relationship as he had a car which helped Hayley travel with three children; and she was socially isolated and clinically depressed. Rehousing Hayley nearer her parents was the beginning of a huge improvement in Hayley's confidence; she recovered from her depression and began to take more interest in her children, asking her parents for advice on how to handle Charlie, whose behaviour could be very challenging. She also socialized more with Emma, finding a new boyfriend.

Interestingly, meeting Hayley's needs not only impacted on her ability to parent her children but, on retesting, her cognitive age was found to be that of a 14-year-old. It is important when assessing people with special needs to remember that under stress they function at a much lower level than usual.

Specific needs assessments

There are some children's assessments that need to consider other guidance and legislation. Children and young people may be vulnerable to harm and exploitation from social and environmental pressures, and this is recognized in legislation such as the Counter Terrorism and Security Act 2015. People assessed as being vulnerable to radicalization under this legislation can be

referred to channel panels, and where this affects children and young people the assessments should be aligned with the principles and guidance of the Children Act 1989 where possible (https://www.gov.uk/government/publications/channel-guidance).

THINKING POINT

Jason is 15 and has been expressing violent racist views at his school towards other students who are Muslim. His friends say that he has joined several far-right social media groups and has posted inflammatory racist and homophobic images and blogs on his social media profile. Jason's parents are supportive of him and have held 'White Pride' events at their home, but they are concerned that he is 'going too far'. He has been referred to the local Channel Panel for assessment.

- How would you begin to assess Jason?
- What questions might you want to ask him?
- How would you assess how vulnerable he is to becoming radicalized?
- Would your assessment be different if he was Asian and Muslim posting racist and homophobic material on social media?

Assessments of disabled children should include a consideration of whether the provisions of Section 2 of the Chronically Sick and Disabled Persons Act (CSDPA) 1970 are relevant and necessary to provide for their identified needs. Where it is thought that the parent of a disabled child requires support, an assessment is made under S.17ZD of the Children Act 1989.

Young carers have been increasingly recognized as potentially in need of support, and there is specific guidance provided by the Young Carers' (Need Assessment) Regulations (HM Stationery Office, 2015) under S 17ZB of the Children Act 1989.

The Children and Families Act (2014) establishes a single assessment process to support children, young people and their families from birth to 25 through a new Education, Health and Care Plan (EHC). This will be run jointly by health services and local authorities. A personal budget will be provided to support families who will be involved in discussions and decisions relating to their care and education.

Assessing safety

In the example of Hayley above, the complicating factors, the circumstances of the family that lie behind the neglect or abuse – such as mental health issues, drug and alcohol misuse and family violence – were insufficiently

mapped in the initial assessment. Mapping complicating factors is an essential element in the *Signs of Safety* approach This was devised initially by Turnell and Edwards (1999) as a comprehensive safety assessment process that documents both concerns and safety alongside identifying the goals and perspectives of both professionals and family members. The primary focus is on developing and increasing levels of safety for children; thus, parents are required to demonstrate behaviour that is measurably safe. The assessment is structured so that parents understand others' concerns and what needs to be different for the professionals to be no longer concerned, with clear outcomes for the children. What is already happening that contributes to child safety is acknowledged and used as a basis for increasing safety in other areas of family life. Safety assessments have been further developed to include families where child abuse is denied (Turnell and Essex, 2006), domestic violence (Milner, 2004, 2008a, b, Milner and Myers, 2017), with young people whose behaviour is sexually harmful (Myers, 2007a; Bateman and Milner, 2015) and elder abuse (Milner and Myers, 2017). The Signs of Safety approach is currently being piloted in several local authorities (Turnell and Murphy, 2017; Baginsky *et al.*, 2017). It is both collaborative and forensic, drawing on the strengths and capacity of family members to increase safety, and assessed 'constantly, after and during each successive contact, with every case' (Turnell and Murphy, 2017, p. 25).

The risk assessment is taken with the full involvement of all stakeholders 'both professional and family, from the judge to the child, from the child protection worker to the parents and grandparents' (Turnell and Murphy, 2017, p. 26). There are four domains of inquiry:

- What are we worried about? (past harm, future danger and complicating factors)
- What's working well? (existing strengths and safety). [NB: Strengths are not signs of safety in themselves; they are capacities to be utilized in the development of safety.]
- What needs to happen? (future safety)
- Where are we on a scale of 0–10, where 10 means there is enough safety for the child protection agencies to close the case and 0 means it is certain the child will be (re)abused?

The emphasis is on assessing whether there are sufficient, **measurable** indicators of safety for the family to remain together. What these will look like is charted in initial safety assessments so that parents are fully aware of what is expected of them. Follow-up charts are used to document progress – or lack of it. Where there are no signs of safety, it is clear that the situation is too dangerous for the children to remain with their families or a parent to be allowed home. The charts follow a three-column format as demonstrated below.

PRACTICE EXAMPLE

Donna has five children (ranging in age from eleven years to three months) to three fathers. The eldest four children are in foster care but see their mother and baby brother regularly at a hostel where her parenting is being assessed. The middle column shows Donna what she is already doing that contributes towards safety. The end column shows her what safety measures she needs to demonstrate for professionals to be happy for her to be reunited with her children.

Initial Safety Assessment: Amber, Thomas, Nisreen, Saqib and Tyler

What we are worried about	What's working well	What needs to happen
1. Donna has a history of misusing cannabis and amphetamines, resulting in her children being allowed to play in the park on their own and her house getting into a very poor state.	The tests Donna has undertaken show that she has been substance-free for six months. She attends a substance misuse prevention group.	Donna will be continuing to provide test evidence that she is not misusing substances. Other evidence will be a clean and tidy house, playing with the children rather than letting them go to the park on their own, doing reading practice with Amber and Thomas. Being on good terms with her family so that she has support.
2. Donna chooses the wrong sort of men as partners. Mark cheated on her and damaged the house when he was angry. Abdul was physically violent to her. Carlton drank heavily and was occasionally violent to her when drunk. Amber witnessed her mother being hit.	Donna took out an injunction against Carlton and changed her telephone number so that she and children were free of him. After three bad choices, Donna now recognizes that apologies and promises to change don't mean anything. She would rather live on her own at the moment.	She will be living alone with the children, focusing on them and making sure that they are properly looked after. She will be meeting new people as result of undertaking activities outside the home (e.g. attending college). She will be on good terms with her family.

3. Various professionals are concerned that Donna minimizes the above concerns, acknowledging them at a superficial level only.	Donna accepts responsibility for the behaviour which resulted in the children being removed from her care. She is reluctant to talk about it for two reasons: i) She is ashamed and embarrassed. ii) She knows what she did was wrong and wants to find a solution so that she doesn't do these wrong things again.	Remorse is easy to express and impossible to quantify. More **measurable** indicators of safety would be those listed at points 1 and 2.
4. Donna suffers from depression and has self-harmed in the past.	Donna has not self-harmed since the first threat to remove the children from her care. She consults her GP and takes her medication regularly. She is handling stress better these days.	Donna will be confident and well. There will be no self-harming. She will ask for help when she has difficulties and be well supported socially.
Children's goals	**Parent's goals**	**Social Care's Goals**
1. The children wish to return home to their mother.	Donna wishes to get the children returned to her care and a home.	Donna to be substance-free, doing the caring of the children, ensuring their safety, sticking to a routine, and cooperating with professionals.
2. Amber wants her mum to stop smoking and give her dad a second chance.	Donna wants an opportunity to prove that her behaviour has changed.	Doing something for herself.

THEORY INTO PRACTICE

Lincoln is living apart from his children and partner Lily following an assault on his daughter Milly, the third child of seven ranging in ages from thirteen years to eighteen months. He has regular, supervised contact with his children at a Family Centre. He is permitted to phone Lily. He has no contact with Dee, the mother of Sam. This chart indicates the progress he has made, all but one item of which is in the middle column; he is making progress but it is early days.

Second safety assessment: Sam, Sean, Milly, Megan, Mark, Cameron, and Jordan

What we are worried about	What's working well	What needs to happen
Historic		
1. Lincoln hit Dee's head against a wall when she was holding Sam when he was a baby.		
2. He has been violent to Lily, witnessed by Sam and Sean.		
3. Sam and Sean report being afraid of Lincoln when he is 'in a mood' after drinking cider and smoking cannabis.		4. Since he left the family home, all Lincoln's drink and drug tests have been negative.
Recent:		
5. He has heated arguments with Lily, witnessed by the children.	6. He is talking calmly on the phone with Lily. 7. He is handling his frustration at the separation calmly.	
8. Milly, Megan and Mark are scared when their dad shouts, becomes angry and throws things.	9. On contact, Mark told dad that his face was stern and Lincoln apologized.	

	10. He has been keeping his voice quiet on contact, explaining things to the children, and working with the older children on temper control.	
11. He hit Milly when she disrespected him.	12. When Milly did a pretend disrespect (the fake tongue ring) at contact, Lincoln stayed calm and controlled his upset. 13. He allows the children to disagree with him and gives explanations. 14. He asks the children what they have been doing and praises them. 15. The older children say that he is doing discipline without shouting. 16. He gives all the children attention and talks to them one at a time. 17. He plays with the little ones at their own level (in the tent, reading stories). 18. All the children greet him enthusiastically and say how much they are enjoying seeing him. 19. Lincoln is less tense about being supervised and is enjoying the children too.	
Children's goals	**Lincoln's Goals**	**Professionals' Goals**
1. To have dad back home and no shouting or hitting.	1. To show Lily his love for her and be a good father to his children.	1. Have more conversations with the children, praise and enjoy them.

2. All the family to show more respect for each other.	2. Talk quietly and calmly, praise the children and talk to them all, one at a time.	2. Do discipline without shouting. 3. Understand the impact of the assault on Milly. 4. Lily to be safe.

Complete column three: decide what measurable indicators of safety Lincoln needs to demonstrate (in relation to the goals) for you to be happy for him to return to the family home.

Assessing the wishes and needs of children

Whether the situation is one of possible risk or of unmet need, or both, or parents are contesting contact and residence arrangements, the focus of assessment is the child. As part of making a positive contribution, children are expected to be able to engage in the decision-making process, but the Cleaver and Walker study (2004) found very little evidence of informing or *consulting* children and young people during the assessment process. They suggest that this may be because social workers are so involved with case management that they have little experience and/or confidence in direct work with children (p. 265). Taylor (2004) suggests that there are other factors at play here. She identifies the reinforcement of social work's reliance on psychological knowledge as a means of understanding behaviours and relationships and identifying causes for concern, particularly the use of child development theory. Viewing children as preparing for adulthood, rather than viewing them as people in their own right, living their lives and accomplishing things in the here and now, means that their capacities for understanding and reasoning are underestimated, and they are not deemed competent to make decisions. Ferguson (2004) noted that social workers are often at a loss regarding how to communicate the enormity of a child protection investigation to children. He also found that there are times when social workers' reflection is either limited or non-existent because they defend themselves against the sensory and emotional impact of the work and the high anxiety they are experiencing (Ferguson 2018). Children are aware that something major is happening in their lives when they see their parents distressed, the police coming to their home, or a sibling taken to hospital or foster care. Without an explanation, they often make up their own; for

example, Turnell and Essex (2006) tell of a 5-year-old boy who witnessed his stepfather being arrested for alleged sexual abuse. Later, he saw a television news story about an IRA bombing and came to the misguided conclusion that that was why his stepfather had been arrested.

Where parents are contesting issues of contact, residence and/or parental responsibility, there are difficulties, most notably the very real issues for a child of not offending the residential parent and how to assess whether or not a parent is attempting to promote a partial view (for a fuller discussion, see Mantle *et al.*, 2007; Hobbs, 2002). There is also the issue of possible disagreement between the children about contact; for example, in the case of Peter mentioned above, he did not want contact with his father as he found it more difficult to get his own way under the stricter discipline in this home. This meant that his mother's initial solution to the concerns – drinking only when all three children were with their father – was impossible to operationalize.

THINKING POINT

To what extent should children's wishes be accepted as paramount, and to what extent do they have free choice when this impinges on the rights of other siblings to have their wishes and needs met?

Cleaver and Walker (2004) found that social workers had little confidence in direct work with children. Partly, this may be due to their preoccupation with case management, but there is also evidence that they rely heavily on interviews with parents and the parents' willingness to cooperate to make judgements (Holland, 2000). This means that it is the quality of the worker–parent relationship that forms the basis for decision-making, not the quality of the parent–child relationship (Taylor, 2004). Rarely are there in-depth observations of this relationship, except where contact is supervised. This supervision is not usually undertaken by the social worker and we have evidence from our work that these observations tend to focus on deficits rather than competencies. Eight years later, Munro and Lushey found little had changed:

> Although children were seen and spoken to, social workers did not always adopt effective strategies to actively engage them or ensure that their voices were at the centre of the assessment (this was particularly the case in respect of younger children. (2012, p. x)

The Munro review (2011, 2012) had the effect of increasing flexibility in the completion of assessments, allowing social workers more time to engage with children and explore their wishes. Yet social workers still struggle to

communicate with children. The Talking and Listening (TLC) project found that – despite calls for social workers to reclaim the importance of relationships in their work (see, for example, Featherstone *et al.*, 2014; Ferguson, 2016) – it was still difficult for social workers to build and sustain protective relationships with children where bureaucratic procedures dominate. Morrison (2016) points out that there is a fundamental mismatch between the ways children communicate and the linear process of formal assessments.

What seems to happen is that the assessing social worker makes a token attempt to assess the children's wishes separately from the parents – especially in child protection assessments. Thus, the child is either seen in school or taken out for a burger or to the local park, while the parent or parents wait anxiously for their return. This is not entirely satisfactory for a number of reasons:

- If the child has not been given an explanation for earlier events that led to Social Care involvement in the family, they will be puzzled as to why they are being taken out by a relative stranger and may not understand why they are being asked about their wishes. This leaves the social worker with having to 'interpret' any chance comment made by the child.
- Where the child knows only too well the seriousness of the situation, they may hesitate to talk freely as they may worry how the social worker will use any information given. They do have to return to the home and may well face questions from parents about what they said.
- Many children do not like being interviewed at school as this leaves them with the need to invent a story for their classmates.

