



Care Planning for Children in Residential Care

By Sheree Kane

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NCB promotes the voices, interests and well-being of all children and young people across every aspect of their lives.

As an umbrella body for the children's sector in England and Northern Ireland, NCB provides essential information on policy, research and best practice for our members and other partners.

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Foreword

Why plan?

The essence of planning is thinking before doing

Guy Browning (April 26th 2003) How to...plan. The Guardian

This may seem like a simple question but unless we understand the rationale for planning, it can easily become a paper exercise with no purpose and no direction. It is easy to understand how confusion can arise with the range of plans required for looked after children. Although there are different types of plans relating to specific activities, making sense of what is required can be as daunting for those working in the residential sector as it is for the children and young people for whom these different plans are intended.

A social worker with responsibility for looked after children once said to me, “I have no time for planning.” This was puzzling. Without a plan, how do we know where we are going, what we are trying to achieve. Although planning for every scenario, every action one might take in life would leave little room for flexibility or surprises, not planning at all might be regarded as leaving too much to chance or even reckless. Planning can reduce “fire fighting,” in other words having to constantly respond to crisis. Planning can increase opportunities to anticipate problems that are likely to occur or needs that subsequently arise. Decisions can be made on how to handle situations or in some cases may help to avert a potential crisis.

Thompson (2004) provides a clear example of why planning within child care practice is important.

The importance of care planning

Good Child Care Practice



Planning



A sense of security and direction;
A focus on needs; clear targets to aim for;
partnership

Poor Child Care Practice



Lack of Planning



Drift aimlessness;
insecurity and tension;
confusion/lack of clarity and direction;
isolation

in Thompson, N (2004) Group Care with children and young people. Lyme Regis: Russell House Publishing. 2nd edition. Pg. 36

Planning is not an isolated activity. As Thompson (2004) states, “ *in order to achieve effective planning, we must have a sound assessment of the circumstances, needs and wishes of the children or young people.*”(pg 45)

A plan should follow an assessment but often the two happen simultaneously. However as Thomas points out,

“ there is an important conceptual distinction between the collection and analysis of information in order to produce a judgement about what needs to be done, and the formation of a consequent plan of action to achieve the objectives that follow from the assessment.”
(pg 75)

Most would argue that planning is a process, which requires constant review and adaptation. As Fallows (1998) states, “ *this means changing either the assumptions, or the objectives or the strategies.*” In the world of marketing planning is seen as increasing the chances of recognising and adapting to change before the competition (Fallows 1998).

With regards to children in care, this recognition helps plans adapt to changes as a child grows and develops and moves through transitional stages. A plan has to be flexible to respond to changes to both the child’s internal and external world.

However just seeing care planning as a process or an activity misses the important fact that social care professionals need to have the skills and competence in order that care plans have any meaning and actually make a difference to children’s lives. As Sinclair et al (1995) suggest,

“ It is clear that planning procedures are a necessary but not a sufficient component; they can guide the intervention, but cannot replace the need for a consistent exercising of social work skills.” (pg 297)

The aim of this practice document is to break down exactly what is meant by care planning for looked after children. However it is recognised that given the diverse nature of the residential sector a one- size –fits- all approach would be impossible to achieve. Therefore this document aims to provide a framework for care planning which can be adapted for use in any establishment.

Involving children and young people in the care planning process is a key ingredient and therefore an integral part of this document. This document has been brought together to assist residential homes, schools, units and organisations to reflect on their own practice with regard to care planning and to contribute to the growing body of knowledge of what works in residential child care.

Sheree Kane
January 2007

Chapter 1 – Care Planning

Plans

Before looking specifically at the process of assessment and planning within residential care, it is important to clarify the different plans that apply to all looked after children regardless of where they may be placed;

- The Care Plan
- The Personal Education Plan (PEP)
- The Health Plan
- Placement plan

and for older children

- Transition plan (if the child has a disability)
- Pathway planning

And for those with needs around communication

- A communication plan

What is a care plan?

Although different residential establishments, schools, homes may operate their own system of what they describe as a care plan (their plan of work with a child or young person based on either their own assessment or needs identified at placement or as a vehicle to identify how the placement will meet the needs of that child/young person) there is in fact only **one LAC care plan** that provide the overall plan for a child or young person. The Care Plan is the responsibility of the Local Authority Social Worker. All other plans stem from it.

Confusion can often occur if the residential establishments also have their own document called a care plan, which specifically relates to the work of the establishment. Ideally this should be called something different. So what do we mean when we talk about the Care Plan?

This question was posed to young people at a national event hosted by Voice, Fostering Network and NCB during Care Leaver's Week 2006. The following are examples of how some young people described a care plan.

“A plan about your life for the next six months and then it should be reviewed.” **Aged 13**

“Don't know” **aged 16**

“A plan that maps out what a young person will undertake whilst in care i.e. education, aims for the future, whether they will be in foster care or in a child's home.” **aged 17**

“A plan of how they'll try and look after you.” **aged 18**

“Looks at needs for the future and how to meet them- health, leisure, education!” **aged 16**

“Care plan is where the social worker plans where they're going to put you and what your future is, your school plan etc.” **age unknown**

Although the answers provided by these particular young people suggest they had an idea what a care plan is, research suggests that overall, children and young people in the care system are not always aware of the purpose of a care plan, let alone involved in contributing to it.

Shaw (1998) noted however that of all of the groups of children in the care system, children and young people in residential care were the most likely to be aware of what a care plan is, had a better understanding of the formalities involved in the care system and knew how to complain. This is extremely positive for the residential sector. That said, Shaw (1998) stated that, “ *having or knowing about a care plan had little impact on children and young people’s experiences of having a say on other aspects of day-to-day living.* ”

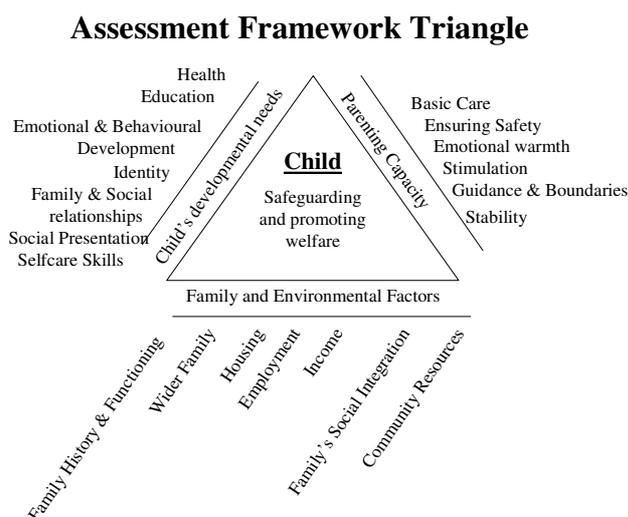
The following is a definition of the LAC care plan.

“This determines why it is in the child’s best interest to become looked after or whether other support services would be able to meet their needs; it identifies their assessed needs and the services to meet those needs, and sets out the framework for the services provided to the child and family to enable the desired goals and outcomes to be achieved.”

The Care plan as defined in the glossary of Williams, A and McCann, J (2006) Care Planning for Looked After Children- a toolkit for practitioners.

The care plan contains within it the long-term plan for the child and how permanence is going to be achieved. All children who are looked after should have a care plan, personal education plan and health plan in place.

Williams and McCann (2006) state that, “ the care plan is built upon a holistic specialist assessment which identifies developmental need, the capacity to meet need (parenting capacity and family and environmental factors) and an evaluation of what has happened to the child (history and chronology). The assessment must be continually updated and feed into revisions of the care plan and into the review process.



(DOH 2000)

The diagram above shows the Assessment Framework (DOH 2000), which details what areas should be covered when doing an assessment of a child in need and what constitutes a holistic assessment of a child.

The Framework for the Assessment of Children and Need and their Families was published in 2000 providing a “*systematic way of analysing, understanding and recording what is happening to children and young people within their families and the wider context of the community in which they live.*” (DOH 2000 pg viii)

Howarth (2001) described the Framework as providing a, “ conceptual map for undertaking assessments of children in need and their families, which ensures that practitioners, managers and policymakers maintain a child focus, irrespective of how the world of the child changes and develops over time.”

Field social workers base their assessments on the Assessment Framework. Some residential establishments also use the Assessment Framework as the basis of their own assessments.

The assessment is followed by a care plan.

The care plan should include the following

- The child’s needs and how the child’s needs might be met
- What services are to be provided
- The type and detail of the proposed placement
- Support in placement
- Arrangements for contact and/or reunification
- Arrangements for health care and education
- The aims, desired outcomes and timescales
- Action to be taken and by whom
- Contingency plans

The views of the child, their parents or guardians and other professionals working with the child and family should be integral to the creation of the care plan.

It is also important to record all the needs of the child even those that the local authority may not be able to meet immediately so that these are not missed at a later stage.

Personal Education Plan (PEP)

All looked after children and young people should have a Personal Education Plan.

The social worker is responsible for drawing up the Personal Education Plan (PEP) in partnership with the child, teachers (this would be a Designated Teacher for looked after children in maintained schools), parents, relatives and carers. Residential Staff- the Key Worker for example would be a key person involved in drawing up this plan.

There will be particular times in a child’s life when the plans concerning education are more critical. (Williams and McCann 2006) indicate that such times are likely to be;

- A change in placement- there could be implications for a child’s education if the proposed placement or placement made in an emergency is located away from the child’s school or college.
- A school transition- i.e. move to secondary school or starting GCSEs
- Leaving school- considering further education, training or employment
- Transition within children’s services- i.e. to a leaving care team
- Leaving care- decisions about placements, preparing for independence (impact on education particularly when a young person is approaching 18)

- Transitions for young people with disabilities- (i.e. to adult services, changes in provision, services and support)

For children and young people with special educational needs, Williams and McCann (2006) clearly state that *“care planning, the review of their statement and their transitional plan should come together and all should be clear about their individual and collective responsibilities.”*

An Evaluation of the Local Authority policies, protocols and guidance that underpins PEPs with a specific focus on the relevance for young people living in residential child care will be available on the NCERCC website Spring 2007.

