New Directions in Social Work Practice
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Introduction

This book is relevant for social workers and people working in social care with an interest in how social work is changing and moving forward.

Chapter 1 provides an understanding social work within mental health services, community and institutional. It covers the Care Programme Approach, policies and processes and how social work is placed within the multidisciplinary teams.

Chapter 2 will focus on how to apply the principles of the UNCRC to communicate with young children. Real life excerpts of conversations from a detailed real life case are used to highlight key stages of the communication process.

Drawing on relevant findings from the Wakefield enquiry, Chapter 3 will discuss the key changes to legislation. The author has used their own research to compile a study regarding the quality of the assessments of lesbian and gay men as prospective foster carers.

Chapter 4 explores Zimbabwean social workers’ right to have rights within the workplace. It focuses on Zimbabwean social workers who migrated to the UK and claim citizenship rights in both this as their country of destination and their home country.

In Chapter 5 the author uses case studies to highlight and describes three types of support – empowerment, maintenance and containment – and considers the service users who can benefit from these.

The ability to assess is a core skill of social work practice, Chapter 6 looks at the principles of assessment and provides definitions and theoretical approaches as well as specific assessment tools to be used in practice.

Chapter 7 touches on a number of important themes that provide a way forward for a critical and reflexive sociological practice for social workers and probation officers.

Note to readers: References from the original chapters have not been included in this text. For a fully-referenced version of each chapter, including footnotes, bibliographies, references and endnotes, please see the published title. Links to purchase each specific title can be found on the first page of each chapter. As you read through this FreeBook you will notice that some excerpts reference previous chapters – please note that these are references to the original text and not the Freebook.

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The Social Work Role in Mental Health Services
1. The Social Work Role in Mental Health Services

By the end of this chapter you should have an understanding of:

- the historical debates around the transition from institution-based to community-based care;
- the policies and processes that have influenced the integration of mental health services;
- the place of social work within multidisciplinary mental health teams;
- the role of care management and the Care Programme Approach in mental health;
- implications of the ‘personalisation agenda’ and direct payments for mental health services;
- the role of social work in ‘new’ mental health services, including the contribution of values-based practice and empowerment perspectives;
- the skill base that social work brings to multidisciplinary mental health practice, including communication skills; assessment; relationship-based practice; building partnerships; advocacy; and utilising social work intervention methods.

The context of practice

From institution to community

Social work, perhaps more than most professions, is shaped by the context in which it is practised. Consequently, it will be helpful to review briefly the broad historical development of the pattern of mental health services. Put at its simplest, this has been a story of transition from treatment and care based in large institutions to care in the community, although that simple statement belies substantial areas of controversy, including disagreement about the main engines of reform (whether they are political and professional self-interest), what is meant by the concept of the community, and to what extent deinstitutionalisation has been achieved.

The historical and sociological analysis of mental health services has undoubtedly been heavily influenced by the work of French social theorist Michel Foucault (e.g. Miller and Rose 1986; Porter 2003). His seminal work, Madness and Civilization (1961), argued that the template for treatment of people with mental health problems since the seventeenth century has been the treatment in the Middle Ages of people who had leprosy. This contagious disease had been introduced to Europe by soldiers and others returning from the crusades. It was contained and eventually eliminated (despite a lack of any scientific understanding of the disease) by containment of infected individuals in large institutions located away from centres of population. This approach and its efficacy, Foucault argued, became a model for the management in Western societies of social deviance, including mental illness. This accompanied a transition in attitudes in the seventeenth century brought on by the philosophical epoch known as the Enlightenment, which saw difference and non-conformity as the basis of categorising
individuals as 'other' and even non-human. Thus, Foucault argues, the 'great confinement' began across Europe that involved the building of large institutions, located away from towns and cities within which were detained those who transgress against social norms, initially on an undifferentiated basis, lumping together criminals, older people, people with impairments, and people with mental health problems.

Some time has been spent here outlining Foucault's argument because, although its detail is heavily disputed by other historians, it contains important perspectives for critiquing the subsequent evolution of mental health services. In the 1840s, legislation was passed in Britain requiring every county to have its own 'county asylum' for the treatment of the mentally disordered. These institutions housed, in addition to those who appeared mentally disordered, individuals who had socially transgressed, including a significant number of women whose only 'sickness' was that they had been unmarried mothers. Social work was represented within these asylums as 'almoners', terminology which is in itself a legacy of the monasteries within which there were individuals responsible for the dispensation of welfare to the poor and needy. In 1974 the contracts of employment of social workers located within hospitals was transferred from the National Health Service to the newly emergent post-Seebohm, i.e. generic, local authority social services departments, although the social workers remained located within hospital settings.

By the 1960s pressure was building to dismantle this regime of institutionally based care, not least under the direction of the Conservative Minister for Health, Enoch Powell, someone not associated with progressive views. Indeed, there is disputation between historians about why the era of asylums was brought to a close. The main lines of argument divide between the so-called Whig historians who view reform as part of the process of gradual enlightenment in the approach to mental disorder of professionals and the wider public, and those of a more Marxian persuasion who saw this as part of a 'fiscal crisis' of welfare states, that they could not afford to maintain crumbling Victorian institutions (Scull 1977). Others detect the influence of the pharmaceutical companies (Rose 2007), who had begun to manufacture and market so-called 'major tranquillisers' for the treatment of psychotic conditions, which offered the prospect of maintaining people outside hospital through the use of depot (slow release) injections. For those commentators who drew on Foucault's analysis, this scenario explains how the psychiatric professions were able to maintain their medical sphere of influence even without the physical existence of the asylums, that they could consolidate their claim to expertise and extend their power and control into non-institutional settings through the use of these new drugs.

This controversy continues, but whatever the academic disputation, the empirical reality for the last thirty to forty years has been the progressive closure of the asylums, the
development of smaller units with fewer beds in locations closer to home, and the development of services in the community, many of which operate without the availability of residential beds. This trend has run in parallel with the broader development in health and social care of ‘care in the community’ or ‘community care’. This policy development incorporates several themes but includes the philosophy that care should be available on a personalised basis reasonably close to where people live, that it should be available on the basis of people’s needs rather than the interests of professionals, and, controversially, that the introduction of market mechanisms would create more efficiency and responsiveness in services. These objectives were enshrined in the National Health Service and Community Care Act (1990), and, despite innumerable shifts in the detail of policy, not least the introduction of internal markets into service development, this has remained the broad direction of travel.

The development of social work within mental health services has followed, and sometimes prefigured, this transition from institution to community. The first qualified mental health social workers were employed in the UK in the 1920s with the first mental health social work training course in the UK beginning at the London School of Economics in 1929 (CSIP/NIMHE 2007). The training was influenced by psychosocial explanations of mental distress. Social workers were employed in the community in child guidance clinics as well as psychiatric hospitals. At the time, hospital-based social workers were the only professional group of mental health workers to bridge both the hospital and the community settings. Much of their work was focused on the assessment of family and social circumstances. Even in the beginnings of the profession, mental health social workers had a clear identity grounded within an explicit value base. For example, in 1939 the Association of Psychiatric Social Workers declined the suggestion from the British Medical Association to become registered as medical auxiliaries (CSIP/NIMHE 2007).

Integration of services

A further message of the community care agenda has been the assumption that services lacked coordination, that sometimes they duplicated provision, leading to what has been referred to as ‘death by assessment’ or alternatively gaps in the provision of services. Consequently, in parallel with the process of deinstitutionalisation has been movement towards integration of services, notably health and social care services. In mental health this has a somewhat longer history than in relation to areas such as children or adult care services. As long ago as 1975 Better Services for the Mentally Ill (Department of Health and Social Security 1975) provided joint funding between the NHS and social services for new initiatives, though progress was patchy and haphazard (Fawcett and Karban 2005). Also, the Care Programme Approach (discussed in more
detail below), introduced in 1991, required coordination between services. The requirement under the Care Programme Approach to appoint a ‘keyworker’ (later ‘care coordinator’) signalled in the genericism of these roles that traditional professional roles and boundaries should be superseded by roles defined by generic function.

A recurrent theme of mental health policy is the characterisation of people with mental health problems as being dangerous (the fallacious nature of this assumption is discussed in Chapter 8), and this has also been a driver towards service integration. A series of public inquiries into homicides committed by people with histories of mental disorder have cited lack of service coordination as a contributory factor in these tragedies. The landmark inquiry in this respect was in relation to Christopher Clunis (Ritchie et al. 1994), an ex-patient who stabbed to death Jonathan Zito on Finsbury Park station. Clunis was someone who had led a fairly itinerant life and drifted out of contact with services.

The public climate created by these cases contributed to the view taken by the incoming Labour government in 1997 that ‘community care was dead’. This did not signal a return to institutionalisation but rather a determination to drive through reorganisation of services, mainly under the rhetorical mantle of ‘modernisation’. Professional roles were to become less strongly demarcated so that there was greater flexibility about who did what, and boundaries between services became more blurred so that individuals did not ‘slip through the net’ and received ‘joined up services’ (these clichés have tended to characterise this debate). The blueprint for the reconfiguration of services was developed in a series of White Papers and in particular the National Service Framework for Mental Health published in 1999 (Department of Health 1999). The Health Act (1999), implemented in 2000, gave statutory permission for progression of integration with the creation of so-called ‘Health Act flexibilities’. These allowed NHS mental health services and councils with social services responsibilities to formalise partnerships, many of which had already begun to develop under informal arrangements. Flexibilities covered various activities including pooled budgets, delegation of commissioning, and arrangements for integrated provision of services (Bogg 2008). The legislative permission created under the 1999 Act has now been superseded by Section 75 of the NHS Act (2006), but the essential nature of the flexibilities remains the same.

The implications of this for social work practice are far-reaching. Many social workers had already been working in mental health settings under a variety of secondment arrangements, but have now been caught up in processes of statutorily based service integration which some commentators have described as over-prescriptive and directive (see Glasby and Peck 2003); workers have found themselves answerable to multiple inspection and regulation regimes and ambiguities concerning who employs
them and establishing clear lines of accountability (British Association of Social Workers and The College of Social Work 2010). The sites within which these tensions are primarily experienced and played out by mental health social workers are within mental health teams (Evans et al. 2012).

**Teamwork and multidisciplinarity**

A deeper examination of the development within mental health services of specialist teams and the skills of multidisciplinary work are given more extensive analysis in Chapter 9, but here, in terms of setting the scene of mental health social work, we need to consider the broad issues posed by the context of service integration and multidisciplinarity. As we have seen, it can be argued that mental health social work practice has longer antecedents of multidisciplinary teamwork than other mainstream areas of practice. Social workers in mental health teams typically find themselves located in settings where they may be the only representative of their profession (Evans et al. 2012). This is quite different from the position of social workers who work in adult services or children and families teams that have evolved from generic post-Seebohm social services departments, where social work represented the dominant professional ethos, often led by senior management teams who were social work trained.

Mental health social workers work in multidisciplinary teams which will typically contain psychiatrists, clinical psychologists, community psychiatric nurses (CPNs), and perhaps others such as occupational therapists, development workers, and support workers. This environment brings opportunities and challenges. For some social workers this is part of the attraction of mental health practice, that it brings the intellectual stimulation of working alongside others who bring alternative perspectives and methods. However, a significant amount of research also shows that mental health workers have to cope with a range of tensions. These have been usefully summarised by Bogg (2008). There is role ambiguity and conflict, where there are boundary disputes about whose responsibility it is to undertake particular duties, perhaps offering information on statutory rights or providing particular psychosocial interventions such as family therapy. This can lead to very basic professional insecurities about the validity of the contribution made by a team member. Communication difficulties can arise where team members have been educated and socialised within the particular frameworks of their profession, be it the psychological theories underpinning the clinical psychologist’s training, the medical orientation of the psychiatrist, or the values-based orientation of social work training. Such differences manifest themselves through the discourse of the team and even very basic discussions about whether people with mental health problems should be referred to as patients, service users, or
clients. Communication difficulties are also often compounded by incompatibility of information systems, where health and social care databases are developed and owned separately. The development of a team ethos or shared identity can be hampered by these competing professional orientations and rivalries. The strong possibility that individuals will be line managed by someone from a different professional background, overlain perhaps by dual lines of accountability to management and clinical structures, exacerbates these tensions and can produce lack of faith in management understanding and effectiveness. The hierarchical nature of health and social care organisation and the experience of being line managed by another profession can produce overt or covert power struggles, not least where an occupational group such as social workers feel that a social perspective is inherently threatened by the status and dominance of clinical professionals. Finally, all of this can generate priority and perspective conflicts, where each professional believes that their own approach justifies setting priorities for service users or service developments that are disputed by others; perhaps a social worker feels that their commitment to developing social inclusion initiatives is undermined by a team focus on monitoring compliance with pharmacological treatment.

It may be felt that all this overemphasises the negative aspects of multidisciplinary working and neglects the potential benefits of service users receiving whole person care. However, it is important to note that this cumulative evidence from research into integration has to be acknowledged if the dysfunctional aspects of multidisciplinary teamwork are to be addressed and overcome. This has been the subject of various government and voluntary sector initiatives, not least the Department of Health’s ‘capable practitioner’ initiative and New Ways of Working programme. The latter addressed the challenges of multidisciplinary work by seeking to identify the core competencies that should be part of any practitioner’s toolkit, whatever their professional identity (‘The Ten Essential Shared Capabilities’, considered in detail in Chapter 9), and the specific and distinct contributions that can be made by the various professions within the mental health arena (the New Ways of Working programme, see CSIP/NIMHE 2007). Thus, it is hoped to support practitioners by emphasising their commonalities whilst also defining their particular expertise.

**Care management and the Care Programme Approach**

A key role in the introduction of community care in adult services was the creation of the role of the care manager. This was the person who was responsible for assessing the service user’s needs for services and then was responsible for creating a ‘package of care’, a collection of services that met the needs that had been identified. Influential research by the Personal Social Services Research Unit (PSSRU) had evaluated ‘case
management’, the forerunner from the United States of care management, as a more efficient and effective method of delivering services to older people with complex needs than traditional models of service delivery (Challis et al. 1990). It is a matter of contention whether the PSSRU evidence was appropriately generalised as the template for the new approach to service delivery, but this was the approach embraced by the Department of Health for community care implementation. Social workers were drafted in to be redesignated as care managers; some felt that they had become bureaucratic functionaries who had been forced to renounce their traditional therapeutic role, others claimed they could subvert the care management process to retain their ‘true’ social work identity (Baldwin 2000), and some embraced care management as a method that allowed social workers to combine creatively their former role with new, innovative responsibilities for commissioning services (Gilbert 2003).

Within mental health services, case management took a different path to implementation. Contemporaneous with the introduction of care management, but also influenced by the moral panic surrounding the Christopher Clunis case, discussed earlier, and the Spokes case – a service user who killed social worker Isabel Schwartz (Schneider 1993, cited in C. Pritchard 2006) – the Care Programme Approach (CPA) was introduced in 1991 as a mental health variant of care management (Department of Health 1991; Rethink Mental Illness 2015). As is suggested by this allusion to a high-profile homicide case, in the mental health arena the assessment of need was hitched to the assessment of the risk of the service user to others. It was followed in 1994 by the creation of Supervision Registers in order to monitor the supervision of high-risk service users. CPA in its original guise contained four elements:

- The assessment of health and social needs for those referred to specialist mental health services.
- The drawing up by the clinical team of a care plan which identified who was to deliver the various elements of the care package.
- Appointment of a key worker (later redesignated as a care coordinator) to monitor and coordinate the elements of the care package.
- Regular review and adaptation of the care plan.

CPA indicates a commitment to multidisciplinarity with the non-specification of the professional background of the key worker who could be any individual within the team, usually a social worker, nurse, or occupational therapist. A plan is formulated at a team meeting, usually attended by the service user and carers. The agenda of the meeting will be to specify the context of the service user’s problems, assess their personal circumstances, identify their medical, psychological, and social needs, and draw up a care plan to address these needs, including a timescale for implementation of the plan and identification of individuals responsible for implementing the plan.
(Department of Health 2015). CPA guidance (Rethink Mental Illness 2015) states that the approach is available to mental health service users who have:

- A severe mental illness (including personality disorder).
- Problems with looking after oneself including:
  - Self-harm, suicide attempts
  - Harming other people (including breaking the law)
  - A history of becoming unwell and needing urgent help
  - Not wanting support or treatment
  - Vulnerability (for example, financial difficulties because of mental illness, physical or emotional abuse, being open to exploitation).
- Severe distress at the moment or have felt a lot of severe distress in the past.
- Problems working with mental health services or have done in the past.
- Another non-physical condition alongside mental illness (for example, learning disability, drug or alcohol misuse).
- Services from a number of agencies, such as housing, physical care, criminal justice, or voluntary agencies.
- Recently been detained under the Mental Health Act or are detained at the moment.
- Recently been put in touch with the Crisis/Home Treatment Team or are getting their help at the moment.
- A need for a lot of help from carer(s) or provides a lot of care to someone else (children or an adult).
- Disadvantage or difficulties due to:
  - Parenting responsibilities
  - Physical health problems or disability
  - Unsettled accommodation or housing issues
  - Employment issues
  - Mental illness significantly affecting day-to-day life
  - Immigration status, language difficulties, sexuality or gender issues because of your ethnicity.

Until an official review in 2008 (Department of Health 2008a) of the care planning system, anyone could be the subject of CPA, although there were two levels of intensity of the approach, depending on whether individuals presented ordinary or enhanced levels of need, usually more narrowly interpreted as risk. CPA has been the subject of dissatisfaction by professionals and service users alike (and has never been implemented in Wales). Although at a policy level CPA seemed benign and balanced in its approach, at the local implementation mental health workers often claimed it was a formalistic and bureaucratic exercise that required boxes to be ticked but constrained the exercise of professional judgement (Rogers and Pilgrim 2001). Surveys of service
users revealed confusion; often individuals did not know whether or not they were subject to CPA or even who their care coordinator was, and they complained that the contents of assessments were not shared with them (Rose 2001). Also, although national guidance is in place it is not binding on local mental health authorities, and there is considerable local variation in implementation (Rethink Mental Illness 2015).

There has been extensive consultation over the delivery of CPA, and the Department of Health has reformed the system in an attempt to 'refocus' the approach (Department of Health 2007c; Department of Health 2008b). Part of the reconstruction of the policy is an emphasis on CPA as a cornerstone of the 'personalisation agenda', that is, the espoused shift towards maximising service choice and individualising the match between need and services. Individuals subject to CPA will have available to them:

- support from a care coordinator;
- a comprehensive multidisciplinary and multi-agency assessment of needs;
- an assessment of financial needs including direct payments (see below);
- a written comprehensive care plan including risk and contingency plans;
- assessment of needs for advocacy services;
- periodic review of the care plan;
- information given to carers of their entitlement to assessment of their needs.

At the policy level the new CPA approach is justified in terms of the personalisation agenda. 'Refocusing' implies a more targeted use of scarce resources, but it can also be seen as rationing comprehensive assessment to a relatively small number of service users, with the danger that CPA will be stigmatising in its effect. Social workers will often find themselves continuing to be designated as care coordinators where they are the most appropriate person to work with a given individual, but may be dependent on all their skills to make CPA a positive experience for the service user.

**Personalisation and direct payments**

As we have seen, there have been themes which have been consistently developing through both Conservative and Labour administrations in relation to deinstitutionalisation, diversification of suppliers of care through the introduction of market mechanisms and the promotion of 'choice'. At times it seems that many policy initiatives are introduced as reforms of mainstream health care delivery and that mental health is an afterthought. Nevertheless the Department of Health’s strategy document, No Health Without Mental Health (Department of Health 2011) espouses a commitment of government to parity between services for physical and mental health.

An umbrella term that has been emerging for aspects of reform has been the concept of 'personalisation', a later manifestation of the so-called 'choice agenda'. The Green
Paper *Independence, Well-being, and Choice* (Department of Health 2005b) set out the terms of reference for this vision, which were then amplified in the White Paper *Our Health, Our Care, Our Say: A new direction for community services* (Department of Health 2006a). The core messages of these policies are expressed in the executive summary:

This White Paper confirms the vision in the Green Paper of high-quality support meeting people’s aspirations for independence and greater control over their lives, making services flexible and responsive to individual needs.

Since 2007 it is government policy in England that people eligible for publicly funded social care support should be offered a personal budget or direct payment (Department of Health 2007c). A personal budget is an amount of money allocated to an individual based on an assessment of their social care needs and desired outcomes. Money may be passed directly to them or a proxy (a ‘direct payment’), or may remain in the control of the local authority (a ‘managed budget’), to be spent on meeting outcomes in line with an agreed support plan (Hamilton et al. 2015). The support plan should be developed by the service user and social worker or other practitioner together, often with input from family members and others involved in supporting the individual, and must be approved and reviewed by the local authority. Local authorities have a duty to offer direct payments to those assessed as eligible, but take-up of direct payments has been slow and variable within mental health, with some commentators finding a correlation between low levels of implementation, and local authorities with protectionist attitudes towards public sector jobs (Riddell et al. 2005). A study of direct payments for users of mental health services in Scotland concluded that a significant obstacle to implementation was the low level of awareness amongst professionals of the potential of the scheme, and lack of flexibility in devising innovative approaches to supporting independence (Ridley and Jones 2003). A more recent study in England found that professional boundaries and competing priorities undermined the development of shared, collaborative approaches to providing personal budgets, in particular reinforcing a view by individual professionals that they were someone else’s job (Hamilton et al. 2015). A research study by the Joseph Rowntree Foundation sought to identify factors that would make a difference to take-up of direct payments by mental health service users (Newbigging with Lowe 2005), and these are summarised in Box 3.1.
Box 3.1 Factors that could make a difference to take-up of direct payments by mental health service users

- Service users, carers, and professionals require straightforward, accurate, and accessible information about direct payments which is specific to mental health.
- Both service users and professionals can be confused about the distinction between access to an assessment for receipt of direct payments and access to services, where the threshold may be much higher and based largely on clinical considerations. This can affect take-up.
- Mental health users require specific advocacy and practical support to facilitate access to and use of direct payments.
- The absence of a streamlined process integrated with the Care Programme Approach adds to the sense of direct payments being a burden rather than an opportunity.
- Ways to increase take-up by people from black and minority ethnic communities include developing resources and approaches, including outreach and direct support services specific to those communities.
- A change in the culture of mental health service provision is required. This would need a tangible commitment to promoting self-determination, evident in the way staff interact and support people experiencing mental distress.
- Introducing direct payments requires effective leadership to drive the process of implementation from national direction and guidance through to local leadership, at both a strategic and an operational level.
- Fostering partnerships across organisations and supporting collaborative problem-solving could facilitate learning about the implementation of direct payments.
- Introducing direct payments in a planned way requires thought as to how existing services can be reviewed, reconfigured, and recommissioned.
- There is a need to review what direct payments cover in mental health: the distinction between health and social care in mental health is not an easy one, and arguably no longer relevant given the integration of health and social care to provide mental health services.

