NSPCC

The 8R's to Achieving Permanence

When children are in or on the edges of care

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A PRACTITIONER'S HANDBOOK

EVERY CHILDHOOD IS WORTH FIGHTING FOR

Contents

Introduction

This handbook has been produced to support practitioners working with children, young people and their families who are in care or on the edges of care. It supports practitioners and their managers to apply professional judgement to complex decisions about permanence for children, and the support needed to ensure permanence can be achieved and sustained.

It supports practitioners to:

- build relationships with children and their families based on trust, honesty and transparency, to understand the dynamic nature of the risks they face, as well as the mitigating value of their strengths and resilience
- understand changes that are needed for children to return to birth parents and/ families from care; or remain safely at home, as well as the support needed for families to facilitate and sustain such changes
- support and strengthen resilience in families
- evidence their professional judgement in the complex decision-making about whether children can be safely cared for by their birth parents/families and plan for permanence
- critically reflect on their practice, including their analysis, their decision-making and their direct work with children and their families

Most importantly, this handbook places children and the importance for them of stability, security and a positive self-identity at the centre of decision-making.

The approach of this handbook has been developed to complement and build on existing work and support provided by local authorities, and not replace it. It complements approaches that may already be adopted by local authorities including:

- Reflective practice and reflective supervision
- Relationship-based and strengths-based practice, including approaches such as motivational interviewing, appreciative inquiry and Signs of Safety
- Restorative approaches, such as Family Group Conferencing

This handbook is not statutory guidance – it is a resource that local authorities can use to support practice improvements in permanence planning, for children in care, on the edges of care or when a return home from care is being considered.

This handbook is based on the NSPCC's Reunification Framework. However, it has been further developed so that it can be applied more widely than decision-making and the provision of support relating to children returning home from care. It has been developed to include all possible permanence options, as well as decision-making and the provision of support for children who are at risk of entering care.

When to use the handbook

Many of the children and families to whom the handbook applies will already be known to children's services. They will be involved in ongoing assessments and support work. This handbook is designed to build on this. It is intended to support practitioners to understand whether children should enter care when there are concerns relating to abuse and neglect; whether children who are in care should return to the care of their birth parents or families, or whether permanence should be pursued outside of the birth family network.

The handbook may be used when **children are living with birth parents/families**, and there are concerns relating to abuse and neglect. It can be used to facilitate decision-making about whether a child can remain safely being cared for by their birth parents/families, and to assist in their future plan for permanence, this includes when:

- a local authority is considering that a child may need to enter care
- a child is on the edge of care and in pre-proceedings
- a child is the subject of a Child Protection Plan

The handbook may also be used when a **child is living away from birth parents**, including foster care, residential care, or with family/friends, to assist decision-making about whether it is appropriate and safe for a child to return to the care of their birth parents. Additionally, this handbook can be used in pursuing permanency through family/friend's care, including Special Guardianship Orders, and in decision-making about the appropriateness of pursuing permanence outside of the birth family network, such as foster care, residential care and adoption. Including when:

- a child is accommodated under Section 20 of the Children Act 1989
- a child is the subject of a Care Order or Interim Care Order
- a child is living informally with family/friends and a Special Guardianship Order is being considered

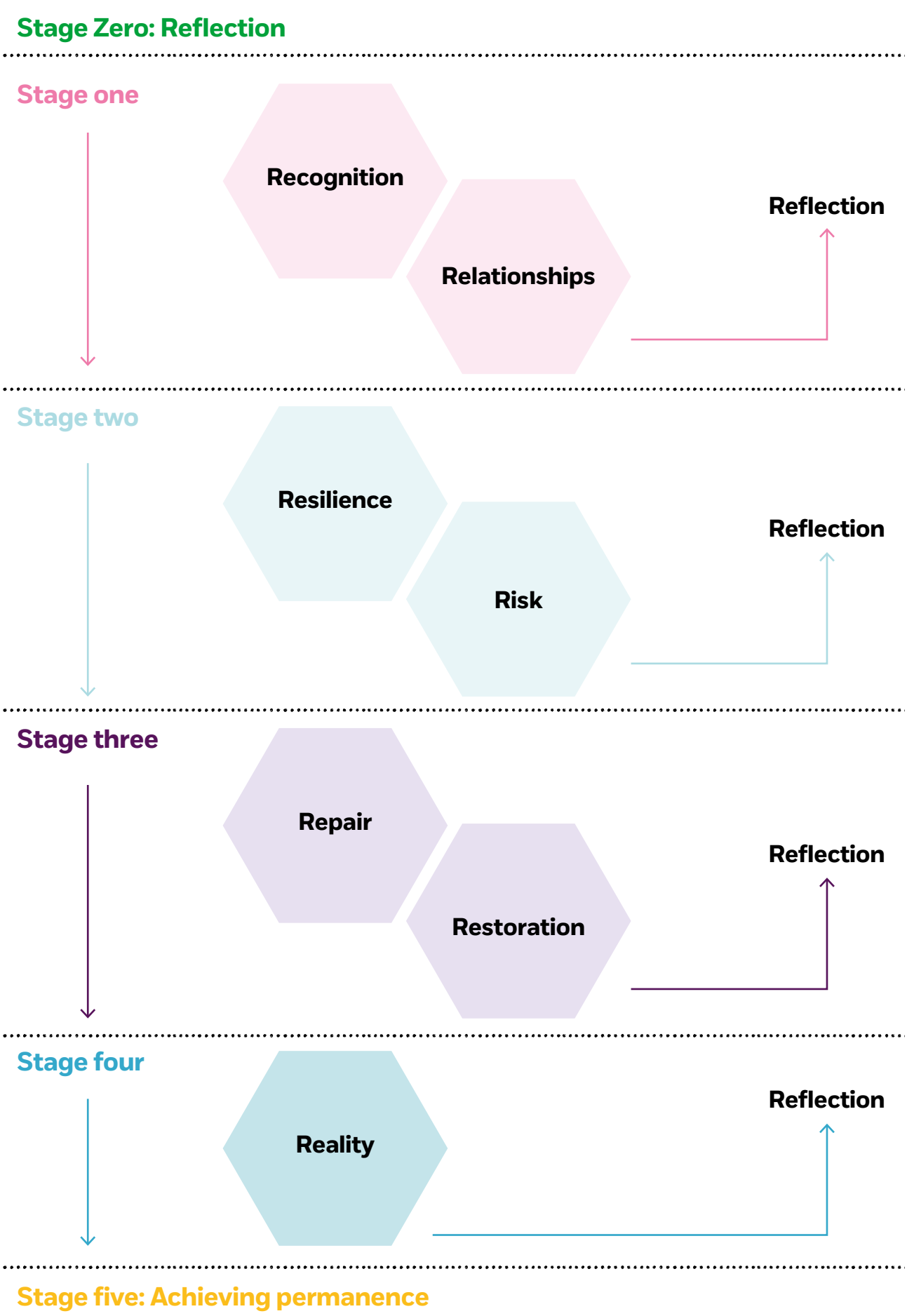
Summary of the approach

This handbook **promotes professional judgement** enabling practitioners to apply their judgement within a clearly structured evidence-informed approach. **Critical and analytical thinking underpinned by reflective practice is essential to its implementation**.

The aim of the handbook is to improve outcomes for children and their families, by supporting practitioners to make the best possible decisions about whether children for whom there are concerns relating to abuse or neglect; can remain safely with birth parents, be cared for permanently by family/friends or by carers outside of the birth family network, or return safely to birth parents/family following a period in care.

The approach outlines the essential building blocks, the 8R's, to achieving permanence.

The 8R's to Achieving Permanence



This handbook provides templates for the tools or approaches included in the table below. The local authority can adopt these into their existing assessments and care planning templates.

Table 1: Summary of the 8R's to Achieving Permanence

Stage Zero

Reflection (1) – reflective practice is essential to successfully adopting and implementing the approach outlined in this handbook. It is to be used throughout the process.

Tools/approaches to assist:

- a reflective supervision model should be effectively implemented within the local authority

Stage One

Recognition (2) and Relationships (3) – recognition theory provides the foundation for relationship-based practice and ethical engagement with families. Relationships underpin social work practice in all its forms.

The purpose of stage one is to:

- establish relationships based on trust and respect with the child, their parents, and their wider families and carers. It involves working towards an understanding of their emotional lives.

Tools to complete to assist with stage one:

- Genogram
- Analytical chronology
- Critical analysis and working hypotheses

Stage one also involves:

- Identifying a trusted adult for the child to talk to
- Identifying an advocate for the parent/s

Stage Two

Resilience (4) and Risk (5) – strengthening resilience, and understanding mitigating value of protective factors, and the dynamic nature of risks and needs.

The purpose of stage two is to:

- analyse the levels of resilience, risks and parental capacity to change to facilitate decisions about possible permanence options for the child.

This section of the handbook supports practitioners to structure their professional judgement, to make well informed decisions, and to communicate these effectively and humanely with children and their families.

Tools to complete to assist with stage two:

- Factors associated with future harm – evidence from research
- Risk and resilience matrix

Stage Three

Repair (6) and Restoration (7) – considering and working towards the possibilities of repair and restoration.

The purpose of stage three is to:

- consider and work towards the possibilities of repair and restoration
- explore and promote family potential, with a focus on strengthening resilience and reducing risks.

Tools to complete to assist with stage three:

- Support and Solutions Plan

Stage Four

Reality (8) – a pause to reflect on the work completed so far, a reality check.

The purpose of stage four is to:

- reflect on the support needs for the family
- review whether resilience has been strengthened and risks reduced
- continue planning for permanence

Stage four is a reality check, an opportunity to reflect on the work that has been completed so far.

Tools to complete to assist with for stage four:

- Re-analysis of the Risk and resilience matrix
- Update to the Support and Solutions Plan

Stage Five

Achieving permanence – stability, security and a positive sense of self.

The eight themes are being presented discretely within the five stages of the approach for the purpose of this handbook; in practice, it is expected that they be considered throughout the management of the case.

Tools underpinning this approach

- Genograms: See page 18 – to understand familial relationships, potential sources of support, as well as potential sources of anxiety and risk
- Analytical chronologies: See page 22 – to understand historical significant events and their impact or meaning
- Critical analysis and working hypotheses: see page 23 – to understand the narrative of the family, developing hypotheses about the meaning of the story, and exploring professional curiosity
- Risk and Resilience Matrix: see page 32 – to understand the interaction between risks, protective factors and parental capacity for change, and to make evidence-informed decisions about permanency, and to promote effective collaboration with children, their parents, wider family and other professionals
- Support and Solutions Plan: see page 37 – to promote repair and restoration, and to promote effective collaboration with children, their parents and wider family

The 8R's to Achieving Permanence and NSPCC's Reunification Practice Framework

NSPCC's Reunification Practice Framework developed by Elaine Farmer and Mandy Wilkins (2015) was written as a response to research findings about the recurrence of maltreatment and poor outcomes for children returning home from care (see for instance Davies and Ward 2012). This research showed that failed reunifications can be associated with poor practice, including lack of, or limited assessments and inadequate support for children and families before and after reunification. The Reunification Practice Framework therefore aimed to fill a gap in practice guidance by bringing together key messages from reunification research into a practical guide to support practitioners working with children and families in and on the edges of care.

NSPCC's 'Reunification: An Evidence-Informed Framework for Return Home Practice' can be accessed here:

learning.nspcc.org.uk/research-resources/2015/reunification-practice-framework/

The Reunification Practice Framework outlined five stages, as well as accompanying tools and resources that are underpinned by robust evidence from research for practitioners to complete when they are working with children and families where reunification is being considered.

A central element of the Reunification Practice Framework was the Risk Classification Framework, or otherwise known as the 'Traffic light tool'. This was originally developed by Rebecca Brown (author of this handbook), in response to key research messages from a longitudinal study exploring professional decision-making, life pathways and outcomes for a cohort of extremely vulnerable young children (see Ward, Brown and Westlake, 2012). The traffic light tool was incorporated into the Reunification Practice Framework by NSPCC to develop practice when it is being considered whether a child should return home to be cared for by their birth parents/families following a period in care.

In response to further research (see Brown et al. 2016) and key messages from the Children's Social Care Innovation Programme (see Sebba et al. 2017), the tool has been re-visited and further developed by Rebecca Brown to reflect contemporary social work, and research showing the benefits of relationship-based practice, and strengths-based approaches. The integrity of the tool remains the same, however there is a greater focus on resilience and its mitigating value to ensure that there is not an over focus on risk, which can alienate families. Throughout this handbook, this tool is referred to as the **Risk and Resilience Matrix**.