PRACTICE EXAMPLE

The investigating social worker in the case of Peter, Laura and Michael (above) interviewed Michael at school. This interview consisted of direct questions about his mother's drinking and the preparation of an eco map. She was left in a quandary after this interview as, on the one hand, Michael confirmed that mum's drinking worried him but, on the other hand, his eco map left out dad's new partner. The worker was worried that contact with dad was impacting on his welfare as much as mum's drinking.

Michael's mum later complained to us that she did not want her children interviewed at school as it 'showed them up'. Michael confirmed this: 'It was right embarrassing. The teacher sat in with us and I didn't want her to know all that stuff'. When asked about his eco map, he added: 'I did it right quick, just to get it over with so I could get back in class'.

Whittaker's research into how child protection practitioners make decisions found that most of those who are highly experienced not only use their repertoire of experience to link intuition and analysis, cross-check their analyses and cope with potential information overload but also demonstrate skill in assessing children in the home:

> I went to do the home visit for a 7-year-old girl because we had concerns that her violent Dad was living in the house. She was colouring in on the living room floor and Mum was sitting on the sofa. So I got down on the floor with her and I saw a man's trainer shoved behind the sofa. Later, when I asked Mum about this, she said he didn't live there and the shoes were her brother's. But I made sure I was looking at her daughter when I asked the question and she looked surprised, she was too young to hide it. When I was talking to the girl on her own, I knew not to ask her directly because she would back Mum up. Instead, I asked her about her daily routine and it soon came out that her Dad was there when she woke up. (2018)

Whittaker suggests that a good mix of practitioners with different levels of experience is helpful in the assessment process.

Smart *et al.* (2001) show that children are capable of a sophisticated understanding of issues and dilemmas and able to construct ways of dealing with them, so it is more productive to provide children with an honest explanation of events and issues, however young they are. Turnell and Essex (2006) use words and pictures as a way of explaining *the concerns* to children, along with the parents. This process covers the following areas:

- Who is worried about the children.
- What they are worried about.
- What happened then.
- Private parts (in cases of alleged sexual abuse).
- What we (family and professionals) are doing about the worries.

PRACTICE EXAMPLE

Assessing Jonathon's wishes and needs

Jonathon's foster carer was very worried about Jonathon being talked to about his previous abuse and she also complained that he wasn't very good at writing and was 'fed up' with the 'wishes' questionnaires his social worker had asked him to fill in, so an introductory session consisted simply of explaining our role and

asking him to make a list of the things he's good at for the next visit. The second session with Jonathon took place with his foster carer present. After discussing his list of good things about himself, one of which turned out to be 'good at drawing', Jonathon was asked what he understands about court and he surprised us by giving a sophisticated answer: 'It's where judges make decisions about bad people'. He had seen this on *Coronation Street*. We explained that family courts are rather different, and what they do to protect children, and asked him to draw a picture of a court.

His drawing was remarkably accurate; he even drew an accurate representation of the insignia on the judge's bench. We explained who sat where in court and he drew stick figures representing the judge, solicitors, social workers and his mother and family. We then asked him what happened at school when someone has been naughty and a teacher says 'Who did that?'; we agreed that all the children say 'It wasn't me.' We then explained that's what everyone said when the judge asked who gave Jonathon the bruises, and the judge then said that, to keep Jonathon safe, he would send him to live with his foster carer. Jonathon understood this and asked if he could keep the picture in his life story book.

We then fast-forwarded his life to the here and now and talked about him now having two mums and how he would like this to be. Jonathon was very clear that he would like to see his mum every other week, sometimes at her house, sometimes at his foster carer's house. He wanted his foster carer to be present at these contacts.

Both mum and the foster carer could readily accept Jonathon's wishes – mum because it gave her more time with him to build up their relationship and the foster carer because it removed her fears that Jonathon would be suddenly removed from her care.

Interviewing children separately from their parents *to ascertain their views* on family life (not *to make a decision*) is sometimes necessary, but we find it most useful to ask all family members for their views on the concerns, what needs to be different when everyone feels safe, and what their best hopes are as a family. Even families where there are serious child protection concerns still have high hopes and aspirations for a better and more satisfactory family life. We do this by means of listing the concerns and asking everyone for details of the good things about living in this family (a 'thin' answer from a child to this question frequently encourages a parent to change their behaviour so that they can get a better response next time the question is asked). Then we ask everyone the miracle question (for more details, see Chapter 9). We give everyone a piece of paper and a pencil and ask them to write down

the answer to the question we are about to ask. (Pre-school children are invited to draw their answer; very young children are given a sheet of paper, stickers and crayons to make a picture which they can then present to an adult; and older children without speech are linked with another family member who the family has identified as the person best able to represent them.) We keep this lighthearted by reminding them that no one must see their answer and to put their arm round the paper as they do at school to prevent copying. Then we ask: 'Suppose, while you are asleep tonight, a wonderful thing happens and everything that is worrying Social Care has disappeared. When you wake up, what is the first thing that you would notice that would tell you that things are better?' It is helpful for the social worker to do this too as it helps him/her to identify precisely what evidence of safety would look like and present this to the family.

Reminding everyone to keep their answers hidden, we then ask them in turn to guess what another person has written. This is not done randomly; we ask the non-abusing parent to guess what the youngest child has said as this is relatively non-threatening and gives that person the opportunity to demonstrate his/her understanding of the child's needs and wishes. Then we ask the most confident child to guess what the (alleged) abuser may have put. Finally, we ask the abuser what they think a child has said (we usually select the most vulnerable child here). Where a family gives superficial answers, such as 'He would have a new bike', we add the family pet to the exercise and ask everyone what the pet would notice. After this has been talked about, we ask each person what they actually put and then discuss differences of perceptions. This exercise has several advantages:

- It gives children the opportunity to express their needs and wishes.
- It enables parents to hear these.
- It encourages discussion about what changes can be made.
- It enables a non-abusing parent to talk about the difficulty of being what one parent described as 'piggy in the middle'.
- It provides a snapshot of family dynamics in action.

The latter observations are important as they reveal family strengths (for example, a parent being unexpectedly caring towards a child) and weaknesses (for example, a father looking shocked when his son's miracle is that dad isn't hitting mum or a mother's reaction to all the children saying 'mum won't be hung over'). It is less threatening to point out weaknesses during the exercise, and parents enjoy their competencies being noticed and commented upon. Observing families is easiest when the social worker makes an effort to see them at ordinary family times; we cannot stress strongly enough the value of visiting families outside working hours. Families can be very different in the evening and at weekends.

The Signs of Safety approach engages children by using another three-column chart: Three Houses (good things, bad things, dreams). Words and pictures explanations are also used for parents to explain what has happened and what is happening to the children and, if applicable, set out the safety plan. Words and pictures serve as both the explanation that children need to understand their situation and as a catalyst for change for families. By these means, the child's voice is brought into the assessment, and most critically as a catalyst for change, to the family. The inspectorates of Ofsted, the Care Quality Commission, HMI Constabulary and HMI Probation praised the use of such ways of communicating with children as contributing to the importance of direct work to support children who have experienced domestic violence (www.cypnow.co.uk/cyp/news/2002878/ofsted-hails-eileen-munro-signs-of-safety-in-domestic-abuse-cases).

Dumbrill (2006) and De Boer and Coady (2007) found that families are most likely to make changes that will benefit children when social workers exercise their power softly and judiciously; treat families with kindness, dignity and respect; and are honest and genuine. This is not always easy to do when the assessing social worker is faced with organizational pressures to prioritize maintenance of the records by which the agency will be audited, and we suggest that establishing genuine working partnerships demands enormous moral courage on the part of social workers as well as endless persistence (and sometimes resistance) in responding to organizational pressures.

Critical comment

Although there has been an improvement in information collection and the involvement of parents, especially in the assessment of need, Rose *et al.* (2006) note that practitioners still encountered difficulties when it comes to analysis, judgement and decisions about when and how to intervene. Despite three fifths of assessments in the trials of the more flexible assessment practice being judged to be good, Munro and Lushey (2012) note that there was a lack of reference to research or explicit use of theory in the vast majority of assessments. This is understandable given the theory and research evidence that is promoted in government guidance.

There are two major problems with this guidance. First, the research evidence is lopsided in terms of understanding child abuse and thus encourages practitioners to search mainly for 'risk' factors. This does not facilitate shared perspectives about concerns between parents and professionals and leaves the worker with a plethora of negative information on which to make decisions about safety. The guidance does include advice to focus on strengths as well as problems, but it is important to remember that family strengths do not in themselves equate to safety although they can be used to build safety.

Second, the underpinning theory is largely psychological, leading to other dimensions of the framework being neglected. This is especially the

case where there is low risk but high need. The significance of the social and economic environment people find themselves in is being increasingly recognized, particularly the damaging effects of poverty (e.g. Featherstone *et al.*, 2018), but how do assessments acknowledge this and suggest support that will be of material help? Additionally, the emphasis in the guidance about the importance of attachments ignores the fact that such an assessment should logically lead to psychodynamic interventions but these are rarely provided as they are lengthy and expensive. Not only would such interventions mean delay for a child, but there are few adequate resources available for them. As a result, assessments and subsequent interventions are often theoretically inconsistent, as the example below demonstrates.

PRACTICE EXAMPLE

Jacob is a large 13-year-old with mild learning difficulty who has raped his 10-year-old sister, Paige. An AIM assessment identified him as low-risk, but he has been re-referred following acts of disruption, vandalism and violence which have resulted in him being excluded from school.

The social worker's assessment identified several risk factors:

- Jacob has attention deficit hyperactivity disorder (ADHD), which is partially controlled by medication. He remains impulsive.
- His parenting is inconsistent: his mother tends to find excuses for his behaviour while his father is critical and demanding.
- Disagreements about handling Jacob's behaviour have put the marital relationship under severe strain.
- Paige is unwilling to talk about the rape and has refused to be interviewed by the police.
- Her parents support her in this as neither of them want it 'dragged up'. They are uncomfortable in talking about sexual matters.
- The family is financially stretched as they have recently bought a large house that is in need of extensive renovation.
- The parents are unable to have a social life as they feel the need to supervise Jacob and Paige at all times.

Not having identified family strengths, and ignoring the community and environmental factors, the social worker instigated interventions based on psychological factors. A referral was made for couples therapy for the parents and adolescent psychological services for Jacob. Additionally, Paige was

offered counselling and a referral was made to a specialized service dealing with young people whose behaviour is sexually harmful. Jacob was provided with a support worker. The social worker saw her role as managing the case, not offering any direct work.

On the surface, this sounds like a reasonable package of care. However, it turned out to be completely inconsistent: the marital therapy was based on systemic family therapy ideas; the adolescent service used cognitive behavioural therapy, the counselling was person-centred, the work on sexually harmful behaviour was solution-focused, and the support worker used the Good Lives model. Not surprisingly, the family was totally bewildered by the differing demands and therapeutic advice offered. There was no change in Jacob's behaviour.

Roose *et al.* (2014) and Keddell (2014) researched strengths-based and SOS practice respectively and identified the need for a strong theoretical grounding for the approaches to ensure a consistent understanding and response. They also raised concerns about the potential to minimize structural dangers and to concentrate on the intricacies of people's lives in ways that could lead to pathologizing them. We recognize this and would encourage practice that locates people in their wider situations.

Difficulties in intra- and inter-agency decision-making

All government guidance prioritizes intra- and inter-agency working as a means of sharing information and improving decision-making. However, several heads are not necessarily better than one, especially where the 'one' is a highly experienced child protection practitioner (see Whittaker, 2018). There are three serious distortions that can occur when we work in groups, especially when making decisions involving risk (for an overview of the psychological factors involved in team work, see Nicholson *et al.*, 2006, Chapter 7).

Groupthink

One popular explanation of reasons for defective decision-making in groups is the concept of *groupthink*. This describes decision-making in groups under stress where a group engages in particular types of behaviour. When Janis and Mann (1977) studied several disastrous policy decisions, they found that these behaviours include the following:

- Shared rationalizations to support the first apparently adequate course of action suggested by an influential group member.
- A lack of disagreement between group members.
- A consequent high level of confidence in the group decision.

Groupthink has been found to be exacerbated where group members are under stress (Badie, 2010).

This concept of groupthink has already been aired in the child protection literature, and suggestions for improving case conference performance with reference to making corrections to the symptoms of groupthink have been promoted in training packs (Lewis *et al.*, 1991). However, there are two fundamental problems with the application of correctives. First, the concept of groupthink itself suggests that once a group is subject to its symptoms, it will be too deeply entrenched in its behaviour to see a need for re-evaluation or change. This is especially the case in an age where social media supports and multiplies a 'hive mentality' (Gross, 2011). Second, it may be the case that an individual can exert far more influence on the decisional direction of the group owing to framing effects.

THINKING POINT

Read the Orkney Report (Lord Clyde, 1992, London: HMSO):

- Identify the 'correctives' and consider how they failed.
- What could have been done to prevent the groupthink effects?

Group polarization

Whyte (1989, 1993) suggests that rather than alter the original framing of the problem, a group would be subject to the effects of *group polarization*, and this would *accelerate* the tendency to risk or caution of the original framing, group polarization effects demonstrating that people in a group take a more extreme position than they would as individuals (Moscovici and Zavalloni, 1969). This, suggests Whyte, means that rather than act as a countercheck to any unwarranted optimism, if the decision is framed in terms of losses, the group will commit resources to a course of action initially agreed on by the group, even when it is failing. Group members will bolster this decision by self-justification, such as 'The plan needs more time to work' or 'We need more resources'. Group polarization effects increase exponentially as group members reinforce each other's opinions (Myers and Twenge, 2018); these effects are made increasingly evident due to social media platforms with increasing hostility and discrimination towards those who think differently (Iyengar and Westwood, 2014).

The group then has the potential to become so risky that there is always the possibility for a decision fiasco. This group behaviour is not only found in social work assessments of risk. As Leiss and Chociolko (1994, p. 31) comment on industrial risk assessment: 'The significance of an event's probability tends to decrease as conceivable consequences increase, until what is possible becomes more feared than what is probable'.