(Newbigging with Lowe 2005: x–xi)

The personalisation agenda is not without critics (Glasby 2012), some of whom claim that the term is used in inconsistent and contradictory ways (Cutler et al. 2007). Ferguson has argued that the development of these approaches is part of a move to shift risk from the state to the individual, and that ‘the philosophy of personalisation is
not one that social workers should accept uncritically' (Ferguson 2007: 387).

**The social work role in ‘new’ mental health services**

The evolving ‘modernisation’ of mental health services towards care in the community, integration of services, and multidisciplinarity has generated for the various professions uncertainty about their role and identity. This was formally addressed through a government-sponsored programme of work led by NIMHE called New Ways of Working (CSIP/NIMHE 2007), also discussed in Chapter 9. A series of special interest groups and working parties, including one for social work, sought to articulate the distinct but complementary contribution of each profession. The report confirmed that social work values, skills, and knowledge already encompass the approaches set out in current government policy which have already been indicated, including the Mental Health Bill, in the Green Paper Independence, Well-being, and Choice and the social inclusion agenda. All emphasise the need for service users to participate actively in their own care. Social workers have historically worked in partnership with service users to which, more than any other profession, their value base is most closely aligned. As the report states, ‘Social work is therefore a crucial component to mental health service development if stated policy objectives are to be achieved’ (CSIP/NIMHE 2007). The New Ways of Working programme endorses the centrality of social work to mental health services in ways that most social workers probably welcome, although the value base needs to be further elaborated and critiqued.

**Values-based practice**

Social work tends to struggle to define its contribution to the caring professions in terms of its methods or knowledge base: methods tend to be common with other disciplines such as psychology – for example, cognitive behavioural approaches – and its knowledge base draws widely from the social sciences. Instead, it is sometimes argued that social work is values-based and it is those values that make social work distinct. In relation to mental health practice these assertions about social work should not be accepted uncritically. In the context we have been considering of multidisciplinary practice, social work's knowledge base is distinct in that it is the only profession whose professional curriculum includes sociology and social policy, providing practitioners with a more structural appreciation of the nature of social problems. Social workers also have studied areas of law that impact on practice, so bringing to the team context knowledge of crucial areas such as child protection. On the other hand, the other professions that are represented in mental health services would regard it as impertinent for social work to assert that it is the only profession that is mindful of and shaped by values and principles!
Nevertheless, the discussion of values in social work has taken some distinct turns, particularly in relation to anti-discriminatory and anti-oppressive practice, when compared to the clinical disciplines. This is again quite distinct from social work's earlier discourses around values and ethics. Social work has been heavily influenced by the work of German seventeenth-century philosopher Immanuel Kant and his concept of the categorical imperative, namely, that we should do to other people what – in the same circumstances – we would want them to do to our-selves, and that this will hold to be universally true. The strongest legacy of Kant's ideas is in the writing of Biestek (1961) who formulates a set of universal principles of social work that would be presumed to hold true in all circumstances. Kantian thinking is also reflected in the codes of ethics that have emerged for social work in various countries, and in the UK most specifically in the General Social Care Council's and later The College of Social Work's codes of practice. Yet, these Kantian perspectives have been strongly challenged, and the critiques have particular relevance for mental health practice. The arguments of Kantians such as Biestek are premised on a principle of self-determination by individuals as to their choices and preferences. However, the underlying – often hidden – assumptions of this argument are that self-determination is only achievable by individuals with the capacity to be rational and autonomous. This seems to preclude many of the individuals who use mental health services, who the wider society would not see as being rational, having capacity to make their own choices and achieve self-determination. These traditional approaches to social work ethics appear to leave practice with people with mental health problems as vulnerable to coercive and paternalistic practice, in their 'own best interests'.

The alternative approach to ethical practice is that which is referred to as utilitarianism, derived from nineteenth-century philosophers such as John Stuart Mill, which rejects the individualism of Kantian ethics and states that what is good is that which promotes the happiness of the greatest number of people. This refutes the idea of universality, that a particular action such as maintaining confidentiality will be good in all situations, and asserts that we should consider the consequences of actions – will the impact of doing this produce happiness for more people than if we did something else? Within the mental health context, this again may be problematic as it may be used to justify coercive approaches to social control, restricting the liberties of people with a mental health problem, on the (usually unfounded) grounds that this is for the good of the wider society.

However, there has been a rediscovery of utilitarianism in relation to mental health policy and practice from the direction of economists, notably in the work of Richard Layard (it is no coincidence that the early utilitarians were political economists). This argument recognises that the problems of mental disorder, particularly the common disorders such as depression and anxiety, impose a heavy financial burden on society,
as well as the misery of the affected individuals and their families. Layard (2011) has argued for major programmes of investment in treatments that are effective for anxiety and depression to alleviate the unhappiness of individuals, but also justified by the wider economic efficiencies that will be produced. This argument was very influential with the post-1997 New Labour government, giving rise to significant investment in increasing the availability of evidence-based therapies for common mental disorders. The downside to this may be that making economic utility the criterion for providing intervention may create an ‘underclass’ within mental health service users, people who have longer-term, seemingly intractable mental health problems, who have little chance of avoiding unemployment and dependency on welfare benefits (Gould 2006a).

The very different assumptions that underpin Kantian and utilitarian approaches sometimes appear to produce irreconcilable perspectives over what should be done in a particular situation; for example, in mental health this may be in relation to different perspectives between service users (expecting to be treated as autonomous and self-determining) and families (claiming that their interests come first and that they are greater in number). Within health and social care this has stimulated interest in alternative ethical perspectives of which two should be mentioned here. The first is a return to the writing of Aristotle, the Greek philosopher of ancient times, who emphasised the importance of considering the virtues of the person who aspires to be a good practitioner. This approach to virtue ethics, particularly identified in social work with the American author Rhodes (1986), says that our primary concern should be to identify the traits that characterise a person that we would consider to be virtuous and how they would act to demonstrate those virtues in a given situation or dilemma. In relation to mental health practice this might direct us to think about how as practitioners we can demonstrate such virtues as compassion, courage, and authenticity in decision-making. Critics of virtue ethics find such a list rather arbitrary and reflective of prevailing ideological views of the virtuous person that may derive from dominant, prejudicial attitudes.

Another important perspective that is contemporary with the revived interest in Aristotle derives from feminist perspectives and is referred to as the ethics of care. Social work has tended to borrow from writing about nursing ethics in this regard, and particularly the work of Caroline Gilligan (1982). This approach claims that from the Enlightenment onwards ethical discourse has privileged values that are inherently masculine and paternalistic, espousing ideals of rugged male individualism, and has overlooked qualities that are most often demonstrated by women, which are shown through relationships with other people, particularly those that are nurturing and caring. This point of view does seem to share some terrain with virtue ethics, namely, that the determination of what is good derives from the quality demonstrated by the person, though it ‘reclaims’ what it means to be virtuous in terms that are asserted to
be inherently feminine. Again, there are critics of this position who argue that the ethics of care are too vague to offer prescriptions for practice in particular situations, and that the premise that ‘care’ is always something that is good is largely unexamined (Allmark 2002). Nevertheless, feminist perspectives in relation to value positions taken by practitioners sensitise us to the inherent patriarchy of caring institutions, most dramatically revealed by surveys of abuse of women by staff and fellow-patients in mental health units.

Activity 3.1 Ethical perspectives in mental health practice

Joyce is a 33-year-old woman from a white British background who lives with her parents and 25-year-old brother, David. Three years ago Joyce was diagnosed with schizophrenia and has not worked since that time. She refuses to take medication, as she says this makes her feel unwell and causes her to gain weight. She has a number of paranoid delusions that incorporate her parents, and as a result she is often hostile towards them. This is causing anxiety within the family, particularly as Joyce’s father has deteriorating physical health due to a heart condition. David also finds the atmosphere in the house stressful and recently asked his GP for help with feelings of depression and anxiety. Joyce’s mother has recently given up her own job to stay at home because the needs of the family were so acute. You are the social worker from the community mental health team and have been trying to discuss with Joyce other possible accommodation options, but Joyce is insistent that this is her home and she has a right to remain where she is.

Analyse this situation from Utilitarian, Kantian, virtue ethics, and feminist approaches and compare and contrast the issues that are highlighted by each perspective.

Social work brings to the multidisciplinary ‘table’ sensitivities that are shaped by these mainstream approaches to ethics and values. Arguably though, social work’s more radical and distinctive contribution derives from the broader sphere of anti-discriminatory and anti-oppressive practice. We have already commented on the structural analysis of social problems that derive from sociological understandings of mental health. This includes appreciation of the hierarchical relationships of power that exist between social groups, including the relative disadvantage of people who are mental health service users, and the over-representation within the population of mental health service users of social groups that are relatively disadvantaged, such as members of black and minority ethnic groups. Anti-discrimination and anti-oppression can also address the issues raised by feminist ethics of care, where the specific disadvantages of women within the mental health system are addressed. There is now an extensive literature in social work on these approaches, including the central contribution of Thompson (2012) through his PCS (Personal, Cultural, and Social) model of anti-discriminatory practice. Thompson’s argument is that progressive values need to be incorporated in practice that addresses personal, cultural, and social levels. This analytical approach is generically stated but is also an important contribution to
multidisciplinary practice in mental health, and one which social workers can value as their contribution. One of the foremost psychiatrists writing about racism in mental health practice, Fernando (1991), has referred to social work as the leading discipline in this area. The influence of social work is discernible in frameworks for generic core competence in new mental health services, particularly the Ten Core Competences, as already cited.

**Empowering service users and promoting autonomy**

The social work literature makes extensive reference to the desirability of empowering service users and promoting their autonomy. There is a sense in which these are ‘hurrah’ terms (for what reasonable person could be against them?), but with little analytical precision. Parsloe expressed her reservations in trenchant terms:

> It [empowerment] is a most unfortunate word for social work to have adopted because it can well be argued that the very idea that one person, a social worker, can empower another, a client, runs counter to the whole idea of greater equality of power on which the concept supposedly depends.

(Parsloe, cited in Barnes and Bowl 2001: 19)

This is sometimes referred to as the ‘empowerment paradox.’ Nevertheless, there have been some attempts to gain some precision in the use of these terms in order to make them meaningful aims for social intervention. Indeed, attempting to increase an individual's autonomy, their capacity to take responsibility for their lives, seems a basic aspiration of mental health social work and one which touches on fundamental human rights, and is closely linked to what we understand by ‘empowerment’. Barnes and Bowl expressed this idea directly:

> If, by definition, someone experiencing severe psychological distress is perceived as having impaired autonomy then this has important implications for their level of empowerment, both because of the impact this can have on perceptions of self, and because this can lead to actions which reduce objective opportunities to exercise autonomy.

(Barnes and Bowl 2001: 8–9)

In a very influential theoretical examination of the concept of autonomy, Doyal and Gough (1991) argue that this is a basic and universal human need, one that will be shaped by local cultural norms, but fundamental to the well-being of all people. Their arguments for universal definitions of need are supported by international empirical evidence that they support wellbeing. They identify the factors that are necessary to achieve autonomy, regardless of cultural context, and it is useful to set these out as
criteria for considering whether social work intervention is indeed supportive of the enlargement of a person’s autonomy. These are:

- having the capacity to formulate aims and beliefs common to a form of life;
- having confidence to want to act and to participate in a form of life;
- being able to participate socially, formulating aims and beliefs and the ability to communicate with others about them;
- being able to understand that actions have been done by them and not by someone else;
- being able to understand the external, objective constraints on one’s actions;
- being able to take responsibility for what one does.

Sometimes users of mental health services are judged (and condemned) on the basis of whether they possess ‘insight’. This is a slippery concept with no fixed meaning within psychiatry, but can be little more than the judgement of a professional about whether their definition of a situation is accepted by the service user (i.e. if they do not, then they lack insight). Unpacking, in the way exemplified by Doyal and Gough, the ingredients of the concept of autonomy may well be a more empirically grounded approach to thinking about what needs to be achieved in order to live a life that is self-determined but also socially engaged.

**Skills for practice**

Functioning effectively within the context as discussed in this chapter requires social workers to be skilful as well as knowledgeable. Within subsequent chapters dealing with particular kinds of mental health problems, we will consider specific methods and skills relevant to those problems. However, mental health social work builds on many of the generic skills that are fundamental to contemporary social work practice. They are covered in detail in generalist textbooks, but here we touch on some aspects that are particularly relevant to mental health.

**Communication**

The 1983 Mental Health Act requires that service users are interviewed ‘in a suitable manner’. Although this stricture specifically relates to assessments for compulsory admissions to hospital, it is a principle that should underpin all mental health practice. The intention of the Act was not only that individuals should be seen face to face, but that the interviewer should be culturally competent and proactive in anticipating and meeting the needs someone may have that require special help in order to
communicate. This may include interviewing someone who is not sufficiently proficient in the English language. Assessing someone's mental state requires attention to the nuances of language, particularly if metaphorical expression is not to be mistaken for a delusional belief. An interpreter may be needed, and there should be sensitivity to the possibility that a family member will probably not be appropriate, or possibly a member of the interviewee's local community, where matters of confidentiality or norms of cultural appropriateness may be jeopardised. It should be remembered that people with hearing impairments are disproportionately represented amongst people with mental health problems, and an interpreter with signing skills might need to be called upon (Ridgeway 1997).

Communicating with individuals with delusional beliefs also requires tact and skill: directly challenging a belief may provoke irritability or even aggression, while collusion (unquestioning agreement) can be condescending as well as reinforcing the delusion. A neutral position needs to be maintained where the social worker indicates that she is hearing what is being expressed and acknowledges the emotion accompanying what is being said such as anger or fear, but without literal acceptance of the delusion. Where the person is withdrawn and even mute, a social worker needs to have the capacity to show that they can be alongside someone and accept their feelings, even though nothing is being directly communicated other than through body language. If someone has a condition that involves impairment of short-term memory, patience is required to repeat information or to use additional devices to make sure that something is remembered, for instance, putting important information in writing.

Assessment

Assessment is perhaps the most important stage in the care management process, and it is also central to the care plan approach. However, as has been discussed, there is also social worker dissatisfaction with the extent to which assessment has become proceduralised with tightly prescribed items to be completed and entitlements to be quantified. Yet psychosocial assessment is a rich part of the heritage of social work's legacy, particularly within mental health practice where social histories have traditionally made a fundamental contribution to holistic psychiatric assessments. A person's early history, the dynamics of their family, and their experiences of living and working within their community offer profound insights into the nature of a person's problems and psychological distress. Similarly, the variation of someone's condition may reflect anniversaries of significant events in the person's earlier life, or a social history may uncover patterns in the onset of a person's distress, revealing the triggers for changes in their mental health. All this makes a strong case for the continuation of social workers bringing their assessment skills to multidisciplinary team working. At
the same time there has to be sensitivity to over-intrusion into the lives of people who may be in contact with several agencies and service users, and carers alike are rightly upset when assessment becomes repetitive and intrusive.

**Working through relationships**

A theme that repeatedly emerges from debates about care management and care planning has been the anxiety that these approaches replace social work's emphasis on the importance of establishing productive relationships with users of services with bureaucratic and impersonal procedures. Recent years have seen the 'rediscovery' of the relationship as a primary element of practice through which effective practice can be delivered. This is being referred to as relationship-based practice (Ruch 2005; Megele 2015) and connects directly with early social work traditions of psychosocial practice, informed by concerns with the inner, emotional world of the individual along with external social factors. Wilson et al. (2008) have identified the core elements of relationship-based practice as: acceptance of the uniqueness of any encounter between social worker and service user; recognition of the complex interplay of conscious and unconscious motivations influencing behaviour; the importance of psychosocial responses to problems; recognition that the relationship is an element of any intervention; and the importance of the 'use of self' and relationship as the medium through which an intervention is delivered.

In mental health practice, the social worker's success in making a relationship may be severely challenged when a service user at times of distress presents behaviour that breaches social norms; this may include unusual levels of suspicion, fear, withdrawal, and emotional volatility. Patience and persistence are premium virtues. Although their research was undertaken some years ago, the findings of Truax and Carkhuff (1967) remain pertinent, that the most effective relationships for achieving therapeutic success demonstrate unconditional positive regard for the other person, empathy with their feelings, and congruence.

**Advocacy**

Modern welfare systems comprising networks of services, each with their own criteria of entitlement for services, are characterised by complexity. Many people who wish to access services or who feel they are without control of circumstances that effect their lives are possibly going to seek advocacy to establish their entitlement or autonomy. The role of social work may be to advocate on someone's behalf, to support them to advocate on their own behalf, or to refer them to a specialist advocacy agency. Both the Mental Capacity Act 2005 and Mental Health Act 2007 now provide for specialist
advocacy support for individuals in defined circumstances. Some of the considerations that applied to communication carried across to advocacy. Members of some black and minority ethnic groups find themselves over-represented in the population of people with mental health problems, and yet under-represented amongst the people able to obtain supportive services. They may also have special advocacy needs in terms of understanding of their cultural and socio-economic situation (Rai-Atkins et al. 2002). Research shows that specialist advocacy services are thin on the ground and that there are particular gaps in relation to groups most disadvantaged by mental health services such as African-Caribbean men (Newbigging et al. 2007). Bateman (1995) identifies the core skills of advocacy as: interviewing (being able to elicit what the service user wants and any relevant information); being able to be assertive in presenting a case without slipping into being aggressive; skills of negotiation; self-management (making use of yourself as a resource); research skills to find and collate information; and ‘litigation’ skills (being able to present a case cogently to an arbitrator).

Building partnerships

It has become something of a truism to argue that the full complexity of people’s lives cannot be addressed by one agency, and that the assembly of packages of care requires practitioners to be able to work alongside and in cooperation with workers from other agencies. ‘Partnership has come to be an all-embracing term applied to collaboration at so many levels that it may have lost terminological exactitude. Despite this, mental health social workers find themselves working within organisations that describe themselves as ‘partnership trusts’ by virtue of the various forms of combination of health and social care services. The normative presumption is that partnerships produce better outcomes for service users, but the research evidence for this is inconclusive (Glasby and Dickinson 2008). Interestingly for the purposes of this volume, one of the most significant case studies of partnership working is of a mental health service, the Somerset Partnership NHS and Social Care Trust (Peck et al. 2002). A significant finding was that the process of coming together produced a ‘J’-curve effect, where the organisation experienced short-term decline in morale and efficiency before improvement began to be experienced. The lesson seems to be that workers should not expect immediate improvement. At the same time, and this is part of the ambiguity of the evidence base, surveys of service users also found mixed results with better service coordination but concerns about reductions in therapeutic support. Despite these inconclusive messages from research, many social workers will de facto for the foreseeable future find themselves working within partnership organisations. Glasby and Dickinson (2008) have attempted to distil the messages from research for practice in partnerships and identify as the primary lessons the need to clarify terminology so that the objectives of a partnership are understood, to make identification of desired
outcomes the priority around which specific partnership relationships are formed, and not to assume automatically that partnership is the best approach to a given problem.

**Using social work intervention methods**

Social work is often in thrall to the methods of other professional disciplines, particularly clinical psychology, but should not overlook that it has its own ‘indigenous’ methods of intervention which are evidence-based and applicable in working with people with mental health problems. It is beyond the scope of this book to review the totality of social work methods, but there are compendiums available to students and practitioners such as Payne’s Modern Social Work Theory (2014). An example would be task-centred practice, a structured and time-limited approach that was developed entirely within social work (Kelly 2009). Subsequent research has shown this to be effective with a range of moderately complex service user problems (Kirk and Reid 2002).

**Key points**

- The main historical shift in the delivery of mental health services has been from hospital-based care to care in the community, though concerns remain that these non-institutional services can still create dependency and impede recovery.
- Social workers in mental health settings have had to adapt to working in multidisciplinary teams, though the advantages and disadvantages of integration are still not fully evaluated. In mental health services, care management has been delivered through the Care Programme Approach. There are concerns that the system is increasingly used to justify rationing services to a small number of service users who are deemed to be high risk.
- The current policy agenda emphasises personalisation, but the implications for implementing this in mental health practice are contested.
- Social work brings to multidisciplinary teamwork a values-based approach that is strongly grounded in anti-discriminatory and anti-oppressive approaches to practice.
- Social work theory and methods also contribute to the skills mix of multidisciplinary teamwork through their communication, relationship, assessment, advocacy, partnership-building, and intervention skills.
Key reading


CHAPTER 2

Communicating with Young Children
2. Communicating with Young Children
Stages and Skills

Summary of chapter content
This chapter discusses the application of the principles of the UNCRD to social workers communicating with young children. Using the detailed case example of Aine (aged 7 years) and real-life excerpts of conversations with her, the chapter illustrates the stages of the communication process, the skills required to communicate effectively with young children and the ways in which both are embedded in a child rights approach. Exercises and general pointers for effective practice are also provided.

Introduction
While there are many recent examples of helpful resources regarding general communication skills (Trewhittick 2005; Koprowska 2008) and specific resources for communicating with children (Butler and Williamson 1994; Davie et al. 1996; Bannister et al. 1997; Milner and Carolin 1999/2000; Jones 2003; NCB 2004, 2006; Luckock and Lefevre 2008; McLeod 2008b; Lefevre 2010; SCIE 2010), what is often missing are real-life and detailed transcripts of social workers’ conversations with young children (under the age of 8 years) showing the application of the required knowledge, skills and values in practice. There is thus a danger that the resources that are available remain useful external reminders but, because of a lack of practical examples, there is limited opportunity for them to become embedded in the day-to-day practice of social workers. This and the following chapter seek to fill this gap by using examples from my own research with young children to explore, discuss and draw out general themes and demonstrate some of the ways they can be applied in practice.

In this chapter the focus is on one case study, that of Aine, aged 7 years, to illustrate the stages in the communication process, the skills used and the issues arising during conversations and how these were dealt with. Some readers might find some of the interview excerpts that follow lengthy. However, I have purposely not shortened them because they, in their entirety, represent the actual real-life communication process with Aine and illustrate, in detail, what is possible in terms of building relationships and communicating with young children. Moreover, to shorten them would do a disservice to Aine’s own capabilities and to her story. It would also do a disservice to those of you who have never had the opportunity to communicate directly and in detail with young children and for whom this might represent the first occasion you have to get close to experiencing first-hand what happens. Before introducing the stages of communication the chapter begins with an introduction to Aine and her family. Ethical issues relating to the research process in respect of Aine, and all other children featured in this book, are detailed in Chapter Seven.
Background information on Aine

In many ways Aine's circumstances, as will become clear, were similar to those of the children whose deaths provided the focus for official inquiries as outlined in Chapter One. Aine lived with her two younger sisters, older brother and her parents. The family had been known to social services for a number of years. There were a number of concerns about her parents including mental health difficulties, violence in their relation-ships, alcohol dependency and the vulnerability of Aine's mother, who had been in care as a child herself. Social services had offered the family practical and financial support including provision of day nursery places and home visits by a family support service because of concerns about the physical and emotional neglect of the children, who appeared dirty, unfed and who had been left unsupervised for long periods of time.