Health Plans

All Looked after children and young people should have health assessments carried out by a qualified medical practitioner to formulate the health plan. In some Local authorities this might be carried out by the designated looked after nurse, doctor or by the child’s GP.

Health assessments/plans are extremely important to ensure continuity of health care if a child has a medical condition or an ongoing health problem. Some children’s experience prior to coming into care may have meant that their health needs were overlooked or neglected. Treatment may have been disrupted or health issues may remain undiagnosed.

Details about a child and their family’s health history i.e. immunisations, conditions, illnesses might be incomplete, misplaced or have not followed the child. In regards to children and young people who are asylum seekers or refugees there may be additional issues to consider.

It may be difficult to ascertain full or in depth information for many reasons. Firstly the information on health history may not be known especially if the assessment is on an unaccompanied minor. The child/family may have concerns or worries about divulging information about health as there may be an assumption that this will have an adverse affect on their immigration status/application. Definitions of health issues, health needs and desired outcomes may differ across cultures and therefore one cannot assume that there are common understandings. Everything needs to be explained.

More generally children may be concerned or show reluctance to attend health checks for many reasons. In these instances it is important to try and find out what the concerns or fears might be.

“ The role of carers in promoting health and well-being is crucial to improving outcomes for looked after children’s health and well-being, and has been developed as a distinct area of practice within many partnerships. NCB worked with local partnerships to devise a Carers Health Promotion Training Programme, now available within the family of Healthy Care document resources from NCB.

Experience shows that where carers are supported, trained and resourced to deliver the training it enhances their care practice, improves self-confidence and demonstrates the relevance and benefit of the training for developing the looked after children’s workforce.”

Taken from National Centre for Excellence in residential Child Care Conference proceedings. Issue 21-Spring 2006 pg 9

There is an NCERCC practice document regarding Healthy Care in Residence (Katrack and White 2007) on the NCERCC website www.ncb.org.uk/ncercc.

Transition Plan

Transition refers to the move from secondary school to further or higher education, employment, and preparation and planning for adulthood. When a young person reaches Year 9, the Annual Review of their Statement of Special Educational Needs should include a Transition Plan. The Head Teacher must ensure that a Transition Plan is drawn up and this should be done with the involvement of the Connexions Services.

The Department for Education and Skills Special Educational Needs Codes of Practice 2001 states that:

"The Annual Review in Year 9 and any subsequent annual reviews until the young person leaves school must include the drawing up and subsequent review of a Transition Plan. The Transition Plan should draw together information from a range of individuals within and beyond school in order to plan coherently for the young person's transition to adult life. Transition Plans, when they are first drawn up in year 9, are not simply about post-school arrangements, they should plan for on-going school provision, under the Statement of SEN as overseen by the Local Education Authority."

Transition planning should be carried out in a person centred way. Young people should be helped to identify their dreams and aspirations and then a plan should be put in place to enable them to realise them. Depending on the young person's needs, input into the plan may be required from education, social care, health and any other relevant agencies.

The Connexions Service Personal Advisor (PA) must be invited to and attend the year 9 annual review meeting and be invited to all subsequent annual reviews. The Connexions Service is responsible for overseeing the delivery of the Transition Plan and the Connexions PA should co-ordinate its delivery.

Local authorities usually have transition social workers or a dedicated, multi agency transition team to work with all disabled young people in the transition process. For more information about the transition process go to: www.transitioninfonetwork.org.uk

Pathway Plan

All children and young people that come under the umbrella of the Children (Leaving Care) Act 2000 should have a needs assessment and a pathway plan

Categories under the Children (Leaving Care) Act 2000

- Eligible children:** children aged 16-17 who have been looked after for at least 13 weeks since the age of 14 and who are still looked after
- Relevant Children:** children aged 16-17 who have been looked after for at least 13 weeks since the age of 14 and who have left care.
- Former Relevant:** aged 18-21 who either been eligible/relevant or both. A young person continues to remain 'former relevant' after the age of 21 if they are still being helped by the LA with education/training. Support would continue until the end of the agreed programme of education/training. (cut off point is 24)
- Qualifying children:** children aged 16-18 who leave care but have only been looked after for less than 13 weeks since the age of 14.

A needs assessment forms the basis of the pathway plan. As a looked after child, an eligible child will already have a needs assessment in order to formulate a care plan and this should form the basis for the assessment required under the Children (Leaving Care) Act 2000. (Kane 2006a)

In accordance with the Children (Leaving Care) Act 2000 (Regulation 7 (4)) the needs assessment should look at

- The child's health and development,
- The child's need for education, training or employment,
- The support available to the child from members of his family and other persons,
- The child's financial needs
- The extent to which the child possesses the practical and other skills necessary for independent living and
- The child's needs for care, support and accommodation

A needs assessment should be completed within 3 months of a child becoming eligible. Central to both the needs assessment and pathway plan is the young person. Young people should be actively involved.

Regulation 6 of the Children (Leaving Care) Act 2000 makes it quite clear that local authorities have to take all reasonable steps to ensure that young people's views and wishes are taken account of in the assessment, planning and review process. As well as being a statutory requirement, it also makes good practice sense as the DOH (2001) states, "*Clearly the further the young person can be involved in the process the more successful it will be.*" Pg 36

For young people over 16, the Pathway Plan builds on the existing care plan and other relevant plans and becomes the care plan for the child when they attain care leavers status as defined under the Children (Leaving Care) Act 2000.

As Burrows (2005) clearly points out, "*pathway planning was always intended to be an extension of care planning- the reassessment of needs at 16 and the related development of the pathway plan should be approached with exactly the same thoroughness and attention to detail as care planning.*" Pg 3

The Pathway Plan should detail how the needs identified in the needs assessment are going to be met, the timescales for meeting the needs and who is responsible for carrying out the action require to implement the plan.

The Pathway Plan also has to identify what the outcome should be and the progress to be achieved by the next review or other specified date. Within the pathway plan, the contingency plan should also be identified should any of the arrangements made in the Pathway Plan fall through or cannot be financed.

As suggested in Kane (2006b) when it comes to pathway planning for asylum seeking and refugee children, unless a young person has been allowed to stay permanently in the UK, a parallel planning approach has to be applied to ensure that the needs identified and the

pathway plan cover all eventualities and all possible outcomes. This means that the needs assessment has to look at the following;

- The needs if a young person remains in the UK long term: integration, settlement, preparation for leaving care, adulthood and independence in the UK
- The needs of the young person if they have to return to their country of origin as a result of their immigration status
- The needs of the young person if at some point they become failed asylum seekers and may not be able to access services
- The needs of young people separated from the family: family tracing, locating family and reunification if this is possible

This does not mean that different needs assessments and several pathway plans need to be made but the one needs assessment and one pathway plan has to cover all the eventualities until such point as it is clear what outcome the future plan can concentrate on. (Kane 2006b)

Further details on assessment and planning for asylum seeking and refugee children and young people can be found on the NCB ARC website www.ncb.org.uk/arc.

For further details and information on generic pathway planning, see the ICS (Integrated Children's System) website at www.everychildmatters.gov.uk/socialcare/ics/

The Pathway Plan is not static. It should change over time as the young person moves towards and into independence and adulthood. Residential establishments that work with young people would need to consider how they will contribute to the pathway plan; its formation and assist in carrying out the tasks identified.

What is a Placement Plan?

This question was posed to young people at a national event hosted by Voice, Fostering Network and NCB during Care Leaver's Week 2006. When it came to describing what a placement plan is, young people did not find this question so easy to answer, hence the diverse range of responses.

"A plan of where you are placed and where you will be living for both short and long term placements." aged 13

" For the young person telling them where they will live." aged 15

" When a child is looked after by a foster carer, children's home etc, this details how things will be run." aged 17

" Tells you where you are staying, for how long and why you are there." aged 17

" Plan for where you live." Aged 18

" A plan of where you are placed now; short and long term." aged 20

" Where a child will be placed and for how long." aged 17

" A plan to show where you are placed and if it is suitable for your needs and routine." aged 15yrs

" Where social workers see what a suitable placement is 4 U." age unknown

The following is a definition of the Placement Plan as described by Williams and McCann (2006)

The “ placement plan/placement information record: this takes forward the care plan into a written plan for the child’s daily life in placement. It details how the child will be looked after, how his or her needs will be met by the home/carer.”

All placements should have a clear and detailed placement plan for each child, which emanates from the overall care plan and complements the child’s personal education and health plan.

Although the Department of Health created a placement plan format as part of the LAC materials, many local authorities and placement providers have formulated their own style of placement plan.

Halton Borough Council for example, have designed a placement plan links to the five outcomes every child matter. The Principal Manager for Residential and Intensive Support at the time of writing, Jennifer Turnross, states that the Placement Plan “ assists us in identifying every achievement, no matter how small.”

The NCB Care Planning Project devised their own placement plan proforma as follows. (Williams and McCann 2006)

Placement plan and action template

(taken from Williams and McCann (2006) care planning for looked after children. NCB)

Task	Person(s) responsible for carrying it out	Who needs to be involved/consulted?	By when?	Monitoring and review	Comments/ what next
Describe each task/piece of work that needs to be undertaken Under each heading				How/when will this be reviewed	What will happen if the task has been achieved, including rewards for the child?
Health					
Education/cognitive and language development					
Emotional and behavioural development					
Identity					
Family and social relationships					
Social presentation					
Care plan/other					

This example is aimed at helping placement providers to identify the role of the placement and making the plan work. It focuses on the detailed tasks to achieve the outcomes for the child

Communication plan

In the case of a child or young person for whom English is not their first language; or requires electronic or other assistance with communication; a clear communication plan should be formulated.

The aim of a communication plan is to ensure that children and young people are not isolated and enables integration into school, home and the community. (Williams 2004 pg 15)

Communication passports provide one approach.

