

# **Community based social work with children and families**

Manual on Prevention  
and Reintegration

Ruse, Bulgaria 2002-2005



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#### **Dedication**

This resource manual is dedicated to the children and families of Bulgaria whose lives have been touched, and will continue to be touched, by the impact of the Take Me Home 2 project.

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Save the Children would like to thank CARE some of whose original forms for use in reintegration work were adapted by Save the Children and used in TMH2.

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We were trying to show the most burning issues we have come across in the implementation of the project and the lessons we have learnt. The project team has achieved quite a lot in improving the life and future chances of many children in Ruse. We hope to support and guide other practitioners in the country who are trying to achieve similar results.

## Introduction

### Save the Children UK in Bulgaria: supporting New Social Policy for Children and Families in Bulgaria

Save the Children UK first came to Bulgaria in 1926, supporting children and families who were refugees after World War I. Save the Children returned to work in Bulgaria in 1996 where it established an office in Sofia; a second office was set up in Ruse in 1999. Much of the work of Save the Children in Ruse has been based around the implementation of a major, multi-year project '*New Social Policy for Children and Families in Bulgaria*' funded by the UK Department for International Development (DfID) from February 1999 until March 2004. This project aimed at supporting child welfare reform in Bulgaria, modelling new approaches and social work practice and providing evidence and ideas to inform Save the Children's work supporting the development of new child protection policy and legislation.

### Institutional care

As part of this large project, Save the Children undertook an action oriented research project which studied in-depth issues surrounding children at risk of abandonment and institutionalisation. This research project - '*Take Me Home*' - led Save the Children to the conclusion that the high number of children living in institutional care was *the* most pressing problem facing children in Bulgaria. The reasons for this reliance on institutional care were found to be many - including high levels of poverty experienced by many sectors of the population due to the on-going transition; a belief by many institution staff, a sizeable percentage of the public and some policy makers that institutional care presents the best option for many children from disadvantaged backgrounds; and a scarcity of demonstrable community based care alternatives to provide social support to vulnerable families.

Through this research work, Save the Children also understood that although there was a general commitment to de-institutionalisation as the best strategy for child welfare and development, the majority of stakeholders - child care institutions, health care professionals, those involved in the provision of social services, policy makers, parents, the public - were not necessarily willing, or able, to support de-institutionalisation. Save the Children therefore committed to implementing a pilot project to advance models of alternative community-based care and to reduce institutionalisation. The vision of such community-based services included the idea of children and families at risk avoiding separation and institutionalisation by receiving support from social workers experienced in practical work. This project was '*Take Me Home 2*' (TMH2) - the learning from which is summarized in this manual.

### Take Me Home 2 Project

TMH2 aimed at working on two levels - local, where ideas and models could be tested in practice; and national, where learning from the practice could be transformed into policies. From the outset the project was seen as a collaborative effort between Save the Children and a number of government institutions at national and local levels. It was decided to work specifically with an institution for children aged 0-3 (DMSGD - formerly known as 'mother and baby' home) as Bulgaria had the highest rates of infants in institutions and such institutions are often the 'front door to the institutions system'.

The goal of the project was to provide vulnerable families (in danger of placing their children in state institutions or who already have children in state care), a range of social services, benefits and support measures that allow them to keep their children at home as an alternative to temporary placement of children of socially disadvantaged and unemployed families in DMSGD. The specific objectives included to:

- gain inter-agency commitment to a pilot project on community-based care from which critical lessons and experience could be gained by the state's child protection and care bodies, needed to reduce institutionalised child numbers on a national scale
- prevent, and make unnecessary, placement of children in the mother and baby home on poverty grounds alone
- encourage families with children already placed in state care for economic reasons to take their child out of the institution and back in the family.

### Much more than a 'project': modelling a new inter-agency approach to child welfare

TMH2 began in April 2002. Partners at a central level were the Ministry of Health, Ministry of Labour and Social Policy, the Ministry of Finance, the Ministry of Justice and the State Agency for Child Protection. Local partners were the Social Assistance Directorate (including the Child Protection Department), Ruse

Municipality, the Home for Medico-Social Care (formerly 'mother and baby'), the Regional Health Directorate, Ruse Maternity hospital and local NGOs.

The project team consisted of:

- two social workers from CPD who were directly involved with the families and the coordination of the team work on prevention and reintegration - with wider support from the whole of the CPD team
- the social workers from Social Assistance Department
- the team of DMSGD
- some of the staff of Maternity Hospital

This team and their clients received financial support from Save the Children such as office equipment, the furnishing of family rooms in both the CPD and DMSGD and money for the prevention and reintegration fund. At present these commitments have been taken over by the state ensuring sustainability, a very welcome development. But *the* most important and valuable contribution was made by Save the Children through the provision of technical assistance for more than 3 years (discussed in detail in Chapter 3).

From the start of TMH2, all the partners were aware that it was not just a pilot project within a specific timeframe but the testing of an innovative inter-agency approach towards implementation of national policy on de-institutionalisation of child care. Key to the success of the project and its impact were the regular meetings of the inter-agency steering committee which discussed project developments, planned future work and ensured that lessons learnt at a local level were filtered through to those at a central level responsible for child welfare policy.

**The experience gained throughout the project - good practices and lessons learnt - as well as the training plan used by the technical assistants are shared through this manual.**

#### **Who is this manual for?**

Save the Children has been fortunate to work with a group of extremely committed people in Ruse and the project team has achieved quite a lot in improving the life and future chances of many children in Ruse. We hope through this manual to support and guide other practitioners in Bulgaria who are trying to achieve similar results. Save the Children hopes the manual will be useful for Child Protection Department social workers, the staff of institutions and their managers. It is intended to facilitate day-to-day work on social work with children and families. In writing the manual, Save the Children wanted to show the most burning issues we have come across in the implementation of the project and the lessons we have learnt. There is a particular emphasis on prevention and reintegration but the lessons in the Manual can be transferred to all aspects of child welfare work.

## Burning issues in prevention and reintegration

### Introduction

The purpose of this chapter is to demonstrate the practices in child welfare that have been developed during Save the Children's Take Me Home 2 project (TMH2) (2002-2005). Our current practices have emerged over the lifetime of the project and have been part of a developmental process that has involved all the main partners in the project at the local level ie. the Child Protection Department (CPD), the Department for Social Assistance (DSA), the Home for Medical and Social Care (DMSGD), Save the Children (SCUK) and the Maternity Hospital. So when you read 'we' or 'us' in this chapter it refers to a combination of all of these partners, as everything we have achieved has been as the result of joint effort. Please note that the names used in the case studies are fictional.

The most 'burning issues' we have come across in the development of good child welfare practices in the TMH2 project are as follows:

- 1.0 Case management procedures for prevention and reintegration**
- 2.0 Assessment**
- 3.0 Planning**
- 4.0 Preparing children to move between placements**
- 5.0 Child abuse and child protection**
- 6.0 Using jargon**
- 7.0 Supporting contact visits between parents and children**
- 8.0 The restructuring of the services offered at DMSGD**
- 9.0 Caring for the carers**
- 10.0 Conclusions**

Each of these 'burning issues' is addressed in this chapter, along with some conclusions and recommendations for future work.

This chapter attempts to show the processes we have gone through, shares our experiences and the lessons we have learnt from developing child welfare systems in Ruse. Some of these lessons have been learnt the hard way - and it is hoped that by sharing our experiences with others on the same path, we can help to make the journey a little easier. As well as drawing attention to the main things we have learnt, there are cross-references throughout the chapter to the Appendices, where the reader can find other useful tools and good practice guidelines that we have developed during TMH2.

### **1.0 Case management procedures**

There have been two specific case management procedures developed under the TMH2 project, known as the Prevention Procedure and the Reintegration Procedure. These procedures form the backbone of all our work. The way we work now, in 2005, and what we did at the beginning of the project is totally different, and that is due to our increasing knowledge and understanding of what constitutes good practice, as well as changes in legislation (sometimes as a result of the practical front line experience of TMH2). Child welfare workers are always on the look out to improve their practices so that they most closely reflect the best interests of the child, and so consequently the procedures will continue to evolve and improve. The procedures and forms in the Appendices are a true reflection of the actual procedures currently in use, and are a combination of State forms and forms that have been developed locally here in Ruse.

**1.1 "The Prevention procedure"** refers to all the casework done, largely by CPD, to prevent a child entering the residential institutional system in the first place. This key area is the first stage of any work done with the child and the family. This is because of the proven emotional and developmental damage that is done to children (particularly babies and toddlers) by an admission to residential care and separation from their families. Despite the best and determined efforts of the committed staff team, they cannot replace a family. Every child has the right and need to grow up in a family environment, their own family, or where this is not possible, a substitute family. The prevention procedure can be found in Appendix 1. This is a really important area of work, as, as it is well known, 'prevention is better than cure'. A key partner for CPD in this process has been the Maternity Hospital, and a huge effort was made at the beginning of the project to strengthen this working relationship. This was in order to ensure that, as required by the Child Protection Act 2000, colleagues in the Maternity Hospital referred vulnerable mothers to CPD, so that CPD colleagues could do early intervention work to prevent the child being placed in an institution. We refer to this important work as 'gate keeping'.

## 1.2 Case example of a prevention intervention at the Maternity Hospital

*“Right at the beginning of the project, after we had set up our formal cooperation with the Maternity Hospital, we got a referral from them about a woman called Nenka who had just given birth and had told maternity staff that she intended to leave her baby, Liuba, for adoption because she had too many problems to take her home with her. We went down to the Maternity hospital straight away, sat on Nenka’s bed, and talked to her. It was clear that she did not want to abandon Liuba, but that she felt she had no choice. She did not have a good income, the baby’s father had left her during her pregnancy, she had other children to take care of, and she was under a lot of emotional pressure from her own mother to leave the baby in the Maternity Hospital and not bring her home. Once we realized she genuinely wanted Liuba but needed support, we opened the case and we helped her go through her problems one by one. We supported her to maximize her welfare benefits and get everything she was entitled to. We helped her talk with her own mum, who started to soften her ‘hard line’ approach when she actually saw the baby. We provided her with some basic supplies for the baby using the project Fund. We also did some work with her other children (who adored Liuba from the beginning). This took some of the pressure off Nenka and made her more able to cope with the baby. We worked on this case for about a year, taking a ‘whole family’ approach - and it worked. We prevented that baby from being abandoned, and she now lives with her own family, where she belongs. Things are not perfect, but they are good enough, and Liuba is loved and wanted. And who amongst us can say our family is perfect? It is a good feeling to know that, as a direct result of our work, we kept a family together.”*

### **Social worker from CPD**

CPD also get referrals for prevention work from other sources, such as GPs, other departments of DSA, hospitals, and self-referrals from clients plus referrals from other professionals.

After completing their assessments, some of the main interventions that CPD use in prevention work include: supporting clients to arrange their identity documents, without which they cannot access their basic rights; referring clients to DSA and maximizing welfare benefits; providing consultations for changes in marital status (this again relates to accessing rights); supporting older children in the family by, for example, registering them at kindergartens (using the ‘whole family’ approach); supporting clients to identify and register with a GP to access health care; supporting clients to improve their living conditions; improving deteriorating family relationships; referring clients to other NGOs or agencies that can offer help such as the Employment Service and motivating and involving the extended family. It is worth noting however that, when asked, clients consistently identify **‘being listened to’** as the most valuable service they can get from a social worker.

A key part of the CPDs work with families, is their access to the State Fund. Following the experience of the project’s ‘Prevention and Reintegration Fund’, and the experience of other CPD based funds used in EveryChild project sites in Plovdiv and Haskovo, a similar fund has been established by the State. This Fund is based at a local level, accessed through a CPD assessment and can form an integral part of the child’s care plan, helping the social worker to alleviate some of the effects of poverty on the family. The Fund is only accessed after all other DSA social welfare benefits have been maximised. The Fund is used actively and in a targeted manner by CPD, based on the individual needs of the child and their family. It has many benefits in both preventing unnecessary admissions to care and promoting reintegration. Its creation is a vital step in the development of community based responses to the problems of socially vulnerable children and families, however there are some frustrating limitations to it. For example, it is not possible under the current legislation to provide monthly payments (on a temporary targeted basis) to support the reintegration of children from institutions with their birth families, although this is possible for reintegration with extended families. It is only possible to provide birth families with a one off support payment from the Fund when their child is reintegrated. This seems hard to understand, and the CPD reports many cases where it would be useful to be able to provide monthly support to birth families to support the reintegration of the child, particularly where the family incurs additional expense as a result of a child’s medical problems.

## 1.3 Other public services

Although the State Fund has been a crucial step in the development of community based services, it cannot always help social workers support our most socially vulnerable clients to solve some of their most fundamental difficulties, which are often related to extreme poverty and social exclusion. Through the implementation of TMH2, we have learnt that social work is not a magic wand that can solve everything, and that much more needs to be done in wider society to alleviate the grinding poverty and social deprivation that affects many of our clients in areas such as employment opportunities, housing accessibility, education and community health care. Social work does not sit as something separate to these essential public services but as an integral part of a much wider picture.

For example, one of the major lessons of TMH2 has been about the impact of poor housing on children and families. This is an issue that, in some of our cases, has proved to be a significant obstacle to the implementation of care plans that are in the best interests of the child. Despite our best efforts, it has been almost impossible to explore the real parental capacity of some of the parents who request placement of their child at DMSGD, or who already have children at DMSGD. This is because the parents are, in effect homeless, or are 'squatting' illegally in appalling conditions. Without reasonable housing conditions it is very difficult to put together a package of support to prevent admissions to care or to enable families to take their children home. It is a really basic issue, as well as being a basic human right. By inadequate housing we mean illegal occupation of a property due to poverty, limited or no water and electricity, overcrowding, limited or no cooking or washing facilities, and varying degrees of damp, unhygienic and lice infested conditions. That any citizen of a European country should live in these slum conditions in the 21<sup>st</sup> century is totally unacceptable.

Anyone involved in child welfare in Bulgaria, at whatever level, who has not had the opportunity to visit the homes of one of our clients in these circumstances, should try and get themselves an invitation. It is a very humbling experience and it gives you an insight into the severity of the social problems faced by some of our clients, and why they might turn to institutionalizing their children. In our experience, families from the Roma community are particularly affected by slum housing conditions because, as in many different areas of life, they are the most socially excluded ethnic group. We have many examples of good decent families who want to 'take their children home' (as the title of our project suggests), or indeed not abandon them in the first place, but without at least some very basic living conditions it is very difficult for them.

It is true to say that often in cases where housing is an issue, there is usually a complex combination of problems in the family, and inadequate housing is rarely the only one. This is due to the cumulative effect of grinding poverty and social exclusion. For some parents, even if the municipal housing department provided them with decent housing, they would still not be able to provide good enough parenting. So we must beware of seeing the provision of housing as a 'cure all'. It is not. These are complex child welfare judgments, but without the provision of at least very basic living standards, families have few chances to successfully parent their child because inadequate environmental conditions impact so heavily on babies and young children. Consequently, the children of many of these families are at a high risk of spending prolonged periods in institutional care, and in our experience we cannot blame the families for this or recommend removal of parental rights in the majority of these cases (even if it were legally achievable, which it rarely is, more on this later in the manual). The children's needs are not being met in institutions, but neither would they be met by removing them from potentially loving and functioning families, who, given the appropriate housing situation, may well be assessed as having good parental capacity and thus be able to look after their children themselves.

In TMH2 we have learnt that this is not an issue that can be solved solely through the provision of different types of child welfare services; it needs to be addressed through a redirection of public funds into the public housing stock for the poorest sections of society. In addition, the local housing department needs to work much more closely with child welfare agencies such as the CPD and the Child Protection Commission. Despite our best efforts in TMH2 we have not been very successful in our attempts to achieve this. This type of co-operation would ensure that, when public housing is being allocated, the best interests of socially vulnerable children and families are taken into account as key criteria in order to prevent abandonment, separation from birth families and unnecessarily prolonged periods of institutionalisation.

**1.4 "The Reintegration procedure"** refers to all the casework done by both CPD and DMSGD after the child has been admitted to institutional care, whether for temporary residential care or weekly care (see below for details of weekly care scheme). For some children, an admission to residential care cannot be avoided, and CPD have to make a referral to the DMSGD. This is, in most cases, due to a shortage of alternative family based placements such as foster care, rather than a reflection of the baby's need to live in a large institution. No baby or child needs that (although clearly a minority of babies will continue to need short term intensive care in a small unit for medical reasons such as premature birth or low birth weight). We have learnt in TMH2 that it is important that once the child has been admitted to DMSGD, the case is not allowed to drift, but that purposeful assessment and case work is done with both the child and the family to promote family reintegration (where this is in the child's best interests), or to make significant changes to the child's care plan (where it is not). The reintegration procedure was developed to ensure that this happens. It can be found in Appendix 2.

## 1.5 Developing the reintegration case management procedures:

The reintegration case management procedures and individual documents we have developed have had to a) meet the legislative requirements of DMSGD b) meet the legislative requirements of CPD and c) promote high quality and professional case management standards. Sometimes these three demands have conflicted! We have put a lot of effort into dovetailing all the various procedures and forms in order to ensure effective working together between these two vital agencies. This is in order to ensure that decisions are made in the cases that reflect the best interests of the child, and to avoid unnecessary repetition of work.

## 2.0 Assessment phase

### 2.1 The purpose of assessment

Assessment is the basis of everything we do in a case. If the assessment is not sound we will not make sound plans. If the parents are not fully involved in the assessment they will feel alienated from the whole process and less likely to agree with the subsequent plan and consequently, they are unlikely to want to play their part in implementing the plan. If assessments are not conducted in a multi-agency fashion then things get missed. One agency cannot know everything, and sometimes different agencies have conflicting version of the facts in a case, or see the same facts differently. Instead of blaming the other agency for 'getting it wrong', we have learnt that we need to look at the mechanisms we have for collecting evidence and making assessments, and ensure that we make appropriate changes to these mechanisms to prevent similar mistakes happening in the next case.

### 2.2 The "assessment triangle"

The current multi agency assessments in the TMH2 case management procedures have been in part inspired by the 'assessment triangle', which focuses our thoughts on the three essential parts of the puzzle that must be filled in so that we can make a proper assessment of the child and families situation. (See Appendix 1 for the assessment triangle). These are a) the child's needs, b) parental capacity to meet those needs and c) wider family and environmental factors. If we gather high quality information about the child in each of these areas we will have a comprehensive view of a case. We have learnt that this is essential to avoid a one sided view that, for example, only concentrates on the child's needs but does not take into account the family situation, or conversely only concentrates on the family situation and ignores the individual needs of the child.

### 2.3 Quality assessment practice

In TMH2 we have learnt that when completing assessments with a family, it is very important that the emphasis is on the 'with', that is to say that assessments should always be done in a way that helps parents or carers, children (where appropriate) and other relevant family members to have their say and encourages them to take part. Parents and carers invariably want to do the best for their children, and the assessment process should help them to identify their own strengths and needs, rather than being a professional task that is done to them, or about them. When writing up assessments, we have learnt that social workers should ensure that they leave some space to analyze and weigh up all the information they have gathered, some of which may be conflicting. It is really important that the social worker distinguishes between the facts they have gathered, their own judgment and interpretation of these facts and the action they have taken or plan to take. For example:

### 2.4 Case study

#### **Individual case file of Ivan Petrov,**

#### **Home visit: 2 April 2005**

Purpose of visit: to gather more information for initial assessment following self-referral by Mrs Petrova

#### Information gathered:

*I visited the family home of Mrs Petrova on 2 April 2005, the visit lasted approximately 40 minutes. On the day I visited there was dirty washing all over the furniture, boiling pans on the edge of the stove and what looked like dog excrement on the floor. The 6-month-old baby, Ivan, was sitting on the floor and did not have a nappy on. He was crying continuously whilst I was there and Mrs Petrova made no attempt to comfort him. During the visit Mrs Petrova was very tearful herself, saying that she could no longer cope and was going 'to give the baby away to the State' or even kill herself.*

#### Social worker's assessment/judgment/interpretation:

*Following our initial meeting at the office, I continue to be concerned about the Ivan, Mrs Petrova and the older siblings. In my view the conditions in the house are dirty and unhygienic, especially for a baby of this age. I am also concerned that Mrs Petrova is not coping emotionally and that this is affecting her parenting capacity and her ability to respond to her children's physical and emotional needs. Since her husband left*

her for another woman immediately after the birth of their son, it is my opinion that she has become increasingly isolated. At the moment my judgment is that Mrs Petrova's threats to abandon the baby or to kill herself are really a cry for help and that she needs support and some close monitoring as she is going through a personal crisis which in my opinion is an understandable response to the situation she finds herself in. After we talked Mrs Petrova seemed calmer and more in control, but I think she is very vulnerable at the moment and I am concerned about the impact of this on the children, especially the baby. I think the situation needs close monitoring to ensure the safety of the children and to rebuild Mrs Petrova's confidence and capacity to successfully parent her children. Mrs Petrova admits that she needs help.

**Action taken during visit and plan:**

I listened to Mrs Petrova tell her story and reinforced again to her that my job was to help her to help herself and her family, but that I could not do anything without her support. I expressed my concern about the dog excrement on the floor, and how unsafe this was for the baby. Mrs Petrova blamed the older children for letting the dog in the house. I told Mrs Petrova that everybody's house gets untidy from time to time, but that this was totally unacceptable and it needed to stop for the sake of the children's safety. Mrs Petrova agreed and said she would take care of it. I talked to her about what else seemed out of order in the house, and we made a list of things that needed taking care of, prioritizing the three most important things from the perspective of the health and safety of the children. I arranged to visit again on Friday to see how she was doing. I also said that if she wanted I could arrange for her to talk in a more in depth way to somebody about how she was feeling (our departmental psychologist). Mrs Petrova said she would think about it. We also agreed that on the next visit I would do a check on her welfare benefits to see if she is getting all the benefits she has a right to claim. On my return to the office I discussed the case with our departmental psychologist and my line manager. Agreed short term approach and decided to do fuller assessment once initial risks have been addressed. Line manager also suggested that, with Mrs Petrova's permission, I try contacting members of her extended family to see if they can offer her any support.

**Signed: Mariella Ivanova, Case social worker**  
**4 April 2005**

## 2.5 Assessments that are evidence based

A key lesson from the TMH2 experience has been that no judgments should be made about a case unless they are based on hard facts and evidence, and not on assumptions, guesswork or speculation. It is very easy to assume facts that turn out not to be true. We all make some level of assumptions in our everyday lives, but in conducting assessments we are professionally obliged to check, check and check again, and to not let our own assumptions of, for example, the way a family operates, cloud our judgment. All judgments, assessments and conclusions must be evidence based. Are we sure we have the right facts? What is our evidence? Sometimes this can involve asking clients some very personal and private questions, and this requires a lot of sensitivity and skill on the part of the worker. But it is imperative that these questions are asked so that we have a full picture of the situation, so that we don't miss anything and so that we don't assume anything.

We have learnt that ultimately this involves sitting down with clients on several occasions over a period of time and talking with them about their lives, in order to get a genuine picture of their strengths and their needs. This of course requires that the worker has a manageable enough caseload to devote this kind of time to their assessments. However we have learnt that there are no short cuts to comprehensive assessments in child welfare work, and that if we attempt to work on a case with a flimsy or superficial assessment of the family's situation, we will always make mistakes. We have learnt this lesson the hard way. This of course has resource implications for our work, more of which later in this chapter.

In some ways, the more experienced a worker becomes, the easier it is to make assumptions: 'ah, this is this kind of case, this is this kind of child, and this is this kind of family'. We have learnt that every case is different and although there may be similarities if we do not check out our assumptions we will be making mistakes. In addition, modern understanding about children's needs is constantly evolving and as such it is also important to base our assessments and recommendations on the most up to date research about what every child needs to reach its full potential in life. For example, we know the emotional and developmental damage done to young children by institutional care because of 50 years worth of research and hard evidence, and it is this evidence that informs the plans we make for the children in our care. For more hints and tips on completing assessments see Appendix 3 'Completing child-care assessments: 10 common pitfalls and how to avoid them' and 'Guidance on completing a comprehensive assessment'.

## 2.6 Prompt questions

In order to support the assessment process, we have developed a series of 'prompt questions' (see Appendix 3). These are intended to guide the practitioner in what specific questions to ask when they are

assessing parental capacity and wider family and environmental factors. It is all very well to know that you need to assess, for example a family's living conditions, but what does that actually mean? What specific things should the practitioner be on the look out for when they do a family visit? What about assessing the parent's capacity to offer a child stability and emotional warmth? What sort of things should you be looking out for? The prompt question guidelines aim to support the practitioner to ask the right sorts of questions, and to help them when their minds go blank. The 'family and environmental factors assessment' looks at the home conditions and community resources, the financial situation of the family, health issues in the family and family relationships and most importantly, considers the impact of all of these factors on the child. The 'assessment of parental capacity' looks at the parents' ability to provide good enough basic care for the child, to ensure the child's safety, to provide emotional warmth, guidance and boundaries, stability and stimulation. Appendix 2 shows the specific detailed questions that can help when assessing a child's developmental needs. The TMH2 project has focused largely on children aged from 0-3 and so the form was developed to reflect the needs of children in this specific age range.

*Quote: I find the 'prompt questions' quite helpful. They support me to be more thorough in my assessments, and I can be confident that I am not missing something important. They are a very practical tool that helps me in my day-to-day work'. Social worker from CPD, Ruse.*

## 2.7 Assessments for reintegration

When completing an assessment of the suitability of the reintegration of a child in DMSGD with their birth family, we have learnt that it is important to ask the following kinds of questions:

- What were the reasons for the child being placed in the institution in the first place?
- Has the situation changed?
- What is the family's understanding about the impact of institutionalisation on the child?
- Do they have a realistic understanding of the impact of separation and the challenges of the process of reintegration?
- What are the risks associated with the return of the child to the family home, and how do these risks balance with the effects of institutionalisation on the child?