To underpin the Risk and Resilience Matrix, and to reflect key messages from the Children's Social Care Innovation programme, as well as feedback from practitioners, the author has developed the 8R's to Achieving Permanence which are outlined in this handbook.

The 8R's represent the essential building blocks to effective practice in planning for and working towards permanence for children for whom there are concerns relating to abuse and neglect. It expands on the Reunification Framework by considering all options for permanence. The 8R's are presented across five stages so that they interface on the stages outlined in the Reunification Practice Framework, which can therefore by used to accompany this handbook.

Table 2: The 8R's to Achieving Permanence and how they interface on the stages outlined in the Reunification Practice Framework

The 8R's to Achieving Permanence	NSPCC Reunification Framework
Stage Zero	
Reflection (1) – reflective practice is essential to successfully adopting and implementing the approach outlined in this handbook. It is to be used throughout the process. **Tools/approaches to assist:** • a reflective supervision model should be effectively implemented within the local authority	
Stage One	**Stage 1: Assessment of risk and protective factors and parental capacity to change**
Recognition (2) and Relationships (3) – recognition theory provides the foundation for relationship-based practice and ethical engagement with families. Relationships underpin social work practice in all its forms. The purpose of stage one is to establish relationships based on trust and respect with the child, their parents, and their wider families and carers. It involves working towards an understanding of their emotional lives. **Tools to complete to assist with stage one:** • Genogram • Analytical chronology • Critical analysis and working hypotheses **Stage one also involves:** • Identifying a trusted adult for the child to talk to • Identifying an advocate for the parent/s	**Aim:** To engage the parents and the child in the assessment of the risk and protective factors if the child were to return home, and begin to assess the parent's capacity to change. **The following tasks will be completed:** • **Task 1:** Produce an analytical case history and genogram • **Task 2:** Engage children and parents in the assessment process • **Task 3:** Conduct the assessment with parents and children • **Task 4:** Identify a trusted adult for the child to talk to • **Task 5:** Write up the assessment.

The 8R's to Achieving Permanence	NSPCC Reunification Framework
Stage Two	**Stage 2: Risk classification and decision on potential for reunification**
Resilience (4) and Risk (5) – strengthening resilience, and understanding mitigating value of protective factors, and the dynamic nature of risks and needs. The purpose of stage two is to analyse the levels of resilience, risks and parental capacity to change to facilitate decisions about possible permanence options for the child. This section of the handbook supports practitioners to structure their professional judgement, to make well informed decisions, and to communicate these effectively with children and their families. **Tools to complete to assist with stage two:** • Factors associated with future harm – evidence from research • Risk and resilience matrix	**Aim:** To classify the risks associated with return home and make a decision about whether or not reunification will be possible at this time. **The following tasks will be completed:** • **Task 1:** Classify risk using the Risk Classification Table (Traffic Light Tool) and make decision on the potential for reunification • **Task 2:** Decision on the potential for reunification • **Task 3:** Communicate the decision to children, parents, foster carers/residential workers and all relevant professionals • **Task 4:** Work with children and parents where reunification is not possible
Stage Three	**Stage 3: Parental agreements, goal setting, support and continuing the assessment of parental capacity to change**
Repair (6) and Restoration (7) – considering and working towards the possibilities of repair and restoration. The purpose of stage three is to consider and work towards the possibilities of repair and restoration, explore and promote family potential, with a focus on strengthening resilience and reducing risks. **Tools to complete to assist with stage three:** • Support and Solutions Plan	**Aim:** To set clear goals with parents on what needs to be achieved before their children can return home, and to put in place services and support to assist them to meet these goals. **The social worker will complete the following tasks:** • **Task 1:** Communicate with children about the aims and activities of this stage • **Task 2:** Draw up written agreements with parents (and children where appropriate) including SMART goals that need to be achieved (Specific, Measurable, Agreed with parents, Realistic, Timely) and the timescales in which to achieve them • **Task 3:** Provide direct relationship-based social work support to children and parents • **Task 4:** Create a team around the child and family, with packages of services for parents and children • **Task 5:** Create contingency plans and share them with the parents

The 8R's to Achieving Permanence	NSPCC Reunification Framework
Stage Four	**Stage 4: Reclassification of risk, decision making and planning for reunification**
Reality (8) – a pause to reflect on the work completed so far, a reality check. The purpose of stage four is to reflect on the support needs for the family, review whether resilience has been strengthened and risks reduced and to continue planning for permanence. Stage Four is a reality check, an opportunity to reflect on the work that has been completed so far. **Tools to complete to assist with stage four:** • Re-analysis of the Risk and resilience matrix • Update to the Support and Solutions Plan	**Aim:** To use the evidence gathered in Stage 3 to re-classify risk, make a decision about reunification and plan for return home where relevant. **The social worker will complete the following tasks:** • **Task 1:** Reclassify risk and decide on reunification (with the team manager) • **Task 2:** Update the parental agreements, goals and support plans • **Task 3:** Agree a multi-agency reunification plan • **Task 4:** Prepare children and parents for return home
Stage Five	**Stage 5: Return home**
Achieving permanence – stability, security and a positive sense of self.	**Aim:** To support parents and children in the immediate reality of return home. **The social worker will complete the following tasks:** • **Task 1:** Increase contact and gradual return home • **Task 2:** Coordinate support and services as detailed in the reunification plan • **Task 3:** Monitor and review post return • **Task 4:** Re-classify risk

Resources that can underpin the 8R's

There are several resources/practice models that can be used to implement the 8R's and they are mentioned where relevant throughout this handbook. However, it should be noted that to implement the 8R's no one model is endorsed over another. Practitioners are encouraged to utilise existing models within their own organisations, as appropriate, to apply the themes outlined in this handbook.

Stage Zero: Reflection

Reflective practice is essential to successfully adopting and implementing the approach outlined in this handbook.

> "We need to foster resilience by providing…staff with the scaffolding they need to get out there, work with the most vulnerable members of our society with emotional intelligence and compassion that will make a difference. Relationships are at the heart of good…practice and relationships must be at the heart of the way we supervise and manage as well"
>
> (Wonnacott, 2013).

The approach outlined in this handbook is underpinned by the fundamental importance of relationships and strengths-based direct work in safeguarding and supporting change for children and families. A reflective practitioner is therefore essential to its success. Effective reflective practice involves the capacity to build quality relationships and to empathise and be thoughtful in making sense of complex situations (Gibbs et al. 2014 p.11).

There are two key elements of reflection, that were coined by Schön (1983), who was interested in practitioners' ability to develop practice by 'thinking on their feet':

Reflection-in-action: a competent practitioner can think on their feet and use learning from previous situations to apply to their current situation. This can involve practitioners' intuition or practice wisdom (Brown and Turney, 2014).

Reflection-on-action: a reflective practitioner will look back at what they did, think about how it went and consider how it might have been done differently (Brown and Turney, 2014).

The role of the team manager/case supervisor is crucial in ensuring that children and families receive evidence-informed practice that places children and their families at the centre and in ensuring that practitioners can provide the direct work needed to fully implement this approach. This involves a continuum of learning and reflection, facilitated by reflective supervision. The supervisor should engage the supervisee to:

- Explore the supervisee's practice and factors influencing their practice responses (including emotions, assumptions, power relations, and the wider social context)
- Develop a shared understanding of the knowledge base informing their analysis and the limitations of their thinking, and
- Use this understanding to inform next steps

(Wonnacott, 2014)

Six principles of reflective supervision (identified by research undertaken by Research in Practice, 2017):

1. To deepen and broaden workers' knowledge and critical analysis skills.
2. To enable confident, competent, creative and independent decision-making.
3. To help workers build clear plans that seek to enable positive change for children and families.
4. To develop a relationship that helps staff feel valued, supported and motivated.
5. To support the development of the workers' emotional resilience and self-awareness.
6. To promote the development of a learning culture within organisations.

Research in Practice have produced a helpful resource pack on reflective supervision. It is available here: **rip.org.uk/resources/publications/practice-tools-and-guides/reflective-supervision-resource-pack-2017**

Adopting a reflective supervision model is essential to enabling the reflective practice required to successfully implement this framework

There are several models of reflective supervision that can be adopted. Research in Practice have outlined these in the resource pack cited above. A model for reflective supervision that links well with the approach outlined in this handbook is the Safeguarding and Restorative Supervision Model (SRS model), developed by Jane Wonnacott and Sonya Wallbank (2016).

The underlying premise of this model is that developing resilience within the staff group and enabling practitioners to work positively with emotions is not an optional extra within safeguarding but is a fundamental aspect of the supervisory relationship. The SRS model demonstrates how effective safeguarding supervision needs to be underpinned by the supervisor providing a safe and emotionally contained space to enable critical reflective practice and thinking to take place.

Key facets of the restorative model are:

- Providing a safe space which enables the professional to be open about their true sense of self
- Providing a supportive and challenging supervisory environment
- Improving the capacity of the individual to remain resilient in the face of challenging case work through their ability to recognise personal triggers
- Enhancing the ability of professionals to build relationships with fellow professionals to avoid isolation and reduce difficult collegiate behaviours
- Encouraging the professional to focus on the events and/or situations they can change so they experience less helplessness
- Improve the ability of the professional to communicate issues so they can be escalated effectively

Table 3: Safeguarding Restorative Supervision Model (Wonnacott and Wallbank, 2016)

Experience	Reflection
• Engage with the experience of service users • Observe accurately • Recognise significant information	• Challenge assumptions and biases driving practice • Individual learning and personal development
Safe Space Containment Process experience and work with anxiety	
Action	**Analysis (Critical thinking)**
• Creative solutions • Collaboration with others • Challenge others • Organisational assurance	• Understand the meaning of information and behaviour • Focus on strengths • Evaluate risk and remain 'risk sensible' • Creative thinking • Understand organisational requirements

Further information about the Safeguarding Restorative Supervision Model can be found here:

in-trac.co.uk/wp-content/uploads/2016/04/SRS-background-paper-March-2016-V021.pdf

Summary of Stage Zero: Reflection

- The approach outlined in this handbook is grounded in reflective practice.
- Reflective supervision is integral to promoting effective reflective practice. The role of the team manager/case supervisor is crucial to ensuring this.
- There are several models of reflective supervision that can be embedded throughout an organisation.
- The Safeguarding Restorative Supervision Model links well with this handbook.

Stage One: Recognition and Relationships

The purpose of Stage One is to establish relationships based on trust and respect with the child, their parents, wider families and carers. It involves working towards an understanding of their story and emotional lives and developing an understanding of the parents' hopes and aspirations for their child and themselves; as well as what limits their capabilities to care safely for their child. The stressors that make parenting difficult should be recognised, so that conversations and work to address these can begin.

Tools to support for Stage One are:

- Genograms: For an overview refer to the Family Trees, Genograms and Ecomap Guidance developed by Lynch, Keating and MacFadyen (2014) (link: **search3.openobjects.com/mediamanager/northsomerset/fsd/files/early_help_family_trees_gempgrams_ecomap_guidance.pdf**) - To understand familial relationships, potential sources of support, as well as potential sources of anxiety and risk.
- Analytical chronologies: See page 22 - understand historical significant events and their impact or meaning
- Critical analysis and working hypotheses – See page 23 – for understanding the narrative of the family, developing hypotheses about the meaning of the story, and exploring professional curiosity
- Risk and Resilience Matrix: See page 32 – to understand the interaction between risks, protective factors and parental capacity for change, and to make evidence-informed decisions about permanency, and to promote effective collaboration with children, their parents and wider family

Practitioners should also:

- Identify a trusted adult for the child to talk to
- Identify an advocate for the parent/s

Genograms: For an overview refer to the Family Trees, Genograms and Ecomap Guidance developed by Lynch, Keating and MacFadyen (2014) (link: **search3.openobjects.com/mediamanager/northsomerset/fsd/files/early_help_family_trees_gempgrams_ecomap_guidance.pdf**) - To understand familial relationships, potential sources of support, as well as potential sources of anxiety and risk.