As Sally Millar, the inventor of the communication passport states;

Passports aim to;

- Present the person positively as an individual, not as a set of ‘problems’ or disabilities
- Provide a place for the person’s own views and preferences to be recorded and drawn to the attention of others;
- Reflect the person’s unique character and sense of humour etc;
- Describes the person’s most effective means of communication and how others can best communicate with, and support the person
- Draws together information from the past and present, and from different contexts, to help staff and conversation partners understand the person and have successful interactions;
- Place equal value on the views of all who know the children well as well as the views of the specialist professions.

Taken from www.communicationpassports.org.uk/html/introductions.html

Further information including a template for a Communication Passport can be found at www.callcentrescotland.org.uk

What makes a good plan?

According to the Riverland Development Corporation (2000) in Australia, there are several key principles to planning;

A plan must be:

1. **Explicit:** all steps completely spelled out
2. **Intelligible:** capable of being understood by those who will carry it out.
3. **Flexible:** capable of accepting change.
4. **Written:** committed to writing in a clear concise manner.

In specific reference to care planning for looked after children, Williams and McCann (2006) made the following suggestions as to what constitutes a good and bad care plan.

What makes a good one?	What makes a bad one?
Needs-based assessment – analysis – outcomes – services – review	Service-led
Child participates and understands the care plan	Child is excluded and does not understand the care plan
Participation of all those with parental responsibility, and carers	Non-participation of other agencies, and/or all those with parental responsibility, carers not involved
Specific Measurable Achievable Realistic or relevant Time-limited	Not specific concerning who is responsible for what action; outcomes cannot be evaluated; not achievable nor realistic; no timescales
Focused	Lacks direction
Proactive	Reactive
Brings together other plans	Separate from other plans
Has a contingency plan	No contingency plan

Although the above table suggest what a good care plan looks like, the principles could equally apply to any other type of plan.

Multi-disciplinary working

Although there may be a lead professional/s responsible for different aspects of care planning for looked after children, an obvious but nevertheless important point is that there has to be a multi-disciplinary approach to assessment and planning for children. One person cannot hold the key to meeting all the child's needs.

ACT (2003) in their guide to effective care planning suggest the following principles for effective multi-disciplinary working

- Clarity on lead role/responsibility
- Early joint planning
- Co-operation between disciplines and agencies
- Clear channels of communication
- Shared information
- Shared protocol re consent and confidentiality
- Understanding each others' roles and terminology

Residential staff

Meeting diverse needs

Children and young people who come into the care system have diverse needs. Although a residential establishment may specialise with a particular client group; children with disabilities, young parents, asylum seekers, adolescents in secure units and so on even within such categories each child or young person will be unique.

An obvious and important part of the assessment and planning process is the worker themselves and the organisational context in which the work takes place. Also equally important is the understanding of the environment of residential care; the policies, procedures, aims and objectives, tools used in assessment, planning and interventions, training and the external factors that influence the establishment. Like the worker themselves, the organisational environment can have an impact on how assessments are carried out; how the information is gathered, analysed and interpreted. (Holland 2004)

Daziel and Sawyer (forthcoming) in their work in looking at putting analysis into the assessments of children and families highlight the importance of doing a cultural review.

“ The purpose of undertaking the cultural review is for the practitioner to alert themselves to areas where their own assumptions, prejudices or simply lack of knowledge might have a bearing on their response to a family and, ultimately, on the approach taken to working with them. Similarly, issues that a worker may be carrying in their head, such as agency norms and awareness, will also have an impact; as will the families’ likely assumptions about the worker and the agency.”

Cultural review

- What do I know about children and families with this particular background or life experience?
- Where does my knowledge come from?
- What prejudices may I hold (positive or negative)?
- What do I know/expect about children of this age, their lives and needs?
- What might surprise me about this child/family and why would it be a surprise?
- How might the child/ family/ community perceive me?
- How might the assessment and my agency be perceived?
- What impact might the assessment have on the child and family’s life and on their perception of their lives?
- What agency norms and practices do I take with me on an assessment? (e.g. awareness of risk, resource restrictions, and theories used within the work.)

Cited in Dalzell and Sawyer (forthcoming) Putting the analysis into assessment. London: NCB

Research suggests that listening and really involving children and young people is the key to effective care planning. At the 2006 NCERCC conference, participants of the care planning session were presented with the following ideas that came out of the Blueprint project (2005) Start with the Child, Stay with the Child. London: Voice.

- Within social care children are often seen as either at risk or as posing risks
- Do our Perceptions of children form the basis of services we provide?
- Child focused- are we child centred?
- Challenging negatives ideas and developing positive ideas about children and young people
- Seeing children as experts, competent
- Seeing the world through their eyes
- Working with them to promote their well-being

These ideas provoked much debate and difference of opinion, which highlights that there is no consensus across the sector on how children are viewed.

Involving children and young people presents challenges. However this has to be given serious consideration if we are to overcome the barriers to meaningful participation. There is considerable debate as to what consultation and participation actually means in real terms. Sinclair (1991) suggests that consultation and choice has to be set within known boundaries.

“Consulting with a child does not mean that they are responsible for the final decision- nor does it mean letting the child have their own way. For participation to be positive everyone must be clear about what choices are or are not available and why.”(Sinclair 1991)

Participation is discussed in more detail later in this practice document.

Children in Residential Care

Identifying and Meeting the Needs of Children in Residential Care

Given that residential staff either live with or spend the majority of their working time with a child placed in residential care, its fair to say that they have a lot to contribute to the care planning process.

Although the carer or key worker should routinely be asked to contribute to any assessment taking place, and in making plans, this does not always happen.

Residential staff have an important role as advocates for children, ensuring that they have a say in what is happening and what is written in assessments and plans. This might mean simply explaining things again to a child, answering questions or this could mean communicating on behalf of a child who doesn't feel able to express their views on paper or in meetings.

Identifying and meeting the needs of looked after children can feel overwhelming and a bit daunting. The looked after children population is diverse and each child will have different needs.

The role of residential care in meeting the needs of children cannot be underestimated. As Williams (2005) citing Rutter (1991) states;

“Rutter (1991) demonstrated that environment and interventions can influence and compensate for damaging experiences providing new pathways and opportunities for children to develop and achieve.”

Acquiring knowledge about child development, attachment theory, resilience and understanding risk factors are essential to care planning.

Although this practice document does not cover these areas in any detail, there is already a lot of literature available that can help in building knowledge, skills and confidence, a sample of which is mentioned in the bibliography at the end of this document. A recent publication by Ryan (2006) on understanding attachment provides a good starting point and can be downloaded from the NCERCC website www.ncb.org.uk/ncercc

As well as looking at the internal world of a child, considerations have to be given to the environment in which the child lives; past, present and future. There may be needs that have to be addressed as a result. There also has to be an awareness that looked after children may face discrimination on many levels; because of their ethnicity, culture, religion or beliefs, their gender, sexuality, age or because they are in the care system.

As a child even if they are near adulthood there are safety issues to consider; do they know how to look after themselves, what to do if they find themselves in a difficult situation, how to keep themselves safe when they are on their own or with friends. For young people who require long-term support post 18 securing support from adult services may not be straightforward as the criteria for services may significantly differ from that set for children.

As with all children, needs change over time and support and services will need to alter to meet those needs. The next section looks specifically at a conceptual model for assessment and planning

Conceptual model

This model originated from the NCB care planning project and was adapted for use on the NCB Asylum Seeking and Refugee Children Developing Good practice project. The Needs Outcome Model can be used with any child in any setting.

The following explanation has been adapted from a practice document that was written for assessing the needs of asylum seeking children. (Kane 2006c)

In order to make the job of assessing and meeting needs manageable the following model has been devised to help residential staff focus on breaking down the task. The aim is to provide a tool to help residential staff feel more confident in identifying needs more effectively and therefore be more confident in contributing to the child's assessments and plans.

The model places the child's needs at the centre. It will help staff to avoid making service-led as distinct from needs- led assessments. The difference is demonstrated in the following case study.

Case study 1

Morgan has been having regular nightmares, getting up in the middle of the night and falling asleep in class. Both the social worker and the school are concerned.

The social worker feels that Morgan needs counselling.

What is being described here is a service and not a need. Saying Morgan needs counselling might suggest that a specialised service is required and that only someone with counselling expertise is able to offer help. It may be the case that there is a long waiting list for counselling services or no services available in the area. If the social worker said that Morgan's need is counselling- straightaway we might think that this need can't be met.

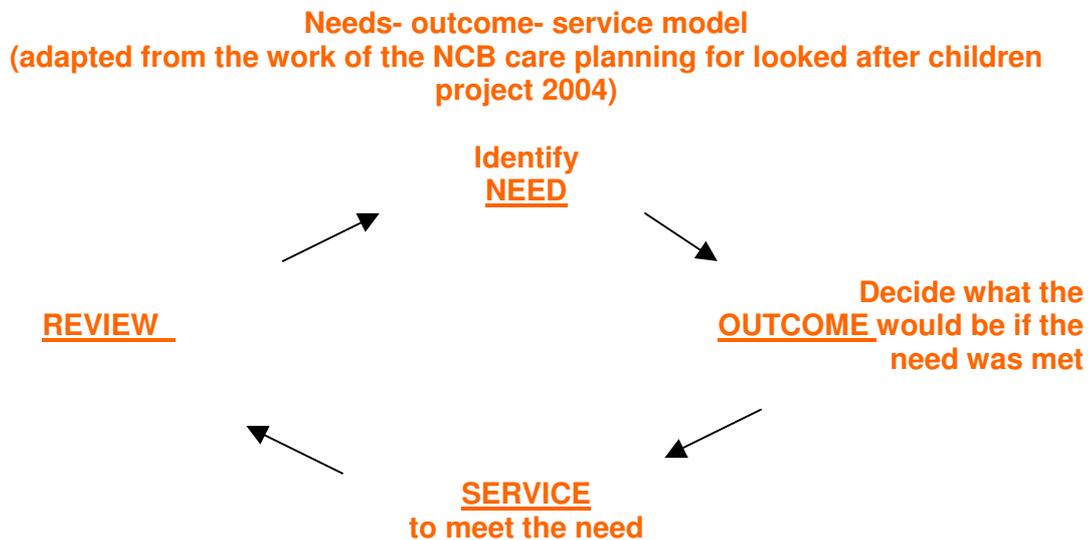
Morgan may not wish to see a counsellor or may not understand what a counsellor does. If Morgan came from different country, it would have to be recognised that in some countries this service might not exist or may have negative associations with mental illness. Counselling in some cultures might be perceived as a sign of weakness.

