University of Southampton

REFLECTING ON PRACTICE: PERSPECTIVES ON SOCIAL WORK ASSESSMENT IN FAMILIES WHERE THERE IS PARENTAL MENTAL ILL-HEALTH

Susan Margaret Beresford MSc CQSW

Doctor of Philosophy
Social Work Studies Department
September 1997

(Master Copy)

UNIVERSITY OF SOUTHAMPTON

ABSTRACT

FACULTY OF SOCIAL SCIENCES

SOCIAL WORK STUDIES

Doctor of Philosophy

REFLECTING ON PRACTICE: PERSPECTIVES ON SOCIAL WORK ASSESSMENT IN FAMILIES WHERE THERE IS PARENTAL MENTAL ILL-HEALTH

by Susan Margaret Beresford

Concerns about the adequacy of social work assessment in the area of child care have been highlighted by research and inspection. In particular, social workers' use of relevant knowledge in the assessment process is unclear. A move towards 'proceduralisation' in assessment has been noted within the profession. The meaning of this development for professional practice has been questioned. Child care and mental health are often viewed as discrete specialisms within social services. Practitioners grappling with the day-to-day experiences of families know that, whatever the organisational structure, life is rarely that clear-cut. With the emphasis on one aspect of the overlap between child care and mental health — the impact on children of parental mental ill-health — the practitioner-research aimed to understand assessment more fully by exploring factors of influence for social workers undertaking initial assessments in families with parental mental ill-health and clients' experience of the process. Social workers' use of formal knowledge and the place of informal client knowledge were particular aspects of the wider exploration.

The research strategy emphasised qualitative techniques, in-depth interviews being the main method of data collection. In order not to overlook issues of practice wisdom, prior to finalising the topics to be discussed in the individual interviews, social worker group interviews were conducted within participating settings (Area Team, Child Guidance and Adult Psychiatry). As well as interviews with assessing social workers, parents whose family situations had been assessed were interviewed where possible. A total of 58 interviews were undertaken. The following additional data were collected: basic information about the families and details of the written assessments (from case records); information about the social workers' training, experience and interests (self-completion questionnaire); and formal departmental policy, procedures and practice guidance of pertinence to the task of assessment.

Findings are grouped as follows: (1) the area of overlap (as viewed by parents and social workers) and social workers' knowledge base; (2) the assessment process, notably the influences of case characteristics, organisational context and social workers as 'managed' professionals; and (3) social worker-client communication and the client's experience. The place of knowledge within the assessment process is explored within the context of further consideration of the nature of professional knowledge. What informed, and the influences on, assessing social workers is discussed, particularly the dominance of organisational considerations and the relative lack of focus on issues of professional concern. Social workers need to develop clearer understandings of the assessment task and its context from the point of view of practice. A redressing of the balance between organisational/managerial and professional/practice concerns is called for. The role of clients within the initial assessment process is examined. The honouring of different ways of knowing, working in partnership with clients and empowerment are issues that coalesce in the context of current understandings of the assessment task. Such matters of practice and professionalism demand reflective practitioners.

CONTENTS

ACKNOWLEDGEMENTS

Acknowledgement and grateful thanks are due:

- first and foremost, to all those who participated directly in the research — without their generous contributions, there would be no study;
- to Tracey Tilley and Gerard Jones, members of the management team in my then employing authority, whose active support of my endeavours made undertaking the project possible;
- to Dawn Warwick similarly and for additional supervision of the research in the early stages;
- to Graham Tuson of the University of Southampton's Social Work Studies Department for reading and advice on the draft in the later stages;
- to Jackie Powell, also of the University's Social Work Studies Department, for supervision of the project and for her unstinting support and encouragement throughout; and
- lastly, to my many supporters, family and friends, particularly John Lynch, for his active support and also because his confidence in me never wavered.

LIST OF TABLES

LIST OF APPENDICES

Foreword

Becoming a practitioner-researcher — a personal account

Three years after qualifying, I had reached the stage in my development as a practitioner where I had a fair amount of experience and a good basic level of competence. In terms of my practice, I was making the move from 'how am I *supposed* to be doing this?' to 'how will *I* do this?'. The corollary of such a shift was an increasing interest in issues of social work practice *per se* — 'how do *we* (as a profession) do this?'.

In embarking upon the research project that is the subject of this thesis, aside from my personal musings, I was seeking to reflect upon matters of practice in a more structured way and certainly in a more public forum. I had a combination of motivations. The personal and intellectual challenge of doctoral studies was undeniably present. Equally strong, however, was the desire to contribute, through research, to the pool of professional knowledge. I saw such professional knowledge as being 'my' pool, for where else might I, as a practitioner, gain useful, relevant knowledge? I was aware, though, that many social workers were far more dismissive of research than I, arguing that they were doing the job, they worked with real people in real situations, they knew things that research could not tell them or it told them things they already knew. It was a view with which, as a busy and experienced practitioner myself, I had some sympathy. From these differing perspectives, the self-evident gulf between research and practice seemed to me to be, at the same time, both understandable and perplexing. I held on to the thought that, given that I was a novice practitioner-researcher, I needed to 'trust the process' and proceed.

And yet I was uneasy. I had many unanswered questions — about the practice of social work, clearly, but also about the practice of research. I think it is true to say that I was a 'typical' social worker (or perhaps, more accurately, a typical citizen) in my

understanding of what research was/ought to look like — basically, positivist in approach, 'objective', with controlled variables, and focusing on such things as effectiveness and outcomes. My difficulty was that I was unable to square this picture with what I was interested in finding out about — in essence, process. Nor did it make any sense in terms of what I considered important when interacting with people — namely the social work values of empathy and empowerment — even if (arguably, especially if) those people were being 'studied' in the name of science.

With these questions as my starting point, so began my education about the nature of research in the social sciences. I was, of course, relieved to find there were well established schools of thought — broadly, the interpretive paradigm — with which I could ally myself philosophically. From such a base, then, it was possible to explore a practice *process* of interest and importance to me (and hopefully others), *in a way* that accorded with my personal and professional values, notably, by giving due prominence to the perspectives of those involved. As is the way of things, finding 'answers' raised more questions. For example, how was it that, as far as social work and the wider world were concerned, positivist notions of research so effectively eclipsed other approaches? I was in the realm of epistemology. And yet I had started off with such a clear view of what constituted knowledge ..... thus I began to examine my own assumptions much more closely. So, in becoming a practitioner-researcher, my education continues.

INTRODUCTION

The thesis that follows is practitioner-research. As such, it seeks to contribute to bridging the gap that exists between social work practice and research (Kahan, 1989; Everitt *et al.*, 1992; Munn-Giddings, 1993). It does so from the very particular perspective of what has come broadly to be known as the 'reflective practitioner' (Schön, 1983; Everitt *et al.*, 1992; Munn-Giddings, 1993; Powell, 1995). Practitioner-research as a general notion provides the context for the research methodology and is explored further in Chapter Three: Devising the Methodology.

Broad & Fletcher (1993) contend there is an optimum time for practitioner-research: *"The right time is when, after initial training and qualification and some years of experience, a professional feels ready for another substantial challenge"* (p5). In these terms I was ready for the next stage of my professional development — becoming a practitioner-researcher. Clarifying the practice issue to be investigated was a process that had unfolded over time as I extended my knowledge and skills as a social work practitioner. That process, culminating in the formulation of research aims, is now described.

TOWARDS BECOMING A PRACTITIONER-RESEARCHER: IDENTIFYING THE PRACTICE ISSUE

THE GENERAL TOPIC AREA: THE IMPACT OF PARENTAL MENTAL ILL-HEALTH ON CHILDREN

The general topic area of the thesis is the impact of parental mental ill-health on the welfare and developmental progress of children. Interest in this area arose directly out of my professional training and experience as a local authority field social worker. In common with many social workers, particularly those practising in metropolitan areas, my experience was that what I had accepted as a post-qualifying generic social work position in an intake team had rapidly become, in effect, a child care specialist post,

with a workload comprising entirely statutory cases, colloquially known as the 'heavy end' of social work. The high profile nature of this work, the risks inherent within it and its sheer volume, gave me, as a practitioner, the opportunity to focus upon issues of child development and good-enough parenting and to hone my social work knowledge and skills in these areas.

Arguably a close second to statutory child care work, both in terms of professional status and the acknowledged requirement for specialist expertise, is the work of the Approved Social Worker (ASW) as laid down in the 1983 Mental Health Act. A long-standing interest in the area of mental health generally and specifically in the role of the ASW led me to undergo the training and assessment procedures in place within my employing authority and subsequently to act as an ASW. My still predominantly child care caseload was adjusted accordingly.

The stimulation of the course, the challenge of developing fresh expertise, in combination with time away from my cases and the demands of the office during the sixty day training period, gave me an opportunity to reflect in a more general way on my professional practice. Mindful that, in the view of many, I would, following ASW approval, be juggling two distinct specialisms, I was keen to explore how knowledge from the two spheres of child care and mental health could, at least to some extent, be usefully integrated, with the aim of enhancing both my practice and my sense of job satisfaction.

There is no unanimity over what characterises mental health, but indicative traits commonly proposed by psychologists include: efficient perception of reality; an ability to exercise voluntary control over behaviour; a sense of self-esteem and acceptance; the ability to form affectionate relationships; and productivity (Atkinson *et al.*, 1996). Taking the widest understanding of the term 'mental health', then, it is generally acknowledged within social work that the mental health concerns of parents impinge

significantly on matters of child care. My ASW training led me to consider how the presence of mental disorder in a parent might affect a child's development. Mental disorder is defined in the 1983 Mental Health Act as *"mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind"* (Jones, 1996 p18). Clearly this is an all-embracing definition, not least because it encompasses conditions of learning difficulty (mental handicap).

The focus of my interest was, more accurately, parental mental ill-health. There is considerable debate to be had concerning different models for understanding mental distress and their relative merits (see, for example, Pilgrim & Rogers, 1993). Such an undeniably important debate, is outside the scope of this thesis. Moreover, while acknowledging that terminology is in itself a controversial issue the terms mental ill-health, mental illness, mental disorder etc. are used interchangeably within this thesis to cover significant mental/emotional distress, such as to warrant attention by health and social services (see Chapter Four: Design of the Study). Use of such essentially medical/legal terminology is not, however, meant to imply wholesale allegiance to those particular ways of understanding to the exclusion of psychosocial understandings.

The area of overlap between parental mental ill-health and matters of child care was not a subject considered in any great detail on my ASW course, nor had it been addressed on any of the in-service child care or mental health social work training courses I had attended. Moreover, I was unaware of research findings in this area and I thought this a significant gap for a practitioner with experience and expertise in the areas of both child care and mental health. In other words, I presumed there existed a body of formal knowledge of which I was largely unaware but which was likely to be relevant for social work practice. (The term 'formal knowledge' is used throughout to mean theories and concepts which have as their base systematic research and codification, loosely, what Curnock & Hardiker (1979) refer to as 'theories of practice'.)

FOCUSING DOWN: ASSESSMENT

In thinking about whether or not parental mental disorder might affect a child's development, I recognised that, though ignorant of any 'hard facts', I nevertheless had some beliefs and perceptions concerning the issue which I would, as occasion demanded, bring to bear in my assessments of such family situations. That is to say, my judgement would be informed by the range of knowledge currently available to me. I recognised also that, if this were the case for me, it was probably so for other social workers. Whether or not they were similarly ill-informed as regards formal knowledge, such perceptions and beliefs might be widely at variance with my own if other social workers had, for example, experienced different emphases in initial training, pursued different enthusiasms within their careers, had different personal and/or professional experiences of mental health from my own or, perhaps more importantly, if they worked in settings other than an area team with emphasis on other than statutory child care work.

Having become interested in social workers' perceptions of the question of whether or not mental disorder in a parent affects a child's development and in how these perceptions might differ, I moved on to consider the perceptions of those more directly involved, that is, the perceptions of parents and children. Arguably, the meanings individuals attach to experience are of greater significance than what 'objectively' or factually happens to them. The perceptions and understandings of individuals in families where there is parental mental ill-health might very well differ from the perceptions of social workers and from those of other individuals in objectively similar circumstances. In other words, we might say that each and every client is able to contribute their own very specific 'knowledge' with regard to the question under consideration.

Essentially, then, still set within my general area of interest, I was beginning to focus more closely on the specific and related areas of client and social worker perceptions.

These are crucial, in social work terms, since they form the basis for assessment. How social workers perceive situations and the extent to which they take account of client perceptions of the same situations are clearly vital aspects of the assessment process, in itself widely acknowledged as the key to effective social work planning and intervention.

Assessment has been described as *"a process of learning about the newly presented client and reaching conclusions about recommended action"* (Davies, 1994, p150). This simple statement, however, belies the complexity of the process. Hughes (1993) provides a more detailed definition:

> *The process of assessment ... not only involves the recognition of a problem or issue, and the ability to identify and collect all the relevant information from a variety of sources. Assessment also involves 'making sense' of that information, and in order to do so, the information about an individual has to be interpreted in the context of current knowledge, theory, ideas, and common practice which is relevant to the characteristics of that individual and his or her situation.* (Hughes, 1993)

While it is true that it has long been recognised within the profession that a sound assessment is a prerequisite for good social work across all client groups (Coulshed, 1991; Davies, 1994), at the time of beginning the research project there was a resurgence of both professional and wider concern about the adequacy of assessment particularly as it related to the protection of children (DHSS, 1985; DoH, 1988). For example, Department of Health (1988) guidance in the realm of child protection described the purpose of assessment as being *"to understand the child's and family's situation more fully in order to provide a sound basis for decisions about future actions"* (p21). To achieve this end, the recommendation was that social workers needed to adopt a more systematic and structured approach to assessment, so ensuring the necessary solid basis for decision-making and plans of action.

Concerns regarding the adequacy of the child care assessment and planning process were backed by a variety of authoritative research evidence (DHSS, 1985). A general lack of clarity about the assessment process was identified:

> *The Dartington research (Bullock et al., 1984) confirms that early definitions made by the social worker about the family's problems are accurate predictors of children's length of stay in care. It is not clear how social workers arrive at these definitions nor whether they possess the knowledge and understanding necessary to make adequate assessments of the parent's present and future competence.* (Isaac *et al.*, 1986)

The findings of a number of key child care research studies led to serious questions being asked by the researchers *"about the way knowledge is used — or, more often, not used"* (DHSS, 1985, p18)

A recent inspection of social services departments' family support services (Social Services Inspectorate, 1996) indicates that concerns about the adequacy of assessment continue. Assessments are in evidence, but they lack clarity, consistency and ready explication:

> *Although [the majority of social workers] were able to provide a rationale for the work they were doing, they often could not justify the approach they were using in a systematic way* (SSI, 1996, p19)

THE SPECIFIC AREA OF INTEREST: ASSESSMENT IN FAMILIES WHERE THERE IS PARENTAL MENTAL ILL-HEALTH

Assessment generally within the child care arena, then, appears a far from transparent process. In relation to the area of specific interest, that is, where the fields of child care and mental health overlap, smaller-scale research has similarly highlighted a lack of clarity about what informs social workers' assessments of family situations and, in particular, how they take account of parental psychiatric history:

> *A considerable overlap between problems of child care and parental mental disorder was evident in the study. The assessment of the parents' capabilities appeared to be a vital consideration in child care decision-making. ... Casefiles revealed that social workers were often aware that parents had a history of psychiatric treatment but it was not clear how this knowledge influenced their assessments.* (Isaac *et al.*, 1986)

INCORPORATING THE PERSPECTIVES OF CLIENTS

Assessment is clearly an arena in which the perceptions of clients and social workers need to be negotiated. Social workers form views of the situations they assess and bring to bear in that process knowledge which may or may not include specific, formal knowledge. Although their knowledge may be more informal in character, so too, regarding their own situations, do clients. Research studies reveal that unresolved discrepancies of view are commonplace (Fisher *et al.*,1986; Petch, 1988; Kelly, 1990):

> *It was very difficult to find examples of social workers and parents ... agreeing on the difficulties and working together to try and resolve them.* (Kelly, 1990, quoted in DoH, 1991, p40)

The clear implication is that, despite the significance within the process of a *negotiation* of perspectives (not least if the notion of partnership is to be workable (DoH, 1995)), it is social workers' views that hold sway over and above those of their clients. As a hard-pressed practitioner I was aware, on the one hand, of the need to keep clients central to the process and, on the other, of organisational imperatives and the siren call of expediency. I was interested, then, to explore for myself the extent to which social workers achieved meaningful incorporation of clients' perspectives within their assessments.