Recognition theory provides the foundation for relationship-based practice and ethical engagement with families

> "Understanding the emotional lives of parents does not excuse cruelty, does not do away with the need for punishment and societal retribution, does not mean children should be left in danger to prevent further harm to parents, but does create the possibility for conversations and thus for change."
>
> (Featherstone, White and Morris. 2014 p.50)

First developed by Axel Honneth, using insights from psychology and psychoanalytic theory, recognition theory asserts that social recognition is necessary for the formation of identity and a sense of self. Honneth proposed three forms of social recognition:

1. Recognition of love: According to Honneth, this is the most fundamental element of social recognition. It addresses the process by which an individual 'learns to relate to themselves in such a way that they conceive of their physical needs and desires as an articulable part of their own person' (Honneth 2007 p. 136). When a person receives this form of recognition – a level of emotional concern in the context of a relationship of love, friendship or care; they can then develop self-confidence and security in their own sense of self (Turney 2012). Failure to experience recognition of love, for instance within abusive relationships, is likely to affect how a person perceives themselves; as someone worthy of being of genuine concern and interest to another, which can lead to impaired self-confidence (Turney 2012).
2. Legal recognition: this element of social recognition is rights-based and involves seeing the individual as a 'morally accountable member of society' (Honneth 2007 p. 74), affording them a form of self-respect (Turney 2012).
3. Social appreciation: the third element of social recognition involves acknowledgement of a person's achievements and abilities. 'Esteem is the positive acknowledgement of a particular type of person in light of the distinct characteristics that they possess. It may refer, for instance, to ideas of identity or difference, culture of community' (Thomson, 2006 p. 15 cited Turney, 2012 p. 4). This links to anti-oppressive practice and respect for difference.

Experiences of recognition can lead to positive effects on identity formation. However, Honneth was also concerned with the consequences of the failure or refusal of recognition. Recognition is closely related to respect. Therefore, the withdrawal of recognition, or the experience of misrecognition is perceived as a form of disrespect. When a person is denied recognition, 'they will generally react with moral feelings that accompany the experience of disrespect – shame, anger or indignation' (Honneth 2007 p. 72).

The importance of respect is an integral principle of the 8R's, and of social work practice more broadly

Recognition requires understanding of the emotional lives of the children, young people, parents and families who are being supported. When this is achieved, it can form the basis of relationships that are based on respect and trust, that future support can emerge from, and where meaningful conversations can be held about change. However, where children, young people, parents and families are labelled by their behaviours, rather than a deeper understanding of their emotional lives, motivations and drives; a sense of injustice can pursue, leading to barriers to meaningful conversations about change and the provision of effective support. Misrecognition can include labels such as:

- The resistant mother
- The dangerous father
- The naughty child

Where parent/s emotional lives are being recognised by the practitioner, parents are more able to model similar recognition within their relationships with their children. They can begin to experience their child as a person with their own thoughts, feelings and desires, that may be different to their own. This can help the child regulate their own internal experiences, and help them to develop an understanding of the mental states in other people (Fonagy, 2004).

> "A good deal of what helps to keep at-risk children safe depends on the quality of the relationship between the worker and the parent...and that the more recognised, acknowledged and contained the parent feels, the more the practitioner can help them keep the child in mind"
>
> (Howe, 2010).

Recognition can therefore promote parenting capacity by developing parents' ability for reflective function. Reflective function is the capacity to respond to emotions and intentions in others, rather than just behaviors which enables us to engage emotionally with others. How parents understand their children's thoughts, feelings, wishes and desires – their intentions, will determine how they will respond to them (Barlow and Underdown, 2017).

For example, 'my child is deliberately behaving like that to annoy me', compared to 'my child is trying to get my attention, they may be worried about something'.

Relationships underpin social work practice in all its forms

> "Relationships underpin social work practice in all its forms...social worker-service user relationships are strengthened by a deeper understanding of the psychodynamics and emotions of those relationships, set within the systems and organisational contexts in which these interactions take place. Many presenting cases have strong psychological demands which require service users to talk about their worries; to face their fears and to gain confidence in their capacities to cope"
>
> (Bryan, Hingley-Jones and Ruch, 2016 p. 229).

The concept of relationship-based practice has become a way of articulating the centrality of the relationship between social workers and the children, parents and families they support. It is not a method or an approach with a set of instructions. Rather, it is a principle central to work across different client groups and domains of practice.

Relationship-based practice draws on psychodynamic ideas, which explain human personality and functioning in terms of conscious and unconscious desires and beliefs, feelings and emotions, based on life experiences, including early childhood (Ingram and Smith,

2018). Effective social work therefore requires a practitioner to tune into the emotional world of a client and be able to communicate this understanding within the relationship. The concept of the relationship also involves an awareness of contextual factors such as power, professional role, poverty, social exclusion and political ideology (Ingram and Smith, 2018).

> "Service users benefit from care which includes talking with professionals about their worries, concerns and problems; they seek dependable relationships in whatever form, and via any means necessary, with strong, caring practitioners to help them cope with problems and to lead fuller lives. This involves paying attention to the emotions behind the presenting issues and the context within which they emanate and are to be worked with"
>
> (Bryan, Hingley-Jones and Ruch, 2016 p. 230).

It is important for practitioners to work within the real-life contexts of family homes and neighbourhoods and move beyond a more narrowly defined 'home visit', which can often be perceived as a form of surveillance. Spending time with, and getting to know families in their own places and spaces can help practitioners understand and make visible what life is like for them. This is in relation to hardships as well as strengths and acts of resilience, especially where the primary aim is to help fulfil needs (rather than solely manage risk), including the children's need for a safe and nurturing home (Sear-Herman et al. 2017 cited Featherstone et al 2018 p.110).

Trust is the foundation of effective relationships

It is important for practitioners to model trustworthiness by behaving transparently and honestly. Practitioners should offer children, parents and families the experience of being treated with respect by being explicit about concerns, risks, requirements for change, and presenting this in a clear and compassionate way (Turney, 2012).

The tools presented in this handbook facilitate straight talking with warmth

It is important for practitioners to remain open minded and curious. It is O.K to be uncertain, but it is essential to hypothesise and re-hypothesise which is at the heart of reflective practice. Framing hypotheses and testing the tentative explanations for situations or behaviours encountered, can help the practitioners remain alert and focussed. Meanwhile avoiding becoming overwhelmed by a mass of information, or overly committed to a particular account or outcome before there is adequate warrant for it (Turney, 2012).

> "If we cannot do this basic empathic and imaginative work, if we cannot have difficult conversations, we are obviously in danger of leaving children in profoundly unsafe situations living with very unhappy adults or removing them without having the kinds of conversations that might support healing and some form of closure"
>
> (Featherstone et al. 2014 p.129).

Two examples of assessments that may lead to misrecognition:

Mum fails to protect child from the domestic abuse she experiences perpetrated by her partner. Mum fails to prioritise her child's needs for safety above her own needs for an intimate relationship. Child is at risk of emotional and physical abuse. Mum needs to end the relationship with her partner to keep her child safe.

Child has been having regular contact with mother at the contact centre. Mother has attended 10 out 12 contact sessions. The general attachment between mother and child is good. Child is meeting all her development milestones. Child presents as happy and content.

Before completing Stage One practitioners should have:

- Introduced the Risk and resilience matrix (page 32 and 33) to the families, to ensure there is transparency within the relationship (this will be being fully implemented during Stage Two)
- Completed a Genogram to understand familial relationships, potential sources of support, as well as potential sources of anxiety and risk
- Completed (or reviewed) an Analytical Chronology to understand historical significant events and their impact or meaning – see Analytical Chronologies below
- Identified a trusted adult for child to talk to
- Identified an advocate for the parent/s
- Considered their critical analysis and working hypotheses – see Critical analysis and working hypotheses

Analytical Chronologies

The purpose of the analytical chronology is to analyse the case history, focusing on the risk and protective factors associated and evidence of parental capacity to change.

Writing the chronology involves systematically gathering and analysing data from sources about the child's life so far, and the services they have received.

This can include information from (for example):

- If the child is subject to a care order – the court legal bundle;
- If the child is looked after under Section 20 Children Act 1989 – the assessments; Child in Need plans; Child Protection Plans; HOSDAR reports; Permanence Panel documents e.g. minutes;
- Social work case records including child protection records.
- Care Planning documents;
- Contact records;
- Review records (start here to build the timeline);
- Case chronology;
- Case records on full or half siblings should also be used as sources to inform the chronology.

The chronology should be presented as a critical analysis of these themes in the family's history, and not a list of events. The chronologist will seek to bring out the underlying reasons for the parents' difficulties.

The evidence available needs to be probed and explored to establish its accuracy and meaning. Action should be taken to address any gaps in the information. This may involve interviewing those with direct knowledge of the child and family.

Significant events

To complete an analytical chronology, it is essential to consider the whole story as a sum of its parts. This often involves considering even small details in the first instance to later decide what events/incidents hold meaning in the wider context of the full chronology.

When considering the significance of an event, ask the following:

- Is this event relevant in the context of constructing this chronology for this child now?
- Has this event had an impact on the child or on family members who are important to the child?
    - If so, what might the impact be and what evidence of impact do I have?
- Is there a link between this event and the current difficulties?
    - If so, what is it?
- Is there a link between this event and historical difficulties?
- What does research tell us about what this event might mean for this child in terms of likely harm?

It can also be helpful to colour code the chronology to help visually categorise the information. This involves using different coloured fonts for chronology entries. Consider colour coding to align with the Risk and resilience matrix presented on page 32, to indicate levels of resilience and risk within the child's life pathway so far.

Critical analysis and working hypotheses

To prepare for moving from stage one to stage two, it is important that practitioners consider their critical analysis and working hypotheses. The template provided below may be helpful.

It may also be helpful to refer to the following resource produced by Research in Practice:

'Analysis and critical thinking in assessment', which can be accessed here: **rip.org.uk/resources/publications/practice-tools-and-guides/analysis-and-critical-thinking-in-assessment-resource-pack-20132014**

Consider the following

What is your understanding of the family's story so far?

- What is the parents' stories, individually and together? What is the child's story? What is the wider family's story?
- What are parent/s drivers, enablers and barriers. What are their aspirations and their fears?
- What signs of resilience have you discovered? What is your understanding of risks and how do these relate to needs, for the child, and for the parent/s.
- What is the child worried about, what are the parent/s worried about, what professionals are worried about?
- How do the parent/s view their role as a parent/within their wider family/within their community?
- How does the child view their role within the family?

What are your working hypotheses about the meaning of the story? (There is likely to be more than one possible interpretation of the story) Consider:

- How the family's story effects relationships with each other?
- How the family's story effects relationships with professionals? Consider feelings of shame, stigma and fear.
- How does the story effect behaviour, barriers to parenting and risks?
- How do risks interact, what heightens the risks and what lessens/mitigates them.
- Does the resilience have the potential mitigate the risks?

What can the story tell you about the needs of the child, their parents, and their wider family?

- What are the needs of the child?
- What are the needs of parents and wider family?
- How do the needs of the child link with the needs of the parents?
- Am I being specific in my descriptions of needs, and are they fully understand by the family?

In describing needs, it is important to avoid the following:
(adapted from Brown, Moore and Turney, 2012)

Universal terms eg the child needs to have their emotional needs met	This is too general and true for all children. Need to be more specific about the nature of their emotional needs and/or the causes of unaddressed emotional needs
Service terms eg the child needs to be referred to CAMHS	This is a process led output. It is unclear to the child and their family as well as CAMHS what the service is for. It is important that the service is specific to the needs to ensure it has the most chance of being effective.
Assessment terms eg the child needs to have their special needs assessed	This does not allow understanding of the difficulties leading to the assessment, and why the assessment is being carried out.

What are you still curious about?

- What further information do you need?
- Where or who will you get the information you need?
- What further conversations do you need to have, with the child, with the parent/s and with wider family members?
- Are there any discrepancies in the information you have so far (consider your observations, your conversations, information from other professionals and historical information from the analytical chronology)?
- What are your feelings or senses about the case? Do any of these make you feel worried? What would make you feel less worried?