An analysis of child protection case conference decisions (Kelly, 2000) showed that:

- Most child protection assessments are framed in the domain of losses.
- The *key decision-maker* is the individual social worker who deals with the initial referral and prepares the report for the case conference.
- The case conference does not act as a check against this initial assessment. (It does, as Whyte predicted, escalate rather than reduce risky decision-making.)
- Although individual social workers perceive other case conference members to be more powerful than themselves, these members actually have little influence on the decision.

This does not imply notions of unwarranted optimism or careless assessment work on the part of social workers *per se*. The social-psychological theory explaining these effects is universal, and there is no evidence that other case conference forums are any more effective in realistically assessing risk (Whyte, 1989, 1993). What it does imply is that an individual social worker would make less risky decisions than a group when a losses frame is applied and that an interagency group can operate more effectively when a gains frame is applied. O'Sullivan (1999) cautions that social situations are complex and uncertain, with sound decisions arising from a process which includes involving service users to the highest feasible level; consultation between it all the stakeholders; careful framing of the decision situation; and making a systematic choice between options.

Prospect theory

Kahneman and Tversky (1979) offered an explanation of how individuals make decisions that tend towards the direction of risk or caution depending upon whether or not the initial choice is framed in terms of options that involve *gains* or *losses*. If the possible options are framed in terms of gains, individuals will be risk-averse; that is, they will opt for a certain, although perhaps smaller, gain as opposed to another larger gain that is uncertain or risky. In other words, they will be less likely to gamble or risk losing the certain gain. However, if the options are framed in terms of losses, individuals will be more risk-seeking and will tend to avoid a certain, although smaller, loss in favour of another, larger loss that is uncertain. They will be more likely to risk the gamble, exposing themselves to a potentially greater risk. Positive framing leads to caution, and negative framing to risk-taking. The various options open to social workers are often all unattractive, desired outcomes usually having a low probability and less desirable outcomes having a high one. All the options can usually be framed either positively or negatively, and this will affect riskiness in decision-making.

Many of the dilemmas in social work involve choices between two unattractive options. For example, a social worker is faced regularly with leaving children in an abusive family or placing them in different foster and children's homes. While family support and specialized fostering services remain underdeveloped, the first option in these examples is highly desirable for the social worker, but, in opting to avoid a certain loss (of family life), other possible losses (further harm to the children) are ignored and risky behaviour sets in (see, for example, Kelly and Milner, 1996b). Cautious behaviour (that is, seeking to achieve certain gains) is more likely to lead not only to re-evaluation and contingency plan-making but also to creative and effective social work. To avoid a shift towards risk-taking, social workers need to frame options in terms of certain and uncertain gains. Safety-focused assessments facilitate this more than do other types of intervention as they emphasize safety, which is more easily measured than is risk.

Hackett and Taylor (2014), in their study of children's social workers, suggest that various conditions can create overconfidence and lead to intuitive decision-making (heuristics), anchoring and confirmation biases and restricting openness to other explanations and solutions. Munro (2011) identified that there are systemic processes that can lead to such practices, not least the pressured, bureaucratic and formulaic approaches to social work practice in many children protection situations. It is clear that we need to be aware that all our decision-making is contingent and that we need to be open to new possibilities, however difficult we may find this. Turner-Daly and Jack (2014) found that good supervision and open discussions with colleagues can help to identify and deal with bias but that often supervision was focused on process issues rather than looking at the reasoning behind sense-making.



Summary

- The law relating to child protection is complex, the policies are specific and the guidelines are numerous.
- Expected outcomes for children's well-being are detailed in government guidance.
- It has at least shared the focus on children at risk with children in need, who should get a better joined-up service in the future.
- The frameworks for assessment are comprehensive checks that ensure nothing should be ignored if they are followed. On their own, however, they do not guarantee effective assessments in terms of ensuring the outcomes.
- Outcomes have been defined better than before, although how they will be achieved via the high level of strategic planning and the commissioning of services is not clear.

- The research basis for assessment of risk is not without its critics.
- The emphasis on partnership with children and their families is a step in the right direction but it needs to be practised with a high level of professionalism. It is not a guarantee of service.
- Intra- and inter-agency work does not necessarily improve decision-making. Cognitive distortions can arise in group decision-making.



Further learning activities

- Select one of your cases where you are frustrated with the parents' lack of cooperation with your assessment and/or your concern about their untruthfulness.
- Make a note of the possible reasons for this and what you have already done to promote partnership.
- What else can you do to promote partnership?



Further reading

Bateman, J. and Milner, J. (2015) *Children and Young People Whose Behaviour Is Sexually Concerning or Harmful. Assessing Risk and Developing Safety Plans.* London: Jessica Kingsley Publishing.

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Featherstone, B., White, S. and Morris, K. (2014) *Re-Imagining Child Protection: Towards Humane Social Work with Families.* Bristol: Policy Press.

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Milner, J. and Bateman, J. (2011) *Working with Children and Young People Using Solution Focused Approaches. Enabling Children to Overcome Challenges and Achieve Their Potential.* London: Jessica Kingsley Publishers.

Munro, E. and Lushey, C. (2012) *The Impact of More Flexible Assessment Practices in Response to the Munro Review of Child Protection: Emerging Findings from the Trials.* Childhood Wellbeing Centre.

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11 ASSESSMENT IN ADULTS' SERVICES

What this chapter is about

In this chapter, we will focus on mostly service users, particularly older people, people with mental illnesses, and disabled people and their carers. We will stress, however, that all these people have many problems in common (for example, health, safety, housing, income support and discrimination). They all can be vulnerable and neglected and, in the not too distant past, the services responsible for them were seen as Cinderella services, which depended on unqualified workers and were underfunded. Services have improved over the years with an increase in qualified workers with government undertaking a large-scale transformation in adult services, based on entitlement and choice and involving individual personalized budgets. This has been followed by the further development of integrated health and social care services.

We remind the reader that the ideas in the 'maps' chapters, Chapters 5 to 9 – about ways of helping people to be more independent, take responsibility for self-care and for behaviours (physical and mental), keep a positive outlook, mobilize their own resources (internal and external), be creative and engage with others – are to be drawn on so that assessment is not separated from intervention. The response of a person to such help is a key element in any assessment.

Main points

- The statutory framework and the main guidance from government.
- Integrated assessment: underlying principles, processes, and outcomes.
- Decision-making and risk.
- Assessing vulnerable and/or dangerous adults.
- Critical comment.

The statutory frameworks

The four nations of the UK have begun to diverge in terms of how they organize and deliver social care services through the introduction of legislation within their respective devolved arrangements. Relevant legislation includes the Care Act (CA) 2014 for England; the Social Services and Well-being (Wales) Act 2014; the Social Care (Self-directed Support) (Scotland) Act 2013, and the Health and Social Care (Reform) Act 2009 for Northern Ireland.

The CA 2014 consolidates previous legislation, including the National Health Service and Community Care Act 1990, the Carers Recognition and Services Act (1995) and the Community Care (Direct Payments) Act 1996. The underlying principle of the act is for the well-being of the individual with local authorities having a general duty to promote this. Well-being is defined within guidance as being composed of the following:

- personal dignity (including treatment of the individual with respect);
- physical and mental health and emotional well-being;
- protection from abuse and neglect;
- control by the individual over day-to-day life (including over care and support provided and the way it is provided);
- participation in work, education, training or recreation;
- social and economic well-being;
- domestic, family and personal relationships;
- suitability of living accommodation;
- the individual's contribution to society.

The local authority must also act in ways that prevent, reduce or delay the need for care and support, and there is a statutory requirement to collaborate and cooperate with other public bodies such as the NHS to promote integration of services (S.2 CA, 2014). 'Prevent', 'reduce' and 'delay' can be seen respectively as 'primary prevention' (promoting well-being), 'secondary prevention' (early intervention) and 'tertiary prevention' (formal intervention), providing a graded approach to supporting people.

Example: Promoting well-being

The Campaign to End Loneliness identified that help with transport and technology were key solutions to reducing loneliness, which has been found to be a significant health risk (Age UK and the Campaign to End Loneliness, 2015).

Example: Early intervention

A person who finds that they are struggling with the stairs in their home may benefit from the fitting of handrails. Adaptations to enable people to remain safely in their own home can help prevent a crisis. Support may also be given to carers to help them help others.

Example: Formal intervention

People who are finding it hard to manage their complex health needs or disability may require more intrusive intervention, perhaps spending some time with specialist services either in or away from home for a period of time, to maximize their quality of life. Carers can also benefit from services such as respite care.

Where (generally) older people are at risk of admission to or have left hospital, they may access Intermediate Care. This is defined by the National Audit of Intermediate Care (NAIC, 2017) as having four aspects: a crisis (short-term) response of up to 48 hours; home-based intermediate care for people by a multidisciplinary primarily health team; bed-based intermediate care away from home; and re-ablement to enable people to live independently in their own homes with the support of a primarily social care team.

The CA 2014 also requires the local authority to assess young people and their carers in transition from childrens' to adults' services, a process that has been previously identified as lacking. Indeed, as part of the drive to develop integrated services, the local authority needs to consider how their services are working together, including how different legislation (for example, the Children and Families Act, 2014) can dovetail into adult services.

There is a duty (S.4) to provide information and advice to the whole community, informing people how the system works; what is on offer; how they can access the services; financial advice and how to raise any concerns about the well-being or safeguarding of someone. This information should be accessible to everyone and so needs to be presented in a range of appropriate formats.

The CA 2014 has introduced clear expectations about assessment and eligibility for services, recognizing assessment as both a *process* and an *intervention*. It is outlined in Sections 9 to 13 of the CA, and guidance is in the Care and Support (Assessment) Regulations 2014 and the Care and Support (Eligibility Criteria) Regulations 2015.

> The assessment and eligibility process is one of the most important elements of the care and support system. The assessment is one of the key interactions between a local authority and an individual, whether an adult needing care or a carer. The process must be person-centred throughout, involving the person and supporting them to have choice and control. (DHSC, 2018)

The assessment must be appropriate and proportionate, taking into account the person and their situation, and the guidance supports several methods of undertaking this, including face to face; supported self-assessment; online or by phone; jointly with other agencies and combined with other assessments such as that of the carer or child. The intention is to be as flexible as required to establish the needs and wishes of the person, including a flexible approach to the timescale needed for them to contribute fully. It should enable the person to:

- develop an understanding of the assessment process;
- develop an understanding of the implications of the assessment process on their condition(s) and situation;
- understand their own needs, the outcomes they want to achieve and the impact of their needs on their own well-being to allow them to engage effectively with the assessment process;
- start to identify the options that are available to them to meet those outcomes and to support their independence and well-being, and
- understand the basis on which decisions are reached. (DHSC, 2018)

The aim of the assessment is to identify what needs the person may have but also what outcomes they want to enable them to maintain or improve the quality of their life/well-being. Identifying what support needs to be put in place to achieve the outcomes is part of this process, and the assessment should consider the personal, family and community resources available to meet these. To do this, the guidance recognizes that the assessors need to be trained and competent. The assessment will inform whether the person is eligible for services and, if so, which ones. If someone is eligible for services based on their determined needs, then a financial assessment will be made to see if or how much someone has to contribute to the cost of their care.

If people lack the capacity to make informed decisions and it would be in their best interests to be assessed, or there are concerns about safeguarding people from abuse, then people's choice not to have an assessment would be overridden. This has to take into account that people's capacity may fluctuate; for example, the presence of stress, depression, or physical infection adversely affects people with learning difficulty or dementia.

THEORY INTO PRACTICE

43-year-old Sarah has mild learning difficulties and has been deaf since birth, although her speech is intelligible and she can lip read in one-to-one situations. Following the death of her mother, she gave

up the tenancy of her council house. After a period of living on the street, a police officer took her to a short-stay hostel for homeless people where staff contacted Social Care as she was malnourished and so very distressed that they were unable to have a meaningful conversation with her. The specialist worker with deaf people assessed that she was unable to manage her affairs and she was found temporary accommodation in a care home. She quickly settled in and became much more coherent, telling her key worker that since the death of her mother she had been subject to abuse by a gang of youths on the estate. She had been afraid to leave the house to shop for food because of their taunts and afraid to stay in the house because of eggs thrown at her windows and fireworks in her garden. As her physical health improved and she felt safe, it became clear that she was capable of managing her affairs with support.

There is an emphasis in the CA, guidance to recognize the person's strengths and abilities, including social assets, and support the person to maximize their use of these. For a fuller discussion and practice examples, see Milner and Myers (2017).

The Social Care Institute for Excellence (SCIE) (2015) produced a useful guide to the assessment and eligibility processes of the CA, highlighting that the following themes should be considered at all stages of the process:

- Mental capacity
- Advocacy and participation support
- Impact on the family and carers
- Safeguarding
- Strengths-based approach
- Proportionate and appropriate.

Mental capacity

Before we look at integrated assessment in more detail and how this will affect specific service user groups, we look briefly at the Mental Capacity Act (2005) and the Mental Health Act (2007) as these affect more than one area of vulnerability. In Scotland, the legislation is contained in the Adults with Incapacity Act 2000. Sections 9 and 13 of the CA 2014 are relevant here.

The Mental Capacity Act 2005

- This Act states that capacity is to be presumed until proven otherwise. By 'capacity' is meant the ability to comprehend information relating to a decision, to retain that information, to use and weigh it to arrive at a choice and to communicate the decision (even if only by blinking an eye).
- The Act obliges services to take all practical steps to support people in making their own decisions as far as is practicable, in an environment in which the person is comfortable with the aid of an expert in helping him to express his views.
- Capacity is not to be ruled out simply because a person makes an unwise decision – s/he has the right to irrational or eccentric decisions that others might judge to be not in their best interests.
- If capacity is judged to be lacking, services must use the least restrictive option for caring, the option that would least restrict the right to freedom of action.
- A person may lack capacity in regard to one matter but not to another.
- The incapacity may be caused by mental or physical illness, learning disability, dementia, brain damage or a toxic or confused state.
- Any action taken on the person's behalf must be based on their best interest, not simply on age, appearance or assumptions based on condition or behaviour, or assumptions as to whether s/he will have quality of life without treatment. All relevant circumstances are to be considered and none is to be seen as more important than another.
- It cannot be assumed that a person will not recover capacity later on.
- Past and present wishes and feelings are to be considered, along with any written statements and religious beliefs.
- The Act does not mean that a doctor has to continue life-sustaining treatment when it is not in the person's best interests.
- The burden of proof of incapacity lies with the assessing health professional, who would work with social workers, as many decisions involve considerations of care provision.