My dual interest in the area of overlap and in how perceptions of a given situation may differ led me to become interested in clients' perceptions in two different respects.

Firstly, I was interested in parents' own perceptions of whether or not (and, if so, how) their own mental ill-health had impacted their children. Secondly, I was interested to explore the perspectives of clients more generally with regard to the assessment/ intervention service in which they participated.

RESEARCH AIMS

Following on from the above, the aims of the research can be summarised as follows:

> (1) The exploration of clients' and social workers' perspectives on what informs and influences the assessment process when issues of adult mental health and child care overlap, with particular reference to the needs of children;
>
> (2) Within that exploration, exploration of the extent to which social workers call upon pertinent formal knowledge, as well as exploration of informal client knowledge (specifically, clients' own views of the impact of parental disorder), form an important kernel.

It is important to note at this point, however, that, in undertaking the research project, my experience was one of a spiral of learning and reflection. This notion and its impact on the thesis is discussed further in Chapter Three: Devising the Methodology.

PLAN OF THE THESIS

CHAPTER ONE: LITERATURE REVIEW

Chapter One reviews literature concerning the impact of parental mental ill-health on children. The problematic nature of this body of specialist knowledge in terms of its usefulness or otherwise to social workers is noted. The complex nature of knowledge as a topic is acknowledged and signalled for later discussion.

CHAPTER TWO: LITERATURE REVIEW (CONTINUED)

Chapter Two reviews literature in two further areas relevant to the study: (1) child care assessment practice; and (2) the perspectives of clients, particularly in relation to assessment and intervention in the areas of mental health and child care.

CHAPTER THREE: DEVISING THE METHODOLOGY

Chapter Three sets out the selected research strategy, its underlying rationale and the research methods. The notions of a developing methodology and of a learning spiral are explored, the latter in the context of practitioner research. Ethical questions and the approach to data analysis are also covered.

CHAPTER FOUR: DESIGN OF THE STUDY

Characteristics of the study participants and of the assessment situations, together with location and timing of the study, are described in Chapter Four.

CHAPTER FIVE: FINDINGS (I)

Chapter Five sets out findings: (1) concerning social workers' and parents' perceptions of the interface between parental mental ill-health and the progress of children; and (2) in relation to the knowledge base of social workers.

CHAPTER SIX: FINDINGS (II)

Findings relating to the assessment process, in particular the influence of case characteristics, organisational influences and the influence of social workers being 'managed' professionals, are set out in Chapter Six.

CHAPTER SEVEN: FINDINGS (III)

Chapter Seven sets out findings relating to the assessment process as viewed largely from the client perspective, in particular with regard to social worker-client communication and the clients' experience.

CHAPTER EIGHT: DISCUSSION OF FINDINGS

In Chapter Eight the findings are discussed. The nature of professional knowledge and the place of different types of knowledge within the assessment process are explored. What informs and the influences on social workers' assessments are discussed, with particular reference to the dominance of the managerial/ organisational perspective and the relative lack of focus on issues of professional/ practice concern. The need for a redressing of this balance via the route of reflective practice is argued. Current and potential roles of clients within the initial assessment process are discussed, particularly with regard to the notions of client empowerment and partnership.

CHAPTER NINE: CONCLUDING DISCUSSION

Chapter Nine moves the debate on. The question of how knowledge in all its complexity can be accessed and developed is explored with reference to the specific area of overlap between adult mental health and child care. The changing nature of assessment is acknowledged. It is contended that social workers need to develop clearer understandings of the aim of the task and its context from a professional perspective, and further that the balance between organisational/managerial

imperatives and professional/practice concerns needs to be redressed if this is to be satisfactorily achieved. The honouring of different ways of knowing and partnership are issues that entwine in the context of current understandings of assessment. Such matters of practice demand reflective practitioners.

It will be apparent that certain key themes were of interest from the outset. Broadly, these are: the overlap between adult mental health and child care; the negotiation of differing perspectives, namely those of social worker and client, as required by assessment in this area; and the reliance (or otherwise) by social workers on formal knowledge as an aid to the assessment process. These themes, among others, are explored in the literature reviews that now follow.

CHAPTER ONE: LITERATURE REVIEW

THE IMPACT OF PARENTAL MENTAL ILL-HEALTH ON CHILDREN

Chapter One reviews literature concerning the impact of parental mental ill-health on children. The problematic nature of this body of specialist knowledge for social workers is noted. The complex nature of knowledge is acknowledged and signalled for later discussion.

LIMITS OF THE REVIEW

This part of the literature review aims to summarise literature that constitutes a formal body of knowledge pertinent to the particular social work task that is the subject of this thesis, the assessment of families where there is parental mental illness. By far the bulk of this literature derives from the disciplines of psychiatry and psychology, and is frequently North American in origin.

It is contended that a primary consequence of social work assessment may be the necessity to intervene if it is apparent a child's development is either being significantly affected or is put at immediate risk by environmental (and, therefore, influenceable) factors. As in many other areas of human development, debate about the balance of contributions from 'nature' as opposed to 'nurture' continues within the body of knowledge which addresses the impact of parental mental disorder on children and their development. It is clearly beyond the social worker's remit to act in the face of genetic risks alone. Acknowledging, then, that there is a body of research that focuses more specifically on the issue of the genetic transmission of psychopathology from parents to children (Watt *et al.*, 1984; Trad, 1986), this review concentrates primarily on the effects during childhood of parental mental disorder, that is to say, on how children are impacted when a parent experiences mental illness.

It is also outside the social worker's remit, albeit more arguably, to act if the effects of parental mental disorder are not apparent to any great degree during childhood irrespective of any risk of manifestation in adulthood. Also outside the scope of this review, then, is literature addressing the issue of where the effects of parental mental disorder are manifest in later life (for example, as mental distress or in relation to parenting difficulties (see Rutter, 1990)), as well as literature commenting upon the likely linkages between childhood psychiatric disorder and later adult psychiatric disorder (Earls, 1987).

A TREND IN THE LITERATURE

Much of the early work in the area from which the literature is drawn explored the genetic transmission of psychopathology and focused particularly on the parental diagnosis of schizophrenia, with the emphasis on identifying in the children of schizophrenic parents pre-morbid risk markers which related to the development of schizophrenia in later life (Mednick *et al.*, 1981; Watt *et al.*, 1984). In an attempt to study depression at its earliest onset similar 'high-risk' type research with its premise of genetic risk has also been conducted focusing on the children of depressed parents (Goodman & Brumley, 1990). Silverman (1989) suggests that, in preference to other distinct high-risk populations, children became the focus for much research in the belief that, by identifying risk factors in the child or its environment, preventive interventions might be possible.

A widening of focus to include the influence of psychosocial factors is evident in more recent years. At the same time, there has been a shift in emphasis away from the children of schizophrenic parents and onto the children of depressed parents. Downey & Coyne (1990) point out that at first the children of depressed parents served as controls in high-risk research focusing on the children of schizophrenic parents (see

also Goodman & Brumley, 1990). Following on from the unexpected finding that the children of depressed parents were just as disturbed as the children of schizophrenic parents, there has been in recent years a mushrooming of interest specifically in the effects of parental depression on children. The apparent decreased interest in the study of children of schizophrenic parents in their own right might reflect the fact that, as a population, they are less accessible to researchers (Feldman *et al.*, 1987). In contrast, parental depression, since it is a much more prevalent disorder, is not only more accessible in research terms but, more importantly, exposes large numbers of children to parental mental ill-health. It seems likely, then, that this combination of factors may account, at least partially, for the burgeoning of research in this area (Downey & Coyne, 1990).

THE PREVALENCE OF PARENTAL MENTAL DISORDER

Recent figures show that about one in seven people living in private households in Britain suffer from mental disorders (OPCS, 1994). Studies indicate that in the United Kingdom during the course of a year 12 million adults attending GP surgeries have symptoms of mental illness, that is one in four of the UK population. GPs identify, on average, six in 10 cases, the remaining five million cases going undetected. The great majority of medically identified mentally ill people are adults of working age with more women than men being diagnosed (55%:45%) (Thompson, 1993). (Although research data consistently suggests that certain ethnic groups, notably African Caribbean and Irish people, are over-represented in psychiatric hospitals (Mind, 1995), it will not escape notice that ethnicity as a dimension goes largely unaddressed in the literature under review here.)

In line with the general population, mental health problems in parents are common. In a reflection of the general pattern whereby anxiety states and depressive disorders account for some 80% of mental illness (Thompson, 1993), the most common

disorders experienced by parents are characterised by depression and anxiety (Graham, 1986). The incidence of depression is about twice as high in women as in men (Blackburn, 1987). Among women of child-bearing age, depression is a highly prevalent disorder (Boyd & Weissman, 1981; Weissman, 1987). Approximately eight per cent of mothers are clinically depressed at any one time (Weissman *et al.*, 1987), the figure rising to 12 per cent in mothers who have recently given birth (O'Hara, 1986).

In comparison with the disorders of depression and anxiety, the incidence of schizophrenia is less widespread, with about one in 200 people diagnosed as schizophrenic at some point in their lives. Men and women are affected equally (Mind, 1991). The suggestion is that those who do experience such difficulties become parents less often (Feldman *et al.*, 1987). It is known, however, that women usually develop schizophrenia somewhat later than men, typically between the ages of 25 and 30 years, with the result that by this time approximately a third of women with schizophrenia have already had at least one child (Erlenmeyer Kimling *et al.*, 1980).

Despite its less widespread incidence, then, it cannot be overlooked that schizophrenia is experienced by significant numbers of parents, as indeed are other, more contentious psychiatric categorisations such as personality disorder (Graham, 1986). Referring particularly to the high rate of serious psychological problems in the children of depressed parents, Downey & Coyne (1990) maintain that the statistics suggest an important social and public health problem. If a wider perspective is taken encompassing parental mental disorder in general, in the context of the considerable evidence for the links between such disorder and children's development (for example, Rutter & Quinton, 1984), the widespread incidence of parental mental health difficulties poses a major threat to the well-being of considerable numbers of children.

EXTENT OF THE IMPACT OF PARENTAL MENTAL DISORDER ON CHILDREN

Rutter's 1966 research, wherein he reported that parental illness including mental illness could have a detrimental effect on the well-being of children, is widely acknowledged as a landmark study in this area. Since that time a considerable body of knowledge has grown up exploring in more detail the impact of parental psychiatric illness on children, the possibility of linkages having been speculated upon as early as the 1920s (Kraeplin, 1921; Janet, 1925).

The consensus is that there no longer appears any doubt about the reality of the links between psychiatric disorder in parents and disturbance in their children (Beardslee *et al.*, 1983; Rutter & Quinton, 1984; Cox *et al.*, 1987; Feldman *et al.*, 1987). An influential four-year prospective study by Rutter & Quinton (1984) found that the children of mentally ill parents had a substantially increased risk of developing psychiatric disorder during childhood years, with a third of the 292 children studied exhibiting a persistent emotional or behavioural disorder. While this was a significant number, it was nevertheless far from inevitable that the children of psychiatric patients would suffer; a further third showed purely transient psychiatric problems while the final third of children showed no emotional or behavioural disturbance during the whole of the four year period.

The idea of a link is reinforced in that some studies have shown significantly more psychiatric illness in children with two disordered parents than in children with one or no disordered parent (Gershon *et al.*, 1982; Cantwell & Baker, 1984; Hammen *et al.*, 1987; Feldman *et al.*, 1987). Nevertheless, since by no means all children appear adversely affected, the association between parental mental disorder and child psychiatric disturbance is considered to be of only moderate strength. In addition, it is only of weak specificity, that is, there is only a slight tendency for the disturbance in

the child to be the same as that of the parent (Rutter & Quinton, 1984; Cox *et al.*, 1987; Silverman, 1989).

While some investigators focus on child outcome in terms of disorder/disturbance, that is, psychopathology, others focus instead on the effect of parental mental disorder on different aspects of children's development — for example, their intellectual, emotional or social functioning. Those inclined towards an interactional perspective would argue that the latter emphasis is likely to be more fruitful (Goodman & Brumley, 1990). Both approaches, however, remain evident in the literature and have the potential to be equally informative from their differing perspectives.

DIAGNOSTIC CATEGORISATION AND CLINICAL VARIATIONS

Based on current knowledge, with the exception of personality disorder (Rutter & Quinton, 1984), diagnosis *per se* seems to bear little relationship to outcome in the child. For example, the children of affectively disturbed and schizophrenic parents show similar deficits when compared with control children (Rutter & Quinton, 1984; Downey & Coyne, 1990). Downey & Coyne (1990) point out, however, that the growing use of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, now DSM-IV), with its increasingly precise diagnostic criteria, may yet reveal that children of schizophrenic parents are more impaired than those of affectively disordered parents, citing some evidence (Weintruab, 1987) to support their contention.

One view is that specific parental diagnosis is less relevant to child adjustment than other dimensions of parental psychopathology (Watt, 1984). For example, some studies have found that severity of impairment (Keller *et al.*,1986; Lee & Gotlib, 1989; Frankel & Harmon, 1996, but c.f. Goodman & Brumley, 1990) and chronicity are stronger predictors of child adjustment than diagnosis (Sameroff *et al.*,1984; LaRoche

et al., 1985; Keller *et al.*, 1986; Wynne *et al.*, 1987; Frankel & Harmon, 1996). Kashani *et al.* (1987) found that parental abuse rather than parental diagnostic label was more likely to be the crucial factor in predicting psychopathology among children (see also Downey & Walker, 1989).

Moreover, clinical variations within diagnostic categories, and the possibly differential effects of such variations, muddy the picture. This point is perhaps of particular importance in relation to the diagnosis of depression. Rutter (1990) notes the wide variations in depressive symptoms:

> *Depression may be characterised by anything from an exaggeration of the occasional lowering of mood seen in most people from time to time to frank psychosis, by either apathy and loss of interest or by agitation, irritation, restlessness and hostility, and by impaired social functioning that ranges from none to severe"* (Rutter, 1990)

He thus cautions against the tendency to assume that the diagnosis of depression reflects a homogenous grouping even though parental depression may frequently be treated as a single categorical variable (see also Murray, 1992). Orvaschel *et al.* (1988) addressed this problem by seeking to decrease such heterogeneity; their results confirmed that rates of psychopathology in the children of depressed parents were consistently higher when compared with control children.

Further, as psychiatric diagnosis is refined, the comparison of like with like that is necessary if an accurate profile of research knowledge is to be achieved becomes complicated (Downey & Coyne, 1990). Also acknowledged in the literature are the hazards of generalising uncritically from researched parent populations, who may often be comparatively more disturbed with frequent episodes of hospital or clinic treatment, to, for example, parents who for the most part function in the community

with perhaps only a low level of treatment or who go untreated (Gizynski, 1985; Downey & Coyne, 1990).

As research in this area has progressed, the complex and multifaceted nature of the links between parental psychiatric disorder and its impact upon children has become increasingly apparent. There is general agreement among researchers that there is still much to be learned, particularly now, given the certainty of the link, with regard to gaining a better understanding of the processes and mechanisms involved (Dodge, 1990; Rutter, 1990).

MECHANISMS THAT UNDERLIE THE LINK

That the nature versus nurture debate continues has been mentioned. Within this realm, however, there are signs of a growing consensus among researchers that a combination of influences is likely to be at work (Earls, 1987; Silverman, 1989; Downey & Coyne, 1990; Rutter, 1990).

Silverman (1989) contends that *"parental psychiatric illness confers increased risk on offspring but that the risk may be genetically, biologically, or psychosocially mediated".* Rutter & Quinton (1984) note that a variety of possible mechanisms underlie the recognised link between psychiatric disorders in parents and disturbances in their children, suggesting four:

1. genetic transmission;
2. direct environmental impact, for example arising out of parental hostility, delusions, etc.;
3. via the indirect effects of parental mental disorder, for example where the disorder interferes with the parenting task, where there is family disruption, the experience of Care, etc.; and

4. via the correlates of parental mental disorder, for example, marital discord, rather than from the disorder itself.