The multi-agency team, and especially the CPD social worker, is not looking for perfect living conditions or perfect parents (as there is no such thing!), but is looking to identify the strengths and needs of the family and to develop alongside them a plan of support in order to empower the family to meet the child's needs. Post reintegration monitoring and support is a vital component of reintegration, and not just an optional add on, and it is crucial that social workers do not have to take on more cases than they can safely monitor. We have learnt that post reintegration work does not have a specific format; it depends on the individual family. The number of meetings and the type of work are individual for each case. The purpose of post reintegration work is to ensure that the needs of the child are being met and to provide ongoing support to the parents of the child in their parenting role. When a child has been reintegrated with their family after a period of time in institutional care, there are inevitably challenges for the family and the child to overcome, however much the reintegration is desired. The role of the post reintegration worker is to support the family as they readjust to having the child at home, and to support the child to settle back into the home environment. The work can involve both emotional and practical support, and also has a monitoring function.

## 2.8 Working together

Another important lesson that we have learnt in TMH2 is that different agencies involved in the lives of children in the care system must work together and share information in order to operate in the best interests of the child. This is not just an issue in Bulgaria but an issue that is endemic in childcare work the world over! In the UK for example, new laws and practice guidelines are constantly being passed to improve the capacity of child welfare services, the police, health and education to work together in cases of concern regarding children. And they are constantly trying to learn from their mistakes in cases where this does not happen and a child subsequently dies. See Appendix 4 for more hints and tips on working together.

*Quote: 'The assessment procedures we now have in place for our joint work with DMSGD have completed the circle of information gathering and assessment, and have ensured that all aspects are covered whilst at the same time avoiding duplication of effort'. Head of Ruse CPD*

## 3.0 Planning phase

### 3.1 Care planning and review meetings for each individual child

After all the comprehensive assessment work has been completed, the next stage is to hold an individual care planning meeting for the child, which involves all parts of the multi-agency team, including the parents. If the children at DMSGD were older, they too would be invited to planning meetings. Not only is this their

right under the UNCRC and Bulgarian legislation, but also it is common human decency. It is their life, after all, not ours. How would we like people to make decisions about our lives without including us? As the children at DMSGD are small babies and toddlers, it is not appropriate to involve them. However, we have found that it is very important that any members of the multi-agency team who do not work directly with the child go and visit them before the meeting, to get a sense of how they are doing. This sensitizes you to the reason for the meeting, and makes it easier for the best interests of the child to remain at the centre of all your planning discussions. See Appendix 3 'Chairing child centred planning and review meetings: good practice for independent chairpersons' for more details about care planning meetings. We record the outcome of the meetings using one of two protocols, depending on whether it is an initial or review meeting. See Appendix 2 for copies of these protocols.

### 3.2 Case example for reintegration

*"I attended a planning meeting for a little boy called Gheorghe. He had been admitted to DMSGD 4 weeks previously because his family had many social and economic problems, and this was the initial meeting following his admission. The case-planning meeting worked well because it followed the completion of a multi agency comprehensive assessment, and everyone that was important in the case was involved both in the assessment and in the planning meeting. Most importantly, this included the mother of the child, who was fully involved in the decision making process. This meant we were not making decisions about her child without her. What would be the point of doing that? It is her child at the end of the day, not ours. I learnt things in the meeting that I did not know before about the mum's situation. It helped me connect more with her as a human being, rather than someone with a big list of problems that I have heard about 'on the grapevine'. Actually I felt sorry for her. She does not really want to put her child in an institution but she has so many problems. I wish there was more help for people like this.*

*Despite her seniority and expertise, the Doctor involved in the case had a wonderful human approach to the mother. She did not try to put herself up high on a professional pedestal, but instead worked with the mother as a real partner in the care of the child, as did all the other participants including the CPD social worker. Everyone listened to each other and appreciated each other's opinion. The result of the meeting was a sound plan, firmly rooted in reality, which reflects the real needs of Gheorghe and his family. The overall goal in this case is reintegration, and we now have a clear idea of how we are going to get there in a step-by-step manner. Everybody knows what her responsibilities are and when they should be completed. Even the mum went away with a list of 'things to do', and we clarified exactly how often she will visit her son. We will be reviewing this case again in 3 months. The meeting really helped us to focus on coming up with a plan that was in the best interests of the child, not on our professional disagreements. When I first started attending these planning meetings I was really shy, I didn't know what would be expected of me. But now I like these meetings, they really add an interesting dimension to my job. I even came in on my day off to attend the last one."*

**Key worker from DMSGD**

### 3.3 A revolution in practice

The multi-agency case planning and review meetings have proved to be a revolution in the joint work of DMSGD and CPD. The meetings rely on full inter-agency cooperation and are, most importantly **child and family focused**. The child and the family are at the centre of the meetings. They are treated as genuine partners in the process and their views are sought. They are treated with the respect and dignity they have the right to expect as human beings and users of the public child welfare service in Ruse. We have learnt that every time we hold one of these meetings with various different combinations of families, doctors, social workers, psychologists, nurses and pedagogues we are spreading our message: these families are our customers. They are the reason we all have jobs. Their right to be treated with respect is not negotiable. And by treating them with respect and empowering them, we aim to support them to move from passive recipients of our services to genuine partners, and 'good enough' parents.

## 4.0 Preparing children to move between placements

### 4.1 Preparation plan

When we are planning to move a child from DMSGD we have learnt that it is vital that it is done in a planned and organized way. It is absolutely essential that the possibility of moving is only discussed with the child when we have a clear and definite plan of where the child will be moving to, which can only happen after the care planning meeting. In addition, it is too stressful and overwhelming for a three-year-old child simply to be told that they may move away from their home and all that is familiar to them. They cannot comprehend what it means at all. Children who are pre-verbal or have limited verbal ability and understanding cannot grasp the

changes in their lives simply by being told what is happening, particularly when we, the adults, are not clear ourselves what these changes will be or when they will occur. Moving babies and toddlers to an unfamiliar contact and unfamiliar people without proper preparation can be extremely frightening and traumatic for them, and may result in disturbed behaviour and developmental delays. For some comprehensive hints and tips on preparing young children to move from one placement to another, we have developed 'Preparing and moving children: a good practice guide' using the experience of the TMH2 project. This can be found in Appendix 3, and includes some guidelines on developing life story work.

#### **4.2 Case study for preparing and moving children**

*"We had some training from the TMH2 project officer about making preparation plans when moving children from DMSGD to a new placement. I was really interested in it and used the plan the next time a child was due to move. His name was Dimo, he was three years old, and, because there was no family based alternative for him (which was what he really needed) he was moving to Nedezdhe home. We identified that Dimo had a very strong bond with his key worker, Diana, and she supported him very closely through out the whole process. Dimo's first visit from his new Nedezdhe carers took place at DMSGD, as we thought it was important that it should be in a place that was familiar to him. Diana was there with him all the time, talking with him and reassuring him, showing him by her actions and behaviour that the carers from Nedezdhe were people he could trust and like, because she trusted and liked them too. We built the visits up gradually. One carer from Nedezdhe brought a toy as a 'transitional object' to help the move go smoothly. After the visit she took the toy back to Nedezdhe and told Dimo that it would be waiting for him when he arrived. We even gave the toy the name of one of his close friends, and made sure that everyone understood the significance of this toy for this child. It helped Dimo a lot to know that three of his little friends from DMSGD had also recently moved to Nedezdhe.*

*When the time seemed right, Dimo started to visit Nedezdhe, slowly building up the length of his visits, and always supported by his key worker Diana from DMSGD. In between visits, we were constantly reinforcing to Dimo that this move was going to happen and that it would be positive and whom he would see and what he would do at Nedezdhe. We also talked with him about any sad feelings he had about moving, and made sure he understood it was ok to be sad, that it was normal. We did this through playing games, so, for example, when Dimo came back from a visit to Nedezdhe we used a toy telephone and got him to pretend to call one of the other staff and tell her all about his visit. All the time we tried to put ourselves in Dimo's position and imagine how it was for him, as a three year old boy who had lived at DMSGD nearly all his life, to move somewhere else. We learnt that we needed to make his psychological and emotional well being the most important aspect in the move, and that everything needed to happen in a slow and step-by-step manner, going at his pace, not ours. Eventually Dimo moved, but we still keep in touch with him and go to visit him, to reassure him we are still here, and that we still care about him. Resources permitting we will continue to do this for some time to come until Dimo doesn't need us to do it anymore. I think the plan worked very well, and we are using what we learnt from the experience and transferring it to all the moves that children have to make from DMSGD."*

#### **Psychologist from DMSGD**

### **5.0 Child abuse and Child protection guidelines**

#### **5.1 Responding to and recording issues of concern**

We have learnt a lot from one case in TMH2 in particular. In a case assessment meeting with DMSGD and CPD colleagues, one of the issues talked about was concern about the nature of the relationship between a child who lived at DMSGD and her father. Several different professionals involved in the case had expressed concerns about things they had seen the child say and do, and things they had seen the father say and do, and these incidents led them to be concerned about the child's welfare when she was in her father's care. However, unfortunately it was difficult to get specifics in the case because none of the incidences of concern had been recorded. These incidents had taken place over quite an extended period of time, therefore, we could not really get a clear picture of what had happened and when, and what the detailed facts of each concern and allegation were. It is absolutely essential that the appropriate people are immediately alerted to issues of concern, that they are clearly and accurately recorded on the child's file and that immediate action is taken to assess the risk to the child and appropriate plans made. We cannot place children in a position of risk or harm with their parents or anyone else. It is very important that we have a full and clear picture, based on facts, not on assumptions, in order to devise a plan that is in the best interests of the child. That is why it is important to record the incident as soon as possible after it has happened while it is fresh in our mind. As a consequence of this discussion, we, alongside our colleagues, developed some good practice guidelines to support front line practitioners who deal with these sorts of issues every day. They can be found in Appendix

3, entitled "Protecting children from harm: responding to and recording incidents of concern regarding children at DMSGD".

## 5.2 Case study for child protection

*'We used the child protection procedure in one case where there was a brother and sister about whom we had real concerns about the treatment they were getting from the father. The father seemed to have a sexual interest in his daughter. We could not be exactly sure what was going on, but our gut instincts told us something was wrong. We used the recording form to record precise incidents of concern, and then in the planning meeting the multi-agency team was able to come up with a straightforward plan to protect the children whilst assessing the real nature of the risk to them and the father's capacity to address his behaviour with appropriate support. Because we had written records of each incident of concern, the plan could be drawn up on the basis of hard evidence and facts, rather than on supposition, interpretation or hearsay. In addition, we checked out with prosecutors the possibility of forcibly removing this father's parental rights against his wishes, if this proved to be the course of action that was in the best interests of the children. As I understand it, this is very difficult to achieve in the current political and legal climate, and this is a gap that needs urgent attention'.*

### TMH2 project Technical advisor

## 5.3 Parental rights versus parental responsibility

In our work we have learnt that it is more appropriate to talk about 'parental responsibility' rather than 'parental rights' as is the current terminology in the law. Parents do not have rights over their children, they do not own them. But they do have responsibilities towards them. Unfortunately for the children we work with, although this position is supported to some extent in the Family Code, it is not supported by current judicial practice. The law of the land, the judiciary and best social work practice need to work together to protect the best interests and rights of the child, and the current situation seems to be that the 'rights', and therefore the stated wishes, of the parents, whatever they happen to be and whether they reflect the needs of the child or not, often take precedence, much to the frustration of CPD colleagues. In some cases the best interests of the child would be served by severing the legal link with their birth parents, whether the parents want this to happen or not. This is only in a few cases, as in most incidences parents want to do the best for their children, in which case our job is to support them to do this. But it does happen. Examples of such cases are where there are concerns about child abuse issues, or after repeated attempts to support the parents to demonstrate 'good enough' parenting skills, it becomes clear that this is never going to happen. A small minority of parents are positively dangerous for their children. The right of the child to a safe, family based upbringing has to be the most important principle, rather than the parents' rights over their child, and the legal system and the judiciary need to be able to respond to the complex social work judgments that are involved in these cases. These cases are always very complex, and making a judgment in them is one of the most difficult decisions the team has to make. They need support and guidance in how to do this and a legal system that will offer them the opportunity to press for the forcible removal of parental rights when this proves to be in the best interests of the child. They also need other resources, such as a better developed foster care system, so that they have different alternatives for placing children should they need to be removed from their parents for child protection reasons.

## 6.0 Using jargon

Given its emphasis on inter agency working, it became obvious to us that all interactions and communications between the different people and groups involved in the TMH2 project needed to be clear, understandable and 'jargon free'. Jargon is essentially professional short hand, and within one professional grouping where all the members understand each other it can be fine. But when we work in a multi-agency and a multi-disciplinary way it is essential, in our experience, to talk and write in simple, jargon free language, so that everyone understands. Sometimes people hide behind their professional jargon as they feel it 'protects' them and excludes everyone else: it makes them feel clever and makes everyone else feel stupid. But this does not help anyone. There are many other ways to show your professionalism, such as meeting your agreed obligations on time and treating clients with dignity and respect, but using jargon is not one of them. Sometimes people are so used to using jargon they do not even know they are doing it! This is why we have put a glossary at the end of this manual to explain any jargonistic terms we have used.

TMH2 project has encouraged us to work in as jargon free environment as possible. If one of our colleagues in the multi-agency network uses jargonistic terms we do not understand, the chances are that there will be plenty of other people who don't understand either! Professionally and diplomatically asking the person to explain what they really mean is the only way to find out what is really going on, and we no longer feel ashamed to do this (after a lot of practice!). Hopefully once a 'jargon loving colleague' has had to explain

what they mean many times over they will realize that it is much less frustrating for all involved if they just use simple language that everyone can understand. Most importantly, this helps our clients, both parents and (where appropriate) children, who rarely understand what we are talking about when we use professional jargon, and as a consequence become excluded from discussions that are about **their lives**. And how ridiculous is that? We have learnt in TMH2 that where we must use jargon, we must also try to get into the habit of explaining what we mean in very simple, everyday terms.

## **7.0 Supporting family contact visits between children and their parents**

### **7.1 Family visiting area**

As part of the TMH2 project Save the Children supported both CPD and DMSGD to develop a Family Area. In DMSGD the purpose of the room is stated in 'The Family area concept paper', which can be found in Appendix 3. The key purpose of the room is to support and strengthen the relationship between parent and child after the child has been admitted to DMSGD, and to this end, DMSGD has appointed and trained a duty team to provide cover during all the official visiting times at the home. Depending on the child's needs (as specified in their individual care plan drawn up in the multi-agency planning meeting), DMSGD workers work alongside the parents to observe their visits to the child, to encourage the bond between parents and their children and to model good parenting skills. The aim of all of this work is to assess and strengthen parental capacity. Workers periodically record their observations and assessments of family visits. They do this using 'The Family contact visit observation form' (see Appendix 3). This form is then placed on the child's file, and a copy should be forwarded to CPD for their information. **It is very important that this information is shared with CPD, as it is the only way they can get an accurate and realistic picture of parental capacity, and the quality of the relationship between a child living in DMSGD and his or her parents. This is essential in order that they can assess whether reintegration is in the child's best interests and how it should be organised. This prevents the child from 'drifting' in the institutional system and provides the CPD with the quality of evidence they need to take a case before the Court.**

When completing the form, we have learnt that it is very important to record only what you see and hear, and to be very specific. For example, rather than saying 'the child was very happy to see her mother' it is better to say 'the child smiled and reached up her arms to her mother to be picked up'. For more hints and tips see Appendix 3 'Issues to consider when planning a family contact visit' and 'An example of a family contact plan'. During the development of our work in the Family Area, we have learnt that it is very important that the room is both child and parent friendly, and is a place where they can both feel comfortable. Families do not need the room to be very grand; they need it to be cosy and welcoming. More work needs to be done in the Family Area at DMSGD in order to fully achieve this goal, but at least we have made a start.

### **7.2 Family visiting questionnaire**

When we started our work in the DMSGD Family Area, we realized that we really didn't know what the families themselves wanted from the room. This seemed ridiculous. The room was aimed at them, and yet we didn't know what they wanted or expected from it. To rectify that, we developed a questionnaire and interviewed a cross section of 12 parents and other relatives to find out their attitudes and opinions regarding the family visiting arrangements in place at DMSGD. During the interviews emphasis was placed on encouraging the parents to be as relaxed and open as possible in order to achieve the most useful results. Many of the parents were not used to being consulted in this way, and found it a little overwhelming at first. But with patience and persistence, the interviewer managed to win them over. See Appendix 3 for the results of the questionnaire, and our recommendations for follow up work.

The process of completing this piece of work taught us many valuable lessons. We realized that it is only by asking the 'users' of the service what they think and feel that we can hope to develop new services within DMSGD that are truly based on need. We realized that seeking and including the views of parents is a crucial part of developing the 'jigsaw' of community-based support services for vulnerable families. We learnt that with skill and patience even the most socially vulnerable parents can be empowered to make a useful contribution to new service development, and moreover, it is their right to be asked. We concluded that the question is not if we should include the views of parents when we are developing new support services that are aimed at them, but rather how. As a direct result of completing this piece of work, important changes were made at DMSGD to strengthen our work with families, including a new notice board at the front of the building, with the visiting times clearly stated in both Bulgarian and in a diagrammatic format for those parents who cannot read (a clock with the visiting times shown by a shaded area).

## 8.0 Restructuring the work of DMSGD

### 8.1 Developing weekly and daily care services

As well as the continuing development of the Family Area, DMSGD has made other changes to the services it offers to children and families. This is in an attempt to decrease the over reliance on long term residential care (which few children need) and instead offer a more comprehensive package of support to children and families who are in desperate need of community based support services that help them to stay together, rather than separating children from parental care. The main services that have been developed include a new weekly care scheme (which ensures that children go home to their families every weekend), a day care scheme for chronically ill children and a daily rehabilitation programme for children with disabilities. Like the residential care places in the home, all of these services are accessed via an assessment of need and request for support from the CPD. All of these new services are operated under strict criterion to ensure that the services are really reaching those who are most in need, and are offered in addition to the purely medical service of the Special Care Baby Unit for premature and underweight babies who come directly from the Maternity Hospital.

There is more information about the new services in the next chapter in this manual on the 'Stock and Flow' of children in the home. The agreements for weekly care that are signed between the CPD and DMSGD and DMSGD and the family can be found in Appendix 2. The day care and daily rehabilitation assessment system and referral form can be found in Appendix 2. Although we still have concerns about the separation of children on the weekly care scheme from their parents, in the current climate these new services represent important steps in the right direction. It is clear from our experience that many new types of services need developing in order to drastically reduce the over reliance on residential care for vulnerable children and their families. For more details see the conclusions at the end of this chapter.

## 9.0 Caring for the carers: stress, supervision, support and team building in child welfare

### 9.1 Stress

Through the development of the TMH2 project we have realized that one of the most often forgotten about 'burning issues' is that of staff supervision and support. Social welfare work with children and families (whether in CPD or DMSGD) is one of the most stressful and demanding jobs there is. This is because the 'people focus' of the work involves several intrinsic factors that can lead to stress:

- **Uncertainty** - child welfare workers operate in a constantly changing environment, and working with people is inherently uncertain, as people, unlike machines, are rarely predictable.
- **Vulnerability** - when things go wrong in a case, as they sometimes do (even with the best case management practices in the world), it is often the front line workers that have to shoulder the blame.
- **Pain and suffering** - the lives of the majority of our clients are rooted in pain and suffering. If they weren't, then they wouldn't be clients of the child welfare service.
- **Poverty** - this has a grinding effect and can severely limit the options for solving problems within a family in a way that is in the best interests of the child.
- **Discrimination and oppression** - Many of our clients are victims of this. It is hard to be a daily witness to its affects and to ensure that we don't compound them through our action or inaction because of our own prejudices or stereotypes.
- **Care versus control** - Child welfare workers are often charged with caring for their clients, but also controlling their behaviour, which can be a very difficult balance to achieve. This is especially the case where the workers' legal powers seem insufficient to operate in a way that promotes the best interests of the child (see the section above on child protection).
- **Resistance and intractability** - some clients are highly resistant to change, despite the best and most sensitive efforts of the workers involved. It is stressful to witness the affects of this on the child.
- **Violence and aggression** - It is not unusual for child welfare workers to be on the receiving end of violence and aggression, both physical and verbal.
- **Insufficient resources** - On top of all of the above stressors, child welfare workers often operate in an environment that is starved of resources. This is both in terms of being able to access appropriate support services for their clients and also in terms of being overworked, underappreciated, and vastly underpaid. Not a good recipe for a stress free life.<sup>1</sup>

*Quote: "We could not be more committed to our clients, but we are only human beings. Even if you managed to clone each one of us ten times over there would still not be enough workers to cope with all the things we*

<sup>1</sup> Reference: Meeting the stress challenge, Thompson, Murphy, Stradling, 1998, RHP

have to do". Training workshop feedback from CPD colleagues during an exercise entitled 'a message to our managers'.

*Quote: 'There are many instances where the system works against us in our work with vulnerable families. For example, impoverished families are entitled to have the cost of applying for their lichnacarte identity card reimbursed at the end of the process, but many of my clients simply do not have the 20 leva needed up front. Without their lichnacarte, they cannot access any of their basic rights, so it is a catch 22 situation. In some cases, I have found that the only solution is to lend them the 20 leva out of my own pocket, and then they pay me back later. It is easy for families to become demotivated and give up when the systems put in place to supposedly support them seem to work against them'*

**Social worker from CPD**

## 9.2 Useful tools in stress management, supervision and team building

**Because of the stressful nature of child welfare work, staff supervision and support is a hugely important issue.** In the THM2 project, we have proved the enormous significance that stress, staff supervision and support have in our work. If a team is not well supervised, then team members, and ultimately the work itself, suffer considerably, and supervision in child welfare is much more complex than merely 'overseeing' the work of the team. All three of the external evaluations of the TMH2 project have highlighted the need to make supervision more of a priority in order to achieve quality casework and good team support. This issue has been shown to be a central cross cutting theme that impacts on all aspects of a quality child welfare service. For hints and tips on facilitating successful supervision in child welfare see Appendix 4 'Supervision: good practice guidelines'.

Other tools and good practice guidelines that we have found useful can also be found in Appendix 4. 'A framework for reflective practice' helps workers to think deeply about their practice and is something they can complete before supervision as a learning method in order to show the supervisor they have actively reflected on their experiences in a particular case, and learnt from it. 'Developing the abilities and skills of social workers through professional supervision; the ten key areas of professional social work' gives suggestions on the sorts of professional practice issues that can be addressed in supervision. 'Skills of effective supervision' gives hints on how to provide effective feedback. "Symptoms of stress" shows what to look out for when assessing whether you or your colleagues are suffering from stress related illness. 'The Team openness exercise', 'The Building blocks of an effective team' and 'The Signs of healthy and unhealthy teams' help us to focus on team building as an essential staff support method.

**The main lesson we have learnt in this area of work from our experience in TMH2 is that the staff team is the most valuable aspect of any organisation. Workers in child welfare in Bulgaria do an incredibly difficult job and they need rewarding, supporting and investing in by every single layer of management that is above them, right up to the government itself.**

## 10.0 Conclusions

### 10.1 Widening the provision of child welfare services through redirecting existing resources

Through the implementation of Save the Children's TMH2 project, we have become very aware of the wide range of child welfare service that need to be developed in order to meet the needs of the children who are at risk of being institutionalized, or are currently institutionalized. **Some of these services, as described by this manual, have already been started. Some work very well, some could be vastly improved to become more child and family focused, and some need developing from the beginning. These services include:**

- I. **Prevention and reintegration child welfare services** (including the targeted use of the State Fund and gate keeping at the Maternity Hospital as described in this manual)
- II. **Mother and Baby Residential Unit** (to support the residential placement of mothers and their babies together, to promote attachment and prevent the separation of mother and child and ultimately prevent abandonment).
- III. **Daily rehabilitation and day care services** for children with disabilities living in the community (see 8.0 'Restructuring the work of DMSGD').
- IV. **Foster care placements** to meet a wide range of needs including:
  - a) Pre-adoption/emergency reception foster care to prevent institutionalisation at the point of the initial separation from the birth mother, whilst longer-term plans are made for the child. This

can also include foster care placements for reasons of child protection even when this is against the parents' wishes if the child is at risk of significant harm (see 5.0 'Child Abuse and Child Protection').

- b) Short term foster care: for children currently resident at DMSGD as a stepping -stone to reintegration with their birth families or to temporarily support families under stress where the child is currently living in the community.
- c) Respite foster care for children with disabilities (see also (v) below).
- d) Long term foster care where the child is not suitable for adoption either for legal reasons, or because of disability, or because we want to keep a sibling group together and cannot find an appropriate adoptive placement, or where continued contact with the birth family is in the child's best interests. (See Save the Children's manual on foster care for more details).

**V. Small specialist family type residential units** for children with disabilities, both for permanent residential care and /or respite care to support families in the community with the stress of bringing up a child with a disability (another alternative would be for this services to be provided by specialist foster carers who would need the back up of other community based services such as day care etc).

**VI. Adoption social work:** assessment, matching, preparation of children, life story work etc.

## 10.2 So much has been achieved!

In doing the research and writing new material for this manual, we have been incredibly struck by how much things have improved in child welfare in Ruse and Bulgaria since Save the Children's TMH2 project started in 2002. Some of our partners might be reluctant to acknowledge this, partly because they are naturally modest and partly because sometimes it is easier to focus on what is wrong in our work rather than what we have achieved. It certainly was not in the forefront of my own mind until I started to look back and remind myself what things were like three years ago. But I can honestly say, as a partially outside observer and supporter of the process of change, it is very impressive how much services and systems have improved in such a short space of time. Hopefully the technical assistance from TMH2 project has made a useful contribution to building the capacity of the child welfare services in Ruse and nationally. However, the child welfare world in Bulgaria is not based on a self-contained project with a start and finish date. In the world of CPD and DMSGD life goes on, practices improve, children and families are helped and workers are stretched to the limit. TMH2 made a three year contribution at the beginning of their journey, but the process of change and improvement in child welfare services will be ongoing as services move ever nearer to reflecting systems and practices that operate in the best interests of children. As they are on the front line of delivering those services, our hard working partners will need to save some time and energy to devote to lobbying for change, as they are in the best position to judge what changes would have the biggest impact on children's lives, and where the biggest gaps and problems are. And those in the position of policy and law making will need to listen very intently to what our colleagues, and the children and families themselves, have to say, in order to have a child welfare service in Bulgaria that is child centered and genuinely responsive to need.