Some children and young people may not want to talk to someone they see as a stranger, preferring to talk to someone they have already begun to build up trust with whether this be a foster carer, their key worker or social worker.

So how do you Establish Morgan’s Needs?

The Model

The following model can be applied to the assessment process of any child.



NEED What children and young people require to thrive, for their health and development in order to maximize their opportunities to reach their full potential as they move towards adulthood and beyond

OUTCOME Think about what do you want to achieve. In order to know whether you met the need, you need to establish exactly what outcome you are looking for. If the outcome states that the young person be happy, this would be too vague. How would you know if you achieved this? Is this actually a realistic outcome as no human being is happy all the time? Outcomes need to be SMART

- S** Specific
- M** Measurable
- A** Achievable
- R** Realistic
- T** Time limited

You should also be able to provide evidence that the outcome has been met.

SERVICE

Think about the task that needs to be done to meet the need and who will do this. A service can be a person like a foster carer doing a particular task i.e. listening to a child about their concerns or it could be an organisation providing or doing particular task/s that can meet a particular need i.e. a counselling service providing trauma counselling

REVIEW This is when you look at whether the service you put in place, or the task undertaken to address the need has achieved the outcome you were looking for. If the need has not been met, then you may need to look at another service to meet the need

UNMET NEED It is extremely important to record needs that have been identified and have not been met or cannot be met and the reasons for this. This information is important for the Local Authority in terms of strategic planning and for highlighting issues affecting the ability to meet identified needs

Applying this to Morgan

In applying this needs, outcome, service model, Morgan's situation looks different.

Case Study 1

Morgan has been having regular nightmares, getting up in the middle of the night and falling asleep in class. Both the social worker and the school are concerned.

- Need-** Morgan needs to sleep and not have trouble sleeping. He needs ways to express the fears causing his nightmares so that this does not intrude on his sleep.
- Outcome-** That Morgan sleeps free from nightmares, Morgan is not falling asleep in class
- Service-** The social worker to provide the opportunity for Morgan to talk about his nightmares and express the fears that may be causing the nightmares to occur. The Social Worker and Morgan to explore strategies for dealing with the nightmares.
- Review-** If the service put in place doesn't achieve the outcome described above- then a different service should be put in place.

It may be that after trying different approaches to addressing Morgan's nightmares that a specialist counselling service might be required but this would be done with Morgan's full agreement. In order for any service to be effective, the child or young person should be consulted and be in agreement to the rationale behind the service being offered. This case study has used the example of a social worker providing the service but it could easily be the foster carer or the key worker or another member of the residential staff team that a child trusts that is providing the support.

This is only a case study but it should highlight the importance of talking to children about the needs that have been identified, as the child concerned may be able to offer solutions and ideas about how they might wish this need to be addressed.

Chapter 2 Reviews

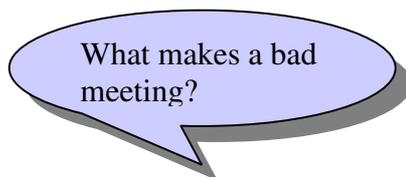
Meetings

Meetings are commonplace within social care. They can play an important part in bringing key people together, to ensure work is progressing, evaluate, review and agree future action.

A child will experience a range of meetings during their time in care and research suggests that although meetings can produce positive outcomes for some children they can feel uncomfortable, boring and sometimes irrelevant.

Although the final decisions may rest with the adults involved in the child's life, it is extremely important that children feel included, are listened to and are aware of their choices and options.

ARX (Advocacy resource Exchange) produced a report in November 2005 entitled "Growing up and Speaking out"- a guide to advocacy for young learning disabled people in transition (14-25 years) by The Sounds Good Project. During their conference in May 2004 they ascertained what young learning disabled people thought about meetings. The following is an example of what they said. Their comments may not come as any surprise.



What makes a bad meeting?



What makes a good meeting?

Not listening to me- the meeting's about ME not YOU

People listen to me

Moving on too quickly

Having a recap of what has been said so That I understand

When people don't really know you
Lots of people- it's overpowering

Having people there I chose

People talking for you and not asking your opinion

To have an advocate beside you and able to help

People talking over you

Preparing for the meeting with someone before it happens

Taken from The Sounds Good Project (November 2005) Growing up and Speaking out"- a guide to advocacy for young learning disabled people in transition (14-25 years) ARX pg 32 and 33 at www.advocacyresource.net/

Statutory Child Care Review and Pathway Planning Meetings

What review meetings are for

It is a legal requirement that the care plan for looked after children and young people is reviewed. This is done in a meeting called a Statutory Child Care Review meeting or LAC (looked after child) review. All Statutory Child Care Review meetings have to be chaired by an independent person called an Independent Reviewing Officer (IRO).

LAC reviews or statutory child care review meetings take place as long as the child and young person is looked after by the Local Authority.

Before the age of 16, the care plan will be the main focus of the review meeting. Once a young person turns 16, the pathway plan becomes the care plan. Once the young person turns 18, if they have continued to qualify for services under the Children (Leaving Care) Act 2000, then their pathway plan should be reviewed at least every six months until they reach 21 or beyond if they continue to receive support and services from the Local Authority.

The aim of the review meeting is to look at what has happened since the last review meeting, how the child is progressing in all aspects of their development and to decide what action needs to be taken, to continue to meet the needs of that child. From the age of 16, the focus of any plan should be about preparation or transition to adulthood.

The role of residential Staff

As the main carer, residential staff play an important role in providing feedback on the placement and how the child has been progressing.

It is important that residential staff feel confident and able to provide comprehensive feedback;

- summarising what has been happening since the last review meeting,
- summarising how the placement plan is being carried out,
- identifying the child's additional needs and
- contributing to the discussion about how these needs might be met and
- For making the future plans.

It is really important to get a full account of the child's strengths and their progress in all aspects of their development and any areas that require action. This will help the Independent Reviewing Officer to ensure that the appropriate plans are put in place and that the child is getting all the support they need.

Residential staff also play a vital role in helping children to express their wishes and feelings within the review process.

As well as your preparation for the review meeting, a child may need help with preparing for the review meeting. The following is a checklist to help with preparations.

Preparation checklist- for Practitioners

- Is the review meeting child centred, will it get the best out of the child I am working with or supporting, is there a different way the meeting could be run or held that will help?
- Will the child need a “ dress rehearsal,” or support/work to prepare them for the meeting
- Do I know when and where the review meeting is taking place?
- Do travel arrangements need to be made if the review is not taking place at the child’s placement?
- Has school, college been alerted that the child has to leave early or come in later- if the review is being held during the day?
- If the child has additional communication needs, have all the necessary arrangements been made i.e.
 - has the interpreter, signer been arranged?- It may not be your job to do so but it is worth checking that social worker has made all the necessary arrangements.
 - will communications aids be required to facilitate communication?
- Have you and the child been provided with the opportunity for consultation prior to the review i.e. consultation forms, electronic consultation, pre-review meeting etc ?
- Does the child understand the purpose of a review meeting and who has been invited to attend?
- Is there anyone that the child would like to be present or not present? - This would need to be communicated to the social worker or Independent Reviewing Officer as soon as possible.
- Do you know what you are going to say; have you discussed this with the child, your line manager?
- Do you or the child have a list of questions for the review?
- If the child or young person does not like review meetings, are there ways that could make the review more child centred, that could encourage participation?
- Is there a strategy in place to ascertain the child’s views if they opt not to attend?
- What support might the child need following the review meeting?

The child’s social worker is responsible for arranging the review meeting. The meeting should be held at a time that is most convenient to the child and ideally in a place that they feel most comfortable. This is usually their placement

As well as Statutory Child Care Review meetings, residential establishments may have their own distinct way of ensuring the plans for a child are relevant and on track as highlighted by the following example from The Mulberry Bush.

Mulberry Bush Internal Case Conferencing by the Mulberry Bush School

The Process

All children have scheduled 6 monthly meetings. Preparation for these meetings takes place in all 5 service areas, Group Living, Education, Psychotherapy, family team and the Shifford Support Team. These teams will primarily discuss the individual treatment plan, complete a behavioural and emotional assessment form and assess the previous targets. A representative will then take their feedback to the case conference and a discussion will take place facilitated by a chair. The aim of the discussion is to reach a sense of the whole child and how he presents in different areas with different staff/parents/carers. Inconsistencies are noted and looked at. Through this approach we are able to share strategies that work with as well as look at ways we can provide consistent responses and care for the child.

From this meeting targets are developed or changed to fit the need of the child. Alongside these targets the process of how they should be achieved is then transferred into the practice guidance section of the child’s individual treatment plan

Role of the Chair: to facilitate open and honest discussion around the child, impact on individuals and the organisation, feedback on any tensions or complicated dynamics that may become apparent during the meeting, monitor the individual treatment plan and attend the review in order to provide oversight, consistency and continuity to the treatment plan and target setting process.

Ways to improve review meetings

Helping children and young people to participate

Advice from the New South Wales Commission, Australia

“ In decision making, the process can be as important as the outcome. For many kids, being involved in the process is the most important thing.

Children and young people need preparation, practice, support and encouragement to be able to take part in decision-making.

TAKING PARTicipation Seriously kit – 2003 NSW commission for children and young people. 2003 accessed via www.kids.nsw.gov.au/publications/taking.html

Review meetings are an important part of the care planning process where important decisions are made about the care plan for looked after children and young people. Children and young people are an integral part of the decision making process and therefore everything possible has to be done to help children and young people feel involved, get involved and be listened to and taken seriously.

It is acknowledged that in order to create the right environment, it requires a commitment and willingness on the part of those involved in the child care review to make the whole process more child centred.