It will be important for practitioners to reflect on their critical analysis and working theories during reflective supervision with their supervisor and during group supervision. It may be helpful to present your analysis and theories on flip chart paper as part of your reflective discussion about the case with your supervisor; suggested headings are found below:

The story so far:	**Working hypotheses:**	**Needs (child, parent/s, wider family):**	**Curious about:**

Summary of stage one

On completion of stage one practitioners should have developed the following:

- Understanding of the narrative for the child, their parents and wider family
- Relationships based on honesty, respect and trust
- Recognised the emotional lives, hopes and aspirations for the child, their parent/s and wider family
- Understanding of what limits parents' capabilities to care safely for their child
- Understanding of the stressors that make parenting difficult
- Discovery of signs of resilience and strengths
- Understood the needs of the child, their parents and wider family
- Considered how this handbook aligns with other approaches/assessments/frameworks utilised by the local authority and other professionals, and how they can complement the work completed from this handbook

Stage Two: Resilience and Risk

The purpose of stage two is to analyse levels of resilience, risks and parental capacity to change; to facilitate decisions about whether the child can safely remain being cared for by birth parents/family, be returned to the care of their birth parents/family, or whether permanence should be pursed within the wider family, or outside of the birth family network. This section of the handbook supports practitioners to structure their professional judgement, to make well informed decisions, and to communicate these effectively and humanely with children and their families.

Tools to support Stage Two are:

- Factors associated with future harm – evidence from research (see table 4 on page 27)
- Risk and resilience matrix (see page 32)

Being able to tell a story of where you have come from and how you understand your present and future is essential to building resilience

Exploring family potential, requires that the family's experiences of complex, interwoven disadvantage are not overlooked in a binary analysis of risk and protective factors (Featherstone et al. 2014 p.135). Exploring family potential requires those:

> "...engaged in supporting families to be able to articulate their underlying assumptions about how families exercise ethical agency and care in responding to vulnerability and risk. There is value at arriving at a framework that reveals the assumptions being made, and a need to avoid simplistic, binary analyses of family co-operation/non-cooperation as the guide to risk and harm. Within this must sit an analysis of the place and function of care"
>
> (Featherstone et al. 2014 p. 143).

It is important to understand risk as a wider concept that is a product of influences and is situational. If there is an over focus on risk, parents and families will be prevented from asking for help.

It is important that families do not 'receive' this assessment, but are supported throughout the whole approach

In analysing risk, the following critical questions can be helpful:

- **Rating:** Which concerns are the most relevant?
- **Probability:** How likely are the possible negative events to happen?
- **Timescale**: Are your concerns immediate or long-term?
- **Frequency:** Are they recurring concerns or rare events?
- **Movement:** Are the strengths/vulnerabilities static or dynamic?

See Research in Practice, 'Assessing risk of further maltreatment: a research-based approach' available from: **rip.org.uk/resources/publications/practice-tools-and-guides/assessing-risk-of-further-child-maltreatment--a-researchbased-approach-practice-tool-2013**

The 'Factors associated with future harm' (see Table 4) tool supports practitioners to take a research-based approach to analysing the risk of further child maltreatment. It assists practitioners to apply their professional judgement in a structured format along with evidence from research, that considers the unique circumstances for each child of the risks and strengths within their family and wider environment.

The factors associated with future harm are drawn from two systematic reviews of research studies (Hindley, Ramchandani and Jones, 2006; White, Hindley and Jones, 2015) of factors associated with recurrence of maltreatment (Annex one provides definitions of these risk and protective factors). Practitioners should collect information on the presence or absence of each of these risk or protective factors.

All factors listed in the table are associated with future risk of maltreatment and therefore need to be considered. Practitioners should examine these factors for each parent, both separately and together. If appropriate, it can also be applied to other family members, if they are being assessed for the long-term care of the child, such as where Special Guardianship Orders are being considered. The factors with the strongest association with recurrence of maltreatment are in italics.

The 'Factors associated with future harm' table should be used to assist and not replace professional judgement

There may, for example, be only one risk factor present but this could be so significant that the overall risk is severe. Or there may be a clustering of factors that cause concern.

Practitioners need to scrutinise the quality of the protective factors. They also need to identify those protective factors which mitigate the risks to the child. These factors need to be distinguished from positives or strengths which may not be sufficient to alleviate the specific risks to the child. For example, parents may attend a parenting course and may try to implement their learning, which would be positive and show motivation to change. However, if this is not actually effective in addressing the identified problems in their parenting, it cannot be described as protecting the child from risk.

There is a growing understanding of the risks faced by older children from outside the home, for example from sexual exploitation and gangs. These risks may have been the reason why the child was brought into care/accommodation, or they may emerge whilst the child is looked after. The practitioner should consider the changes needed in the child's life and environment in order for them to be safe either at home or in care/accommodation.

Table 4: Factors associated with future harm

NB Items in italics and bold are most strongly associated with maltreatment occurring

Factors	Future significant harm more likely	Future significant harm less likely
Abuse	Severe physical abuse including burns/ scalds ***Neglect*** Severe growth failure Multiple types of maltreatment More than one affected child in the household ***Previous maltreatment*** Sexual abuse with penetration or repeated over a long duration Fabricated/induced illness Sadistic abuse	Less severe forms of abuse (defined in terms of harm, duration and frequency)
Child	***Developmental delay with special needs*** Child's mental health problems ***Very young child – requiring rapid parental change***	Healthy child Child does not blame him/herself for sexual abuse and recognises that it caused harm Later age of onset One good corrective relationship
Parent	***Personality disorder (anti-social, sadistic, aggressive)*** ***Paranoid psychosis*** ***Significant parental mental health problems*** Learning disabilities plus mental illness Lack of compliance Denial of problems Alcohol/drugs abuse Abuse in childhood – not recognised as a problem History of violence or sexual assault	Mental disorder responsive to treatment Non-abusive partner Willingness to engage with services Recognition of problem Responsibility taken Adaptation to (coming to terms with) childhood abuse

Factors	Future significant harm more likely	Future significant harm less likely
Parenting and parent/ child interaction	Disorganised attachment; severe insecure patterns of attachment Lack of empathy for child Poor parenting competence Own needs before child's ***Parent-child relationship difficulties***	Secure attachment; less insecure attachment patterns Empathy for child Parenting competence in some areas
Family	***Inter-parental conflict and violence*** ***High stress*** (associated with family stress, parental stress, large family size, poor home conditions and housing instability) Power problems: poor negotiation and expression of emotions; poor sense of autonomy	Absence of domestic abuse Non-abusive partner Supportive extended family Capacity for change
Professional	Lack of resources Poorly skilled professionals	Resources available: • Partnership with parents • Outreach to family • Therapeutic relationship with child
Social setting	Social isolation ***Lack of social and family support networks*** and lone parenthood Violent, unsupportive neighbourhood	Social support More local child care facilities Volunteer network Involvement of legal or medical services

(compiled from Hindley, Ramchandani and Jones, 2006; White, Hindley and Jones, 2015)

Analysing resilience, risk and capacity for change

The Risk and resilience matrix was originally developed by the author of this handbook in 2011, in response to key findings from a longitudinal study exploring decision-making and long-term outcomes for a cohort of infants who were highly vulnerable to experiencing abuse and neglect (Ward, Brown and Westlake, 2012). In its original form, it was labelled the 'Risk classification framework', or the 'Traffic light tool'. In response to further research and understanding from the Children's Social Care Innovation Programme (see Sebba et al. 2017), the tool has been re-visited and further developed by the author to reflect contemporary practice, and a greater focus on relationship-based practice, and strengths-based approaches. The integrity of the tool remains the same, however there is a greater focus on resilience and its mitigating value to ensure that there is not an over focus on risk, which can alienate families.

The Risk and Resilience Matrix is a dynamic approach to assessment, which involves effective relationships based on honesty, trust and transparency with families

It considers the dynamic nature of the relationship between resilience and risk. It allows for a broader understanding of risk; how it is located within the wider environment and situation of families. It allows for true collaboration with families, to work towards reparation and restoration (see stage three).

The Risk and Resilience Matrix should not take a snapshot view of the family, or label risks, without consideration of their context

On completion of Stage Two, the levels of resilience and risks are analysed in the following way:

- **Green Zone:** Strong resilience; low risk; parental capacity for change
- **Yellow Zone:** Some resilience; medium risk; parental capacity for change
- **Orange Zone:** Minimal resilience; high risk; no parental capacity for change
- **Red Zone:** No resilience; severe risk; no parental capacity for change

This analysis will guide the decision about whether the child can remain or be returned safely to live with their parents/birth families, or whether permanence outside of the birth family network should be pursued. The practitioner and their supervisor should collaborate on this decision, as well as, ideally, an independent practitioner who has reviewed the case.

The Risk and resilience matrix is intended to guide and structure decision-making, considering the age, abilities and unique characteristics of each child and their relationships. It should not be used in an overly prescriptive way. The tool indicates which decision about permanence is most likely to be appropriate based on analysis of resilience, risk and parental capacity for change.

It should be used throughout:

- As a basis for collaborative work with parents, involving straight talking with warmth
- As the basis for planning support and services
- To communicate effectively and humanely with children, parents and families, involving honesty, transparency, respect and challenge
- To review progress and understand change

The intention is to support parents and families to move down through each zone, until they can demonstrate strong resilience; low risk and parental capacity for change as described in the green zone for at least six months. Alternatively, if parents and families present high or severe risks with minimal or no resilience and are unable to change, the tool assists practitioners to decide to seek a placement away from the birth family, and to communicate these decisions effectively and humanely to children and their family.

Decision-making within a child's timeframe

Timely and purposeful decision-making is crucial when supporting children and families for whom there are concerns about abuse and neglect. There are strong messages from research that the step-down of support should be gradual, when parents are able to make positive changes to promote the welfare of their children; as well as being responsive and pre-emptive at times when risks heighten.

If return home from care is being considered, there are further messages from research that they are more successful when they are gradual, and when there is sufficient evidence of the parent's ability to sustain changes. It is important to note that there is a widely held misconception that returns home are most successful if they happen within the first six months of a child entering care. This is not true. Returns home may be more likely in this time, but research shows that when reunifications happen without enough time to support parents to change, the children are more likely to re-experience abuse and neglect, and to come back into care.

Six months is the suggested minimum amount of time needed for parents to evidence that they can sustain the changes they have made. However, if risks increase, then immediate action should be taken to review the zone classification, to ensure children do not remain, or are not returned to families where there are substantial risks of harm. Cumulative harm is also an important consideration, particularly where there are concerns of chronic neglect. Therefore, where cases have been classified in the Orange Zone ie minimum resilience and high risks, and do not demonstrate capacity for change within six months, the case should automatically be reviewed and re-analysed in the Red Zone, ie no resilience and severe risks. This acknowledges the detrimental impact of cumulative harm, and ensures drift, particularly in chronic neglect cases can be addressed.

The Risk and resilience matrix suggests the following in relation to decision-making within a child's timeframe:

Green Zone (strong resilience; low risk)

When there is strong resilience and the level of risk is analysed as low, it is highly likely the child can live safely with their family and return home should be actively considered. The practitioner, the child and their parents and family will create a Support and Solutions Plan, detailing goals to work towards and services and support that will be provided (Stage 3). Continued support will be needed but provided changes are maintained and no new or pre-existing risks emerge or escalate it may be possible to close the case, or gradually reduce the level of support. Where a child has successfully returned home from care, this continued support should be provided for a minimum of six months after the child has returned home.

It should be acknowledged that there may be times that children, parents and families experience times of adversity and heightened stress which can involve trauma. It may therefore be appropriate to provide episodic support during these times and ensure that parents feel enabled to access support during times of stress. Parents and children should be aware of how to access such support and the parent's/caregiver's advocate has an important role in enabling parents to voluntarily access services they require.

It may be appropriate to re-analyse the case should resilience be impeded and risks emerge or remerge. This ensures that parents are getting the most appropriate level of support and the needs of the child are kept in focus.

Yellow Zone (some resilience; medium risk)

Where there is some resilience and the risk is medium, there is some possibility that abuse or neglect will take place; however there are also indications that resilience can be strengthened, and the risks mitigated. Therefore, it is likely that the child can live safely with their parents, and return home from care should be considered, providing parents are able to remain on their change trajectory. The practitioner, the child and their parents and family will create a Support and Solutions Plan, detailing goals to work towards and the services and support that will be provided (Stage 3). Continued support will be needed but provided changes are maintained and no new or pre-existing risks emerge it may be possible to move the case to the Green Zone. However, if resilience is impeded and new or pre-existing risks emerge, the case may require re-analysis and moving to either the Orange or Red Zones depending on the nature of the risks, the presence of protective factors and the evidence of capacity for change.

Orange Zone (limited resilience; high risk)

Where there is limited resilience and the risk is high, there is a strong possibility that abuse or neglect will occur if the child remains at or returns home. Further support and evidence of change are therefore needed before a return home can be considered if the child's timescale allows (Stage 3). If the child remains at home an intensive support package will need to be established to ensure the child's welfare can be protected and promoted; parents will also need to be supported to make changes.