## 10.3 What's next?

What is next for child welfare in Bulgaria? So much has been achieved, but yet there is still so much to do. Relative to population size, there are still more children reliant upon institutional care in Bulgaria than in any other European country. What a shocking statistic for a country about to enter the European Union. We have helped to lay the foundations of a more responsive child welfare service, but there are still many new services that need developing and a lot of resources that need to be redirected to reduce the number of children in residential care to its lowest possible number. There will always be a need for a small number of residential services for children (in small family type homes), however, as we all know, the majority of limited public resources should be channelled into strengthening and developing community based alternatives that actively work to keep families together. This is both in line with the UNCRC and the Bulgarian Government's own strategy for deinstitutionalisation.

**Closing long-term institutions is never a primary goal in itself**, and it is absolutely clear from our experience in TMH2 that there are many talented, child centered and committed staff who currently work in the institutional system who, given the chance, would make an enormous contribution to community based alternatives. The **primary goal** of deinstitutionalisation is to find for every child the appropriate, long-term solutions that are in his or her best interests, within a family or family like environment. The **main aim** is to place the child with caring adults who will accept the responsibilities of parenthood. The **real task** is to find for each child a secure long-term family based solution. Through decentralizing services, and redirecting

resources to develop community-based solutions that really meet the needs of the children and their families, the true mission is to ensure that large-scale long term residential institutions are no longer necessary in Bulgaria.

**Rachel Nightingale, Technical Advisor  
2002-2003, 2004-2005**

## Training and Technical Assistance for Take Me Home 2 (2002-2005)

*"You must be the change you wish to see in the world", Mohandas Gandhi, 1869-1948*

### Introduction

Training and technical assistance has been a key component of Save the Children's Take Me Home 2 project. The aim of all our training has been to build the capacity of our partners to deliver high quality child welfare services. The reason we thought SCUUK could make a contribution to this is that this way of working was, and continues to be, quite new in Bulgaria. Social work is a very new profession, in its early stages of development. Although many of the new social workers were qualified, they lacked the practical skills and experience to do real hands on work with vulnerable children and families. This is because there has not been a long history of social work in Bulgaria, and so from the lecturers' point of view it is very hard to teach someone how to do something if you have never done it yourself. Social work is a very practical task. Good knowledge of theoretical concepts is very important, but unless the practitioner has the skills to turn this knowledge into quality social work practice, they will not succeed.

*Quote: "I learnt more about how to work with families in a 3 day course delivered under the Take Me Home 2 project than I did through out my entire University social work Masters course" Social worker from Ruse CPD*

Before deciding what training to facilitate under the TMH2 project, and how to do it, we did an initial needs analysis. This was to ensure that any training we facilitated was based on the real needs of the multi-agency team, and not on our preconceived ideas of where the gaps might be. We did that by asking our partners what kind of issues they would like to receive training on, and by spending time with our colleagues, observing their practices and noting strengths and gaps in knowledge and skills.

Through this initial needs analysis, we learnt that what the multi-agency team needed was training that was really practically based and that gave them the opportunity to network with each other. Thus, SCUUK provided technical assistance in a number of different ways, sharing expertise and experience and supporting partners to find their own approaches to the difficult issues they faced in their daily work.

The training programme we devised ran over the course of the project and had several different components: formal training courses, hands on training, and study tours.

### Formal training courses

Formal training took several different forms. The very first training we did was for thirty participants from CPD, DMSGD, the Maternity hospital, municipality representatives, workers from the different regional offices of DSA, and representatives of local NGOs. The purpose of inviting so many people was to create a strong network of practitioners from all the key agencies that would need to work together in order to strengthen the child welfare system in Ruse. The training lasted for a week and was entitled 'Community based social work with children and families'. The main subjects covered included introduction to the project, management of change, use of self in child welfare, community profiling, values and attitudes, basic principles of social work, working with the Roma Community, listening to children, the UNCRC, attachment theory, children's needs, linking TMH2 to the research that preceded the project (TMH1), interviewing skills, genograms, assessments, prevention and reintegration work, dealing with aggressive behaviour, child abuse and child protection, case recording and working with other professionals. Some of the materials from the training can be found in Appendix x.

After this initial induction training, we held several other workshops and training courses, based on the developing needs of the project. Some of these courses were just for CPD and some were just for DMSGD. But by far the best received courses were those that invited participants from both agencies as this strengthened their capacity to work together more successfully. The subjects we covered in these courses included prevention and reintegration procedures in social work with children and families, establishment and use of the project Fund (later superseded by the State Fund), team building, support and supervision, working in a multi-agency network, weekly care scheme, communicating with children, chairing client centered meetings and supporting family contact visits at DMSGD. Some of the materials from these trainings can be found in Appendix x.

Where possible, we tried to arrange courses on a residential basis a short distance outside Ruse. This was to enable participants to give the course their full attention without the distractions of their every day jobs. It also helped to build up the interpersonal relationships between team members, which helped with team building and in terms of supporting colleagues with the stress of their jobs, as they got to know each other better as people.

When it was possible we tried to facilitate courses over a period of two days. This gave more time to build up a full exploration of the topic, and allowed participants time for thought and reflection.

The approach we used was one of 'participatory learning and action', otherwise known as 'learning by doing'. We used this approach because research has shown that adults learn much more by actually taking an active part in their own learning, rather than just sitting and listening to a lecture. This is particularly true in the field of child welfare and social work, which is so practical and skills based.

In each training course we attempted to equip the participants with the knowledge, skills and values they would need to strengthen this particular area of their practice. This meant we used a wide range of training methods to explore our subjects such as full and small group discussions with feedback, using case studies, role-plays, short presentations, providing handouts, using flash cards and training 'games'. Each training started with an icebreaker exercise to warm up the participants and focus them on the reason for the training. This was followed by an exercise to determine what the participants hoped to get from the training, and any worries they had. The courses always aimed to be action focused, that is they aimed to finish with a clear plan of how the participants were going to implement what they had learnt in their daily work, any obstacles there would be to this and how they planned to overcome them. At the end of each course we always asked participants for their written feedback on the course, so we could understand how useful the course had been to them and improve our own training skills. The course facilitators and speakers came from a wide variety of backgrounds in order to further enhance the learning environment. This included Technical Advisers with extensive social work experience from the UK, experts from Bulgarian state and NGO structures and the real experts: service users themselves.

After each course we always distributed a training report. This included the main recommendations that came out of the training from the perspective of the participants, comments from the course facilitators, copies of any flip charts the participants had completed, a copy of the feedback the participants had given about the course and finally a contact list so that participants could continue to network with each other beyond the course. This was particularly important in courses where there were participants from several different agencies.

Some of the training delivered under TMH2 was delivered within the same time period as the World Bank training that was organised under the Child Welfare Reform project. Our colleagues were involved in this as Ruse was a pilot site for this project. Although it was good for the participants to get different perspectives on child welfare issues, at times CPD colleagues in particular were in danger of being overwhelmed by training without having time to implement it, despite our best efforts to avoid this. This shows how important planning is when it comes to training and technical assistance.

### **Informal training**

In addition to the formal training sessions, one of the components of the technical assistance to the TMH2 project was informal hands on training. We learnt that this was just as important as formal training sessions, in order to follow up the learning from the formal training sessions and help with the implementation of new practices. By having a foreign Technical Adviser and a Bulgarian project assistant attached to the project on a full time basis, it meant that we were on hand to answer any queries and support colleagues in taking the work forward. As the confidence of colleagues improved over time it was not necessary to have a foreign Technical Adviser present all the time. At this point, the role of the Bulgarian project officer became much more crucial, as she became the person who was on hand to advise the colleagues with the implementation of the new forms and systems that had been developed during the formal training.

Our approach was very much one of facilitation and support, rather than didactic lecturing of 'how things are done abroad'. This is of very little use in the Bulgarian context. What is useful is to learn about new methods of working, values and approaches that can be adapted to the Bulgarian context, bearing in mind the legal system and culture of this country. By taking a team approach and encouraging a learning environment, we were all able to learn from each other.

### **Study tours**

In order to complement the formal and informal training that took place throughout the project, SCUK facilitated study tours for key partners to other parts of Bulgaria and abroad. The focus of the study tours was on targeting front line practitioners who would benefit from seeing similar types of projects to TMH2 and to share and exchange experiences with colleagues doing similar types of jobs.

Two of the first study tours we conducted were to EveryChild project sites in Plovdiv and Haskovo, to learn from their experience of establishing child welfare procedures and systems within the CPD and large-scale

residential care institutions for children. This was extremely useful as we learnt that we were not alone in our journey. As we gained more experience, we have also opened our doors to study groups from other parts of Bulgaria such as Razgrad, plus other CPDs in the Ruse district, so colleagues from these municipalities can learn from our experiences.

In addition to these study tours in Bulgaria, SCUUK also facilitated international study tours to Romania and Ukraine. The Ukraine study tour was organized by EveryChild Lviv office. It was very useful to compare our experience with Ukraine, as they were implementing a very similar project within the equivalent of a CPD and a DMSGD, and were just a few steps ahead of our project. The study tour was very useful for colleagues from both countries. The Romanian study tour focused on visiting child welfare services and examining the structures and systems our neighbours across the Danube have in place. Again they are a few steps ahead of Bulgaria, particularly when it comes to decentralization and developing community based child welfare services at a local level. It was really interesting to see how the reform process was developing in a country so close at hand.

We specifically chose to have study tours to places that were close to Bulgaria, both in terms of geography and recent history and politics. Both Romania and Ukraine are countries in transition from a centrally planned communist philosophy to a market economy, with all the subsequent challenges that presents for socially vulnerable children and families. Both these countries have a history of placing big numbers of children in large-scale residential public care, in the way Bulgaria has. Hence study tours to these countries were of much more relevance than tours to Western Europe which has a very different political and therefore child welfare history, and in any case, the project was already getting the benefit of western experience via the Technical Advisers. This combination of experience exchange from all over Europe proved very useful in allowing project partners to take the best from everywhere and decide what has the most relevance to the Bulgarian context.

## **Conclusions**

We have learnt from the implementation of the TMH2 project that child welfare professionals need the following things from their training in order to provide clients with a quality service:

1. Training that is practice based with a very practical agenda.
2. Training that is facilitated using a participatory approach and a variety of different methods.
3. Training that promotes and facilitates networking opportunities with professionals from other relevant agencies.
4. Training that is genuinely based on need, not just pushed on them because someone else thinks it is a good idea.
5. Training that is part of a broad overall plan to support workers and increase capacity in a structured manner.
6. Training that is a mix of theory and practice
7. Training that gives exposure to new ideas and methodologies, and space to reflect on these and adapt them for their own context.
8. Training that allows for follow up support, either through subsequent training or hands on support.

**Rachel Nightingale, Technical Advisor  
2002-2003, 2004-2005**

## Monitoring the statistics of children at DMSGD: The Take Me Home 2 Stock and Flow Analysis

### The importance of having the full picture

At the start of the project, we found that the information provided by DMSGD about the numbers of children in the home was patchy, incomplete and with internal inconsistencies. To tackle this problem, at the beginning of 2004 we devised and implemented alongside DMSGD a new monitoring system, which we named "Monitoring sheet - Number of children at DMSGD, Ruse - Stock and Flow analysis". (See Appendix 2) It was enormously helpful to the implementation of the project because it gave us the opportunity to see the wider picture in a much clearer and more straightforward way.

Six categories have been developed on the monitoring sheet/stock and flow analysis:

- 1) Adoption
- 2) Baby Care Unit
- 3) Temporary care
- 4) Weekly care
- 5) Daily care
- 6) Daily rehabilitation

This way we were able to observe:

- The number of admissions and discharges of children to DMSGD per month
- Where the children came from, broken down into categories of birth family, extended family, other institutions, alternative service, or from the street.
- Where the children went at the point of discharge, broken down into categories of birth family, extended family, adoption (national or international), other institutions and other alternative services.
- The total number of cases transferred within DMSGD to another category each month and the reasons for the transfer, which gives information about the development of the cases.
- The geographical spread of children admitted to the institution. It is often the case than there are more children from certain geographical areas in institutions that from others. This information assists in planning the appropriate geographical location for alternative services.

We maintained the monitoring for one full year from January 2004 - December 2004. The following are some observations based on the data collated:

#### Observation 1

The number of the children for adoption has been reduced from 59 at the beginning of 2004 to 32 at the end of the year.

#### Comment:

- ✓ Due to the Ordinance for Prevention of Child Abandonment and Re-integration adopted in August 2003 and Recommendations for Co-operation between Maternity Hospitals and CPD (both documents informed by our THM2 experience) good communication between the CPD and the Maternity Hospital has been established. CPD social workers are now informed immediately about every individual case when there are strong indications that the mother is inclined to declare the child abandoned. That gives them the opportunity to visit those mothers in the Maternity Hospital and to support them to rethink their decision, when possible.
- ✓ **No child can be placed in DMSGD if he/she has not been referred by CPD.** In comparison to the past when the children could be directly placed in DMSGD for adoption or care, simply by means of a contract between the parents and the Director of the Home, the current situation is completely different. No child can be declared abandoned and admitted in DMSGD before the CPD social workers make a comprehensive assessment of the family situation and the needs of the child, including support to the mother and the family to reverse their decision for abandonment. (1)

#### Observation 2

- The number of the children for temporary care has increased from 47 at the beginning of 2004 to 56 at the end of the year.

- The number of the children for weekly care has decreased from 23 at the beginning of 2004 to 16 at the end of the year.

**Comment:**

- ✓ There is a link between the reduced number of children for adoption and the increased number of children for temporary care (see (1) above). This shows that there are many cases in which the families, although in very difficult social and economic circumstances, would prefer not to declare their children abandoned if they can be supported adequately by the social workers and allowed time to resolve their problems.
- ✓ Some of the children currently receiving temporary care have been transferred from weekly care. (That is why the number of the 'weekly care' children has decreased). It was agreed between DMSGD and CPD (initiated by SCUUK) that children applying for weekly care will have to meet a fixed criterion: the child or their carers must have a medical problem. In addition, the parents of the child have to take the commitment to regularly take their child home for two days weekly. These two points are underpinned with a formal contract entitled '**Agreement Between the Child's Parent or Guardian and the DMSGD**' (See Appendix 2). This was developed during the project and has been in operation since February 2004. Parents/carers sign this contract at the point of admission of the child. According to the Agreement "failing to take the child home each week may result in the child losing his/her place on the Weekly Care Service". This agreement is reviewed regularly during the individual child's case planning meetings and all the children who do not continue to meet the criterion and haven't been taken home regularly are transferred to temporary care. This provides a more accurate reflection of the true picture of the nature of the children's placements at DMSGD.

**Observation 3**

- The number of children using the daily care service has increased from 18 at the beginning of 2004 to 28 at the end of the year
- The number of children using the daily rehabilitation service has increased from 3 at the beginning of 2004 to 20 at the end of the year

**Comment:**

- ✓ All the children using these two services must meet the criteria of having a medical problem. All of them are referred by CPD in line with the new Regulations for DMSGD introduced in October 2004. **It has become apparent that many families from the community demand these kinds of services, and many children benefit from the input.** At the same time however, these services can be provided by other, non-institutional agencies.
- ✓ There is no logical reason why the number of daily care and daily rehabilitation children should be added to the total number of children residing in the Home on a full-time basis. (This overall figure is then the basis for forming the budget of the DMSGD, including staffing levels). Daily care and daily rehabilitation services have to be costed and budgeted separately, as the children who use them receive only daily and (in many cases) hourly care, in contrast to the residents who have full-time care.

Through monitoring the Stock and Flow of children with our DMSGD partners, we learnt that although the total number of children has remained the same (within a narrow range of fluctuation), the internal flows for 2004 have been in favour of the part-time services. These are services such as temporary placement with a plan for re-integration or foster care (including a strong emphasis on encouraging parental visits), daily care for children with health problems and daily rehabilitation for children with disabilities from the community.

Based on the data collated for 2004 we produced a series of graphs that demonstrated, on a monthly basis:

- The number of children in each broad category
- The internal dynamics of the adoption cases
- The number of children for adoption (according to municipality)
- The frequency and type of admission and discharge etc.

See a sample chart in Appendix 2.

We have learnt that monitoring and analyzing the statistics of the stock and flow of children in DMSGD is one of the best possible methods of assessing whether the new procedures we have implemented in relation to prevention and reintegration are, in fact, working. This has two possible impacts. First it is good for our confidence: we know - because we can prove statistically - that we are working in the right direction to achieve our ultimate goal. Second, if the figures are not as good as we hoped then this shows us clearly

what we have to change. **One of the clear outcomes of this process has been the confirmation that we desperately need foster care placements, potentially for the overwhelming majority of children who are currently living at DMSGD, particularly those on temporary care orders or waiting for adoption.**

From our experience, we can highly recommend this method of monitoring the number of children as it provides the full picture of the movement of children in and out of the institution and is very helpful when planning the development of alternative services and resources, all aiming to operate in the best interests of the children.

**Diana Georgieva, Project officer  
May 2005**

## Glossary

Please note that this glossary represents definitions of words, terms and phrases as they are specifically referred to in this manual.

- **Assessment (initial and comprehensive):** a preliminary and then a full investigation into the circumstances of the case, includes gathering information, analyzing it and drawing conclusions. Provides information about child's needs, parental capacity and wider family and environmental factors (see assessment triangle in Appendix 1)
- **Attachment:** the bond between a child and his or her parent/main carer.
- **Best interests of the child:** this should be the guiding principle in all decisions made about the child, what decision would serve their interests the best?
- **Birth family:** the child's own biological family
- **Care Plan:** the plan of work in a case, most effective when agreed on by multi-agency team
- **Care planning meetings (initial and review):** preliminary and then subsequent multi-agency meetings to make a plan for work that is in the best interests of the child
- **Care system:** refers to all aspects of the system as it relates to children in public care, be it institutional or community based e.g. foster care
- **Case:** the situation of an individual child as it relates to your organisation
- **Case file:** an individual file in which all the records relating to the child are kept
- **Caseload:** the number of cases/clients that one worker has responsibility for
- **Case management:** managing the work in the case in an effective and appropriate manner
- **Child abuse:** physical, sexual, emotional abuse and neglect of children
- **Child centered:** focused on the needs and best interests of the child
- **Child Protection:** work to prevent and address child abuse
- **Client/Service user:** the customer of the child welfare service
- **Community based services:** support services based in the community that encourage families to stay together rather than separating children from parental care
- **Community resources:** the services that are available in the community to support a family e.g. GP surgery, kindergarten
- **Contact plan:** a written plan that shows the nature and frequency of visits between parent and child
- **Contact visits:** visits between children in institutions and their parents
- **Daily care/rehabilitation:** a service offered on a daily basis to children with disabilities who are living in the community, similar to a kindergarten. The child goes home every night.
- **Decentralisation:** the process of redirecting resources away from centrally controlled budgets and services to locally controlled budgets and services e.g. away from a centrally run Ministry in Sofia to a locally run and accountable Municipality.
- **Deinstitutionalisation:** the process of developing community based services on the basis on need, redirecting resources away from institutions towards these alternative services and ultimately closing institutions
- **Developmental delays:** set backs in a child's ability to achieve certain goals by a certain age (either physical or mental), usually as a result of growing up in an institution. Developmental delays can be recuperated very speedily on placing a child in a family environment.
- **Discrimination:** actions against certain people or groups of people on the basis of prejudice
- **Empowering:** helping people without power and influence to have power and influence in their own lives and beyond
- **Family type homes:** Small residential homes which are set up in a manner so as to be as close to a family model as possible.
- **Foster family/substitute family:** a family that can look after a child when the child's birth family cannot do so for a multitude of reasons. A key alternative service to residential institutions for children.
- **Gate keeping:** preventing unnecessary admissions to a service and ensuring only those who meet its criteria use the service. For example, ensuring children are not unnecessarily placed in institutions.

- **Good enough parenting:** parenting that, though not perfect, is of a reasonable enough standard to meet a child's needs
- **Good practice:** the best way of doing things according to professional standards
- **Home visit:** a visit to the home of the child's family, for example to complete an assessment
- **Institution:** residential care home where large numbers of children live
- **Institutionalise:** put a child in a residential care home
- **Institutional system:** the system of residential care homes
- **Intervention work:** work that is done in a case to achieve a particular outcome
- **Jargon:** language and terms that are only understandable to people in a certain profession
- **Key worker:** worker in an institution with specific responsibility for a child
- **Life story book:** a book made together with the child that explains what has happened to them at each stage of their life, who they lived with and why, what they did at which age etc. Very useful for children in the care system who have been separated from their parents and are often looked after by many different adults during their childhoods. These children find it hard to conceptualise their past as there is often not one person who can tell them the story of their life in the way a mother or father would.
- **Maximise welfare benefits:** ensure the client is receiving all the state and child benefits they are entitled to
- **Multi-agency:** many different organisations e.g. CPD, DMSGD, the Maternity Hospital
- **Multi-disciplinary:** many different professions e.g. social work, medical, psychology
- **Parental capacity:** the ability of a parent to meet a child's needs, and their potential ability to do so given the correct support and encouragement
- **Parental rights/responsibilities:** a parent's rights over their child, and their responsibilities towards their child
- **Practitioner:** a front line professional e.g. social worker, nurse, Doctor, psychologist
- **Prejudice:** negative preconceived ideas about a person or group
- **Prevention:** preventing admissions to residential care
- **Procedures:** systems and ways of doing things
- **Referral:** the point the organisation is first made aware of a case
- **Reintegration:** returning children who have lived in residential care home to their families
- **Respite care:** Occasional care. For example, a child with a disability might go and stay with a foster family for 3 nights respite care each month to give their parents a well deserved break from their additional caring responsibilities.
- **Restructuring institutions:** moving the focus of institutions away from offering residential based services and towards offering services that are more community based
- **Slum:** housing conditions that are not fit for human habitation
- **Social exclusion/deprivation:** refers to people who are on the outside edge of society who have no power and influence and who are not included in mainstream society due to, for example, poverty, racism or a lack of educational opportunities
- **State Fund:** set up at a local level to provide additional finance for community based social work with children and families, accessible through CPD recommendation.
- **Stock and flow analysis:** gathering and analysing statistics of children who currently live in an institution, and have recently been admitted to or left the institution
- **Supervision:** a system to monitor and support child welfare professionals in their work
- **Transitional object:** a toy or other object that can psychologically help a child to move from one placement to another.
- **UNCRC:** United Nations Convention on the Rights of the Children, a key piece of international legislation to which Bulgaria is a signatory with legal commitments to protect children's rights.
- **Weekly care scheme:** residential care which is provided for a maximum of five nights out of seven. Child returns to birth parents for at least two nights per week.