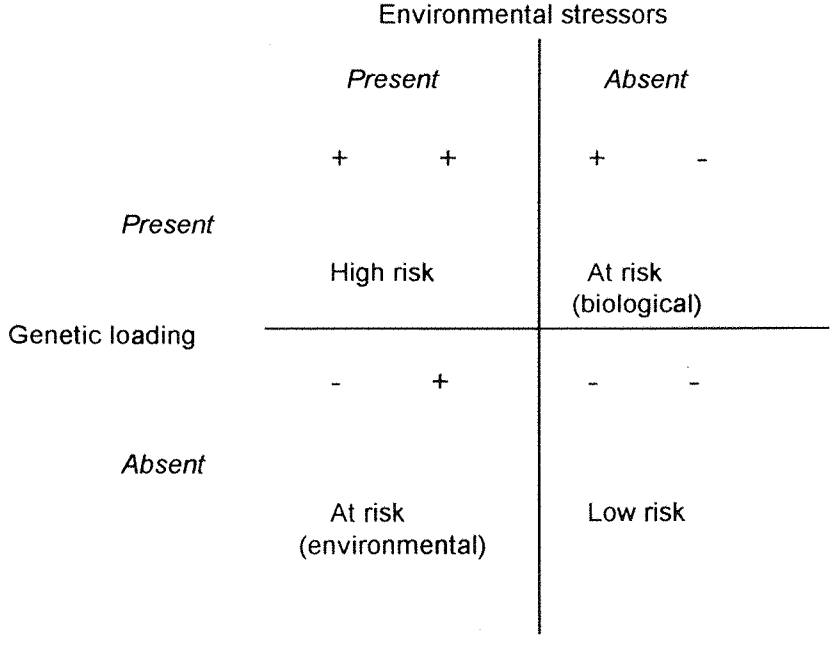
   (Source: Rutter & Quinton, 1984)

Similarly, in considering the impact of maternal depression on young children, Cox *et al.* (1987) postulate seven possible mechanisms:

1. genetic
2. interaction of genetic and environmental influences
3. exposure to symptoms
4. via alterations in parenting
5. via changes in family structure or function
6. depression incidental; correlated factors influential
7. interaction of depression and correlated factors

   (Source: Cox et al., 1987)

Silverman (1989) presents the different permutations of possible influences in diagrammatic terms:



(Source: Silverman, 1989)

Some researchers point out, however, that despite the fact that a genetic contribution to aetiology has been shown in most major adult psychiatric disorders, the position with regard to the genetic component of childhood disturbances is far from clear, with the result that any interaction between genetic and environmental influences can as yet only be speculated upon (Cadoret, 1983; Cox *et al.*, 1987).

Despite the acknowledged complexity of the links, which it appears are likely to be different for different disorders (Emery *et al.*, 1982; Rutter & Quinton, 1984; Earls, 1987; Downey & Coyne, 1990), Feldman *et al.* (1987) comment that very few studies examine the systematic interrelationships among genetic and environmental factors, noting that the handful that do are rudimentary. Indeed it is common for reviewers (for example, Rutter, 1990; Downey & Coyne, 1990) to point out the considerable methodological shortcomings in the existing body of research and to call for more effort on the part of researchers to be put into investigations integrating biological and contextual risk factors.

HOW IS THE CHILDREN'S DISTURBANCE TO BE EXPLAINED?

We have seen, then, that a variety of possible mechanisms underlie the link between parental psychiatric disorder and disturbance in children. Further, it is evident that the 'webs' in which children of mentally disordered parents are enmeshed are intricate (Feldman *et al.*, 1987). Unpicking and identifying the mechanisms is problematic in the extreme and the difficulties of doing so and of drawing conclusions free of qualifications are commented upon frequently in the literature. The sort of problem encountered is illustrated in the following extract:

> *In theory it is possible to distinguish a direct impact of exposure to symptoms and an indirect impact via the effect of the illness on parenting. However all parent behaviours to which a child is exposed can be seen as a component of child-rearing. To talk of direct and indirect effects of the illness becomes confusing. Therefore it is best to distinguish effects due to*

> *exposure to specific symptoms and those that are due to alterations in parenting, recognising that sometimes these will be the same. For example, parental expression of delusional ideas could induce anxiety in the child. Here there is exposure to a symptom which also constitutes an alteration in parenting. On the other hand, the parent might not express his or her delusional ideas, but be preoccupied with them and so less responsive to the child. Then the child is not exposed to the symptom but the parenting is altered.* (Cox *et al.*, 1987)

Within the realm of the effects of parental mental disorder on children, it is apparent there is a wide variety of research with studies focusing on very differing aspects in an attempt to illuminate the field of endeavour as a whole. Despite the enmeshed quality of the topic and, as a corollary, of the research findings, for the purposes of this review and for ease of reading the imposition of an admittedly simplistic structure will be helpful. Direct effects of parental mental disorder, effects via parenting and effects via correlates of parental mental disorder, child characteristics and protective factors will thus now be considered in turn.

DIRECT EFFECTS UPON CHILDREN OF PARENTAL MENTAL DISORDER

Symptoms of mental disorder manifest themselves via changed patterns of cognition, emotion and behaviour. Researchers point out that it is by no means certain that such symptomatology in a parent will necessarily have adverse consequences for children. Cox *et al.* (1987), for example, found that many depressed women maintained very positive relationships with their children (see also Frankel & Harmon, 1996). However, where consequences are adverse, what are considered to be 'direct' effects are those which arise from exposure to specific symptoms of the parental mental illness.

There is some evidence to suggest that parental symptoms can have direct effects on children. For example, Rutter (1966) found that the association between parental

psychiatric disorder and disorder in the child was strongest when the parent's symptoms impinged upon or involved the child in some way. Children most at psychiatric risk were those who: were the victims of aggressive acts or hostile behaviour by the parents; were the target of parental delusions; were neglected for reasons arising out of parental psychopathology; or were involved in parental symptomatology. In a later study with Quinton, the authors found that the extent to which children were exposed to and involved in their parents' abnormal behaviour (for example, affective symptoms or psychotic manifestations) *was* relevant, but less so than the extent to which they were exposed to family discord, a correlate of the mental disorder (Rutter & Quinton, 1984).

The above refers to psychiatric risk. As regards the risk of physical harm, despite the fears that delusional behaviour in the presence of young children might engender, it is apparently rare for psychotic mothers to seriously injure or kill their children (d'Orban, 1979). Others, however, have noted that risk of injury is certainly present during episodes of acute psychosis and that on occasion even close supervision in hospital may not mitigate this (Margison & Brockington, 1983).

As we saw earlier, the current generally held view is that parental diagnosis *per se* is probably of little import. Kauffman *et al.* (1979) noted that although the cognitive disturbance of a schizophrenic mother might frighten a child, it could be less deleterious overall than the apathy of a depressed parent. Cohler *et al.* (1977) concluded that:

> *the lack of involvement in their child's care which depressed mothers show, and the degree of irritability and resentment which they express about child rearing ... have at least as serious an impact on the child's development as the more bizarre psychopathology of the schizophrenic mother.* (Cohler *et al.*, 1977).

In a review of the literature on maternal depression and child development, Cummings & Davies (1994) note the likely direct impact on children resulting from characteristics of parental depression such as emotional unavailability, altered patterns of behaviour and distorted thinking patterns. By way of example with regard to level of emotional availability, Stein *et al.* (1991) reported that maternal depression during the first year post-partum was linked with subsequent maternal difficulties in communicating and listening to the child at 19 months of age. Regarding distinctive behaviour patterns associated with depression, Cox *et al.* (1987) found that, in comparison to non-depressed mothers, depressed mothers of two-year-olds exhibited greater criticism, disengagement, lack of responsivity to the child's cues and less warmth. In addition, other studies have reported that depressed mothers are more likely to be critical, scolding and physically abusive of their children than non-depressed mothers (Burbach & Borduin 1986; Panaccione & Wahler 1986; Webster-Stratton & Hammond 1988). In general, then, Cummings and Davies (1994) note: *"Depressed parents have been reported to be more negative, unsupportive and intrusive with their children when compared to both well parents and groups of medically ill control parents"* (Zajick & DeSalis, 1979; Gordon *et al.*, 1989; Tronik, 1989; Field *et al.*, 1990).

Moving on to direct effects arising out of distorted thinking patterns associated with depression, Goodman, Radke-Yarrow *et al.* (1993) note that thinking badly of oneself is a frequent symptom of depression. In a continuation of this frame of mind, then, depressed mothers tend also to think badly of themselves as mothers. Depressed mothers frequently feel inadequate and overwhelmed, and as if they have little control over their children's development (Cohn *et al.*, 1986; Coyne *et al.*, 1987). Studies have noted depressed mothers have low levels of perceived parental efficacy (Jaenicke *et al.*, 1987; Webster-Stratton & Hammond, 1988) and relatively little confidence in their care-giving skills (Anthony, 1983; Kochanska *et al.*, 1987). Such perceptions, while having their genesis in the symptoms of depression, may be nevertheless accurate, at least to some extent, since it seems likely that the lowered

self esteem and perceived lack of control typical of depressive symptomatology may, in turn, adversely influence parental responses to child behaviour, including particularly problem behaviours (see Cummings & Davies, 1994).

Puckering (1989) broadens our perspective on the direct effect of specific parental symptoms. She notes that, for example, a child may witness the depressed mother's crying and distress. She postulates that this could have a direct effect on a child's development if a social modelling perspective were taken. In studying the possibility of this effect, however, Jaenicke *et al.* (1987) found that the hypothesis was not borne out since there was no relationship between maternal self-criticism and child self-criticism. Their findings did, however, show that if depressed mothers were critical of their children then the children were similarly critical of themselves. Puckering, then, advances the view that maternal irritability, by no means exclusive to depression but frequently a feature of it, may have a more direct effect on children than a range of other depressive symptoms. Thus she suggests:

> *Other common symptoms associated with depression, anxiety, loss of energy, sleep disturbance, suicidal thoughts, ideas of reference, retardation, self-depreciation, etc. are perhaps less likely to have a direct effect on the child, but may severely incapacitate the mother and change her interactions with her children, or precipitate family disruption.* (Puckering, 1989, emphasis added)

It is to these more indirect effects that we now turn.

EFFECTS ON CHILDREN VIA PARENTING

As we have seen, poor parenting and impaired parent-child relationships do not always arise as a result of parental mental illness. Referring specifically to maternal depression, Goodman, Radke-Yarrow *et al.* (1993) make the point that it is, though,

likely to complicate matters: *"Maternal depression does not necessarily lead to poor mothering; it is a hardship in mothering".*

A variety of studies, however, have found that, in general, parenting by women who are diagnosed as schizophrenic or affectively disordered is of poorer quality than that of women with no mental illness (Weissman & Paykel 1974; Cohler *et al.*, 1977; Cohler *et al.*, 1980; Weissman, 1983; Davenport *et al.*, 1984). Summarising these studies, Goodman & Brumley (1990) state:

> *When results have been combined across studies, parenting by disturbed women has been found to be less reciprocal, less responsive, and less involved, in general. Furthermore, disturbed women were noted to display more negative affect and to be less open in emotional expression.* (Goodman & Brumley, 1990)

In contrast to previous studies, many of which did not attempt to distinguish differences in parenting as a function of diagnosis (the few which did found few differences in the parenting of schizophrenic versus depressed women relative to well mothers), Goodman & Brumley (1990) aimed to study the relative impact and quality of parenting by schizophrenic and depressed mothers. The authors found that, as they had hypothesised, quality of parenting was lowest in schizophrenic women and more variable in depressed women. They concluded, however, that diagnosis as such was less relevant to outcome than quality of parenting. Certain parenting practices — in particular, for example, where mothers were observed to be more enthusiastic and involved, expressed more positive affect, and showed more enjoyment, interest and responsiveness — significantly predicted young children's IQ scores and social behaviour. Thus the authors found that parenting practices and not diagnostic status *per se* accounted for much of the children's intellectual and social competence.

With particular reference to the diagnosis of depression, increasing interest in the social context of women who experience depression, including the mother-child relationship, is apparent in the literature. Weissman & Paykel (1974) succeeded in highlighting some of the ways in which the parenting of depressed women may be impaired and thus disadvantageous to children in their care. Since this influential work, numerous studies have aimed to identify and explain some of the specific problems for children and mother-child relationships associated with maternal depression.

Focusing specifically on the diagnosis of maternal depression, then, Goodman, Radke-Yarrow *et al.* (1993) usefully summarise the position with regard to a range of potential parenting impairments. They note, for example, that providing adequate and appropriate stimulation for infants is problematic for depressed mothers. This is noticeable in the area of language inasmuch as depressed mothers tend to be less consistently aware of, and responsive to, their infants' signals and make fewer initiating interactions. They vocalise less and do so in ways that differ significantly from the vocalisations of non-depressed mothers (Field *et al.*, 1985; Bettes, 1988). Depressed mothers seem to be less tuned in to their infants' needs and rhythms, to the extent that their care can sometimes be perfunctory and lacking in tenderness (Field, 1987). It has been noted that depressed mothers express little positive affect and much negative affect (Cohn *et al.*, 1990; Field *et al.*, 1990). Field (1987) reported that a similar pattern was also apparent in their infants, their affective state being unstable and hard to gauge. Others have noted that, in effect, a two-way process unhelpful to either mother or infant is set up (Tronick & Giuanino, 1986). Disturbances in attachment are more frequent in infants of depressed mothers (Teti *et al.*, 1992). Risk for later attachment difficulties is also apparent in infants of depressed mothers. Murray (1992) reported that diagnoses of maternal depression at two months post-partum significantly increased children's risk for developing insecure attachments with the mother sixteen months later. Puckering (1989), reviewing studies concerned with

interactional mechanisms, notes that the infant's innate propensity for social interaction is:

> *clearly disrupted by the experience of an unresponsive mother, even at a very early age. At 3-6 months, babies had already accommodated to their mothers' depressed style, and carried this maladaptation to further social interactions. The normal infant at this age is tackling the foundations of social interaction and reciprocal interaction, and disruption has the potential to influence later language, social responsiveness and perhaps the reaction of others to the child.* (Puckering, 1989)

Such difficulties continue beyond infancy as the developing child confronts the mother with new challenges. Parental depression has been linked repeatedly with insecure parent-child attachments, although secure attachments are also often made. Looking at patterns of attachment in two- and three-year old children of depressed mothers, Radke-Yarrow *et al.* (1985) found that depression (both uni-polar and bi-polar, the latter more so) decreased the likelihood of secure attachment between mother and child (see also Lyons-Ruth *et al.*, 1986; Spieker & Booth, 1988). Cummings & Davies (1994) make the general observation that insecure attachment patterns can be conceptualised as the children's way of coping with the discord and parenting impairments within depressed families.

Others have found that, in effect, mother and child can become maladaptively attuned in still other ways, resulting in enmeshment (Radke-Yarrow *et al.*, 1988) or decreased sensitivity to the need for interaction and communication (Cox *et al.*, 1987). Rutter & Quinton (1984) found that depressed mothers were slow to respond to the overtures of their two-year old children. Verbal communication with young children is likely also to be affected. Breznitz & Sherman (1987) reported that depressed mothers speak less and are slower to respond to their child's verbal initiatives and do not reward their child's efforts in the area of language. The use of authority and the setting of appropriate limits is a further area of parenting difficulty for depressed mothers.

Various studies have shown that the depressed mother is likely to show impaired disciplinary functioning, typically employing inappropriate control techniques rather than supportive behaviour in response to a young child's distress (Davenport *et al.*, 1984; Rutter & Quinton, 1984; Kochanska *et al.*, 1987).

As for all children, parenting quality, then, appears vitally important for the continued well-being of the children of mentally ill parents. Parenting alone, however, does not provide us with the whole picture when it comes to ensuring children's optimal development. We turn now to an examination of other indirect consequences for children of parental mental ill-health.

EFFECTS VIA CORRELATES OF PARENTAL MENTAL DISORDER

Many researchers comment that since poor parental mental health and adverse family and psychosocial circumstances tend to occur together, the relative importance of the various influences in terms of the impact on children has yet to be disentangled with any degree of certainty (Rutter & Quinton, 1984; Puckering, 1989; Cummings & Davies, 1994).

Maternal depression, for example, will often co-exist with any or all of the following: marital problems (Coyne *et al.*, 1987; Gotlib & Hooley, 1988); inadequate social supports (Brown & Harris, 1978); economic strains and deprived circumstances (Belle, 1982; Lyons-Ruth *et al.*, 1984; Birtchnell *et al.*, 1988); having a child with a difficult temperament (Thomas & Chess, 1984); and accumulated stressful life events (Paykel, 1974; Teti *et al.*, 1990). In short, then, many variables are present in these sorts of family situations. In terms of what influences what and how, the picture is far from clear with many potential interactional and interpersonal mechanisms yet to be investigated.