According to the professionals, the parents' care of their children seemed to improve and support tailed off. After the birth of their youngest child, Angela, social services again received several referrals from the extended family expressing concerns about the care of the children who, it was alleged, were not being fed and supervised appropriately. Social services and health professionals responded and, while managing to make contact with Aine's mother, often did not get to see the children. Following further referrals, social services visited the family home and, on this occasion, insisted on seeing the children who, according to Aine's mother, were asleep upstairs. The social worker found the two youngest children upstairs in appalling conditions. It was apparent that they had been locked in their bedrooms for hours on end without food and access to a toilet. One child, in hunger, had eaten her own faeces. Mattresses had no bedding and were urine sodden. Faeces covered the floor and the walls as high as the children could stand. Later it became clear that all of the children had endured these conditions over a period of several weeks, if not months.

Aine was separated from her siblings and placed in foster care. Her siblings either went into foster care or residential care. At the time of my research Aine had been living away from home for just over two years. She had remained in face-to-face contact with her siblings and birth parents through contact arrangements supervised by social services. Throughout this period she had remained placed with the same foster carers.

Stages and skills in the communication process

The development of knowledge, skills and values in communicating is a key aspect to social work training (Trevithick 2005; Koprowska 2008; Wilson et al. 2008; McLeod 2008b; Luckock and Lefevre 2008; SCIE 2010). In this chapter these are applied specifically to communicating with young children to illustrate their application in practice. This is a crucial aspect to improving social workers' relationships with young
children, especially in a context where newly trained social workers feel ill-equipped to undertake this vital work (CWDC 2010).

In essence, the process of communicating – which could involve communicating formally in assessment interviews, court proceedings and meetings or less formally in home visits, for example – consists of three stages: beginnings (getting to know you), middle (exchange of information) and endings (conclusions) (Wilson et al. 2008). The fact that the process can be broken down into three stages should not be taken to mean that the communication process is uncomplicated. Trevithick (2005: 81–5) illustrates the complexities involved in terms of the knowledge and skills required. In this chapter each of these stages will be explored and illustrated through the relationship I developed with Aine. The discussion of each stage begins with the outline of some general principles before showing how these were applied in conversation with Aine.

**Beginnings**

Good beginnings are essential (Koprowska 2008: 51–2; Wilson et al. 2008: 301). Having said that, if a conversation does not start well, the situation is not necessarily irretrievable but it may take longer for a conversation to fully develop. Good beginnings are made up of establishing rapport (Trevithick 2005: 147–8) and creating the right conditions (UN 2009: 7–8, 12 and 17) for communication to occur. To establish rapport means to have created a connection that facilitates confidence and cooperation in verbal and non-verbal communication between the people involved in the conversation. The processes of building a rapport can either be slow and gradual or quite immediate. Social workers will know of those occasions where, within a few minutes of a conversation with someone, it feels like a connection has been formed. They will feel comfortable, at ease, safe, secure and there is often a rhythm and a compatibility in terms of the verbal and non-verbal exchanges that take place. Social workers will also know of those occasions where the process is a lot harder.

Some people believe it is particularly hard to build rapport with a young child because of differences in age, size, ability and experience (Alderson 2000/2008). However, adults can often exaggerate these differences, whereas, in fact, young children might have much more experience than their social worker does of certain situations and they may have developed much better skills than their social workers in relation to those situations. For example, Alderson (1993) found that children’s experience of living with complex illnesses had enabled them to develop an expertise in their own condition that was more developed than expected. There is thus more overlap in the skills and abilities between children and adults than is often given credit for. In addition, experience shows that each child is different. As such there are no simple ‘blueprints’
that can be followed but rather, as will now be outlined, a broader set of guiding principles and processes.

To begin with, and where possible, it is a good idea for the social worker to become a familiar figure by visiting the home, school and/or clubs when the child is there in the few days before they are due to speak with them. While no in-depth communication might take place between the social worker and the child, the child will have seen the social worker in different settings of familiarity to them and a social worker’s presence in those settings builds up a bank of shared memories on which the social worker and child can both draw when the meeting does take place. It is worth the social worker therefore taking a note of the different contexts in which they have seen the child so that when they do later meet they have concrete things to talk about. For example, a conversation might begin with the question, ‘Do you remember the last time I saw you? You were at the family centre playing with that doll’s house with the little bed in it?’

Creating the right conditions, as noted in the previous chapter, involves a number of things including: having the right attitude towards children’s capacities; respecting the individuality of each child; affording the child security; providing the right materials, support and equipment and providing the right kind of information (UN 2009: 7–8, 12 and 17). For these to make sense and to become embedded in practice social workers need to see them in action and that is what the interview excerpts with Aine will attempt to illustrate. In terms of what else social workers can practically do to get the best beginning, following some or all of the ideas outlined in Table 5.1 might help.

The focus of the beginnings stage is to ensure that the child knows who the social worker is, what their job is and what the purpose of the visit is. This information has to be shared in a clear and accessible manner (Koprowska 2008: 53; Trevithick 2005: 118–9; Wilson et al. 2008: 303; UN 2009: 26, para. 134; also, article 13 UNCRC). In order to ensure this and to be sure that this process reflects the individuality and the skills and abilities of each child it is important for the social worker to think about ways, other than verbal exchange, through which this information might be imparted (Trevithick 2005: 119; Marchant 2008: 151–8; UN 2009: 17, paras 80–3). Hence Table 5.1 illustrates that social workers might want to include the use of postcards, photos, small picture albums and other materials.

Table 5.1 also assumes that children will want to have a conversation with their social worker. However some children will not. In these cases this choice is to be respected (UN 2009: 6, para. 16). However, it is also important to be clear that the child’s reluctance is not down to the social worker’s failure to give appropriate, accessible, clear information in a suitable format or the social worker’s failure to take account of a particular context that might act as a hindrance to a child engaging in a conversation (UN 2009: 26, para. 134). As stated, social workers are required to respect the choices of
young children while also making it clear that they will be available for them to talk with if they wish on another occasion.

Having outlined what helps make a good beginning to an interview there is now the opportunity to see these principles in practice in the following interview excerpt, which involves the introductory process with Aine.

**EXERCISE**

Take time to read the following excerpt involving the introduction to Aine, and answer the following questions:

- Find examples where I introduce myself, give information about job title and role, confirm reason for visit and seek permission to talk.
- Find where and how Aine and I engaged in the process of setting up the interview room in a way that Aine was happy with.
- List examples where you think things could have been done differently and/or better.

KW: Now Aine do you remember me asking you whether you could help me understand a little bit about your thoughts and feelings?
Aine: Yep.
KW: Yep?
Aine: [Nods head to say yes.]
KW: And would you like to do that today?
Aine: [Nods] Look! Are these baby things [pointing to craft materials on the table that include a pack of stickers designed around the theme of a newborn baby]?
KW: Yes.
Aine: These are baby things.
KW: Shall we take some of these out of their boxes and put them on the table in case we want to use them?
Aine: [Nods.]

[Gap in conversation where Aine and KW both set up the room and craft materials and sort the chairs out. Aine leads in terms of selecting the craft materials and placing chairs where she wants. She decides not to use chairs to sit at the low table but crouches at the table on her knees. KW copies.]

KW: Can you remember […] what my job is with you today?
Aine: No.
KW: Do you remember that little leaflet with the pictures on the front?

Aine: [Nods.]

KW: And it told you about some special work I am doing to find out what children like you think and feel?

Aine: Ah hah.

KW: And that my work is to help social workers do their job even better?

Aine: [Nods.]

KW: One of the things I do with children is these boxes [KW shows Aine a shoebox], where, on the outside, they make what they think they look like – right? And then on the inside is all the things that go on in your head and your heart all your thoughts and feelings.

[Aine begins to work on her box sticking down stickers. There is a pause in conversation while she does this. KW watches.]

KW: Aine, do you remember talking about Ann and Angela [referring to conversation about her sisters that had taken place on the way into the room]?

Aine: There you can use the scissors for me. [KW helps Aine cut out a piece of material.]

From this excerpt it can be seen that I attempted to establish rapport with Aine and create the right conditions for our communication by clarifying my role, the purpose of our meeting and through the process of setting up the room for our time together. These principles reflect the child rights-based approach outlined in the previous chapter. In particular, in terms of addressing the power imbalance in the conversation, while it was me that controlled the process of arranging the actual interview, some control was given back to Aine in the interview process by seeking her agreement to continue the interview (rather than merely assuming that she will want to do this) and by her exercising choice as to the way the room was organized. More control could have been given by allowing Aine to choose freely from the materials on offer rather than me directing her to a particular method which, in this case, was the shoebox, a method which is discussed in more detail in Chapter Six.

**EXERCISE**

Think about conversations you have had with children and consider the following questions:

- Think about what types of topic should you begin an interview with.
- Think of a few examples and give reasons as to why you think they might be a good way of beginning.
Another important way of giving control to a child in a conversation is by initiating a discussion around an issue that you know they do not find threatening or intrusive. This aspect of the beginnings stage is illustrated below in a conversation that leads on from Aine and myself setting up the room and Aine talking about her sisters, Ann and Angela, as she walked into the room:

KW: Ah hah. And what were you telling me about Ann and Angela?
Aine: That they moved house.
KW: And have you seen them in their new house?
Aine: No haven’t seen their new house.
KW: And you told me it might be sad when they move?
Aine: Yes.
KW: Why did it make you sad?
Aine: Because it wasn’t fair.
KW: Because it wasn’t fair?
Aine: Move house too.
KW: You wanted to move house too? So why did you want to move house?
Aine: Cos I didn't like my other house there, right over [referring to the box she is decorating].
KW: That's it. You didn't like your house that you are in and you wanted to go to a new house? [Gap while Aine plays with craft materials.] And why don’t you like the house that you are in?
Aine: Cos it’s not good.
KW: Cos it’s not good? And which bits are not good about it?
Aine: Cos I go on a naughty chair.
KW: Oh. Cos you go on a naughty chair. Oh dear! And when do you come off the naughty chair?
Aine: Don't know. I DO NOT know [saying words in an exaggerated American accent].
KW: So you don’t like it cos there’s a naughty chair?
Aine: Yeah.

[Aine proceeds to look around and talk about the room we are in. She sees a mirror. Aine and KW chat about the height chart on the wall and then Aine returns to her
drawing].
KW: So Aine who lives in the house that you’re in?
Aine: My daddy.
KW: Your daddy and?
Aine: Mummy and my brother and [Aine does not finish sentence] …
KW: And?
Aine: Me and [Aine does not finish sentence. Voice trails off. Her thoughts seem to preoccupy her] …
KW: And?
Aine: Doggy. I’ve got two doggies.
KW: What’s your doggies names?
Aine: Boots and Dempster.
KW: And how long have you lived with your mummy, your daddy and your dogs?
Aine: 29.
KW: 29. And where were you living before that?
Aine: At my mummy’s house, at my other mummy’s house.

This excerpt shows that the topics introduced at the start of an interview are an important consideration to help put children at ease and reduce their possible feelings of anxiety or fear. As stated earlier it is best to start with a neutral issue or an issue that the child feels confident in exploring (Lefevre 2008: 133). In this part of the conversation with Aine this involved a discussion about her sisters. Although I took the lead in terms of introducing the topic it seemed a safe one to start with as she had already raised the issue. Again this action was important in signalling to Aine that she would have some control in the interview process. An indication that Aine felt comfortable with the beginning of our conversation together was that she quickly moved from identifying who was in her foster family to expressing some of her feelings about these matters. This reflected a combination of building rapport and creating the right conditions, particularly in terms of providing the right kind of information and materials and respecting her individuality. For example, it took time for Aine to choose and then set out the materials and the room and it was crucial that her pace was respected.

In the above conversations with Aine, although not completely apparent from the transcript, further important skills in rapport-building included mirroring and pacing.
These involved copying the speech (volume, speed and tone of voice), language (the words used) and body language (hand movements, gestures, resting elbows on table, sitting with legs crossed) of Aine. Mirroring and pacing are subtle processes, often not carried out consciously, where people often replicate the signals and behaviour of the other. They convey a non-judgemental attitude and create feelings of safety and security for the child involved. It is probably this that leads people to feel they are ‘clicking’ with someone. Being aware of these skills helps reduce some of the power differential between the social worker and the child (Lefevre 2008: 130–45). It is especially important to be aware of the issue of power in relation to children because, as Koprowska (2008: 96) argues,

>[a]dults are inherently more powerful than children [and] vulnerable and disadvantaged children, especially younger ones, are highly susceptible to adult influence. They defer to adults, are sensitized to verbal and non-verbal cues and comply. We have to be careful not to cue them into telling us what they think we want to hear.

It is possible to find examples of verbal mirroring in these conversations with Aine. The use of the word ‘doggies’ for example and acceptance of Aine’s description of the length of her placement in foster care as ‘29’ are examples. These skills are reflective of a child rights-based approach in which the individuality, the choices and the contributions of Aine are respected, valued and encouraged (UN 2005; UN 2009: 26–7, para. 134).

**Middle**

The middle of the communication process represent a stage where the process and quality of information exchange and also the level of interaction should deepen (Wilson et al. 2008: 306). This stage of the communication process raises a number of important issues for social workers to consider, including: their skills base, recognizing and managing emotions (in themselves and the child), recognizing and respecting the social agency of the child (the child’s own choices and contributions in the direction and content of the conversation) and the use of methods to facilitate the conversation. Each of these four issues will be illustrated through my own conversations with Aine.

**Social worker’s skills base**

**EXERCISE**

- List what skills you think you might need to communicate with children in the middle stage of an interview/meeting/visit.
- Consider whether any of those skills you have listed are more important than the others?
- Reconsider your answers when you have read the next conversation with Aine.
The conversation below continues where the last one, noted earlier, left off. The purpose of my conversation with Aine was to explore a number of key questions with her – namely, What did she remember about home? Did she understand why she was removed from her parents’ home and therefore the reasons why she was in care? What were her feelings? And did she have an opportunity to convey her perspectives to help inform decision-making about her? This is a long excerpt. However, and as explained earlier, this is important because these are Aine’s words; they demonstrate quite clearly that she is able to convey information about difficult issues competently and that she has the capacity to engage in a sustained and lengthy conversation.

KW: And who lived in your other mummy and daddy’s [birth parents] house?
Aine: [Pause] My mummy and my daddy and my brother Andrew and my two sisters.
KW: Do you know why you don't live with your mummy, daddy, Andrew, Ann-Marie and Angela?
Aine: Yep.
KW: And why is that?
Aine: Cos I was cheeky to them.
KW: [Later in interview] And when you lived at your house in Old Way what, tell me what happened every day.
Aine: Ann-Marie wanted to steal my toys and I wanted to steal her toys and then we started fighting.
KW: So you and Ann-Marie started fighting a lot? And were the toys upstairs or downstairs?
Aine: Upstairs.
KW: And did you spend a lot of time in your bedrooms?
Aine: Yeah cos I spent a lot of time staying in there playing and fighting and putting poo on our head.
KW: You put poo on your head?
Aine: Yeah where it comes out your bum.
KW: [Later in the interview] So the poo that comes out your bum you get out your bum and you just put it on there [pointing to head]?
Aine: And then we put it all over our walls.
KW: Did you? And why did you do that?
Aine: Cos it comes on our nappies and we took our nappies off.
KW: I see, so the poo comes out of your bum into your nappies, you took your nappies off?
Aine: And I had a nappy.
KW: And you had a nappy? So you took your nappy off, got poo and put it there [pointing to head and walls] and then who sorted that out for you?
Aine: No one.
KW: No one sorted it out. Did anyone clean your hair?
Aine: Dad and Ann-Marie screamed.
KW: [Later in interview] And how did it make you feel when you were putting poo from your nappies on your head and on the walls?
Aine: Not good.
KW: Not good. No.
KW: [Later in interview] What else went on when you were at home?
Aine: Don’t know and then I would throw my mattress off my bed and jumped around on it.
KW: Did you ever play anything else in your bedrooms?
Aine: No.
KW: And then what happened when you were not in your bedrooms?
Aine: Not nowhere.
KW: Did you used to go downstairs at all?
Aine: I had a lock.
KW: You had a lock and where was the lock?
Aine: On the top.
KW: On the top. Whereabouts on the top?
Aine: On the door.
KW: [Later in interview] So who used to put the lock on your door? You know when you went in through your door? Who put the lock on?
Aine: No one. My daddy did when I went to bed.
KW: Why do you think he did this Aine?
Aine: Cos he kept thinking in case I get out.

KW: Did you used to try and get out then?

Aine: No.

Of course probably the first thing that is striking is how appalling Aine’s experiences were and how she is able to convey them so lucidly. It is very difficult to imagine a child of Aine’s age being locked in her room and neglected to the extent where she regularly smeared faeces on her head and on the walls. Her memories are likely to evoke strong emotional responses from those who listen to her account.

EXERCISE
Before continuing, write a list of your emotional responses, keep them to one side and we will return to them shortly to engage in proper exercises and a full discussion.

The first issue to be considered in relation to the middle stage of communication is the social workers’ skills base. Table 5.2 provides a summary of the listening skills, questioning skills and responding skills that are used to successfully navigate the way through the middle stage of the interview. For those interested, each of these is described in detail elsewhere (Koprowska 2008: 82–9; Trevithick 2005: 140–89).

Some may mistakenly interpret Table 5.2 as implying that during the course of an interview these skills are exercised by social workers in an ordered, hierarchical fashion. This is not the case. All three interweave throughout the course of a conversation with some more prominent at certain points than others.

In relation to my own listening skills in the conversation with Aine, sometimes I listened with silence (Wilson et al. 2008: 310–11) and sometimes I responded to Aine’s comment with a comment or a question. What is important, but cannot be well reflected in written excerpts, is an attitude of listening with non-verbal responses such as head nods, positioning (leaning body forward or with head to one side, for example)

Table 5.2 Communication skills base with children

<table>
<thead>
<tr>
<th>Skill</th>
<th>Skill in action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listening skills</td>
<td>Listening is an active rather than passive activity. It involves being attentive, concentrating, responding and searching for meaning. It means showing interest, empathy and support. Finally, it involves using silence where appropriate.</td>
</tr>
<tr>
<td>Questioning skills</td>
<td>The use of open, closed and probing questions.</td>
</tr>
<tr>
<td>Responding skills</td>
<td>The use of verbal skills in reflecting, paraphrasing, clarifying and summarizing.</td>
</tr>
</tbody>
</table>
and facial/eye movements (Koprowska 2008: 38; Trevithick 2005: 119–21). These cues are very important in conveying the message to the child that they are being listened to attentively and completely.

Good use of questioning skills is also central to any interview process, with the aim of the interviewer being to uncover facts, feelings, reasons and detail. There are four types of questioning: open, closed, probing and leading (Trevithick 2005: 140–89). An open question is usually prefixed with ‘how’, ‘why’ or ‘what’ and is designed to allow the interviewee to reveal information with them taking the lead. An example of an open question in the interview with Aine is:

KW: And when you lived at your house in Old Way what, tell me what happened every day.

A closed question results in a short response rather than detailed elaboration. Often a closed question is designed to gather specific information about a particular issue. Examples of closed questions from the interview with Aine include:

KW: Did you used to go downstairs at all?
KW: You had a lock and where was the lock?
KW: On the top. Whereabouts on the top?

The above might also be counted as a series of small probing questions where I was gathering detail on a sensitive issue, in this case Aine's experience of being locked in her bedroom. A probing question can be open or closed and is used to begin to touch upon an area of interest but often indirectly. Probing questions can rely on a child's recall ('Tell me about what you did in the morning') or they can rely on recognition ('Was the lock metal or wooden?'). Generally it is felt that questions that rely on young children's recall help children explore and express their experiences more freely (Larsson and Lamb 2009). The last type of questions are leading questions, so called because they are suggestive to children. Examples include ‘you did come downstairs sometimes didn't you?’ or ‘you must have felt very angry mustn't you?’ Because they can be experienced as coercive and constraining they are best avoided.

As Aine started to reveal her memories she required reassurance from me that what she said had been listened to. Good responding skills include the following: reflecting (i.e. I hear and understand your feelings), paraphrasing (i.e. I hear and understand the content of what you are saying), summarizing (i.e. similar to paraphrasing but usually with longer summaries) and clarifying (confirming the accuracy of what has been said.
and sorting out confusions) (Trevithick 2005: 164–9). These should occur in a context in which the child feels that they are valued, respected and accepted (UN 1989, 2005, 2009). Examples of these skills can be seen in the following excerpt:

KW: And did you spend a lot of time in your bedrooms?
Aine: Yeah cos I spent a lot of time staying in there playing and fighting and putting poo on our head.
KW: You put poo on your head [reflecting]?
Aine: Yeah where it comes out your bum.
KW: [...] So the poo that comes out your bum you get out your bum and you just put it on there [pointing to head] [paraphrasing]?

Recognizing and managing emotions

**EXERCISE**

Return to the list of emotional responses that you made earlier and consider the following:

- What were your emotional responses?
- What might have been Aine's emotional responses in the circumstances she describes?
- Why is it important to be emotionally self-aware?
- What strategies can you think of to help you manage your own emotions?
- What strategies can you think of to help you manage Aine's emotions and also to help her manage her own emotions?
- What were your other reactions? And how might these be dealt with?

As stated earlier, it is likely that reading about Aine's memories of her home life will have evoked strong emotional responses. If social workers accept that young children can share their views, and if social workers have built a rapport and established the right conditions for the interview, we must be prepared to listen to what children might then go on to tell us. It is not easy to listen to Aine's memories. Her interview stirs up all sorts of emotional responses towards the parents including horror (‘how could they do this?’), anger (‘how dare they do this!’) through to confusion (‘why did they do this?’). There are also emotional responses towards Aine including sadness, anger and/or shock (‘your experiences were appalling’), sorrow and guilt (‘so sorry that no one helped you earlier’) through to admiration (‘I am amazed at your resilience’).