Rachel Nightingale, Technical Adviser  
May 2005

## Index of documents in appendices

### Appendix 1: Prevention case management system

- Assessment triangle

### Appendix 2: Reintegration case management system

- Flow chart
- Initial planning meeting protocol
- Case review meeting protocol
- Weekly care agreement 1
- Weekly care agreement 2
- Sample chart
- Monthly statistics

### Appendix 3: Tools and good practice guidelines

- 10 common pitfalls in child care assessments and how to avoid them
- Guidance on completing child care assessments
- Child protection guidelines and form for recording concerns
- Good practice in chairing client centred meetings.
- Preparing and moving children and life story work.
- Issues to consider when planning a family contact visit
- An example of a Family Contact plan
- Family area concept paper
- Family visiting questionnaire report
- Family contact visit observation form

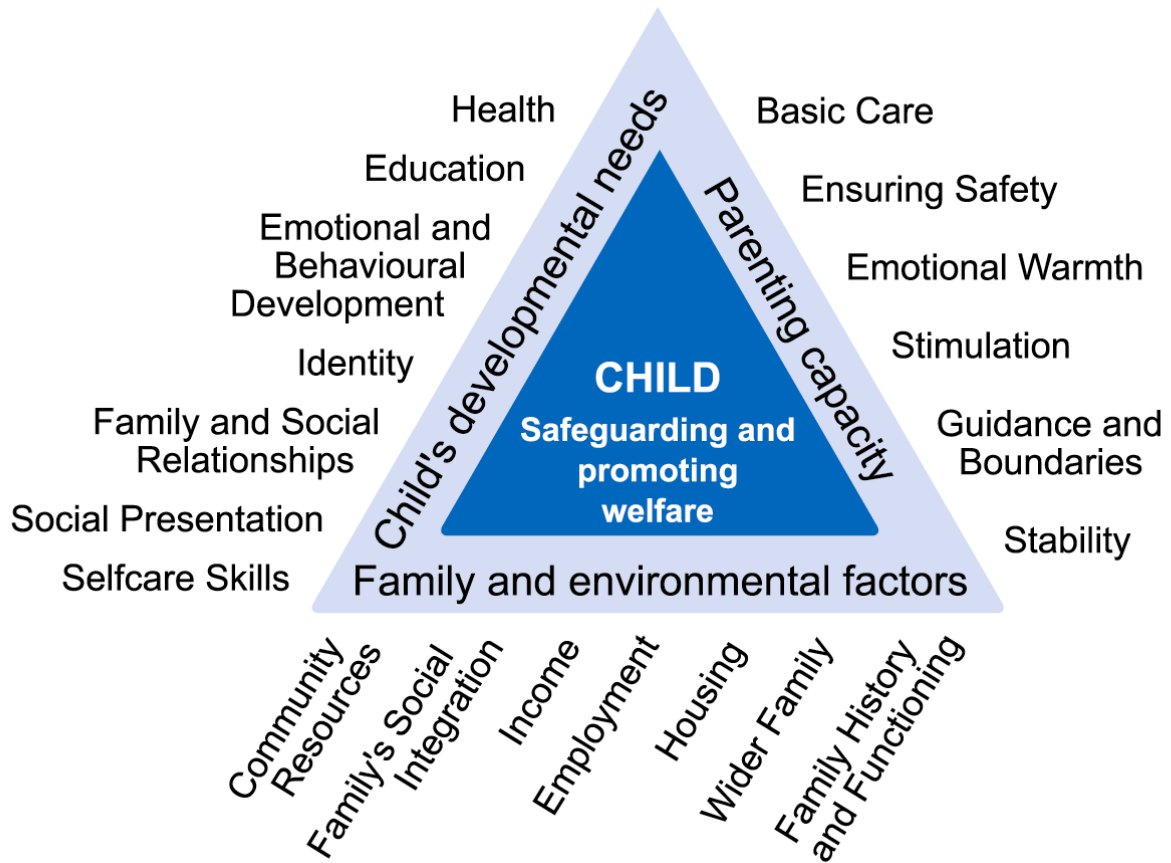
### Appendix 4: Training materials:

- **Training for social workers in community based support**
- **Team building, support and supervision workshop**
  - ❖ Symptoms of stress
  - ❖ Supervision: good practice guidelines
  - ❖ Record of supervision
  - ❖ Skills of professional supervision: giving feedback
  - ❖ Framework for reflective practice
  - ❖ Ten key areas of professional social work
  - ❖ Unhealthy teams
  - ❖ Team openness exercise
  - ❖ Building blocks of an effective team
- **Working together training materials**
  - ❖ Aims of working together
  - ❖ Trust versus mistrust
  - ❖ Who benefits from working together?
  - ❖ How to encourage and promote working together

Rachel Nightingale, Technical Adviser

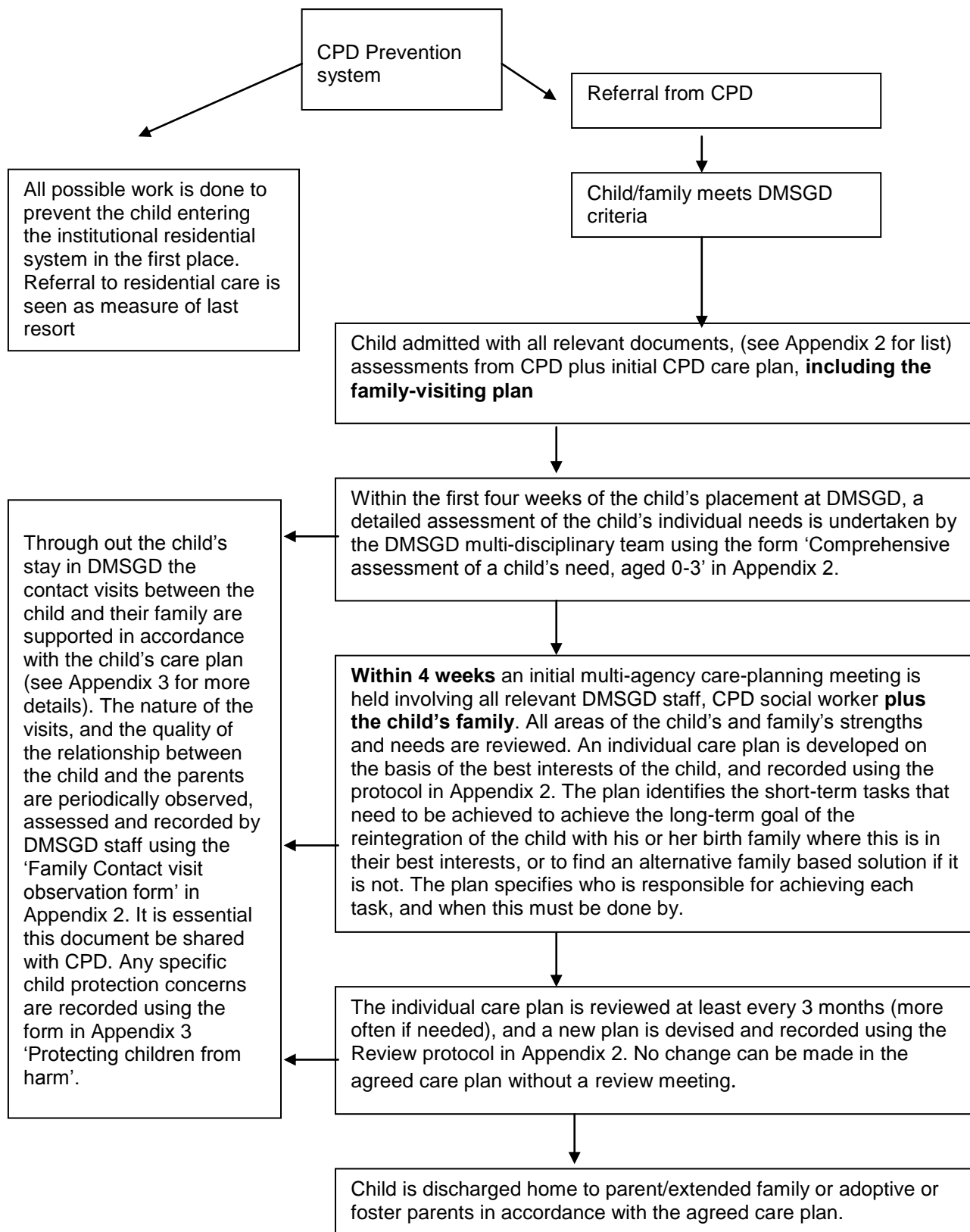
May 2005

## Appendix 1 Assessment triangle



## Appendix 2 Multi Agency Reintegration System

(Court involvement as per CPD case management procedure see Appendix 1)



### Protocol

#### Initial individual Child's plan

Name of the child: .....

Date of the meeting: .....

Persons present:

Parent	
Social worker from CPD	
Social worker from DMSGD	
Doctor	
Key worker	
Educator	
Psychologist	
Chair person	
Minute taker	

Age of child at the date of the meeting: .....

**Content of the discussion:**

**Family situation: (See attached social report from CPD social worker that includes information on all members of the family, financial and employment situation, housing conditions, health conditions of the family. Other siblings of the child, including where they live, their education, health and development).**

.....

.....

.....

.....

.....

**Family contact visits and visits to the family home (describe how often these happen, how long for and which family members take part):** .....

.....

.....

.....

**Health of the child:** .....

.....

.....

.....

**Physical development of the child:** .....  
.....  
.....  
.....

**Intellectual development of the child:** .....  
.....  
.....

**Speech (is the child communicating at an appropriate level for his/her age?):** .....  
.....  
.....  
.....

**Socialisation skills (include the child's ability to play co-operatively, take turns, join in games, recite nursery rhymes, dress and feed him/her self).**  
.....  
.....  
.....

**Physical and mental disabilities (are there any diagnosed physical or mental difficulties with this child, if so how does it affect his/her daily activities?)**  
.....  
.....  
.....

**Parents' opinion:**  
.....  
.....  
.....

**What is the overall plan for the child?**

- Return to birth family**    **Date :** .....
- To live with relatives or friends**    **Date:** .....
- Long term/short term placement with foster carers**  
Delete as appropriate
- Adoption**
- Weekly Care**
- Temporary Care**
- Other (specify)**



Please give details of those who disagree with any of the provisions of the Plan, and reasons why:

.....  
.....  
.....  
.....

Date of the next review: .....

Parent: 1. ....  
(Name) (Signature)

2. ....  
(Name) (Signature)

DMSGD: 1. ....  
(Name/role in relation to the child) (Signature)

CPD: 1. ....  
(Name/role in relation to the child) (Signature)

Chair: .....  
(Name) (Signature)

Minute taker: .....  
(Name) (Signature)

Date: .....

## Weekly care service provided by DMSGD

### Agreement of Cooperation and Understanding between DMSGD and Ruse Child Protection Department

**This agreement is between Ruse Child Protection Department and the Director of Ruse DMSGD in connection with the Weekly Care Service to be provided by the staff of the DMSGD.**

**We agree that the Weekly Care Service will operate under the following conditions and in cooperation with the Child Protection Department and the DMSGD:**

- The Weekly Care Service will offer services to children aged between 1 and 3 years old with a disability or chronic medical condition or where a child's parent(s) or adult carer have a disability or medical condition that affects their ability to provide adequate care for the child.
- Children attending the Weekly Care Service must go home to their family for two days every week. Visits to the child in the DMSGD will not be counted as meeting this requirement.
- The CPD will undertake a full assessment of the child and family's situation following a request for the child to attend the Weekly Care Service and prior to the acceptance of the child into the service. In the case of a child's sole carer being hospitalized or suddenly taken ill and there being no suitable extended family member to care for the child, the acceptance of the child by the Director of the DMSGD will be on a temporary basis until a full assessment can be undertaken by the Child Protection Department. This will not commit the DMSGD to provide ongoing Weekly Care for the child if his/her and family situation do not meet the criteria for the Weekly Care Service following the emergency situation.
- Following the Child Protection Department's assessment and the child meeting the Weekly Care Service criteria, the Social Worker will refer the family to the Director of the DMSGD. The referral will be accompanied by a copy of the Child Protection Department's assessment, Initial Action Plan and other documentation pertaining to a diagnosis of the child or parent's illness or disability and the child's needs.
- An Initial Care Plan Meeting will be arranged where the child's needs can be discussed and a Care Plan devised to meet the health, educational, physical, psychological and developmental needs of the child.
- A Review Meeting will be set 3-months from the date of acceptance of the child into the Weekly Care Service.
- The DMSGD will provide the appropriate services to meet the needs of the child from a range of services including; physiotherapy, massage, play, educational, psychotherapy, hydrotherapy, medication and training parent(s) to care for their children with disabilities and special needs at home.
- An agreement will be made between the parent(s) or carer of the child and the DMSGD when the child is accepted into the Weekly Care Scheme. The agreement will include the days each week the child will go home to their family, and if the child is repeatedly not taken home without an appropriate reason the child may lose their place and will return to the parent's care.
- If the parent or carer fails to meet the requirements of the Weekly Care Service, then the Child Protection Department will be informed and this will necessitate a further assessment to see if the child needs to be placed on a Temporary or Placement Order. No child will remain under the category of Weekly Care when he/she is not taken home for at least two days every week.
- Once a child's status is changed from Weekly Care Service to another category a decision may be taken to remove the parent(s) entitlement to receive Child Benefit for the child
- Parent(s) will be informed that the child's place on the Weekly Care Scheme is not guaranteed but is subject to his/her need and the family's situation and that this will be reviewed every three months. The parent(s) or carer(s) attendance and cooperation with the review process is part of their agreement with the DMSGD.
- Any information that comes to the notice of either the Director of the DMSGD or the Child Protection Department that constitutes a significant change in the child or family's situation will be immediately

provided to the other party. An early Review Meeting maybe required taking into account the new information.

- The Director of the DMSGD will inform the Child Protection Department if the child is not returned (within one day of the expected day of return), to the DMSGD without an explanation from the parent or carer.
- Where a child returns from his/her weekly visit to the family and an injury has occurred, or the child appears unkempt or unfed, this information will be given to the Child Protection Department.

We the undersigned agree to abide by the terms of this agreement and for the Weekly Care Service to be evaluated in 6 months of the date of this agreement, to ensure that it continues to meet the needs of the children it is aimed at.

Director of DMSGD: .....

Team Manager of Ruse CPD: .....

Date: .....

### Weekly care service at DMSGD

#### Agreement Between the Child’s Parent or Guardian and the DMSGD

This agreement is made between

.....  
(Name of Parent or Guardian of Child)

Dr V. Hristova, Director of DMSGD, in respect of:

The Child: .....

PIN: ..... Date of Birth: ..... Place of Birth: .....

Current Home Address of Child:: .....  
.....

The Director agrees to the attendance of the child on the Weekly Care Service from ..... (Date) in accordance with the Service’s criteria and conditions. This agreement is made on the understanding that the child and his/her family have been assessed by the Child Protection Department and the child’s needs would be met by attendance on the Weekly Care Service.

This agreement will be reviewed every three months to ensure that the child’s need to attend continues  
The first Review will be held on ..... (Date)

..... has agreed with the Director  
(Name of parent or guardian)

that they will take ..... home every  
(Child’s Name)

..... and ..... The child will be returned by .....  
(time)

on ..... Failing to take the child home each week may result in the child losing his/her  
(Day)

place on the Weekly Care Service.

#### **Responsibility of Parent(s):**

1. To abide by the conditions of this agreement
2. To inform the Director of the DMSGD immediately if there are any changes to their family circumstances, change of address, new partner or marriage, new baby born, partner leaves, new job.
3. To take their child home as stated above and return him/her at the agreed time and day. Visits to see the child in the DMSGD will not meet the requirements of the Weekly Care Service.
4. To inform the Director if the child has any allergies to medication or food.
5. To give the child any prescribed medication as instructed by the staff of the DMSGD.
6. To maintain the child’s health and hygiene routine while he or she is at home.
7. To contact Dr Hristova or the Social Worker in advance, if the family is unable to take the child home on any occasion. The reason for the child not to be taken home must be provided. If your child does not go home regularly he or she may lose their place on the Weekly Care Service
8. To inform Dr Hristova if the child or any other member of the household is diagnosed with an infectious illness.
9. To attend the 3-monthly review meetings arranged by the DMSGD and to provide information about the family’s current situation at the review.
10. To provide two week’s notice to the Director, if you no longer wish your child to attend the Weekly Care Service.
11. To work with the social worker from the Child Protection Department.

**Responsibility of the staff of the DMSGD:**

1. To inform the parent(s) of the contents of this agreement before the child starts his/her attendance on the Weekly Care Service.
2. To understand the child's needs as stated in the Assessment undertaken by the Child Protection Department and to prepare a Care Plan to meet those needs.
3. To provide the parent(s) with a copy of the Child's Care Plan with the activities their child will take part in.
4. To give the name of the child's Keyworker to the parent(s), so that they can speak with her about their child's progress.
5. To provide daily care for the child appropriate to his/her age, developmental ability and needs and to maintain his/her overall welfare.
6. To inform the parent(s) if their child becomes ill or has an accident or needs to attend the hospital.
7. To advise the parent(s) in the care and hygiene of their child whilst he/she is at home with them.
8. To provide the parent(s) with a copy of the DMSGD representation, (complaints) procedure.
9. To provide the parent(s) with a copy of the DMSGD's policy on Child Protection.
10. To inform the parent(s) when the 3-monthly Review Meetings will take place.
11. To inform the Child Protection Department if the parent(s) do not collect their child as agreed.
12. To provide two week's notice to the child's parent(s) if the child no longer meets the criteria to attend the Weekly Care Scheme or the conditions of this agreement are broken by the parent(s).

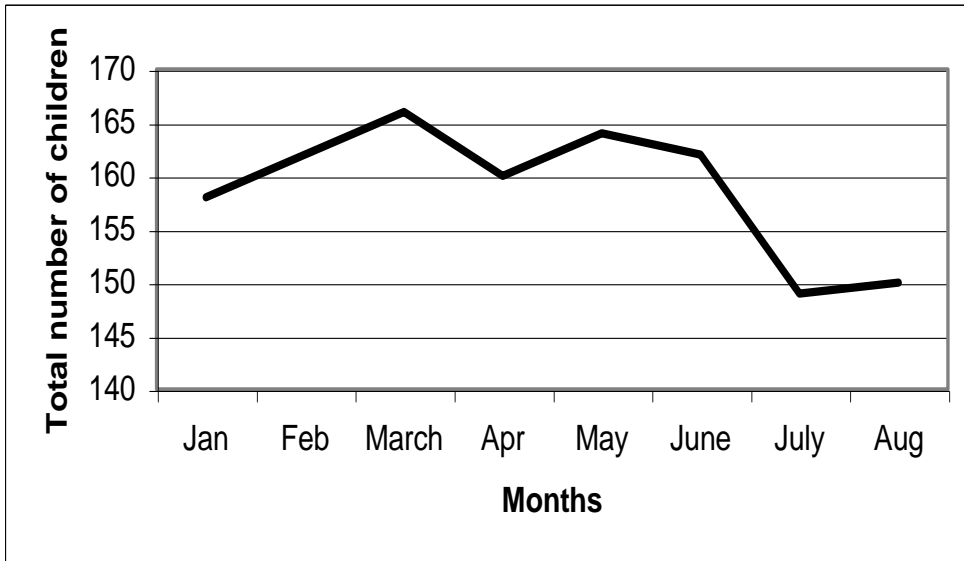
**We agree to the conditions contained in this agreement and understand that if we do not abide by them our child could lose his/her place on the Weekly Care Service.**

Parent or Guardian of Child: .....

Director of DMSGD: .....

Date of Agreement:: .....

### Sample Chart





**Monitorina sheet**

**Number of children at DMSGD. Ruse. Stock and Flow analysis**

Category	Jan	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec
<b>Adoption:</b>												
In procedure from Ruse Municipality												
In procedure from other municipalities												
With declaration from Ruse Municipality												
With declaration from other municipalities												
Expired placement from Ruse Municipality												
Expired placement from other municipalities												
With severe disability from Ruse Municipality												
With severe disability from other municipalities												
<b>Total for adoption:</b>												
<i>Total number of new cases admitted or accepted for Adoption this month</i>												
<i>Total number of new adoption cases transferred within DMSGD from another category this month</i>												
<i>Total number of new cases placed with national adopters this month</i>												
<i>Total number of new cases placed with international adopters this month</i>												
<i>Total number of adoption cases transferred to another institution this month</i>												
<i>Total number of adoption cases transterred within DMSGD to another category this month</i>												
<i>Total number of adoption cases where Mother rescinds her declaration of adoption and child returns home this month</i>												
<i>Total number of adoption cases matched with potential adopters but still living at DMSGD Ruse this month</i>												
<i>Total number of adoption cases placed on national adoption register this month</i>												
<b>Baby care unit (premature and underweight):</b>												
Need to stay longer at BCU,(admitted last month)												
Need to stay longer at BCU,(admitted this month)												
<b>Total in BCU:</b>												

Category	Jan	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec
<i>Total number of new cases placed in BCU this month</i>												
<i>Total number of BCU cases discharged home to their parents this month</i>												
<i>Total number of BCU cases transferred within the DMSGD to another category</i>												
<i>Total number of BCU cases planned to be transferred to another DMSGD service (but still at BCU) this month</i>												
<b>Temporary care: Administration (CPD) and Placement (Court) Orders for full time (7 days per week) residential care</b>												
Children without disabilities placed by Ruse CPD												
Children without disabilities placed by other CPDs												
Placed under old legislation (Home - parents contract) from Ruse Municipality												
Placed under old legislation (Home - parents contract) from other municipalities												
Children with disabilities placed by Ruse CPD												
Children with disabilities placed by other CPDs												
<b>Total for Temporary Care:</b>												
<i>Total number of new cases placed for temporary care this month</i>												
<i>Total number of new temporary care cases transferred within DMSGD from another category this month</i>												
<i>Total number of temporary care cases discharged home to their parents this month</i>												
<i>Total number of temporary care cases transferred within DMSGD to another category this month</i>												
<i>Total number of temporary care cases transferred to other institutions this month</i>												
<b>Weekly Care (residential care for 5 days per week, maximum):</b>												
Referred by Ruse CPD (no prior placement)												
Direct agreement with parents or other family member (no prior placement)												
Referred by other municipality												

Category	Jan	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec
Transfer from other DMSGD service under Ruse CPD reintegration work												
Transfer from other DMSGD service by direct request of parents												
Children with disabilities receiving weekly rehabilitation												
<b>Total in Weekly Care:</b>												
<i>Total number of new weekly care cases admitted this month</i>												
<i>Total number of new weekly care cases transferred within DMSGD from another category this month</i>												
<i>Total number of weekly care cases discharged this month</i>												
<i>Total number of new weekly care cases transferred within DMSGD to another category this month</i>												
<b>Daily Care (with minor health problems):</b>												
Referred by Ruse CPD												
Placed by parents or family members directly												
<b>Total in Daily Care</b>												
<i>Total number of <u>new</u> daily care cases admitted this month</i>												
<i>Total number of daily care cases that have left the Daily Care Scheme this month</i>												
<b>Daily Rehabilitation for disabled children:</b>												
On full day basis												
On hourly basis												
<b>Total for Daily Rehabilitation</b>												
<i>Total number of <u>new</u> daily rehab cases admitted this month</i>												
<i>Total number of new daily rehab cases transferred within the DMSGD from another category this month</i>												
<i>Total number of daily rehab cases that have left the Daily Rehabilitation Scheme this month</i>												
<b>Total Number of Children in DMSGD on 30th of month:</b>												



## Appendix 3

### Completing child-care assessments

#### Appendix 3

##### Completing child-care assessments:

##### 10 common pitfalls and how to avoid them

##### 1. The high status of the person/agency that makes the referral has an impact on the assessment

###### Ask yourself:

- Would I see this case differently if the referral had come from another source?
- Am I allowing the status of the referrer to influence my assessment?

##### 2. Assumptions and pre-judgments about the family lead to observations being ignored or misinterpreted.

###### Ask yourself:

- What are my assumptions about this family?
- What, if any, is the hard evidence that supports them?
- What, if any, is the hard evidence that refutes them?
- Have I looked for both?
- Have I separated fact from opinion and backed up my statements with evidence?

##### 3. Professionals think that when they have explained something to the family as clearly as they possibly can, then the family must have understood it.

###### Ask yourself:

- Have I double-checked with the family and the child (ren) that they understand what I have said and what will happen next (if necessary have I asked them to repeat it back to me)?
- If appropriate, have I used an interpreter in order to talk to the family and child(ren) in their first language/mother tongue, so that they are not at a disadvantage?
- Have I put plans in writing to the family as soon as possible? Have I considered language and literacy issues?

##### 4. Parents' behaviour, whether co-operative or unco-operative, is often misinterpreted.

###### Ask yourself:

- What is the reason and motivation for this parent's behaviour?
- Are there any other possibilities besides the most obvious?
- Could their behaviour have been a reaction to something I did or said rather than something to do with the child?
- How does my identity affect the situation, for examples if I am a white Bulgarian and the family is Roma, how might this affect how the family perceives and relates to me?

##### 5. Not enough attention is paid to what children say, how they look and how they behave:

###### Ask yourself:

- Have I been given appropriate access to all the children in the family?
- If I have not been able to see any of the children in the family, is there a very good reason, and have I made arrangements to see him/her as soon as possible, or made sure that another relevant professional sees him/her?
- How should I follow up any uneasiness about the child(ren)'s health or well-being?
- If the child uses a language other than Bulgarian, or alternative non-verbal communication, have I made every effort to enlist help in understanding him/her?
- What is the evidence to support or refute the child's account of the situation?

##### 6. Attention is focused on the most visible or pressing problem and other warning signs are not appreciated.

###### Ask yourself:

- What is the most striking thing about this situation?
- If this feature were to be removed or changed, would I still have concerns and if so what?
- Am I ensuring that my assessment looks thoroughly into all the strengths and weaknesses of this family and is not just responding to the most pressing or obvious issue?

- Am I confident in my skills to ask personal questions that are potentially awkward or embarrassing in order to get the true picture of the whole situation?
- If I don't know something about the case because there is a gap in my knowledge, what am I going to do to find out?
- Am I sure that I am basing my recommendations in the case on a thorough assessment of the child and families needs, rather than just responding to what the parents say they want?

**7. When faced with an aggressive or frightening family, professionals are reluctant to discuss fears for their own safety and to ask for help, which can affect their professional judgment of the case.**

Ask yourself:

- Did I feel safe in this household?
- If not, why not?
- If I or another professional should go back there to ensure the child(ren)'s safety, what support should I ask for?
- Am I allowing my fears for my own personal safety affect my judgment regarding the assessment of the child and family's situation?
- If necessary, have I put my concerns and requests in writing to my manager?

**8. The impact of racism and discrimination on the social and economic context in which children and families from ethnic minorities live (eg Roma) is often disregarded, resulting in an assessment which is incomplete**

Ask yourself:

- Have I considered the impact of racism and discrimination on the family's access to decent housing and jobs and to full social integration in the community?
- Have I considered the impact of racism and discrimination on the child's opportunities to develop a strong positive self-image and sense of cultural identity?
- Am I basing my assessment on real facts that have been checked out with the family rather than on common racial stereotypes and myths?
- Have I considered the impact of racial abuse on the child/family?
- Have I assessed the extent to which children from ethnic minorities separated from their families in institutions have the opportunity to learn their first language and have access to a lived experience of their culture, for example, music, food, traditional rituals and religious beliefs?

**9. Insufficient time is allowed to complete the assessment**

Ask yourself:

- Have I allowed time for myself and the family to get to know each other and establish mutual trust before completing official looking forms and asking highly personal questions (apart from in situations where there are concerns about the child(ren) being in immediate danger of significant harm or abuse)?
- Have I allowed several home visits in order to ensure the family has enough time to tell their story and I have enough time and information to make a thorough assessment?
- Have I clearly explained the purpose of the assessment?
- Am I clear about the difference between the information gathering stage, the assessment and analysis stage and the planning and review stages of the case?
- Am I using a framework to structure each stage of the case management process?
- Do my notes show clearly the difference between the information the family gave me, my own direct observations and my interpretation or assessment of the situation?
- Whilst keeping the child(ren) as my central focus, am I genuinely working in partnership with the family?
- Am I clear about the potential limits to the partnership approach when there are concerns about the child(ren) being at possible risk of significant harm or abuse?

**10. Information is not sufficiently shared or crosschecked between key agencies involved in the case, resulting in a limited or unbalanced view of the child and family's situation**

Ask yourself:

- Have I involved other key agencies in the information gathering stage?
- If there are significant differences, has the information been cross-checked?
- Am I taking into account the motivation different individual's may have for sharing or withholding certain information, or for taking a particular view on the case?

- After gathering and cross checking all the relevant information from all the relevant sources, am I confident enough to take my own position on the case, even if this does not agree with other professionals?

**Adapted from “Assessing risk in child protection”, Cleaver, Wattam and Cawson, National Society for the Prevention of Cruelty to Children, United Kingdom, 1998**

**Rachel Nightingale, Technical advisor  
June 2004**

## Guidance on Completing the Assessment of the Child's Needs

### Making an Assessment of the Child's Needs.

The most important features of an Assessment are that they involve the child and his/her parents or carers, and **are the product of multi-disciplinary and inter-agency work.**

The form, **Assessment of the Child's Needs** is designed to be completed, by a small multi-disciplinary group, who know the child and his/her family. It is advisable for the form to be completed in small meetings or alternatively for parts of the document to be separately completed by specialist workers, eg speech therapist.

The assessment is based on an holistic, ecological and social model of children's needs. It illustrates the three domains that contain features that influence a child's development. These cover:

- the type of parenting offered by family or substitute care
- the needs of all children of this age and stage of development
- personality of the child and their past experiences
- the environments in which they have lived.