As Rutter (1990) points out, the situation is made yet more complex by the fact that it is common for affective disorders to be associated with other psychiatric conditions such as alcoholism, drug dependence and various forms of personality disorder (Rutter & Quinton, 1984). Such co-morbidity is rarely addressed in studies. In such instances, it may be, then, that it is these associated conditions, rather than depression itself, that constitute the main psychiatric risk for the children of mentally ill parents.

An aspect that has been examined to a certain extent is the impact of the ongoing stresses and strains often associated with mental illness. Hammen *et al.* (1987) reported that children of mothers with affective disorder (especially uni-polar) had high rates of impairment when compared with those of mothers who had chronic medical illness or of normal mothers. They found this not just to be attributable to maternal psychopathology but also to the concurrent chronic stress in the families, commenting that the role of stress in the impairment of children at risk remains poorly understood, the relative contributions of stress and maternal symptomatology to children's outcomes requiring further investigation.

It has been noted elsewhere that a number of studies have found that chronicity of illness in the affected parent is an important variable in relation to adverse outcomes for children. A community survey of schizophrenic patients and their families carried out by Gibbons *et al.* (1984) underlines the impact of the strains for such families, noting that while some five years following initial diagnosis the indications were that adult relatives became resigned to the difficulties, 65 per cent of children involved in their study showed emotional or physical ill-health or conduct problems.

A further indirect effect of parental mental illness that may account at least in part for adverse outcomes in children is the often considerable family disruption that co-occurs, especially when such disruption results in children being separated from their

own homes (Rice *et al.*, 1971). Webster (1990) notes that temporary separations of children from schizophrenic parents are common since, in its acute phase, the condition is most often treated in hospital. Most children stay within the home or are looked after within the extended family at such times, although young children may experience the additional burden of multiple family care-takers (Sobel, 1961) and school-aged children may experience inadequate care at such times or be left to care for themselves (Rice *et al.*, 1971). Children whose parents are in an acute phase of an illness such as schizophrenia form a small proportion overall of children entering the formal care system, although studies have shown that the children of mentally ill parents form a larger proportion of children who remain in care (Aldgate, 1977; Isaac *et al.*, 1986; Millham, 1986).

It will be clear that the relative influences of such correlating psychosocial variables have yet to be definitively determined. However, one such psychosocial risk factor that has been accorded considerable attention by researchers is that of hostility and violence within the home (commonly referred to in the literature as 'marital discord'). Rutter (1990) points out that numerous studies have shown the very high frequency with which depressive disorders in adults are associated with marital discord (Rutter & Quinton, 1984; Birtchnell, 1988; Gotlib & Hooley, 1988). Goodman, Radke-Yarrow *et al.* (1993) note the same association, commenting that researchers draw mixed conclusions about which is the cause and which the effect. Following a thoroughgoing review of the literature relating to the children of depressed parents, Downey & Coyne (1990) concluded that, the tendency for a specific increase in diagnosable depression in children apart, in relation to more general problems of adjustment: *"marital discord is a viable alternative explanation for the general adjustment difficulties of children with a depressed parent"*. Such an explanation would account for the fact that the children of depressed parents share a propensity to general problems of adjustment with the children of mothers with physical illnesses, with psychiatric conditions other than depression and of mothers who are otherwise under stress. Once again,

however, the call is for more process-oriented research since, while the connections between parental disorder, hostility and discord within the home and child outcomes are increasingly being made, little is yet known about underlying processes and mechanisms (Downey & Coyne 1990; Rutter, 1990; Cummings & Davies, 1994).

In their influential study, Rutter and Quinton (1984) concluded that, while parental mental illness was important as an indicator of psychiatric risk for children, the *main* risk stemmed from the associated psychosocial disturbance, with discord and hostility within the family constituting the chief mediating variable between parental mental disorder and psychiatric disturbance in the children. Both discord between the parents and hostility directed at the child were influential:

> *Quarrelling, hostility and disruptive family relationships may stem from a variety of sources but it seems that whatever their origin, they constitute a potent risk factor for the children.* (Rutter & Quinton, 1984)

Researchers concentrating specifically in the area of parental depression similarly point up the importance of marital discord. Caplan *et al.* (1989) reported links between maternal depression and marital conflict in the early years of child-rearing, considering marital discord to be more closely related than parental depression to behaviour problems. Cox *et al.* (1987), noting the reciprocal nature of the relationships between marital discord and maternal depression, found that marital discord was more closely related to disturbances in mother-child interactions than maternal depression *per se*.

Taking a different but related perspective, in a follow-up study of children of parents with manic-depressive illness, LaRoche *et al.* (1987) found that better marital adjustment in spouses/well parents was significantly associated with the absence of diagnosable disorders in the children (see similarly LaRoche *et al.*, 1985). Keller *et al.* (1986) also emphasised marital harmony with an absence of psychopathology and better outcomes for children.

It seems, then, that some factors might prove protective for the children of mentally disordered parents. Before further consideration of what is known in terms of protective factors in these sorts of family situations, we turn first to a consideration of particular characteristics in children which might reduce their level of susceptibility to being impacted by parental mental ill-health.

CHILD CHARACTERISTICS

Various studies and commentators remark upon the diversity of response in children that is apparent (Downey & Coyne, 1990; Rutter, 1990; Cummings & Davies, 1994). On this topic of individual difference in vulnerability, Rutter and Quinton (1984) comment:

> *the findings emphasise the extent to which children vary in their susceptibilities. We know very little about the basis for these individual differences in vulnerability but their existence is not in doubt.* (Rutter & Quinton, 1984)

The situation remains that, as yet, insufficient research has been undertaken to know with any certainty the reasons for such heterogeneous responses in children to parental mental ill-health.

An obvious issue concerns the part played by age differences. Teasing out the situation with regard to age-related differences with any accuracy is not straightforward however. The picture may well be muddied, for example, by the effects of chronicity or recurrent parental mental ill-health. The current consensus, at least in relation to depression, appears to be that a child's age is not a vital factor in terms of outcome in the sense that any one age group is more vulnerable than another to parental mental ill-health and its correlates (Cummings & Davies, 1994).

Summing up the literature relating to the effects of parental depression, Rutter (1990) concludes:

> *On the whole, the child's age has not been a crucial factor. The ways in which children respond are influenced by developmental considerations, but no one age group seems either particularly protected or particularly at risk.* (Rutter, 1990)

The picture with regard to gender-linked differences in children's adjustment is less clear-cut, findings on this aspect often proving contradictory (Cummings & Davies, 1994). One issue is the tendency for boys and girls to appear differentially vulnerable to different forms of adverse outcome. Boys, for example, tend to exhibit more 'externalising' problems and girls more 'internalising' problems. There is also some suggestion (Rutter & Quinton, 1984) of gender difference with regard to relative vulnerability to an environment of parental mental ill-health. While girls initially proved relatively resilient in the face of family discord compared with boys, faced with persistent adverse family circumstances over a four year period girls too became affected and gender differences greatly narrowed. At the moment, then, Rutter (1990) concludes *"the data are too few for strong general conclusions"*, although the suggestion is that it is unlikely that a general gender difference in psychological vulnerability will be identified in the long run.

The relevance of gender difference is complicated by the cross-over between gender difference and differences at the level of individual temperament. Gender notwithstanding, children have greatly differing temperamental characteristics which mediate their adjustment to an environment of parental mental ill-health (although the extent to which children's dispositions result from innate temperament as opposed to early environmental influences is not in itself necessarily clear (Cummings & Davies, 1994)). In addition, far from being merely passive recipients of environmental stimuli, through their own individualised styles of thinking, feeling, interpreting and behaving,

children play a part in shaping their own developmental destinies (Rutter & Quinton, 1984; Downey & Coyne, 1990; Rutter, 1990; Cummings & Davies, 1994). Some studies (Pelligrini *et al.*, 1987; Downey & Walker, 1989; Garmezy & Masten, 1991) have focused on particularly 'resilient' children, often highlighting the importance of superior social and cognitive skills which enable the child both to elicit positive attention from other adults and to avoid negative attention from the ill parent as a basis for such resilience.

It is undoubtedly true that, as parents influence their children, so too do children influence their parents. It is not a one-way street. Focusing specifically on the children of depressed parents, Downey and Coyne (1990) remark:

> *Evidence from multiple sources and across multiple situations shows that children of depressed parents pose a greater parenting challenge than the average child. Problems emerge early in these children, and they may be more difficult from birth than other children. As with spouses, the feedback available from interactions with children may further validate the feelings of ineptitude, worthlessness, and rejection that characterise depressed persons, thus maintaining their depression.* (Downey & Coyne, 1990)

We see here, then, the idea of, if not a 'vicious circle' as such (although notions of circularity have been remarked upon (Stiffman *et al.*, 1986; Cummings & Davies, 1994), at least the idea of there being transactional mechanisms involved where both parents and children take active roles in outcomes both ways (Rutter & Quinton, 1984; Rutter, 1990; Sheppard, 1994a). It appears the leading edge for research in this area is the longitudinal study of the interactions between parent and child characteristics that give rise to such varied patterns of response (Rutter, 1990).

Despite the gaps in research knowledge, a clear implication of the operation of such interactive mechanisms is the requirement for professional interventions to take account of both ends of the process. Arguably this implication has particular relevance

in relation to the social work task of assessment. We shall turn shortly to a consideration of the extent to which social workers have involved themselves in this area of interface between parental mental ill-health and child-care. First, though, since it also has relevance for the social work assessment process, we consider what is known in relation to potentially protective environmental factors for children with mentally disordered parents.

PROTECTIVE FACTORS

It is easy to overlook the fact that many children are brought up in families where there is parental mental disorder without suffering undue consequences and in some cases even develop as particularly colourful and creative children (see, for example, Anthony, 1976; Kauffman *et al.*, 1979). As Cummings & Davies (1994) point out:

> *While children of depressed parents are at risk for maladaptive outcomes in a probabilistic sense, a concern with psychopathology should not obscure the fact that many children from at-risk environments develop adaptively and competently (Garmezy & Masten, 1991), and the full range of outcomes needs to be accounted for in a complete model of family effects.* (Cummings & Davies, 1994)

Downey & Coyne (1990), noting a tendency for research in this area to 'mother bash', comment similarly on the complete lack of investigation into the strengths that depressed mothers may bring to family situations. They comment:

> *The ability of depressed mothers to continue to provide for their children, even though they are demoralized and highly symptomatic and the children are difficult and unrewarding, may be a protective factor in the face of other adversities.* (Downey & Coyne, 1990)

There seems some way to go when it comes to the clear identification of what is protective for children, both in terms of children's own coping mechanisms and

'steeling' effects (Rutter, 1990) and of more environmental factors. The presence of a good relationship with one or more parent has been found to be protective (Rutter, 1989) and it seems that good peer relationships are also likely to be important in this regard (Pellegrini *et al.*, 1986).

Having reviewed the literature concerning the risk to children of depressed parents, Reid & Morrison (1983) cite as the most prominent mitigating factors: the presence of some source of consistent parenting in the environment; and recognition of the parent's illness by other members of the family who can support the child's impression that something is wrong.

Having similarly reviewed the wider literature concerning the children of psychiatrically ill parents more generally, Silverman (1989) cites protective factors in the child's environment as: the presence of normal adults; positive relationships with siblings; and independent sources of feedback.

Following investigation into the parenting of children with schizophrenic mothers, Webster (1990) contends that the greatest support for such children comes from their fathers, regardless of whether or not parents stay together. Certainly studies suggest that families where there is parental mental illness tend to cope without outside help if they can (Ekdahl *et al.*, 1962; Hugman and Phillips, 1992/3). It is true to say, however, that, on the whole, spouses/fathers remain largely unknown beings within the research literature. In a series of three studies that looked at the impact of parental mental illness (whether that of the mother or the father) on a total of 652 children, Rice *et al.* (1971) ultimately focused on mothers, in preference to fathers, since *"the mental illness of mothers was found to have more impact on children and the problems of child-care"* (p231). Other research indicates that husbands of mentally disordered mothers tend to be disturbed in their own right (whether by assortative mating or by 'contagion' is not entirely clear) and that there is often marital conflict

(Rutter & Quinton, 1984; Downey & Coyne, 1990). Having regard to the specific diagnosis of depression, depressed fathers as a group have certainly received considerably less attention from researchers than depressed mothers. What little there is regarding the impact of paternal depression on children is contradictory, some studies reporting that such children are less disturbed than those with depressed mothers (Klein *et al.*, 1985; Keller *et al.*, 1986) and others finding similar levels of disturbance (Billings & Moos, 1983; Klein *et al.*, 1988). Commentators note there is a gap yet to be filled with regard to fathers (Downey & Coyne, 1990; Cummings & Davies, 1994).

IMPORTANCE OF THE BODY OF KNOWLEDGE FOR SOCIAL WORKERS

It will be clear from this review of the literature that there is much that will be informative for social workers even though the area has by no means yet been exhaustively researched. Indeed, throughout the literature it is generally held that there is a long way to go before comprehensive understanding within this realm is achieved (Feldman *et al.*, 1987; Downey & Coyne, 1990; Rutter, 1990). Nevertheless, despite its acknowledged inadequacies, it is contended here that this is an important body of knowledge with which social workers would do well to familiarise themselves. As we have seen, the prevalence of adult mental disorder is widespread; and, of course, adults often become parents. In the words of Munk (1993), *"Let us assume that adults with mental illness will bear children and that they will want to be responsible parents"*. Researchers in this field invariably conclude that professionals need to be alert to the potential impact for children when a parent has a mental illness, that families need to be supported and, at times, children protected (Rutter & Quinton, 1984; Puckering, 1989; Webster, 1990).

Various studies have established that there is considerable psychiatric morbidity among the clients of social workers, for example, in area teams and general

practitioner attachments (Fisher *et al.*, 1984; Huxley & Fitzpatrick, 1984; Isaac *et al.*, 1986). Indeed, research has revealed that significant numbers of social services clients (53%) experience mental health problems at the level of 'caseness' (Huxley *et al.*, 1987). Clearly considerable numbers of children whose parents have mental health problems — some of whom undoubtedly already come the way of social services departments — are at least *at risk* of developing marked difficulties in their own right, lending support to the view that this is a significant body of knowledge in relation to the social work task. Certainly this would appear to be an important area of literature for social workers given the prominence of parental mental illness in families that are investigated under child protection procedures (Gibbons *et al.*, 1995) and the relatively high numbers of children with psychiatrically ill parents who end up in the care system (Aldgate, 1977; Isaac *et al.*, 1986; Millham, 1986).

Despite the importance for social workers of the impact of parental mental disorder on children as a topic, examination of the literature reveals that as yet it is unclear how social workers use knowledge of parental psychiatric history within the child care assessment process. In a study comparing in terms of parental psychiatric history 31 families with children who had stayed in care for at least 12 months with 26 families with children who had been in care for up to three months, Isaac *et al.* (1986) found that the children in care for the longest periods were more likely to have parents suffering from long-standing psychiatric disorders. The study pointed to considerable overlap between problems of child care and parental mental disorder with, on the one hand, assessment of parents' capabilities appearing to be a vital consideration in child care decision-making and, on the other, a lack of clarity about how knowledge of parental mental illness was brought to bear in the assessment process.

Concentrating specifically on the area of maternal depression and its implications for social work intervention, Sheppard (1993, 1994a, 1994b) has noted in a series of

articles that, to a large extent, social workers have so far failed to address themselves adequately to the topic as it relates to child care, making the general observation:

> *Although child care and mental health constitute major aspects of social work responsibilities there has been little attempt in social work to make connections between the two.* (Sheppard, 1994a)

Despite its potential value, then, we are left at this stage with the distinct impression that this particular body of formal knowledge is not necessarily one with which most social workers are likely to be familiar. As we have seen, investigating the extent to which social workers call upon pertinent formal knowledge is one of the objectives of this thesis and the findings in that regard are contained in Chapter Five: Findings (I). However, for our purposes here, if that impression were to be accurate, the obvious next question is: 'why not?'. It is a question that demands response on two levels.