If, by working through the approach set out in this handbook, the parents are able to demonstrate positive change for a minimum of 6 months, the case can be re-analysed and reduced to the Yellow Zone, at which point there is less likelihood of abuse and neglect and a return home could be considered. However, if the case remains in the Orange Zone for six months, without demonstrable evidence of positive change this should lead to escalation to the Red Zone and plans for an alternative placement should be made in the child's best interests. These timescales may need to be adjusted either way depending on the age of the child, but 'drift' should be avoided. It should be noted that 'no change' within a specified period should be considered a risk factor.

Red Zone (Very little or no resilience; severe risk)

Where there is very little, or no resilience and the risk is severe, the possibility of abuse or neglect is too high for the child to remain at or return safely home. An alternative out-of-home placement should be pursued, and if necessary, care proceedings initiated. Work should be undertaken with the child and parents to support them through this most difficult of decisions. Consideration needs to be given to the nature of continuing links and the role that parents and other family members can continue to play in the child's life.

Risk and resilience matrix

Green Zone	Yellow Zone	Orange Zone	Red Zone
Strong resilience	Some resilience	Minimal resilience	No resilience
Low risk	Medium risk	High risk	Severe risk
Parents able to demonstrate capacity for actual change	Parents able to demonstrate capacity for actual change	Parents unable to demonstrate capacity for actual change	Parents unable to demonstrate capacity for actual change
Parent/s and child both want to remain together/ return home	Parent/s and child both want to remain together/ return home	Parent/s and/or child ambivalent about remaining together or child returning home	Parent/s and/or child ambivalent about remaining together or child returning home
Strong likelihood that child's welfare protected at home with lots of opportunities for their own resilience to build	Likely that child's welfare at home will be protected with opportunities for their own resilience to build	Likely that child's welfare at home will not be protected, with minimal opportunities for their own resilience to build	Strong likelihood that child's welfare at home will not be protected, with very little or no opportunities for their own resilience to build
Return child home/child remain at home. Continue working through 8R's (Child in Need Plan/Placed with Parents)	Return child home/child remain at home continue working through 8R's (Child in Need Plan/Child Protection Plan/Placed with Parents)	Child should not be returned home at this stage. Follow 8R's to understand if progress can be made.	Child should not be returned home at this stage. Follow 8R's and plan for permanency in out of home care.
Green Zone for at least 6 months = case closure	Parent/s maintain and build on their resilience; risk factors are addressed, or are being mitigated by protective factors; and parent/s have demonstrated capacity for actual change for at least at least 6 months = move to Green Zone	If child is at home, it may be unsafe. Consider an out-of-home placement. Continue to work through 8R's to understand if progress can be made. If no progress is made within 6 months = move to Red Zone and out-of-home placement.	If child is at home, it is likely that it is unsafe. Out-of-home placement should be actively pursued. Continue to work through 8R's to understand if progress can be made. This should be time-limited to 6 months.
Parent/s maintaining their resilience, however, new risk factors emerge/ previous risk factors re-emerge. There is still evidence of capacity for actual change = move to Yellow Zone	Parent/s maintain their resilience and are developing ability to restore and repair purposefully using the support available to them. Some risk factors are apparent, but they are mostly being mitigated by protective factors = remain in Yellow Zone	Parent/s maintain and build on their resilience; risk factors are being addressed, or are mostly being mitigated by protective factors; and parent/s have demonstrated capacity for actual change for at least 6 months = move to Yellow Zone	Parent/s maintain and build on their resilience; risk factors are being addressed, or are mostly being mitigated by protective factors; and parent/s have demonstrated capacity for actual change for at least 6 months = move to Orange Zone
Parent/s resilience has reduced; new risk factors have emerged/previous risk factors re-emerged; and there is no longer evidence of capacity for actual change = move to Orange Zone	Parent/s resilience has reduced; new risk factors have emerged/previous risk factors re-emerged; and there is no longer evidence of capacity for actual change = move to Orange Zone	Orange Zone for at least 6 months with no positive change = move to Red Zone	
Parent/s resilience is no longer apparent; new risk factors have emerged/ previous risk factors re-emerged; and there is no longer evidence of capacity for actual change = move to Red Zone	Parent/s resilience is no longer apparent; new risk factors have emerged/ previous risk factors re-emerged; and there is no longer evidence of capacity for actual change = move to Red Zone	Parent/s resilience is no longer apparent; new risk factors have emerged/ previous risk factors re-emerged; and there is no longer evidence of capacity for actual change = move to Red Zone	

Risk and Resilience Matrix developed by Rebecca Brown (2019)

Originally referred to as the 'Risk Classification table' or 'Traffic Light Tool'

Risk and resilience matrix for families

Green Zone

Strong resilience; low risks

Child's welfare protected

You have achieved lots of positive changes.

The case will close if you remain here for at least 6 months

→ Resilience reduced and risks increased, move to the **Yellow Zone**. We are becoming worried, you may need extra support.

Yellow Zone

Some resilience; medium risks

Child's welfare mostly protected

Work towards strengthening your resilience and reducing risks

→ Resilience strengthened and risks reduced, and with support you can maintain changes for at least 6 months, move to **Green Zone**. You are making good progress in achieving lots of positive change.

→ Resilience reduced, risks increased and your positive changes are not maintained, move to the **Orange Zone**. We are becoming really worried that you and your child may not be safe.

Orange Zone

Limited resilience; high risks

Child's welfare not protected

Work towards strengthening your resilience and reducing risks

We are worried that if you do not make positive changes, you and your child will experience harm.

→ Resilience strengthened, risks reduced, and with support you can begin to make and maintain changes for at least 6 months, move to the **Yellow Zone**. You are making good progress.

→ Resilience reduced further, and risks increased, move to the **Red Zone**. You have been unable to show us that are able to make the positive changes you need to ensure you and your child remain safe.

Following a period of support for 6 months, resilience has not been strengthened, and risks remained the same, move to **Red Zone**. We have tried hard to support you to make changes to protect your child's welfare. The changes you needed to make have not been achieved.

Red Zone

Very little or no resilience; severe risks

Child's welfare not protected

We are so concerned about the welfare and safety of your child, we have tried to help you make changes and to understand your situation.

It is best for your child, at this stage, to live away from home. We will support you and your child through this.

→ Resilience is strengthened and the risks reduced. With support you can begin to make and maintain changes for at least 6 months and you will move to the **Orange Zone**. You have begun to make good progress; however, we are still really worried about the welfare of you and your child and will continue to support you to help you maintain these changes.

Summary of stage two

On completion of stage two practitioners will have considered the following:

- Completed the Risk and Resilience Matrix and considered how risks, protective factors and capacity for change interact
- Reflected on conclusions and decisions made as a result of using the Risk and Resilience Matrix during supervision
- Communicated the findings from the matrix with children, their parents and wider families, and held meaningful conversations about change.

Stage Three: Reparation and Restoration

The purpose of stage three is to consider and work towards the possibilities of repair and restoration, and to explore and promote family potential with a focus on strengthening resilience and reducing risks. This involves working collaboratively with children, their parents and carers and wider family to have meaningful conversations about change, to agree goals and to put in place services and support to assist.

Tools for stage three:

- Support and Solutions Plan (see page 37)

It is crucial to explore the possibilities of repair and restoration

Restorative practice is based on the premise that,

"...human beings are happier, more cooperative and productive, and more likely to make positive changes in their behaviour when those in positions of authority do things with them, rather than to them, or for them." (International Institute of Restorative Practices)

Restorative practice involves bringing all parties together to improve their mutual understanding of a problem and collaborate to reach the best solution. The process helps people to reflect on how they interact with others and to understand that individuals are responsible for their choices and actions and can be held accountable (McNeish, 2017).

Restorative practice is about building and maintaining relationships and involves working 'with' people at every opportunity. It provides positive challenge and clear 'bottom lines'. There are two key elements of this:

- **High challenge**: which involves holding people to account in a meaningful and constructive way and agreeing clear boundaries to work within.
- **High support**: involves providing the right support and encouragement that enables families to achieve their goals.

A restorative approach is characterised as 'high challenge and high support'

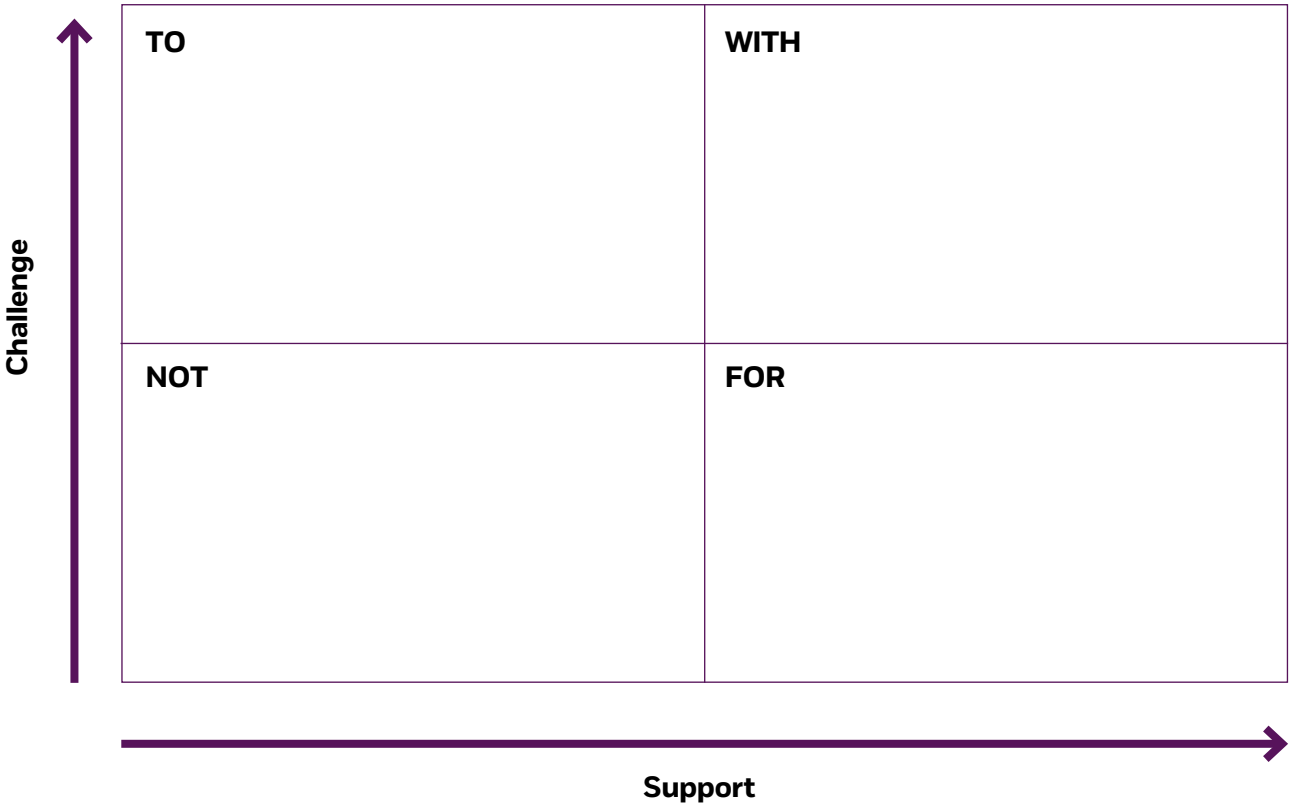
It means working with an individual or group to address issues, rather than doing something to or for them and facilitating a collaborative, non-confrontational approach to problem-solving. It is important to take into account a family's strengths as well as their vulnerabilities, alongside efforts to ensure that families understand and take ownership of their role in the decisions being made by children's services.

Restorative Practice is a way to be, not a process to follow or a thing to do at certain times

It is a term used to describe principles, behaviours and approaches which build and maintain healthy relationships and a sense of community; this can help to resolve difficulties and repair harm where there has been conflict. It is a way of being with people, essentially, a way to work with and alongside others to create sustainable change.

Principles of restorative practice: A way of being

Adapted from: Wachtel T & McCold P in Strang H & Braithwaite J (eds), (2001), Restorative Justice and Civil Society, Cambridge University Press, Cambridge



Restorative practice enables those working with children and families to focus on building healthy and positive relationships that create change. Creating change requires both challenge and support. Formal and informal processes enable social workers, parents, children, young people and other professionals to communicate effectively by removing barriers, setting clear bottom lines, allowing for family led problem solving and decision making and shared accountability.