The assessment has been designed so that it can be largely completed by non-specialists. Non-specialists can use common sense and experience to identify, and prioritise most developmental needs. Specialists may contribute to medical, dental, or psychological aspects.

Assessors are describing

- How the child is now,
- Comparing this child with others of their age and developmental stage, (average children, not just those living in institutions) and
- Generating ideas about how the child whose development is delayed or impaired can be helped to overcome these shortfalls.

So for example, children who cannot speak, may never have been spoken to, or may need to learn a new language. The child may be deaf. (This information will be important when devising the child's Individual Action Plan or Care Plan).

### How to Complete the Assessment of the Child's Needs

#### For Children Currently Living in Institutions:

- It is important that only factual information, (not presumptions), is recorded and if the information for any questions is not known, that the questions is either left blank or 'Not Known' is written.
- **Document 1 (pages 1-3)**, will be completed by the mentor or keyworker of the child in the institution. The keyworker should use both the written information contained in the child's file, but also factual information known by various members of staff. Staff who have worked for many years in an institution have acquired a lot of information about a child that is not always written on the child's file.
- **The Assessment of the Child's Needs (Document 2 for over 3 years old or Document 2A from birth to 3 years old)**, will be completed by a multi-disciplinary group. This normally involves a meeting to work meticulously through the form and discuss all the aspects of the child's development, welfare and abilities. The child, if able should take part in the completion of his/her Assessment. The Assessment Document covers a wide range of children's ages and therefore only some of the questions will be pertinent to the child you are discussing. Those that are not should be left blank or marked not age appropriate.
- In general the questions within Document 2A are designed to range from the youngest baby up to a child of 3 years old, so for a baby of 6 months the questions from the top section of each page will be most relevant. **Do not mark that a child is unable to do a task**, when there is no opportunity for the child to undertake the task within the institution. (This is not an inability of the child, but a consequence of living in the institution).
- At the bottom of each Part is a box entitled, Notes for Care Plan. After completing each section, the multi-disciplinary group should compare the child's development/behaviour with that of an average child of his/her age. If any topic shows that a child is delayed, then a note should be made in the Notes Box, as a reminder that this area will need some specific attention to improve the child's ability. If everything is well with the child, then this box can be left blank, as there is nothing additional to be undertaken with the child other than age appropriate activities.

- If any member of the multi-disciplinary group has any information or concern about a child within any area of his/her development or behaviour that is not specifically asked for in the Assessment Report, it can be noted in the Notes for Care Plan. This would include such concerns as a child not attending school regularly, a child that is stealing, a child that is very distressed after contact visits with his/her parents, a child of 8 years old, that has started to wet and soil him/herself. These types of concern are very relevant to the overall welfare of the individual child and need to be addressed by the staff and professionals involved in his/her care.
- Part 12 of the Assessment Document looks at the opportunities provided by the Institution for the child to be involved in activities appropriate for his/her age within the community and with his/her peers. Those caring must promote a child's particular interests and talents by incorporating leisure activities into his/her weekly routine. The older a young person the greater the need for the young person's integration into his local community and activities.
- The last page of the Assessment Document allows for comments to be made about the priority areas of concern about the child's welfare or development, that have been recorded, so that they will be included into the child's Care Plan.
- In the Notes for Care Plans and the last page of the Assessment of Child's Needs, you must be specific in recording the actual needs or delayed aspect of a child's development.
  - Eg 1) A child of 2 years old does not speak at all. Record what work will actually be done with this child in order to improve the situation.
    - (a) Have the child's hearing examined to test for any deafness or impairment.
    - (b) The nurse to spend 5 minutes every day speaking with the child face to face on their own, repeating the name of 5 objects.
    - (c) When the child can name these objects, the nurse will repeat the process with a further 5 objects.
    - (d) The nurse and her colleagues caring for the child will use the learnt words in everyday conversations to enforce the learning and the child's speech.
  - Eg 2) A child is not visited by his/her parents, and this causes the child to be unhappy.
    - (a) Keyworker will telephone or speak to the parents to find out, why they are not visiting their child.
    - (b) A regular pattern of visiting will be agreed between the parents and the keyworker.
    - (c) Parents will be requested to telephone the keyworker if for any reason they cannot visit the child as planned. The keyworker will then be able to inform the child that his parents cannot visit and the reason for this. This will prevent the child from worrying about his parents not arriving for the visit.

#### **For Children Living with their Families or in other Family Homes:**

- It is important that only factual information, (not presumptions), is recorded and this information is checked out with the various family members and other professionals working with the family and child.
- **Document 1 (pages 1-3)**, will be completed by the CPD Social Worker responsible for the child. The Social Worker will use the written information contained in the child's file and other gathered information from other sources.
- **The Assessment of the Child's Needs (Document 2 for children over 3 years old or Document 2A from birth to 3 years old)**, will be completed by a multi-disciplinary group, including child and family members. This normally involves a meeting to work meticulously through the form and discuss all the aspects of the child's development, welfare and abilities. The Assessment Document covers a wide range of children's ages and therefore only some of the questions will be pertinent to the child you are discussing. Those that are not should be left blank or marked not age appropriate.
- In general the questions within Document 2A are designed to range from the youngest baby up to a child of 3 years old, so for a baby of 6 months the questions from the top section of each page will be most relevant.

- At the bottom of each Part is a box entitled, Notes for Care Plan. After completing each section, the multi-disciplinary group should compare the child's development/behaviour with that of an average child of his/her age. If any topic shows that a child's development is delayed, then a note should be made in the Notes Box, as a reminder that this area will need some specific work to improve the child's ability. If everything is well with the child, then this box can be left blank, as there is nothing additional to be undertaken with the child other than age appropriate activities.
- In the Notes for Action/Care Plans and the last page of the Assessment of Child's Needs, you must be specific in recording the actual needs or delayed aspect of a child's development.  
Eg A child of 2 years old does not speak at all. Record what work will actually be done with this child by his/her family in order to improve the situation.
  - (a) Arrange with the parents for the child to have his/her hearing examined to test for any deafness or impairment.
  - (b) The mother or father or an appropriate adult will be asked to spend 5 minutes every day speaking with the child face to face on their own, repeating the name of 5 familiar objects.
  - (c) When the child can name these objects, the adult will repeat the process with a further 5 objects.
  - (d) All members of the household can encourage the child's speech by using the learnt words in everyday conversations to enforce the learning.
  - (e) If older children are speaking for the child, they should be persuaded not to do this and wait until the child asks for what he or she wants.
- If any member of the multi-disciplinary group has any information or concern about a child within any area of his/her development or behaviour that is not specifically asked for in the Assessment Report, it can be noted in the Notes for Care Plan. This would include such concerns as a child not attending school regularly, a child that is stealing, a child that is very withdrawn or wary in the company of his/her parents, a child of 8 years old, that has started to wet and soil him/herself. These types of concern are very relevant to the overall welfare of the individual child and need to be addressed by the professionals involved in his/her care.
- The last page of the Assessment Document allows for comments to be made about the priority areas of concern about the child's welfare or development, that have been recorded, so that they will be included into the child's Individual Action Plan.

If a professional, (eg a teacher, a GP), is unable to take part in the multi-disciplinary group meeting, then his/her comments and opinions should be sought prior to the meeting by the Social Worker and presented at the multi-disciplinary meeting. No area of the child's development or welfare should be omitted from this Assessment.

### **It is important to identify and work through the child and family's strengths.**

The multi-disciplinary group identifies the areas with **the most urgent need** for immediate intervention. The individual notes and concerns from each Part are synthesized. This is done partly when the multi-disciplinary group are doing the assessment, and finally during the discussion at the Initial Individual Action Plan or Initial Care Plan Meeting.

Representatives of the multi-disciplinary group (for example the educator, doctor) should come to the Care Planning Meetings with ideas about:

- The overall longer term plan
- The short-term goals and priorities.
- The activities to be undertaken in the Review period, the deadlines and the names of the persons, responsible for each activity.
- Tasks will be assigned both to the child, (if age appropriate) family members and professionals.

Implementation of the Individual Action or Individual Care Plan is a shared responsibility of the multi-disciplinary group.

**Ingrid Jones, Technical Adviser**  
**2004**

## Protecting children from harm

### Responding to and recording incidents of concern regarding children at DMSGD

***‘The state is obliged to prevent children from being abused by their parents or carers and to establish programmes for prevention of abuse’***

**Article 19, United Nations Convention on the Rights of the Child.**

*‘Every child has a right to protection against all methods of upbringing that undermine his or her dignity; against physical, psychological and other types of violence; against all forms of influence which go against his or her best interests’*

Article 11 (2) Bulgarian Child Protection Act, 2000.

*“The care provider must make a referral to the competent agencies for every incident connected to child protection for the children placed in the institution”*

Article 42, Chapter five (Standards for specialised institutions), *The criteria and standards for social services for children, 2003, Order 256 from the Council of Ministries*

### Notes for guidance

#### What is an incident of concern?

- An incident of concern is any incident that leads us to believe that a child may be at risk of significant harm or abuse. This may be physical abuse, sexual abuse, emotional abuse or neglect. The suspected abuser may be a parent or sibling of the child, or some other family member or friend. Or it may be someone who is working with the child or has access to the child via some other means.
- An incident of concern may be something you hear the child say or see the child do. It may be something you hear or see the parent(s)/carers or other significant family members say or do. If it is something that makes you concerned about the safety of the child, you should report it and record it. Childcare professionals, whether they are social workers, pedagogues, Doctors, or key workers, are professionally and legally obliged to report and record incidences of concern regarding children. This is not information that we can keep confidential.

#### Why should I record it?

- Protecting children from harm and abuse is one of the primary responsibilities of professionals working in the child-care field. Staff must be trained to recognise signs and symptoms of abuse and to recognise what constitutes an issue of concern, as they are often in the best position to detect this at an early stage. (See the Appendix 1 ‘Signs and symptoms of the abused or neglected child’). Working closely with children brings with it professional and legal responsibilities to report and record incidents of concern.
- Sometimes in cases of abuse it transpires that a range of different professionals have had concerns about the child over a period of time, but that they did not do anything about those concerns. They did not report them, and they did not record them. This might be because they are not sure how to respond, because they are frightened themselves or because they dismiss their concerns. It is very important that all issues of concern are reported and recorded so that plans can be made to protect the child at the earliest opportunity, and staff need training and support in order that they can protect the children in their care from harm.
- By reporting and recording the incident you are not making an assessment of the nature of the risk to the child or judging what the response should be to this situation. You are just recording the facts as you see them. This will allow the multi-agency team to make an assessment of the risk to the child and come up with a plan on the basis of real evidence, not gossip or hearsay. Thorough risk assessments can only be made on the basis of factual evidence.

#### How should I record it?

- Record the incident as soon as possible after it happens while it is fresh in your mind. It is easy to forget important facts after a period of time, or to confuse facts.
- A copy of the record should be placed in the child’s individual file.
- Use a format such as the one below to help you record the incident in a thorough and professional manner.
- **Date and time:** It is very important to record the date, and if possible the time the incident occurred. This information is important when trying to piece together the facts of the case.
- **Incident:** When recording the description of what happened, make sure you only record facts, not your assumptions, interpretations or opinions. What did you actually see or hear happen? State

whether you are recording something you witnessed yourself, or whether this is third party information. Record the exact words used as closely as possible. Was anyone else a witness to what you saw or heard happen? Record their names.

- **Explanations:** Record any explanations made by the parent(s)/carer(s) and/or child. The reasons they give for the incident are very significant.
- **Advice:** Record any advice you gave to the parent(s) or child regarding the incident. See Appendix 2 'How children send signals that they have been abused' and Appendix 3 'Some key things to say to a child' for guidance on how to respond to the child.
- **Action:** Record what action you took. For example, did you feel the need to remove the child from the situation? Who did you inform about the incident? Incidents of concern should usually be reported to the Chief Doctor on the ward, DMSGD social worker and Director, who should inform CPD. After this a multi-agency assessment of the situation should be made of the risk to the child, and a plan drawn up that is in the child's best interests.
- A whistle blowing policy should be in place to deal with the potential risk for children suffering harm or abuse within the institution itself. This keeps children safe and protects staff.

### **Support:**

- It is very important that any professional who witnesses an incident of concern is given support and debriefing by the DMSGD management team. It can be very painful and personally distressing to be involved in such situations, and it is essential that the worker be given the support they need to understand what has happened and make sense of their own emotions. How did the incident make them feel? Are they happy about the way they handled it? What can they and the institution learn from their handling of the incident? It can be very difficult and frightening to get involved in situations where a child is being abused. We have a professional and legal responsibility to record and report incidents of concern, and a professional right to expect personal and professional support from colleagues and management.
- Occasionally there may be concerns about issues of staff security associated with the incident. This should be taken very seriously and dealt with by the DMSGD management team. Actual or implied verbal or physical threats to staff must not be tolerated. Staff must be supported to come forward and report all incidents of concern in order that they can protect the children in their care.

### **Case example**

Pepy Angelova (not her real name) is three years old, and has lived at DMSGD for a year. Her smaller brother also lives at DMSGD. She has contact with her father, and her mother reportedly lives abroad. There have been several incidences of concern involving Pepy.

**On some occasions when her father comes to visit her at DMSGD, he is clearly drunk. On one occasion he asked Pepy whether anyone at DMSGD hurts her, and that if they do he will hurt them. He asked her if she remembered how he used to beat her mummy and that he will do the same to anyone who hurts her. On one occasion Pepy's father was advised by a member of staff not to give her baby brother chewing gum as he could choke on it. In front of his children he replied that it was not a problem as the children's mother had swallowed plenty of sperm in her life and it had never done her any harm. Pepy has also said that the way people die is when someone gouges their eyes out with a knife. She reportedly said that her father told her this and that he said he intends to do this to her mother. She demonstrated what happens to people when they die by asking other children in DMSGD to lie down straight and cross their arms over their chest as though they were in a coffin. Pepy also told her kindergarten teacher that her mummy is not a good person, she is a slut, and that her father had told her this. She said this in the context of a discussion in class about 'reasons we love our mummy'.**

On one occasion she told a member of staff that her Daddy kisses her legs. On another occasion when she went to stay overnight with a member of staff she said that she does not want a man to watch her having a shower, that she hopes the carer's husband will not come in while she takes her clothes off, and that she doesn't want the carers husband to sleep in the same room as her.

**Suggestions for possible interventions in this case:** Several different members of staff have witnessed several different incidences of concern regarding Pepy. Some of these incidences involve threats of violence to her mother. Some involve indirect threats of violence to staff. Several of the incidences lead us to be concerned about Pepy's safety. The incidences in themselves may not be considered to be not conclusive proof of physical or sexual abuse, or to prove who the abuser may be, but they are disturbing enough to cause us enough concern to report and record them so that a more thorough assessment can take place.

They could certainly be considered potentially emotionally abusive at the very least. Some suggestions for recording one of these incidents are suggested in the record chart attached.

On the basis of the evidence so far, an assessment should be made of the potential risk to Pepy. In addition to looking at the written record of concerns on the child's file, the assessment may include seeking the opinion of a psychologist/psychiatrist with experience in child abuse and/or Doctor (if there is the possibility of physical evidence), CPD social worker, kindergarten teacher and CPD lawyer. Most importantly it will involve talking to the child. If it seems that a criminal offence may have been committed the police will need to be informed.

On the basis of the assessment a plan can be made by the multi-agency network to keep Pepy safe. This may include deciding whether unsupervised contact with her father is in her best interests, monitoring and supervising the visits, attempting work with the father to address some of his behaviour, and ultimately assessing whether her father is a fit parent or whether court proceedings should be considered to challenge his parental rights. The answers to all these questions will be found by conducting a good quality risk assessment. At all points the best interests of the child should be the guiding principle of the decision making process.

Finally the safety of the staff involved should be considered, as the father has made actual verbal threats of physical violence towards them. Supporting the staff team through this process is extremely important, in order that they can support and protect Pepy.

**In conclusion:**

Some people do terrible things to children. Child abuse cases often throw up a lot of difficult and frightening issues for the professionals involved. They can make us, even as adults, feel helpless and afraid. This is sometimes why some people chose not to report and record what they have witnessed. However, even when we are afraid or unsure, as childcare professionals it is our professional, legal and moral responsibility to ensure we act promptly to defend the right of every child to be protected from harm and abuse. By working together and supporting each other, we can achieve this.

**Rachel Nightingale, Technical Adviser  
June 2004**

**Suggested format for recording incidents of concern**

Name of child: Pepy Angelova

<b>Date and time of incident</b>	<b>Incident</b>	<b>Explanations given by parent(s)/carer and child</b>	<b>Advice given</b>	<b>Action taken</b>	<b>Name, job title and signature of worker</b>
<p>Example:</p> <p>12.03.2004 15.00</p>	<p>This is third party information.</p> <p>During a class discussion at kindergarten about 'reasons we love our mummy', Pepy said 'My mummy is not a good person. She is a slut'. The kindergarten teacher, Miss Ivanova, informed me of this when I went to collect Pepy.</p>	<p>Miss Ivanova stated that she then asked Pepy why she had said this, and Pepy replied 'My addy told me that Mummy is a slut'.</p>	<p>I asked Miss Ivanova what she said to Pepy next, and she admitted that she horrified and didn't know what to say.</p> <p>I told Miss Ivanova that I would be reporting and recording the incident and asked her to keep an eye on Pepy and inform me of any further concerns she has. She agreed to do so.</p>	<p>Incident recorded and placed on Pepy's file. Director of DMSGD and CPD Social worker informed</p>	<p>Galia Ilieva, Pepy's keyworker at DMSGD.</p>

## Appendix 1

### Signs and symptoms of the abused or neglected child

#### 1. Categories of child abuse and definitions

Child abuse can be considered in terms of four categories: physical injury, neglect, emotional abuse and sexual abuse. Although emotional abuse is a category in its own right, emotional harm is usually associated with all types of abuse. The following definitions are based on those established by the U.K. Department of Health in 1991.

1.1 Physical injury: - Physical injury to a child where there is a definite knowledge, or a reasonable suspicion, that the injury was inflicted or knowingly not prevented. This includes deliberate poisoning and suffocation.

1.2 Neglect:- The persistent or severe neglect of a child, or the failure to protect a child from exposure to any kind of danger (including cold or starvation), or extreme failure to carry out important aspects of care, resulting in the significant impairment of the child's health and development, including non-organic failure to thrive.

1.3 Emotional abuse:- Persistent or serious emotional ill treatment or rejection, which has a severe adverse effect on the emotional and behavioural development of the child.

1.4 Sexual abuse:- The involvement of dependent, immature children and adolescents in sexual activities that they do not really comprehend, to which they are unable to give informed consent, which violate the social taboos of family life, and are knowingly not prevented by the carer.

#### 2. Physical signs of abuse

Physical signs of abuse may include the following:-

- Bruising: Consider -           The age of the bruising  
  The location of the bruising  
  The appearance of the bruising;
- Bite marks: Consider-       The size of the bite marks (did an adult or a child inflict them?)
- Scratches;
- Burns and scalds;
- Fractures and joint injuries;
- Poisoning;
- Brain and eye injuries;
- Internal injuries;
- Scars;
- Failure to thrive;
- Cold and mottled skin;
- Inappropriate clothing for the time of year;
- Genital/rectal discharge or warts;
- Tears or lacerations to the genital or rectal area;
- Child left alone before he/she has reached a sufficient age and level of maturity.

#### 3. Behavioural symptoms of abuse

- Behavioural symptoms of abuse may include the following:-
- Withdrawn and passive;
- "Frozen watchfulness";
- Short attention span;
- Aggressive;
- Insecure, anxious attachments to care-giver;
- Destructive;
- Developmental delay - motor and/or social;
- Language delays;
- Low self-esteem;
- Poor ability to play;
- Underachievement at school and/or non-school attendance;
- Running away;
- Enuresis and/or encopresis;
- Fire-setting;
- Poor ability to form positive close relationships;
- Self-harm;
- Attempted suicide;
- Poor self-care;
- Anti-social behaviour, including delinquency;

- Substance misuse (for example, glue, alcohol, prescribed drugs, illegal drugs);
- Sexual abuse of other children;
- Eating disorders.

#### **4. Other possible indicators**

Other possible indicators of abuse may include the following:-

- Inconsistent explanations given for injury - by the child, carer, other significant person;
- Implausible explanations given for injury;
- Delay in seeking medical treatment for the child.

#### **5. Risk factors in parents**

Research undertaken by Kempe and Kempe (1978) and Greenland (1979) has indicated that there are a number of parental characteristics that may be found in families where a child has been abused or neglected.

If a family has these characteristics, it does not mean that they will definitely abuse their child. They are possible risk factors that should be carefully considered within the full assessment of the family and child.

- Young, immature parents;
- Parent experienced abuse or neglect as a child;
- Parent has already abused or neglected a child in the past;
- Mental ill health;
- Low self-esteem, depression, social isolation;
- Relationship difficulties between the parents (or parent and partner);
- Violence between the parents (or parent and partner);
- Social deprivation - for example, inadequate accommodation, poverty, debt;
- Substance misuse (for example, alcohol, prescribed drugs, illegal drugs);
- Multiple moves of accommodation;
- Violent outbursts of temper;
- Rigid, unrealistic expectations of the child's behaviour;
- Harsh punishment of the child;
- Rejecting of the child; difficulty in forming a bond with the child;
- Parent perceives the child to be difficult and provocative;
- Self-harm and/or suicide attempts;
- Criminal behaviour;
- Mental disabilities;
- Chronic illness;
- Partner is not the birth father of the child;
- Another child in the family died in uncertain circumstances.

#### **6. Risk factors in the child**

Again, these are not certain indicators of abuse, but are possible risk factors that should be particularly considered in the family and child assessment.

- Unwanted pregnancy or the parents have ambivalent feelings towards the pregnancy;
- Difficult pregnancy and/or birth;
- Premature baby or low birth weight;
- Baby is unwell at birth;
- Mother and child are separated after birth for prolonged period;
- Child has difficulties feeding and sleeping;
- Child has special needs (physical or mental disability, chronic illness, or developmental delay);
- Child has been previously abused or neglected;
- Child is under five years of age at the time of abuse or neglect;
- Cries frequently, is difficult to comfort;
- Difficulties with toilet training;
- Temperamental irritability - "difficult to care for".

**Material from EveryChild adapted by Rachel Nightingale for Save the Children, Bulgaria programme**

## Appendix 2

### How children send signals that they have been abused

1. **Physical signs: e.g.**
  - bruises or other obvious injuries
  - Signs of neglect (such as failure to gain weight, poor appearance resulting from poor hygiene, lack of personal care)
2. **Behaviour: e.g.**
  - unusually withdrawn, aggressive, or nervous
  - Unusual fears (e.g. of close contact, being alone, men)
3. **Indirectly talking about it: e.g.**
  - Telling you about something which happened to a 'friend', to test your reaction
  - Telling a story, about something that happened to a fictional or mythical character
4. **Directly telling you: e.g.**
  - Telling you in their own words that somebody has done something to do them, which they do not like

Of all the ways a child might **first** signal to you that they have been abused, directly telling you is only the fourth, and least common. Adults who regularly come into contact with children should constantly be on the lookout for the other three types of signal.

Material from EveryChild, adapted by Rachel Nightingale for Save the Children, Bulgaria programme

## Appendix 3

### Some key things to say to a child when they tell you about abuse

#### 1. “I believe you”

Children rarely lie about abuse. If they think you won't believe them they won't tell you. Even if they do not immediately tell you the exact truth, there will be a reason for why they wanted to tell you something.

#### 2. “What happened to you is serious and it is wrong”

Children who have not experienced good treatment by adults often do not know what is normal and what is not, what is right and what is wrong, in terms of adults' behaviour towards children. Sometimes a sexual abuser might say to the child 'it is just our little game', to try and make the child feel it is not necessary to tell anyone.

#### 3. “What happened to you is not your fault”

Children often feel guilty after they have been abused, but they should never be made to feel responsible for abuse committed by others.

#### 4. “It is good that you have told me and you will not be punished for it”

Some children will feel guilty that they have told someone, fearing they have betrayed the abuser, or fearing that other adults will punish them for talking about such things.

#### 5. “I will help you and make sure that you are safe”

Make sure to keep that promise. Remember many children have been told by the abuser that nasty things will happen to them, or to people they love, if they tell anyone.

#### 6. “I cannot promise not to tell anyone about what happened. Some people need to know so we can keep you safe, but we can agree together who we will tell.”

Some children say you are the only person they have told and ask you to keep it a secret, but to do so would make it impossible to protect the child and punish the abuser. Nevertheless, it is important not to betray the child's trust by telling others without informing the child you are doing so.

**Material from EveryChild, adapted by Rachel Nightingale for Save the Children, Bulgaria programme**

## Chairing child centred planning and review meetings: Good practice for independent chairpersons

### Purpose of this document

To provide good practice guidelines for independent chair persons involved in chairing care planning meetings for children and families, both for Take Me Home 2 project and other municipalities and institutions implementing the new 'standards and criteria for service providers'.

### Introduction

Chairing planning meetings for children and families is a very skilled task. Chairpersons develop their own style with experience, but some general guidelines and principles should be adhered to in all meetings and these are detailed in this document. All these guidelines have been developed from the experience of holding care-planning meetings for the children at DMSGD, and are an accurate reflection of the manner in which we conduct these meetings, not just theoretical points.

It is very important that the Chair of the meeting is independent, rather than a representative of one of the agencies involved in the care of the child. This ensures that the meeting is truly child focused rather than agency focused. The overall task of the independent person is

- 1) To empower the child and their family in order that the child can be supported to reach their full potential in life,
- 2) To facilitate a real, high quality discussion between all the participants in the meeting, and
- 3) To identify a specific action plan that will lead to achieving the overall goal in the case within a given time frame.