The Mental Capacity Act 2005 is relevant in working with not only those who are mentally ill but also those with dementia, learning disability and end-of-life care. Developments in case law have highlighted the limitations of the Deprivation of Liberty Safeguards Code of Practice in guiding assessment making.

In the Cheshire West ruling, the majority verdict of the Supreme Court was that three people with severe learning difficulties had been deprived of their

liberty. Lady Hale highlighted the key principle that human rights are universal and thereby apply to everyone whether or not they have mental or physical disabilities. This means that many more people will require authorization for deprivation of liberty – even where their living conditions are comfortable.

In the case of *Aintree* v. *James*, the patient was dependent on artificial ventilation, feeding and nutrition, thus not able to make decisions about his medical treatment. The view of the clinical team was that it was not in his best interest to receive these treatments but his family disagreed. On the issue of 'best interests', Lady Hale said:

> The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say his wishes will prevail, and more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his views were in the past, they may well have changed in light of the stresses and strains of his current predicament. (Brindle *et al.*, 2013, p. 104)

Important implications arising from this case are the need to be wary of certain terms such as 'futility' and 'recovery' as these are not narrow clinical definitions. Similarly, the worker needs to be careful when using the term 'quality of life' as this requires a value judgement perhaps better made by those who know the patient best rather than clinicians.

Anorexia nervosa presents particular problems in the assessment of capacity – which the person is likely to have – and whether or not they should be forced to continue with treatment – which they frequently refuse. Assessment is further complicated by the cognitive decline that accompanies a body mass index of less than 18. To date, case law has been largely determined by whether or not every treatment with a prospect of success had been tried. There is no case law at present regarding the prescription of antipsychotic drugs to people with dementia.

THINKING POINT

A 73-year-old Muslim man with a history of serious physical impairment and mobility problems experienced a cardiac arrest from which he didn't regain consciousness. His family objected to the do-not-resuscitate order placed in his notes. An intensive care anaesthetist explained that the experience of intubation, ventilation, weaning, the passage and management of cannulas, etc. would be unpleasant and painful. However, the family was of the view that this suffering was the will of Allah and to deprive him of it would mean he did not experience a purifying process in preparation for death.

How would you assess this man's best interests?

(Adapted from Brindle *et al.*, 2013, p. 105.)

However, the rules and principles of the Mental Capacity Act do not necessarily apply if the person has a mental disorder that presents risks to their health or safety or to other people.

The Mental Health Act 2007

This law amends the 1983 Act, the Domestic Violence, Crime and Victims Act 2004 and the Mental Health Act 2005, stating that mental illness can be treated without consent when a person's health or safety, or that of the public, is threatened. The European Court of Human Rights ruled in 2004, however, that detention in a hospital is not lawful unless medical treatment of a person's disorder, considering all the circumstances, is available. Using the principle of necessity to keep a person in hospital is contrary to article 5 of the Human Rights Act. The old 'treatability' test is abolished, and supervised community treatment is introduced to ensure people receive the treatment they need and to avoid the 'revolving door' situation.

THINKING POINT

Eloise has suffered with severe anorexia nervosa for many years. She is in hospital now refusing to eat but accepting very small amounts of water. Her weight has dropped to a level that means she is likely to die without treatment. The chances of successful treatment are estimated at 20–30 percent.

Would making an assessment under the Mental Health Act result in a different decision from making an assessment under the Mental Capacity Act?

Assessments must ensure that the person understands the questions that are being asked and are capable of providing answers to these and that they understand the implications of the process as well as being able to state how they feel about this.

Advocacy and participation

Ensuring that the person can engage fully with the assessment process is key to developing a quality, helpful outcome. 'Doing with' rather than 'doing to' is useful to remember here: finding out what is the best way for people to work together with the social worker.

People might be better supported to be involved by 'reasonable adjustments' under the Equality Act 2010, assisting people to participate in their assessment by, for example, providing interpreters or other methods to make communication easier. If this proves to be inadequate and the person has substantial difficulties in engaging, then asking people to choose someone

from their family, or a friend or carer who is trusted by them should be considered. There is guidance about how to define 'substantial difficulties' (DHSC, 2018, Ss 7.10–7.16), which include to what extent the person can *understand, retain* and *weigh up* information and also *communicate* their views, wishes and feelings. This 'appropriate individual' (DHSC, 2018, S. 7.32) should not be someone who has a conflict of interest which includes anyone who may have a financial or professional interest, anyone the person does not want, nor should it be someone who does not have the capability to act effectively as an advocate. The local authority has responsibility for deciding if the appropriate individual can meet the expectations of the role.

If the local authority decides that there is no suitable appropriate person, then it has a duty to arrange for an Independent Advocate and also to ensure that there is sufficient provision of independent advocacy services in their area. The role is a key one and has become increasingly professionalized with a recognized qualifications framework (www.qualityadvocacy.org.uk). Advocates must be experienced; trained; competent; have integrity and be able to work with and challenge the local authority as well as having regular supervision to reflect on their work.

Cooper and Bruin (2017) found that it was a challenge for advocacy services to meet the new demands of the CA 2014 and that more consideration needed to be given as to whether an advocate was needed, particularly through safeguarding processes. The service is taking time to become embedded into practice.

Impact on the family and carers

People are usually networked to a greater or lesser extent with family, friends and professionals, so any assessment needs to consider not just how these networks can provide support but what will the impact of any plan be on them. If the person feels that, for example, it would be helpful to have a relative regularly providing direct care for them and the relative agrees this, then seeing what additional support the relative may need to do this is helpful. The local authority must consider this and ensure that the relative has access to appropriate information about relevant services, including a carer's assessment if necessary. The CA 2014 strengthens the recognition and rights of carers, and with the new emphasis on prevention carers should be able to have the support they need to reduce the chance of reaching the breaking point. Gridley *et al.* (2012) suggest that assessing the needs of carer and cared-for person jointly is an effective way of delivering care, although there may be the need to discuss issues separately to allow people to be clear about their feelings.

The carer's assessment should also look at how sustainable the caring role is, as people may want to provide help but may struggle to achieve this without compromising their own well-being. As ever, needs fluctuate and it is helpful to think about the impact of any possible changes in the circumstances of both the person and the carer.

THINKING POINT

When her mother began to have minor heart attacks, Marie moved to a house nearby in the small village. She was able to retain her work as a freelance chiropodist but reduced her hours. Her eldest son, Daniel, moved in with her after his relationship broke down and she supervises contact with his baby son to guard against his ex-partner's accusations of neglect. She shops, cooks and cleans for her mother, tasks which are made difficult by her father's verbal abuse. He has always been aggressive towards both Marie and her mother, favouring his younger daughter, Sandra. His aggression has worsened and become less predictable since he has been diagnosed with dementia. Her younger son, Dominic, and his partner, Shanice, who live many miles away, have recently had a baby boy who required special baby care after a difficult birth. Marie has been visiting the couple fortnightly to help out and the couple have asked her to babysit two days a week so Shanice can return to work.

Marie's husband, Milton, had been feeling increasingly tired and depressed and has now been diagnosed with motor neuron disease. Marie is desperate for a break and has suggested taking Milton to a spa hotel where he can lounge by the pool but he lacks the energy or will to do this, spending most of each day sitting on the sofa where his brother and friends visit him regularly.

- How sustainable do you think Marie's caring responsibilities are?
- How would you assess her needs?
- How could you help her prioritize her needs and responsibilities?

There is also a duty to identify and refer young carers to consider whether they are being required to do tasks that are inappropriate for their physical or emotional development or their well-being is compromised. If a child is missing school to care for their parent, then this would need to be investigated to see what could be done to help both the parent and the child to meet their respective needs. This requires a joined-up approach across relevant services, including a young carer's assessment under the Children Act 1989.

Safeguarding

The CA 2014 made safeguarding adults a statutory responsibility (Chapter 14 of the DHSC, 2018) and is defined as:

> 14.7 Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and

> experience of abuse or neglect, while at the same time making sure that the adult's well-being is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.
>
> 14.8 Organisations should always promote the adult's well-being in their safeguarding arrangements. People have complex lives and being safe is only one of the things they want for themselves. Professionals should work with the adult to establish what being safe means to them and how that can be best achieved. Professionals and other staff should not be advocating 'safety' measures that do not take account of individual well-being, as defined in Section 1 of the Care Act.

The approach taken is one of 'Making Safeguarding Personal' (MSP), an initiative that was trialled and tested in local authorities. Up-to-date research, learning and guidance on MSP can be found here: https://www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/making-safeguarding-personal.

MSP grew out of concerns that adult 'protection' was overriding the wishes and feelings of people and not providing them with the support to make informed, creative choices. They were not seen as experts in their own lives and decisions were often made for them, albeit for frequently benign reasons. The CA 2014 changed this, identifying six principles that should underpin all adult safeguarding work: *empowerment, prevention, proportionality, protection, partnership and accountability.*

THINKING POINT

- William is a 44-year-old man with complex needs. He is cared for by his parents, who have always refused respite care services. They are in their late seventies and not in the best of health. His father had a stroke recently and his mother is struggling to care for them both.
- How would you give this mother choice and control over her decisions for the future care of her family?
- How would you apply the six principles to this situation?

Decision-making and risk-taking

A key area for the assessment of all adults is that of enabling people to make their own decisions while minimizing risk or harm. People using care services or health services said that they wanted more control over their lives to be able to make real choices and take control of things most people take for granted (Lawson, 2017). The decisions some people make can seem to be quite risky, placing workers in a dilemma. Avoiding all risk constrains people's choice, yet the worker strives to not make decisions for people. To help with the dilemma, there are some guiding principles:

1. People have a right to live lives to the full so long as this does not hinder the rights of others.
2. Trying to remove risk altogether can destroy a person's quality of life. Choice, control and dignity are primary values to be respected.
3. Informed choice includes the option to choose 'unwisely'.
4. Decisions made on behalf of those who lack mental capacity must be made in their best interests and be the least-restrictive option.
5. If a choice involves risk of abuse, protective measures need to be put in place.
6. Human rights must underpin the actions of all public authorities.
7. Where there is a duty of care, foreseeable harm and negligence are concerns for the legal system, as is putting people at risk.
8. If a worker is in doubt as to whether going along with a risky decision involves negligence, s/he should consult a manager.

The real goal is to enable the person to be where they want and to do what they choose, so that this will enhance their quality of life, but without undue risk of harm to themselves or others and in line with the legal framework, respecting human rights (DoH, 2010, p. 56).

THEORY INTO PRACTICE

Bill had been caring for Florence (both in their late seventies) over a three-year period which saw her becoming increasingly dependent following a series of strokes and Parkinson's disease. Bill then suffered a heart attack and was admitted to hospital only to discharge himself when he heard that Florence was to be admitted to a care home. The worker provided a package of domiciliary and respite care which met the couple's needs until Florence broke her hip in a fall. Her mobility was seriously restricted, and the worker, concerned about Bill's health, again suggested admission to a home. Bill strongly resisted this plan:

She's [worker] always asking me how I'm coping but that's only to get her into a home. I do it [caring] 'cos I want to. I do get tired but if she's at home, I won't be trotting up here to see her [hospital]. I still hurry home from the shops, I look in the room for her, even though I know she's not there. I can read her, if she gets unsettled, I know what she wants. I know what questions to ask her. Anyone else wouldn't realize this.

- **How would you balance Bill's rights with your concerns about his and Florence's safety?**

Reports of litigation in the news media have had the result of making managers and workers risk-averse, a state that makes it difficult to honour the above principles, so it is encouraging that policymakers are now seeking to move from risk aversion to supported decision-making (in effect, supported risk-taking).

Supported decision-making

How can decision-making be supported? Does supported choice really mean support for the choice you want to make or for the choice the service user wants to make? Is the main concern of managers to avoid being involved in choice-making, because of the potential risk to the service of blame, should some harm follow? In our view, the process of supported decision-making, carefully carried out in collaboration with a service user, can help to clear up many of the concerns that arise in assessing how best a person's quality of life can be safeguarded and risks managed.

First, we need to check whether service users need to be helped to understand the possible consequences of their decisions and to take responsibility for them and, where necessary, to plan what level of protection would balance reasonable levels of risk. As people exercise more choice, more risks are inevitable. Risk-taking is a normal part of a free life, yet no worker or service wants to be blamed when things go wrong.

In applying the first principle above, by considering with people the possible consequences of actions and the likelihood of harm and then setting this against the benefits of a decision for independence and well-being, responsibility for decisions can be clarified and, if necessary, a support plan for managing risk can be put in place. However, staff in various services, or indeed within the same service, may have differing views on acceptable risk, so a process, involving service users and carers, is needed to resolve disagreements in this area. The service providing the funding will probably have the last say. And, of course, local authorities have a responsibility not to agree with any plan where they see serious concerns about being accused of placing an individual in danger. However, 'having a life' is not possible without some

risk and there is acceptance in guidance that we need to question the culture that says 'minimize all risk', whether it is a threat or not, engaging in helping people to make judgements about reasonable risk, supporting them in balancing the benefit and the risk and in finding possible ways of mitigating serious risk. We need to see vulnerable adults as 'people who want to do things' – people whose best interests are not equated with total safety, people who are often capable of accepting responsibility for their actions. A useful parallel is going to hospital for an operation, being told of the risks involved and the chances of things going wrong, and being allowed by the surgeon to decide whether to go ahead or not. The emphasis is beginning to shift from perceived negative impact to benefits and best interest. As Lawson (2017, p. 34) says, 'Working effectively alongside people to support their understanding of risk is key to prevention and resilience'.