Some examples of restorative approaches used when working with children, young people and families are:

- Family group conferencing;
- Signs of Safety;
- Solution Focused Brief Therapy (SFBT).

The aforementioned, as well as other restorative approaches implemented by local authorities, should be utilised wherever possible.

The Support and Solutions Plan set out below is a tool to facilitate a restorative approach. It complements the Critical Analysis and Working Hypotheses from Stage One and the Risk and resilience matrix outlined in Stage Two.

Support and Solutions Plan

The purpose of the Support and Solutions Plan is to;

- work with children and their families to set clear boundaries and bottom lines
- work towards finding solutions to solve problems
- agree goals to be achieved

Support and Solutions Plan

The overall purpose: To consider the long-term, medium-term, short term support needs and provision for the children and family.

Challenge	Solutions	Support, services and plans	Bottom-lines
• Recognising the parents' story and its meaning. • The needs of the child, their parent/s and wider family. • What are our theories, and how do parents understand these theories? • How do families and children understand their own story? • What changes would the child, parent/s and wider family want to achieve?	• What goals are we working towards, and how will we know when they been achieved?	• What support can help? • What support is available, how can support be accessed, and who will provide it? • What is our support plan, and has it been implemented and accessed?	• What are the non-negotiables?

The information in the Support and Solutions Plan can be included in the child's Care Plan, and/or any Child Protection Plan or Child in Need Plan. It should be linked to the Personal Education Plan and Personal Health Plan.

Holding meaningful conversations about change: Agreeing goals

Goals serve important functions for both parents and practitioners

For parents, setting goals collaboratively with their practitioner:

- helps parents to feel involved, rather than 'done to'
- helps parents to focus on key aspects of their behaviour that they would like to change
- reduces ambiguity and confusion
- helps parents to consider what is achievable
- increases the likelihood of change
- has positive therapeutic value – when families recognise that they have been able to achieve a goal, this can lead to an increase in self-efficacy and hope, and support ongoing change
- brings structure during periods of crisis and chaos

For practitioners, negotiating and agreeing goals:

- supports focused, purposeful and practice
- promotes reflective practice
- ensures clarity about which services are needed to help parents achieve their goals
- supports family focussed practice, involving collaboration of formal (professional) and informal (family/friends/community) support networks

Practitioners should agree the overall purpose of the change to be achieved and the support provided. This will be guided by analysis from stage one and stage two. Next steps will include:

- Agreeing 'staged goals' as steps towards the purpose
- Ensuring the goals are SMART:
  - Specific
  - Measurable
  - Agreed with Families
  - Realistic
  - Timely
- Expressing the goals in language suggested by parents so that parents are clear about what is expected of them.
- Defining with parents what you both expect will be achieved, what would be better than expected, and what would be worse than expected, for each goal set (see Annex two, page 56).
- Setting timescales for goals to be achieved and progress to be reviewed.
- Agreeing how goals should be reviewed.

Practitioners need to:

- Regularly monitor progress.
- Be mindful of the barriers that may prevent parents from achieving their goals (which may be influenced by internal or external factors).
- Provide support and encouragement to parents throughout (remember straight taking with warmth).
- Review the effectiveness of the support and services offered to parents.
- Recognise the significance of reaching a goal (for example, through using certificates of achievement) and that this may support a desire to achieve another or bigger goal.
- Be aware that compliance with services alone does not constitute readiness or capacity to change, nor does it demonstrate actual change. Compliance can be seen as parents' stated intention to change, but is not necessarily linked to actual achievements. For example, parents may attend a parenting course and may try to implement their learning, which would be positive and show motivation to change. However, if this is not actually effective in addressing the identified problems in their parenting, it cannot be described as protecting the child from risk.
- Be flexible: vulnerable families often suffer crises and in some cases the work can bring additional disclosures. This may mean that goals need to be reviewed or new goals discussed and agreed, although the overall purpose may remain consistent.
- Be aware that longer-term change requiring ongoing support may not be achieved within the child's timeframe. Social workers need to be prepared to discuss and manage failure by families to achieve the goals they have set. Where goals which were set, understood and agreed with the family and the multi-agency network are not achieved, this may provide evidence of a family's inability to change as needed.

Summary of stage three

On completion of stage three practitioners will have completed the following:

- Developed a Support and Solutions Plan to promote repair and restoration.
- Held conversations with children and their parents and families that are open and honest, involving discussions about bottom lines, and offering challenge.
- Provided appropriate support to facilitate change.
- Linked with restorative approaches implemented by the local authority.

Stage Four: Reality

The purpose of stage four is to reflect on the support needs for the family, to review whether resilience has been strengthened and risks reduced and to continue planning for permanence. Stage four is a reality check, an opportunity to reflect on the work that has been completed so far.

Tools for stage four:

- Re-analysis using the Risk and resilience matrix
- Update to the Support and Solutions Plan

Reflecting on support needs and planning for permanence

Over the course of stage three, practitioners will have gathered evidence of parents' ability to make and sustain changes, and to provide loving and safe care to their children. Together with parents, other children and key members of the kinship network, they will have identified the support and services needed to maximise the chances of the child safely remaining within or returning to their birth family network. The child's social worker and their manager – with input from foster carers, residential staff, family support workers and other key members of the team around the family – will agree a re-analysis of resilience and risks, using the Risk and Resilience Matrix. Practitioners should remember that evidence of actual and sustained changes rather than an apparent willingness to change is needed. Practitioners will apply their professional judgment and experience when using the Risk and resilience matrix.

At this stage practitioners should be reflecting on all of the work completed so far, and reviewing the progress of the Support and Solutions Plan, so that concrete decisions can be made about the permanence plan for the child.

Indicatively stage four should occur around six months from the start of Stage One. This is to allow for enough time to review whether parents/families are able sustain changes beyond an initial spurt of motivation for change. Practitioners should note that these timeframes are indicative – they should exercise judgment and take account of the age and circumstances of the child.

The practitioner will communicate effectively with the child and their families their analysis, from both the Risk and resilience matrix, and review of the Support and Solutions Plan, and any subsequent decisions relating to the permanence plan for the child. The practitioner should also explain that the analysis of the Risk and resilience matrix remains live and continues until they achieve the Green Zone (strong resilience; low risk) and have remained there for at least six months.

A note about relapse

Experts in human behaviour change consider relapse to be a natural and inevitable part of the recovery cycle. The definition 'to deteriorate after a period of improvement' is applicable to parents learning new parenting skills, as well as those overcoming addictions. Social workers should be looking for evidence of a general trajectory toward sustained changes. They and the parents should expect and plan for some relapse (especially in the early stages of recovery) and not see it as failure. Practitioners should work towards being able to manage relapse, by ensuring there are the protective factors in place to support parents through adverse periods, and to manage the risks associated with harmful parenting.

When the plan is for the child to remain within the birth family network, or return to the birth family

When parents/families have been able to make and sustain sufficient positive changes, have made progress in strengthening resilience and reducing risks, and analysis from the Risk and Resilience Matrix indicates that they have sustained a minimum of six months in the Green Zones, practitioners should be working towards reducing the levels of support to plan for case closure. If the child is in care, reunification to their birth parents/family should actively be planned.

If there has not been sufficient change whilst in the Yellow Zone, the practitioner will decide whether to allow more time, or to escalate the case to the Orange Zone. If the child is in care, reunification should not be actively planned at this point.

As in stages two and three, the practitioner will communicate their analysis and decisions about permanence to the child and their parents and families. The Support and Solutions Plan will be updated, with a greater focus on the gradual reduction of statutory support, and emphasis on continuing support from universal services as well maintaining informal support networks.

Where the decision is for return to the birth family from care, the Support and Solutions Plan used will be updated with a focus on the reality of reunification happening.

The information in the updated Support and Solutions Plan can be included in the child's Care Plan, and/or any Child Protection Plan or Child in Need Plan. It should also be linked to the Personal Education Plan and Personal Health Plan.

The advocate for the parents/families will have an active role in maintaining low levels of support, in enabling families to access universal services and in encouraging further strengthening of the parents'/families' informal support networks as the case progresses towards case closure.

Further considerations for children returning to birth families from care

It is important that practitioners, parents and wider family members understand and manage the impact on the child of leaving their care placement, especially if they have built up an attachment to their foster carer/residential worker. In some cases, it may be beneficial for the social worker to arrange for the foster carer or residential setting to provide ongoing support and potentially respite care once the child has returned home. Support for maintaining a relationship with foster families may also be useful. It will also be important to consider the support needs of siblings/step-siblings already living within the home.

The local authority is required to outline the assessment of the support and services needed for a child returning to their birth family in the Child's Care Plan. A Reunification Plan Template is provided in Annex three (page 57) to support a multi-agency agreement, it sets out the roles and responsibilities of the various agencies involved in supporting the parents and the children in relation to return home.

There may be no formal Care Plan for children accommodated under Section 20. In these cases, the local authority will decide if a further assessment of the needs and safety of the child is warranted.

Preparing children and parents for reunification

When preparing families for their child to return from care, it is important for practitioners to consider the following with children, their parents and families.

Preparing children:

- Return home is a major transition for children, relationships may need to be renegotiated, and return home may re-trigger trauma.
- Children need to feel they have a place in the family home to return to, bedrooms and possessions are important considerations.
- There may be changes in the family, such as; the birth of new siblings or the arrival of step-siblings. Parents may also have new relationships. These will be important considerations for how best to support the child to adapt to these changes.
- Continuity is an important factor, particularly when children are experiencing changes of home and carers. It is important to consider therefore what can be kept the same for the children during these times of transition, such as remaining at the same school, nursery and youth club etc.

Preparing parents:

- Parents need to be aware that children may be anxious that the return home will not work, and that children may miss their previous carers, such as their foster carers.
- Parents may have doubts about children returning home from care and worry about their ability to cope.
- Preparation for parents should include what to expect when children return home and that they are likely to experience times when it is going well, and times when it is not.
- The parents' and child's fears about rejection from one another should be explored.
- Reassurance in advance that such difficulties are normal and to be expected is crucial. Parents should be encouraged to talk about any difficulties with professionals and it should be explained that asking for support will be seen positively.

When the plan is for the child to remain or be placed in permanent out of home care

Where there is a decision for permanence to be pursued outside of the birth family network, it remains highly important to keep a focus on the repair and restoration of relationships, to work towards achieving longer term outcomes to support the child to establish a strong sense of their own identity throughout the transition period, and into their future.

Once a decision has been made that permanence will be pursued outside of the birth family network, the following should be considered:

- Who is the most appropriate person to relay this decision to the parents/families and to the children?
- The family friendly Risk and resilience matrix (page 33) can be helpful to communicate decisions.
- In some cases, it might be appropriate to have a joint session with the parents/families and the child so that the parents/families can help explain the decision to the child.
- Some parents/families will benefit from one or two sessions with a trusted worker to discuss the next stage of their child's life and the role the parents may continue to play.
- In some cases, it may be beneficial to have a facilitated meeting between new families and birth relatives to develop a shared understanding of the child's needs.

Life story work for children

It is important to consider life story work with the child, to ensure they can develop an understanding of their life history, and the reasons decisions were made, so that their own sense of security, stability and identity can be promoted. At the end of the assessment children are not always able to process all the information provided.

Later life letters can be undertaken for all children, whether they are adopted or remain in long-term care. Later life letters need to be factual, accurate and written with a view of an older child reading them (there is an example of a later life letter in Annex 23 of NSPCC's Reunification Practice Framework).

Families who experience multiple removals of their children

There will be some families for whom the decision to pursue permanence outside of the birth family network, will follow other children having been permanently separated. Local authorities may have strategies for trying to reduce the numbers of families experiencing repeat removals. An example is the Pause project which works with women who have experienced, or are at risk of, repeat removals of children from their care. Through an intense programme of support, it aims to break this cycle and give women the opportunity to reflect, tackle destructive patterns of behaviour and to develop new skills and responses that can help them create a more positive future.

The social workers and other professionals involved need to show great sensitivity at this stage, which takes account of parents' feelings of grief, loss and trauma, as well as anger towards children's services.