How was it possible for Aine to describe her own feelings and how was it possible for me to manage Aine's emotions (interpersonal skills) and my own (intrapersonal skills)?
Morrison (2007) and Howe (2008) state that these interpersonal and intrapersonal skills comprise what is termed emotional intelligence. First, in relation to my own emotions, emotional intelligence is crucial to building meaningful relationships and communicating with young children. It enables children to feel safe, to express difficult feelings without fear of rejection or judgement and to begin the process of making sense of the past, the present and what might be in the future. As highlighted through the interviews with social workers in Chapter Three, those who avoid confronting and dealing with their own emotions and/or the emotions of children are more likely to have distant relationships with them which can, in turn, and as demonstrated so vividly in the child abuse inquiries, contribute to practice in which children’s safety and well-being are compromised. As Morrison argues,

[a] lack of self-awareness or suppression of emotion may result in important information being missed, either about the presence of external dangers or about intrusions from the worker’s own experience, which may distort observation and assessment.

(Morrison 2007: 255)

Morrison (2007) and Howe (2008) discuss how being emotionally intelligent involves a process of understanding and recognizing, labelling and expressing, and managing and controlling emotions. How does this work in practice? In relation to my emotions, while I attempted to keep them visibly in check during the interview with Aine, I did nonetheless experience emotional responses. I remember being shocked almost to the point of disbelief (‘Did I hear Aine right?’ ‘Did she just say that she had put poo over her head?’), appalled (‘The smell from which there could have been no escape’) and guilty on behalf of the profession as a whole (‘How could we, as social workers, have allowed things to get so bad?’). The key though was not to express these emotions during the course of the interview because this could convey the impression that I was either not coping, did not believe and/or could not listen. Having said this, rather than burying these emotional responses completely I later had space with the supervisor of my research to explore these feelings and my own management of them.

Second, in relation to Aine’s emotions, the interview process allowed her to explore, express and vent her emotions safely without her feeling that they were being judged, curtailed, minimized or dismissed. An example of this is where, during the course of the interview, Aine expressed her feelings of sadness as follows:

KW: And what was messy about Andrew’s room? What kinds of things were messy in his room?

Aine: [Delay in response and silent play] All his play stations and his pens an all and his bed was all messy.
KW: Was it?
Aine: [*Lets out a half-scream*]
KW: And what was messy in his bed?
Aine: All of his bedware, clothes off and his sheets were minging [*meaning filthy and/or dirty*] and he was moaning.
KW: And what was he moaning about?
Aine: Cos he didn’t get to eat anything and he got too much bed.
KW: And so he didn’t get to [*interrupted by Aine letting out a loud and unpleasant baby Waaah noise*]. Oh is that what he used to do?
Aine: Yes.
KW: Is that the noise he used to make?
Aine: Yeah.
KW: I see and how did you feel when he made that noise?
Aine: Sad.
KW: Sad. Yes. […] What do you do when you’re sad?
Aine: [No response.]
[Aine engages in silent play. KW watches Aine smearing paint all over her paper in circular motions.]

Aine engaged in the action of smearing paint all over the paper in circular motions with both hands for several minutes. When she was asked what her actions reminded her of, she responded:

KW: When you are doing this does it remind you of anything?
Aine: Um um.
KW: What does it remind you of?
Aine: Not to scream in my house.
KW: Not to scream. And what happens if you scream?
Aine: You get a sore throat.
KW: What else does that remind you of? [*Silence in interview as KW watches Aine moving hands in a circular motion across paper.*] Does it remind you of anything?
Aine: No. [*Delay. More silent play.*] And Ann-Marie did put stuff [poo] in her own gob.
KW: Did she?
Aine: Yep and I didn’t get to do stuff. Write things.
KW: Write things down?

The important point about these excerpts is that Aine expressed her emotions vividly. Her mimicry of her brother’s screams was loud and piercing. Her actions of smearing paint on paper were a vivid re-enactment of the smearing that went on in the bedroom. While both were shocking, and could easily have led to attempts by me to cut their expression short, the process of managing Aine’s emotions involved supporting her to make sense of them. Hence, in the conversation, when I asked her what the smearing actions reminded her of she said they reminded her not to scream. They also reminded her that she saw her sister put faeces in her mouth.

Third, in relation to the management of the process more generally, the use of empathy was a key skill which Trevithick describes as ‘trying to understand, as carefully and sensitively as possible, the nature of another person’s experience, their own unique point of view and what meaning that carries for the individual [in this case Aine]’ (Trevithick 2005: 153–4). She was not interrupted by me in this process but supported until she brought this aspect of the conversation to an end and it moved on to another issue. Similar processes were at play when Aine explored, later in the interview, her feelings about her removal from the family home.

KW: Who brought you over to your new mummy and daddy? How did you get there?
Aine: A girl brung me.
KW: And were you happy to be there?
Aine: No sad. I went to my granny’s house over and across the road near to my mummy’s and then I came there [meaning foster placement]. I went there.
KW: And did you understand why you couldn’t live at home anymore?
Aine: No!
KW: Did no one sit down and tell you?
Aine: No.
KW: Do you think they should have done?
Aine: What?
KW: Told you why you couldn’t live at home?
Aine: [No answer.]
KW: So this lady just brought you over to there and you didn’t know why?
Aine: Yeah.
KW: Goodness me.
Aine: So that was not fair.
KW: So that was not fair? And what would have been fair Aine?
Aine: That I would get to see my mummy and I didn't want to move and then they left me.
KW: And that wasn't fair?
Aine: No.

Aine’s emotional responses to her removal are probably quite surprising in that one might have expected Aine to be relieved, grateful and/or happy at having been removed from such appalling conditions. However, she expressed none of the expected emotions. She felt angry, let down and abandoned. The process of managing her feelings included me acknowledging and accepting them rather than admonishing them. Skills such as reflecting back, paraphrasing and summarizing were crucial to this.

Recognizing and respecting children’s social agency

So far it has been seen that a successful interview depends on developing a good rapport, the use of good listening, questioning and responding skills, sensitivity to non-verbal skills and the ability to recognize and manage emotions. A further crucial component to the success of the middle stage is social workers' ability to respect, accept and value the social agency of the child.

EXERCISE
Think of young children that you know either professionally or personally and consider the following questions:

• What do you understand by the term 'social agency'?
• How might children show agency in the course of a conversation?
• Why is it important to recognize and respect children’s agency?

In the examples below I provide illustrations of Aine’s strategies to exercise control over the pace, depth and direction of the interview. These included Aine's use of silences, distraction and deflection, humour, boundary-testing and re-enactment of past behaviours. These are types of social agency through which Aine challenged, controlled and took charge of the direction and dynamics within the conversation. Aine’s responses should be a reminder to social workers that Aine is a person with her own
personality and perspectives who is to be valued, respected and treated with dignity (UN 2009). In this case this means respecting the choices and control that she exerts, while simultaneously seeking meaning and understanding about these. It is this aspect of communicating with young children that is often missing in books and training materials. And yet it is this aspect of communication (i.e. what children say and do themselves) that is so important in terms of respecting, protecting and fulfilling young children’s rights and in further challenging our own limited view of young children’s social competence (Alderson 2000/2008). The remainder of the chapter considers each type of social agency – namely, use of silences; distraction and deflection, humour, boundary-testing and re-enactment of past behaviours in turn.

At certain points in the interview excerpts included in this chapter, Aine found her memories difficult to talk about. It was not that she did not want to talk about them but just that she found them emotionally challenging. As we have seen, she used silences to regain her composure and gather her thoughts before moving on to discuss her memories. The challenge to me as the interviewer was to not retreat from the poignancy of these moments and/or to try and rescue Aine from the pain of her own feelings by denying her an opportunity to express them. We both had to ‘stay with the silences’ (Koprowska 2008; Wilson et al. 2008: 310–11). Trevithick (2005: 175) explains this process further when she states that ‘the assumption is that talking is better than not talking and that nothing is being communicated when silence prevails. This is not the case, because words can be used to create or kill real dialogue, to conceal rather than to reveal.’ These processes are illustrated in the interview excerpts above where Aine was talking about her lack of food, her brother’s room and his distress, and her sister Ann-Marie putting faeces in her own mouth.

When Aine started describing some of her experiences of loss – namely, of her granny and pet dog – associated with her move into care she used distraction and deflection to reduce the intensity of the interview and to retain control over her own emotions. By turning her attention, thoughts and effort to the craftwork she was able to create ‘thinking space’ to recover and compose herself sufficiently before proceeding with the interview. This can be seen in the following:

KW: And you said to me that your granny lived nearby did she?

Aine: [Pause from Aine.]

KW: Did she live next door?

Aine: [Aine does not answer question] Oh it’s the wrong way [referring to piece of craft work she is making].

[Aine and KW talk about the craft materials, cutting and who is going to do it. Aine seems pre-occupied.]
KW: And who else lives in Allwood that you know?

[Aine deflects from answering by making comments on her craftwork. Looks to KW for next question.]

KW: Aine, who else lives in Allwood?

Aine: DOGGY [shouting this word out].

KW: What was your doggy's name?

Aine: ANGUS [proceeds to laugh out loud with forced laughter].

[Aine is upset at having to leave granny and the dog behind when she came into care. Aine and KW return to the discussion about Aine's craftwork.]

As noted in the earlier discussion she used humour, in this case the use of a theatrical American accent, to manage her exasperation at her foster carers' practice of using the naughty chair. The use of this accent brought smiles and laughter from both Aine and I, which performed the function of diffusing Aine's feelings of frustration and anger. The diffusion did not detract from the content of what was said, the seriousness of what was said or the strength with which the opinion was held. Rather, it allowed Aine to create a space for herself to keep her feelings in check.

Similarly, in one of the other conversations where she talked about Andrew screaming, she gave an example of how his screaming sounded to her. The screaming was loud, painful and quite shocking. It felt as if Aine was trying to induce in me the feelings that she had experienced when she heard Andrew's screaming, including feelings of panic, shock and embarrassment and as a way of testing boundaries. I felt that this was, in part, a test of my authority (what was I going to do about it and what could I do about it?). This process was managed by not 'giving in' to Aine's testing but by seeking clarification from her and acknowledging her strength of feeling.

As already noted Aine re-enacted some past behaviours (smearing actions through the use of paint and paper) when discussing some of her feelings. As she told me her story I felt as if we had been locked in the room together and that I was observing what she did in that room to cope. My role in these parts of the conversation where Aine was demonstrating different types of social agency was just that, an observer, passing no judgement and not interfering with the process.

From the above section on children’s social agency it can be seen that, far from young children being passive recipients of communication from adults, they use every opportunity to be active and to engage in reciprocal exchanges. It can be seen from the examples included that the term social agency refers to the capacity of children to exercise their own choices and control, and to change the dynamics, direction and
decisions within their particular context. In communicating with young children social workers need to be clear that while it is they who set up the interview, with an agenda often controlled by them, it is possible for young children, within the constraints of the interview context, to operate their own choices, control and changes. These exchanges may be verbal and/or non-verbal.

Social workers need to have flexibility, insight and wisdom to tune in to and respond to the choices and controls that children exert. As McLeod (2007) notes in her own research with older children in care, it is important to respect the choices and controls that children are exerting, particularly in situations where they feel they have had little previous control in communication processes. This might involve practical tasks such as children choosing what it is that they wish to talk about and how they wish to do this. This child rights-based approach respects and values the contributions of children to the communication process. In this sense the communication process is based on reciprocity where there is an exchange of ideas, control of the process is shared rather than dominated by the social worker and ideas that emerge are the result of children and their social workers working in collaboration. These processes also draw attention to the importance of understanding communication in its broadest sense and of according, for example, as much weight to body language during an interview encounter as to the spoken word (Connolly 2008; Christensen and James, 2008b).

Methods to facilitate the communication process

So far, this chapter has considered the following as crucial to the process of social workers’ communication: skills base, ability to recognize and manage emotions (in themselves and the child) and ability to recognize and respect the social agency of the child (the child's own choices and contributions to the direction and content of the conversation). One last area that will be touched on this chapter and developed further in the next concerns social workers’ use of methods to facilitate conversations with young children.

As seen in earlier conversations with Aine, she used paint and craftwork during her conversations with me. In one of my early conversations with Aine I outlined to her the use of shoeboxes to depict feelings. Aine engaged with this particular method immediately to explore her views about herself and her feelings. During the course of the interview she constructed shoeboxes depicting herself and her feelings. On her first box she constructed an image of herself on the outside of the box to illustrate what she looked like and wanted to look like to others around her. The comparison between her description of herself at home (hair and head covered in faeces, naked and physically constrained for lengthy periods in one room) was a stark comparison with the image she constructed of herself in which she was neat, clean, sparkly and a dancer.
In the inside of her first box, shown in Figure 5.1, she depicted her inner feelings – the ones that people do not see – that focused on her dogs, smearing and her foster carers’ back garden. The paper with sparkles on it was initially smeared with paint and then at a later stage sprinkled with glitter to represent the garden of her new foster home. Alongside this, Figure 5.2 shows the outside of Aine’s second box, which captures her interests and hobbies.

She said that she liked cycling, dancing and animals (pink feather). On the inside of the second box Aine made a smaller box. Inside the smaller box she placed pieces of paper with feelings on them folded over and covered by a lid as shown in Figures 5.3 and 5.4. To read the feelings the lid has to be removed. Reflecting the personal nature of its contents, it was important to seek Aine’s permission to take out the contents of the little box to photograph them even though she had asked me to write the labels on her behalf.

The feelings in her box represented the friends that were important to her and also her longing to remain connected with her mother and father. The craftwork with Aine was particularly important because it enabled Aine and I to establish a good rapport. Furthermore, the methods provided a vehicle through which she and I could explore her thoughts and feelings. Importantly, during this Aine used the methods to control the depth, pace and content of the interview. Lastly, the methods served as a visual representing the depth of Aine’s feelings and experiences. These and other issues related to participatory methods are explored in the next chapter.

Endings

Ending conversations with young children is as important as beginning them as well (Trevithick 2005: 181–7; Wilson et al. 2008: 306–7). In my research there are several examples of young children who, once they had engaged in the interview, did not want it to end. In the following excerpt there are some practical ideas about how to end communication with young children well:

**EXERCISE**

Consider the following and make notes of your answers:

- Why is it important to end conversations well?
- What are some of the common mistakes made in ending communication with each other?
- What types of strategy could you use to end a conversation with a young child well?
KW: Aine can you see the clock?

Aine: [Nods head.]

KW: It is nearly time for us to finish. Shall we tidy up together?

Aine: [No answer.]

[Aine continues to play. KW lets Aine continue to play for a few minutes.]

KW: Aine it is time for us to finish. Let’s tidy up together. If you like you can choose a pack of stickers to take with you.

Aine: Can I take these [pointing to pack of stickers] and one of those [holding pom-pom in hand]?

KW: Sure. Is this the picture you are taking to your foster-mum? Let’s put it over there so we don’t lose it [packing away]. You have told me lots about your memories and feelings today.

Aine: Ah-ha.

KW: I think it might be a good idea for you to spend some more time doing this. What do you think?

Aine: Ah-ha.

KW: OK. I will talk to your social worker.

[KW and Aine discuss again items being made for foster-mum and interview terminated. Process of clearing up takes several minutes.]
Summary

Through the use of a detailed case study this chapter has outlined the key stages of the interview, the processes involved and the issues that emerge in each stage and how

Table 5.3 Endings stage of the communication process

<table>
<thead>
<tr>
<th>Endings</th>
<th>What you can do to help</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warning</td>
<td>Five minutes before the end of the interview let the child know that the interview will shortly be coming to an end.</td>
</tr>
<tr>
<td>Summing up</td>
<td>Involve the child in summing up the main issues that have been discussed today.</td>
</tr>
<tr>
<td>Clearing away</td>
<td>Begin to clear up the room together.</td>
</tr>
<tr>
<td>Thanking</td>
<td>Thank the child for their time and for their input. Let the child know that you have valued your conversation together.</td>
</tr>
<tr>
<td>Planning ahead</td>
<td>Explain what will happen next. Ensure the child has your contact details on a postcard.</td>
</tr>
</tbody>
</table>

these should be managed. The chapter has shown that communication with young children involves establishing rapport, creating the right conditions, the confident use of listening, questioning and responding skills, appropriate management of feelings and emotions, respect for the choices of the child and the use of methods to facilitate the interview process. Most importantly, the chapter has shown how all of these processes and practices are reflective of and grounded in a child rights-based approach. The next chapter considers the use of methods in more detail, drawing upon examples from other case studies from my research.
The Assessment of Lesbian and Gay Prospective Foster Carers: Twenty Years of Practice and What has Changed?
3. The Assessment of Lesbian and Gay Prospective Foster Carers: Twenty Years of Practice and What has Changed?

Introduction

This chapter draws on the findings of a small, explorative, qualitative study I undertook in the autumn of 2009; building on a colleague’s and my own previous work addressing the content and quality of the assessments of lesbian and gay men prospective foster carers (Brown 1991, Brown and cocker 2008, cocker and Brown 2010). This chapter provides an overview of key changes to the legislative framework relevant to this area of social work practice and considers relevant findings from the Wakefield Inquiry (Parrott et al. 2007).

In the study I considered social work practitioners’ ideas about the implications of changes in this area of social work practice and the impact they thought those changes had on the quality and content of their assessments of prospective lesbian and gay foster carers. I also examined if being located within a fostering agency that had experience of assessing lesbian and gay men as prospective foster carers affected the quality and the content of the assessment of lesbian and gay prospective foster carers, and if so how?

The research study, informing this chapter, consisted of two focus groups conducted with social workers in an Independent Fostering agency (n=6) in the South east of England and one in a local authority fostering team (n=7) also in the South east of England. the focus groups were taped and the content of the tapes transcribed. these transcriptions were then read for themes that emerged from the discussions.

The local authority team was located in a London borough that had considerable experience of assessing lesbian and gay prospective adopters. although the fostering team in this borough had less experience of assessing lesbian and gay prospective foster carers than their adoption colleagues, between all the team members they had accrued significant experience. One of the social workers within the local authority team had experience of the assessment of lesbian and gay foster carers going back to the early 1990s. the social workers, however, in the independent fostering agency team had no experience of assessing lesbian and gay foster carers. one of the independent fostering agency social work team members had been a member of a local authority fostering panel that had approved lesbian and gay applicants. She was therefore able to bring this experience to the discussion. this independent fostering agency team also had experience of working with two sets of foster carers who had undertaken introductions for their foster children to their new adoptive families; one being a lesbian couple and the other a gay male couple.

Despite the different levels of experience between the teams, one of the interesting findings from this small study was that the discussions within both teams were
remarkably similar. One of the questions I wished to explore in undertaking these two focus groups was whether or not the experience of assessing lesbian and gay foster carers had an impact on the teams’ thinking in this area of social work practice. The findings from this study indicated that the experience of undertaking assessments had little or no impact in differentiating the quality of the discussions between the local authority and the independent fostering agency teams. What was notable was the level of sophisticated discussion, confidence and critical thinking within both the teams. I have argued elsewhere that:

in my experience capable social work practitioners work capably with all service users and carers and, similarly, incompetent ones work incompetently with all (Brown 2005:270).

What was notable was that both fostering teams had amassed considerable experience of assessment of a diverse group of prospective foster carers per se, and were confident assessing individuals and couples irrespective of their gender, sexuality, religion, ethnicity or single or couple status. For example, the independent fostering agency team had experience of assessing a transgender applicant as well as single male carers and although the issues may be different from those raised in the assessment of lesbians and gay men, these experiences had meant that they had had to think about a number of questions related to the quality and content of their assessments, particularly regarding sex, gender and sexuality.

**Reviewing the past and considering the present**

In the last five years there have been a number of publications reviewing the past as it relates to social work/social care with lesbians and gay men (Fish 2007, Brown 2008, Brown and Kershaw 2008, Fish 2009) and in particular lesbians and gay men and foster care (Hicks 2005, Brown and Cocker 2008). In preparing for writing this chapter I was struck by the number of similar papers. Indeed, the title I had chosen for this particular chapter was one that yet again looked backwards. Why, in 2010, are a number of academics taking this historical positioning whilst writing about social work/social care and lesbians and gay men; particularly as this ‘looking back’ is unusual for social work academics? My understanding of this interest in looking back is that quite simply, the rate of social and legislative change, relevant to lesbians and gay men, has been so considerable in the last twenty years that social work academics interested in this area are needing ‘to take stock’; this seems to have been particularly the case since the passing of the equality act 2006 and its Section 81 related Sexual orientation regulations 2007. Fish argues that ‘recent legislation marks a watershed in lesbian, gay and bisexual people’s access to services...’ (Fish 2007:221). It is this ‘watershed’ that we are trying to understand and consider what its impact is, and will be, on social work
practice.

The legislative changes for lesbians and gay men as they pertain to social work that Fish refers to, have been considerable and are covered elsewhere (Fish 2007, Brown and Kershaw 2008). For the purposes of this chapter suffice it to say that in going from the legal position of twenty years ago to where we are now we have witnessed considerable legal and policy change. Twenty years ago the criminalization of some male same sex sexual activities, contributing to negative discrimination against gay men, was still on the statute books, and the persistent pursuit of lesbians and gay men by the British conservative government from 1979, portraying them as the archetypal enemy of the family, was the norm. The period since 1997, with the election of the new Labour government, has seen the re-positioning of lesbians and gay men in the UK as a group that is legally protected from negative discrimination. This new position has come to fruition through both the repealing of discriminatory legislation and the passing of a number of new acts including: the adoption and children act 2002; the civil Partnership act 2004; the equality act 2006 and its related Sexual orientation regulations 2007 and the equality act 2010. These legal changes have not been won easily and some of the debates that have accompanied their passage through the house of commons and the house of lords bear witness to the fact that sometimes public opinion lags behind legal change.

Hicks (2005) provides us with a thorough coverage of the history of lesbian and gay fostering and adoption in the UK and links this to the changing legal and policy landscape. He looks, as well, at the development of lesbian and gay foster carers and adopters’ organizations and lobbying groups such as the lesbian and Gay Foster and adoptive Parents network, the Positive Parenting campaign and Pink Parents UK. He also notes the national conferences organized by lesbians and gay men addressing adoption and fostering since 1988 and the impact such initiatives have had (Hicks 2005). The increasing visibility of lesbian and gay foster carers is set in the context of critical debates about the meaning of ‘the family’ and what its constituent parts should or could be. The critical analysis of ‘the family’ and social work’s relationship to it has been part of social work thinking since the 1970s.

The concept of the universality of the family is valid only in so far as account is taken of these diverse patterns, and when it is not used to force this diversity in to a uniform shape, or prove the intrinsic superiority of a particular form (Statham 1978:37). The diversity of family forms, their meanings, our understandings of them and their relationship to the State are still contested.