So how do we go about having these conversations with people? The following Supported Decision Tool was used in the MSP programme to inform assessment conversations, including the use of aide-mémoires and prompts to help workers keep a focus on participation (Johnstone, 2014).

Supported Decision Tool (DoH, 2007e)

1. What is important to you in your life?
2. What is working well?
3. What isn't working so well?
4. What could make it better?
5. What things are difficult for you?
6. Describe how they affect you living your life.
7. What would make things better for you?
8. What is stopping you from doing what you want to do?
9. Do you think there are any risks?
10. Could things be done in a different way, which might reduce the risks?
11. Would you do things differently?
12. Is the risk present wherever you live?
13. What do you need to do?
14. What do staff/services need to change?
15. What could family/carers do?
16. Who is important to you?
17. What do people important to you think?
18. Are there any differences of opinion between you and the people you said are important to you?
19. What would help to resolve this?
20. Who might be able to help?
21. What could we (practitioner) do to support you?

22. Agreed next steps – who will do what?
23. How would you like your care plan to be changed to meet your outcomes?
24. Record of any disagreements between people involved.
25. Date agreed to review how you are managing.

This tool encourages a conversation that is capable of leading to more balanced and safer decisions than the use of the risk tick-boxes in the previous single assessment process. Enabling people to exercise choice and control over their lives is an essential part of the CA 2014; therefore, assessing and managing risk proportionately and realistically are vital. It is also important, however, to ensure that use of the above supported decision tool is accompanied by standard agency arrangements for safeguarding vulnerable people from harm, for preventing unnecessary harm and for not putting people at risk. For social workers engaged in making assessments, treating people in a holistic way means not only promoting independence and clarifying risks that can follow from decisions independently made but also considering any health risks and involving health professionals in the process. Cooper *et al.* (2016) identified one local authority that was encouraging assessing staff to ask three straightforward questions: what people want to happen, how people want that to happen, and what are the outcomes they want. This seems a good basis from which to start.

While we need to remember the basic right of people to take an active part in the community, learning new skills, working and developing new confidence (making a contribution) – these things are not possible without some risks. Risk is, ultimately, indefinable as the notion that levels of risk can be categorized as 'negligible, minor, severe and extreme' or 'insignificant, marginal, critical and catastrophic' are not only social constructions of personal perceptions in practice but also of little use, in that most people fall into the middle range. Professionals making assessments can discuss situations with informed colleagues, preferably including colleagues from other services involved and managers before making judgements about acceptable risk, but good practice focuses on human rights and timely support for decisions that suit people best. In situations of uncertainty, testing the risk is often worthwhile – for example, when a frail person returns home from hospital and lives alone, having a short trial stay at home can help the social worker to assess the situation better with the person and answer questions about whether the action is too risky.

Section 42 of the CA 2014 outlines the need for an enquiry by the local authority where it has reason to believe that someone:

- has needs for care and support (whether or not the authority is meeting any of those needs);
- is experiencing, or is at risk of, abuse or neglect; and

- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the person's case and, if so, what and by whom. 'Abuse' includes financial abuse which involves having money or other property stolen, being defrauded, being put under pressure in relation to money or other property and having money or other property misused.

The CA 2014 made it a duty for each local authority to set up a Safeguarding Adults Board (SAB) with the purpose of providing strategic direction to services in order to prevent abuse and neglect. It will create an annual strategic plan and report on its activities, facilitating collaboration between relevant agencies. Key agencies include the Local Authority, the Clinical Commissioning Group and the Police, and any other relevant agency can be invited to be part of this. This is intended to respond to local circumstances and to be inclusive of any service that could play a part in safeguarding adults in that area.

Strengths-based

Taking a strengths-based approach to adult care has been developing over the previous years. It has been increasingly recognized in guidance, for example:

> Ensuring that people themselves are at the centre of decisions about their health, care and well-being, and they remain in control and enabled at all times to maintain this well-being. This means building on the *strengths* people have, and their networks and community contacts, in order to promote independence. (SocialServicesNSM@Wales.gsi.gov.uk, 2013, p. 4 – our emphasis)

Within the CA 2014, there is strong recognition that people need to be encouraged to recognize strengths and capabilities they have, both in themselves and in their wider environment. This can generate hope and motivation as well as being their assessment of themselves rather than that of the worker. Often the labels that people are given can have consequences that are unhelpful. Mattelin and Volckaert (2017) give an example of the concerns that family and friends had of someone with autism who appeared to be socially isolated because they had few friends. However, the person with autism was perfectly happy with just a couple of friends and some social media contacts, which raised the question about who is to judge what constitutes a 'good enough' social life.

We look at strengths-based approaches in more detail in Chapter 9, with examples of how these can be applied.

Proportionate and appropriate

The guidance emphasizes the need for assessments to be both proportionate and appropriate. For example, someone may wish for information about services without wanting to discuss this face to face with a professional, or they have the capacity to fund their own care without the need to go through a thorough eligibility assessment. Proportionate can be thought of in terms of intrusiveness – what is the minimum intrusion into someone's life to have the maximum benefit for them. If someone clearly has quite significant need, they may require a more thorough and intensive assessment necessitating more personal questions and the involvement of a range of different professionals. This will always need to be done sensitively but also bearing in mind that there may be underlying conditions that are not always apparent at first.

The guidance encourages the use of supported self-assessment as a way of giving the person some control over the process. This can be achieved, for example, by asking the person to complete a questionnaire, working with them to interpret the questions and clarify their answers, or by other means. The assessment schedule should be as similar as possible to the one that the professional would use (DHSC, 2018, C6). Social workers should be reflecting continually on whether what is being done is appropriate for the person, recognizing that needs and levels of engagement can fluctuate. If it is clear that the process is not being helpful for the person, then it is worth doing something different.

Eligibility

The legislation introduced a national eligibility threshold for adults needing care. This is outlined in the Care and Support (Eligibility) Regulations 2015 and was introduced to try to reduce the 'postcode lottery' effect of differences in local service thresholds. Of course, there is still an element of interpretation involved as well as budgetary constraints.

An adult meets the national eligibility criteria if:

- Their needs are caused by physical or mental impairment or illness.
- As a result of the adult's needs, they are **unable to achieve** two or more **specified outcomes.**
- As a consequence, there is or is likely to be a significant impact on the person's well-being.

The **specified outcomes** are:

- Managing and maintaining nutrition.
- Maintaining personal hygiene.
- Managing toilet needs.
- Being appropriately clothed.

- Being able to make use of the home safely.
- Maintaining a habitable home environment.
- Developing and maintaining family or other personal relationships.
- Accessing and engaging in work, training, education or volunteering.
- Making use of necessary facilities or services in the local community, including public transport and recreational facilities or services.
- Carrying out any caring responsibilities the adult has for a child.

An adult is to be regarded as being **unable to achieve** an outcome if the adult:

- is unable to achieve it without assistance;
- is able to achieve it without assistance but doing so causes the adult significant pain, distress or anxiety;
- is able to achieve it without assistance but doing so endangers or is likely to endanger the health or safety of the adult or of others; or
- is able to achieve it without assistance but takes significantly longer than would normally be expected.

Combining and integrating assessments

The CA 2014 suggests that, where it is appropriate and agreed by the people concerned, assessments can be combined so that the process is less intrusive or repetitive. This hopefully avoids people experiencing 'assessmentitis', a condition described to us by one person who had received multiple assessments from different agencies.

> 6.77 Where more than one agency is assessing a person, they should all work closely together to prevent that person having to undergo a number of assessments at different times, which can be distressing and confusing. (DHSC, 2018)

THEORY INTO PRACTICE

John has a mental health condition that has deteriorated and left him severely depressed. He lives in poor housing with his 10-year-old daughter Emily, who has not been attending school consistently so that she can look after John when he is very down. John appreciates the support of his local church although he feels unmotivated to engage with it at the moment.

- How would you go about undertaking an integrated assessment for John?
- Which agencies should be included?
- Seehttps://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983.

Following on from this, where someone has both social care and health needs, the local authority and NHS should work closely together to ensure that the process and output of the assessment is coherent, coordinated and aligned, leading to a care plan that is meaningful and effective. There is flexibility here to tailor the approach to the specific circumstances of the person.

Assessing vulnerable and/or dangerous people

Previously, we have been guilty of categorizing vulnerable adults into service user groups, such as old, mentally ill and physically impaired, although we did write about people who fit into more than one group, such as those with a dual diagnosis or people with learning difficulties who are also parents under scrutiny. With gains made in the improved health, well-being and longevity, these categories are less helpful in determining what interventions are needed than previously. For example, older people constitute a diverse group with more living alone, being divorced or never married, higher numbers of black and minority ethnic elders, non-traditional models of family support and care-giving, and higher levels of poverty. Also, there are more older people who are healthy, active, employed and sexually active (Ray *et al.*, 2014), although 25 per cent of over-60s admitted to acute hospital care are affected by alcohol misuse (Wallace *et al.*, 2010).

The gains of improved health and well-being are not spread evenly across older populations. In England alone, there are now over fifteen million people who have a long-term condition and they account for a large percentage of the money spent on health and social care. Most of these people have complex needs which defy simple categorization. Should older people admitted to hospital with an acute condition and then discovered to misuse alcohol be considered under the umbrella of dual diagnosis? Does a young adult recovering from a stroke have the same experiences as an older person? Is a person who was born deaf likely to have the same needs as a person who loses their hearing later in life?

> My experiences are naturally different from those who are born deaf because I have made the bleak journey from the world of hearing to the world of silence. The born deaf are denied the advantages gained by the deafened before hearing loss. I had enjoyed the natural acquisition of speech and language and had

> a knowledge of the hearing world. These are priceless assets in attempting to cope with total deafness. But I am painfully aware of what I have lost. My perception of loss is a lifetime burden. (Lord Ashley, quoted in Denmark, 1994, p. 25)

There is also the question of who is vulnerable and who is dangerous. Marie's father (earlier in this chapter) is vulnerable due to his increasing dementia but this condition is making him even more aggressive towards his wife and daughter. Neither are carers an homogenous group, having unique relationships, needs and resources. It is not always clear who is carer and who is cared-for.

> I nicknamed my husband BUB, or Back-Up Brain, and we find this terminology far easier to live with than carer or even care partner. ... My husband says he cared for me long before I had dementia and objects to this title or label. He is my best friend and husband, and sometimes he supports me. Sometimes I support him. (Swaffer, 2015, p. 240)

Where caring is joyfully done, there will eventually be loss of a satisfying role and well as the loss of a person.

> Shortly after helping my mother through terminal cancer, I lost my job due to anxiety. I hadn't realized how much I identified my self-worth through my roles as mother, professional career and caring for my mum. ... I completely lost a sense of who was the real me, and the feelings of lack of self-worth and despair were deepening into a black hole. (Hindson, 2018, p. 5)

Where a person has been semi-willingly co-opted into caring – more likely to be a woman – there will be ambivalence at best and resentment at worst. And not all carers are adults; children of all ages and gender become carers, although young women are most likely to be carers for single mothers with mental health issues (Mainstone, 2014). Historically, this group has been the least likely to be offered a carer's assessment (Blewitt *et al.*, 2011) or followed up once an initial assessment has been made.

CASE EXAMPLE

Fourteen-year-old Jackie became the carer for her wheelchair-bound mother and younger sister Annie after her alcoholic father left home. She received some domestic help in the home and was enrolled on a young carers' scheme which provided her with two hours' respite one evening a week. Some months later, she turned up at the young

carers' scheme expressing fear of her father. Apparently, he had been violent towards her mother for years. In attempting to defend her mother, she was beaten up in turn. She continues:

> 'I saw him yesterday and he said he's coming round to see Annie. I can't stop him. I can't stop her having a relationship with her dad. She likes him. She never saw the hitting. My mum had the locks changed but he says Annie will tell him where we keep the key. When I saw him, it all came straight back, feeling the panic but he wasn't doing anything. I had a flashback because I actually felt it, physically.'

Nelson-Becker *et al.* (2013) talk about making it possible for older adults to be able to minimize some of the negative effects of losses that are often associated with ageing – such as loss of loved ones, employment and some physical or mental ability – and maximize the benefits that accompany a long life, such as a wide network of family and friends, the wisdom developed through years of facing and overcoming obstacles, and accumulated material and socio-emotional assets. But this should be an aspiration for any vulnerable adult whose physical or mental impairment involves losses of some sort to be enabled to live as full a life as possible, accepting that the situations in which they find themselves are often complex.

People with communication difficulties

Workers' communication skills often need augmenting when faced with people who are unable to speak, or whose speech doesn't make sense, or who don'tunderstand speech easily, or sometimes people refuse to talk. Where a person is unable to speak as a result of a stroke or was born mute, there is a range of high-tech devices – voice output communication aids (VOCAs) – to assist communication but there are also simpler ways of communicating in these instances. These include all the non-verbal ways of communicating such as gestures, pointing – both with your eyes or fingers and signing. They can be augmented by drawing, pen and paper, cartooning, alphabet charts, and using symbols. However, before one embarks on one of these methods, it is important to recognize that communication is a challenge for a person with limited speech, or comprehension of speech so the assessment needs to start with one foot in acknowledgment of the person's situation and one foot in what needs to happen for improvement in the person's situation. The Stroke Association (www.stroke.org.uk) advocates keeping it simple, saying when you don't understand, sticking to one topic at a time, using gestures, talking naturally, and listening. It also helps to make sufficient time to develop a way of communicating, reducing background noise, maintaining eye contact, asking what helps and – most importantly – finding out how the person communicates yes

and no. Not all people signal yes with a nod. Where there is brain damage and the person is left with dysphasia, the person may well be able to speak but much of their speech may not be particularly comprehensible. Osei-Mensah (2018) recommends that the worker find out as much as possible from relatives about what was important to person previously and then use a 'guess and check' technique to find out what the person wants to be able to do.

Where a person additionally has visual difficulties, remember to identify yourself as the person cannot necessarily tell it is you by your voice. Other organizations that provide helpful tips include www.communicationmatters.org.uk; Chest, Heart and Stroke Scotland www.chss.org.uk; and www.aphasiaalliance.org.uk.