As a starting point, ideas on how to make child care reviews more child centred could be explored within staff meetings or resident’s meetings. It’s worth being creative and finding ways that suit the particular client group and setting.

Another alternative that would create a child centred approach from the outset is to have a mixed meeting of children/young people and the staff team together to work on how to improve child care reviews. Independent Reviewing Officers could also be involved.

Material available to help think creatively about reviews

The following are a sample of useful practical resources

- *Try a different way-Review Menu and Start with the Child, Stay with the Child* VCC/NCB Blueprint project (2004) which can be downloaded from www.voiceyp.org
- *Involving Children and Young People in Meetings and Reviews- A Participation Pack* produced by the Yorkshire & Humberside SEN Regional Partnership in conjunction with Barnardos. (June 2006) at www.thepartnership-yh.org.uk
- Lanyon, C and Sinclair, R (2006) *My Turn to Talk*. London: NCB
Two guides to help children in care aged 11 and under and 11+ have a say about how they are looked after
- *TAKING PARTicipation Seriously kit* (2003) NSW commission for children and young people.
at www.kids.nsw.gov.au/publications/taking.html
This toolkit comprises of a series of booklets and information sheets that give information about children and young people's participation. It includes a booklet called Meeting together- deciding together- kids participating in case planning decisions that affect their lives.

Chapter 3 Children's Participation

Involving and consulting with children and young people throughout the process of planning is extremely important (Williams 2005) and as Sinclair (1991) states, "*listening to and consulting with children and young people is not only good practice, it is a duty under the law.*"

The Children Act 1989 states in section 22;

(4) Before making any decision with respect to a child whom they are looking after or proposing to look after, an authority shall, so far as is reasonably practicable, ascertain the wishes and feelings of-

- (a) the child;
- (b) his parents;
- (c) any person who is not a parent of his but who has parental responsibility for him; and
- (d) any other person whose wishes and feelings the authority consider to be relevant.

(5) In making such decision a local authority shall give due consideration-

- (a) having regard to his age and understanding, to such wishes and feelings of the children as they have been able to ascertain;
- (b) to such wishes and feelings of any person mentioned in subsection (4) (b) to (d) as they have been able to ascertain; and
- (c) to the child's religious persuasion, racial origin and cultural and linguistic background.

Timms, J.E. & Thoburn, J (2003) state that "*experience tells us that plans have a better chance of succeeding where the children themselves have been involved in their preparation.*" One would assume that involving children and young people in this process would be an important component to an achievable and successful care plan.

However research suggests that children and young people are not as engaged with the care planning process as they should be and this appears to cut across the whole of the care population.

Chamberlain (2005) proposed that one of the barriers to participation and involvement is the way in which the professionals see children.

Adults

Seen as mature
Rational
Adults know best



Children

Seen as immature
irrational
children have little to offer
they don't know what's best for them



This exclusive way of thinking can make it difficult for adults to listen and children to participate. Participation and involvement with children and young people require time and effort. Children will need help in developing the skills to participate especially where many adults are often involved in the decision making process. These skills are invaluable as children grow and develop.

“We want – don’t we – to see a society, which is composed of adults, people who can choose and act and change. Who can hope; who can assume that they can make a difference; who can be sorry when they fail, who can empathise, who can continue learning. It doesn’t happen by accident”

Archbishop of Canterbury (Monday 11th April 2005) Formation: Who’s bringing up our children?
Citizen Organising Foundation lecture, Queen Mary’s College, University of London, Mile End

There may be some professionals who are sceptical about participation and believe that children do not know what they need or cannot express themselves in a way that can assist in the planning process. There is the argument that it is the adult who should make the decisions and that children should be allowed to be children and not have those sorts of responsibilities. However learning the skills to participate and learn decision making skills cannot be switched on when a child turns 18. With families in the community these skills of decision making and consequences develop over time. Children as young as three are able to demonstrate the ability to make choice and make decisions. Participation and involvement does not mean children and young people taking over the decision making process and all the responsibility.

It should be a gradual process that is appropriate to the child's developmental stage and creative in finding ways to assist children and young people to become more involved in their care plans.

More effort may be required in helping participation particularly for some children more than others. Chamberlain (2005) found this in relation to younger children and children with disabilities. " younger children and those who are disabled are presumed to lack competence, or to have any capacity at all to make decisions, to such an extent that little attempt is made." (pg 53)

Hertfordshire Children's Trust Partnership have done a lot of work around partnership and involving children and young people and they offer the following advice.

Hertfordshire Children's Trust Partnership Framework for Involvement suggest that when working with children and young people that workers and organisations should

Ensure that the piece of work is **child/young person focussed**, by:

- *Relating to children and young people as experts at this point in their lives*
- *Valuing their perspectives of their lived experiences*
- *Being open to hearing the views of children and young people when they are ready to share them, not just when adults require them*
- *Making it safe*
- *Using language and communication methods that are inclusive, engaging & meaningful for the child/young person*

Consider what you may need to do to **empower** children and young people, including:

- *Giving them support and access to relevant information*
- *Ensuring they have appropriate and actual choice*
- *Getting their consent to take part and having the opportunity to withdraw*
- *Making agreements over confidentiality*
- *Facilitating dialogue with those who have decision making responsibility*
- *Ensuring access to a complaints or representations procedure and informal feedback mechanisms*
- *Offering support from a trusted or independent person/advocate, who could be an adult or peer*
- *Offering accredited training*

That Staff may need to build confidence in communicating and working with children and young people.

The process of involving children & young people should:

- *Be an integral part of decision making*
- *Ask carefully considered questions*
- *Record accurately what children & young people say*
- *Check that you understand what children/young people are really telling you*
- *Collate, analyse and report the findings*
- *Evidence action as a result.*

- *Published with permission from the Hertfordshire Children's Trust Partnership*

Chapter 4 Examples of Assessment and planning models

The residential sector is extremely diverse and to provide examples of all the assessment and planning models currently being used across the UK would probably fill several volumes. The following chapter has been written by guest authors showcasing the work of SACCS and NorthernCare and giving their perspective on care planning.

SACCS- ASSESSING THE NEEDS OF TRAUMATISED CHILDREN TO IMPROVE OUTCOMES

Written by Patrick Tomlinson, Strategic Development Director at SACCS

SACCS is a UK organisation providing treatment based in residential and family settings for children who are severely traumatised by abuse and neglect. SACCS offers an integrated service in providing recovery for children and young people between the ages of 4 and 14 (on admission) who need, but are not yet ready to spend their lives in a family environment.

SACCS services include a pre-admission assessment and a dedicated recovery team. They provide experienced care therapy and life story staff supported by a group of consultants including a Psychiatrist, Psychologist and Psychotherapist. Residential care and therapeutic parenting are provided along with life story work and individual therapy for each child together with support (where needed) in mainstream education.

We have put an outcomes approach based on the child's recovery at the centre of our work. The following is an example of how the process works. Jack is typical of the children placed with SACCS. The case material has been anonymised for the purpose of confidentiality

JACK

Jack was 7 when he was placed with SACCS

- He cannot accept being found responsible for his actions - he becomes sulky and withdrawn showing little remorse – it's always 'everybody else's fault'.
- He has completely distorted thinking and escapes into fantasy – he feels indestructible in this way.
- He is always asking 'why?' even when something has been explained to him.
- His learning is delayed by approximately 3 years. He continually says 'I'm bored' and is unable to concentrate.
- His levels of regression have grown and teachers are very concerned about this.
- The intensity of his emotions is overwhelming for him and often for those with him.
- Some adults are uncomfortable with hugs from him, as they feel sexualised and overbearing.
- He cannot express his feelings appropriately – when he is not being aggressive he always says what he thinks adults want to hear.
- The only feeling he can recognise in others is anger.
- He is controlling, dominating and aggressive with children at school but complains of being bullied.
- He bites his arm and scratches himself to gain attention.
- He will throw himself around when very distressed and hits himself on the head with objects.
- He is drawn towards females but also physically attacks them and will treat them as inferior.
- He is fearful of men and particularly at bedtime.
- He avoids any sense of closeness or affection with adults.
- He becomes excited by delinquent behaviour and this often feels sexualised.
- When he becomes sexualised he will hit himself on his head and pulls his ears.
- Jack's early life was one of huge deprivation and abuse, and unfortunately many breakdowns in foster placement following that.

At SACCS we work with children like Jack using an integrated model of Therapeutic Parenting in the residential home, as well as individual therapy and life story work outside of the home setting.

Briefly,

- Therapeutic parenting primarily holds the child's present and future,
- Therapy the child's relationship between his external and internal world and,
- Life Story work the child's past and works on present understanding.

These 3 strands of therapeutic work are strongly integrated, so that everyone involved works together as a team in supporting the child's recovery. Issues such as confidentiality are held by the whole team rather than 'split off' into professional factions.

In 2002 we began to define Outcomes in work with Traumatized Children. In other words, how would we know if the work with a child had been successful, what would a 'recovered Jack look like'?

We arrived at **24 Outcomes for Recovery**, for example,

When the child;

- has a sense of self – who they are and where they've been.
- is able to make appropriate adult and peer relationships.
- is no longer hurting themselves or others.
- has normal eating behaviours.

We have defined the meaning of each outcome, for instance,

When the child has a sense of self - who they are and where they have been

- This means that the child has a sense of their own identity, and culture regardless of creed, race, nationality, or religion, especially if there are also issues of disability and/or gender.
- They understand about their family of origin, have worked through what they love, hate, are angry about, are frightened of, and are not in denial.
- They know who they are in relationship to important people in their past and significant people in their present.
- They have integrated their past experiences into their present reality.
- Their personality is clear and intact.
- The child is living mostly in the present.
- Their past is no longer controlling their lives.

We have defined the tasks that need to be completed by the child to achieve the outcomes, and have provided guidance to our practitioners, on 'how to' support and enable the child in this process. This is all incorporated into the **SACCS Recovery Programme**.