(Weeks et al. 2001, Cahill and Tobias 2007)

During the early 1990s the conservative government made several concerted efforts to limit the possibility of lesbians and gay men parenting either through: access to fertility
services (the embryology act 1990), adopting (department of health 1992) or fostering (department of health 1990); in all cases their efforts failed. the conservative government's one success in this arena was the passing of section 28 of the local government act 1988. this section prevented local authorities using their resources in such a way that might be interpreted as 'promoting homosexuality' as well as forbidding 'promoting the teaching in any maintained school of homosexuality as a pretended family relationship'. section 28 had little 'teeth' and indeed there were no successful prosecutions under it during its life time. however, it did have symbolic power in that it created anxiety within local authorities who might, as a result, have become more cautious in their pursuit of equality for lesbians and gay men. section 28 was repealed in 2000 in scotland and 2003 in england.

the speed of change regarding the legal position of lesbians and gay men, which has placed them on the same footing as their heterosexual counterparts, has been so fast that it can be argued it has outstripped the rate of change in public opinion. i have argued elsewhere that social workers are part of the public and some of those social workers might have found the speed of change too fast:

changing the law is one thing, changing social workers' attitudes is another. it appears that whilst there generally seems to be more tolerance and acceptance of lesbian and gay lifestyles there is no room for complacency, because ... despite positive legislative changes, homophobic attitudes, prejudice and discrimination still exists. legislation does not force people to change their views, however it does require them to be more tolerant and treat people alike.
(brown and kershaw 2008:129)

this places social workers in the field of fostering in an interesting position. they are required by law to treat lesbian and gay applicants the same as their heterosexual applicants, however public opinion remains ambivalent towards lesbian and gay families. both fostering and adoption have played a significant part in the creation of lesbian and gay families, despite some social workers reflecting society's ambivalence towards them.
(hicks and mcdermott 1999)

the wakefield inquiry

an outcome of this ambivalence can be the creation of organizational and practitioner anxiety when working with lesbians and gay men. some of this anxiety relates to negotiating unfamiliar territory. when working with groups which have been historically negatively discriminated against, social workers can feel anxious that they will be accused of also being negatively discriminatory. another possible outcome can
be the over focusing on the sexual orientation of the applicant/s in the assessment process or conversely the complete ignoring of the applicant/s sexuality:

The Independent Inquiry into the circumstances of child Sexual abuse by two Foster Carers in Wakefield – (Parrott et al. 2007) ... noted that the 'homosexuality' of the foster carers became the primary focus of social work anxiety. this happened at the expense of holistic considerations of both the carers' potential and their actual foster care practice.
(Cocker and Brown 2010:20)

This important inquiry report recorded a number of problematic dynamics about how the gay male couple who were eventually imprisoned for sexually abusing looked-after children who were in their foster care were assessed, supervised and reviewed. the inquiry report in effect provides us with a case study of where matters related to the assessment of lesbian and gay foster carers went very wrong. It is important that we learn the lessons from this inquiry report. For my study, while preparing for conducting the focus groups with the local authority and independent fostering agency social workers, I noted a number of points from the report as I wanted to see if the social workers had taken on board the report's findings and how those findings might have influenced their foster care assessment practices.

In June 2006 two gay male foster carers who had been approved by Wakefield council were given prison sentences for the sexual abuse of boys who had been fostered by them. the resulting inquiry report noted that the social workers demonstrated anxiety about being perceived as discriminatory, as well as demonstrating an inability to discriminate appropriately:

[...] alongside anxieties on their part about being or being seen as prejudiced against gay people. the fear of being discriminatory led them to fail to discriminate between the appropriate and the abusive. discrimination based on prejudice is not acceptable, especially not in social work or any public service. discrimination founded on a professional judgement on a presenting issue, based on knowledge, assessed evidence and interpretation, is at the heart of good social work practice. these anxieties about discrimination have deep roots, we argue – in social work training, professional identity and organizational cultures...
(Parrott et al. 2007:4)

Parrott et al also noted that: the assessment of the couple had

‘failed to cover important psycho-social features of them as individuals and of their relationship with each other’
(2007:38)

In addition they recorded that there had been a failure to address the problematic
dynamics that built up between social workers as well as other professionals and the carers; and that there emerged an organizational position that developed towards these carers that new worrying information failed to influence. One of the informants to the Inquiry said:

I think that one of the problems was that the family placement team were very clear that we’ve got these carers and they are unique ... the fact that they were a gay foster couple ... we need to do everything to support them, to help them remain foster carers really and that was very clearly coming across even though we were sort of saying, although not stating specifically that we felt the boys were being abused but were saying that we’ve got numerous concerns about these carers that need dealing with and ... whatever we were saying I felt was not really being listened to one hundred per cent because ultimately they wanted these foster carers to remain foster carers.

(2007:74)

Munro argues that practitioners should keep judgments under constant critical review and that they have to accept the possibility that their assessment might have been wrong (2008). In this Wakefield case it seems that this was an example of what Janis (1982) named ‘Groupthink.’ Janis is referring here to when a group or organization develop a perception of a situation which they then rigidly adhere to irrespective of information that might contradict that perception. the group’s perception of a situation becomes to them a reality. the quote above denotes just such a phenomenon. Dissension from the organizational or Wakefield foster team’s position regarding their view of these carers was not only difficult but also unlikely.

Findings from the LA and IFA focus groups

I met with both the independent fostering agency and local authority fostering teams which were located in the South east of England in the autumn of 2009. at the start of each of the focus groups I asked the individual members to complete a short questionnaire which asked for details of their ethnicity, age, gender, sexuality, years since qualification and years working in the field of foster care. Completion of this questionnaire was voluntary; two participants chose not complete it. In total I met with thirteen social workers. of the thirteen, six described themselves as white British, three as Black British, one as Black African and one as Bangladeshi. their ages ranged from between 20–30 to over 60. all of those who completed the forms described themselves as heterosexual. the total experience post qualification between them was 138 years and their cumulated time in foster care was 72 years. In terms of experience, the independent fostering agency were the most experienced in terms of time in social work post qualifying and also time spent in the field of fostering.
I asked both groups the same questions about what they perceived to be the same as well as different in the assessment of lesbians and gay men as compared to the assessment of heterosexual carers, and if they thought there had been changes in this area of practice in the last twenty years. I also asked them if and how the Wakefield inquiry had impacted on their assessment practices.

**What was the same as well as different in the assessment of lesbians and gay men as compared to the assessment of heterosexual carers?**

What should be the same and what should be different in the assessment of prospective foster carers has been a question within the literature since 1991. Both Brown (1991) and Hicks (2005) conclude that the assessment process and content need to be the same as well as different. Hicks, writing about the assessment of lesbian and gay foster carers, argues that:

> it is important to remember that assessing lesbians and gay men is not just ‘the same’ as assessing heterosexuals. there are areas particular to living as a gay or lesbian family in the UK that need consideration and discussion.  
(Hicks 2005:52)

Writing fourteen years earlier I stated that:

much of the debate about gay and lesbian parenting has centred on whether the assessment process should be the same for lesbian and gay applicants as it is for heterosexual applicants ... the same thorough assessment should take place, but in addition the following areas should be addressed: the individual's experience of their homosexuality, their own and their family's response historically; how confident they feel in relation to their sexual orientation, how comfortable they are as lesbians or gay men; how homophobia and heterosexism have impinged on their lives and how they feel they've dealt with this, and what present coping devices they use; what are their present relationships – sexual, emotional, supportive, family, etc. how do they negotiate homophobia within close relationships, e.g. siblings; with reference to the future, how they have thought about relating to birth parents of foster children, how they have thought about relationships with outside carers, e.g. schools, playgroups, child minders. how much investigation have they done regarding attitudes of local institutions .... how they would help a child who experienced prejudice because of their carer's sexual orientation.  
(Brown 1991:16)

The additional areas that I suggested should be explored in the assessment of lesbian and gay prospective foster carers were incorporated into the British association for adoption and Fostering good practice guidance on the recruiting, assessing and supporting of lesbian and gay carers and adopters (Mallon and Betts 2005).
The focus groups reflected this debate about whether the assessment of all carers should be the same or whether there should be some differences. What was interesting was that in both the independent fostering agency team as well as the local authority team this question was still open to debate. Both teams thought that considering this area made them more critical in their thinking about assessments being undertaken with heterosexual prospective carers. Susan from the independent fostering agency summed this up when talking about the assessment of lesbians and gay men's couple relationships, she said:

I think I would be less inclined to make assumptions about the relationships ..., I've more experience of heterosexual couples, whereas with same sex couples I think I'd be more careful to ask for the detail of their relationship. I hope I do that with heterosexual couples but I can see that it would be much easier to make assumptions.

Assia from the LA team reflecting on an initial visit she had undertaken with a lesbian couple who were applying to foster thought her assessments were the same irrespective of someone's sexual orientation:

I ask the same questions I ask heterosexual couples in the initial visit, ask them about their relationship, ask them about how long they've been together, how they would work together as a couple, their motivations and because they're not going to have children of their own what was motivating them to foster which would be the same question I would ask a heterosexual couple who is childless. I felt I did the same thing, I would ask the same questions.

Gloria from the local authority team noted some areas of difference that she felt were important:

I think the other thing that can be different is about the need to have a discussion about some of the discrimination they're going to meet when they start fostering from within the community and how we're going to help them but also how resilient they are about actually being able to manage that as well, because if they're not resilient, you know, it's not going to work.

The need for resilience was a theme that emerged within both focus group discussions. The resilience that they were looking for was evident in a local authority's initial assessment of a lesbian couple which Delia described:

I asked them what their relationship was like with other people around the local community just to get a grasp on how they were dealing with being discriminated against. But speaking to the couple it was eye-opening for me because where they were living they had very good friends and they said yes they had been discriminated against or felt that people were looking at them in a funny way but
because of their confidence, they were confident about their relationship, they were very secure, other people didn’t find it very easy to point fingers at them. Which meant because they were secure in their own relationship any foster child coming into their home would feel that sense of security. So that’s a very positive thing.

This discussion about the need for resilience raised the question in the independent fostering agency team about whether or not we are asking more of gay and lesbian foster care applicants than we do of heterosexual ones. This was best articulated in a discussion which took place primarily between Janet and Albert:

Janet – So are you saying that you think they would need special qualities over and above those that you would expect of heterosexuals?

Albert – Maybe, yeah.

Janet – But I don’t know whether we should be or why you might be....

Albert – I’m saying that lesbian and gay carers are going to potentially come across situations that are difficult and therefore they are going to need emotional resources to deal with that.

Janet – But all foster carers are going to come across difficult situations. I’m not sure that we would want different qualities .... can they do the job is what you’re asking, whether it be of a single carer, a heterosexual couple, a gay couple ... each situation will throw up particular potential difficulties that you need to identify and explore ....

One of the areas that Hicks and McDermott identified in their research looking at the experience of lesbians and gay men being assessed as foster carers and adopters was ‘that many talked about the gender concerns raised by social workers and/or panels’ (1999:162). This was particularly related to domestic arrangements and the question of who does what within the home and within the community. The assumption being that within heterosexual families’ roles and responsibilities are usually divided according to gender (Brown 1992, Weeks et al. 2001). This concern emerged within the focus groups: Keisha from the independent fostering agency thinking about what would be the same and what would be different in the assessment of lesbians and gay men said:

I suppose in terms of what would I do the same; to look at how they are with their own family, how they are connected to the community and how they are settled as a couple, you know it’s all the same things that I would look at. Say if it was two men in a partnership you might think well if they didn’t have any children themselves you might think well it’s always the lady in the man-wife situation who goes to the school and makes contact with the school, you know you make these assumptions
but then you think well if its two men in a partnership, who would take on that role? What is their experience in that role? So you'd kind of be thinking how do they see themselves within the community?

This led on to a discussion about the very different domestic arrangements that all couples have and the need to not make assumptions about any couple but rather, in the words of Chantelle from the independent fostering agency:

I feel fine trying to pull it apart and saying OK let's scrap the initial model and look at what happens in your family. With a heterosexual couple there is a danger that we can make generalized assumptions.

Both the local authority and the independent fostering agency teams were committed to detailed and rigorous assessments of all applicants irrespective of their sexual orientation. Included in this rigorous approach was critical analysis of the quality of the relationship between the assessor and the applicants. Chantelle from the independent fostering agency summed this up when she looked back at an assessment where the sexuality of one of the applicants had needed to be fully explored:

What you're looking for in any assessment is people getting why your, understanding why you're asking the question, you might have to explain why you're asking the question, that's fair enough but kind of tuning into that and being able to show insight and openness in exploring that theme with you, you'd want them to understand why you were exploring how that might be for a child. the problem in that particular assessment was that it was kind of like drawing teeth at the beginning and that it's a kind of hidden subject and at some stages there was a very limited understanding as to why I was asking the questions.

The LA team was aware that some lesbian and gay men are wary of how they might be treated in the assessment process because of past experience of negative discrimination and that this can have an impact on the quality of the relationship that they establish with the assessor. Amina voiced a concern as follows:

I think I'd be wary of people's increased sensitivity really and expecting to be discriminated against and the initial, maybe first half an hour, is about getting over that barrier and thinking of ways of working together positivity. that's been my experience on occasions. they've been, I think, very surprised about how welcoming we are but still have been a little bit apprehensive about ... I suppose things like, - 'we'll need to speak to family members' – if there's been some rift associated with their sexuality and disclosure and us having to be clear about why we have to undertake those interviews.

Another local authority team member Ola talked about how her experiences as a black woman helped her make links with lesbians and gay men's experiences of
discrimination and how this, in her experience, helped the working relationship during the assessment:

When I did my assessment it was about their resilience and how they coped with telling friends and family about their sexuality and how people also responded to that. But I think I based some aspects of my assessment on my sense of being a black woman with regard to different types of racism and discrimination I’ve experienced. I linked it to their experience of their sexuality and I think I worked it like that and it worked quite easy for me and I felt quite comfortable about it as well so I think that’s how I turned the assessment around.

Assia from the local authority team having summed up what she was looking for in carers, which included having the skills and knowledge to undertake the ‘fostering task that has become increasingly complex’ said that she consciously considered:

Whether we can work with people, how has the dialogue been between us and have we been able to establish that professional understanding.

Has this area of practice changed in the last twenty years and if so how?

Hicks noted the considerable degree of change that there has been in this field since 1988:

there are now greater numbers of lesbians and gay men applying, gaining approval and having children placed in their care, although this tends to be concentrated in certain inner city or progressive authorities (2005:52).

He also records the increasing confidence of applicants who are open from the start about their sexuality. The findings from the focus groups in my study reflect a general increase in confidence on behalf of the social work assessors. This increase in confidence means that both assessors and applicants can potentially be more open, clear and challenging in their assessments. Gloria, from the local authority team, said that she was aware of this need for confidence:

thinking back to an assessment I did, now this was back in the 90s, I think I approached it exactly the same way I would as if it was a single heterosexual woman, as I would have done any other assessment. But I think actually what I learnt from that was this bit about people being resilient and positive and this particular person wasn’t in retrospect very secure in her own identity as a lesbian woman. When we started to place children with her they very very quickly homed in on that and really really quickly picked that up and actually became very abusive and because she wasn’t secure she wasn’t able to deal with that. I think we learnt a lot from that assessment about the need for people to be very secure about
themselves which is no different from other people really.

A more appropriately intrusive and challenging assessment of this foster carer might have revealed more about her lack of confidence and insecurity.

Chantelle from the independent fostering agency noted real changes in the placement of children with approved lesbian and gay foster carers when she thought back to her previous foster panel experience:

the panel I was on only had the one experience of each gender but the male carers were assessed and approved with no problem but they were never ever ever used in my lifetime in that job. So the politically correct thing was to put on your strap line 'you can be black, white, young, old, gay, straight,' but there's other ways to dodging the problem, which was that they never had children placed with them for whatever reason. that in itself raises other sort of questions. Just because you can be assessed as being able to do the job and get through that assessment process with whoever it is that approves you doesn't mean that someone else is going to agree and then use you as a foster carer.

Gloria in the local authority team made a similar point as that raised by Chantelle as follows:

When I worked in fostering in the 90s there was a very ambivalent attitude about whether or not we wanted to recruit gay or lesbian foster carers. on the one hand there was this message of 'yes recruit' but then there was also another message that was coming from the authority about 'oh God we're going to get headlines in the papers about recruiting gay and lesbian foster carers' we're going to get loads of negative publicity. I think actually we've moved on from that, I don't think that that's there anymore. I think that we now genuinely welcome people.

This local authority team went on to talk about their pro-active recruitment of lesbians and gay men, advertising in the gay press and the local authority fostering team providing information sessions at the lesbian and gay London Pride festival.

Assia, from the same team, noted the following changing attitudes of social workers about placing children with lesbian and gay carers:

I think we have learnt quite a lot on an individual level as well as on a professional level when we think about the assessment of lesbians and gay men as foster carers because I remember when I was in my previous team in child protection there was a same sex couple from an agency. one of my colleagues wanted to place children with that couple and it was a big issue for, not necessarily for the team, but particularly pressure was coming from various other teams, as well as from the child and their family and the Guardian who was involved. I think probably .... I
think in general we have moved on. We have done quite a lot and our approach and our attitude has changed in a positive way.

The independent fostering agency team had experience of working with heterosexual foster carers who were undertaking introductory work for foster children they were caring for where the new permanent family was gay. Janet noted changes in this area of practice:

My sense is that gay and lesbian foster carers and adopters have been well and truly established as in the mainstream in many London local authorities. So we’re talking about children, and these were two bright baby girls, who would be plum children for adoption: two of them! Two little girls; two children to die for. Now five years ago if you were gay or lesbian you would have taken the leftovers in terms of children for adoption, you would never have been offered the sort of child that people would be willing to fight for.

One of the dynamics that the Wakefield Inquiry (Parrott et al. 2007) noted was a degree of fearfulness on the part of the social worker, when assessing and working with lesbians and gay men, about being considered negatively discriminatory. This ‘fear’ was not evident in either of these teams. This might have been different in the past. They were aware of this potential dynamic and the Inquiry report had emphasized this for them. Susan from the independent fostering agency said:

It makes all of us sort of think because we are doing assessments with a variety of people, we have to address all issues. It showed me we can’t sort of back away from tackling issues because of our insecurities or for fear or beinglabelled as discriminatory so I think in that way it’s helpful to keep that in mind when you’re undertaking any assessment.

Gloria from the local authority also said:

I think the change is that we are more confident about lesbian and gay assessments. What I mean by that is that we are more confident about addressing the issues in the same way we would with any other carer. We’re not worried about being told we’re discriminating. We’re confident about explaining why we’re asking questions.

What was evident through the focus group discussions was that many of the recommendations of the Inquiry report (Parrott et al. 2007) for both these teams were already in place. However, they had considered the Report’s findings and for both teams they were reminded of the need for rigorous, thorough and analytical assessment of all aspects of applicants’ lives irrespective of their sexuality. Albert, a member of the independent fostering agency team, was considering his work in a new light as a result of the Wakefield Inquiry report. He was working with a heterosexual couple where the
detail of their relationship was gradually unfolding:

I’m referring to the couple who are taking time out from having children placed with them, who I met last week, the heterosexual couple. I think the whole Wakefield thing and talking about the psycho-social is so important. For that heterosexual couple really understanding the absolute importance of their relationship and how they are relating to each other and how that will have an effect on fostering, really breaking it down has been essential. I still see issues there and I think the sexuality and the relationship is absolutely critical in understanding and appreciating how those foster carers relate to each other and in turn relate to children.

Keisha, from the independent fostering agency team, summed up when she talked about some of the benefits of assessing lesbians and gay men as foster carers:

So what you’re looking for is resilience and the ability to deal with either the specific questions that their history brings to the fore or whatever other problems fostering might throw at them. Because in a way with a gay couple, I think, it makes it easier to find issues that they may have had to deal with in their lives that you can talk about and relate to fostering and looked after children. Whereas sometimes Mr and Mrs Conventional you struggle to find anything in their lives that’s been problematic that you can use to actually help them to get them to talk about how that might relate to fostering.

Summing up

Lesbians and gay men have experienced a period of unprecedented change in their social and legal position in the UK over the last twenty years. Those changes have been reflected in them being able to apply to be foster carers and where appropriate for them to be approved as foster carers. This small study showed that both the independent fostering agency and the local authority teams were aware of significant change in this area of practice. There were no obvious differences between the independent fostering agency and the local authority teams in what they discussed. Despite the varying levels of experience of assessing lesbians and gay men as prospective foster carers, this didn’t seem to impact on the quality or content of the discussion. This might be to do with the geographical location of the teams and the fact that both teams are located in areas that have diverse communities including significant gay and lesbian populations.

Both teams were thoughtful and reflective in the discussion about the practice detail of their assessments and both were focused on the paramountcy of the child. Both were relatively confident and were not overly concerned about being accused of being
negatively discriminatory. Both teams, through focusing on the assessment of lesbian and gay prospective foster carers, had considered the quality and the rigour of their assessment of heterosexual prospective foster carers, particularly regarding gender, domestic arrangements and sexuality. In addition the fostering teams saw resilience as being a key attribute that all potential foster carers needed. Overall the content of the discussions was quite different from the findings of the Wakefield Inquiry. However, retrospective discussions about practice that this study relied upon are not necessarily accurate indicators as to how people actually behave in the present or might behave in the future.

The social work practitioners in this study, when assessing lesbian and gay prospective foster carers, covered areas that they would address with all prospective foster carers, as well as those identified by Brown (1991) and Brown and Cocker (2008). The main change that can be noted from this research was the growth in confidence of social workers in undertaking this work.
Called to Serve: Zimbabwean Social Workers Employed in the British Welfare State

Introduction

Citizenship is commonly seen as a legal relationship between an individual and a nation-state, with entitlement to civil, political and social rights and services (Stasiulis and Bakan, 2005). In its narrowest sense, citizenship boils down to nationality; while in its comprehensive sense, it signifies membership in a self-governing community (Bauböck, 2002). As globalisation has increased the flow of people, ideas and goods across national borders, criticism of the nation-state has emerged, even as the power of the nation-state continues to be acknowledged (Butler, 2009).

Arendt’s (1966) proposition of the ‘right to have rights’ is adopted in this chapter to define a citizen simply as someone who has rights. This is a useful starting point in arguing for Zimbabwean social workers’ right to have rights within the workplace. Migrating to the UK as professionals locates these social workers within the initial framework of economic citizenship. The concept of economic citizenship ‘refers to the rights and rules through which people are incorporated into the labour market and to the expectations and obligations that employees, employers and societies have for work and employment relationships’ (Hann and Teague, 2012: 623–624). This chapter focuses on Zimbabwean social workers who migrated to the UK and claim citizenship rights in both this as their country of destination and their home country. Transnationalism refers to the process by which immigrants as part of a wider diaspora transcend national boundaries to sustain contacts and participate socially, economically and politically in more than one country, simultaneously (Portes et al., 1999).