Some people can speak but have difficulty understanding; for example, a person with a learning difficulty may be very literal and struggle with abstract concepts or imagined futures. People with learning difficulties function less well when stressed so it is vital that you allow for this or you may underassess the person's capabilities. We have found that the basic principle is to reduce the speed of everything by:

- Talking more slowly and repeating or rephrasing important points several times.
- Using pictures and symbols to explain complex concepts such as thoughts and emotions.
- Explaining yourself through written or drawn materials as this can be less threatening than face-to-face conversations which can be seen to demand immediate responses.
- Recognizing that it takes time to learn new behaviours so repeat short chunks of information several times and in fresh ways. Charts and stickers act as useful visual reminders.
- Keeping changes to the minimum.
- Using social stories, anecdotes and tailor-made scenarios to help people prepare for new social situations. These should be personalized and future-oriented. (Milner and Myers, 2017)

THEORY INTO PRACTICE

After being tortured, Adnan fled Syria with his wife, Rasha, and their children. They have been settled in a small terrace house but now that their safety fears have subsided, they are experiencing a sinking sense of what they have lost. Rasha's parents have been refused permission to enter England. Adnan has just been told that there are no medical treatments that can restore him to good enough health to take up work. They are learning English so the assessing social worker talks with Rasha using English words and story cubes.

He asks her to choose five images which represent her journey so far and five images of how she hopes her life will be in the future. To represent her journey, she chooses images of a nightmare, lack of voice, question marks, a sense of injustice and children. To indicate her future hopes, she chooses images of a big house, travel, children, a pizza and a horse (Scott, 2018).

1. What questions might you ask her about her journey so far that would enable you to discover what strengths she possesses?
2. What questions might you ask her about any progress towards her future hopes?

Mattelin and Volkaert (2017) explain how people with autism process social information, often giving different meanings to experiences which are hard for people without autism to understand. They recommend that the worker communicate more effectively by:

- Keeping topics unambiguous and concrete, using short, clear questions and going at a slower pace so that the person can process both your words **and** their meaning.
- Using visual images to support your conversation as these are more easily understood and less ambiguous than words.
- Organizing any information you need to impart beforehand so that the agenda for the meeting is clear.
- Avoiding small talk as it may be seen as a confusing digression.

Swaffer (2015, pp. 144–5) tells of spending time two to three times a week with a lady with advanced dementia who did not speak, sitting and walking together until the lady began to smile in recognition at first and then begin to talk about her past life. It is unlikely that an assessing social worker could devote so much time to gaining the person's confidence, so a speedier method is required. Baker (2015) suggests researching a person's preferences when they **did** have capacity. This involves talking with friends and relatives to collect information about the person's life story through the construction of portable memory boxes, digital frames that provide a continuous stream of memories (and which the person does not need to hold), and A4 life summaries. This information highlights the person's preferences about care so that they are not given food they don't like or given a shower when they would prefer a bath and that they choose their own clothing (which is unlikely to be tracksuit bottoms, however easy this makes the care role). Goldsmith (2014) recommends that the assessment also analyze pain which often goes untreated in older people with dementia: 'Dementia does not supersede existing conditions, and therefore pain relief can have a huge impact on the course of the disease' (p. 173).

People in the grip of psychosis are often excluded from conversations, partly because of the need to make a rapid assessment about what needs to be done to safeguard them and possibly others and partly because much of what they say seems weird or nonsensical. Hawkes *et al.* (1998) challenge this view, finding that there is often a desire to be free of troubling hearing voices, to be able to trust people, or to be calmer. They give the example of person deciding to line his room with tinfoil to block out radio waves that plague him. Although this a bizarre solution to his distress, it is rational – he seeks peace: 'If you look beyond the client's attempted solution the end they desire is often salient, understandable and sane' (p. 91).

CASE EXAMPLE

Bob is married with two children. He has a long-standing belief that the water supply to his house is poisoned, despite the fact that this has been extensively investigated and water pipes replaced. He has stopped using the water for washing as well as drinking and cooking, relying instead on bottled water.

It is perfectly reasonable to not want to be poisoned but his fixed idea is seemingly unmovable. He is very gently challenged by introducing curiosity and puzzlement at his family's ability to drink the water without harmful effects and he is invited to think about it. It is not suggested that he is wrong or an attempt made to reinforce reality, simply sowing the seeds of doubt and therefore choice. As Bob begins to eat food cooked in the water, he is not pressed into 'reality', to think he has been wrong all those years and feel shame-faced.

People who see no future for themselves

With many chronic diseases where the medical situation is not going to improve long term, there is often a high level of depression (Burns, 2016), where people have high levels of pain and feel that they have been given up on (Dargan *et al.*, 2014; Simm *et al.*, 2014), or where people feel that life simply isn't worth living make assessment particularly difficult because these people often have no goal for the future. They are either 'giving up' or seriously contemplating suicide and this must be attended to as well as any assessment of their physical needs. The assessing worker may feel that talking about suicide may provoke the act but can take relief from the research (see, for example, Gallop and Stamina, 2003). Instead, it saves the person having to explain the seriousness of the situation, spares the person unhelpful 'cheering' comments, and opens up alternative answers to the problem:

> It's not our role to dissuade them from the intensity of their feelings, only to help them find a different way of coping with these feelings. By giving permission to feel bad about traumatic events, you humanize these feelings, introduce ideas that they may be universal and that anyone could feel as bad, given the same circumstances. (Hawkes *et al.*, 1998, p. 105)

Henden (2008) helpfully provides a graded set of assessment questions for people who pose a suicide risk:

- At this point, how much more do you feel you can cope with?
- How far is this getting you down right now?
- How often, recently, have you felt you are getting to the end of your tether?
- I expect sometimes you feel you have had your lot?
- At the moment, how far do you feel able to go on?
- How close do you feel, right now, to ending your life?
- If you decided to go ahead with the last-resort option, what method would you use? How prepared are you should you decide? (Paradoxically, having made preparations is indicative of both very high risk and low risk, as some people are comforted by being prepared and therefore do not feel the need to go ahead with the last-resort option.)

Sample questions once suicidal intent has been established:

- Tell me about a time in the last week when you felt least suicidal?
- Before you were feeling as you do at the moment, what did you do in the day that interested you?
- What has stopped you taking your life up to this point?
- On a scale of 1–10, how suicidal do you feel right now?
- On a scale of 1–10, how suicidal were you before you decided to seek help?
- What would you be doing/thinking/feeling to be another half-point higher?
- What have you done in the last week that has made a difference to the terrible situation you are in?
- On a scale of 1–10, how determined are you to give another option (other than suicide) a try first?
- Let us suppose you went for the last-resort option and actually died. You are at your own funeral as a spirit looking down from about 10 feet up at

the mourners below. What might you be thinking about another option you could have tried first? At this funeral, who would be the most upset among the mourners? What advice would they have wanted to give you regarding other options?

- When was the last time, before this current time in your life, that you thought of ending it all?
- What did you do then that made a difference and enabled you to pull yourself back?
- Suicide is the last resort, as we know; what other ways have you tried so far to crack this problem?

Trauma can also be an experience of learning as well as distress, so follow-up questions can be asked to discover what strengths have emerged:

- This must be an unbelievable experience for you, a nightmare. Knowing yourself as you do, what have you learned about yourself that has allowed you to get this far with the problem?
- Does it surprise you that you have been so strong, that even given this you are still around? What about others in your life, would they have known you are as strong as this? (adapted from Hawkes *et al.*, 1998)

Hawkes *et al.* also caution about timeframes: 'Is this something that will take more time to resolve? Are you being hard on yourself, expecting to feel different than this' (p. 62).

People who feel helpless

The purpose of an assessment is discover what needs to be done to help a person live a life that is as satisfying and safe as possible. This is extremely difficult to do when a person feels helpless about effecting any change in their lifestyle despite this causing harm. This may be a person who neglects to take the medication and maintain a diet needed to control diabetes. Or it may be a person with a habit that is damaging, such as a chronic drinker whose efforts to become sober have met with relapse after relapse. Or it may be a person who is so obese that the thought of losing several stones is too daunting a challenge. It is worth realizing that all these conditions also have benefit for the person because they are to some degree comforting whether this be over- or under-eating, misusing substances, cutting oneself, etc. There is a tendency in these instances to recommend attendance at education, such as attendance at a smoking cessation group, dietary advice, or exercise sheets. This often leads to people feeling bad about themselves, and workers wonder how else they can talk constructively; as Couzens says, 'It's pretty hard to have an interesting conversation if everything is negative' (1999, p. 26). The assessment would flow more easily if the worker asked questions about the effect of the problem on the person rather than the person as a problem,

using gentle challenges such as those in the example of Bob earlier in this chapter. For example, you might ask a binge eater:

- Is cake for you or against you?
- How did cake convince you that you need it in your life?
- What effect does cake have on your life, on those close to you, and your relationships?
- Given a choice between cake and life free of cake, which would you choose?
- What prevents you from resisting cake? How does cake use these things to move in on your life?
- Does it suit you to be dominated by cake?

Or you could ask safety questions. For example, you could ask someone who takes risks with their diabetes medication:

- What are your thoughts about the usefulness of this medication for you?
- What could you do to make sure the medication works for you?
- What do you already know about the possible side effects of this medication?
- What possible side effects would you be willing to live with?
- When you go our drinking at the weekend with your mates and miss an injection, how will I know that you will be alright?
- What could you do, and what could I do, to help me understand that you will be alright?
- What are the things that make you know you will be alright?
- Could you tell me about them? I might feel a whole lot safer if I knew those things.

These questions can be varied for a wide variety of risk-taking situations, such as taking responsibility for physical health (Milner and Myers, 2017), sexual health (Myers and Milner, 2007), anorexia (Jacob, 2001), mental health (Macdonald, 2011).

PRACTICE ACTIVITY

Identify one service user who appears despairing, hopeless or helpless.

- **What, if anything, do you know about what matters in their life?**
- **Construct some assessment questions that would allow you to open up options for this person. (adapted from Walsh, 2010, p. 144)**

People who are nearing the end of life

Longevity is considered cause for celebration in our society with people receiving telegrams from the Queen on their 60th wedding anniversaries and 100th birthdays. Local newspapers frequently report 100th birthday parties for care home residents, who are invariably asked for their secret of longevity. Longevity is less celebrated by the individuals who attain it. Stern (2011) held extended conversations with elderly people who had reached 100 about their wishes and hopes and it transpires that it can take a lot of getting used to, which, combined with worries about how dying will be, created anxiety for these centenarians.

CASE EXAMPLE

Sarah said, 'it is a hardship' not to know when and how it would happen. 'It is awkward waiting to die. Everything is an effort. My time is dragging out. I am ready to go. ... Will I be on the toilet and then suddenly fall down? I hope that it will happen when I'm in bed and asleep'.

The thought of reaching 103 was not a comforting one; in fact, it filled her with dread. She lamented, 'Young people die, why can't I? It would be kinder; the sooner the better'. At one stage, Sarah thought that her 'time had come'. She said, 'I made myself up and lay in bed in the middle so I would look good when they found me. In the morning, when I woke up, I was very disappointed. I thought that I was ready to go' (Stern, 2011, p. 61).

For some older people paying for their own care, reaching 100 means that they will be broke. And few people want to prolong their lives with invasive treatment, preferring palliative care where they can participate in the process of dying. That is to say, have a say whether treatment continues or not and whether to die in hospital, at home or in a hospice. Other people may wish not to speak about it. This not necessarily 'denial'. In Scragg (2012), there is an example of woman who spoke of her terminal cancer as only 'white spots'. This was her strategy to follow her optimistic nature and not depress her son. She had previously discussed her terminal condition with a friend and grieved at that point. 'All this points to individuals having very different views of what counts as a good death and similarly many variations in the process of dying' (p. 140).

A problem for the assessing social worker is where a person cannot express their own wishes and their relatives have differing ideas about whether to continue invasive treatment which may prolong life itself but not the quality of it.

CASE EXAMPLE

Mrs. Patel suffered a major stroke from which she has not recovered well. She requires constant nursing care. She is no longer able to speak or swallow, so it has been suggested that she be fitted with a feeding tube in her stomach. Her elder daughter, Rani, is against this as she thinks her mother would be tortured by it. Her youngest daughter, Samira, wants the procedure to go ahead as she sees it as matter of life and death. The sisters are at total loggerheads over this.

The social worker asked the sisters, 'suppose you are looking back after your mother dies and you are pleased with how you have done things, feeling that you have done the right things by her, what will you be pleased about?' This refocused the conversation on the needs of their mother rather than their own feelings.

The hopes and wishes of a terminally ill person will change as they do in other circumstances, so some assessment questions could include the following:

- Suppose you look back after you die and you are pleased with how you have lived, what will you be pleased about?
- In here [hospice, hospital, etc.], how have you managed to keep going? What have you kept doing that you would normally be doing outside? Have you surprised yourself with how you've dealt with it? How will you know when you are dealing with it even better?
- What ideas do you have about what comes after this life?
- How will things look better for you when you have worked out what it will look like?
- How do you want your life to be between now and [next week, next month, etc.]?
- What are your best achievements?
- What hopes do you still have?
- What do you best want to be remembered for?
- What small changes in living will make a big difference for you?

Assessing safety

The Signs of Safety approach devised initially by Turnell and Edwards (1999) as a comprehensive safety assessment process for children (described in Chapter 10) is entirely applicable to vulnerable adults. The basic questions remain the same:

- What are we worried about? (past harm, future danger and complicating factors)
- What's working well? (existing strengths and safety). [NB: Strengths are not signs of safety in themselves; they are capacities to be utilized in the development of safety.]
- What needs to happen? (future safety)

Even in cases of acute psychosis, openness and confidence in the person's ability to manage their own risks make it possible to assess intent, as this brief extract from an interview with Alan demonstrates (Macdonald, 2011, pp. 152–4).