Firstly, it will be clear from the foregoing that there remains much uncertainty about what can authoritatively be said in this area; there are many gaps of knowledge and qualifying statements in relation to the various research findings abound. Because of this, in some ways it is not easy either to get to grips with this body of knowledge or to put it to use in any meaningful way in, for example, the social work assessment context. Importantly, though, what is clear is that the presence of parental mental illness can reliably be taken as a *potential* indicator of problems on the part of children, whatever their precise genesis or direct or indirect associations with the parental mental disorder. We have seen that Rutter & Quinton (1984) found that one-third of the children of mentally ill parents they studied exhibited persistent emotional or behavioural disorders. In relation to the prediction of adolescent affective disorder, Beardslee *et al.* (1996) concluded that *"Affective disorder in parents serves as an identifier of a constellation of risk factors, which together lead to a poor outcome in youngsters".*

In terms of the social work assessment task, there are clearly many overlaps with the 'ordinary' parenting issues addressed routinely by social workers, particularly those whose focus is specifically on families and children. We are faced, then, with the question of whether or not the body of literature under review adds anything of value over and above a wider, less specific pool of knowledge in relation to good-enough parenting and child care issues which is taken to be accessible to social workers (later debate within the thesis notwithstanding). It is argued here that the presence of parental mental illness undeniably adds an important dimension to family situations and to the experience of children. Specific aspects of a parent's difficulties, such as symptomatology, prognosis, precipitating factors and/or 'knock on' effects, warrant attention in their own right and need — with open mind for, as we have seen, many children weather parental mental ill-health very well — to be weighed in the balance alongside other factors.

For all its self-evident shortcomings, the body of knowledge concerning the impact of parental mental illness on children is thus an important one for social workers, not least because, once the difficulties that may accrue for children from parental mental ill-health take hold, they are not by any means easily overcome even if and when parental adversities abate (Rutter & Quinton, 1984). In terms of accessibility to social workers, however, the incremental and evolving nature of formal knowledge in this realm is undoubtedly problematic. In the initial assessment context, the starting point for busy practitioners should, perhaps, be cognisance that there is a good deal of work being carried out in this realm that is likely to be informative for social workers and access to at least the bones of what research consensus there is. To this end, an *aide-memoire* has been compiled (Appendix A).

The second response to the question of why social workers might not readily call upon a seemingly relevant body of formal knowledge concerns the complex nature of knowledge. A social work study carried out in the US is of interest at this point.

DeChillo *et al.* (1987) looked at the nature of contact between hospital psychiatric social workers and the children on their caseloads. They found considerable contrast between the practitioners' familiarity with the body of knowledge concerning the impact of parental mental illness on children and the level to which, in practice, the social workers chose to be in contact with the children on their caseloads. The authors queried whether practitioners felt competent to intervene on behalf of children:

> *Results of the qualitative survey showed that social work staff otherwise well-trained felt somewhat inept in their ability to encourage children to come to the office, to engage them, and diagnostically to assess their functioning.* (DeChillo *et al.*, 1987)

This study points up, then, that formal theoretical knowledge in itself is insufficient. Social workers are required also to have a range of interpersonal, diagnostic and therapeutic skills which enable them to make use of theory in practical situations. Achieving an acceptable balance may well be particularly challenging in situations where two usually distinct areas of specialist knowledge and skill overlap — for example, in the area of interface between adult mental health and child care.

The crucially important topic of the complex nature of knowledge is examined in detail in Chapter Eight: Discussion of Findings. In the meantime, the body of literature that has been reviewed here — with all its unanswered questions, outstanding conundrums and lack of subtlety — has served to illustrate the often problematic nature of formal knowledge and its relevance to the professional context of social work.

As Silverman (1989) reminds us: *"Not all psychiatrically ill parents are inconsistent or ineffective at parenting, and not all children of psychiatrically ill parents are impaired or unable to cope"*. It is certainly gratifying to recall this and to take it as a baseline. There will undoubtedly be times, however, when skilled and knowledgeable

assessment is required to establish the extent to which this is or is not the case. We turn now to an examination of the literature relating to assessment in child care.

CHAPTER TWO: LITERATURE REVIEW (CONTINUED)

Chapter Two reviews two areas of literature germane to the thesis. First, literature relating to the topic of assessment as it relates to child care is considered. This is followed by an examination of literature relating to client perspectives, particularly as they relate to assessment and intervention in the realms of child care and mental health.

ASSESSMENT IN CHILD CARE

A CENTRAL ACTIVITY

Within contemporary social work, the activity of assessment is accorded considerable importance irrespective of with which client group or under which legislative umbrella social workers work. CCETSW (1995) views assessment as one of social work's core activities.

Taking a longer view, assessment has, of course, been viewed as a key component of the activity that is social work since the profession's inception (Lloyd & Taylor, 1995). General guidance on the topic is incorporated into basic social work texts, both generic and specialist (for example, Butler & Pritchard, 1983; Adcock & White, 1985; Huxley, 1985; Preston-Shoot & Agass, 1990; Sheppard, 1990; Coulshed, 1991). A recent text (Gopfert *et al.*, 1996) offers guidance specifically in relation to the area of overlap that concerns us here. From the point of view of professional practice, then, the clear implication is that, if effective social work is to ensue, some initial understanding of the situation that presents itself must first be gained.

Assessment is not, however, purely a matter of practice, of interest and concern only to front-line practitioners. Its very nature ensures attention from a much wider audience, both within the profession (Howe, 1991) and from outside:

> *Problem-definition and assessment is not a simple objective measure but a complex process which involves values, principles, agency policies and procedures, the current legal position and the perspectives of social workers and their managers.* (Hardiker, Exton & Barker, 1989 p112)

Lloyd & Taylor (1995) contend that, during recent years, a change in climate with regard to the social work task vis-à-vis public accountability has been in evidence such that it:

> *... put social workers into the uncomfortable position of having to demonstrate exactly why they had, or had not, taken particular actions. Assessment assumed importance as social work practice in its own right, rather than as a stage in some potentially therapeutic process.* (Lloyd & Taylor, 1995, emphasis in original)

Thus, as well as providing the foundation for effective intervention that has long been its purpose in relation to practice, we might say that the task of assessment has also now become, in effect, an accountability tool. When viewed as such, it is perhaps unsurprising that the activity and outcomes of assessment should provoke interest and concern on the part of managers and others in addition to practitioners.

IMPORTANCE IN RELATION TO MANAGEMENT AND PLANNING

While by no means an exclusively managerial/administrative aim, the activity of planning and the systematised achievement of service aims and objectives are arguably more clearly central to the domain of policy-makers and managers than to that of the rank-and-file practitioner. Received wisdom dictates that assessment and planning take place essentially in tandem. That they are activities that will co-occur appears axiomatic (see, for example, CCETSW, 1995). It is hardly surprising therefore, that, from a managerial perspective, assessment is likely to be viewed as a

vital activity, the all-important first step on which to build well-targeted, planned and effective service provision.

As noted in the introduction, the quality of assessment in the child care arena came under close scrutiny in the mid 1980s and was found wanting. In particular, it was considered that the deficiencies identified had serious implications for the sound planning of constructive work with families. Prestigious, publicly-commissioned research had revealed that such planning was largely absent:

> ... *social workers and their seniors are not offered the opportunity to acquire the sophisticated skills, knowledge and qualitative experience to equip them to deal confidently with the complex and extremely emotive issues raised by work with children and families. ... The result is that the whole basis for planning is shaky. Decisions are made on inadequate evidence and it is not surprising if goals are unclear or if there is a lack of congruence between goals and what is actually done.* (DHSS, 1985, p21)

This focus on the need for good assessments as a basis for planning, particularly longer-term planning, was echoed in subsequent Social Services Inspectorate Reports (SSI, 1986; SSI, 1989). The influential 1986 report concerned inspection of social work practice in child abuse cases handled by nine social services departments. The inspection took place following increasing public and professional concern about child abuse during the early 1980s and was guided as to its focus by an earlier DHSS Report (DHSS, 1982). A conclusion of this study concerned the inadequacy of assessments in child abuse cases:

> *A major characteristic of many cases is the failure to bring together all available information and to use it in a structured, objective way, by carrying out full psycho-social and medical assessments.* (DHSS, 1982, quoted in SSI, 1986, p4)

The inspection revealed that, to a very large extent, initial assessments involving careful marshalling of information and a multi-disciplinary approach were good and provided a sound basis for short-term planning. It was beyond this initial phase that any systematic approach to the task of assessment appeared to fall down badly. Thus the view was taken that overall the inspection findings bore out earlier concerns and it was noted that:

> *in the absence of a structured approach to comprehensive assessment crucial decisions about the children's long-term care were often made without adequate and properly evaluated information.* (SSI, 1986 p41)

A recommendation of the inspection, therefore, was that, *inter alia*, social services departments establish an operational policy for planning for children in care which ensured the completion of comprehensive assessments for long-term planning, together with the provision of guidance thereto.

A further and related recommendation of the 1986 Inspection Report, specifically to the Department of Health and Social Security, proposed the setting up of a small working party of relevantly knowledgeable members of the profession with a view to preparing a practice guide for social workers in relation to the assessment and long-term management of child abuse cases. It was directly out of this working group, set up in 1987, that the colloquially-known 'Orange Book' guidance (DoH, 1988) emanated, its purpose being *"to assist social workers (and their supervisors) to adopt a more systematic and structured approach to undertaking and recording assessment"* (accompanying communication, 1988).

Evidence from the 1996 Social Services Inspectorate Report strongly suggests that there is still some way to go before sound planning procedures based on adequate assessments, at least in relation to the realm of social services department's family support services, are the norm (SSI, 1996).

A KEY PRACTICE ISSUE

That the aim of the Orange Book guidance (DoH, 1988) was to assist with both *"undertaking and recording"* illustrates well the point that the activity of assessment is of key interest, not only to managers with their appropriate concern for planning and accountability, but also to practitioners in whose hands, guidance notwithstanding, the task ultimately resides. That said, one of the chief aims of the guidance was undoubtedly to set out a clear practice framework for comprehensive assessment in the realm of child protection. It acknowledged the concerns of many that, in the wake of the child abuse scandals of the 1970s and early 1980s and the consequent concentration on formal procedures to ensure effective management of the child protection process, crucial issues of practice had become lost. No doubt with an eye to the prevailing climate of 'proceduralisation', and perhaps a concern that the framework on offer would exacerbate the situation, the authors were keen to point out the limitations of the guide, remarking:

> *It should not ... be used in isolation but as part of knowledge gained from the literature, training and the practitioner's own experience*

and further that:

> *the emphasis placed on the systematic gathering of information about the child and his or her family should not be seen as minimising the importance of observing and noting the processes operating within families and between families and practitioners.* (DoH, 1988 p5)

The authors also took the opportunity to spell out the prevailing philosophy and value base of social work practice in the child protection arena. Many of these ideas — paramountcy of the child's interest and welfare; the independent rights of children; parents' rights to clear information, meaningful participation in the process and a supportive service; sensitivity to issues of race and culture; the need for the effective

management, supervision, consultation and training of social workers; and the importance of a well-managed, co-operative multi-disciplinary commitment to a level of protection that is neither negligent nor over-intrusive — are also identifiable, with varying emphases, in other contemporaneous guidance relating to child protection (DHSS/Welsh Office, 1988). Indeed they were themes later to become embodied in legislation, namely the Children Act 1989 and related guidance thereto.

THE CHANGING BACKDROP

Production and dissemination of the Orange Book guidance (DoH, 1988) was set against the backdrop of a changing legislative context. This is noteworthy, not least because it demonstrates how, official guidance notwithstanding, managers and practitioners are also required to interpret and be responsive to the ebb and flow of politics and policies. A review of the child care law was under way (DHSS, 1985a), heralding first a White Paper (DHSS *et al.*, 1987) and ultimately the ground-breaking 1989 Children Act, described as:

> *the most comprehensive piece of legislation which Parliament has ever enacted about children ... a new balance between family autonomy and the protection of children.* (DoH, 1989, piii)

In an article analysing the advent of the 1989 Children Act, Packman & Jordan (1991) describe it thus:

> *One of its striking features is the way it grapples with the many difficult and conflicting issues which [the Cleveland] report — and all the other soul-searching reviews of the 1980s — had highlighted. The simplified and more rational legal framework that it introduced is unified by some powerful principles that speak to those issues. In the process, some old, well-established concepts, are radically reframed. As many commentators have observed, a change in attitude is a large part of what the Act is about.* (Packman & Jordan, 1991, emphasis in original)

On the face of it, this change of attitude was signalled by the fact that, alongside the duty laid upon local authorities to continue taking the lead role in the protection of children, the Act also recognised that some children — termed 'children in need' — require additional support if they are to achieve/maintain a reasonable standard of health and development. Thus, it also laid upon local authorities the duty to identify and provide support for such children and their families. In this way the Act embodies the idea that child protection and family support are essentially two sides of the same coin, both requiring similar attitudes, approaches and skills (Packman & Jordan, 1991).

Realistically, however, such shifts in thinking take time to percolate down, to permeate systems and mind-sets. By all accounts, the change of attitude and consequent shift in focus heralded by the Act is not, as yet, firmly in evidence. For, as the most recent child care research dissemination exercise (DoH, 1995) notes:

> *the research studies suggest that too much of the work undertaken comes under the banner of child protection.* (DoH, 1995 p54)

PROFESSIONAL JUDGEMENT

Throughout the Act and related guidance the impression gained is that good assessments are, not unreasonably, something of a *sine qua non* in the whole process — although, as we have just seen, what constitutes 'good' is relative to the moving goal-posts of context and many influences are brought to bear in the drawing of the intervention 'threshold' (DoH, 1995). In relation to how the law should be carried out, the Act and, more particularly, later related guidance (DoH, 1989; DoH, 1990; Home Office *et al.*, 1991) is stronger on guiding principles than practice guidance as such. Clear principles (forty-two of which are itemised in detail in DoH,1990 pp7-15) alongside the legal framework are seen as essential foundations to a good child care service, the key to good practice. There is, however,

acknowledgement that *"the application of principles can only be as good as the practice skills and practical resources which are available and used"* (DoH, 1990 p17). Here, then, we come to an important nub with regard to effective work in the child care arena — alongside workable systems and procedures, adequate services and resources together with sound judgements and practice decisions on the part of practitioners are vital to the process.

Without fail, all the various documents of guidance refer to the need, not only for reliable and agreed procedures, but also for considerable skills, knowledge and judgement, backed up by relevant training and supervision:

> *The ingredients of the assessment remain fundamentally the same; properly documented information from a range of sources including a full social history at an early stage; specialist advice where appropriate; and professional judgement supported by training and supervision.* (SSI, 1989, p24)

The findings of the most recent publicly-funded child care research are synthesised in the publication *Child Protection: Messages from Research* (DoH, 1995). Importantly, it is acknowledged therein that, alongside the influence of moral/legal questions, it is the pragmatic concerns of professionals that are of crucial influence on the assessment process:

> *Professionals, in addition to observing procedural rules, also make a number of pragmatic judgements related to whether interventions will help. Such assessments should consider the whole situation and the interventions applied will take account of potential behaviours and responses in their wider context. Ideally, professionals should assess the severity and duration of the suspected abuse; they consider the child's reaction and his or her perceptions; they look at the parents' attitude and willingness to co-operate; and they sometimes think about the effects upon the child's development. Ideally, they look for any protective factors for the child, something that will make his or her life more viable.*

> *Professionals also have to weigh up the effects of the intervention on the child's long-term well-being.* (DoH, 1995 p16)

QUESTIONS OF PRACTICE REMAIN

In the light of the 1989 Children Act, the antecedents which informed it and the guidance that supports it, we are undoubtedly becoming clearer about the overall task to be undertaken in the area of child care, the principles that underpin that task and the varying weights of the disparate influences upon it. The yawning gap which remains, for assessment as well as for social work decision-making more generally, concerns the honing of both the knowledge (in all its complexity) and the skills (interpersonal, information-gathering, analytical and recording) that are necessary, not only to carry out the task effectively, but also to be seen to do so.

These vital questions of practice have continued to be highlighted by research and inspection. *Patterns and Outcomes in Child Placement* (DoH, 1991), forerunner to the most recent research dissemination publication already mentioned (DoH, 1995), similarly summarised child care research. The report concluded that a theme of 'profound' importance that recurs is the question of the evidential basis for assessment and decision-making:

> *The whole child care service, from strategic planning to monitoring of individual outcomes, is permeated by questions of evidence. Gathering, testing, recording and weighing evidence are tasks basic to professional competence, but are seldom addressed in these terms.* (DoH, 1991 p77)

What followed was a plea to practitioners to, in some senses, honour their social scientific roots and to develop their research skills to support them in their task (see also Everitt *et al.*, 1992; Sheppard, 1995). The authors noted the many parallels between the disciplines of research and social work. However, they considered that

where they were most likely to part company was around the treatment of evidence (or *'facts which lead to conclusions'*):

> *Researchers are constantly challenging themselves and each other to get accurate complete data, to avoid bias, assumptions and the drawing of unwarranted conclusions. A social worker's role as service provider and/or therapist has inevitably meant that more emphasis has been given to empathy, negotiation and building relationships and less to objectivity and a rigorous search for reliable evidence.* (DoH, 1991 p78)

It was acknowledged that, while parallels might be drawn with research, social work is undoubtedly a more complex task requiring a greater range of skills, and one that is often, of necessity, carried out under considerable pressure. The authors concluded, however, that dealing with evidence in a disciplined, transparent way was crucial to the betterment of professional standards and that the requisite skills undeniably needed further development.