Clearly, these outcomes are of benefit to the child. If they are achieved to a 'good enough' degree, the child will have the potential to develop and live a happy and safe life into adulthood.

We believe that the only purpose for our work is to enable children to achieve positive outcomes. This may sound obvious but it is easy for us to become focused on professional processes and the quality of these, rather than what is achieved by the child. Alternatively we become solely concerned about the most tangible aspect of our work, such as the child's safety.

At SACCS we have created an assessment model so that we can monitor children's progress and focus their work more clearly on addressing children's needs.

The assessment looks at the child under 6 broad developmental areas, based on the 24 outcomes. These are,

Learning
Physical Development
Emotional Development
Attachment
Identity
Social & Communicative Development

For each child, SACCS provides a Recovery Team consisting of the child's Therapeutic Parenting Team, Therapist, and Life Story Worker. Each carry out their own assessment, scoring the child against a number of questions and providing anecdotal evidence to support their score.

Therefore the assessment is both quantitative and qualitative. The child is scored in comparison to what we would expect of a healthy child of similar age. A score of,

1 = Severe Concerns; poor functioning in this area
2 = Substantial concerns; some signs of progress but a range of aspects to address
3 = Moderate concerns; one or two aspects to address
4 = Positive functioning in this area, possible minor concerns

We also evaluate the child's **Internal Working Model**, using Bowlby's definition, which leads us to ask questions, as for example, does the child believe he is good or bad, lovable or unlovable, competent or helpless? Are his caregivers responsive or unresponsive, trustworthy or untrustworthy, caring or hurtful? Is the world around him safe or unsafe; and is life worth living or not worth living?

The assessment is carried out every 6 months and the whole Recovery Team meet to consider their assessment and from that, develop a recovery plan with the child to address his needs.

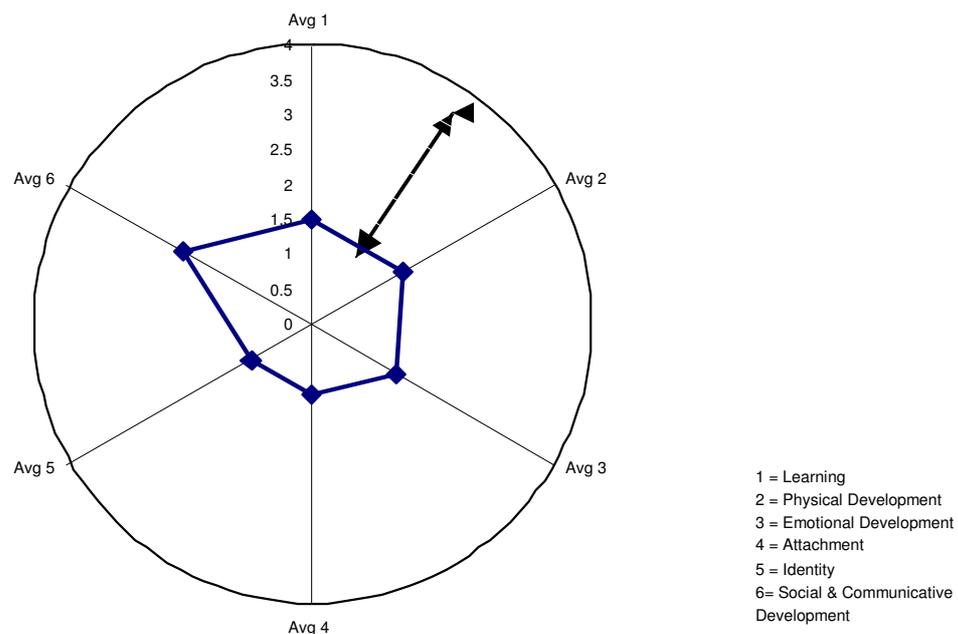
At SACCS, we recognise that effective assessment requires a significant investment of time and other resources. We have identified a number of benefits in regards to our method of assessment which are encapsulated as follows;

The Assessment process helps us at SACCS;

- To think about children together – this is very important for these children who have had lives where the adults caring for them have not been able to think about them and their needs, or in some cases have only been able to think about the child in terms of meeting the adult's need. So we are providing the child with the experience of being thought about in a positive and caring way.
- To understand children better – through the assessment we have a better understanding of the child, which enables us to respond more effectively to him. For the child, the experience of being understood may be new.
- To understand the meaning behind behaviour, for example, 'attention seeking' behaviour may be 'attachment needing' behaviour.

- The process helps us to develop a shared language and approach – very valuable when working in multi-disciplinary teams.
- We aim to integrate our work in therapeutic parenting, therapy, life story, so that everyone is working together, consistently and in a focused way to achieve the same aim – models similar to this have been referred to elsewhere by Diana Cant as ‘Joined up Psychotherapy’ or by John Woods as ‘Multi-Systemic Therapy’. It is not a question of which therapeutic approach is the best, but of how the different approaches can combine to achieve the most positive outcomes for the child.
- The process clarifies what we need to put in place to achieve these outcomes.
- And to evaluate our approaches - what works and what does not.
- To summarize, as Adrian Ward has said, ‘You can have assessment without treatment but you certainly can’t have treatment without assessment.’

To help get a picture snapshot of the child and his development we use a spider diagram, sometimes also called a radar diagram.



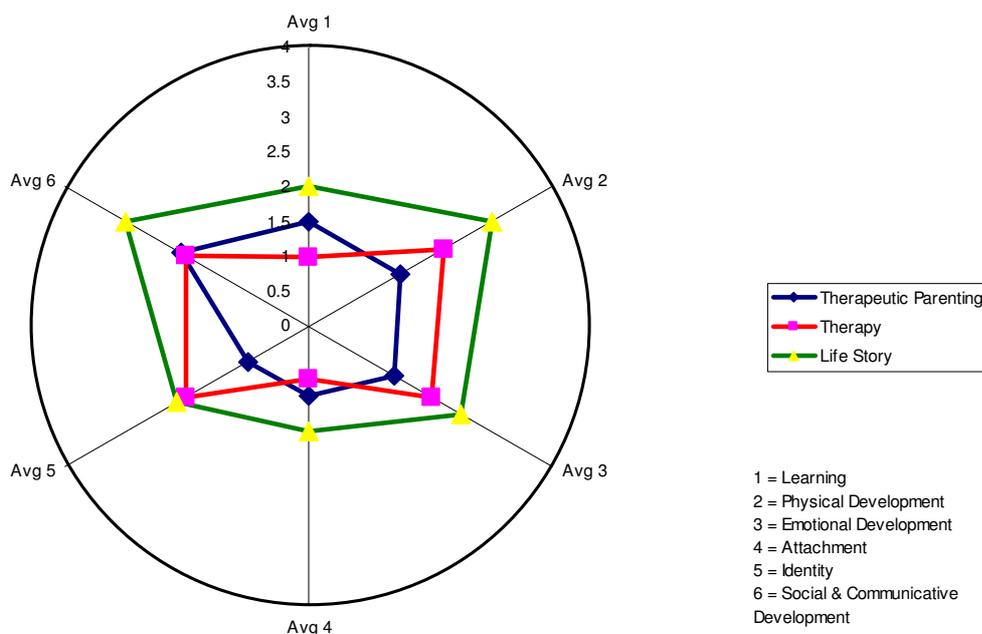
The 6 developmental outcome areas are represented by the 6 axis. The child’s score is plotted along each axis and the points are joined together to create a shape within the circle.

The outer circumference represents where a child with ‘normal’ or healthy development could be and the shape of the assessed child shows where the gaps are and how far there is to go.

The greater the gap between the circumference and the inner shape the greater the therapeutic support the child will need. This gap is similar to Vygotsky’s concept of the ‘Zone of Proximal Development’, or, how the child is able to function on his own compared to how he could function with the input of others. The support necessary to enable the child to move from where he is now to where he could be, Vygotsky termed ‘scaffolding’. In our context this is where the therapeutic work takes place.

The time needed to help a child reach his potential whilst at SACCS is normally three years or more.

The scores from the 3 parts of the recovery team are plotted on the same diagram and this creates an instant and striking view of how the child is perceived and functions in the 3 different areas.



i) This is how the therapeutic parenting team saw Jack

ii) The therapist

iii) The life story worker

The picture presents a child who is extremely damaged in his development and who has huge needs. However, there are differences in the 3 pictures.

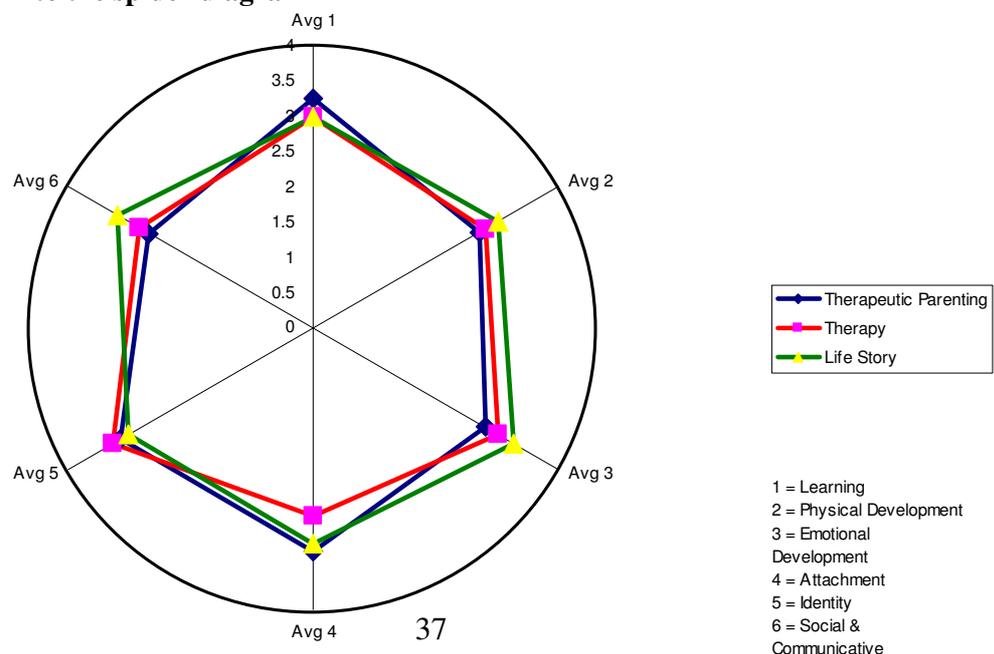
We often see this with a child like Jack – a child that Winnicott may have called ‘Unintegrated’, or Main, a child with ‘Disorganised Attachment’. He will be different things to different people at different times, compliant one minute and chaotic the next. Through the integrated work of the recovery team these fragmented aspects of Jack’s fragile personality are held together and reflected back to him in a consistent way.