THEORY INTO PRACTICE

Alan was disturbed for several days before being detained under legal powers at his home. He resisted transfer by ambulance and was brought to the secure unit in handcuffs by police. This extract is from an interview the following day after questions established that a diagnosis of paranoid illness could be made and his needs and wishes had been elicited (sorting out his money and getting some sleep):

Interviewer: *So thinking about a scale of 1–10 where 10 is you get out of hospital and things are going well, and 0 is as bad as things were before, where are you right now on that scale?*

Alan: *Nought.*

Interviewer: *So how have you kept going when you were at nought?*

Alan: *Getting some sleep helped.*

Interviewer: *So sleep is really important for you. When you move up half a point on the scale, what will be different for you?*

Alan: *I won't feel like hitting people.*

Interviewer: *Who do you feel like hitting?*

Alan: *The neighbours and that policeman. He had no right to put handcuffs on me.*

Interviewer: *How come the police were there?*

Alan: *I told the ambulance man I would cut him if he tried to come into my flat.*

Interviewer: *Have you cut anyone before? Or hit anyone?*

Alan: *No, but I could have done it.*

Interviewer: *How come you did not do that?*

Alan: *They came in before I could get a knife from the kitchen.*

Interviewer: *Do you still think about getting a knife or cutting someone?*

Alan: *I sometimes think about it.*

Interviewer: *How do you manage to think about it but not do it?*

Alan: *I think to myself that they will put me in hospital again if I cut someone. The neighbours might get me for it while I was sleeping.*

Interviewer: *Are there specific people that you think of cutting, neighbours or anyone else?*

Alan: *I felt like hitting that policeman.*

Interviewer: *Have you thought about cutting or hitting anyone in this hospital?*

Alan: *No.*

Interviewer: *How can we tell if you are thinking about cutting or hitting someone?*

Alan: *I don't know.*

Interviewer: *Will you tell us if you are thinking like that?*

Alan: *[no reply]*

Interviewer: *When you are thinking like that, what can we do to help?*

Alan: *Let me stay in my room; the other people here are strange.*

Interviewer: *Will you tell us when you need to stay in your room?*

Alan: *Yes.*

Interviewer: *OK; we will ask you if we're not sure. I guess that hitting or cutting someone will not help you get out of hospital sooner.*

Alan: *[nods]*

Interviewer: *Anything else to mention today?*

Alan: *No. I'm tired just now.*

PRACTICE ACTIVITY

Chose a safeguarding situation in your current practice and:

1. List your concerns on the left-hand side of a piece of paper.
2. On the right-hand side of the paper, list the constructive, measurable behaviours that concerning person will be doing differently that completely answer each concern.
3. On a separate sheet, list what the vulnerable person will be doing differently that provides you with firm evidence that they are safer.

Checklists and predictive tools are not always necessary for assessing risks and needs when the assessing worker shows no fear of the worst scenario and talks sincerely and genuinely with service users about their pain as well as their dangerousness, joining with them to generate other possibilities at the same time as ensuring that they are responsible for any decisions they make, in other words, using social work skills in direct practice rather than relying on tools as a means of case management.

THEORY INTO PRACTICE

Andrew is a looked-after child who has lived as a single resident with 24-hour supervision in a specialist children's home following his sexual and physical abuse of his siblings at the age of 13. Previously, he had been sexually abused by his father from the ages of 3–7. Although he has a complex learning difficulty, he has been educated in mainstream schooling where he has a full-time mentor to assist with both his learning and his aggressive behaviour towards other pupils. School has entered him for nine GCSEs, but his expected

grades are below the minimum pass mark. He has been subjected to numerous assessments, the latest stating that he is at high risk of sexually reoffending as he takes any opportunity to leave school and visit his family, and he has little understanding of the impact of his offending behaviour. He is now approaching his sixteenth birthday, at which point the children and families team will have to hand over his care to another team, so a multidisciplinary team meeting is being held to decide on which branch of social care will be responsible for his care in the future and what type of further education will be most suitable for him.

His careers advisor informs the meeting that Andrew hopes to become a policeman or enter the armed forces, so he has obtained Andrew a place on an access course preparing young people for a career in the armed forces at the local college.

His carers comment that Andrew is unable to use public transport as he does not understand the direction signs on buses and that, as the college is on three sites, he will either get lost or walk to his family home where his mother is unable to refuse him entrance as she is fearful of him.

The representative from the leaving care team says that Andrew is not suitable for the provision they use for preparing young people for independent living.

The representative from the learning disabilities team says that they cannot accept Andrew as his IQ is one point above their cutoff point of 70. Although it is pointed out that his IQ score of 71 is inflated by his superficial verbal ability and that his conceptual ability is very much lower, the team remains adamant that he does not qualify for their service.

The representative from the vulnerable adults team says that their services are geared towards elderly people and that they would be unable to provide him with the services he may require.

The meeting concludes with the recommendation that a further assessment be undertaken.

- What level of risk do you consider Andrew to pose?
- What are his needs?
- Bearing in mind the resource limitations listed above, how could you assess the needs and risks?

The Care Act 2014 places a duty on local authorities to carry out a transition assessment for a young person or carer, in order to help them plan, if they are likely to have needs once they (or the child they care for) turn 18. The groups of people who have a right to a transition assessment include young people, under 18, with care and support needs who are approaching

transition to adulthood; young carers, under 18, who are themselves preparing for adulthood, and adult carers of a young person who is preparing for adulthood. Local authorities must assess the needs of an adult carer where there is likely to be a need for support after the young person in question turns 18.

THINKING POINT

- Look again at the case example of Andrew.
- How would you conduct your assessment to ensure that his rights as a young person, to attend college and live a full life, are balanced against the need to safeguard other young people?

Critical comment

The values and intentions of integrated assessment are noble. Placing service users at the centre of the process, maintaining high standards of inter-agency-cooperation, streamlining assessment, planning and action to avoid duplication and devising a single action plan constitute the very bedrock of sound assessment practice. The acid test of integrated assessments is effectiveness; are service users' needs met and do they express satisfaction with the assessments? With respect to longer established integrated assessments, the answer is no. The Scottish evaluation report on integrated assessment (Gibson *et al.*, 2006) found that assessment records were of variable quality and did not provide the level of detail about the lives of children which the frameworks expect, and there was little documentary evidence of analysis and clear planning for the future. Similarly, integrated provision for people with long-term neurological conditions was found to be patchy and slow (Bernard *et al.*, 2008). In their final report (Bernard *et al.*, 2010), major problems were revealed. Despite the intention of delivering a structured and systematic approach to delivering treatment for people with long-term conditions, there was little evidence of personal choice, empowerment or the experience of continuity of care.

These findings could be explained as teething problems, but later research painted an equally gloomy picture. A study of long-term mental health conditions in England (Gillard *et al.*, 2012) found that the scope for self-care remained poorly conceptualized, with little evidence of shared decision making or staff–service user relationships. In Northern Ireland, there was little evidence of streamlined assessment for older people with a diversity of referral and care pathways that are myriad and complex (Taylor, 2012). This may be due to the way integrated assessment and care is conceptualized by professionals. An evaluation of integrated care pilots (Ernst and Young, 2012) found that a horizontal integration between community-based services was the favoured form rather than vertical integration between primary and secondary care. Professionals reported improvements in care in this study but

these claims were not supported by service user evaluation, leading us to suspect that there had been little real engagement with service users around decision-making and choice.

And the most recent British Social Attitudes Survey (Robertson *et al.*, 2018) shows that service user satisfaction is low. The 2017 satisfaction rates remain the same as for 2016 at 23 per cent, but dissatisfaction rates have increased by a further six percentage points to 41 per cent. This cannot be excused on grounds of insufficient funding alone as it compares unfavourably with the lowest NHS ratings of 52 per cent for A and E and 55 per cent for inpatient services. Funding is indeed in short supply but is no excuse not to maintain consistently high levels of assessment practice. The choices open to an older person may well be to remortgage their home to fund community care or take risks in order to save an inheritance for family. These are bleak choices, but effective, person-centred assessment would still find a way of helping a person make the choice that is the right one for them.



Summary

- We have mentioned the key statutory context and requirements in working with a range of adult service user groups.
- The increasing drive for integrated working has been discussed.
- The complexities of decision-making have been raised.
- The importance of preserving and encouraging independence and dignity has been emphasized.
- The requirements that assessments be personalized and bring out the individuality, uniqueness and strengths of each person have also been stressed.



Further learning activities

- What do you value most in life?
- What makes life worth living?
- What will be most important to you when you are dying?
- If you were to die soon, what would be left undone in hour life?

Further reading

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Simcock, P. and Castle, R. (2016) *Social Work and Disability*. London: Social Care Workforce Research Unit.

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12 A MAP OF THE UNIVERSE: SPIRITUAL APPROACHES

What this chapter is about

In this chapter, we return to Bronfenbrenner's macro system, briefly looking at the factors which have led to a resurgence of interest in spirituality. The multifaceted nature of modern spirituality is explored and the implications for assessment outlined.

Main points

- The multifaceted nature of spirituality: religious, humanistic, and modern spirituality.
- Spiritual practices and practice.
- Implications for assessment.
- Critical comment.
- Outcomes.
- Summary.

Spirituality: a multifaceted concept

Payne (2005) points to two main influences underpinning the interest in incorporating spirituality into social work practice. The first is increasing recognition that social work is practised in societies where religion and spirituality are integral to people's lives. Partly this is a response to the impact of immigration revealing strong religious practices in minority ethnic populations. This increases religious as well as ethnic diversity and also impacts on established religions. For example, in the third edition of this book, we noted a decline in the social significance of Catholicism in the UK (Aldridge, 2006), but an influx of Polish migrants reaffirms traditional Catholic practice. It is estimated that between 30 and 50 per cent of people think there is a soul and a higher purpose to life. Partly it is also to do with trends in the delivery of

social work which has begun to show an interest in the role of faith communities and churches in making a stronger contribution to organized care and community services.

THINKING POINT

- Re-read the case example of Katie and Jennifer in Chapter 2.
- How could Jennifer's church membership be developed into organized care?

Second, Payne points to a reaction to consumerism and commodification in Western societies and a 'perceived need to rebalance these tendencies with different ways of finding meaning in life' (2005, p. 190). This runs alongside growing interest in ecological issues with a desire to interconnect with the social and natural environment. Bronfenbrenner (1979) was concerned about the way in which modern economic materialism has led to a decay of human values, resulting in spiritual decadence, cheapness and bullying (all opposed to care of others and authentic relationships). Bronfenbrenner was conscious of the eco-environment and the spiritual sense of connectedness between people and between people and nature. He saw language, culture and spirituality as important elements in peoples', and in nations', well-being. Eagger and McSherry (2011) suggest that spiritual distress is manifested in a number of ways:

- Anger – directed at others.
- Bitterness – what have I done to deserve this?
- Regret – I should have been a better person.
- Guilt – I must have done something wrong.
- Doubt – is there a purpose for existence?
- Fear – I'm not sure there is anything after death.
- Loss of hope – no future.
- Isolation – abandonment, rejection.

Carr (2011) makes the point that LGBT people may wish to remain hidden, concealing large parts of themselves from family and friends to avoid rejection.

Religious spirituality

Gilligan and Furness (2010) argue that social workers need to be able to respond appropriately to the needs of service users for whom religious and spiritual beliefs are crucial. They say that 'service users need opportunities

to discuss their religious and spiritual beliefs and the strengths, difficulties and needs that arise from them' (p. 44). Indeed, it has been argued that knowledge and understanding of religious spirituality are essential components of cultural competence. However, religious practice and spirituality are highly nuanced. Carrington (2013) outlines the spiritual ideologies of Hinduism, Islam and Buddhism, each of which emphasizes slightly differently aspects of spirituality. Like Christianity and most other world religions, they speak of living simply (that others might simply live), of needing to 'bear good fruit', of being just, making peace and being merciful, and avoiding hypocrisy.

Many writers stress the need to distinguish between religion and spirituality – the former is seen as including doctrine, rituals, social activities whereas the latter transcends the physical world and focuses on connectedness and mutuality. While some people can be both, not all are; some studies suggest that non-spiritual religious people are more judgemental and see God as punitive, whereas the more spiritual-orientated are more likely to be humanitarian and to see God as merciful and humans as having innate worth. Where people are both, as in the training of hospital chaplains in acute children's illness wards, there is the need to develop an *integrated theological reflective practice* that addresses a child's spirituality, sense of belonging, the strength of their connectedness and therefore resilience, their attachment to others and to their God, helping them to cope with the disruption of their lives. This chaplain training seems to focus on interpreting the child's constructs and how they make their own meanings, helpful or otherwise, and co-constructing more useful meanings with them.

PRACTICE EXAMPLE

Ella, a 5-year-old child, is in hospital with a serious illness, distressed by the treatment and by being separated from her family. You hear her say to her grandfather, 'Do you know that there are two Gods, the big God who makes the world and the little baby God?' 'Which do you prefer?', he asked. She replied, 'I prefer the little God – he had a hard time you know'.

- **How would you use this information to help/support her?**

Existential spirituality

This topic can seem so abstract and strange that many shy away from it; however, if the reader attempts to grasp the nettle, it can be almost too obvious because it has already entered our thinking. But if this is new to you, you may need to read it very slowly! Philosophy is the last of the 'knowledges' not to become a 'science'. *Existentialism* is a form of ontology, a branch of philosophy that studies 'being' and that explores the absurdity and angst of living with which the human spirit has to cope.

Developed in Denmark by Kierkegaard (ob. 1855) and by Heidegger (ob. 1976) in Germany, it was popularized by Jean-Paul Sartre (ob. 1980) in France. To understand this philosophy, it is useful to see it as the opposite of the main Western philosophy of *Essentialism*, whereby the Churches and the sciences seek to understand and teach the essential qualities (essences) of objects, living things and human beings. Here, 'beings' can be translated as 'things' – nouns. Existentialism, on the other hand, while accepting that science is useful for repairing our physical body, holds that it is not useful in understanding the human spirit – what matters is not our essence but the fact of our actively (doing) 'being in the world' – where 'being' is a verb (being). Sartre's book title *Being and Nothingness* is a play on words. It is about 'Be-ing (a verb) and No-thingness' – we are studied not as things but as having been 'catapulted' into existence, into be-ing here or there, without choice of time or place but with the ability to make our own world (such as the world of social work or the world of fashion or of trading) and our own meanings, valuing our 'thereness' rather than our 'thingness'.