### Key issues

#### 1. Principles

- The most important principle of a care-planning meeting is that it must be an empowering experience for the child and the family. In TMH2 all the children are babies or young toddlers, so it is not appropriate for them to attend their meeting. However, it is very important that older children are encouraged to attend their planning meetings and to have their voice heard. It is their life after all, not ours. Empowerment involves being aware of the power associated with your role as chair person, and of the role authority of other professionals in the room, and doing everything you can to diminish that power and increase the power of the child and the family, who despite being the most important people, are actually the people with the least power. This is particularly the case when the parent has additional difficulties such as mental health problems or learning disabilities. Each family member has a right to speak and to voice his or her opinion. Do not ignore someone just because they have additional difficulties. Empowerment is about trying to equalize the unequal power relations involved in child care work so that rather than being passive recipients of a service, families can take the center stage and be supported to take real control over their lives and thus more effectively support their children. Empowerment is a leading principle in all aspects of childcare social work, and it is equally as significant in the care planning meeting itself.
- As a rule the family must always be invited to the meeting. There must be a very good reason to have a care-planning meeting without the family. If families cannot attend then the date of the meeting should be postponed.
- The other key principle of chairing child centred planning meetings is that they must be action focused. This means they must be focused on developing child and family centred action plans, with specific responsibilities set for each individual involved, including the parents, and deadlines for certain tasks to be completed. These tasks should, in a step by step manner, lead to the achievement of the overall goal (which may be, for example, reintegration).

#### 2. Practical arrangements

- Ensure that families are prepared prior to meeting. Give them an idea of what the meeting will be like so they are not overwhelmed.
- Ensure that all the relevant people have been invited. Think flexibly about who this might be, however, do not overwhelm the family by inviting many different people who may not strictly be relevant to this particular case. Ask the child and the family who they think should be there.
- Arrange for someone other than yourself to take the minutes. It is impossible to effectively chair meetings and take the minutes at the same time. Ensure that the minute taker is properly briefed and

has a framework for what and how to record. TMH2 project uses two specific recording forms, one for initial care plan meetings and one for review meetings.

- Ensure you have enough time for the meeting. Experience in TMH2 project suggests that up to 2 hours should be allowed for an initial planning meeting, perhaps less for subsequent review meetings. Do not try to squeeze in too many planning meetings in one day as the participants will be too exhausted to give each case the full attention it deserves.
- Ensure that the room is comfortable, at the right temperature. Try to make drinks available, especially on hot days.
- Make arrangements to ensure that the meeting will not be interrupted, apart from in dire emergencies. This is precious time that should be totally focused on this child and their family, and not on other things. Ask people to turn off their mobile phones.
- Think about seating arrangements. In TMH2 we sit in a circle around a coffee table. We avoid sitting behind a large desk, with the family on the other side, as this just reinforces the superiority of professionals over the family, and this is what we are trying to get away from. As the Chair person, make sure you can make eye contact with all the people around the circle, and ask people to move around a bit if you can't. It is good practice for the Chair to sit immediately next to the family.

### **3. At the meeting**

- The aim of the Chairperson at the start of the meeting is to make everyone feel as comfortable and at ease as possible. Some people may feel nervous and apprehensive and unsure what to expect. The way you start the meeting will set the tone for the entire meeting. Direct all of your introductory comments to the family. Tell them explicitly that they and the child are the most important people involved in the case and welcome everyone to the meeting. The more comfortable the participants feel, the more likely you are to have a real discussion that results in a positive outcome for the child. Encourage the family to speak up and ask questions, or correct professionals if they feel they have got something not quite right.
- Ensure that everyone who has attended introduces themselves and their role in the life of the child.
- State explicitly the purpose of the meeting. Why are we here? What do we hope to achieve from the meeting? It is quite common to sit in meetings and not have a clue why you are there.
- Explain to families why it is important to have planning meetings: so that their child does not get lost in the system. Explain that it is not rocket science, but just a systematic way of ensuring the child's needs are met. Don't allow the family to get the impression that the process of planning a child's care is highly technical and that only childcare professionals can do it. It isn't. It's just a way of trying to replicate good parenting in a system that serves hundreds of children, rather than just one or two. In planning to ensure a child can reach his or her potential, we are just doing something that most parents do quite naturally for their children.
- Go through the various parts of the case in a step-by-step fashion, including discussion of the child's developmental needs, the parental capacity and the wider family and environmental factors. The group will have completed their multi-agency comprehensive assessment prior to the meeting, so this should be easy. Never attempt to hold a planning meeting before the assessments have been completed. It is like having a shower with your clothes on: a pointless activity. First the assessments are completed, and then we have a planning meeting, not the other way around.
- At each step, explain to the family why it is important we talk about this and ask them to comment or correct or ask questions. Try to imagine what it must be like to listen to other people talking about your life, your most personal and painful problems, and your relationship with your child.
- Try to remember to ask questions about the child personality (what does s/he like or dislike etc), not just their health and social needs. This is an important and personal question, and will often help the group to focus on the real reason they are all sitting there: the child. It is also important to ask questions about the nature of the relationships between siblings, and the degree of attachment between parent and child.
- Be aware of participants' non-verbal behaviour and what it is saying to you about how they are really feeling.
- Don't be afraid to express emotion. Many of our cases are rooted in the enormous pain and suffering.
- With practice, the process of conducting a child centred meeting will become like a well-oiled machine. All the different professionals involved will know what their role is and what is expected of them. However, for most parents it will be the first time they have sat in on a meeting of this nature. Try to remember that, and to explain at all stages why you are doing what you are doing and not take anything for granted. What hopefully is routine for you and your colleagues may be brand new and rather scary for the parents. Try to put yourself in their shoes as much as you possibly can.

- Encourage real and genuine discussion, focused at all times on the needs of the child and the family. Encourage people to speak up if they do not understand something. If you yourself do not understand something that someone has said, say so. If you do not understand it, the chances are you won't be the only one, but you might be the only one brave enough to say so. By modeling open and real dialogue, you will encourage it in the other participants.
  - Encourage all the participants to use simple jargon free language. It is very important that everyone has a clear understanding, particularly the parents. This is particularly the case when it comes to talking about important medical issues.
  - Ensure that you have a general plan for how to intend to get from the start of the meeting to the end of the meeting successfully, but be prepared to deviate from that plan if the discussion leads you in a certain way. Some meetings can appear to the outsider to be more organised than others, depending on the personalities of the participants and the issues discussed, but all meetings should have an underlying sense of direction, and the Chairperson is the person to ensure this happens. Try to keep the group focused on the main goals of empowering the parents and achieving a realistic action, and do not be afraid to tactfully interrupt people if they are straying too far away from the subject.
  - If it is a review meeting, rather than an initial care planning meeting, ensure that you review the list of action points agreed on in the last meeting. Identify which tasks have been achieved, and if they have not been achieved, what the reason is. Perhaps someone has not completed a task they promised to do, or perhaps they were not realistic tasks after all? Perhaps the overall plan needs to be changed in the light of the experience since the last review meeting? In review meetings, do not go through the entire family history all over again as this is unnecessary. The basics of the case will have been established in the initial meeting, there is no need to restate them. We are interested in new developments that have occurred since the last meeting, in discussing the current situation and in establishing real and achievable goals to move the case forward.
  - Ensure you set a date for the next meeting. Explain to the parents why you are doing this.
  - Ensure you record any disagreements with the overall plan and explicitly record the parents' point of view.
  - Ensure you gather the signature of representatives of all the different agencies, the parents and the child (if appropriate). Explain to the clients why you are doing this.
  - Always end by asking if anyone has anything else they would like to say, and by thanking the participants for their hard work.
4. After the meeting:
- After each meeting, have a debrief session with some of the main participants. Try to learn as much as possible from each meeting in order to develop your practice
  - Ensure that the minutes of the meeting are distributed to all participants.

### **In conclusion**

It has been said of the care planning meetings held within TMH2 project that they are rather like swans. They look effortless as they move gracefully on the water, but underneath they are paddling furiously to get to the final destination: good outcomes for children.

**Rachel Nightingale, Technical Adviser**  
**July 2004**

## Preparing and moving children

### A good practice guide

#### Key points of this good practice guide:

- *Placement moves can be highly traumatic for children, particularly children aged 0-3.*
- *The best way to support children is to ensure that any placement change is a positive move to family based care, and, as far as possible, that it is the last move the child has to make.*
- *We can turn a potentially traumatizing experience into a positive one if we follow a careful preparation and transition plan based on the individual needs of the child.*
- *In addition, life-storybooks are very useful tools in helping a child develop a strong sense of self and thus move successfully from one placement to another.*

#### Introduction

Children who are pre-verbal or have limited verbal ability and understanding cannot understand changes in their lives simply by being told what is happening. But this does not mean that we do not need to prepare them for moving placements. Moving babies and toddlers without preparation to an unfamiliar context and unfamiliar people can be extremely frightening and traumatic for them and may result in disturbed behaviour and developmental delays.

Although we cannot, in any adequate manner, verbally explain to these children what is happening to them, nevertheless preparing them for the move is relatively straightforward. Since each child is an individual with complex needs, it is difficult to provide a 'recipe' for the perfect preparation programme. Instead, below are presented suggested activities for babies and toddlers in the 0-3 age range that can be adapted as necessary according to the individual needs of the child.

#### A positive move

The most important factor that will ensure the success of the transition is that the move is a positive one for the child. If the child is moving from one large institution to another, whilst preparation may ease the trauma to an extent, it is unlikely that the move will be trauma-free. This is because the child's life does not significantly improve as a result of the move, but he or she still has to go through the difficult process of learning new rules, getting to know an unfamiliar place and new people, and missing old friends. This is why it is so important that every child from an institution is moved into a family (their own, a foster family, an adoptive family, or small family type home) and not to other institutions. In addition, because placement moves are potentially so traumatic for children, the next move that is planned for them should, to the greatest extent possible, be the last one they have to make. To these ends, these suggestions are made on the assumption that the child is moving to a family based placement. However, if necessary the recommendations can be adapted to other placement moves.

Firstly, once the child has been matched with the appropriate family placement, they should be introduced to the new family and be given opportunities to form a relationship gradually with the new family. The first visits should take place in a location familiar to the child - i.e. most probably the institution - and a carer known to the child should be present throughout.

#### The role of the current carer in promoting the new family relationship

If the child has formed an attachment with a current carer at DMSGD, then the attitude of the current carer towards the new carers is important in assisting the children to learn to trust and feel comfortable with them. The current carer with whom the child has a trusting relationship should communicate to the child that it is okay to trust the new carer. This giving of permission will help the child in forming the initial contact with the new carer.

Where the child has not formed an attachment with a member of staff in the institution, the therapist involved in preparing the child can take on this role of attachment figure. That is, the therapist first develops a trusting relationship with the child and then helps introduce the child to the new long-term carer, demonstrating to the child that they (the therapist) trust the new carer and that it is therefore okay for the child to trust them too.

#### Next steps

Once the child has begun to get to know the new carer they can safely spend time alone together. The carer should be made aware of methods to assist in forming an attachment. Therefore the visits can be planned to include constructive play activities, appropriate to the child's stage of development, which give opportunities for the child to achieve and for the carer to express pleasure at the child's achievements. In this way, the relationship with the carer begins to develop on the basis of positive reinforcement of the child. From this type of interaction, the child benefits as follows.

- The individual attention, coupled with the obvious pleasure of the carer as a result of the child's actions, will help to increase the child's self-esteem.
- Constructive play activities, appropriate to age and level of development, will assist the child to begin to recuperate developmental delays and to attain some of the developmental milestones he or she has missed.
- The carer genuinely begins to delight in the child's achievements, which helps them to bond with the child.
- The child begins to learn that positive behaviour is rewarded - the beginnings of moral development

### Transition objects

Once the child has begun to develop a relationship with the carer and evidently feels comfortable with them, visits to the new placement context, accompanied by the new carer, can begin. In order to assist the child with these visits and the move in general, it is suggested that they have access to a transition object, such as a small teddy bear or an item of clothing or blanket that they are attached to. The therapist can assist the child to prepare for moving to the new home by involving the transition object in the process. Plans can be made for 'moving teddy' to his new home and the child can be encouraged to 'take care of teddy, because he is a bit scared of moving'. Once the child has moved, the transition object acts as a link between the previous placement and the current one, helping the child to feel that he or she has not been 'cut off' from the past altogether.

It should be noted that in many institutions, children do not have their own possessions and moreover, may not even understand the concept of individual ownership. It is important, therefore, that if a special toy is given to a child as a transition object, that all staff in the institution should be aware that this toy needs to remain with the child, and that the child should be encouraged to play with it. It is important to introduce transition objects in a careful manner. It may be that the child is given a specific toy during therapeutic sessions, but that the child is encouraged to help 'put teddy to bed' in a locked cupboard each day, 'to keep him safe' until such time as the child and teddy are ready to move. The new carers should also be introduced to the transition object during the preparation programme, so that they understand the importance of this treasured possession and ensure that the object remains with the child in the new placement.

Another useful method is for the new carer/parent to bring specific toys to the first meetings at the institution and to take the toys home with them at the end. Then when the child first visits the new placement, the toys should be produced. They will be familiar to the child and, like the transition object, help to form a bridge between the old and new placements.

If the visits are all going well with the new carer, then overnight stays can be planned, followed by the move itself. Once the child moves, it is usually helpful to retain some of the child's usual routines in order to help them feel safe and only change routines gradually, as the child becomes more and more familiar with the new carers and environment. It is usually helpful for the child not to be introduced to many different people and places at one time. Whilst it is likely that many people may wish to visit once the 'new baby' has come home (particularly in the case of an adoption), it is probably more healthy for the child to have few visitors until such time as he or she is secure in the new environment and has begun to form a healthy attachment to the parents/carers.

It is suggested that the therapist involved in preparing the child to move should also be involved in supporting the new placement for a period of time, as a figure of continuity. In addition, preparation tools such as life-storybooks can help the child to cope with the move (more about this shortly). If the child had special friends or special relationships with carers in the institution, they should be given the opportunity to visit them.

It is estimated that the period of matching and visits should be approximately two weeks for very young babies, about a month for older toddlers.

### Post-movement support

**Even though a child has been prepared for a move and supported during the move, post-placement support is essential to ensuring that the new placement is a success. Therefore it is important for the therapeutic team to be involved in supporting the move, by visiting regularly and continuing to be involved in the child's life. Visits can reduce as the child becomes more and more attached to the new carer. The rate at which visits are reduced should depend upon the needs of each individual case, the levels of distress of the child and the concerns of the new carers.**

### Monitoring and evaluation

Once the therapists are sure that the child is feeling safe and secure and that the carers are confident in their new role, visits might be reduced to weekly or in some cases monthly intervals. However it is essential that the child and carers know that they can contact the therapists at any time if they have any concerns. In addition, as children grow and develop, new challenges appear and carers may need guidance in dealing with unexpected behaviour changes. Although good assessment and preparation will minimise the potential for placement breakdown, practitioners should be ready to intervene as early as possible where placement breakdown does occur. Equally it is vital to recognise that “settling in” is not a quick, one-off time or activity. Children will require support and monitoring for a substantial period to ensure that the integration process is going well and to pick up any ongoing problems.

### Preparation tools

There are many different kinds of preparation tools that can support the therapist to prepare the child for a placement move, such as life story work, road of life exercises and mirror work.

### An example of one preparation tool:

#### Life-story work

The most common form of life story work is the life-storybook, which, if the child is old enough, is created together with the child. The life-storybook contains essential information regarding the child’s history, which helps children come to terms with what has happened in their lives. It helps them to understand why, when and how they were separated from their birth parents and what happened next. It also helps develop a strong sense of identity since it contains important details regarding a child’s development (when the child first walked, first talked, what the child liked to eat, what games the child liked to play; special events such as holidays, trips away). These memories are usually held by parents and are told to the child as he or she grows up. The child feels important and special because these events and memories are obviously important to the parent. This kind of detail, however, can easily get lost if a child moves from one placement to another.

This is where a life-storybook can be very useful, since it follows the child from one placement to another. Each carer responsible for the child in each different placement fills in important details in the book and thus the memories, although not held by one individual or set of parents, are there for the child to identify with. As far as possible the life storybooks should also contain photographs and as many details as possible regarding the birth family (parents, siblings, extended family). Children often wish to know who they resemble, therefore even if photographs cannot be provided, details about the parents’ physical appearance, talents, interests etc can be essential to a child developing a sense of self.

For many children who have spent considerable amounts of time in institutions however, it is rarely the case that such documentation has been kept. Often older children have moved through three or more institutional placements and the record keeping usually refers strictly to medical issues, dates of transfers, details of education, original address of the parents, perhaps some details of siblings. In terms of developing a clear sense of history and identity, the contents of most children’s records are usually insufficient. Many older children in institutions have absolutely no idea what happened to them during their first three years of life. It is not simply that they have no memories, as this is fairly normal, but rather they are not aware of where they lived, with whom and how they developed. Most of us are aware of these crucial beginnings of our histories as a result of being told stories and looking at photographs. As such, it is important to help the children reconstruct their history. For many of these same children, if asked what they would like to do in the future, they rarely have a response. They find it difficult to conceptualise a future. It is difficult to understand your present and imagine your future if your past is ‘missing’.

#### Content of life-storybooks

Life storybooks should contain the following sorts of details. Note that it is important that these are not simply dry ‘facts’, but that they feel like someone’s ‘story’, including emotions, and that they are written in the child’s voice and from their perspective.

- **Name** (including details as to why this name was chosen, if any are known. Perhaps the child was named after someone in the family, or a favourite actor, or a saint with certain qualities). For example “My name is Ronaldo Radkov Borisov. My last two names are after my first Mummy, and Ronaldo is after a famous Brazilian footballer that my first Daddy liked very much”.
- **Date and place of birth** (including details why)
- **Age when separated from birth family and reasons why**. This should be introduced sensitively and should not paint the birth parents in a negative light. Perhaps a drawing by the child of this event might be helpful (dependent upon the age of the child). For example, “ When I was born my first Mummy and Daddy did not have enough money to look after me, so they asked Auntie Galia at the baby home to look after me instead”.

- **Baby photos.** If not available, then the child might be asked to draw a picture of him or herself as a baby. This is possibly the first occasion on which the child has been encouraged to imagine him or herself as a baby and even if a genuinely accurate picture cannot be ascertained, the fact that the child begins to conceptualise him or herself as a baby represents an important step in reconstructing his or her early history. For example: "This is a drawing of what I think I looked like when I was a baby. And this is the first photograph that was taken of me when I was about two and a half years old. In the picture with me and Auntie Galia and my friends Ana and Borka. We are all in the baby home together".
- **Details and, as far as possible photographs of parents, siblings and extended family.** Who does the child resemble most? If there is a common history with the siblings for any length of time, details of this should be included. Because of the way in which the institutional system operates, it is often the case that siblings were initially placed in the same institution, but then later separated due to age and sex (i.e. at 3 years old children used to move from the DMSGD to a pre-school institution and then at 7 to a school age institution, usually segregated according to sex.). It is rarely the case that siblings are moved at the same time. For example: "This is a photograph of my first Mummy. I do not have a photograph of my first Daddy. This makes me sad and I wish I did. Auntie Galia told me that my first Daddy came to see me once but I was too little to remember him. She said that I really look like him. Here is my drawing of my Daddy instead."
- **Milestones in the child's development.** When did the child, first sit up, take his or her first steps, speak for the first time, learn to eat with a spoon.
- **Details of and reasons for placement moves:** "This is Auntie Galia who looked after me when I was a baby. This is my foster mummy. I call her my Forever Mummy. I was sad to say goodbye to Auntie Galia and my friends in the baby home, but I really, really love my new Forever Mummy because she is mine forever and also because she lets me play in the garden with the dog and makes me nice dinners including chips".
- **Special events in the child's life.** The child's first day at nursery or at school, plus when the child is older, other important details as regards education: who are the child's teachers, what does the child excel in or enjoy best at school, involvement in any team sports or musical or artistic activity, or other hobby. Holidays: where did the child go, with whom and what happened. Specific religious occasions (dependent upon the religion of the child) should also be marked, such as baptism: who are the child's godparents?
- **Paintings and drawings by the child at different ages,** specifically those that marked special occasions or reflect the child's identity in any particular way: handprints/footprints, self-portraits, drawings of the child's family, placement family, friends etc. Make sure the date is on the painting.
- Details of childhood illnesses, vaccinations, and any specific medical or health needs. Include the names of the doctors the child goes to see.

### Life story work for different age groups

Producing life-story books should, as far as possible, be an interactive experience between the child and the carer or therapist/social worker. Evidently for babies, the adult will undertake the vast majority of the production, but as soon as it is possible, the child should be playing an active role. The earlier the life-story book is begun, the easier it is for the adults involved to collect all the necessary data. The older the child, the more difficult this becomes.

**Rachel Nightingale, Technical Adviser  
September 2004**

Material adapted from 'De-institutionalisation of children's services in Romania: a good practice guide, March 2004, Unicef/Dfid'.

## Issues to consider when planning a family contact visit

All of these issues should be discussed in the child's care plan meeting, mutually agreed on by the multi-disciplinary team including the parents, and clearly written in the child's individual plan. This forms part of the contract of care between parents, CPD and DMSGD. It can then be easily reviewed at the next care plan review meeting.

- ⇒ What is the **aim** of the contact visit?
  1. To promote the bond and relationship between parent and child?
  2. To assess parental capacity using an observation form?
  3. To teach parents new skills in order to strengthen their parental capacity?
- ⇒ Given the **aim** of the contact visit, what **type** of contact visit is it?
  1. Unsupervised contact visit. Why?
  2. Supervised contact visit. Why?
  3. Observation visit. Why?
- ⇒ Who is allowed to visit the child and who isn't, and on what basis?
- ⇒ When should the visits take place and for approximately how long?
- ⇒ If it is an observation visit, how will the observation be recorded and who will have a copy of this?
- ⇒ What are the arrangements for canceling the contact visit by each party and who will be informed? Eg if the parents have to cancel a visit, we should expect them to inform us so this can be recorded on the child's file and CPD informed if appropriate. On what basis will DMSGD cancel a visit, eg if the parent is clearly intoxicated. Again this should be recorded on the child's file and CPD informed.
- ⇒ Who will do what aspect of the follow up work?
- ⇒ When will this plan for family contact visits be reviewed?

**Rachel Nightingale, Technical Adviser**  
**April 2005**

## **Example of family contact visit plan: (recorded in child's individual plan)**

### Aim:

The aim of the family contact visits is to strengthen the bond between Mr and Mrs. Georgieva and their son Alexander, and to assess their parental capacity.

### Schedule:

Mr and Mrs. Georgieva commit to visiting Alexander every Tuesday and Thursday from 10-12.

### Cancellation arrangements:

If they cannot come they commit to phoning DMSGD so this can be explained to Alexander and noted on the file. If Mr and Mrs. Georgieva miss more than two consecutive visits DMSGD will inform CPD of this.

### Type of visits:

There are no concerns about Alexander's safety, so most of the visits will take the form of 'unsupervised contact visits'. Three times per month the duty officer using the observation form will assess the visits. A copy of the observation form will be kept on the file and a copy sent to CPD.

### Follow up work:

At the next care plan review meeting, progress will be discussed and if necessary a plan made to teach Mr and Mrs. Georgieva any new skills they might need to acquire before Alexander can be safely reintegrated home.

### Review:

This family contact plan will be reviewed at the next care plan review meeting in June 2005.

**Rachel Nightingale, Technical Adviser**

## DMSGD Family Area: A short concept paper

**Purpose of this concept paper:** DMSGD has, with the support of SCUUK, provided and refurbished the Family Area as part of TMH2 project. In order to fully realize the potential of this resource it is important for us to clarify our common understanding of the following points:

- What is it?
- Why do we need it?
- What can it be used for?

### What is it?

The overall purpose of the Family Area is to provide a specific area of the institution that is dedicated to developing DMSGD's work with families. All the families of the children who reside at DMSGD have huge and complex needs. The vision for the family area is that it will become a genuine and valuable resource for families who are under stress, providing them with support, information, guidance and encouragement.

### Why do we need it?

In the wider context, the role of long-term institutions in Bulgaria is changing. Under new legislation, residential facilities such as Ruse DMSGD are expected to offer a wide range of services to children and families in need, not only residential services. This is because of the damage that is done to children, especially young children and babies, who live for long periods in residential care. Every child needs and has a right to grow up in a family, and despite the best efforts of the dedicated staff in DMGD, they cannot replace a family. Children need to be with their own families, wherever this is possible. If this is not possible then they need to live in an alternative family environment. This is in order that they can be supported to reach their full potential in life. This is the ultimate goal. In order to reach it we have to plan how to get there in a step-by- step manner. It will not happen overnight. The development of the family area within DMSGD is an important and vital step in this direction.

DMSGD is now expected to demonstrate ways in which it works proactively with families to strengthen the bond between parent and child, assess parental capacity, support parents to increase their parental capacity and ultimately promote family reintegration. The development of the Family Area provides a unique and exciting opportunity for DMSGD to strengthen its work with families, be they birth families or potential foster or adoptive families.

### What can it be used for?

We should think widely about how the Family Area can contribute to DMSGD's new and developing role as a service that genuinely reaches out to and empowers families. Here are some suggestions:

- **It is a place to promote contact between parent and child:** A place for children and their families to be together. The child's individual care plan should clearly address the following areas with regard to contact visits:
  - ❖ What is the aim of the contact visit?
  - ❖ Who is allowed to participate in contact visits to the child, and who is not allowed and on what basis?
  - ❖ Are other visitors allowed to be present?
  - ❖ Does the contact visit need to be supervised at all times and if so why?
  - ❖ What are the tasks of the supervisor in each individual case? Why are they there? For example is it to observe the visit, or assess the nature of the relationship between parent and child, or intervene and support the parent or to model good parenting skills etc? Or maybe all of these?
  - ❖ If the contact visit is supervised, should the supervision be recorded and if so in what form? What will happen to this information?
  - ❖ Is more than one supervisor needed?
  - ❖ For how long should the contact visit take place, and how often?
  - ❖ What are the arrangements for canceling the contact visit? For example if the parent cannot make it, or if the parent is clearly under the influence of drugs or alcohol when they arrive for the contact visit.
  - ❖ Who will take responsibility for the follow up work to support both parent and child between sessions?
- **A place to offer different sorts of activities/groups/classes to increase parental capacity:** In addition to the support offered to parents in the contact sessions, the family area can be used as a venue in which to offer a wide range of interventions to increase parental capacity. These can include for example:

- ❖ Parenting classes (basic information on how to take care of a babies needs such as bathing, changing, coping with crying etc),
- ❖ Parent support groups (mutual support groups for parents to come together and discuss the difficulties associated with bringing up children, offer each other support, identify solutions and improve their capacity to be 'good enough' parents through mutual support),
- ❖ Information area to provide parents with specific information on child and family related matters and child rights,
- ❖ A 'drop in' centre for parents to advise them of their rights and responsibilities and refer them to other agencies for support.
- **A place for care planning meetings:** The Family Area is a place to hold child centred care plan and care plan review meetings. These meetings are now taking place on a regular basis within DMSGD and are proving to be absolutely essential in ensuring that we are working with each and every child in a planned and meaningful way. They are another way in which we are empowering parents to take control of their lives and, with support and encouragement, accept the responsibilities of parenthood.