Transnationality within the citizenship framework offers immigrants, like the Zimbabwean social workers in this study, opportunities to enjoy civil, political and social rights in both country of origin and country of destination (Bauböck, 1994). Against this backdrop of increased frequency, intensity and scale of movement across borders, this chapter addresses two main issues. Firstly, it challenges the traditional notion of citizenship being bound by territory and national collectiveness. Instead, it argues for a wider conception of citizenship beyond geographic space and symbolised by transnationality. Secondly, it problematises the exclusionary nature of the citizenship concept which does not take into account the issue of employment rights, at a time when the migration of professionals has become a global phenomenon. As long as economic and social rights are conceptualised as belonging to separate boxes (Lewis, 2003), immigrants will continue to suffer from lack of citizenship rights.

Zimbabwean Social Workers in the UK

Social workers have become part of an international workforce that moves across
borders, sometimes as individuals, at other times as a collective group (White, 2006). On other occasions, as occurred for Zimbabwean social workers, they come from the Global South, having been targeted to work in Western welfare states where there are labour shortages (Moriarty et al., 2008). Despite legislation limiting the number of newcomers coming into the UK, Zimbabwean social workers were recruited as exceptions because their skills were desperately needed. This policy applies to other groups similarly brought into the country (Eborall and Griffiths, 2008). The UK is not alone amongst countries overcoming labour shortages by importing workers from elsewhere (Castles and Miller, 2009) and contributing to a 'brain drain' when the departure of qualified workers leaves holes in the local economy as described below.

Recruitment of social workers from Zimbabwe has been detrimental to its social welfare provision, as non-social workers had to fill gaps left by social workers. Consequently, the planning and administration of statutory services and implementation of interventions at various levels in Zimbabwe suffered, thereby compromising welfare delivery (Mupedziswa and Ushamba, 2006). The loss of trained personnel by developing countries raises moral and ethical concerns and activist pressures (Dominelli, 2005), which led the UK to formulate the Social Care Code of Practice for International Recruitment (SCCIR) in 2006. The SCCIR was launched to guide employers over the recruitment, induction and training of international social care staff and provide guidance to overseas workers in terms of their entitlement to individual and legal rights (SCCIR, 2006). Historically, social work theories, skills and practices were exported to the Global South. To this day, the direction of international social work especially regarding knowledge transmission is defined by power relations, with most contributions coming from developed states (Hugman et al., 2010). As the migration of social workers from the Global South has become more visible, there is now the challenge of re-conceptualising social work training and practice to cater for social workers training in one country but practising in another. Also, considering how migration patterns have become circular rather than linear (Abye, 2007), international social work needs to start focusing on particular social issues through a transnational lens (Hugman et al., 2010).

By focusing on Zimbabwean social workers working in one particular local authority in the UK, this chapter participates in and contributes to broader theoretical and policy debates on citizenship as symbolised by: (1) transnationality; and (2) citizenship's failure to address the 'right to have rights' within the international labour market. The local authority relevant to my study was strategically selected for being one of the largest employers of Zimbabwean social workers in the UK, employing at least 60 of them at its peak. This chapter is based on 24 in-depth interviews with Zimbabwean social workers and 14 questionnaire respondents. Their stories as overseas social workers exposed: the lack of preparation even for those explicitly recruited to staff
social services; the many forms of exclusion that these workers endured; and their resilience and perseverance in pursuing citizenship rights. Their insights for survival will be useful in helping new arrivals in the social work labour force become more supported in the settlement process and successfully claim cross-border citizenship rights.

**The Meaning of Citizenship**

The majority of the Zimbabwean social workers had a broader conception of citizenship shaped by the history of European imperialism (Ong, 1996). With Zimbabwe being a former British colony, Zimbabweans are citizens of a Commonwealth country. This accords those residing in the UK political rights such as voting in local elections. Other countries usually grant voting rights primarily to those with formal citizenship status (Baumböck, 1994). By allowing non-citizen residents to participate in elections, the British state is acknowledging the transnationality of citizenship without recognising it as an integral part of the dual citizenship that it allows. And, Zimbabwean social workers as immigrants continued to suffer from diluted citizenship rights (Stasiulis and Bakan, 2005). In contrast, when white British settlers went to live in Zimbabwe, they claimed more citizenship rights than local Zimbabwean people who were not allowed to live in some areas, visit some places or even exercise freedom of speech, among other things. British colonialism denied them citizenship rights in Zimbabwe where they were the original inhabitants, as occurred with Indigenous peoples elsewhere (see Chapter 3, this volume). Decades later, Zimbabwean social workers are claiming citizenship rights in the UK. Ryan describes their pragmatic attitude thus:

> It is our turn now. It was OK when these people [British imperialists] came to our country and took our gold and our land and settled us in crowded places, while they had big houses with swimming pools and everything. Now we come here to work, not to steal from them, they are complaining about immigrants.

In pressing for citizenship rights in the UK, Zimbabwean social workers exercised agency and highlighted non-geographic citizenship by claiming citizenship rights within and outside their home country. Zimbabwe has policies that exclude Zimbabweans living in foreign countries from acquiring dual citizenship. This strips Zimbabweans of voting rights, and is linked to Zimbabwe’s failure to generate policies that can mobilise its emigrants to invest in the country (Pasura, 2008; McGregor, 2009). These policies have prevented Zimbabwean social workers from enjoying the full benefits of transnationality ‘back home’. Nevertheless, they continue to send remittances to Zimbabwe and actively seek information about and participate in transnational social and political activities like attending Zimbabwean weddings and fundraising for Zimbabwean political parties. Also, the Zimbabwean government
desperately relies on Zimbabweans outside the country as sources of foreign currency, to the extent that the Reserve Bank homelink initiative was launched in 2004 to encourage Zimbabwean migrants to transfer money ‘home’ through official channels (Pasura, 2010). Traversing national borders has allowed Zimbabwean social workers to support the people they left behind, during a period when Zimbabwe suffered from an economic crisis and political instability (Tinarwo, 2011). And, Zimbabwe’s restrictive policies have not stopped Zimbabwean social workers from continuing to enjoy citizenship rights in Zimbabwe. They mentioned that when they go to Zimbabwe, they simply hide their British passport and act like an ordinary Zimbabwean citizen. however, other countries, such as India, Mexico and Ethiopia, now have policies that encourage dual citizenship and those living abroad to participate and invest in their home countries (Newland and Tanaka, 2010; Chapter 9, this book). Below, I discuss Zimbabwean social workers’ journey in their quest to develop careers in Britain while claiming rights to citizenship there.

**Settlement and Career Progression**

England and Henry (2013: 569) argue that ‘a more expansive understanding of citizenship would involve greater valuing of not only care practices but also the range of people providing that care’. From the experiences of the overseas social workers under study, this is lacking within the British welfare system, although the development of the social care code of practice for international Recruitment (SCCIR) could be interpreted as an attempt to address this gap. One principle in the SCCIR refers to assisting international social care staff to acquire a level of knowledge and proficiency equivalent to that of a UK-trained individual, after their induction period. A closely-related principle states that appropriate information, support and induction should be given to international social care staff to enable them to settle well. however, there are no clear guidelines as to what sort of information or support should be provided. While the SCCIR attempts to extend employment rights to overseas social workers, it falls short as support systems for effective implementation and sustainability are weak (Martineau and Willets, 2006).

When Zimbabwean social workers arrived in the UK in 2001, they did not receive the full induction they expected when they started. Yet, employers are responsible for ensuring appropriate induction and training of their workers and displaying greater acceptance and equality in their treatment of immigrants. Brenda, a study respondent, commented:

> The local authority just assumed that we knew what to do. The British can be very ignorant sometimes and we were victims of their ignorance. We were not told what to do, there was no induction, no job shadowing. I remember going to a service
user’s house for the first time and thinking, should I be serious, should I smile?
The Zimbabwean social workers took it upon themselves to make sure that their
employer would develop an appropriate induction package for overseas social workers.
Tino explained:
A few weeks into the job, we sat down with our managers and told them that we
needed an induction and we were going to let them know exactly what we
expected from them, which areas to focus on and so forth. Then they would also
add any information they deemed necessary.
Another issue was that the Zimbabwean social workers had to start at entry grade
despite having years of experience. Most of them expressed their disappointment in
the system which only wanted to know about their Social Work Diploma, regardless of
their having further qualifications. Their employer had no system in place to assess the
Zimbabwean social workers’ existing knowledge effectively or promote them rapidly in
a way that was commensurate with qualifications, knowledge and skills. Thus, for these
immigrants, the route to any dimension of citizenship, even economic citizenship,
remained a site of contention as they continuously struggled for greater recognition
and rights (Stasilius and Bakan, 2005). While the majority of the Zimbabwean social
workers were not satisfied with their progression to senior posts, at the time of the
interviews (seven years later), most of them were by then senior social workers, a
number had become senior practitioners and three had become managers.
Almost all of the participants commented that that they had training opportunities
equal to those of the British social workers. They had undertaken lots of in-house
training and had completed their Post Qualifying (PQ) training. Others had obtained
qualifications from the local university in various fields, including management,
teaching and international relations, and their employer had paid all their costs. In
terms of professional development, the Zimbabwean social workers felt that they
enjoyed the same rights as full citizens. however, they faced additional problems such
as exploitation and racism, which I now turn to.

**Exploitation and Racism**

the concept of citizenship has in recent years been extended from national to
post-national citizenship where immigrants who reside within the nation-state claim
entitlements to enjoy social and welfare rights previously limited to citizens (Bauböck,
1994; Soysal, 1994). Zimbabwean social workers employed within the British welfare
state had a degree of access to social and legal rights through professional bodies and
trade unions, and this distinguished them from other economic migrants, especially
those without specific links to the UK. According to these research participants, their
problems were mostly related to the discriminatory nature of the UK labour market, which operated as a major barrier to these social workers’ engagement in citizenship making processes. Some social workers talked about getting to the office on the first day and realising that their employment contract had been changed unilaterally. Sue remarked:

While we were still in Zimbabwe, they [recruitment agency] told us that we would start at a higher grade, promised us more money and showed us the contract … but when we got here it was a different story and a different contract to sign.

Due to unequal power relations, recruitment agencies took advantage of their relationship with the overseas social workers. The social workers said that they did not know where and how to report such practices and also feared that reporting the issue might have resulted in losing their jobs, and consequently disrupting their fastest route to citizenship. The lack of one standardised document on migrant workers’ rights meant these workers are not aware of their rights nor do they know how to claim them (Brah, 1996).

Zimbabwean social workers felt that racism was rife within the employing organisation. As Panashe puts it, ‘the element of, you could say racism, is there, we have to work harder than everyone else for our efforts to be recognised’: however, some of the social workers were reluctant to mention the word ‘racism’ and used phrases like ‘unequal treatment based on colour’ or ‘ethnic discrimination’. Because their qualifications and work experience were devalued, the Zimbabwean social workers felt that the employing organisation’s policies and procedures disadvantaged them and, being part of an ethnic minority group, they could not challenge this. Other immigrants share the same experiences of ‘indirect racism’ (Layton-henry, 2002; Pasura, 2008; Vasta and Kandilige, 2010). The Zimbabwean social workers also commented that within the employing organisation, policies like the Equal Opportunities Policy, Equal Pay (Amendment) Act 1983 and the Race Relations (Amendment) Act 2000 were just there on paper. If this gap between principles and practice can be narrowed, immigrants may get nearer to enjoying the same level of rights as their British counterparts.

**The Zimbabwean Social Workers Association (ZSWA)**

It is within the context of Zimbabwean social workers’ existence at the margins of citizenship that the Zimbabwe Social Workers Association (ZSWA) was formed. The Zimbabwean social workers came together to create their own space of resistance within which they negotiated and continued to act as active citizens. Kai explained:

We were having problems left, right and centre, social problems like securing a house to rent, money problems and professional ones, of course. We then decided to
come together and form the Zimbabwean Social Workers Association.

As Arendt (1966: 298) argued, ‘the right to have rights, or the right of every individual to belong to humanity, should be guaranteed by humanity itself’. The overseas social workers took it upon themselves and collectively through the ZSWA to provide housing to newly-arrived Zimbabwean social workers. They would also meet up and share experiences, giving each other social support, financial assistance and professional guidance. Also, these social workers realised that they could have more power and negotiate better as a group. The ZSWA negotiated for an increase in their relocation package and helped to prepare a more comprehensive induction package, which tried to address problems that those who had immigrated earlier had encountered. As a group, they also voiced their opinions when they felt they were being treated unfairly or as outsiders. however, there came a time when the Zimbabwean social workers no longer needed the help of the ZSWA to claim rights in the UK, and they abandoned it. After serving for five years as economic citizens, the Zimbabwean social workers qualified for ‘indefinite leave to remain’ in the UK and, one year later, they were eligible to acquire legal status as British citizens which gave them full political and social rights, when the majority of Zimbabwean social workers felt a shift of power in their favour. Tinashe reasoned:

You see, the good thing is we only had to put up with that [treatment of overseas social workers] when we were still on their work permit for about five years, then, from there, I had my indefinite leave to remain so I had the freedom and flexibility to work wherever I wanted to, so I got out.

The Zimbabwean social workers talked about how the red passport (referring to the British passport) enabled them to travel out of the UK and back freely, emphasising the transnational nature of their citizenship. They also mentioned that as British citizens, they could change employers easily, access social welfare benefits and pay lower rates of university fees for their children, among other things. For the Zimbabwean social workers as transnational actors, acquiring British citizenship meant that Britain had finally become a ‘home’ away from home.

Conclusion

This chapter argues for a wider conception of citizenship that extends citizenship rights beyond the country of origin. This practice of transnational citizenship is evident in the way the Zimbabwean social workers demanded civil, social and political rights in both Zimbabwe and the UK. It was, however, challenging to access some citizenship rights such as voting in Zimbabwe where government legislation excludes emigrants by not recognising transnational citizenship rights. The Zimbabwean social workers’ ability to
claim citizenship rights within the UK while retaining links and connections to Zimbabwe challenges the classical notion of citizenship as defined by the nation-state, to show that the boundary that separates citizens from non-citizens is not legally fixed, but permeable, fluid and negotiable (Jones, 1994).

The British state facilitated transnationality by, for instance, allowing the Zimbabwean social workers to participate in UK elections even before they acquired British citizenship, developing codes of practice like the sciiR that addressed the needs of overseas workers and offering these migrant workers dual citizenship after working in the UK for five years. The experiences of the Zimbabwean social workers, however, show that these efforts made by the state have been paralleled by structural barriers to accessing employment rights; and Zimbabwe's rejection of citizenship rights. The workplace became a major site of exclusion for immigrants during their transition period to become citizens, which took five or more years. Therefore, it is important that Western states realise that economic citizenship is not just about the enforcement of employment legislation (hann and Teague, 2012). It is, as it was for the Zimbabwean social workers, a social process which facilitates citizenship awareness and the enjoyment of their rights.

This chapter argues for an expansive definition of citizenship where employment rights and transnationality should fit within the citizenship framework. The Zimbabwean social workers experienced many forms of exclusion in pursuing transnational citizenship in the UK but, with hard work and determination, they became involved in citizenship-making processes in their country of destination until they acquired full legal status as British citizens.

**Note**

All names are fictitious to ensure participants' anonymity and confidentiality.
Support for Different Service Users: Empowerment, Maintenance, Containment
5. Support for Different Service Users: Empowerment, Maintenance, Containment

This chapter describes three types of support – empowerment, maintenance and containment – and considers the service users who can benefit from these. The difficulty of providing support for some service users is recognised (e.g. those at risk of abuse, with personality disorders or brain damage).

Two pointers to good social work practice ring true across the decades. First, Eileen Younghusband considered that social work can help service users 'make a better go of it with themselves and others and have a bit more elbow room in their social circumstances'. Even quite small adjustments can make a significant difference to an individual – for example, access to a chiropody service can allow him to walk to the shops and reduce his sense of isolation. I learnt so much from the occupational therapist in the office on what to look out for when visiting older people at home. A half-day training should be part of everyone's knowhow (e.g. the difficulties with low chairs, risks with dangerous mats, poor lighting, trailing wires, kitchens, bathroom grab rails, etc.).

Second, Donald Winnicott told the Association of Social Workers in 1965 that social work 'counteracts the disintegrating forces in individuals, families and local social groups'. This was a rallying call to social workers not to give in to the negative forces in society. This determination is still present in every healthy social work office, protecting and working with vulnerable clients. As in Jill's tale (page 39), social workers need to look at the different points of view in any family situation, and decide which matters most. Marlene (page 94) supported her client against the housing department, the police and the medical profession, and found a good outcome for all.

Social workers need to be perceptive, curious to the client's real needs, interested in the person behind the problem, and good organisers. They are effective when they make accurate assessments of needs, and provide services to meet them; have knowledge of local resources relevant for the client; and provide counselling and ongoing support when necessary. A mental health service user told a working group that his social worker under-stood his earlier family problems. He felt she was interested in him, and not just his illness.

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Understanding why a client was suicidal

A colleague, a manager in a community mental health team, was short staffed so she had to provide the client's medication instead of the community psychiatric nurse. She was surprised to meet a young man at home who had recently made a serious suicide attempt. In conversation she asked what had driven him to such drastic action. He explained that he had just been diagnosed HIV positive. His need for reassurance and information needed to be met – and not necessarily with doses of strong drugs!

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EMPOWERMENT, MAINTENANCE, CONTAINMENT

Empowerment

Each team worked with slightly different groups of vulnerable adults. Each had varied characteristics. Most of the District Team’s work was focused on ‘empowerment’, the public agenda of social work with its offer of hope, transformation and personalisation for the service user. This gives a sense of practical and emotional betterment, and an easing of hostile landscapes. In this relationship, a service user’s necessary dependence, provoked by troublesome life events or ill health, meets an empathetic response from the social worker and from society. The social worker supplies the necessary ego support for the service user to bring about change, along with practical knowledge to access resources.

Valerie – empowering a client after a stroke

‘I had one couple where the husband had a stroke just after they were married. He was unsteady on his feet and had little strength in his left arm. His wife was always anxious, saying he had frequent falls and often rang the ambulance to collect him. She wanted him to move to residential care. I told her he couldn’t go there as he could still do his personal care – but she did not believe he could cope.

He eventually agreed to go into sheltered accommodation if available. He was given a place in the borough but then said he wanted a motor scooter. I didn’t think he could manage one but he bought it anyway. Last month I was up in town and saw this person riding towards me and I thought “I know that man – and it was him!”

If I had believed his wife rather than listening to him, he would have ended up in a residential home and all his skills would have gone. He then booked a holiday, arranged all the transport and took himself off. Although the staff were quite concerned, he had a great time. I was really pleased for this gentleman. This is a success however you look at it!’

Maintenance

Those vulnerable people who need physical care, often permanently, were evident in the Hospital Team and the District Team. I use the term ‘maintenance’ to describe the care they were expected to receive – that is to help maintain the skills they still possessed. The requirements of meeting the discharge legislation reduced the social workers’ freedom to reach an independent decision. At times they felt ethically conflicted. There is a major responsibility in helping these vulnerable service users to maintain or regain the individuality that is easily lost in an institutional environment. The specialist team for the homeless mentally ill was successful in placing many of its clients in supportive hostels.
Sheila – maintaining support for a client with cerebral palsy

Sheila worked in the District Team, reviewing all the out-of-borough placements for the under 65s. Clive aged 50 had cerebral palsy and lived in a sheltered home in Wales, run by a charity. Sheila had visited every six months in recent years and knew him well.

Clive’s parents had been relieved to see him happily settled, and to know before they died that he was safe and his future was secure. He had a voluntary job helping twice a week in the local library. He and a friend from the hostel were also regulars at the local pub, enjoying the company and quizzes.

Then the charity dropped a bombshell. It would no longer provide homes for adults with cerebral palsy. Everyone in the hostel would be made homeless. The local council would house those in the borough – but the rest were likely to be evicted for their home authorities to sort out. Clive was terrified that he might have to move back to his parents’ borough which he had left as a teenager and where he knew no one.

Fortunately his friend’s sister advocated for both Clive and his friend to stay within the area where he had lived for over 20 years. Sheila was supportive with long-distance calls and visits. She and her manager visited, and were able to reach a deal with the local authority to continue to house Clive while the home authority paid. Whew – and no thanks to the charity!

Containment

The third intervention, I call ‘containment’ – when the behaviour of service users extends from the erratic and demanding, which was fairly common in the District Team, in patients with dementia or Alzheimer’s in the hospital, to acute or chronic mental distress and psychosis covered by the Mental Health Team. The term ‘containment’ may imply more passivity than is meant – help for distressed and difficult people to sustain relation- ships with those who can affect their circumstances is a demanding and active process. These service users, living with chronic and ingrained problems, needed longer timescales of supportive intervention to effect any change in their approach to dealing with life’s problems.

Following on from a successful pilot study ‘Reaching out: think family’, the government set up the Troubled Families Programme in 2012. Local authorities applied for funding for families where no adult was in work, children were not in school, and family members were involved in crime or antisocial behaviour – our old ‘problem families’ of the past. Additionally domestic violence, relationship issues and mental and physical health problems would often be present. The intention was to ‘turn round’ 120,000 troubled families across England in three years. Some key improvements were being measured in the families. Unfortunately, as some leave the programme ‘cured,’ other welfare cuts are pushing more families into this category.
Mrs Y – providing containment for an agitated client

Mrs Y had asked the home carer to collect her children from school. The home care provider had rung the office for advice on a Friday afternoon. Leroy, the duty senior, told me that the office had commissioned an hour and a half’s home care Monday to Friday to help her around the house. He rang Mrs Y and had a courteous but firm conversation with her. He explained that these carers were paid to help her in the house, and that they were not allowed to do child care tasks – only the carers from ‘children and families’ were authorised to do that.

Half an hour later, Sara, the administrator, leant over and said that Mrs Y had phoned back and cancelled the care service as she intended to commit suicide and would not need it. Leroy contacted her again, stressing that his service could not collect children. He was supportive but firm. She said she was going to kill herself and put the telephone down.

Leroy’s discussion with Mrs Y reminded me of similar conversations that I had held in the past with ‘problem families’, when required to set boundaries in a reasonable and almost parental manner. It made me feel quite at home. His calm manner on the telephone suggested Mrs Y was well known to the team. She might have been one of a number of service users who easily became angry or hysterical at the unexpected or in order to get her way.

The home care provider rang an hour later to say Mrs Y had left the house to collect the children. The carer, who had been there for the hour and a half, did not know whether to leave. Leroy advised that the carer should write a note and also return on Monday as Mrs Y was rather volatile and not good at thinking.

Mrs Y did not fare well with her social work contact. She had been told the following Monday both by the District Team and the children’s team that she needed to contact the other, so had rung back in understandable confusion. Rich, another administrator, tried to find out how to amend the contract with the care providers. He discovered that as her carers were paid for by two departments, the departments needed to agree which was the lead agency. The lead agency would then have the power to alter the contract. Until they had agreed that – although it was unclear who ‘they’ were – nothing could be done. Like Mrs Y, I was left unsure if anyone was going to help unravel this Kafkaesque muddle.