In understand others, including service users, we are like a passer-by seeing a person sitting on a bench at the other end of the park reading a book as we try to work out what thoughts are in his/her mind. When we meet people, we can have no presuppositions or theories about them – they and we are from different worlds, and it is what we are actively making of our existence that counts. Getting to know each other therefore requires respect for strangeness and difference – 'starting from scratch', in awe at the infinite possibilities for meanings.

But 'bad faith' (self-deception) is a constant danger. We can think 'this is how I am' – a fixed thing that cannot be anything else. We can also define ourselves by our roles or positions in life, but that involves 'bad faith' too because we can transcend these (we are not our condition) and we can live 'by the will of self', which is 'authentic' living as free actors able to 'unconceal' our futures, despite the anxiety/angst of making enormous choices between such freedom and accommodating to the realities and constraints of society and economic life. If we do not think carefully, such realities can almost predestine our lives, as capitalism offers freedom of choice but is it rather the freedom to shop, to buy what is advertised or presented to us in supermarkets – the 'freedom' to 'grow the economy', oppressed by the immorality of some big banks and big businesses.

Existentialism underpins many social work and counselling values: the value of uncertainty, of approaching an interview from a not-knowing stance and the value of respecting difference and of designing services with people rather than for people. When people's lives fall apart, it encourages us to join them in re-building a new sense of self rather than looking for flaws in their nature. Existentialism underpins humanist values and is pro-choice and pro-the joys of being alive – *Existing* with a Wow! in authentic relationships, alive to possibilities. Thompson (1992) provides examples of the use of existentialist ideas in social work. Payne (2005) offers a neat summary of Thompson's work.

THINKING POINT

Reflect on the following conditions and ask yourself how these may apply to your service.

External conditions: human rights, a positive culture of healing, recovery-oriented services.
Internal conditions: hope, healing, empowerment, connection.

Modern spirituality

Modern spirituality, says Crisp (2010), is separated from distinct religions and centred on the deepest values and meanings by which people live. And it is not just what gives meaning and purpose to life, it is our moral compass (Matthews, 2009): 'being directly related to our value base: those beliefs values, and morals which are integral to us and from which we will not deviate' (p. 6). Free from religious or other bias, spirituality:

> Takes us to the very heart and spirit of social work, what it means to be human, to be in relationships with others, and to make connections with each other and between various parts of our lives. (Holloway and Moss, 2010, p. 2)

THINKING POINT

- List your immoveable values.

Spiritual practices

Individual spiritual practices most commonly include meditation to help a person cultivate their inner life and character. Meditation takes many forms, including private prayer, yoga, quiet reflection, mindfulness, long walks, and – in Judith's case – fly fishing. In Patrick's case, it includes the study and enjoyment of art, whilst in Steve's case, it is mountain biking and opera, though rarely at the same time. As well as having religious aspects, meditation is about creating space for self-care, enabling the person to stay sane, calm and peaceful inside. An awareness of one's own spirituality is essential before attempting to practice spiritual social work.

A strengths approach to spiritual social work practice identifies three main components of spirituality:

- Spirituality is complementary to the physical/biological, mental, and social aspects of a person and transcendental in that it incorporates all. Thus, there can be no categorization.

- Reflecting on the struggle to find meaning and develop a working moral sensibility enables the establishment of a purpose that extends beyond selfish, egotistical concerns.
- It refers to an essence that extends beyond the self and allows us to join and revere the mysteries and complexities of life. (adapted from Saleebey, 2013b, p. 105)

THINKING POINT

Reflect on the following:

- What are your sources of hope?
- What do you hold onto during times of stress?
- What sustains you and keeps you going?
- What are your sources of hope, strength, comfort and peace? (Eagger and McSherry, 2011, p. 133)

THEORY INTO PRACTICE

Create your own safe space by doing the following:

- **Remember a happy time when you felt contented and fulfilled.**
- **List exactly how this place looks, smells, sounds, feels (physically rather than emotionally).**
- **Choose the most salient feature of these (for example, a particular sound or view) and distil it so that you can carry around its essence; for example, a muffin paper in your pocket may remind you of baking smells.**
- **Use this *essence* to revisit your safe space whenever you need to renew your calmness and competence (adapted from Dolan, 1998a).**

Implications for assessment

The most important element of spiritual social work practice is that assessments be unfettered by judgement; people are not labelled with diagnoses or categories. Rejecting diagnosis means that it would be difficult to undertake a spiritually sensitive psychodynamic or traditional behavioural assessment, although Acceptance Commitment Therapy overtly focuses on the spiritual aspects of people's lives with its emphasis on deep meaning, values and meditation. Spirituality and strengths-based assessments are more easily combined. For example, the primary goods of the Good Lives model looks at

what matters for service users. Similarly, solution-focused approaches are sensitive to this and ensure that interventions respect what matters to service users. The notion of spiritual accompaniment is not dissimilar to the framework of solution-focused assessment.

Spirituality	*Solution-focused framework*
Humility	Taking a 'not-knowing' stance
Progress	No absolute answers
Accepting people as they are	Accepting people as they are
Belief in a higher purpose	Asking about preferred futures
Noticing progress	Noticing progress
Seeing self in a system of others	Asking 'what would others notice?', 'what would Jesus notice? (Matthews and Winter, 2018)

And, where a service user is unable to articulate a clear ethical goal, the assessment question would be: what would be different if you took a step in a direction that is good for you?

Not categorizing service users is more problematic for social workers as they work in teams that are organized into categories. Despite the fact that people live mostly in families and all live in communities, social work departments ignore this with specialist teams for mental illness, physical disability, special needs, etc. Only children are acknowledged as living in families. Bronfenbrenner sees spirituality as a layer of all the subsystems that can be particularly strong (for good or for ill) in education and in families where it can have a major influence on children. Increasing multidisciplinary working across health and social care provides social work with an opportunity to begin working with people in their environments. Canda (2013), who has cystic fibrosis, makes the point that 'well-being can include and transcend good physical health. It is also not dependent on good physical health' (p. 10). Nelson-Becker *et al.* (2013) find that older people's practical philosophies emerge out a long trajectory of life experience and 'often contain religious and spiritual aspects … openness to listening to spiritual and religious narratives, both in assessment and intervention, offers a resource' (p. 175).

Rather than ask what is wrong with this person, the spiritual social worker should ask:

- What gives this person's life meaning?
- What is it that keeps this person going?
- What can be done to enhance their being?
- Who do they love and who loves them?
- What practices keep them well?

The emphasis is on moral characteristics such as love, compassion, tolerance, forgiveness, contentment, responsibility, harmony and concern for others (Crisp, 2010; Eagger and McSherry, 2011).

Critical comment

The inclusion of spirituality in social work allows practitioners to work with all dimensions of the person and their lives, informed by evidence-based spiritual practices (Hodge, 2011). However, selection of these practices is by no means straightforward. Carrington (2013) asserts that gaps remain at many levels. The current dearth of theorization of spirituality in social work has created a situation where individual social workers wishing to include spirituality in their practice are forced to rely on their own initiative and inventiveness, with no clear theoretical, practical or ethical guidelines. These initiatives may include experimentation and the application of what has been referred to as an interest in exotica, what Carrington says arises from the misappropriation of spiritual knowledge, theory and practice. For example, she says of meditation: taking a form of meditation, and using it outside paradigmatic guides, changes its intended purpose and outcome (2013, p. 289). This raises ethical concerns as to best practice (Sheridan, 2009). Spirituality has been criticized for being elusive to define and a 'pick-and-mix religion' (Hamilton, 2000), 'spiritual supermarket' (Lyon, 2000) and 'consumerist market religion' (Houtman and Aupers, 2010) that consists of a package of personal likes, preferences and the latest fads. This 'privatization' of religiosity can be said to reflect our neo-liberal age of consumer choice and personal responsibility, viewing problems and their solutions as lying entirely within the individual spirit of the person rather than through external constraints or collaboration. At worst, it can lead to viewing those who experience disadvantage as somehow spiritually responsible for their circumstances.

There are also broader concerns about the introduction of spirituality or 'New Age Ethics' (Houtman and Aupers, 2010) into social work, drawing on Foucauldian analysis to illuminate the social control aspects of what initially appears to be a benign, progressive force:

> Interpreted as a praiseworthy and progressive liberation from external controls by some, spiritual social work is regarded as an unprecedented intrusive new mode of social control by others ... First, it opens up people's inner worlds for public scrutiny by putting human souls on the dissection tables of social workers...secondly, the soul is refashioned by moulding it in such a way as to produce a self that no longer requires external governance. (Gray and Webb, 2010, p 184)

Spirituality and social work looks likely to be a site of increasing debate and discussion.

Outcomes

Canda (2013) provides a comprehensive review of the research evidence into the effects of a spiritual approach to social work, finding that:

> A strong sense of life meaning, purpose, hope, optimism and connection with the sacred, combined with spiritually based healing activities, tend to be associated with higher levels of self reported well-being, lower levels of depression and anxiety, lower frequency of suicidal and family violence, faster recovery from illness or surgery, better mental health recovery, and greater longevity (p. 81)

In other words, it has been demonstrated to defend against the demands and stresses of live and is a means of discovering or creating meaning of seemingly incomprehensible events of daily life.



Summary

We have outlined some types of spirituality and given some pointers to their usefulness in social work. In our view, it is worthwhile considering whether our values include some aspects of the spiritualities we have presented.

As a final reflection, we wish to reiterate that keeping an open mind can never be taken for granted and, as one settles into practice and making assessments, one needs to be aware of the importance of one's first assessment because this will underpin subsequent decisions and may hinder the process of evaluation. One needs to have multiple frames and hypotheses at the outset. In addition, one needs to constantly watch the language in assessments and record keeping to check whether it pathologizes rather than individualizes people and to ensure a balanced account by reporting strengths and potential as well as difficulties and shortcomings and signs of safety as well as signs of danger.

As theory and practice inform and develop each other, we believe that when practitioners make theory their own, they save it from being abandoned to academics and they further the development of their profession. The more we seek to make theory useful, the more we learn from our mistakes and appreciate the value of uncertainty and open-mindedness.

The more we work in partnership with service users, the more they teach us which practice best meets their needs. Messy uncertainty remains part of reality, and the best we can do is 'continue to struggle through our confusion, to insist on being human', as R. D. Laing used to say. 'Being human' includes knowing ourselves and our values, and when we marry these to the values of social work, we are better able to care wholeheartedly for those we seek to serve with resilience and with commitment to their safety and well-being.



Further learning activity

- In your group, discuss how your faith, or lack of faith, will influence your social work practice.



Further reading

Canda, E. R. (2013) 'Chronic illness and spiritual transformation'. In D. Saleebey (ed.), *The Strengths Perspective in Social Work*, 6th edition. London: Pearson.

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CONCLUSION

Keeping an open mind can never be taken for granted. How can we make sound judgements without being judgemental?

First, let the lead social workers, having consulted all those involved, accept responsibility for their own judgements, so that the decision is theirs, not the group's. This is not to say that decisions can be taken in isolation or that it is not a team effort – consulting with a team is not the same as having a team decision.

Second, be aware of the importance of your first assessment because this will underpin all your subsequent decisions and may hinder the process of evaluation. The only way in which you can reasonably engage in evaluation of your assessments, we suggest, is by ensuring that you have multiple frames at the outset. Consider the maps outlined earlier even where they do not fit comfortably with your theories about people.

Third, check your case files for language usage that pathologizes rather than individualizes the person.

Fourth, set out your report in a logical order using some adapted version of the headings listed in Chapter 3. These are based loosely on the work of Meyer (1993) and, as the reader will have realized by now, they reflect the layout of this book and mirror the six stages of the process of making assessments. In particular, in stage 2 (presenting the data), beware how the various 'domains', 'dimensions' and subheadings on assessment guidelines/proforma can conspire towards a biased picture. In each heading, ensure a balanced account by reporting strengths and potential as well as difficulties and shortcomings and signs of safety as well as signs of danger.

In conclusion, the main hallmark of effective *professional* practice is when theoretical knowledge acts as a basis of professional expertise (Sibeon, 1992) but, as theory informs practice, so practice develops theory. We hope, therefore, that practitioners will become less ambivalent about theory, that they will seek to own it rather than abandon it to academics. We hope that by focusing on making assessments useful, we have been able to cut away some of the mystique and bring theory down to earth, making it more useable in the real world.

In social work, we are dealing with unique difficulties each day, and we therefore need to carry on what Sibeon (1992, p. 163) calls a *reflective conversation with the situation.* This approach embraces uncertainty, encouraging its creative use.

Become aware of how the structure of psychocultural assumptions and biases constrains our view of others and take action to counteract them when

they lead to inequality. In other words, we need to avoid assuming that our theories, social roles and expectations are not problematic for others. Such practice is about seeking to make the best use of the theory that is available, learning how to make it more useful or helpful and learning from our mistakes. To do this, we need to work in partnership with service users for they are well, if not best, placed to reflect on the usefulness of the partnership. They will tell us which ways of working best meet their needs.

As a final reflection, we wish to reiterate that keeping an open mind can never be taken for granted and, as one settles in to practice and making assessments, one needs to be aware of the importance of one's first assessment because this will underpin subsequent decisions and may hinder the process of evaluation. One needs to have multiple frames and hypotheses at the outset. In addition, one needs to constantly watch the language in assessments and record keeping to check whether it pathologizes rather than individualizes people and to ensure a balanced account by reporting strengths and potential as well as difficulties and shortcomings and signs of safety as well as signs of danger.

As theory and practice inform and develop each other, we believe that when practitioners make theory their own, they save it from being abandoned to academics and they further the development of their profession. The more we seek to make theory useful, the more we learn from our mistakes and appreciate the value of uncertainty and open-mindedness.

The more we work in partnership with service users, the more they teach us which practice best meets their needs. Messy uncertainty remains part of reality, and the best we can do is 'continue to struggle through our confusion, to insist on being human', as R. D. Laing (1961) used to say. 'Being human' includes knowing ourselves and our values, and when we marry these to the values of social work, we are better able to wholeheartedly care for those we seek to serve, with resilience and with commitment to their safety and well-being.

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