**Conclusion:** As we cannot do everything at once, it is my suggestion that we begin with strengthening the family contact system and, once this is firmly established, then move on to developing other initiatives such as parenting classes etc.

**Rachel Nightingale, Technical Advisor**  
**19<sup>th</sup> September 2004**

## Results and report regarding the 'Family Visiting Questionnaire: What do you think?'

**Aim of the questionnaire:** To find out the attitudes and opinions of a cross section of parents/other relatives regarding the family visiting arrangements currently in place at DMSGD. These opinions will help shape the services offered to families in the DMSGD. The questionnaire was carried out with the full permission of and in co-operation with DMSGD.

**Interviewer:** Diana Georgieva

**Number of interviews:** 12

**Venue:** DMSGD foyer or family area as appropriate.

**Length of interviews:** 20 minutes approximately

**Approach:** During the interviews emphasis was placed on encouraging the parents to be as relaxed and open as possible, in order to achieve the most useful results. Each interview began with some version of the following introduction:

"My name is Diana and I work here in the Mother and Baby home as a project assistant. This is an opinion survey and it is called 'What do you think?' It is called that because we want to know what you think! There are no right or wrong answers to this survey; we just want to know your opinions. Everything you say is anonymous, and it will not in any way affect you or your child.

This home is trying to improve its services to parents and families. We want to become more open to parents and to encourage the relationship between parent and child. As the child's parent/grandparent etc you are the most important person in your child's life. We want this home to be something that really helps you to be a good parent and to develop a strong relationship with your child. Other people are helping us with these changes, such as CPD and SCUUK. As part of these changes we have developed this family area. We want this to be a place where you can be with your child and enjoy your visits together in a relaxed environment.

One of the most important parts of these changes is to find out what you, the parents think about visiting your child here, about how we can improve our service to you. We are very grateful that you have agreed to give us some of your time. This facility is for you, not for us. We really want to know what you think so please try to be as open and honest with us as you can.

If you do not understand any of my questions, or you prefer not to answer any of my questions, please just let me know, as this is ok".

### Questions and collated responses: (not all interviewees responded to all the questions)

#### 1. How often do you visit your child at DMSGD?

- Once a week
- Once every few months
- I come on Sundays because this is the only time when a parent is allowed to visit their child here
- Twice a month
- Two-three times a month
- Every Sunday
- Once a month
- I can't recall, I don't know.
- Once a week
- Twice a week
- Once a fortnight
- Once a fortnight

#### 2. Do any other members of your family come with you on the visits?

- Yes, the father
- Yes, the father
- Yes, the father and her sisters
- No (response from a granny)
- Yes, my mum
- No
- No. The child's mum is not in Bulgaria
- No

**3. How long do you spend with your child on average?**

- ½ an hour
- 1 hour
- Till they come to collect the child
- 1 hour
- 1 hour
- For as they leave the child with me
- 15 min - ½ an hour
- I can't answer
- 1 hour
- 1 hour
- ½ an hour
- ½ an hour

**4. Would you like to spend more time with your child?**

- Of course I would like to
- Yes, but I have other children to take care of who are waiting for me at home
- Yes, but I don't know if I would be allowed to spend more time with her.
- Yes, but the children here have daily routine
- No, 1 hour is enough
- Yes. If they left the child with me for a little longer this would be good
- I'm very busy and I don't have time to spend more time with my child
- Aren't my visits long enough already? (This is a response from the mother who cannot recall how often she comes)
- Yes
- Yes
- Yes
- It is not possible

**5. Which day of the week do you usually visit?**

- Sundays and Saturdays
- Sundays
- Sundays
- Sundays
- Different days
- Sundays
- I'm a driver and I come to visit the child when I'm in the town
- Different days
- Different days
- Different days
- Different days
- Different days

**6. Are the current visiting times convenient for you and your working hours? If not when would be a better time for you?**

- I'm jobless. In the morning is the best time for me - 10/11 o'clock
- I'm jobless.
- I'm jobless. But I have other children to take care of.
- I'm a pensioner, but I find odd jobs. The most convenient time for me is Saturdays and Sundays
- I don't have a job. Any time is ok.
- I'm jobless.
- Whenever I come to visit her they fetch the child
- I'm jobless but I'm very busy
- Yes
- Yes
- Yes
- No

**7. Would you like to visit your child more often? If yes, please give the reasons why this is not possible.**

- Yes, but there is nobody to look after my other children when I come here.
- Yes, but there is nobody to look after my other children when I come here.
- Yes, if I am allowed to I would like to come more often. Sometimes I can come in the morning, sometimes - in the afternoon
- I want to come on Saturdays if possible
- No, because the child gets upset
- Sometimes it's more convenient for me to come on Saturday, but there are no visits permitted on a Saturday
- Yes, but my job doesn't allow
- I can't visit my child more often, I'm busy
- Yes, but I have financial problems that prevent me doing it
- No
- Yes, but my job doesn't allow me
- Yes, but my job involves overseas travel

**8. When you arrive here at DMSGD, how long do you wait before you can see the child?**

- 10 minutes
- 10 minutes
- 15 minutes
- 5-10 minutes
- 10-15 minutes
- 5-10 minutes
- ½ an hour
- 10 minutes
- 5 minutes
- 5 minutes
- 10 minutes

**9. Before we came in here to the Family Area today, did you know about this facility? Do you understand what it is for? Do you use it?**

- No.
- Yes. I come here to visit my child during the weekends.
- Yes. I come here to visit my child during the weekends.
- Yes. I like it
- Yes. I use it
- I was there only once but there were other people visiting too. I prefer my child and I to be alone.
- No. I meet the child here (the lounge)
- Yes, but I have to go right around the Home to the back door in order to get in. I don't like that.
- No. I haven't visited it yet
- Yes
- No

**10. If you have used this room before do you like it? Do you feel at ease in this room and does it help you to have a positive relaxed visit with your child?**

- It's cozy here (at home the mum shares one room with her partner + their 5 children)
- I like it but I don't feel comfortable when there are many people visiting at one and the same time. I need more privacy.
- It's very beautiful here. I would feel more comfortable if there were not other people visiting their children at the same time as me.
- I like it
- I would prefer everybody to see their child in a separate room because I feel nervous when I'm surrounded by other (unknown) people
- I like it
- It looks nice but I only like it if there are not other visitors here at the same time as me and my child
- I have not seen the Family Area. Maybe, some day...

**11. Do you have any ideas or suggestions about how we could make improvements to this room? Eg rugs on floor, drink making facilities etc**

- A carpet, a kettle - for tea, more toys, slippers maybe so we can leave our outside shoes off?
- Curtains (between the rooms to maintain privacy), a coffee machine
- A carpet, toys, curtains between the rooms. I don't know how to prepare coffee using a coffee machine, what will happen if I destroy it?
- I don't think anything else is necessary
- It would be good if there were a carpet here.
- I don't have time to drink coffee. I hold the child in my arms.
- I don't know
- What ever you decide will be good. I don't know anything about such issues. Besides I'm not here to drink coffee.
- No.
- Yes it will be good to have more facilities

**12. Does a member of staff always stay in the room with you when you visit your child? Is that ok with you? Yes/no/I feel calmer**

- There is a member of the staff present. It is ok with me.
- There is a member of the staff present. It is ok with me.
- There is a member of the staff present. It is ok with me.
- There is a member of the staff present. I feel calmer as sometimes the child is crying terribly.
- There is a member of the staff present. I feel calmer.
- There is a member of the staff present. It is ok with me.
- There is a member of the staff present. I would rather they were not there.
- Not always. I just want them to answer my questions and to leave me with the child in private.
- There is a member of the staff present. I feel calmer.
- There is a member of the staff present. I feel calmer.
- Nobody observes but I feel calmer that way and prefer it

**13. Do you have contact with any of the other parents who come to visit their children in DMSGD? Do you talk together about your situations or your children?**

- No
- Yes. We discuss the development of our children.
- No
- I don't have time
- Of course! We have to! We have no choice! We share one room during the visits!
- No. I focus all of my attention on the child.
- No
- No

**14. If we offered a support group for parents in this family area, would you be interested in attending? What sort of things would you like to talk about in the group?**

- I would attend if I have time (she is looking after 5 children) I want to discuss the up bringing of our children.
- I don't need that.
- No. I have other children and I'm skilful enough.
- I don't have time
- No. I know how to raise children
- No
- No
- I don't have time

**15. Would it be helpful for you to have written information displayed on a notice board in this room, informing you of different support services available, and about your rights and your children's rights? What language/form of communication would you need to have this in?**

- I like this idea. I can read in Bulgarian.
- It would be good. I can read in Bulgarian.
- I can't read in Bulgarian and in any other language either
- I can't read very well

- Even if they put boards I would not understand anything. When I want to understand something I ask them and they respond.
- No
- No
- I don't know

**16. Is there anything else you would like to share with me? Remember this conversation is anonymous.**

- No
- I don't like somebody to watch over what I'm doing with the child. I don't feel comfortable.
- I don't believe this conversation is anonymous, I think you are going to check who I am and record my name.
- I want them to give me a decent house and then I will take the child home

**Observations of interviewer (Diana Georgieva):**

- It took me a long time to convince the parents that this was an opinion survey and that we are interested in their views, many of the parents were nervous and it took me a while to calm them down.
- One parent (a father) was clearly intoxicated.
- Another father was very suspicious about me maintaining his confidentiality.
- Two sets of families just refused to participate.
- The best interviews took place after the care planning meetings: by this point, parents could trust my independent status.
- I think that (especially Roma) clients with the lowest social status do not feel comfortable in the family area because they feel the furniture is too 'posh'. They feel out of place.
- I was shocked that one parent thought Sunday was the only visiting time!
- I was also shocked that some of the unemployed parents say they are too busy to visit their children! It seems that the children are not a priority for them.
- During visiting hours the parents need a person on duty who is fully attentive to them, polite and encouraging and does not have 15 other things to be doing at the same time. However, some of the other parents do not want to be observed during the visits at all. Many of the parents expressed their dislike at having to share the Family Area with other parents and children. They want to have more privacy. This is especially the case at the weekend when most of the parents visit.
- We need to have a flexible approach when facilitating family visits - some parents need one kind of approach - others need a different kind. The best interests of the child should be the guiding principle when planning what type of visit it should be.
- Most parents are not really aware of their rights and responsibilities eg 'if they allowed me to I would stay longer', 'If I was allowed to I would come on Saturdays'.
- Some parents think that to visit their child is to literally just have sight of the child, or to feed them (non stop!) with things they bring for the visit. One father told me as an aside "I don't need you to provide toys here in the Family Area. I am not here to play with my child". Some parents don't understand the need to interact and build a relationship with the child. The Bulgarian word that is used to describe these visits is 'svishdane' which is equal to visiting a patient in the hospital, but visiting the children here is not the same as this. It requires time, patience and commitment from the parents and the facilitator/person on duty. A better word is 'poseshtenie' and this means visit in a more broader sense, it includes going somewhere and spending quality time with the person. I would be happy for the parents' visits to be less 'svishdane' and more 'posishtenie'!!

**Analysis and recommendations by TA (Rachel Nightingale):**

**Overall comment:** We understand that this questionnaire cannot be said to be 'highly scientific' as it was used with a relatively small sample of parents, but nonetheless some interesting conclusions can be drawn in the following areas:

**Frequency of visits:**

- I am concerned that one parent thinks that Sunday is the only time they are allowed to visit their child. **Recommendation: I would like to see the visiting times more prominently displayed at the front of the DMSGD building and also near the Family Area (see below regarding**

**information area).** Even if this helps just one parent to visit more often, it would be worth it, although I suspect it will help more.

- I am concerned that some parents visit so infrequently. Regular visits to the child are very important in order to build a bond, particularly in the case of small babies. A parent cannot expect a young baby to be reintegrated home if they only visit once a month or even less. Children need to see their parents regularly. **Recommendation: To ensure a specific, agreed, regular visiting plan is written down in the child's individual plan during the care-planning meeting, and reviewed during the 3 monthly review meetings.** For example: the parents commit to visit their child every Tuesday and Thursday between 10-12. They make this a priority in their lives. If they cannot come they telephone so this can be explained to the child (where this is appropriate) and noted on the file. This is an important part of assessing the parents' willingness to take on the responsibilities of parenthood. If parents are not able to visit regularly because they live a long way away this should be clearly recorded on the child's file. It may be considered reasonable if a caring parent is doing everything they can to visit the child despite many other pressures, but sometimes fails (pressures such as having many other children at home, living many miles away in an isolated village etc). Equally it may be considered unreasonable if a parent visits seldom despite few other responsibilities. For example "I am jobless, but I cannot come regularly to visit my child because I am really very busy" - busy doing what? What is more important than your child? We should not be afraid to have very frank conversations with parents about this as part of the care planning process, as this is important information in assessing the appropriateness of reintegration.

#### Length and quality of visits:

- I think Diana's comment about 'less 'svishdane' and more 'posishtenie' is very interesting and I wholeheartedly agree.
- I think we have a real issue about privacy in the Family Area, especially as it seems that most parents come at the weekends. Several of the parents expressed a desire for more privacy during the visit. **Recommendation: We need to think about how to resolve this, and it may be that curtains between the three rooms in the Family Area are the answer.** The majority of parents do not need to be observed all the time, unless there are real concerns about potential harm to the child in which case all the visits will be in the form of a 'supervised contact' (and this will be a clear, recorded part of the child's individual plan). It is important that parents are given the time and space to spend with their child in order to form a bond in as real a situation as possible. We should think about specifying what type of visit we are offering to parents eg 'unsupervised contact visit', 'observation visit' (for the purpose of formally assessing parental capacity), 'supervised contact visit' etc. We should be clear in ourselves and with parents about what type of visit is planned, and this should be recorded in the action plan. For example, "the parents will visit every Tuesday and Thursday from 10-12. As there are no concerns about the safety of the child the majority of the visits will be 'unsupervised contact visits'. Three times per month the visits will be assessed through observation by the duty officer, and recorded on the contact form". The contact form is then placed on the child's file and a copy sent to the CPD social worker. General 'unsupervised contact visits' do not mean that the duty officer disappears altogether (they will need to have some contact with the parents of course, to exchange information etc), but that they give the family some space to be together. On the basis of the observed visits, a plan can be made about what skills an individual parent needs to acquire before the baby can be safely reintegrated. This can then be discussed and agreed on in the care planning meeting, and a plan made for DMSGD colleagues to teach the parent these skills.
- The visiting hours at DMSGD have recently been extended to include Saturday mornings (10.00-12.00) and this is a very welcome development. **Recommendation: one possible solution to get around the overcrowding of the Family Area at the weekends is to further extend the visiting hours on Saturdays and Sunday and to make parents aware of the extended hours.**

#### Family Area:

- Several of the parents made some interesting comments about the Family Area. It is good to see that many of them have used it and appreciate it. From the comments of the parents it is very important that the Family Area is not seen as too 'precious' in order for them to feel relaxed. ('What if I make it dirty? What if I break the coffee machine?') Sadly, many of 'our' families are not used to spending time in such nice places. **Recommendation: that more efforts are made to make the Family Area more cozy, including some of the recommendations of the**

parents, but especially carpets/rugs that can be easily washed. See my March 2004 report for other suggestions.

**Parent support groups:**

- There does not seem to be a huge interest from parents in attending a parent support group. This may be because it is hard for them to envisage what this really means. **Recommendation: Maybe this idea is too radical for now, but I would recommend that it be kept in mind as an idea for the future.** To give an example, in some cases in the UK, parents about whom we have concerns are legally required to attend parent support groups as a prerequisite to keeping their 'parental rights' over their children. In other parent support groups, parents attend on a voluntary basis because they want support and they want to learn more about being a parent, which is the most important job in the world and yet the only one for which we don't have to have qualifications!

**Notice board/information area:**

- Most of the parents responded that this would not be helpful for them, because they cannot read in Bulgarian (or in some cases in any other language). However, two parents said that it would be useful which is interesting. **Recommendation: My recommendation is that we should put our reservations about this idea to one side, take a leap in the dark and give this a try!** Maybe it will be a success, maybe not. Sometimes it is hard for people to envisage whether something will be helpful for them until they see it. Then they can better understand. A notice board/information area can be achieved without too much expense or work, and in my view, for what it's worth, it creates the right atmosphere in the Home, one of **open access to information** that can be reached by all our service users, and not just a select few professionals (of whatever organisation). This is what I said in my TA report of March 2004: "(It would be great if we could have) an information area for families, with leaflets and information on the range and variety of support services that exist in Ruse. This information area can also be used in the future to post notices of organised events that are of interest to families, such as parenting classes etc. We need to ensure that this information area is as accessible as possible for everyone who will be using the Family Area in terms of the language and manner in which the information is presented. What languages do we need to present information in? Bulgarian, Roma Dialects, Turkish or others? What about people who cannot read, can we find a way to present information in simple diagrams and drawings or using other methods? The information provided by the Bulgarian Family Planning Association is a very good example of how a creative approach can make information much more accessible for the people for whom it is intended..... The key is to be as simple as possible".

**Conclusion:**

It is our hope that this document has shown that it is only by asking the 'users' of the service what they think and feel that we can hope to develop new services within DMSGD that are truly based on need. Seeking and including the views of parents is a crucial part of the developing the 'jigsaw' of community-based support for vulnerable families. With skill and patience, even the most socially vulnerable parents can be empowered to make a useful contribution to new service development. The question is not if we should include the views of parents when we are developing new support services that are aimed at them, but rather how.

**Diana Georgieva and Rachel Nightingale**  
**January 2005**

**RECORD OF CONTACT VISIT TO:**

**NAME OF CHILD:** .....

**Date & Time of Visit, (Start and end)** .....

**People Present at this visit?** .....

**Is this visit part of the Care Plan? YES/NO**

**If No, what is the reason for this visit?** .....

**OBSERVATION OF THIS VISIT**

**Initial Reaction of Child on seeing Adult?** .....

.....

**Initial Reaction of Adult to child** .....

.....

**Adult(s):**

**Does the adult(s) speak with the child? YES/NO Is their discussion appropriate to the child's age?**

**YES/NO Describe topics:**

**Does the adult alter their tone of voice when speaking with the child?**

**Who initiates the play, topics for discussion, drawing, reading, the adult or child? Do they take it in turns?**

.....

.....

**Does the adult comment on the child's appearance or their newly acquired abilities, eg they've grown, they are talking, look at her hair?**

.....

.....

**How do the adults show their pleasure or displeasure at the changes with the child?**

.....

.....

**If the child becomes distressed, how does the adult demonstrate an ability to comfort the child or do they look to the member of staff to do it?** .....

**What questions does the adult ask about their child?** .....

.....

**Has the adult brought a gift or toy to play or give the child? Is it appropriate for the child's developmental stage?**

.....

**Child(ren)**

**Does the child seek attention from the adult? How? Do their requests receive a positive response?**

.....  
.....

**Does the child want the adult to play or read with him/he**

**Does the child ask questions about their home or family?**

.....  
.....

**When the adult attempts to pick up or play with the child, does the child pull away or ignore the adult? Does the adult try again?**

.....  
.....

**Other Noticeable Interactions .....**

.....

**End of Visit:**

**Does the child get upset? YES/NO**

**Does the adult pacify them and explain when they will come again? Does this pacify the child?**

**Describe: .....**

.....  
.....

**Does the adult show any regret at leaving the child? What?**

.....  
.....

**Does the adult give the child a final hug, cuddle or kiss goodbye? Does s/he say when they will come and see the child next?**

.....  
.....

**Observer's Opinion:**

**Was this a good and positive visit for the child? State why with examples? .....**

.....  
.....

**Did the adult show a good understanding of the child's needs and safety?**

.....

**Any other comments:**

.....  
.....

**Name and Signature of the Observer:** .....

**Status of Observer:** .....

**Date:** .....

**Ingrid Jones, Technical Adviser**  
**15/09/03**

## Appendix 4

### Team building, support and supervision workshop

#### Symptoms of stress

##### Some early warning signs

The following are lists of the common physical, mental, emotional and behavioural symptoms of stress. As personal stress increases more of these symptoms are likely to become apparent. By noticing how many of these items you are currently experiencing, either continuously or from time to time, you can obtain an early warning of an increase in stress. Even though some of the symptoms may have a clear physical cause, count them nevertheless, for their occurrence is still likely to be an indirect consequence of stress.

##### **Physical signs:**

- headaches
- indigestion
- palpitations - throbbing heart
- breathlessness
- nausea - feeling sick
- muscle twitches
- tiredness
- vague aches or pains
- skin irritation or rashes
- susceptibility to allergies
- excessive sweating
- clenched fists or jaw
- fainting
- frequent colds, flu or other infections
- recurrence of previous illness
- constipation or diarrhoea
- rapid weight gain or loss

##### **Mental signs:**

- indecision
- memory failing
- loss of concentration, easily distracted
- tunnel vision
- bad dreams or nightmares
- worrying
- muddled thinking
- making mistakes
- less intuitive
- less sensitive
- persistent negative thoughts
- impaired judgement
- more short-term thinking
- hasty decisions

#### **WHAT CAN I DO TO AVOID STRESS**

Although life is stressful, we often make it worse for ourselves. Below you will find listed some approaches that can help to minimise the effects of stress.

1. Work out what ways you put yourself under pressure - and then do something about them. For example, people often put themselves under needless time pressure by leaving everything until the last minute. Do everything you can at a reasonable pace, and avoid hurrying. Plan ahead. Remember that you are probably in the habit of hurrying.
2. Stop trying to do more than one thing at a time. Try and concentrate completely on the job in hand. Then deal with the next one in the same way.
3. Take regular exercise and keep yourself as healthy as possible.
4. Eat slowly, and take your mind off your work while you're eating.
5. Find ways to 'escape' in your spare time from your everyday pressures. Make sure you take regular holiday.

6. Make sure you get enough rest. Try to relax physically and mentally before you go to sleep.
7. Try to avoid getting over-impatient. Very few things are that urgent.
8. If you really get angry about something, try to get it out of your system. Express your anger quietly but honestly, if you can. (Not always possible.) Try to find an alternative way of getting rid of your anger.
9. Make sure that the goal you're working so hard towards is what you really want.
10. Make a special effort not to smoke or drink more than usual when you're anxious. This may only be self-defeating in the long run.
11. Make a positive effort to change things if they're a constant source of anxiety.
12. Make use of meditation and relaxation (if possible) during short spells in the day.
13. Aim to turn your worries into problems. Problems, can be solved!

Examples of Unrealistic Beliefs  
Which May Cause Stress

1. The idea that it is a dire necessity for an adult human being to be approved by all significant others.
2. The idea that one should be thoroughly competent, adequate and achieving important things if one is to consider oneself worthwhile.
3. 3. The idea that human unhappiness is externally caused and that people have little or no ability to control their sorrows or disturbances.
4. The idea that if something is/may be dangerous or fearsome you should be terribly concerned about it and should keep dwelling on the possibility of its occurring.
5. The idea that it is easier to avoid that to face certain difficult situations in life.
6. The idea that one should be dependent on others and need someone stronger than oneself on whom to rely.
7. The idea that one's past history is an all-important determinant of one's present behaviour, and that because something once strongly affected one's life, it should indefinitely have a similar effect.
8. The idea that in order to be caring, one always has to be immersed in other people's problems.
9. The idea that there is invariably a right, precise and perfect solution to human problems, and nothing else will do.

**Source: Alistair Ostell, Occupational Psychology, Management Centre, University of Bradford**

## Good practice guidelines

### Supervision

'Supervision' is a rather jargonistic child welfare term. The word comes from the Latin to 'oversee', and the original supervisors literally stood on a high platform to oversee the work. However, child welfare supervision is much more complex than this.

There are three distinct but very interrelated purposes of child welfare supervision: **to check, to support, and to develop.**

**To check:** to ensure that the work being carried out is consistent with the functions of the organisation. To ensure that workers are clear about their roles and responsibilities.

**To support:** to reduce stress and to value the worker and the work, given the demands of working with vulnerable families in difficult situations. Supervision allows time for the worker to talk about how the stress of the job affects them, in order to help them deal with it. As we have realised, child welfare work has a number of stresses which are related to the job, and if the worker is not appropriately supported this can get in the way of the work and diminish the quality of the service the organisation offers to clients.

**To develop:** to assist the worker in their professional development and to recognise good performance and personal achievement. To meet training needs either in the session or to identify needs to be met by, for example, attending courses or shadowing another worker to gain more experience.

Supervision is a two way process (it is not just about the manager's agenda, nor is it supposed to be intense 'therapy' for the worker). The three strands are interdependent. If you don't check, you can't find out what support or development is needed to get the job done. If you don't support the worker they may not be able to continue to do their job. If you don't develop the worker then clients will receive a less than good quality service.

#### Models of Supervision:

There is not just one way to provide supervision to a staff team. There are many different models, all of which have their merits:

**Individual Supervision.** This model is popular in the UK and the USA. The benefits of this model of supervision (which is essentially a one to one session between the worker and their manager), are:

- It allows for the development of personal practice and for an individual approach to dealing with the workers issues.
- It provides a discrete environment to discuss any problems the worker is having that are affecting their work
- It gives the manager the opportunity to acknowledge work that has been well done
- It provides a place to discuss ideas
- It gives the worker time to reflect and develop their skills.