Summary of Stage four

Stage four provides the opportunity to reflect on the work that has been completed so far, and to finalise decisions about the permanence plan for the child. Resilience and risk will have been re-analysed, using the Risk and Resilience Matrix. The Support and Solutions Plan will have been reviewed and updated according to the decisions that have been made. These decisions will have been communicated effectively and humanely with the child, their parents and family.

Stage Five: Achieving permanence

Achieving permanence is an underpinning framework for all social work with children and families, from family support through to adoption.

"I slowly became aware that I knew nobody that knew me for longer than a year. See, that's what family does. It gives you reference points. I'm not defining a good family from a bad family. I'm just saying that you know when your birthday is by virtue of the fact that somebody tells you when your birthday is, a mother, a father, a sister, a brother, an aunt, an uncle, a cousin, a grandparent. It matters to someone, and therefore it matters to you. Understand, I was 14 years old, tucked away in myself, and I wasn't touched either, physically touched."

(Lemn Sissay: A child of the state, TED Talk. Available from: **ted.com/talks/lemn_sissay_a_child_of_the_state**)

"Permanence is the long-term plan for the child's upbringing and provides an underpinning framework for all social work with children and their families from family support through to adoption. The objective of planning for permanence is therefore to ensure that children have a secure, stable and loving family to support them through childhood and beyond and to give them a sense of security."

(Children Act 1989, Volume 2 Regs and Guidance (2010): Legal definition of Permanence)

Periods of transition

The child's plan to achieve permanence may involve periods of transition between carers, or family members, for instance:

- Children moving from a temporary carer to a permanent carer
- Children moving from birth parents to a carer within the birth family network
- Children returning to their birth family from care

During these times, it is important that transitions occur gradually and in a planned way, whereby visits and time spent together between the child and their future carers gradually increases so that relationships can be established or re-formed. Children should be consulted and included, in an age appropriate way, about the transition period. The child's trusted adult will be an important relationship for the child during this time.

Once the move has happened

Initially there may be 'honeymoon' period, whereby seemingly the transition and move has progressed without difficulties. However, it is important to recognise that difficulties are likely to emerge, and that children, parents, families and carers are prepared to expect difficulties and are reassured that they do not represent failure.

It will be important that the support established throughout the implementation of the 8R's continues following the transition to ensure the child's needs for security, stability and positive self-identity are promoted. It will also be important that the child, parents, families and carers are able to access and establish new support networks including for instance; community-based support, kinship care and foster care networks and post-adoption support.

Reviewing progress

Lastly, it is important to review progress of the plan, to ensure it continues to represent the best possible outcomes for the child.

Where a child has returned home, or remained at home, it is crucial to be alert of difficulties and needs re-emerging, and to take protective action if necessary. The practitioner must see the child alone and exercise professional curiosity if they have concerns.

Families should be aware and able to access support at times of stress and be reassured that it does not represent failure. Being able to ask for help is an integral element of being able to maintain and build resilience.

Where a child has been placed outside of the birth family network, it remains important to continue to consider the possibilities of repair and restoration of birth family relationships so that contact arrangements can positively promote the child's self-identity. Planning for the child to spend time with their birth family involves multiple complexities. It is important for practitioners to consider how these arrangements promote the child's needs and their relationships with siblings, grandparents and the wider family network, as well as with birth parents. Life story work will be an extremely important element of this work.

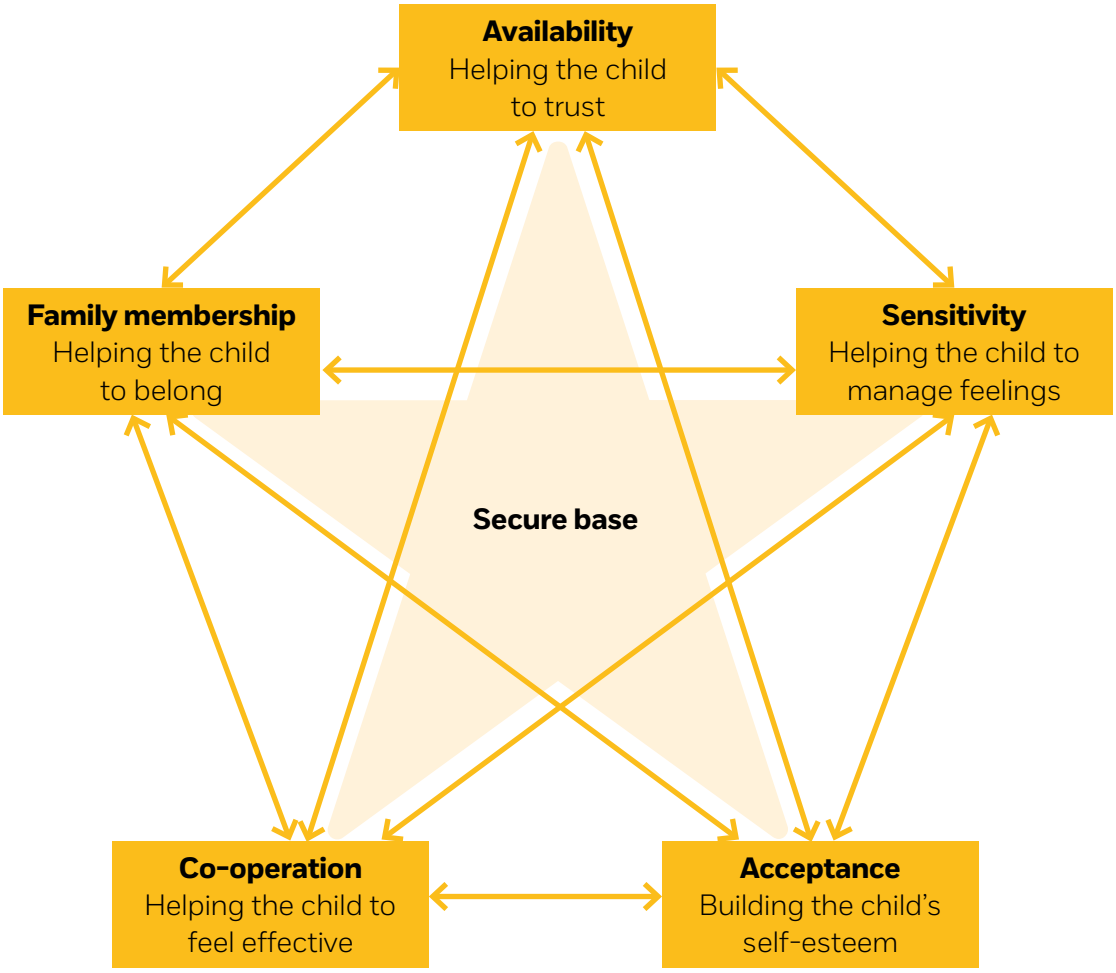
Secure Base

A helpful resource for practitioners, to facilitate the promotion of the child's sense of security, stability and a positive self-identity is the Secure Base Model.

A secure base is at the heart of any successful caregiving environment; whether within the birth family, in foster care, residential care or adoption. A secure base is provided through a relationship with one or more caregivers who offer a reliable base from which to explore and a safe haven to seek reassurance when there are difficulties. Thus, a secure base promotes security, confidence, competence and resilience.

The Secure Base model has been developed through a range of research and practice dissemination projects led by Professor Gillian Schofield and Dr Mary Beek in the Centre for Research on Children and Families at the University of East Anglia, UK.

The Secure Base model is drawn from attachment theory, and adapted to include an additional element, that of family membership, for children who are separated from their birth families. The model proposes five dimensions of caregiving, each of which is associated with a corresponding developmental benefit for the child. The dimensions overlap and combine with each other to create a secure base for the child, as represented on page 47.



Providing a Secure Base, Gillian Schofield and Mary Beek, University of East Anglia, Norwich, UK.
Available from: **uea.ac.uk/providingasecurebase/home**

Stage Five completes the 8R's to achieving permanence. Through the application of the eight themes outlined in this handbook underpinned by reflective and restorative practice; practitioners should have:

- built relationships with children, young people and families based on honesty, transparency and respect
- thoroughly analysed and re-analysed family resilience, risk and capacity to change
- communicated decisions to the child and family in an effective and clear way
- developed an appropriate and fit for purpose support and solutions plan that details goals to be achieved by the parent/birth family and outlines next steps whatever the outcome of the assessment.
- Demonstrated robust and evidence led decision making in relation to the permanence planning for children and young people.

Summary of the 8Rs

Stage Zero

Reflection (1): Reflective practice will have been embedded throughout the work, underpinned by reflective supervision.

Stage One

Recognition (2) and Relationships (3): Relationships built on honesty, trust, transparency and respect will have been established with the child, their parents and families. A **Genogram** and **Analytical Chronology** will have been completed, and the practitioner will have considered their **Critical Analysis** and **Working Hypotheses**, which will have also been shared with the family.

Stage Two

Resilience (4) and Risk (5): Thorough analysis of family resilience, risk and capacity for change will have been carried out using the **Risk and resilience matrix**, and **Factors Associated with Future Harm table**. Decisions from this exercise will have been effectively and humanely communicated with the child and family, using the **Family Version of the Risk and resilience matrix**.

Stage Three

Repair (6) and Restoration (7): Meaningful conversations about potential and change will have been held with the family, and a **Support and Solutions Plan** established, detailing goals to be achieved by the family, and when they will be reviewed.

Stage Four

Reality (8): The work completed so far will have been reviewed, the **Risk and resilience matrix** will be re-analysed, and the **Support and Solutions Plan** reviewed. Decisions about Permanence will be made and plans to establish permanence implemented. Decisions and plans will have been effectively and humanely communicated with the child and family.

Stage Five

The agreed permanence plan for the child or young person will be fully executed, monitored and reviewed.

Annex One: Definitions of risk and protective factors

Factors	Future significant harm more likely	Future significant harm less likely
Abuse	**Severe physical abuse including burns/ scalds** Severe injury caused to child to warrant hospital admission/medical treatment. Examples include; broken bones, head injury. The terminology of 'rough handling' may mask the risks of physical injury or death (Brandon et al, 2009).	**Less severe forms of abuse** Defined in terms of harm, duration and frequency. Physical abuse which does not warrant hospital admission/medical treatment. Note: If severe, yet parent shows compliance with child protection plan and does not deny abuse occurred or their part in it, success is still possible.
	Neglect See section on defining maltreatment in the table below.	
	Severe growth failure Stunted growth and failure to thrive without evidence of a medical reason. Examples include parents forgetting to feed an infant and thus causing failure to thrive.	
	Multiple types of maltreatment Evidence that more than one type of abuse is being experienced by child, including combinations of physical abuse, neglect and witnessing intimate partner violence. See also section on defining maltreatment below.	
	More than one affected child in household	
	Previous maltreatment If either or both parents (if have some responsibility in caring for child) have previously had a child permanently removed, or a child who has been subject to a child protection plan.	

Factors	Future significant harm more likely	Future significant harm less likely
Abuse (cont)	**Sexual abuse with penetration or a long duration** Sexual abuse or sexual grooming that the child's primary caregiver(s) were responsible for or compliant with. See also section on defining maltreatment below.	
	Fabricated/induced illness Evidence from a medical practitioner that the child has been subject to a fabricated or induced illness and that their primary caregiver(s) had been responsible or compliant.	
	Sadistic abuse Child cruelty: child treated in an inhumane and degrading manner.	
Child	**Development delay with special needs** Both developmental delay caused by a disability/illness and/or development delay attributed to poor parenting should be included. There would need to be evidence from a medical/health/educational professional that developmental delay is an issue. Special needs attributed to a disability/illness and/or attributed to emotional and behavioural difficulties should be included.	**Healthy child** A healthy child who does not have any of the following: illness/disability, development delay, special needs, emotional or behavioural difficulties. Note: There may be difficulties with this category for very young children and babies as it may be too early to know whether there are any health or developmental problems. If there is no evidence, then this category should not be included. It should not be assumed that the child is healthy.
		Attributions (eg not blaming self in sexual abuse) Not applicable for infants in first year of life.
	Child's mental health problems Diagnosed mental illness for which medical/therapeutic intervention is necessary. For a baby or very young child this category should not be included.	
	Very young child requiring rapid parental change.	**Later age of onset** Not applicable for infants in first year of life.
		One good corrective relationship Not applicable for infants in first year of life.