Since then, concerns about the extent to which assessments are solidly based have not abated. In the most recent overview of significant child care research (DoH, 1995), it is noted that vitally important dimensions are sometimes missing from assessments:

> *The researchers also concluded that <u>outcome</u> evidence and <u>parent/child</u> concerns should play a greater role in professional decisions about what is and what is not abusive.* (DoH, 1995 p17, emphasis in original)

The most recent national inspection of eight social services departments' family support services (SSI, 1996) found that social workers' assessments lacked clarity, consistency and evidence of any systematic approach. With regard to the issue of transparency and the matter of recording, the inspectors note:

> *The majority of social workers interviewed claimed to have assessed their cases, although the assessment was not recorded on the case file. ... In*

the view of inspectors an assessment has not been undertaken if it does not result in a written report (SSI, 1996 p19/20)

BUREAUCRATISATION AS CONTEXT

Why, then, should it be that such crucial professional skills remain lacking despite the messages of research? Without doubt it is a changing world for social workers. Various commentators have noted the developing agenda for social work in the period since the early 1970s (Cooper, 1989; Hardiker *et al.*, 1991; Packman & Jordan, 1991; Howe, 1992; Lloyd & Taylor 1995). Packman & Jordan (1991) chart the move away from the relatively consensual post-war period, when the implicit basis of child care practice was that there were no fundamental conflicts of interest either between parents and children or between families and the state, towards the growing awareness in the late 1970s and 1980s of the need for social workers, on behalf of the state, to be more effective in their role, not only with regard to the protection of children, but also in their interventions more generally within families where conflicts of individual interest were no longer being ignored. Additionally, these later developments were taking place at a time which saw the introduction both of significant resource constraints and of consumer principles into the provision of social welfare. It seems clear, then, that the social work task and its context is changing; indeed, more accurately, is subject to continual change.

Howe (1992) brings us closer to the heart of the issue as it relates to assessment in an article entitled *'Child abuse and the bureaucratisation of social work'*. Howe notes that social work has become increasingly bureaucratised. He sees as key factors in that process our current understandings of, and responses to, child abuse and maintains that complex and comprehensive solutions to child abuse, such as we now have, favour bureaucratic forms of organisation. The bureaucratisation of social work,

then, has been an unintended consequence of these not necessarily predictable occurrences.

In Howe's analysis, the outlook on child abuse work became transformed in the wake of the scandals of the 1970s and early 1980s, from a stance which sought to restore families to competent functioning to one which aimed to protect children from violence. The professional and therapeutic credentials of social workers ceased to be in the ascendancy since good practice was no longer to do with treatment and rehabilitation. Instead, notions of investigation and monitoring of families came to the fore. With the 'translation' of the problem came a different sort of solution, central to which was the belief that the protection of children from violence would be achieved by improving, standardising and prescribing full and proper methods of investigation and assessment. Thus:

> *Social workers would have to become investigators and not family caseworkers. Managers would have to become designers of surveillance systems and not casework consultants. Parents would have to become objects of inquiry whose behaviour could be predicted and not people whose skills could be improved. The shift is from therapy and welfare to surveillance and control.* (Howe, 1992)

As part of this process the role of the social worker has been transformed in ways that might help us understand why researchers so often find missing the careful testing, weighing, analysing and professional judging of the varying facets of cases:

> *Her role has become that of investigator, reporter and 'gatherer of evidence'. The analysis of the information is no longer left to the discretion of the practitioner. Other actors, including managers, case conference members, and the formulae that indicate the level of dangerousness help assess the information and reach decisions. Throughout these moves and reformulations, the social worker loses much of her professional freedom. Increasingly, the part she is expected to play has been written by those*

who have established their right to determine the solution. (Howe, 1992, emphasis added)

THE BALANCE BETWEEN MANAGERIAL SYSTEMS/GUIDANCE AND PRACTITIONER JUDGEMENTS

An additional factor might be that, as Howe (1992) notes, the bureaucratic response to the problem of child abuse included the notion that families where children were at risk displayed certain characteristics and behaviours indicative of such risk. The theory was advanced that, if such indicators were detected, welfare agencies could better alert themselves to children at risk of dangerousness and, therefore, be in a position to protect them more effectively. There is, however, great debate over the validity and reliability of predictive factors in defining children prone to abuse (Waterhouse & Carnie, 1992) and it is increasingly recognised that checklists by themselves are inadequate, since no such essentially managerial system can accurately identify individual children at risk (Alazewski & Manthorpe, 1991) (see also Dingwall, 1989; Parton & Parton, 1989).

We are brought back to the view that what is needed are *"good professional judgements which draw upon the findings from thoughtful and sophisticated research"* (Parton & Parton, 1989, quoted in Alazewski & Manthorpe, 1991). The change in agenda during the late 1970s and 1980s was from supporting the family unit to a large extent 'warts and all' to, more specifically, the protection of children from violence. It seems likely that social work as a profession may have been unhelpfully side-tracked into placing too heavy a reliance on predictive instruments and checklists concerning dangerousness, losing sight of the crucial importance in the assessment process of its unique professional knowledge and skills. Most recently, of course, we have seen the call for a rebalancing of the pendulum to include more emphasis on family support and less on child protection (DoH, 1995). Once again, then, the onus

will be firmly on lead professionals to produce the often fine judgements that will be essential if the required balance is to be achieved without undue risk to children.

The central requirement for professional judgement is underlined by a further theme identified in the research literature, that of the lack of any clear-cut guidance for practitioners about where the line needs to be drawn between what is acceptable and what is not in terms of child care standards. Thus, Hill *et al.* (1992) make the point:

> *Social science and clinical knowledge provides much guidance about aspects of parenting which may be harmful for children and associated causal factors, but less about how and where to draw the line between what is acceptable and unacceptable.* (Hill *et al.*, 1992)

It is not unusual for social workers to be working in the context of unclear definitions. For example, Gibbons *et al.* (1995) found marked national variation in relation to the criteria social services departments used to decide whether child protection procedures were warranted and in the actual headings under which children were registered. Colton *et al.* (1995) found that seven out of the eight social services departments they examined did not define the phrases 'reasonable standard of health and development' and 'significantly impaired' even though they were incorporated into statements of child care policy. In such circumstances, social workers will, perforce, be thrown back on their professional and, indeed, often highly individual judgements (Dingwall *et al.*, 1983; Fox & Dingwall, 1985).

Waterhouse & Carnie (1992) note the same issue, considering moreover that such lack of clear guidance is likely to be counterproductive:

> *Social workers need a defined moral and social context in which to fit their professional opinions. This in turn might enable social workers to focus on the probability and severity of adverse effects without also having to assume responsibility for deciding what is acceptable behaviour between children and their parents or care givers.* (Waterhouse & Carnie, 1992)

Indeed, Cleaver & Freeman (1995), examining the process of child abuse investigations, found that, in the absence of any sensitively drawn procedural guideline, professional anxiety ensured an arguably unnecessarily low threshold in terms of child protection action.

RISK AS AN ASPECT OF ASSESSMENT

Debates about what is and is not acceptable in terms of child care bring us firmly into the realm of risk assessment, an aspect of assessment which has gained prominence since the early 1980s (Lloyd & Taylor, 1995). Waterhouse & Carnie (1992), in interviews with some 50 social workers responsible for child protection investigations, found that, from an early stage, it was apparent to them that *"social workers defined their main investigatory purpose in cases of child sexual abuse as the determination of child care risk"*. The criteria identified from the interviews were used, in practice, like a set of building blocks, with tall towers representing higher risk and low towers lesser risk.

What was not clear to the researchers is whether variation in risk-taking is linked to a differential ability to assess risk (i.e. as distinct from differing subjective assessments of risk situations). They conclude that, in any case, given the enormous stakes involved with regard to issues of child safety and protection, social workers were under considerable pressure to err on the side of cautious (defensive?) practice.

What constitutes an acceptable risk in the context of social work must ultimately be a matter of professional judgement (Brearley, 1982). Waterhouse & Carnie (1992) make the point, however, that since the Cleveland Inquiry (Butler-Sloss, 1988) social workers are no longer certain of what constitutes a publicly acceptable decision, since poorly-judged removal may be viewed as an error of judgement as serious as failure to remove in cases with tragic outcomes. They note:

> *Child protection decisions are not just about predicting outcomes, which is difficult enough, but about adjudging the social, personal, and economic costs of those potential outcomes and their likelihood.* (Waterhouse & Carnie, 1992)

The pressures on professionals involved in making risk assessments are also noted by others. In an article outlining a framework for the assessment of risk in child abuse work, Hendry & Lewis (1990) comment on the difficulty for social workers in resisting pressure from others, arguing that a systematic approach to risk assessment, where the worker's own perspective is firmly included (after Brearley 1982), provides a way of drawing out differences in values, knowledge and perceptions and thus a more effective basis for sharing decision-making with others.

Clearly this is a difficult realm for professionals since, by their nature, the decisions involve risk and outcomes are not guaranteed. Despite good intentions, the process itself may become disabling and self-defeating. Thus, Farmer & Owen (1995) found that such was the preoccupation with risk assessment in the 120 case conferences they studied that little time was allotted in the process for considering the needs of families and for planning the protective and/or other work that was to come after.

ARTICULACY AND ANALYTICAL SKILLS

A further theme which emerges from the literature concerns practitioners' lack of articulacy about their work. It is commented on by SSI inspectors specifically with regard to assessment work (SSI, 1996). A number of commentators make observations in this realm. In an article focusing on the initial investigation of alleged child abuse, Barmby (1991) referring to Jones (1990) gives an example of a social worker who:

> *under prompting ... found it difficult to give reasons for her assessment, but indicated, in particular, the importance of experience, intuition, further*

> *information that tended to confirm the initial assessment ..., the response and trust placed in her by colleagues and her own feelings about how a child would identify a safe person in whom to confide.* (Barmby, 1991)

The author goes on to observe that feelings and intuition alone are insufficient as a basis for making a critical assessment; experience and empirical and theoretical knowledge are also needed for an integrated whole. It is not particularly clear whether the difficulty social workers may experience in talking about their work stems from lack of articulacy or whether the issue is more to do with lack of analysis or appropriate information-gathering or, even, some combination of all three. So, for example, Clegg (1992/93) in a study focusing on the usage of 1980 Child Care Act Section 1 money found:

> *Although some social workers developed phrases such as 'to diminish the risk of care' to justify payments, the lack of accompanying analysis suggest these represent a further gloss on superficial questioning. This was confirmed by clients who almost all said they had been questioned only on issues of immediate need.* (Clegg, 1992/93)

Mandel *et al.* (1994), in a Canadian study looking at the decision-making skills of 272 child abuse and neglect (CAN) investigators and undergraduates, found that the fewer unwarranted assumptions CAN practitioners made, and the more they generated hypotheses and requested additional information, the more likely they were to disagree with the premature (since the case was indeterminate) decision taken in the vignette they were asked to comment upon whereby the child was removed from home. Interestingly, their findings suggested no evidence that qualified CAN practitioners made better investigative decisions than undergraduates. Professional experience in the area of child abuse and neglect, then, did not mitigate the tendency to accept prematurely an intrusive form of intervention. The authors' conclusions

include reference to needing to find out more about practitioners' analytical skills and thinking structures:

> *Our findings suggest that future research geared towards examining the structure, in addition to the content, of decision makers' reasoning in the area of child abuse and neglect case management would be valuable.* (Mandel *et al.*, 1994)

Hill *et al.* (1992) in the study mentioned earlier focusing on freeing for adoption, echoing earlier studies (Dingwall & Ekelaar, 1979; Hilgendorf, 1981), perceived a tendency for social workers in such cases to be over-optimistic about the extent of their objectivity. This view was not shared by Judges presiding over court proceedings who viewed them as interested parties in disputed cases. The authors went on to suggest that social workers did not help their own credibility by making assumptions about the knowledge available to others outside the profession, thereby failing to articulate clearly enough the underlying thinking for their decisions and recommendations:

> *It seemed to us that social work staff were at times insufficiently aware of the need to spell out their own assumptions about permanency planning and to justify why adoption was the plan, rather than permanent fostering. There was a tendency simply to seek to demonstrate that parents had failed to provide satisfactory care and then presume that adoption was the only possibility.* (Hill *et al.*, 1992)

Again, whether such lack of articulacy is based upon lack of analysis remains unclear. A critique by Clifford (1992/93), however, appears to put sloppy analytical skills in the frame. Clifford is concerned to show how anti-oppressive values need to be better put into practice in the area of assessment (see also Lloyd & Taylor, 1995). He first points out how easy it is to fall into the trap of proceeding on the basis of unexamined assumptions by positing that, certainly with regard to anti-oppressive issues, this indeed is what we are invited to do by official guidance:

> *... it is precisely because the official guidelines for assessment do not attempt to seriously consider an anti-oppressive methodology that in practice it results in a concentration on the social psychology of individual children and their families in relative isolation from the social divisions factors that would not only inform the background of the assessment but re-organise and re-evaluate the foreground.* (Clifford, 1992/93)

The author goes on to dismantle a published assessment of a black child (in Adcock *et al.*, 1988) and to re-analyse it as far as possible using an anti-oppressive methodology which, by its very nature, invites the practitioner to tease out and examine what may be unwarranted assumptions. As might be expected, it is a determinedly lengthy process (which may tell us something about the conscious or otherwise choices social workers make in the course of their work). A fairly lengthy extract will serve to give a fair illustration of his point:

> *It is reported (p33) by the school that Clifford is 'a rather isolated and independent little boy who had difficulty in making friends, often having fights'. It should surely be asked whether this is the result of racism in the playground and the school. Equally, the fact that he tells his white male social worker that he has 'lots of friends at school' could also be surely considered as a defensive manoeuvre by a black child trying to impress a white authority figure. I am not suggesting that this is the only possible interpretation, but I am saying that in order to assess this child properly the social divisions issues have to be systematically considered, otherwise the value of the whole assessment is undermined. In order to consider the emotional and social functioning of this child the social divisions issues also have to be given prominence if a balanced assessment of the factors involved is to be possible.* (Clifford, 1992/93)

That the appropriate unit for assessment is the entire social situation which presents itself, rather than a particular individual within it (Smale *et al.*, 1993), is another way of understanding what Clifford (1992/93) is seeking to achieve. However, he raises an important point, alluded to also by others (for example, Hendry & Lewis, 1990;

Barmby, 1991; Hill *et al.*, 1992), querying the extent to which any assessing social worker can be truly neutral and objective — indeed, anything other than a subjective product of their own cultural background. This being so, such subjectivity needs to be owned and given due attention within the process. Thus, taking his lead from analyses within the black feminist tradition (Williams, 1989; Collins, 1990), Clifford (1992/93) contends:

> *The personal biography and values of the [enquirer] is thus as important as that of the person observed, and the dialogue which must occur for knowledge to increase is not an interference to social understanding, but an essential part of it. ... What social divisions does the observer belong to, and what institutional and personal power does that confer on him or her with respect to the observed client? The differences in perspective and power have to be taken into account: understanding and action must develop dialogically.* (Clifford, 1992/93)

ADDRESSING THE INHERENT DIMENSION OF POWER

Clearly, when we begin to address such issues we are brought face to face with the power dimensions arguably inherent in the worker/client relationship and certainly acknowledged in the literature (Barmby, 1991; Rhodes, 1991; Waterhouse & Carnie, 1992; DoH, 1995). The power dimension is, of course, by no means played out only around ethnic and cultural difference, but in the research literature it is perhaps in this area that it comes most sharply into relief (Rhodes, 1991; Clifford, 1992/93). That said, in his anti-oppressive methodology, Clifford (1992/93) proposes, wherever possible, the systematic consideration of the whole range of social divisions during the assessment process.