Two months later I heard Yvonne, a social worker, ask Andy, the area manager, what she should do as her telephone conversation to reassess carer support for Mrs Y had gone badly. Should she visit to assess her need for home care? Andy suggested she should ask the care agency for feedback on any problems and asked ‘She wasn’t horrible to you, was she?’ Yvonne replied that Mrs Y had tried to be.

I longed to champion Mrs Y’s need for some face-to-face contact rather than the telephone calls, which she appeared to find so difficult. Her outbursts may have affected her reputation as staff seemed to be wary of an assessment, just like Leroy weeks earlier. The continued use of telephone calls seemed a defensive action to ward off involvement.

When planning an intervention with a client, the social worker has to assess in which areas the client needs help. While maximising independence for service users with physical or learning disabilities, the social worker may recommend more practical help with both ‘maintenance’ and ‘containment’ aspects.
DIFFERENT SERVICE USER CONDITIONS

The spectrum of service user dependency

Figure 2.1 illustrates the dynamic flow of a person’s dependency needs from social engagement to depersonalisation – the way these change and increase with age, but also decrease for children as they grow and reach maturity. The horizontal axis represents independence – dependence, the service user’s expressiveness and emotional situation. Service users who possess individuality and the ability to engage with others lie at the left of the axis; those with greater dependence around the middle; and those with loss of individuality lie to the right of the axis – where they risk being objectified by the system, and then depersonalised and at risk of abuse.

Mr J – mentally infirm and becoming depersonalised

The social workers in the Hospital Team worked with those who were often isolated, with no family, memory or social skills to express their individuality. At a multi-disciplinary team (MDT) meeting the staff nurse talked of Mr J – ‘The nursing home wants him transferred’. ‘They are usually pretty good. Why’s that?’ asked the social worker. ‘He’s fine in hospital but he’s quite antisocial with them. He pees into cups and does other horrible things. So they want him to have an elderly mentally infirm assessment’. The risk for such vulnerable service users is that they become objectified and then depersonalised within the care system.

Vulnerability of service users can easily lead to exploitation and abuse. Social workers and others in the field (e.g. police, health workers, teachers) need support to have the inner confidence to recognise and think the unthinkable – and ask questions such as: ‘Is this parent putting the vulnerable child’s needs first, or are they exploiting or ill-treating them (e.g. sexual abuse in the family)?’ There is considerable unconscious pressure to fall in line with the rest of society and believe that all is well. But we are appalled when a group sets up a vindictive witch hunt in response to an individual’s tale (e.g. the abortive high-profile police investigation into claims of a Westminster paedophile ring on the basis of a single witness).

A social worker told me about attempted exploitation

‘My client has a younger sister who didn’t want to know them and was not interested in their life. That changed when my client was awarded £1.5 million in damages for birth injuries. All of a sudden this other sister came out of the woodwork and gave up her job to look after her sister and mother. She now has power of attorney. Both mum and daughter are asking how they can get rid of her. The sister is saying that they are both mad. They accuse her of trying to take the money and she wants them put away in a home’.
Society's ambivalence to dependence and long-term needs undermines the provision of support. Regrettably society values throughput and cure rather than support and marginal improvements. But social workers also require adequate support to understand and withstand the emotional and intellectual pain projected into them by these 'hard-to-reach' or psychologically damaged clients, while still exercising measured thought and judgement (as observed by Andrew Cooper6).

Service users in the District Team, though often dependent, were mainly able to engage the social workers in a joint project to maintain or improve their daily lives. They are shown at the left of the axis in Figure 2.1. Current policies for social workers to empower service users support this group well. However, cuts in the Disability Living Allowance in 2015 had damaging consequences for mentally ill service users and physically disabled people. Hospital service users were often at the maintenance/dependence stage with growing numbers deteriorating such as Mr J.

Being a specialist group, the team for the homeless mentally ill worked mostly with people with chronic symptoms. These service users needed long-term support, based on maintenance and containment. The team's major irritant was that sheltered hostels, which provided the right balance of support and independence, often limited a client's stay to two years when it was needed permanently. The local community mental health teams and their specialist groups took all other referrals, including people with anxiety, depression, schizophrenia and bipolar disorder.

**What is a borderline personality?**

Children are likely to grow up into troubled and troubling people if they have had no containing adult to help them develop the ability to feel and think. They are likely to require the support or intervention of social welfare agencies. Lacking positive relationships in everyday life, they have no internalised good experiences inside themselves. Due to indifference, neglect or cruelty, the infant is denied a nurturing relationship with the mind of his care-giver, and therefore misses subsequent opportunities for developing a mature mental apparatus.

**A deprived mother without the internal resources to provide care**

Jenny and I bonded when we spent two hours together in a traffic jam trying to reach a mother and baby hostel in the rush hour. We failed and Liam, her two-year-old boy, had to stay with an elderly foster carer. The mother was a waif-like girl, needy and impulsive. We sat over cups of tea while she described her ideal job – being a waitress in a café putting flowers on the tables and bringing lovely meals to the customers. Meanwhile it proved hard for her to make a home for them both – which was our shared loss.
The behaviours that make up the clinical syndrome of 'borderline personality' are also recognisable in many service users – including impulsiveness, unstable but intense relationships, identity disturbances, mood instability, inappropriate and intense anger, frantic efforts to avoid abandonment, suicide threats, a feeling of emptiness and boredom.

Most service users with borderline personalities, through ill-treatment in infancy or from early trauma, have a serious problem in functioning in the world. They were typical of the mothers of my children in care and featured in the workload of all three teams. They cannot easily think through day-to-day events and relationships. A small proportion of such clients take a high proportion of social work time. People need to be able to use words and thoughts to sort through current and past anxieties. The Mental Health Team was structured to provide them with effective help, and the District Team also made considerable effort with such clients.

**Well-known clients thrown off a flight for drunken behaviour**

When I asked interviewees to 'tell me about a case that is giving you grief', examples often came from confused and complex families, known to the social services for decades. Those with borderline characteristics were often mentioned. The national news was dominated once by a family of eight aged from 35 to 70. They had been thrown off a charter flight after an emergency landing due to drunken behaviour. They turned out to be well-known clients – a troubled family who had aged but not matured!

**Service users suffering from severe trauma**

In her case studies on survivors of disasters, Caroline Garland8 shows the devastating effect of severe trauma on an individual's mental apparatus. In a state of shock, the victims lose the ability to manage and contain their feelings, even losing the power of words. In the same way as a newborn infant, they try to manage the flood of terrifying images by projection on to those around them. This impacts on their ability to recover:

Since the capacity for symbolisation (using words to represent a feeling or event), and for thinking 'about' something such as an event which itself is over, is a necessary part of working through – of dealing with, of laying to rest – a psychically painful experience.

Garland points out similar assaults are made on an individual's mental structures if they are a victim of less dramatic though equally pernicious traumatic events. These can include physical or sexual abuse, abandonment by a parent, divorce, loss of employment, the death of a child, and other events. Many users of social care services have been such victims. For example, a psychiatrist friend conducted a small survey of
patients on a female acute mental health ward. She was shocked that most had been sexually abused in the family as young girls. There is a danger that people who work with them can be unaware of or inured to the damage they have suffered.

The value of words to banish post-traumatic stress disorder (PTSD)
A few years ago there was a programme on Remembrance Day which included a veteran of the Korean War. He had been an 18-year-old conscript and spoke of the horror of the battlefield and his nightmares throughout his life. Then the previous year, a friend asked him to talk to the school cadet corps about his wartime experience. After some prevarication, he eventually agreed and prepared carefully for the talk, which was well received. To his astonishment, he had no nightmare that night or subsequently.

Service users who depend on others for their care
A large group of people who seek help from the social services have physical or mental frailties and are dependent on others for their personal care. Paul Hoggett notes that 'there is a deep-seated hatred of dependency within our culture which needs to be understood'.9 This hatred, which disguises our deep fear of being dependent ourselves, can lead to dangerous outcomes – as shown by the abuse of young adults with learning disabilities in hospital care (e.g. at Winterbourne View10), or the murder of a vulnerable man in Bristol with learning disabilities who had sought help from the police.

To avoid projecting this fear, we need to acknowledge our own needs. He adds: We all occasionally struggle not to be overwhelmed by feelings and, to the extent that we cannot find the inner resources to contain and give meaning to what we experience, we depend upon others. We depend upon them for reassurance and empathy, to show the strength and confidence in the future that we ourselves cannot at that moment find or just, simply, to be there, reliably and attentively, with us. We call this care, something all of us give and receive.

Social workers recognise the importance of providing a relationship, but also the importance of maintaining a boundary against the sometimes seemingly endless demands of the service user – being clear about the social worker’s responsibility and that of the client. The introduction of care management in the 1990s brought about a diminution of the perceived relevance of the social work relationship. Cases are ‘closed’ after the first review as departments attempt to avoid long-term supportive commitments. However, the District Team successfully managed to provide a core of service users with ‘good enough’ long-term help.
Patrick – able to live in the community with chronic schizophrenia

Patrick was a family friend whom we met every Sunday evening for a drink and meal for over ten years. He had a psychotic breakdown suddenly in his early thirties. After the initial shock and distress to his family and friends, he was fortunate in having the intellectual and financial resources to keep in regular employment between episodes. He gave me much good advice over the decades, such as ‘They ought to give us psychotics key workers’ and ‘Next time I would like to stay at home, looked after by my key worker’. And why not? That came straight from the horse’s mouth!

He relapsed regularly, but he then had a progressive illness to manage on top of this. His remaining family wanted the best for him and thought he should move into a residential home. But he was reluctant to do this. His social worker supported his view and found a regular carer for him. With that support and a simple routine, he continued to live in his own flat in the community.

UNDERSTANDING SERVICE USERS

The next section explores psychological models that throw light on the behaviour of service users. A deeper understanding of service users requires exploration of family relationships and child development. The quality of childhood experience and upbringing has a profound effect on a child’s development.

Mental development early in life

The concepts of ‘attachment’12 and ‘resilience’13 currently inform our attempts to care for children, young people and the socially excluded. To make effective interventions, social workers need to understand the building blocks and nuances of early parental relationships that help children to become resilient through secure attachments with parental figures.

An infant is born totally dependent on his mother or mother substitute. Even before birth, the mother has influenced the development of her baby through her lifestyle and moods, including the use of alcohol and drugs. If she is fearful, perhaps in a violent relationship or anxious, this will be sensed by the baby in the womb. At birth the infant is a collection of sensations held together in his or her skin. The baby gradually develops understanding of his or her boundaries, ‘me’ and ‘not me’, and of the arrival of life-sustaining food and love from the mother. But in the first days and weeks, the infant can brook no delay between catastrophic hunger and this being assuaged.

So often a friendly tip can sort out a potential problem

I remember sitting up in bed in a long Nightingale Ward, tearful and anxious with a three-day-old baby bellowing in my arms. A lovely nurse suggested I drew the bed curtains, stripped myself and the baby, and had a bit of ‘skin time’ to get to know each other. This was perfect advice!
The baby lets the mother feel his persecutory phantasies of ‘no food’ in his screams of distress. But as the weeks go by the baby begins to grasp that hunger, food and satisfaction are interrelated. Wilfred Bion14 says that ‘an understanding mother is able to experience the feeling of dread that her baby was striving to deal with by projective identification and yet retain a balanced outlook’. A mother needs to be psychologically strong enough to accept the infant’s feelings and continue to express her love for the baby when feeding or holding him. The baby takes in and internalises this love as a loving relationship in its psyche, just as he digests milk.

When the distressed baby projects his fear and hate into his mother, she acts as the ‘container’ of her infant’s fears and terror. In her reverie she creates dreamable and, later, thinkable good feelings for the baby to ingest and imagine. Quiet rocking and crooning provide the calming reassurance babies need. These are the outward signs of this process of containment and reflection. The infant will eventually internalise this capacity to manage his feelings and thoughts, and develop his own ability to contain, understand and give them meaning through the use of words.

What happens if the mother cannot cope?

But sometimes a mother feels her baby’s panic and terror as her own. This can immobilise her adult caring capacity. If the mother is unable to act as a receptacle for the baby’s projections, he may continue to project feelings of hate to rid himself of the persecutory phantasies from his unmet need for food and love. This can lead to a deadening passivity and the destruction of the infant’s impulse to be curious, on which his learning and development depend. It might also lead to hatred of others as the withholders of all good things.
The effects of crack cocaine addiction on the daughters of addicts

Twenty years ago there was an epidemic of crack cocaine use in the local housing estates. Fifteen or so years later, a handful of very young mothers were referred for assessment to the charity, St Michael’s Fellowship. They were unable to respond to their babies in an empathetic and reassuring way. They had received no love or emotional care from their addicted mothers, and had failed to build up a store of good feelings inside themselves with which to reassure and love their own babies.

The mothers could not put their babies’ needs before their own needs. They experienced the baby’s cries as an accusation of inadequacy which made them feel terrible. They had expected their babies to give them the unconditional love their mothers had tragically failed to provide.

Occasionally another nurturing adult can step into the gap left by the neglectful mother – an auntie or nana – and provide the young child with the needed affection. But without that opportunity, the child is likely to need an alternative carer. Social workers are faced with the challenge of supporting service users from this background and confronting the truth when a mum cannot put her baby’s needs first. There is a need to help such women find a way forward to live a sustainable life in the community without their children who have new carers.

A facilitating environment to allow positive feeling when away from mother

Donald Winnicott identified ‘potential’ or ‘transitional’ space between the infant and the mother as space of creativity and play. He and Clare Winnicott also explored transitional objects from their work with young evacuees. He considered the way that babies acquire ‘transitional objects’, that not-me but yet very close object, for example a piece of muslin, a teddy or a blanket. He noted how these can act as a symbol for a mother’s actual presence at the boundaries of sleeping and waking, of being together and separating. He believed the baby invests the object with meaning and content, which enables it to stand in for the mother in other situations. This allows transitional objects to be an emotional lifeline to many small children, giving them the sense of security needed to manage new strange situations.

My granddaughter’s transitional object

At the end of the day my three-year-old granddaughter wanted her ‘Duckie’ to join in her game of Lego. Reluctant to climb two flights of stairs, I offered her another teddy. ‘Oh that’s just a toy – I need Duckie’, she said, making it clear that the latter was far more than a toy.

The facilitating environment can contain and hold the baby in the mother’s absence.
The infant can manage to be alone and separate, if there is the sense that 'the mother is reliably present, even if represented for the moment by a cot, pram or the general atmosphere of the immediate environment'. This can take place at an early stage, with the amount of ego support needed from the mother gradually reducing. Eventually the infant is able to tolerate the actual absence of the mother. Flash-backs can occur in adulthood when there is a particular positive feel about a place or situation. Proust had madeleines dipped in tea – I find shadows of leaves on a wall take me straight back to rest time as a toddler.

**Acceptance of the relationship between parents**

Ron Britton suggested that, while the main focus of this stage in the child's development is the relinquishing of an exclusive relationship with one parent and the mourning of that loss, the child's acceptance of the parents' joint relationship provides another perspective. By accepting it, the child is now part of a triangular relationship. This gives him the potential to be 'a participant in a relationship observed by a third person, and being an observer of a relationship between two people'. Many parents have seen their children resist acceptance of the second parent – 'Let Daddy speak!' is a common plea – but by the age of four, children are confident in both parents' love and can let them talk together uninterrupted.

The triangular space formed by these benign relationships serves as a space outside the self, called 'the third position'. This is then 'capable of being observed and thought about'. In this third position, the child can not only observe the relationship between his parents but appreciate that he too can be observed. This lets us 'entertain another point of view while retaining our own, to reflect on ourselves while being ourselves'.

Peter Fonagy describes the ability to form representations of other people's thoughts without direct experience oneself as 'the capacity to conceive of conscious and unconscious mental states in oneself and others'. He thought this mental development, linked with the development of concern and empathy, probably starts in a child at the end of its first year and becomes fully active at the age of three or four. It is always so touching when young children start to express concern for their care-giver – for example, sharing food, making sure they are warm, etc.

Someone who has no empathy or concern for other people at all is usually considered to have psychopathic tendencies, and could be a potential risk to the community. Such an individual may have had an emotionally impoverished infancy, and reacted by withdrawing from any emotional relationship.
Mrs O’Sullivan’s son with psychopathic behaviour

The O’Sullivan family dominated my time throughout one summer. Having fathered three sons, dad kept his distance in a local hostel while mum tried to keep her two extrovert teenage boys on the right side of the law.

On one occasion, she tipped off the police station that a ‘hot’ TV was on the pavement by the telephone box, and complained to me when they failed to collect it! Mrs O’Sullivan believed in the confidentiality of the social work relationship, knowing that I would not tell the police. By the following year, the two older boys had calmed down and moved to more law-abiding hobbies. Later the youngest boy, slightly built like his dad and receiving little affection from his mother, demonstrated psychopathic behaviour. He was expelled from secondary school for threatening a neighbour with a dinner knife. Ten years later, when I read in the local newspaper that he had committed a murder in adulthood, I remembered the lack of affection in his childhood due to an absent father and a mother lavishing attention on the other siblings.

Both of these examples (above and below) illustrate how children with seemingly similar upbringings can have very different emotional experiences within the family or the care environment. Parents are, of course, well aware of the remarkable innate differences between their children.

William and Joe – one with and one without internalised good feelings

In some cases the social worker is forced to acknowledge that there is little that can be done for some service users with difficult personality disorders. I moved William, aged three, to join his brother Joe in a small group home. But Joe, aged seven, lacking internalised good feelings and had already built a defensive carapace to block out the world. He needed specialist help and moved to a home for troubled boys, where he was a bit of a loner. In his late teens Joe hit a youth outside a pub who was found dead after Joe had fled, leading to a tough prison sentence. Social work care had been unable to reach him.

In contrast, though William’s housemother died suddenly on the job when he was four years old, he had the inner resources to soldier on – thanks largely to the loving care of a foster mother in the first 16 months of his life. The boys’ mother died through an accidental overdose of drugs on release from prison when he was aged five and Joe was eight. I remember that I could not stop crying during a session at the local child guidance clinic. I was comforted by the clinician’s phrase, ‘It’s OK – someone needs to mourn this young woman.’

William grew up and found a job and a steady girlfriend. He was on course aged 20 to live a satisfactory life in the community. The affectionate care of a foster mother from birth to 16 months and social work support, based on emotional warmth and empowerment, had been successful.

Organisational containment

Wilfred Bion expanded his concept of the maternal role of containment to suggest that institutions, such as a social services department, provide a containing function for
their members. Anyone who has exchanged office life alongside a group of colleagues for solitary home working (as I did on moving to Topss England) will be well aware of the usually supportive nature of the organisational setting and miss this support if based away from an office. But the dysfunctional and unhelpful relationships that can sometimes occur between different subgroups in organisations also need to be recognised.20

Just as the baby projects his intolerable anxieties and fears onto his mother, institutions, which deal with the difficult emotions brought by distressed people, have to manage their defences against the anxiety, hostility and guilt both within the organisation and externally in society. Social workers can be affected both as professionals and as individuals. Groups survive by splitting off their ambivalent and hostile feelings and projecting them onto colleagues in other groups.

Anton Obholzer points out that organisations such as the social or health services ‘deal constantly with fundamental human anxieties about life, death and annihilation’.21 ‘The individual who is prey to these primitive anxieties seeks relief by projecting them into another.’ The process of containment allows these feelings to become bearable. Similarly, the social services ‘serve to contain these anxieties for society as a whole’. Underlying tensions due to challenging clients cannot be managed ‘by denying and repressing them as that invariably leads to further difficulties and disturbance’. This may need professional understanding of the group involvement in projection, splitting and counter-transference. Managers can benefit from expert assistance in confronting these forces to ensure that particular groups are not unfairly scapegoated in the organisation.

**Marginalisation of seriously dependent people**

Social workers are often ambivalent about service users becoming dependent on them. Is it allowed? Will they be trapped into spending more time than expected? Will they be overwhelmed by this person’s needs, and taken over by the situation? But there is a risk for severely dependent people of being objectified and then depersonalised. This gives rise to the danger of abuse by their carers.

Donald Winnicott suggests that psychiatric practice could benefit if psychiatrists and mental health staff were in touch with the hate and fear of their psychotic patients that were projected into them. ‘However much he loves his patients he cannot avoid hating them and fearing them, and the better he knows this the less will hate and fear be the motives determining what he does to his patients.’22 This needs to be borne in mind by staff in mental health services, services for people with physical and learning disabilities, and services for older people.
The need to reduce the risk of abuse by carers

There is a risk that service users such as Mr J, whom the nursing home wanted to move, are treated with lack of individuality and respect. In extreme cases this can lead to seriously inappropriate treatment or possibly abuse, as happened at the Mid-Staffordshire NHS Foundation Trust.23

Hospital social workers are in the front line to protect vulnerable and dependent people. But total institutions can have difficulty in hearing the warning bells of 'the potential sadistic abuse of the power that staff have over patients'.24 Bells rang for me in a case discussion at a team meeting when a resident was said to have been denied appropriate help with toileting, and again when the operations manager described the efficiency of his IT spreadsheets for moving patients mechanistically through the system to provide the empty beds needed by the hospital.

Matthew – handling an allegation of abuse

Occasionally a social worker has to consider carefully allegations of abuse and make a difficult judgement call.

I had a day-time emergency call to jump on a train to visit a small private boys' boarding school in the West Country and interview a 14-year-old from my local authority. Another boy from our local authority had complained of a young master putting his arm round him. Matthew, my charge, had little time for the allegation, saying that the master was one of the kinder members of staff. As the master had now been suspended and the boy was willing to stay till the end of term, we agreed he should discuss future plans for his education with a permanent social worker, when appointed.

Helping with decision making

Is there any way that routine social work interventions could reduce the risk for vulnerable adults? From my observation in the hospital, a first step would be to engage with service users and discuss planned placements – encouraging them to share their doubts and fears, rather than succumb to the conveyor belt of care. Those with the faculties to appreciate their predicament would be enabled to reach some understanding of the drastic moves which they were being required to make.

A further step would be to obtain details of a patient's past life and contacts so these can be handed on to a new residence as a start of a 'life story book'. A friend prepared such a book of photographs for her mother, who was then able to interest her East European carers in her earlier years as a missionary's wife around the world.
Emily – coming to terms with an unwelcome move

Emily moved in her late eighties into a purpose-built ground-floor flat close to her friends and neighbours. Five years later, she had a couple of nasty falls and wanted to find a nearby residential home. Her only relative was a nephew in her home town 120 miles away. The cost of local residential care was beyond her means, and her nephew thought that she should join her sister-in-law in a home near him.