Factors	Future significant harm more likely	Future significant harm less likely
Parent	**Personality disorder (anti-social, sadistic, aggressive)** Diagnosed personality disorder for which medical/therapeutic treatment is necessary for primary carer(s) of child. **Paranoid psychosis** Diagnosed paranoid psychosis should be included. A parent stating that they sometimes feel paranoid, and without diagnosis should not. **Significant Parental Mental Health Problems**	**Mental disorder responsive to treatment** The primary caregiver should be accessing and responding to the treatment been given for their mental disorder.
	Learning disabilities when plus mental illness Learning disability and mental illness together, and mental illness alone. Mental illness should be diagnosed by a mental health professional or GP. A parent or non-health professional stating that for instance, 'they can feel depressed' should not count. Note: Mental illness alone should be classified as a risk factor; however, learning disabilities alone should not be, unless it comes with mental illness.	
		Non-abusive partner A partner for whom there are no current concerns of abuse either to children or to their partner. This is especially relevant if one parent has a history of abuse, and the other does not, and can be either the father or mother, or stepfather or stepmother. This might also include a partner for whom there have been past concerns
	Lack of compliance Hostility towards professionals, deliberate deception, sporadic engagement, not giving professionals access to children, and numerous cancelled appointments with social workers without justified reason. False compliance should be included – ie, telling social workers what parents think they want to hear, rather than working with social workers.	**Willingness to engage with services** The primary caregiver(s) should be willing to accept social care and other service involvement with their family as a necessary measure to safeguard their children. Appointments should be kept and not cancelled without good reason. Primary caregivers should also be willing to participate with other relevant services. Children's attendance at school/nursery should not be a cause for concern, and children should be taken to all their necessary health appointments which should not be cancelled without good reason.

Factors	Future significant harm more likely	Future significant harm less likely
Parent (cont)	**Denial of problem** Parents' inability to acknowledge their destructive behaviour or deny the part their own actions have had in the abuse of this child or previous children. For example: can a parent understand why a child witnessing intimate partner violence is harmful, or how their own drug use might affect their ability to care for their child and meet their physical and emotional needs?	**Recognition of problem** Parents should be able to acknowledge why their behaviour is affecting or has affected their ability to care for their child and meet their emotional and physical needs.
		Responsibility taken Primary caregiver(s) should be making some steps in taking responsibility for their actions, ie, they should not blame others for their own destructive behaviour.
	Substance abuse An addiction to substances such as class A drugs, class B drugs, alcohol or any other substance that impairs the child's primary caregiver(s') ability to make sound judgements and to meet their physical and emotional needs. A parent on a methadone, or other similar, programme should be included. Primary caregiver(s) who do not themselves take drugs but allow the child's home to be used for drug taking and/or who routinely leave children unsupervised with a non-primary caregiver who is under the influence of drugs and/or is drunk should also be included.	
	Abuse in childhood – not recognised as a problem Any type of childhood abuse should be included. Evidence can be taken from case file papers, assessments and the parents' own accounts. Note: Evidence that a parent does or does not view their own experiences of childhood abuse as a problem can be difficult to ascertain. If there is evidence that a parent experienced childhood abuse but not whether they recognise it as problem it should be included.	**Adaptation to childhood abuse** Primary caregivers who have received therapeutic intervention to help them come to terms with childhood abuse should be included, unless it is clear that the caregiver has not been able to adapt to their earlier experiences. Primary caregivers who experienced childhood abuse and can focus on the needs of their own children should be included.
	History of Violence or Sexual Assault	

Factors	Future significant harm more likely	Future significant harm less likely
Parenting and parent/ child interaction	**Disorganised attachment; severe insecure patterns of attachment** Observed by a health/childcare professional. This information is difficult to ascertain from social care case files, as limited information on the child's development and emotional and psychological needs is recorded and what there is may not be based on a clinical understanding of attachment disorders.	**Secure attachment; less insecure attachment patterns** Observed by a health/childcare professional. This information is difficult to ascertain from social care case files, as limited information on the child's development and emotional and psychological needs is recorded and what there is may not be based on a clinical understanding of attachment. Note: If attachment is not observed/ recorded to be either disordered or normal this category should not be included. It should not be assumed that there is a normal attachment, if an attachment disorder is not recorded/ observed.
	Lack of empathy for child The parent(s) do not show understanding of how the child might experience adverse situations, such as how a child might feel if their parents are fighting, or how a neglected child might feel if their needs are not being met. This would also include the child being treated in a degrading or inhumane way.	**Empathy for child** Understanding of how the child might feel in adverse situations, and/or if their needs were not being met.
	Poor parenting competence Lack of competence in everyday tasks needed for childrearing. This might include some of the following: establishing routines, feeding, bathing and clothing a child, upkeep of a household, paying bills, and going shopping. Inability to help with homework, or to get the child to and from school on time (or at all). This can also include: not showing emotional warmth and affection, and not providing the child with a nurturing environment.	**Parenting competence in some areas**
	Own needs before child's The parent(s) prioritising their own needs. For example, a parent remaining in an abusive relationship to the detriment of the child; a parent appearing more attached to drugs or alcohol than to the child.	
	Parent-child relationship difficulties	

Factors	Future significant harm more likely	Future significant harm less likely
Family	**Inter-parental conflict and violence** Physical and emotional violence between the child's caregivers, or one caregiver and another adult taking place within the child's home.	**Absence of domestic abuse** This would include both families where domestic violence has been a concern in the past but it is not a current concern, and families where it has never been a concern.
		Non-abusive partner
	High stress Examples of family stress include housing problems including homelessness and inadequate housing, financial difficulties, conflict within the extended family, conflict within the neighbourhood, family crisis such as bereavement or relationship breakdown.	**Supportive extended family** Extended family able to provide emotional and practical support for the caregivers and children. It is important that the caregivers view this as beneficial.
	Power problems: poor negotiation, autonomy and affect expression Poor self-regulation, lack of congruence, unable to manage emotions pertinent to the situation.	**Capacity to change** This should be demonstrated with evidence. A parent stating their desire to change is not sufficient. For example, there should be clear evidence that substance misuse has stopped, or clear evidence that an abusive partner has left the household and has no further contact.
	Children not visible to outside world and continuing perpetrator access	
Professional	**Lack of resources** Resources not available, resources not offered when available, resources available but not accessible. No professional or therapeutic relationships with child or family.	**Resources available** Resources available, appropriate and accessible. Good professional relationships with family, therapeutic relationship with child.
	Poorly skilled professionals Definition: child not seen, multiple changes of worker, cases unallocated, lack of professional boundaries, poor practice, professionals do not share information/lack transparency with child or family, over-optimism.	**Partnership with parents** Definition: effective working relationship between parents and social workers based on honesty and trust.
		Outreach to family
		Therapeutic relationship with child

Factors	Future significant harm more likely	Future significant harm less likely
Social setting	**Social isolation** Parents who have little or no contact with others on a social basis. They may stay home most days with little or no contact with their community.	**Social support** Parents are able to access community resources and support on a voluntary basis.
	Lack of social and family support networks and lone parenthood Parents who have little positive contact within their community, and no access to (or no engagement with) community resources.	**More local child care facilities** Preponderance of facilities in their area such as children's centres and community groups etc. Parents should be engaging with these services to be included in this category.
	Violent, unsupportive neighbourhood These neighbourhoods include those where drug taking and crime are rife.	**Volunteer network** Positive community resources and environment.
		Involvement of legal or medical services

Annex Two: Defining and grading expected achievement of goals

An overall objective may be that a parent (Jane) reduces her drinking. However, this goal is too big and unstructured for parents to achieve or demonstrate. Reduction in drinking needs to be specified as to what exactly is expected in terms of drinking and not drinking and over what period. The small steps that are specified can then be measured.

The following table is adapted from an example from Barlow, J. (2012) [Presentation at Home or Away: Making difficult decisions in the child protection system Partnership Conference, 22 February].

Goal agreed between parent and social worker and expected outcomes defined

	Goal1 **Jane reduces her drinking**
Date goals set	17 March 2018
Review Date	17 May 2018
Much more than expected	Jane does not drink alcohol at all. She attends and engages in all treatment appointments. She attends all contact sessions and plays attentively with Mikey.
More than expected	Jane has drunk once or twice. She attends and engages in all treatment appointments. She attends all contact sessions and plays attentively with Mikey.
Most likely outcome	Jane sometimes drinks at night. She is sober during the day, and attends all appointments and contact sessions, where she plays attentively with Mikey.
Less than expected	Jane is still drinking during the day and has missed some appointments. She arrived at a contact session hung over and grumpy and was not able to play with Mikey.
Much less than expected	Jane is drunk most of the time. She misses most appointments, and is not attentive to Mikey when she does attend contact. She has run out of money.

Review of progress made: review date 17 May 2018

	Level of outcome achieved	**Analysis**
Goal 1 Jane reduces her drinking	More than expected Jane admitted to drinking twice since the goals were set in March. She has fully engaged in treatment. She attends all contact sessions and plays attentively with Mikey.	Drinking episodes were triggered by stress, but were limited to two evenings where Jane drank far less than previously. On both occasions she contacted her alcohol support worker the following day. Jane's presentation at contact has been positive and she has played attentively with Mikey. Positive feedback from foster carer.

Annex Three: Reunification plan template

This next section contains suggestions about what and who to include in the Reunification Plan.

Who should be involved in the Reunification Plan?

- Parents, children, foster carers/residential workers, schools and other key staff supporting the family. The plan needs to detail the role and responsibilities of relevant practitioners working with the child and the family, setting out who will lead different areas of activity.
- The social worker needs to arrange a meeting with all the relevant professionals to back up the plan and ensure commitments by the various agencies.
- Any new specialist referrals required need to be clearly identified and agreed during this meeting.
- The plan should be signed by the nominated officer in accordance with the Care Planning and Fostering Regulations (2015), with a copy provided to all the agencies involved.

Outlining the support for children and parents before and after reunification

- The plan will consider the role of the informal support network around the family – especially around teenagers returning home.
- Social workers need to arrange an appropriate level of support, which recognises the difficulty of return home for parents and children.
- Workers should be mindful not to 'prop up' a family if they are unlikely to be able to meet the children's long term needs for safety and stability without intensive support. However, disabled children and parents are likely to need services sometimes long term, more often episodic, to be called on when needed. The plan should state how long services will be provided for, and at what level of intensity (subject to review).
- Parents and children need to be clear that they can access support and services if additional needs arise and how to do so.
- Where children face risks from outside the home, the plan needs to include the key agencies responsible for the environments where abuse may occur. For example, if a young person is moving back into an area where they experienced sexual exploitation, the police need to be involved in the planning and support arrangements.

Timescales for reunification and case review

- The plan should set out the precise timescale within which it is expected that reunification will take place. Consideration needs to be given to school holidays and exam periods (of all the children involved) to minimise any disruption. Extended contact should happen during term times as far as possible, as schools can monitor children and provide extra support. However, it may sometimes be better for full-time return home to happen in school holidays to fit with changes in school when they occur.
- The plan should clearly state how the safety and welfare of the child will be regularly monitored and reviewed. It should state that the risks can be reclassified at any time, and that action may be taken if parents are unable to sustain changes and provide sufficiently for their children.
- Reunification Plans need to set out clearly the dates when the reunification plans will be formally reviewed.
- Good practice suggests that the local authority will continue to provide appropriate support and services with families for a period of time following reunification. However, some families, where the child ceases to be looked after, may refuse services and it is then up to the social worker to assess whether the child is at risk of significant harm.

An Existing Care Plan, Child in Need or Child Protection Plan can be used, adding these additional fields as necessary.

To be used as a guide only. If more than one child in the family is being considered for reunification additional information relevant to each individual child will need to be included.

This is a multi-agency agreement between the following agencies:

(List agencies here and person responsible for this plan in each agency)

Here are the non-negotiables

The timescale for reunification to occur (refer to timeframes linked to SMART goals in Parental Agreements). Consider school timetable

The type, nature and frequency of any preparatory work that needs to be undertaken prior to reunification, including contact between child and family and who will undertake it

The role of foster carers, residential staff and kinship carers in providing support pre and post reunification

The composition of the 'team around the child and the family' (including role of the child's school) and the services to be provided

Who will be the trusted adult for the child?

Detail of visiting schedule

The process by which any concerns or referrals will be collected and acted on post reunification

Schedule for increased contact, including first nights home and who will support and monitor

Frequency and nature of monitoring post reunification – by whom?

The type, nature and frequency of support work for children and parents post reunification

Process and dates for review

Details of the contingency plan if reunification fails

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