Others note the need to be alert to the potential for imbalances in power and status in relation to specific areas of work — for example, particularly given a child protection agenda, between women social workers and female clients (Waterhouse & Carnie,

1992), the 'adultism' that may occur where children are involved in child protection decision-making (Barford & Wattam, 1991) and in relation to assessment of adolescents with learning difficulties (Day, 1994).

In short, the power dimension will be present in any assessment encounter and needs to be fully accounted for:

> *Power must be seen as a critical dynamic in assessment, in its professional, agency, organizational and personal manifestations.* (Lloyd & Taylor, 1995)

It is a dimension that demands to be worked with actively and creatively. However, the most recent child care research overview (DoH, 1995) suggests that, in the context of child protection enquiries at least, achieving the appropriately changing balance with parents is often a challenge for the practitioners and managers involved:

> *as cases progressed, an inquisitorial stance was less than useful ... professionals tended to hold on to their authority long after absolute control served any purpose.* (DoH, 1995, p47)

Smale *et al.* (1993) present a model of assessment (the 'exchange' model) that seeks both to confront and to redress the issue of power. The authors' detailed practice guidance, commissioned by the Department of Health, both reflects and aims to develop current legislative and professional themes, in particular the notions of partnership with, and the empowerment of, service-users, carers and communities. Three different models of assessment — the questioning, procedural and exchange models — are discussed. In particular they examine how each of the models fosters or hinders empowerment of those involved in the assessment process, advancing the exchange model as the optimum model for the achievement of empowerment. Further, they delineate the skills required by workers if they are successfully to

engage with people in jointly assessing situations and to discover, through a process of negotiation, who is able to do what for whom.

The authors highlight the enduring complexity of the assessment process, particularly if the process seeks to be truly co-operative and empowering. Eschewing what might be seen as the helpful but essentially 'wrong-headed' provision of *"a simple, easy approach to assessment and care management with clear guidelines"* (Smale *et al.*, 1993 p73), they instead emphasise the dual importance for the assessment process of professionals internalising the basic principles underlying the processes of empowerment as well as of acquiring the skills supportive of those principles. For, as they say:

> ... *the task is not simple. Assessments will often be made at crucial stages in people's lives when they are confronted with the major issues of living, dying and relating to others. To engage fully with people at such times, professionals have to be able to join with them and struggle with complexity. They will have to be able to act with skill and sensitivity if they are to introduce resources to increase people's choices without taking away some of the control that people have over their lives.* (Smale *et al.*, 1993 p73)

Undoubtedly, however, there will be times and situations, arguably encountered more clearly but not necessarily more often in the field of child care, where social control and the minimisation of risk may be of overriding concern. Barmby (1991) suggests the adoption by social workers of an essentially sceptical, 'investigative' stance at such times. Smale *et al.* (1993), while considering that the spirit of their preferred exchange model will always be appropriate to assessment, nevertheless concede that in such situations a different overall approach (such as the questioning model they detail) may be the preferred alternative. As noted above, however, the ability on the part of practitioners to vary their approach, to 'change gear' and be responsive to changing circumstances, is vitally important.

Commendable notions such as empowerment and partnership notwithstanding, Day (1994) speculates as to how meaningful the concept of choice can be for those likely to be thoroughly familiar with the experience of powerlessness:

> *The ambiguous notion that young people [with learning difficulties] could and should be able to make choices about their future is particular striking. The apparent offering of choice to someone without the experience or information to make the choice placed the young people and their social workers in a confusing position.* (Day, 1994)

The extent to which choice/autonomy in the assessment process is fanciful is alluded to not only by Day (1994) but also by Rhodes (1991) in her study of the assessment of black foster parents in a London borough moving towards the adoption of a policy of 'same race' placement. (While there are significant differences in assessments of this type, the study is included because of the obvious similarities with the type of assessments under consideration.) Both authors refer to the all too frequent expectation of client passivity, noting that assessment is often experienced as a one-way process:

> *The client-worker encounter was not an encounter between equals but between lay and professional, assessed and assessor, in which the balance of power was tipped in favour of the latter ...* (Rhodes, 1991)

Rhodes' study portrays the assessment of potential black foster parents as largely a one-sided process in which: *"Social workers thought of applicants as the passive objects of the assessment process rather than active participants in an interactive process"* (Rhodes, 1991). Interestingly however, when it comes to examination of the relevance of the social workers' cross-cultural competence, the study highlights the influence of applicants on the process since, in contradiction of the overall power imbalance, it appears they shifted the agenda in a quite fundamental way:

> *... in contradiction of social workers' expectations, applicants were reluctant to mobilise their ethnicity in the assessment encounter and refused to accept a simplistic cultural diagnosis of their situation.* (Rhodes, 1991)

Importantly, then, Rhodes' study points up and reinforces the complexities which surround questions of ethnicity (see also Clifford, 1992/93, but c.f. Barmby, 1991) and highlights how such complexities, of necessity, permeate the assessment process, demanding to be grappled with in any thoroughgoing analysis. In particular, we are reminded that in any consideration of the ramifications of ethnicity and culture, issues of power and the experience of oppression should not be overlooked. For applicants in Rhodes' study a simplistic ethnicity/culture-based understanding of their situation, aided by appropriate intercultural skills on the part of the practitioner, proved far from adequate since applicants' own analyses were considerably more complex and included:

> *an interpretation of their problems in economic or class rather than purely 'cultural' terms; a suspicion that differential treatment meant inferior treatment in practice; fear of being relegated to a marginalised service hived from mainstream provision; fear of eliciting a 'white' backlash, and a reluctance to assert a distinctive cultural identity for fear of being labelled 'a problem'.* (Rhodes, 1991)

Applicants' own mistrust of the simplistic cultural diagnosis of their situation, to which assessing social workers sought to give priority, thus helped to shift the frame of reference on to a more general plane — more fundamentally challenging to social workers — concerning the validity of seeking to professionalise family assessment. Significantly, the study highlighted that:

> *Common 'culture' and ethnic affinity were not the only dimensions relevant to the assessment encounter and, for many applicants, were overshadowed by disparities of professional status and social class. The field of contention was not so much the cultural knowledge of different*

ethnic groups as lay versus professional knowledge and experience. (Rhodes, 1991)

In considering the dimension of power within the assessment context, we are thus, once again, brought firmly into the arena of knowledge. In particular, we are brought face to face with the question of whose knowledge/what knowledge is accorded power, privilege and validity within the assessment process. At which suitable point we turn to an examination of what clients have to say about the social work assessment process.

CLIENT PERSPECTIVES

LIMITS OF THE REVIEW

It is generally accepted today that clients' perspectives will be sought in relation to aspects of social work and social service. Gardner (1989) suggests that the main arguments for eliciting users' and potential users' views on the services they receive centre on a combination of moral rights, legal obligations and practical advantages. Acknowledging, then, that there is a broader general thrust towards the systematic seeking out of clients' views, the literature considered here focuses on the perspectives of clients as gleaned via the activity of research. The history, development and particular challenges of the area termed 'client studies' (see, for example, Phillips, 1983; Fisher *et al.*, 1984; Lishman, 1984; Sainsbury, 1987; Sheppard, 1991/2) are not covered here. Instead, the focus is more specifically on what the literature offers from the perspective of clients in relation to social work assessment and intervention, with particular reference to child care and mental health.

PARENTAL MENTAL ILL-HEALTH AS AN ASPECT OF ASSESSMENT AND INTERVENTION

No studies have been identified reporting the perspectives of clients in relation to the particular task of social work assessment in families where parental mental ill-health is specifically at issue. Some light is shed on the area, however, by the previously cited work of Isaac *et al.* (1986). In a study comparing the parental psychiatric history of 31 families with children in care for at least twelve months with 26 families with children in care for up to three months, it was found on interview that parents considered their mental disorder an important factor in over one-third of all admissions of their children to care. Social workers interviewed took a similar view of the importance of parental mental disorder. When the views of parents and social workers were combined, parental mental disorder was seen as an important reason for admission in 42% of long-term and 31% of short-term cases. The researchers considered their most striking finding to be the high rate of psychiatric disorder in the total sample of parents and concluded that it appeared to be an important factor influencing children's admissions into, and discharge from, care.

With regard to social work intervention generally in families where mental health and child care overlap, a search of the literature again reveals relatively little about this specific area of overlap from the perspective of clients. One study identified, however, concentrates entirely on the service users' perspective (Hugman & Phillips, 1992/93). The authors conducted a small-scale in-depth qualitative study exploring the perceptions of social work responses to parents with mental health needs. All those interviewed (24 mental health service users) had experience of mental health problems and of being parents and all had used professional services, including social work, at some stage in their adult lives. Since this area of overlap is so little directly researched it is worth going over the parents' responses in some detail.

Although all the respondents felt that at some time and in some way their mental health problems had a negative effect on their relationships with their children, not all had sought professional help with parenting problems. Strategies for managing such difficulties included relying on family and friends for support and on the coping capacities of the children themselves. Professional help was more likely to be sought when such informal structures ceased to work. Such professional help was sometimes viewed as positive, albeit not without its painful aspects, but was as likely to be seen as intrusive in character and therefore unwelcome except by way of last resort.

The response of professionals was seen as a crucial factor in the experience of parents seeking help outside the family. A major concern for the parents was the extent to which all professionals (social work, however, being the major professional group responding to parents with mental health needs) chose to focus on symptoms and effects of mental health difficulties in their work. While understanding the need for this, parents considered that the breadth of focus needed to be wider as a matter of course, for example to include exploration of housing and financial problems. Where parents did receive the practical help important to them it was welcomed, despite the emphasis on pathology. Where the focus on mental health coincided with the parents' own wish to focus on that aspect of their lives it was unproblematic. For other parents the explicit focus on pathology proved an unhelpful and negative experience, either because it undermined their own attempts to keep focused on strengths rather than deficits or because of the implications such a stance might have with regard to any evaluation of child-care quality/risk:

> *Concern about possible risk to children arising from mental health needs became the pivot of intervention and underlined the extent of parents' problems and weaknesses.* (Hugman & Phillips, 1992/93)

The unambiguous affirming by social workers of parents' strengths was relatively rare (3 of 24 instances). A lack of trust in, or even recognition of, parenting strengths was

more common (one-third of cases), with parents viewing social workers as emphasising weaknesses in parenting and undervaluing strengths. Thus, concern on the part of social workers was more likely to be expressed as:

> *'are your children at risk from your parenting because you have mental health needs?' rather than 'are you having any problems in parenting arising from your mental health needs?'* (Hugman & Phillips, 1992/93)

The main point made by all the mental health service users in this study was that help with mental health needs *per se* is generally patchy, but, where children are involved, it arrives *"thick and fast"*. A significant minority (8 of 24) expressed a stronger view in this respect, considering that the sheer centrality of child protection was the issue which most defined unhelpful professional responses given its corollary of eclipsing the mental health needs of the parent. As the authors put it:

> *When you are experiencing mental health difficulties, to have your problems recognised only in terms of their impact on someone else, even if that person is your child about whom you care very much, can come as a denial of your own needs. That such a denial carries with it the implication that your needs are perceived as deficiencies or threats appears to exacerbate the situation and lead to feelings of hostility towards the professionals involved, at least in some cases.* (Hugman & Phillips, 1992/93)

It is salutary to note that only a few interviewees (3 of 24) regarded social work help in this area as having any positive features at all.

We see here, then, from the clients' perspective, the principle of paramountcy in action, with parents noting a marked and unhelpful skew in professional responses where the areas of child care and mental health overlap.

Skewing of the social work response, towards issues of child care and away from the mental health needs of the parent, is in evidence elsewhere. The picture, however, is not entirely straightforward since parents are not always dissatisfied with such an approach, although it may be less than satisfactory when viewed in terms of social work effectiveness. Without doubt, the best known study in the still relatively little researched area of mental health social work (Sheppard, 1991/2), and one in which clients' and social workers' perspectives are explored side by side, is that of Fisher *et al.* (1984). Data based on a total of 384 mental health cases from three area social work teams was collected over a one year period. Methodology included monitoring of referral and review case forms, a sub-sample (40) of interviews with clients and social workers (all long-term cases), together with informal observation arising from day-to-day contacts in the field.

Of the 40 long-term mental health social work cases investigated in detail, 11 were categorised as 'supervising children in families under stress'. In such families, social work intervention that actively took account of the stresses and strains apparent in the client's everyday circumstances was greatly welcomed by parents:

> *[the children's] care and control were willingly shared with outsiders who were prepared to become involved and who seemed sympathetic. Several clients pointed to the crucial fact of having an outsider to rely on; they had become accustomed to the emotional support of a social worker, much as they would in other circumstances have relied on a friend.* (Fisher *et al.*, 1984, p112)

As might be expected, however, the social workers saw their role significantly differently from that of, in effect, 'friend' since, by their nature, friendships tend not to be purposeful and time-limited. From the social workers' point of view, while they emphasised the emotional distress of the mother as a crucial factor in the case, rather than working with that aspect directly the social work task was principally seen as

supervising the children with the aim of ensuring their proper care and development. Thus, the authors comment:

> *Despite their awareness of the mental stress experienced by the mothers in these families, social workers rarely considered the problems of the mother as a possible focus for intervention.* (Fisher *et al.*, 1984, p133)

Through the medium of such 'protective supervision', the majority of children in these cases (6 of the 11) made some improvement but the social workers were more pessimistic about outcome for the mothers. In 8 of the 11 cases not only was no improvement noted but the social workers were beginning to feel there was no hope:

> *A sense of powerlessness resulted and, whether good or bad relationships existed, social workers gave the impression of weariness in dealing with these clients.* (Fisher *et al.*, 1984, p135)

Based on the study as a whole, Fisher and his colleagues observed of mental health social work practice that overall competence in assessment was not matched by subsequent interventions that were purposeful, constructively goal-oriented and therapeutic in inclination. In particular they noted that social work intervention was not directly concerned with the alleviation of clients' mental health problems. Instead, effort was directed at ameliorating associated environmental stresses — focusing, for example, on practical help, advice-giving or the improvement of strained relationships (including those between parents and young children). The authors noted that this approach was far from without value; indeed, recognition of these difficulties and such 'compensatory' help was appreciated by clients. Such ameliorative work, however, frequently had an aimless and arbitrary quality, not particularly satisfying and often frustrating for social workers and viewed by clients as a variable, hopefully friendly, long-term support to their overall circumstances. The authors went on to suggest that social work intervention of this nature alone generally fails to contribute to the resolution of underlying problems or to prevent the recurrence of social difficulties.

Thus, given the focus (for a variety of reasons, including the social workers' own perceived lack of therapeutic skills) on the provision of practical help, social workers overlooked their potential contribution in helping clients to deal with the sources of stress in their lives or to alter their responses to it.

THE IMPACT OF SOCIAL WORK INVOLVEMENT

The Hugman & Phillips (1992/93) study of mental health service users' perspectives reminds us of the impact involvement with social workers can have on the lives of clients, especially when risk to children becomes the focus of intervention to the exclusion of other salient aspects of the situation.

A number of recent studies (summarised in DoH, 1995) in which clients' perspectives have been given prominence have noted the profound sense of shock, confusion and stress experienced by families caught up in child protection investigations, however they turn out (Cleaver & Freeman, 1995; Farmer & Owen, 1995; Sharland *et al.*, 1995). In circumstances where child protection is given priority, then, it seems that social work assessment is likely to be a stressful and ultimately unrewarding experience for many families. In a study of child protection practice involving observation of 120 case conferences and follow-up interviews with clients and social workers, Farmer & Owen (1995) concluded that too narrow a focus on child protection alone frequently obscured other important facets of the situation such as the severity of parental disadvantage. In some ways, therefore, this much larger study echoes the experience of Hugman & Phillips' (1992/93) mentally ill parents.

THE DIMENSION OF POWER

It would be surprising if the dimension of power were not in evidence in any consideration of the social work process from the clients' perspective. Indeed, implicit

in much of the foregoing is the fact that social workers, by virtue of their professional role, are in a position to wield power over the lives of their clients. Arguably especially for those unused to this unsettling fact, being involved with social services may well be unnerving, as Cleaver & Freeman (1995) found:

> ... *it was clear the impact of suspicion tended to be worst among parents who had been unaware of the gathering disquiet and had no previous dealings with social services.* (DoH, 1995 p59 summarising Cleaver & Freeman, 1995)

In their study Cleaver & Freeman (1995) aimed to understand the experience of families undergoing child protection investigation. They concluded that, for such an investigation to have a successful outcome, the perspectives of parents and professionals needed to converge. The power relationship between parent and professional was specifically noted as one of a number of influences having a direct bearing on parental attitudes towards and participation in the child protection process.