Emily hated the idea and the conflict on what to do upset her. She became short tempered and anxious. She had left home aged 20 in 1940 to work in the church during the war, and had built her life around that. We talked together, lamenting the losses from a move, but I reminded her of the guts that she had shown when younger and that she still had the ability to make the move in a way that would work out.

This helped Emily to remember her internal strengths and put her in the right frame of mind to make the decision to join her sister-in-law. She accepted help from younger friends in packing up – and then settled in quickly and was content with the change.

Comment

People who have not had a loving and containing adult to nurture them when very young are likely to lack internalised good feelings about themselves and others. They take a substantial proportion of the efforts of social workers. William and Joe illustrate the huge difference in the direction in life path of two siblings. One developed psychopathic behaviour, while the other has been able to live a satisfactory life, benefiting from an affectionate foster mother and social work support.
Assessment
6. Assessment

In this chapter the principles of assessment will be considered. Definitions will be provided, a range of assessments will be described and theoretical approaches to assessment will be summarised. An overview will be given of the assessment process and illustrations will be given of specific assessment tools. You will be directed to appropriate social work literature on assessment. The chapter will end by showing how different textbooks approach the discussion of assessment and will provide students with a framework to help them decide on which approaches assist their understanding of assessment.

The ability to assess is a core skill of social work practice, and there is much material in the literature on social work theory and practice. However as Crisp et al. note, ‘a common understanding may not be apparent to the novice reader’ (2005: 16). Elsewhere, they also argue that ‘although assessment has been recognised as a core skill in social work and should underpin social work interventions, there is no singular theory or understanding as to what the purpose of assessment is and what the process should entail’ (Crisp et al. 2003: 5).

Definitions

Assessment is not a single event, it is an ongoing process, in which the client participates or service user participates, the purpose of which is to assist the social worker to understand people in relation to their environment. Assessment is also … a basis for planning what needs to be done to maintain, improve or bring about change in the person, the environment or both.

(Coulshed and Orme 2006: 24)

Assessment is the foundation for all effective interventions; as such it needs to be grounded in evidence from research and theory in disciplines such as sociology and psychology, which illuminate human need.

(Baldwin and Walker 2009: 209)

assessment is both an art and a science since it involves wisdom, skills, appreciation of diversity and systematically applied knowledge in practice.

(Parker and Bradley 2007: 4)

It can be seen that there are common elements to these definitions but also different emphases. Therefore, it is important to read a range of texts on assessment to ascertain the variety of approaches and to consider which approaches best fit the needs of the service user, your value base, and the social work context in order that you can
appropriately integrate theory and practice.

**Range of assessments**

While the above definitions emphasise that assessment is a process, the nature of an assessment can vary considerably with regard to legislative context, purpose of assessment (for example, focus on need or risk), ownership of the assessment, time frame in which the assessment has to be completed, and the multi-disciplinary nature of assessments.

**Legislative and policy context**

Consideration needs to be given to the legislative context and the particular requirements of the law with regard to the content and process of assessment. In the four countries that make up the UK there are different legislative requirements and, following from this, different policy frameworks for social workers in the fields of child care, community care and, in Scotland, criminal justice. So, with regard to preparation, a careful reading of the legislative and policy context is required and students should ensure that they refer to the literature which discusses their own country's framework as there are some subtle but important differences between the countries. This does not mean that literature which discusses legislation and policy in one country is not a useful source to help critique policy in another country. Indeed, comparisons are useful ways to develop critical analyses; however, students need to be explicit about the origin of the legislation.

**Purpose of assessment**

Assessments may be required for a variety of purposes and may be undertaken with individuals, groups or communities. Assessments may be required by legislation and governmental policy frameworks. Social workers may be required to produce reports for courts, children's panels (Scotland) and tribunals, and to adhere to statutory guidance. Assessments, such as the range of assessments in community and adult care, may be required by statute but not presented to bodies such as courts but rather to resource panels, which may be single or multi-agency. These kinds of assessments which produce formal reports will usually be required to be completed within a fixed time scale to meet statutory deadlines. On production of the report the worker completing it may have no more involvement with the service user after decisions are made with regard to risk or need.
Exercise 1
Assessment: No further service
Justyna is a twenty-year-old white young woman, living in Scotland, who was found guilty of shoplifting. The court requested that the Social Work Department provide a report on her background. The social worker undertakes an assessment, gathering information on Justyna’s background and attitude to her offence. The report was completed with a recommendation that probation would not be a suitable disposal and that a fine be considered. The fine was the disposal.

Although the production of an assessment report in itself is a process, it might also be a ‘one-off’ event in the sense of the involvement of a particular social worker, but the service user may receive services from another part of the agency or a related agency. If the assessment results in the service user receiving services from another social worker in another agency, then the assessment process will begin again, but in a different form.

Exercise 2
Assessment: Transfer to another team
David is a white seventy-two-year-old man living with his wife. He has been in hospital for a hip replacement. The social worker based in the hospital has assessed David’s needs on discharge. A community care assessment has been made and a plan has been constructed by the hospital social worker. On discharge a community-based social work agency is contacted and David is allocated a worker from this team. The worker receives the community care plan which forms the basis of the involvement. However, the worker also undertakes a new assessment as David’s circumstances begin to change.

On the other hand, an assessment may take place over a longer period of time, may be undertaken by workers in statutory or voluntary agencies, but be less formal in nature.
Exercise 3  
Assessment: Longer term

Joseph is a nineteen-year-old black man who lives alone. He has been referred to the social worker by his general practitioner, who has prescribed antidepressants but who considers that he needs a range of social supports. Joseph left residential care two years ago. A social worker is allocated to Joseph and begins an assessment of his needs and strengths in order to work with him to improve his situation. There is no time limit on this assessment and no formal report is produced. The process and outcome of the assessment is recorded in case notes and discussed in supervision.

Needs assessment

The term ‘needs assessment’ is usually taken to refer to assessment in the field of community care, as in Example 2 above. The emphasis in needs assessment is that the focus is on the specific and diverse needs of the service user and carer. From the assessment follows a plan or care package, the aim of which is to bring together resources from a range of agencies. A needs assessment aims to start with the service user’s situation, and not with an assessment of the eligibility of the person to receive resources an agency can provide. In the above examples, the needs of the service user will be a focus of attention alongside other considerations such as risk to others and risk to self.

Risk assessment

In all the examples given above there is an element of the assessment of risk. In the last decade there has been an increasing concern with the assessment of risk, and a range of risk assessment tools, which workers are required to use, have been produced at national and agency level. The broad principles of risk assessment are that a thorough examination needs to take place of: a person assessed as a poser of risk; a person assessed as being at risk; behaviour which is seen as being risky; how to accurately identify risk; and the extent to which the risk is acceptable (Kemshall 2002). Concern has been expressed that a simplistic attitude to risk assessment has emerged. This attitude is based on the premise that it is possible to eliminate all risks and does not acknowledge that social workers are required to practise in conditions of uncertainty (Parton 1998). Risk is socially constructed and how risky a situation is seen to be depends upon the social and legal context and the perceptions and understandings of those involved. Over-concentration on risk can lead to defensive and risk-averse practice – that is, where social workers are disinclined to take any risk and the rights of the service user may be compromised (Barry 2007). There is growing
attention to the process of risk management, where the aim is to identify risk factors and to work to remove or reduce them by strengthening protective factors and supports, and improving coping strategies (Kemshall 2002; Barry 2007).

**Multi-disciplinary assessments**

Increasingly, assessments are jointly undertaken by a range of professionals who may use a common or single assessment framework. Each worker assesses the situation from their skill and knowledge base and contributes to the final assessment.

**Exercise 4**

**Assessment: Multi-disciplinary**

Peter and Mary are both in their seventies. They both have restricted mobility and between them have a range of health and social care needs. A multi-disciplinary assessment is undertaken with inputs from social work, community-based health professionals such as the general practitioner, district nurse, and the community psychiatric nurse, and a hospital-based consultant.

**Summary of key features of theories of assessment**

The literature on assessment in social work varies considerably in how explicitly it explains the theoretical, evidence and value base of assessment. Smale et al.'s (1993) work is much quoted in the literature on assessment. These authors proposed three models of assessment: the questioning model, the procedural model and the exchange model.

**The questioning model**

In this model the workers identify the information to be gathered, gather this from service users and other key informants, determine the problem, and recommend solutions. The social worker is seen as the professional expert who determines and provides solutions to a problem. This model has been criticised as one in which the social worker has a pre-determined theoretical basis for conducting the assessment, and is mainly used when the focus of the assessment is on risk (Milner and O'Byrne 2009). On the other hand, it has been argued that a systematic approach to questioning in which information, views and perspectives are sought on a variety of areas and from a range of sources can be empowering (Coulshed and Orme 2006).

**The procedural model**

A worker adopting a procedural model to assessment would be likely to use a fixed
agency tool or framework. The emphasis here tends to be also on assessing risk, ascertaining eligibility for a service and allocating resources; it has been criticised as encouraging a 'one-way process' (Coulshed and Orme 2006: 31).

The exchange model

Smale et al. (1993) argue that service users are the experts on their own experiences and that the process of assessment is one undertaken jointly by the service user or carer and the social worker. The role of the social worker is to assist the service user to articulate their needs and possible solutions and to create a support network working alongside the social worker.

Narrative approaches

Fook proposes an alternative to the above models. She argues that 'a new approach ... involves a broad recognition that the act of assessing involves creating a set of meanings which function discursively' (Fook 2002: 118). Fook suggests that traditional approaches to assessment are based on assumptions that assessment is a linear process, that professionals maintain the power and that they are undertaken with preconceived ideas about underlying causes and solutions. She maintains that assessments need to allow for multiple understandings of a situation. Workers need to understand that, in making an assessment, they are producing their own professional narrative or story about what is going on and why. This narrative is required to be constructed by continually checking assumptions and by being mindful that the aim is that it works in favour of the service user. In doing so, the power of the professional is acknowledged, as is the fact that professional judgement needs to be made. However, this judgement is arrived at after ongoing critical reflection of a range of perspectives.

The assessment process: overview

The process of assessment is variously described in the literature. A search of the literature provides a range of approaches. Texts can be more or less detailed about the content and process of assessment. Some texts provide examples of questions that could be used in the assessment process, for example Hepworth et al. (2002) provide an example of an interview guide. Some, often examining assessment in relation to work with specific service user groups, provide information on specific assessment frameworks, for example in the field of sexual abuse assessments (Calder 2009). Others offer an over-view of the assessment process, for example:

1. Preparing for the task;
2. Collecting data including perceptions of the service user; the family and other agencies of the problems and any attempted solutions;

3. Applying professional knowledge (practice wisdom as well as theory) to seek analysis, understanding or interpretation of data;

4. Making judgements about the relationships, needs, risks, standard of care or safety, seriousness of the situation, and people’s capacities and potential for coping or for change (is the progress good enough?);

5. Deciding and/or recommending what is to be done, plus how, by whom and when and how progress will be evaluated.

(Milner and O’Byrne 2009: 4)

Milner and O’Byrne (2009) develop this summary with a helpful suggestion of what needs to be considered at each stage of the assessment process, so for example with respect to preparation for assessment they suggest:

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

(Milner and O’Byrne 2009: 61)

Milner and O’Byrne’s (2009) overview can be usefully used in a range of assessments as it offers a flexible approach to the assessment process.

The assessment process: tools and frameworks

While undertaking an assessment guided by the broad process such as that provided by Milner and O’Byrne (2009), social workers may, or may be required to, make use of specific assessment frameworks and tools.
Frameworks

Crisp et al. (2005) evaluate a range of assessment frameworks used by social workers. They argue that assessment frameworks, which have explicit theoretical or conceptual underpinnings and are built around a validated evidence base, can offer workers systematic professional guidance. Assessment frameworks may assist workers to be more explicit about the evidence base for their recommendations, be that information gathered in practice or research evidence. However, by providing fixed ‘domain’ frameworks, they may encourage workers to seek only evidence that is requested in the framework (a tick-box approach) and not to search for different kinds of evidence and understandings. In their analysis of four assessment frameworks Crisp et al. (2005) found that:

- There was no agreement about what constitutes an assessment framework.
- Assessment frameworks vary considerably in the amount of detail and topics covered.
- Different assumptions are made about the reader’s knowledge base.
- A key purpose in all frameworks was the assessment or risk.
- There is little discussion of the theoretical underpinnings of the assessment process.
- There is some discussion of the use of research evidence to underpin assessment.
- There are expectations that assessments are grounded in evidence.
- Some assessment frameworks include specific structured tools.
- It is commonly accepted that assessments are multi-disciplinary.
- Partnership with service users is a core principle.

(Adapted from Crisp et al. 2005: 61)

Specific tools

Parker and Bradley (2007) provide a useful summary of assessment tools which can be used in the assessment process, which are summarised below.

Reading the textbooks on assessment

The previous sections have summarised the literature on assessment available in social work literature. In this final section we will use the work of Crisp et al. (2005) to consider how you can begin to analyse the content of textbooks on assessment. A framework for analysis is provided to help you decide on which approaches assist your understanding of assessment.
In their analysis of those textbooks which include a substantial discussion of assessment, Crisp et al. (2005) note the different focuses of assessment in different texts. They found that attention to assessment in the texts they reviewed varied from 2 to 45 per cent. Texts varied in how explicit they were with regard to the theoretical base of assessment. There was also considerable difference in the extent to which the authors made specific reference to the evidence base or research evidence which informed their discussion. For example, they found that Milner and O’Byrne (2002), Clifford (1998) and Parker and Bradley (2003) all discuss how adequate the research evidence is with regard to their suggested approaches to assessment. Similarly, although the importance of the legislative context was acknowledged by many authors, the amount of detail given about the legislative basis of assessment varied across textbooks. It is important to note that the lack of inclusion of such details is not necessarily a criticism, given that legislation can change very quickly. Textbooks varied considerably in the amount of attention given to service users’ and carer users’ participation in assessment and their perspective on the process, and very few texts had separate chapters on anti-oppressive practice. Textbooks on assessment also vary in terms of their target audience, so you will need to ensure that the textbook is aimed at social work students and to consider the usefulness of the text for your stage of academic and practice learning.

Crisp et al. (2005) provide two frameworks to assist the reader in identifying the differences of focus and content in textbooks on assessment and in assessment frameworks, and suggest these are used in assessing their relevance and value. Table 7.1 is an adaptation of Crisp et al’s (2005) frameworks, designed specifically to assist you in evaluating the textbooks on assessment that you are reading.

**Table 7.1**

Guidance for evaluation of textbooks on social work assessment

<table>
<thead>
<tr>
<th>Definitions</th>
<th>Do the authors define assessment; if so, how?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Did they provide a new definition?</td>
</tr>
<tr>
<td></td>
<td>Did they refer to definitions provided by previous authors?</td>
</tr>
<tr>
<td></td>
<td>If so, are these definitions critiqued?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theoretical underpinnings</th>
<th>Do the authors explicitly mention theoretical underpinnings of assessment?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If so what underpinnings do they identify?</td>
</tr>
<tr>
<td></td>
<td>Are they critiqued?</td>
</tr>
<tr>
<td></td>
<td>Do the authors propose a new theoretical approach towards assessment?</td>
</tr>
<tr>
<td>Evidence / research base</td>
<td>What evidence base for assessment is referred to in the text?</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Legislation/ legal frameworks</td>
<td>Is reference made to legislation?</td>
</tr>
<tr>
<td>Process of assessment</td>
<td>Is the process of assessment discussed and analysed? What specific frameworks or tools are discussed and analysed?</td>
</tr>
<tr>
<td>Information obtained during the assessment process</td>
<td>Does the text identify the kinds of information needed in an assessment? If so, what kinds of information are suggested? Are suggestions made about the way information is gathered? What discussion is there of the analysis of the information?</td>
</tr>
<tr>
<td>Needs assessment</td>
<td>Is a definition of need given? If so, how is it defined? What suggestions are given to assist the identification of need?</td>
</tr>
<tr>
<td>Risk assessment</td>
<td>Is a definition of risk given? If so, how is it defined? Is the assessment of risk critically analysed?</td>
</tr>
<tr>
<td>Multi-disciplinary assessment</td>
<td>What attention is given to multi-disciplinary assessments?</td>
</tr>
<tr>
<td>Involvement of service users and carers in the process</td>
<td>What attention is given to the involvement of users and carers in the assessment process? Is any feedback provided on service users’ and carers’ views of the assessment process?</td>
</tr>
<tr>
<td>Language other than English and the use of interpreters</td>
<td>Does the text discuss how the needs of service users and carers who use a language other than spoken English are addressed?</td>
</tr>
</tbody>
</table>

Source: Adapted from Crisp et al. 2005

In this chapter an overview of definitions and processes of assessment has been given. Students have been directed to core texts in this field. A framework and guidance for the analysis of textbooks has been provided. To conclude, it is important to acknowledge the limitations of an analysis of literature only. In order to integrate theory into practice, students need to use the analysis to inform their assessment practice. As Crisp et al. (2005) note:

Readers should not assume that they will develop expertise in assessment only by reading relevant textbooks and assessment frameworks. Attempting learning exercises contained in textbooks and assessment frameworks, discussion of concepts and practices in supervision, and ultimately attempting to put the theory
into practice, are all further steps in becoming a skilled practitioner.
(Crisp et al. 2005: 67)

**Exercise 1**

Choose one chapter on assessment from a social work textbook and evaluate it using the above framework and guidance. Then summarise:

- What are the most useful aspects of the text?
- What aspects are missing from this text?
- Where would you now look to seek out information on the missing aspects?

**Exercise 2**

In your own words, building on the literature summarised in this chapter write three short paragraphs:

- a broad definition of assessment;
- a definition of needs assessment; and
- a definition of risk assessment.

What do you not feel sure about and how will you find this out?

**Key learning points**

- There is no singular understanding of the purposes or processes of assessment.
- There is a range of assessment frameworks, but all are primarily concerned with assessing needs and/or risks.
- Social work texts offer different material on assessment, so it is important to find out their strengths and weaknesses, and use a range of social work literature.

**Further reading**

Towards Sociological Practice
In reviewing the book as a whole, a number of important themes arise that provide a way forward for a critical and reflexive sociological practice for social workers and probation officers.

**Interrogate the commonplace**

Be prepared to ask questions and refuse to accept ‘as read’ the concepts, ideas and perspectives that are part of everyday knowledge and practice wisdom. The family, crime, community, etc. are not the same for all time and in all places. Meanings change, and are created by the very discourses that name and classify the notions they describe (Foucault 1972). Moreover, the ‘knowledge’ on which concepts are based is itself open to question, as we have discovered in our examination of official statistics about crime. Until we have begun to deconstruct the concepts we are using, we will not understand the complexities and contradictions that are likely to affect our practice. We will also fail to appreciate the vested interests that seek to forefront specific kinds of meanings, definitions and evidence.

**Think historically**

Social work is frequently accused of failing to learn from the lessons of the past – of repeating its mistakes, and swinging backwards and forwards from one solution to another and then back again.

Social work’s ambivalence about residential care and adoption provide two pertinent illustrations of this. A critical or post-modern outlook on history helps us to see that there is no ‘continuous smooth text that runs beneath the multiplicity of contradictions’ (Foucault 1972: 155). History is not a story of continual progress or gradual improvement towards a better society, or even the story of inevitable decline and impending disaster. As a consequence, the solutions we put forward today may not (as we might wish them) be qualitatively better than those of the past. Instead, continuities and change are inevitable features of social work. I explored this in an earlier book:

The history of social work is not the story of ever-increasing knowledge, expertise or human enlightenment. Neither is it the story of an ever-expanding state machine designed to find ever-more sophisticated means of controlling the working class or women. On the contrary, every new intervention in social work has been accompanied by both gains and losses along the way, and consequences which are not always expected and predictable.

(Cree 1995: 10)
A historical, sociological approach encourages us to examine those ‘gains and losses’, so that we might make informed decisions about how practice might be organised in the future. This approach also invites a degree of humility, however, because of an awareness that our ‘answers’ may be no less problematic than those of our forebears.

Beware of ethnocentrism

I have made the point throughout this book that it is easy to fall into the trap of being culturally and ethnically blinkered, judging other people and other societies from our own perspective without seeing that our way of thinking and being is simply that – it is our way; not the best way, and certainly not the only way.

Locate issues in their wider social, political and economic context

I have argued throughout the book that individual experience is structured by class, ‘race’ and ethnicity, gender, age, disability and sexuality. Inequality and oppression exist at both individual and structural levels; they occur between people, and are expressed through organisational policy and practice and through society’s institutions (Braye and Preston-Shoot 1995: 3). While post-modern perspectives usefully remind us that there are no ‘essential’ categories by which to define people’s experiences, this should not delude us into underestimating either the power or the durability of structured inequalities. The daily lives of black and Asian people, working-class people, women and disabled people continue to be constituted by exclusion and oppression. Social workers and probation officers work predominantly with people who are discriminated against, marginalised and otherwise on the edges of social life. Individual and psychological approaches to practice cannot adequately address the broader issues of their lives and experience.

Place value on individual experience and meaning

Draw on the wealth of experience that you have already, from your life, reading, films, family and friends, and use this positively to create a provisional framework in which to assess both theory and practice. At the same time, seek to discover and respect the experiences and perspectives of service users. This means not ‘first-guessing’ what people feel like and believe, but instead treating them as experts in their own lives, able to bring meaning and understanding to the matters in hand, if we are prepared to listen (Thompson 1981).
Do not expect to find simple answers

Sociology does not provide simple answers to the complex issues of life. The classical sociologist Weber himself argued that sociology ‘could not tell the members of society what values to hold, but it could demonstrate the possibilities and constraints facing them within their social structure’ (1970, in Bilton et al. 2002). Sociology offers a range of perspectives, commentaries and interpretations of social life and experience, which may help us to make informed decisions about our lives and work. This is a more optimistic message for social work than that presented by Davies (1991) and discussed in Chapter 1. Sociology may not be able to provide social work practitioners with answers, but the questions themselves lead to the potential development of sensitive, anti-oppressive practice. This leads to my final point.

Act with integrity

‘Integrity’ may seem like an old-fashioned word, but it is, I believe, a useful one. It reminds us of a point made early in Chapter 1, that all theories, ideas and practices are based on a particular set of political and moral principles. We therefore have choices to make about which theories we believe are most useful, and what actions will be most helpful (or perhaps least damaging) for those with whom we are working. Social work is fundamentally about values and about value-judgements. Sociological knowledge can provide us with a framework for anti-discriminatory, anti-oppressive practice, by giving us the analytical tools with which to begin to explore the relationship between individuals and society, between ‘personal troubles’ and ‘public issues’ (Mills 1959).