Let us now look at **how Jack is – 3 years on.**

- There are hints that he can feel empathy - sometimes he shows concern for others, he often makes sorry cards.
- He is more secure in his attachment with Julie and allows her to provide him with nurturing experiences.
- He is less anxious around men and has begun to identify positively with Mark.

- He now settles well at bedtime. He sleeps deeply and gets lost in his dreams.
- He is able to communicate quite well with adults and is beginning to talk about important things. He will sometimes chatter to take up ‘thinking space’.
- When he has had time to think about his actions he has the capacity to feel appropriate guilt, which can lead to reparation.
- He has come on greatly in his interactions with others, though he still finds it difficult to compromise.
- He has good health and does not worry as much as he used to.
- He has good use of language, at times trying to be an ‘adult’.
- He normally takes a pride in his appearance and likes to look smart. He will sometimes damage his possessions when angry.
- He is physically well co-ordinated and enjoys playing ball games.
- He likes a variety of food and takes opportunities to try new things. He has good manners and is sociable at the table. He is not so anxious at getting his share.
- He remembers lots about his history and is coming to terms about his role in this.
- He takes a pride in his schoolwork and is more confident when faced with new challenges.
- He is sexually aware and no longer shows inappropriate behaviour.
- However, he does have an issue with feeling fat and he doesn’t want to grow - maybe a fear of growing up? Or an anxiety that he will be like his dad?
- He is proud of his Welsh nationality.
- He is able to play with others – creatively, imaginatively and competitively.

Let’s return to the spider diagram



i) this is how the therapeutic parenting sees Jack now

ii) the therapist

iii) the life story worker

We can see that Jack is on the journey to recovery.

The Zone of Proximal development is smaller; he needs less input to function to his true potential. There are still areas of difficulty and underlying fragility. We also see that Jack's behaviour is more consistent, at different times, with different people in different situations. He is becoming integrated and his attachments are more secure.

To enable our practitioners to work effectively within the SACCS Recovery Programme we have developed a training portfolio unique to Residential Child Care Services. This year we began a Foundation Degree in Therapeutic Child Care, accredited by North East Wales Institute (University of Wales). We are currently working on BA and MA degrees to begin next year.

To conclude, prevention and treatment must always work hand in hand. As long as there are children in the world who are exposed to abuse and neglect, we have a duty to respond not just to the physical injury, but also to the enormous and distorting emotional damage done to young minds. Genuine recovery for these children is also a preventative measure that will protect future generations; enabling traumatised children to achieve in life and go on to successfully parent in their own right.

SACCS

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West Tarn – a new start.
A 28 day assessment model for EBSD young people.

By NorthernCare
Graeme Richardson – Consultant Psychologist
Mark Warrington – Manager of the Assessment Service
Bill Baker – Children’s Services Manager

Nationally....

Harriet Sergeant’s recent report ‘Handle With Care, an investigation into the care system’ is the latest in a series of comments on the failings of the systems that in theory are put in place to protect and nurture the country’s most vulnerable children - those who find themselves being cared for by the state through various corporate bodies and organisations rather than their own families. She compares the objective figures for these children’s educational achievements and their life experiences with those of their peers who remain in the family setting. Not only are children in care under-represented in the GCSE tables and grossly over-represented in the courts but once they have left care the negative pattern is perpetuated as care-leavers form a disproportionately large percentage of young adults who are in prison, unemployed, homeless or supporting themselves through prostitution. The effect is, as Harriet Sergeant notes in the introduction to her report, “Not only is our system failing the young people in care, it is failing society and perpetuating an underclass.”

The report highlights three paradoxes that are described as being “at the heart of our care system”. The first of these paradoxes relates to the high cost of providing successful care provision and the resulting overspends on children’s services; it would be cheaper to allow the children to be failed and to fail.

The second is concerned with the fact that although the cost of these services is so high, and increasing year on year, little or no research or evaluation has been done to analyse results and to decide objectively which interventions produce positive results. In short, though we have an evidence base that informs general themes (What Works in Residential Child Care, Clough et al 2006) no one seems to know what specific intervention work and what doesn’t and decisions are being made based on inadequate information.

The third and most disturbing paradox is: these children find themselves in care as a result of the failure of the responsible adults in their lives to adequately protect them and to provide them with secure and stable homes and yet security and stability are frequently and notoriously missing from the ‘care careers’ of many children. Many of us working in the care system will have anecdotes about meeting children who have been in two, three or more placements per year for several years and have naturally developed a cynical and decidedly uncooperative attitude towards our well meaning, but as far as they are concerned, transitory involvement in their lives.

Historically....

Although Harriet Sergeant has brought these issues out into the public domain for discussion and hopefully to initiate some remedial action, aspects of them were already familiar to us at NorthernCare. Not that we were particularly psychic for as noted above many of Harriet Sergeant’s concerns have been raised in similar forms in the past. In particular we were aware of the problems of the ‘hard to place’ child who may have been tried in a number of types of placement without success and those children whose behaviours and difficulties were sufficiently idiosyncratic that social workers and placement officers were at a loss as to how to help them.

In 2005 a proposal was put forward for a service that would help to address this issue by providing an objective and exhaustive 28 day assessment and evaluation of children's needs and a subsequent corresponding set of recommendations as to optimal future treatment and placements to fully meet those needs. In this model less money would be wasted on inappropriate placements, reducing overspend, and the child would benefit from the increased chances of success in the long term providing much needed stability and continuity. As a private company running children's homes across the north of England we were also of course well aware of the possible benefits to ourselves. An efficient and effective service would provide a source of revenue to the company and although we were determined to be objective and accurate in our assessments and recommendations the service might well serve as an introduction to our own long-term homes.

In order to reflect the fact that we would be seeking to provide a fresh beginning for the children based upon a rational appraisal of their needs, we called the first home providing this service 'West Tarn' – an anagram of 'new start'.

Recognising that young peoples' difficulties and associated needs are produced and sustained by a combination of factors arising from the young person's temperament and inherent vulnerabilities and disabilities; adverse early developmental experiences associated with family disadvantage and dysfunction, and difficulties in social functioning and adjustment, it was decided to perform assessments in three areas: psychological, educational and social.

Psychologically...

We were fortunate enough to acquire Graeme Richardson, a nationally recognised figure in forensic and clinical psychology, as a consultant psychologist for the service. Graeme's specialism is the assessment, management and treatment of children and young people who experience emotional, psychological or mental health difficulties and who present with chronic or severe challenging behaviours. He has had 20 years of experience working in both residential care for young people and in-patient, out-patient, and in-reach psychiatric care for adolescents with mental health and behavioural difficulties, and is currently employed in an NHS Forensic Mental Health Service for Young People.

At the heart of the assessment service is the objective to provide local authorities and referring social workers with a rapid and comprehensive assessment of the young person. The approach taken is a developmentally sensitive needs driven assessment of the young person's developmental maturity, emotional and social functioning, personality development and mental health status. On the basis of the assessment findings, recommendations are made in relation to both therapeutic and placement needs. Graeme has proposed a four stranded psychological assessment model:

1. A description of the extent and intensity of the problems and difficulties the young person is experiencing and presenting along with an examination of the areas that give rise to stress and conflict in their lives. Background information is derived from previous placements, family and other agencies and current information is derived from observations of the young person's daily behaviours and interactions, interviews with the young person and their responses to questionnaires. A comprehensive battery of assessment measures are drawn upon, administered by Graeme himself or by care staff under his supervision.
2. A clinical diagnosis, which is a statement in psychiatric terms and psychological functioning across a range of child and adolescent disorders.
3. A treatment plan which prioritises difficulties and conditions in terms of their range and urgency, and which includes recommendations about the characteristics of the most appropriate placement and supporting services for the young person.
4. A professional judgement about the likely outcome to be expected from the proposed interventions and placement resources.

It is common for our young people to have been previously referred to Child and Adolescent Mental Health Services, but not to have benefited from mental health services. This is typically because they have moved placement and geographical area before receiving an appointment and/or they have previously refused to co-operate with an outpatient assessment of their mental health needs. We believe that a residential assessment service overcomes these barriers to the assessment and identification of the young person's mental health needs. The assessment service is wrapped around the young person in their living environment, and the assessment process is promoted through their relationships with residential care staff. On request Graeme will also conduct detailed risk assessments as to the young person's potential for criminal, violent or inappropriate sexual behaviour, utilising published and validated risk assessment protocols.

Educationally...

All too frequently the difficulties and problems in the child's home life are mirrored by academic failure, school exclusions and a consequent rejection of the concept of education. At NorthernCare we believe that once stability and a degree of security has been introduced into a child's life the next need is for personal growth and success to counter this rejection, promote self-esteem and improve future life chances. As part of the 28 day process a full educational assessment is carried out by Bill Baker, NorthernCare's experienced and well qualified Head of Education who has worked in with disaffected and difficult pupils since 1979 in roles such as Deputy Head of Education for the government's Youth Treatment Service and Advisory Teacher with responsibility for EBSD.