**Group supervision.** This model is popular in mainland Europe. The benefits of this model of supervision are:

- Team members can learn from each other's experience
- It provides an environment where the team can experiment, and use role-plays and case studies to increase their capacity (a sort of mini training within the team).
- It reduces the impact of personality clashes between the worker and their manager
- It supports the process of team building
- It is a good way to make decisions that the majority of the team will support, as if lots of people agree then you are probably making the right decision
- Team members commitment to the job increases as they are all involved in decision making
- The role of team leader is crucial - they should ensure that they are a facilitator, and not an autocrat

The best situation in a team is usually a combination of both individual and group supervision. In addition to these models, you can also have direct or indirect supervision. **Direct supervision** is basically 'learning by doing' and involves the manager directly observing and supporting the worker, going out with them on joint home visits or sitting in on some of their meetings. **Indirect supervision** is less reliant on observation and more reliant on discussion: the manager depends on the workers own briefing of events. Again, the best situation is usually a combination of direct and indirect supervision.

Supervision usually takes one of two main forms: **informal and formal**. Informal supervision usually means 'chats' (often over a cup of coffee). These are especially good if a staff member is in crisis and needs immediate attention and support. However, this form of supervision does not really allow much time for reflection on the part of the worker, nor does it provide a written record of the discussion. Informal chats can sometimes be used as a technique to avoid formal supervision (by both the worker and the manager) and it should not be seen as a replacement for formal, structured supervision.

**Formal supervision** is quite different to informal chats. Its main features (whether in group or individual sessions) are:

- It's structured
- Preparation is made (i.e. a room is made available)
- It's regular (monthly or bi weekly or whatever you agree)
- It has a flexible agenda, to which both the manager and the worker(s) contribute, which can be added to or changed. It is worth thinking about keeping a 'running agenda' that both parties contribute to in the normal course of the working week.
- It has clear time boundaries (usually 2 hours maximum for a supervision session)
- It is confidential. What is said in a supervision session should stay in supervision and should not become the source of gossip outside the room. However there are always some limits to confidentiality as the manager will, on occasion, be obliged to pass information up the line management structure if it involves issues of accountability (such as disciplinary matters) or child protection. The limits of confidentiality should be made clear at the outset.
- The session should be given a priority and should be undisturbed (unless there is a **genuine** emergency).
- Some people like to have a supervision contract, which is agreed and reviewed annually incorporating all of the above elements. This sets out the terms under which supervision will be carried out, and is signed by both the worker and the supervisor.
- It is important that a written record is made of the supervision session (see Appendix x for an example), and that the date and time of the next session is also recorded.

### **Approaches to supervision:**

#### The manager's perspective:

Supervision is sometimes viewed only as a front line management role (that is, for example, it is seen as the job of the CPD manager to supervise his or her staff, but then sometimes the manager's needs for supervision get forgotten about.) Good supervision should really go all the way through the hierarchy so that all levels of staff are having supervision - workers, front line managers, middle managers and senior managers alike. Supervisors may feel that the people they are supervising may have more knowledge about a particular issue than them, particularly if they are new to the job or unqualified, and this might make them feel vulnerable and reluctant to get involved in supervision. However, supervision is about identifying people's strengths and using them for the benefit of the whole team. Everyone in a team may have a speciality which means they can be consulted on a specific issue. The supervisor does not have to know everything, nor should they be expected to.

#### The worker's perspective:

Workers may feel they are being checked up on and their weaknesses exposed, making them feel vulnerable and reluctant to get involved in supervision. However, supervision should be supportive, offering constructive criticism and advice. Any mistakes should be seen as a learning experience and advice offered on how to help the individual develop this area of work. Workers should always leave a supervision session feeling appreciated, supported, listened to, valued and generally more positive than when they went in to the session, even if it is not possible for all the things they are unhappy about to be solved.

**Rachel Nightingale, Technical Advisor  
May 2005**

**RECORD OF SUPERVISION**

Name: .....

Supervisor: .....

Date .....

Time: from ..... to .....

Date of last supervision: .....

<b>Issues carried over from last session</b>	<b>Action</b>

**Continuation sheet**

<b>Main points of discussion</b>	<b>Action</b>

**Договор за супервизия**

Name of person being supervised .....

Name of supervisor .....

**Individual objectives**

**Arrangements for supervision**

1. Frequency of meetings .....

2. Length of meetings .....

3. Place .....

**Mode of supervision:**            **group / individual**

This contact should be evaluated and objectives reviewed and modified annually.

Signed .....

Person being supervised .....

Supervisor .....

Date .....

Date for review .....

Any problem encountered in the organisation of supervision and plans for improvement

Any areas of disagreement

**Person being supervised**

Signed .....

Supervisor .....

Signed .....

Date .....

*Note that the date and time for the next session should be filled in on next record sheet at the end of every session and the first section completed.*

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## Skills of professional supervision:

### Giving feedback, Including constructive criticism

#### 1. Introduction

There are two types of feedback:

- destructive feedback
- constructive feedback.

#### 1.1 Destructive feedback is that which

- is given in an unskilled way;
- leaves the recipient feeling bad or a failure;
- does not provide help to the recipient to improve his/her performance or build on his/her learning.

#### 1.2 Constructive feedback includes

- praise: acknowledging good work or progress achieved;
- creating and using opportunities to enable the development and extension of knowledge and skills;
- constructive criticism: raising and discussing difficult issues when things have not gone so well, or when the quality of work needs to improve.

#### 2. Constructive feedback

##### 2.1 Constructive feedback is important because it/

- increases self-awareness;
- encourages learning and professional development.

##### 2.2 To be effective, constructive feedback needs to be

- given skillfully, and
- received openly.

##### 2.3 To give constructive feedback skillfully, in a way that is most effective for encouraging and developing learning, it can be helpful to keep these three points in mind:-

- make specific comments rather than general /nes,
- (clear information such as 'I think that you did well to keep your tone of voice calm when Mr. Dimitrov started to shout', is more useful to the social worker than simply 'You did a good interview');
- use phrases such as 'I think that...' or 'I consider that...', instead of phrases like 'You are...';
- explain clearly what you are basing your comments on, (for example, 'From reading your casefile on the Georgiev family...').

#### 3. Constructive criticism

There may be times when a supervisor is concerned about an aspect of a social worker's work, and therefore needs to raise the issue in supervision. The following points can be useful reminders to ensure that the constructive criticism is given as skillfully and as effectively as possible.

##### 3.1 Share your concerns with the social worker at an early stage Raise the issue soon after the event has occurred.

##### 3.2 Clarify and plan in advance in your own mind

- what exactly are your concerns?
- what do you want to communicate to the social worker?
- what points do you want to make?
- how will you do this?

##### 3.3 Consider in advance

- what response would you like from the social worker?
- how flexible are you prepared to be?
- how is the social worker likely to view the issue?
- what factors may have contributed to the difficulty?
- might there be another problem of which you are unaware contributing to the situation? How can you explore this with the social worker?
- what other pressures is the social worker experiencing at the moment, and how may these influence his/her response to the discussion?
- what has been your role so far?
- how can you help now?

**3.4** When you need to raise an area of concern with a social worker in supervision, remember to:-

- start with the positive. Refer to a positive aspect of his/her work or a recent achievement before moving on to the area of concern;
- explain why you are raising the issue;
- ask the social worker for his/her views on the issue being raised;
- discuss and identify with the social worker the causes of the problem;
- be assertive, not aggressive.

**3.5** Discuss with the social worker how the problem can be tackled and plan how improvement can be achieved. It is important that:-

- a written action plan is drawn up which clearly states the overall goal and also gives details of short-term objectives to be achieved on the way to the overall goal;
- a date is arranged to review progress.

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### Framework for reflective practice

1. Describe the situation	2. How did I feel about what happened?	3. What was I trying to achieve? (what did I do / say?)	4. What were the consequences (for myself, service user, others)?	5. What knowledge / skills did I draw on in this situation?
6. What values underpinned what I was trying to do?	7. What other choices did I have?	8. What have I learned from this experience?	9. What might I do differently next time?	10. What are my learning and development needs now?

## **Developing the abilities and skills of the social workers through professional supervision**

### **The ten key areas of professional social work**

#### **1. Communication Skills**

- interpersonal communication with clients, children, colleagues and other professionals;
- verbal and non-verbal communication.

#### **2. Assessment and Planning Skills**

- obtaining and analysing information for a comprehensive assessment;
- establishing clear plans and agreements based on the assessment;
- regular review and evaluation of progress.

#### **3. Intervention Skills**

- direct work with clients;
- collaboration with colleagues and other professionals;
- reviewing and modifying plans if/as necessary.

#### **4. Skills of Written Work**

- case records;
- reports and letters.

#### **5. Ability to Work as a Member of the Agency**

- knowledge and understanding of agency policies, procedures, objectives and tasks;
- representing the agency.

#### **6. Ability to Work with Colleagues and Other Professionals**

- developing and maintaining effective working relationships;
- sharing ideas and information.

#### **7. Self - Management Skills**

- organising work and time;
- self-awareness and self-evaluation.

#### **8. Use of Supervision**

- practical aspects (e.g. preparation, punctuality);
- openness to learning.

#### **9. Professional Values and Attitudes**

- knowledge and understanding of social work ethics;
- commitment to continuing learning.

#### **10. Ability to Relate Theory to Practice**

- knows and understands theories and knowledge of social work;
- using relevant theories to guide practice.

**Julia Watts and Jonathan Dickens**

**Prepared flip chart**

**UNHEALTHY TEAMS**

- rigid and uncreative;
- isolated and defensive; inward-looking;
- supervision only looks for mistakes, it does not encourage learning;
- difficulties/mistakes are either ignored or blamed destructively on an individual;
- information is not shared;
- decisions are made without consultation;
- special skills are seen as a threat;
- members avoid responsibility;
- members work alone and unsupported;
- members undermine other members to gain individual advantage.

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## Team openness exercise

- Take turns asking the questions below, choosing them in any order.
- Ask only those questions which you are prepared to answer.
- Any member may decline to answer any question that is asked of him/her.
- Subsidiary questions may be asked to ensure that replies are fully understood ;
- Participants should agree that answers are to remain confidential.
- Questions may be asked more than once.

### Questions to be asked in any order

1. Are you happy in your present job?
2. Are you effective in your present job?
3. What do you see as the next step in your career development?
4. What personal weaknesses inhibit your performance?
5. What do you regard as your major strengths? What are your main development needs?
6. What are the principal achievements you are looking for in your work right now?
7. Where do you see yourself ten years from now?
8. What do you think that I think of you?
9. What do you think of me?
10. Describe your different responsibilities?
11. What was your first impression of me when first we met?
12. Has your impression of me altered since we first met?
13. How do you respond to pressure?
14. Are you enjoying this activity?
15. What barriers do you see to your own advancement?
16. To whom are you closest in our team?
17. Why do you think that is?
18. How committed are you to our team?
19. What is the major contribution you make to our team?
20. Do you receive sufficient feedback from other team members?
21. Do you think I am devious?
22. Does anything about me puzzle you?
23. Describe the politics of our team to me.
24. How do you think our team is seen by other professionals we work with?

*Before closing the activity each person should answer:*

1. How could we better help each other in our work?ю
2. How else can we jointly improve the effectiveness of our team?

**Reproduced from *Activities for Teambuilding*,  
Mike Woodstock, Connaught Training, Aldershot, 1988  
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## The building blocks of effective teamwork

A team is 'A group of people who share common objectives and who need to work together to achieve them'. Teams can be found on the sports field, in social organisations or in commerce and industry.

A team is not a social gathering where people meet for the purpose of enjoyment, neither is it an audience of people who are assembled to listen or to learn. Committees are not usually teams because they comprise people who represent different interest groups. Often they share concerns but they lack a unified commitment to action.

Teams can provide unique opportunities, they can make things happen which would not happen if the team did not exist.

- Like a family, they can provide support and help to their members.
- They can co-ordinate the activities of individuals.
- They can generate commitment.
- They can provide a place to be, so meeting a basic human need to belong.
- They can identify training and development needs.
- They can provide learning opportunities.
- They can enhance communication.
- They can provide a satisfying, stimulating and enjoyable working environment.

Although it is possible to 'go it alone,' the extent of human achievement is limited when people do not work together. One person can have brilliant ideas but may lack the brain power, imagination or objectivity to capitalize on the ideas.

Organisations are essentially about people working together and yet so often they fail to capitalize upon the full potential of this. A team can accomplish much more than the sum of its individual members and yet frequently groups of people are seen to achieve less than could have been accomplished by the individual members working alone. Most organisations have meetings which dampen inspiration and departments which seem to devote more energy to maintaining their own organisational position than to the common good of the organisation as a whole. Teamwork is individuals working together to accomplish more than they could alone, but more than that, it can be exciting satisfying and enjoyable. Perhaps the simplest analogy is with the football team. Were any of us 10 be given the task of building up a new national team we know that the task would involve much more than just obtaining the eleven best players in the nation. The success of the team would depend not only upon individual skills but on the way those individuals supported and worked with each other. The good football team is much more than a collection of individual skills; it is these skills used in a way which produces a united effort. Similarly, with almost any kind of team, its success, its very existence, depends upon the way in which all play together.

In recent years we have seen many approaches aimed at increasing organisational effectiveness and organisations today pay more and more attention to the training and development of their people particularly those who hold managerial positions. Most of that development activity is centred upon the improvement of individual skills, knowledge and experience, but organisations are increasingly finding that this is not enough, that a real key to success is the way in which individuals behave towards each other and the way in which groups of people relate to and work with each other. Teamwork Improves these things.

How then do we recognize where good teamwork and bad teamwork flourish? Perhaps, as with most things, it is easier to start with bad than the good, so let us look at some of the symptoms of bad teamwork.

First, the team can have the wrong balance in its membership. Because essential skills are lacking, tasks are continually not accomplished efficiently. Then there is the symptom of frustration. As organisations get larger the opportunities for personal expression and satisfaction often become less. Too frequently people who work in organisations become frustrated because they can no longer see a clear way of meeting their own needs and aspirations. People just lose inspiration and lack the commitment and motivation which are essential ingredients of effective teamwork.

In many organisations the symptoms of grumbling and retaliation are easily seen. Because people cannot express themselves through the system they do it privately in discussions in the corridors, lavatories and car parks. Often bar room chat is a better indicator of organisational health than the most elaborate attitude surveys. The organisations that experience poor teamwork also seem to spend a lot of time on recriminations. They do not use mistakes as opportunities for increased learning and improvement but as excuses for punishing those who made the mistakes, and they do this in the many and varied ways in which organisations are able to hand out punishments.

Unhealthy competition is another indicator of poor teamwork. Competition is the life-blood of many organisations but there is a great difference between the kind of healthy competition where people can enjoy the just rewards of their deserved success and others can accept that the best person, system or policy succeeded, and the kind of organisation where backbiting, 'dirty tricks' and politics are the everyday pastimes of managers. Similarly great differences in rivalry between departments may be found. Many organisations

owe much of their success to the natural competitive spirit which exists between and to the pride of team membership which departmentalization often brings, but many others have departments which are at constant war with each other, each jockeying for superior organisational position, influence or perks. One particular organisation was characterized for many years by the constant bickering and 'dirty tricks' of its heads of departments, each departmental head taking advantage over the others whenever possible. Not only did that lead to the organisation as a whole missing opportunities, but many more junior employees found that although they wanted to work with others organisational barriers had been erected between them and their counterparts in other departments.

Another sound indicator of poor teamwork is simply the expression which employees wear on their faces. Effective teamwork breeds happiness and the uninformed visitor can often get an immediate impression of whether work is a happy place to be or whether being 'killed in the rush' at 'clocking off' time is a risk. Work does not have to be a dull and unenjoyable place; it can so easily be a really rewarding place where people love to be.

To many who have studied organisations, openness and honesty are the key indicators of organisational health. Unfortunately, some people seem to try honesty only when everything else has failed. Many managers particularly seem to go to enormous lengths to avoid telling the truth. There are, of course, occasions in every organisation where something other than total openness is necessary but where good teamwork exists there is generally no need for locks on drawers, dishonest statements to employees and the taking of false bargaining stances.

Meetings are another key indicator of teamwork. The main reason for having meetings is to utilize the collective skills of a group of people whilst working on common problems or opportunities. Too often, however, we experience meetings which in no way use these skills, meetings where only one or a few people contribute, and meetings where many managers seem to use the occasion as an opportunity to lay down the rules rather than utilize the resources of the team. The quality of meetings can usually be determined by the way in which individuals either look forward to or dread the normal weekly or monthly get together.

In many organisations the quality of relationship between managers and those they manage is so low that effective teamwork just cannot get off the ground. Where people cannot confide in or trust their manager, where they are fearful or where their conversations are on a superficial or trivial level then real teamwork is unlikely to exist. Good teamwork engenders high quality relationships. Another sign of low quality relationships is often that the leader becomes increasingly isolated from the team, failing to represent their view while they do not subscribe to his or hers. The effective team leader needs to be very much a part of the team.

People just not developing is another sure sign of ineffective teamwork. If a team is to be effective it needs to be continually developing itself and this in part means constantly facilitating individual as well as team development. Often development does not happen because:

- (a) there are perceived or real time pressures;
- (b) it is seen as the job of the personnel department or training officer;
- (c) conflict exists between the team's culture and that of the organisation;
- (d) team leaders lack the skills or willingness to make it happen;
- (e) (here is fear of the consequences of development).

Sometimes poor teamwork results in jobs getting done twice or not at all because no clear understanding of roles within and between teams exists. Sometimes although common problems exist people are just not able or willing to get together and work on them.

Then there is the attitude which teams and individual members have to the possibility of external help. The ineffective team will usually either reject offers of help because it fears the consequences of outsiders finding out what the team is really like or will seize all offers of help because it lacks any coherent view of how to proceed and is content to hand over its problems to someone else. The effective team will use external help constructively by recognizing the unique contribution and viewpoint which it can bring, but it will always maintain ownership of its own problems and its own destiny.

Creativity is a delicate flower which only flourishes in the right conditions, mainly conditions of personal freedom and support; freedom to experiment, try out ideas and concepts and support from those who listen, evaluate and offer help. A dearth of new ideas generally goes with poor teamwork because it is within teams that the conditions for creativity can most easily be created.

The degree to which people help and use each other is another indicator. Where effective teamwork does not exist people tend to work in isolation and neither offer nor receive the help of their colleagues. All of us need that help in order to perform at our optimum level.

The conditions described above are indicative of an unhealthy organisation and all of them can be significantly improved by effective teamwork.

What then are the characteristics of effective teamwork? Very simply they are the opposites of what is described above.

The team has the right balance of skills, abilities and aspirations.

People can and do express themselves honestly and openly. Conversation about work is the same both inside and outside the organisation. Mistakes are faced openly and used as vehicles for learning and difficult situations are confronted.

Helpful competition and conflict of ideas are used constructively and team members have a pride in the success of their team. Unhelpful competition and conflict have been eliminated.

Good relationships exist with other teams and departments. Each values and respects the other and their respective leaders themselves comprise an effective team.

Personal relationships are characterized by support and trust, with people helping each other whenever possible.

Meetings are productive and stimulating with all participating and feeling ownership of the actions which result from the decisions made. New ideas abound and their use enables the team to stay ahead.

Boss-subordinate relationships are sound, each helping the other to perform each role better, and the team feels that it is led in an appropriate way.

Personal and individual development is highly rated and opportunities are constantly sought for making development happen.

There is clear agreement about and understanding of objectives of the roles which the team and its individual members will play in achieving them.

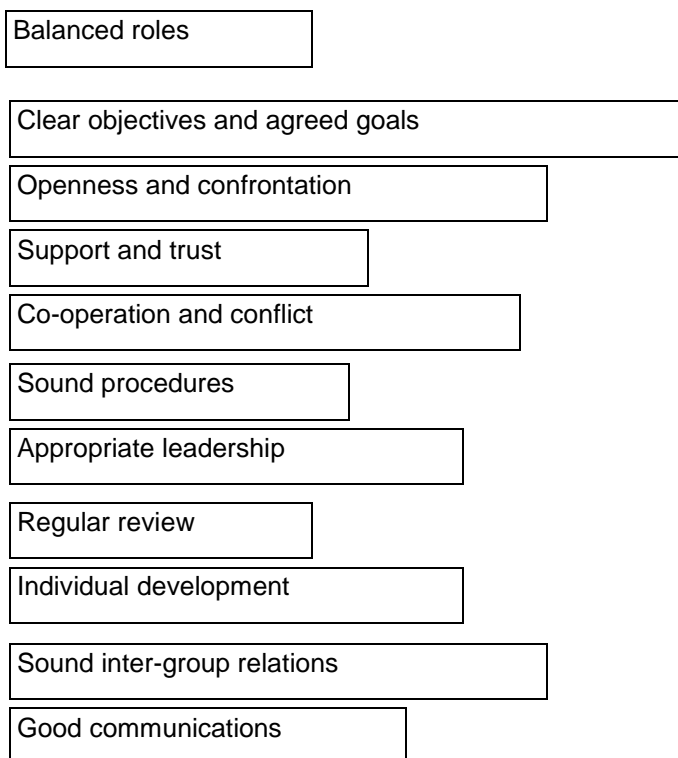
External help will be welcomed and used where appropriate.

The team regularly reviews where it is going, why it needs to go there and how it is getting there. If necessary, it alters its practices in the light of that review.

Finally, communication is effective up, down and across the organisation and with the outside world.

All of this means that 'work' is a happy place to be, people enjoy themselves wherever possible but this enjoyment is conducive to achievement, not a barrier to it. People get satisfaction from their working lives and work is one of the places where they meet their needs and aspirations.

These characteristics can be seen as the raw materials of effective teamwork. I like to see them as 'building blocks' because they are what we can use in a very practical way to build effective teams. Stated as simply as possible they are:



**From: Activities for Teambuilding” by Mike Woodcock  
Connaught Training, Aldershot, 1988**

**EveryChild**

## **Working Together Workshop**

**26<sup>th</sup> September 2003.**

### **Why is Working Together Important?**

- Promotes child-centred practice.
- Aids clearer and multi-disciplinary assessments of all the members of the family, but particularly the child's needs.
- Concentrates on and improves on our understanding of the needs of the individual child, which is paramount in our work.
- Enables practitioners and families to draw up a comprehensive Care Plan for the child.
- Allows for detailed short-term tasks to be set for both professionals and family members, with a realistic time frame for achievement.
- Protects children, as all the areas and stages of development are addressed. Information known by different agencies is shared.
- Enables informed and shared decision-making.
- Prevents the need for children to be placed in residential units, until all alternatives have been explored.
- Promotes quicker and more successful reintegration of babies and children into their families.
- Where reintegration is not possible for the child, action can be taken promptly to find a substitute family for the child.
- Aids the planning process.
- Assists in monitoring change within family situations and enhances reviews.
- Early warning when problems arise in the family or when a plan of action is not being followed.
- Enables detailed reports to be put before the courts.
- Prevents children remaining in the state's care for too long or in a family unable to provide adequate care to meet his or her needs.
- Avoids duplication of work by different agencies and professionals. Families also do not have to repeat their stories over and over again.
- Encourages the best plans and care for the individual child.

**Ingrid Jones, Technical Adviser**  
**1/09/03**

## Working Together Workshop

26<sup>th</sup> September 2003  
Trust v mistrust

### TRUST

#### **Good Communication**

Sharing Information Freely

#### **Face to Face Discussions**

Clear Factual Reports

Multi-disciplinary Meetings and Decisions

Inclusion of Parents in Discussions And Meetings

Professionally Confident

Able to provide one's opinion

Security

Safe and happy to enjoy an open Working relationship

Sharing

Autonomous

### MISTRUST

#### **Lack of Communication**

Keeping Information to Oneself

#### **No meetings**

Use of Professional Jargon that Is Unclear to Others

Unilateral Decision Making

Excluding Parents from Discussions and Meetings

Insecurity in Role

Afraid to express one's views

Fear of Ridicule

Not being Honest and Open in the Working Relationship

Secrecy

Need to keep checking with LineManager - indecisive

1/09/03

## **Working Together Workshop**

**26<sup>th</sup> September 2003**

### **Who Benefits from Good Working Partnerships?**

- *The Parent(s)*
- Brothers and Sisters
- The Extended Family
- The Social Worker
- The Psychologist
- The Doctor
- The Teacher or Educator
- Residential Staff
- Schools
- Prospective Adopters
- Foster Carers
- The Decision Makers
- The Directorate of Social Assistance
- *The Police*
- *The Courts*
- Other Professionals working with the child or his or her family

**Ingrid Jones, Technical Adviser**

**1/09/03**

## Working Together Workshop

**26<sup>th</sup> September 2003**

### **How to Encourage and Promote a Working Together Relationship**

Children have many and differing needs. They need an holistic approach - they are not just an illness, a disability or socially disadvantaged. Every thing in their lives is interrelated, family, education, health, social and financial situation. To meet these needs we need a team of professionals with different skills to work in partnership.

- Listen to each other's professional opinion.
- Respect the other person's point of view. If you do not agree with his or her view then respond to the point of disagreement, but do not criticise the person's right to express their professional or parental opinion.
- Arrange regular meetings to discuss each child's case. Types of meetings will include, Care Plan Reviews, Planning Meetings and when there is a concern that the parent or family are not adhering to the agreed plan or the child's needs have changed.
- Include all relevant professional, parents and when suitable children in all Planning and Care Plan Meetings.
- Each professional attending the meeting should have up to date knowledge and information about the child and/or the family members and be prepared to discuss their information.
- One professional from either the Child Protection Department or the Mother and Baby Home should be nominated the 'Responsible Worker'. It is his or her responsibility to ensure all the tasks are completed by each person and to ensure that the welfare and best interest of the child is upheld.
- Make realistic short-term and long-term goals. Allocate each task to one person, this will also include the parents and set a time for its completion.
- Important information, like missed contact visits, illness of the child or parent, change of address, should be provided to the Responsible Worker immediately.
- The Social Worker from the CPD and the Social Worker/Psychologist/Educator from the Mother and Baby Home should undertake joint home visits. All adults and all children respond and act differently in different social situations.
- Professional should attend joint training courses, to learn from each other and to provide information and professional knowledge.
- Joint working together promotes trust.
- Address problems or concerns in a constructive manner. Don't ignore a problem!
- Parents are part of the working partnership. They are the most significant adults for any child. They are the expert on their family and their child.

**Ingrid Jones, Technical Adviser**

**1/09/03**