This assessment follows a pattern similar to the psychological assessment in that it determines the levels at which the young people are functioning, analyses their abilities and difficulties and recommends any remedial action required. The commonest reasons for the breakdown of educational placements can be broadly categorised as relating either to an inability on the part of the pupil to interact with adults or peers in socially acceptable ways or to disruptive behaviours whose function is to hide the fact that the individual feels he cannot cope academically. Of course these may present in combination and be exacerbated and complicated by factors such as autistic spectrum disorder, hyperactivity or speech and language processing difficulties. Specific recommendations are then made for programmes, materials and classroom-based interventions that may be required to enable the young person to succeed academically in the 'school' setting. Consideration is also given to the type of educational placement that would most benefit the young person in terms of class size and particular weight is given to teaching strategies and management techniques to deal with negative or disruptive classroom behaviours.

Although it is difficult to predict educational outcomes and successes the young person is compared with the national norms and suggestions are made as to qualification and certification routes leading to vocational or further education placements.

Socially...

The assessment service at West Tarn began under Mark Warrington as Home Manager. Mark has had 15 years experience in various care settings, working on a psychiatric admission ward for 4 years before moving into child care. Under his guidance the staff team at West Tarn have developed skills in motivating young people and in quickly building positive relationships with young people. Building relationships quickly has been essential for the home to deliver positive outcomes and establish a true reflection of the young person's future needs in the comparatively short 28-day assessment period.

Assessments are undertaken in areas of day to day functioning and in social skills in the residential home setting as the young person interacts with staff and peers. Abilities, skills,

needs and patterns are monitored, recorded and analysed in order that suggestions and recommendations can be made to address any current or potential difficulties.

The assessment is based around the familiar five areas:

1. Achieving economic well-being: the young person's attitudes, understanding of financial matters and the importance of engaging in education as a means of achieving success in a vocational placement or career;
2. Making a positive contribution: the degree to which the young person can contribute to a social setting and interact appropriately with adults and peers;
3. Enjoying and achieving: staff explore and assess the young person's ability to engage in purposeful recreational and educational activities;
4. Staying safe: potentially dangerous tendencies such as absconding and drug use are assessed and evaluated and
5. Being healthy: issues such as a healthy diet, smoking cessation and exercise are introduced and promoted.

Additional detailed assessment work and risk evaluation is done on the individual's emotional literacy and on areas specifically identified by the placing authority as contributing to previous placement breakdowns or difficulties.

Communicating...

At the end of the 28 day period it is essential that the findings in the three areas are presented and communicated in a manner that is understandable to all parties involved in the process: young person, family and professional agencies. For this reason an open review meeting is held at which the assessment reports and recommendations are presented in written form, fully explained, discussed and clarified if necessary, forming a co-ordinated multi-professional contribution to the planning of the young person's future. The plan that is then drawn up for the young person's transfer includes introductory visits and transition counselling performed by West Tarn staff.

Practically...

...there have proved to be some professional and ethical issues inherent in the process that have affected our practice.

Firstly one of our basic principles is that the young people are actively involved in the assessment process and that their opinions and wishes are heard and taken into account wherever practicable. West Tarn is not run as an institution, it is the young people's home, albeit for a short period, and almost all of them enjoy the experience of living by the sea and taking part in the activities, expeditions and trips. At all times they are encouraged to engage socially with adults and peers and to talk about themselves and their lives either in a group or in confidence to their key workers. Many of them are quite capable of looking at their own histories and past behaviours with a degree of objectivity and can accept the need for change and to cooperate in their future treatment programmes.

The main purpose of the service is assessment but if a behavioural or social skill deficit is immediately apparent we feel it would be unethical to merely observe and assess it. The staff at West Tarn have been chosen for their abilities in working with young people with emotional and behavioural difficulties and they will put a programme in place to amend the deficit. Similarly the young peoples' personal interests are channelled into a broadly educational programme to improve their academic skills and consequent self-image.

We are aware that accurate and comprehensive assessments can be a double-edged sword for professionals and agencies in that they create expectations of solutions. Having identified the problems and needs; then provided advice and guidance on suitable placement and treatment

needs the assessment service and NorthernCare as a company may well be asked for more practical help i.e. to actually provide the recommended placement and treatment interventions. Usually we can accommodate these requests in one of our own homes or assist in finding a suitable placement with another organisation but in extreme cases we may find that we have highlighted needs that prove difficult to meet for financial or organisational reasons. Certainly our experiences so far have led us to develop more effective links with other agencies and facilities that provide treatments and to look critically at ways of improving our own service as a care company.

Modestly...Feedback

The feedback we have received from families, social workers and the young people themselves has proved to be very positive:

“I hope he gets support in the years to come like the support you all gave to him. West Tarn worked for him and I can’t thank you enough.”

“His stay at West Tarn has enabled him to have a more positive view of the future.”

“The care he received was excellent, he felt safe and listened to. I was very impressed.”

“His behaviour changed for the better during his time at West Tarn. I would recommend this placement.”

“Great!”

Summary...

West Tarn opened in Blackpool in 2005 and proved to be an immediate success such that additional ‘assessment beds’ are now available at one of our homes in Bradford and another specifically assessment home is to be opened shortly in Preston. We have shown that we provide a multi-professional and comprehensive assessment of the needs of the young person and can identify the most appropriate and cost effective intervention plan to meet those needs. The 28 day assessment process and resulting comprehensive reports and recommendations presented at the final review provide social workers and placement officers with the objective information they need to choose a suitable longer-term placement with a vastly improved chance of the young person achieving and succeeding. We also instil stability, routine and sense of security into the young people’s lives, paving the way for the smooth transition into this subsequent placement.

We feel that we have gone some way to addressing Harriet Sergeant’s three paradoxes of cost, evaluation and continuity.

NorthernCare

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Resources

Assessment and planning

Williams, A and McCann, J (2006) *Care Planning for Looked After Children- a toolkit for practitioners*. NCB (available on CD format from www.ncb.org.uk)

Department of Health (2000) *Framework for the Assessment of Children in Need and their Families*. London: The Stationery Office

Elston, S (2003) *Assessment of children with life-limiting conditions and their families- A guide to effective care planning*. Bristol: ACT

This publication and other useful material on supporting children with life limiting conditions and their families can be found on the ACT (the Association for Children's Palliative Care) website- www.act.org.uk

NSPCC and University of Sheffield (2001) *The Child's World: Assessing children in need*. London: Jessica Kingsley

Asylum seeking and refugee children

www.ncb.org.uk/arc

Packed with information, research findings and practical tools to help make day to day practice more effective, the website provides a single access point to the most comprehensive collection of resources and information on all aspects of assessment and planning relating to asylum seeking and refugee children.

Kane, S (2006) *The Ecological Approach to the Assessment of Asylum Seeking and Refugee Children*. NCB – see www.ncb.org.uk/arc

Kane, S (2006) *Asylum seeking and refugee children: developing good practice in assessment and planning*. NCB- see www.ncb.org.uk/arc

Kane, S (2006) *Needs assessment and planning for asylum seeking and refugee young people: a good practice note*.- see www.ncb.org.uk

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This 108 page pack is designed for anyone seeking to develop their knowledge and practice of those working with asylum seeking and refugee children which directly covers assessment and planning.

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Children and young people with disabilities

Audit Commission (2003) *Let Me be Me: A handbook for managers and staff working with disabled children and their families*. London: Audit Commission

Beresford, B et al (1996) *What works in services for families with a disabled child?* Essex: Barnardos

Carlin, J et al (2005) *All Kinds of Short Breaks: a guide to providing a range of quality services to disabled children and young people*. Bristol: Shared Care Network

A practical toolkit for practitioners and managers working in family support services for disabled children. Provides factual materials and examples of good practice.

Marchant, R (1999) *Listening on All Channels: consulting with disabled children and young people*. Hove: Triangle.

Marchant, R and Jones, M (2003) *Getting it Right: Involving disabled children in assessment, planning and review processes*. Hove: Triangle

Participation

Headspace toolkit

A self advocacy and rights guide for young people in adolescent psychiatric units. Developed by Advocacy in Somerset as part of the Ready Steady Change programme, led by the Children's Rights Alliance for England.

www.headspacetoolkit.org or call Advocacy in Somerset for details 01823 324762

Participation Works

A unique online gateway to the world of children and young people's participation. Provides a comprehensive source of information on policy, practice, training and innovative ideas.

www.participationworks.org.uk

TAKING PARTICIPATION seriously kit

2003 NSW commission for children and young people. 2003

accessed via www.kids.nsw.gov.au/publications/taking.html

This toolkit comprises of a series of booklets and information sheets that give information about children and young people's participation. It includes a booklet called Meeting together- deciding together- kids participating in case planning decisions that affect their lives.

Triangle (2001) *Two Way Street: Communicating with disabled children and young people*. Training Video and Communication Handbook.

This resource aims to improve practice in communicating with children and young people who have communication impairments and was developed in consultation with a group of disabled children and young people. www.triangle-services.co.uk

Reviews

Lanyon, C and Sinclair, R (2006) *My Turn to Talk*. London: NCB

There are two guides to help children and young people in care have a say about how they are looked after. One specifically for children aged 11 or younger and one for children and young people in care aged 12 and over. These guides offer practical tips and advice to looked after children about how they can have more say in their care. The guides include: a description of the care planning process, advice on how they can have more say in decisions about all aspects of their care, what to do if they are unhappy, and where to go for extra help.

Involving Children and young people in meetings and reviews

A participation pack produced by the Yorkshire & Humberside SEN Regional Partnership in conjunction with Barnardos. June 2006

www.thepartnership-yh.org.uk

Websites

www.ncb.org.uk/ncercc

National Centre for Excellence in Residential Child Care is the principal reference point for all matters relating to residential child care in England

Call Centre (Communication Aids for languages and learning) at the university of Edinburgh

Website: [Http://callcentre.education.ed.ac.uk/](http://callcentre.education.ed.ac.uk/)

DfES (Department for Education and Skills)

Website: www.dfes.gov.uk

Every Child Matters Portal

Website: www.everychildmatters.gov.uk

Info 4 Local

Information for Local Government from Central Government

Website: www.info4local.gov.uk

www.ncb.org.uk/healthycare

The Healthy Care website. Provides information and resources to promote healthy care for looked after children and young people.

www.harpweb.org.uk

Harpweb-Asylum seekers and refugee health portal