In considering the dimension of power, it is perhaps most usual to think of the imposition of procedures and services on clients. However, the relative powerlessness of clients is evident also in relation to the withholding of services perceived by clients as necessary or desirable. What might be construed as an almost capricious quality associated with social work contact is noted by Sharland *et al.* (1995) in their study of professional intervention in the area of child sexual abuse:

> ... *although many families had not welcomed the professional intrusion into their lives at first, they had benefited from it and recognised its value; the trouble was that later, when they would have welcomed continuing support with more open arms, none was forthcoming and they felt abandoned.* (DoH, 1995 p80 summarising Sharland *et al.*, 1995)

Undoubtedly, then, the balance of power between client and social worker is a dynamic that needs to be acknowledged and addressed throughout the assessment and intervention process. Also, it is a multi-layered dimension. We have seen, for example, that social workers may experience themselves as relatively powerless within their encounters with clients (Fisher *et al.*, 1984).

The dimension's complex and dynamic nature is apparent in the previously mentioned work of Rhodes (1991) which focused on assessment of black foster parent applicants. Rhodes found that the black would-be foster carers' view of the assessment encounter frequently differed radically from that of the social workers. Unlike the assessing social workers, they were less convinced of the validity of a cultural perspective on their situation. Rather they were much more aware of the power dimension implicit in the encounter, which for many applicants showed itself in various guises — for example: black people being confronted by social workers (white or black) representative of 'white' authority; class antagonisms; social control; lay versus professional knowledge.

Professional (including inter-cultural) knowledge and skills and their importance were further undermined by the value which applicants placed on personality and common sense, irrespective of race or cultural background. Given the low status of social work as a profession and the fact that a large part of the profession's area of competence — the family — is popularly (and to an extent politically) considered off-limits, Rhodes (1991) found that social workers showed themselves vulnerable to this challenge, noting:

> *A transformation process occurred whereby workers entered the assessment arena on the basis of their professional status but sought to persuade applicants of the appropriateness of their presence on the basis of non-professional, experiential credentials.* (Rhodes, 1991)

It is apparent, then, that the 'powerless' were not, in fact, without influence in the assessment process, reinforcing the point that the dimension of power in such encounters is imbued with complexity:

> *Applicants' rejection of the professionalisation of parenthood enabled them to constrain both the behaviour and frame of reference of the professionals.* (Rhodes, 1991)

That said, a preponderance of power is usually likely to remain with the professionals. The challenge for social workers, then, is to use such power wisely and well. As has been mentioned, recent prestigious studies suggest, however, that there is some way to go in this regard. In its overview of prominent child care research, the DoH (1995) comments on the significance of power relationships within the child protection process and concludes that insufficient attention is paid to the formation of constructive power relationships at an early stage in the process, noting in particular that: *"professionals tended to hold on to their authority long after absolute control served any purpose"* (DoH, 1995 p47).

Without doubt, it is the responsibility of social workers to show the way in engaging productively with people in the assessment and intervention process. In relation to the field of child care, it has been noted that: *"The most important condition for success is the quality of the relationship between a child's family and the professionals responsible"* (DoH, 1995 p45). Since assessment is an operation of vital importance in the overall social work process and one which, of necessity, often takes place in stressful and testing circumstances, we turn next to what research says about the qualities clients find effective and helpful in social workers and their interventions.

WHAT CLIENTS LIKE IN SOCIAL WORKERS AND THEIR INTERVENTIONS

It has been noted that a significant gap in the research literature concerns client perceptions of short-term interventions (Fisher *et al.*, 1984; Sainsbury, 1987). One study in the area of mental health which addresses this gap, however, is that undertaken by Sheppard (1991/2). While acknowledging reservations about the concept of satisfaction as a means for evaluating intervention (for example, see Gutek, 1978; Fisher, 1983; Shaw, 1984), Sheppard's study (by way of client interview and worker questionnaire completion) examines factors relating to the satisfaction (that is, their general sense of feeling positive or negative about the work) experienced by 39 consumers of brief intervention (generally one or two face-to-face contacts taking place over less than a week) from community mental health centre workers (social workers and community psychiatric nurses).

As a result of his findings, Sheppard considers that statements of satisfaction and dissatisfaction (particularly a range of measures wherein degree of satisfaction can be noted) can provide a meaningful shorthand for clients' experiences of intervention. In summary, he found the following. The characteristics of a case — that is, the nature of the client's problems — had little bearing on the degree of client satisfaction. There were also no overall noticeable differences related to the nature or amount of work undertaken. What did appear to be significant was the performance of tasks which clients considered necessary. Where such activities were not undertaken, clients were far more likely to be dissatisfied. Also important was the client's definition of the problem, in that satisfied clients displayed a greater degree of concordance with workers in their definition of their problems than dissatisfied clients. In addition, satisfied clients also displayed greater awareness of workers' definitions of their problems and of the work undertaken on their behalf by workers. A perceived lack of openness by workers was significantly associated with dissatisfaction. Lastly, the clients' perceptions of outcome was closely related to satisfaction.

With regard to implications for practice, Sheppard notes in particular that problems of communication (especially lack of mutual definition sharing and a perceived lack of openness by the worker) appear to be at the core of many factors associated with an absence of satisfaction on the part of clients. The extent to which such difficulties are compounded in work of a brief nature is not clear.

Turning to the area of child care, when considering social worker characteristics most valued by clients, similar key themes have emerged consistently from highly regarded studies in the area of child care decision-making and the provision of local authority care (Rowe *et al.*, 1984; Fisher *et al.*, 1986; Millham *et al.*, 1986; Packman *et al.*, 1986). An early DHSS summarising document (DHSS, 1985) which reviewed all these studies and more puts the picture succinctly:

> *All the research projects which included interviews with parents report similar messages from them. What was appreciated most was honesty, naturalness and reliability along with an ability to listen. Clients appreciated being kept informed, having their feelings understood, having the stress of parenthood accepted and getting practical help as well as moral support. The social workers whose assistance was valued had a capacity to help parents retain their role as responsible, authority figures in relation to their children. These workers were actively involved in the processes, negotiations and family dynamics of admission and discharge. When these qualities were present, social work help was highly valued.* (DHSS, 1985 p20)

Subsequent research in the areas of child placement and child protection provide further confirming evidence of what clients value in social workers along the same lines (DoH, 1991; DoH, 1995; SSI, 1996). Clarity of purpose and information and good, two-way communication are themes which crop up time after time from the clients' perspective. Sainsbury (1987) notes we probably now already have adequate information from client studies about this realm at least, although it is arguable that

continuing to collect such data is a useful way of monitoring the extent of skills development within the profession.

PERSPECTIVES AT VARIANCE

Client and social worker perceptions are the fundamentals of assessment in the social work context. Rhodes' (1991) study is but one example of where social workers and their clients hold substantially differing perspectives on a given situation. Fisher *et al.* (1984) gave us another example. The successful marrying, or at least negotiating, of client and social worker perceptions is clearly vital to the task of social work, arguably particularly when assessment is the prominent phase.

That clashes of perspective between social workers and clients occur during the course of their contact has long been apparent from a variety of social work research studies and commentaries thereon (for example, Rowe *et al.*, 1984; DHSS, 1985; Fisher *et al.*, 1986; DoH, 1991; Rhodes, 1991):

> *Often inadequate attention was paid to the history of the clients problems, to issues of discipline and authority within the home, to parents' expectations of the workers' intervention and to establishing a knowledge base common to all participants. Too often, disagreements about the nature of problems and about methods of handling them remained unexplored undercurrents in exchanges between workers and clients ... (This approach) was extremely unlikely to lead to substantial agreement over the purpose of care.* (Fisher *et al.*, 1986, in DoH, 1991 p40)

The picture is further complicated when a variety of possibly conflicting needs and perspectives co-exist. Webster (1992) noted that professional interventions did not address the needs of children in families with schizophrenic mothers. Simic (1995) found that the views and needs of the carers of people with mental health problems were ignored.

SOCIAL WORKERS AND CLIENTS WORKING IN PARTNERSHIP

There remains for the time being a considerable degree of pessimism about the extent to which differing perspectives are resolved during the course of work with clients in order that such work may proceed on the basis of partnership:

> *Research shows that partnership with parents has not been integral to past or current social work practice.* (DoH, 1991 p51)

In the context of children's hearings, Petch (1988) found that parental perspectives were, in effect, trampled on:

> *Whatever the extent and range of parents' views, in the conduct of the hearing any clash in perspective is dispelled. Children's hearings are accomplished irrespective of the particular analysis afforded by the parent.* (Petch, 1988)

The most recent child care research overview (DoH, 1995) suggests that, although partnership is now underpinned by legislation and guidance and generally considered desirable within the profession, translating the idea of partnership into practice is proving more difficult. Thoburn *et al.* (1995) in a study of 220 child protection cases from across the country, with detailed follow-up in 33 instances, found that meaningful participation was apparent in only a fifth of cases where the child's name had been placed on the register and in only 12% of cases at the investigation stage. Sharland *et al.* (1995) studying professional interventions in cases of child sexual abuse paint a somewhat more optimistic picture, finding that an acceptable level of partnership between parents and professionals was established in just under half the cases. As a profession, then, social work seems still to be on a learning curve in relation to working in partnership.

Moreover, while it is generally acknowledged that some progress has been made (DoH, 1995), the most recent national inspection of eight social services departments' family support services (which involved consultation with service users) indicates that, although there appears goodwill and intention with regard to working in partnership, there is a significant lack of demonstrable evidence as to whether it is actually achieved (SSI, 1996). The inspectors appear to take the view that there remains a fairly low level of active involvement of families in the assessment, planning and review process (SSI, 1996). Regarding the assessment process in particular:

> *From families' points of view, the most positive responses to assessments were those conducted in family centres, because they felt they were actively participating in the process* (SSI, 1996 p19)

Significantly, research findings indicate that the issue of partnership and the client's sense of involvement in the social work process are important not merely for reasons of professional ideology but also from the point of view of outcome:

> *Greater involvement in the protection process is associated with good outcomes for parents. More importantly, parents' satisfaction with the process was also closely related to a positive outcome for the child ...* (DOH, 1995 p51)

The extent to which clients and social workers are able to share meanings and to negotiate (in a sense, come to an accommodation of perspectives), was investigated in a study by Cleaver & Freeman (1995), reference to which has already been made. Their overall aim was to understand the experience of families being investigated as a result of suspected child abuse and in particular to show how the perceptions of parents and professionals influenced events. 583 child protection cases from one local authority were surveyed and a detailed study made of 30 families' experiences of the early stages of child protection inquiries. The authors note that as events unfolded much depended upon individuals' 'operational perspectives', such an

operational perspective being the product of the various psychological and social influences on an individual's view of his/her situation. If the investigation were to have a successful outcome, it was argued:

> *the operational perspectives of parents and professionals must be permitted or, better, assisted to converge.* (DoH, 1995 p60 summarising Cleaver & Freeman, 1995)

Clearly, then, a considerable part of social workers' professional responsibility needs to centre on aspects of the task which are concerned with sharing perceptions and understandings and negotiating ways forward. For it is evident that, although many bureaucratic and human obstacles may stand in its way, partnership with clients is a working relationship well worth aiming for since it invariably helps rather than hinders:

> *A failure to work in partnership could often be attributed to aspects of a particular case, but, significantly, the differences between cases where family members were well-informed and fully consulted and cases where communication was poor could almost always be traced to aspects of agency procedures. There was no evidence that things every turned out badly for children or parents as a result of working in partnership.* (DoH, 1995 p86 summarising Thoburn *et al.*, 1995)

The perspectives of clients are of great importance for the effective practice of social work. Certainly the client perspective is crucial within the encounter that is the social work assessment process. Of course, as we shall see, clients' perspectives necessarily co-exist with other elements also of considerable influence on that process. It is these varying influences that the current study seeks to illuminate. We turn now to a consideration of the methodology employed to that end.

CHAPTER THREE: DEVISING THE METHODOLOGY

Chapter Three details the selected research strategy, the rationale underlying it and the research methods. In particular the notions of a developing methodology and of a learning spiral are explored, the latter in the context of practitioner research. Also covered are ethical questions and the approach to data analysis.

RESEARCH STRATEGY

We saw in the introduction that the researcher's increasing interest in a little understood area of practice was the starting point for the research project. A key aspect in the formulation of a research strategy was that the research should be practitioner research. Although front-line social work practitioners tend to feel at odds with research as an activity, subscribing to the notion that, ultimately, it has little real relevance to them and their clients (Stock Whitaker & Archer, 1989; Everitt *et al.*, 1992), many parallels can be drawn between research and social work practice (Stock Whitaker & Archer, 1989; Everitt *et al.*, 1992). Certainly, for this researcher, there does appear to be considerable similarity between the two endeavours. A conundrum had therefore presented itself. In common with many social workers, the researcher's preconceptions of what constituted 'real' research were based on positivist notions of 'objectivity', 'hard science' and the like. Yet if, when undertaking the social work task, the researcher is already doing something akin to research, it makes no real sense to cast aside the value base and investigative methods already employed, not least because, in doing so, the 'way of knowing' (Rist, 1984, quoted in Munn-Giddings, 1993) central to the researcher's primary work as a practitioner is significantly undermined. Of course, it may be argued that the adoption of a significantly different methodology would be beneficial, that it makes no particular sense either to set out to develop an understanding of, in this case, the process of assessment using an approach that is fundamentally similar to the process it seeks to illuminate. This is noted as problematic.

For this researcher, however, on balance, the 'I', the 'who I am', demanded not to be overlooked. As others (Munn-Giddings, 1993; Powell, 1995) have noted, the influence of biography and of the researcher's self on the research process needed to be acknowledged and grappled with. This sort of 'reflexivity' is a familiar dimension within social work (Tuson, 1996). (While acknowledging its centrality as a key concept within the postmodern debate (see, for example, Bauman, 1992; Cassell, 1993), the term 'reflexivity' is used here in a broad way to denote reflection on and critical thinking about oneself in relation to practice.) What was required, then, was not to discount the researcher's personal and practice values, models and methods, but instead to re-examine, own and account them as defensible — what Mies (1983) has termed *"conscious partiality"*.

Many others had, of course, trodden this route. On further investigation it became clear that positivism is not unchallenged and the nature of research in the social sciences is the subject of much debate. It was apparent that there was indeed scope for enquiry 'from the inside' — research that had its roots, for example, in the interpretive school of thought, that focused on meanings rather than causes and sought to illuminate process rather than simply to judge outcome. Indeed, it is argued that, from the point of view of the reflecting practitioner, conducting research from the interpretive perspective has particular importance precisely because the very doing of it in itself validates the perspective. Moreover, the social work practitioner-cum-researcher is arguably particularly well placed to undertake investigations from such a perspective. The valuing of empathy and the honing of the ability to empathise, central tenets for social work, are vital if one seeks truly to understand the perspective of another, to see in the way the other sees. The activity of research demands, further, that subjects' perspectives be faithfully, and publicly, portrayed. To quote Munn-Giddings (1993):

> *The social researcher is not a mere medium through which knowledge is discovered, s/he can also be seen as constructor of knowledge.* (Munn-Giddings, 1993)

In light of this, a reflexive approach was considered crucial. Researchers need to be thoroughly and transparently conversant with the 'I' in the process in order to differentiate those in whose shoes they seek to stand. Again, sympathy for such notions are embedded in social work practice. It is argued that social workers are therefore likely to be readily attuned with research 'from the inside'. What is vital, however, if validity is not to be undermined, is that such values, understandings and skills are brought *consciously* to bear on the process.

The above process is one example of the sort of learning spiral experienced by the researcher in the undertaking of the project. Three such spirals were noted particularly. The first, as we have seen, came about as the researcher discovered more of what properly constituted the activity of research itself, incorporated the new knowledge and then used her expanded understanding as a basis for moving the project forward. As we shall see, two other learning spirals in particular informed the research: the part potentially played by organisational factors on the process of assessment; and increased understanding on the part of the researcher about the complex nature of knowledge.

Phillips & Pugh (1987) describe doctoral study as an exercise in research training and as becoming a 'full professional' in one's field. In the context of practitioner research it is the understandings gained through practice and reflecting on the puzzles of practice that form the basis for research and thus for new knowledge. Thus, it is argued that, within such an endeavour, the characteristics of the adult learner (typically, building on existing knowledge, taking responsibility for the direction and pace of learning, learning through doing and experiencing (Leigh, 1991)) need not to be disregarded or downplayed. In the writing up of the thesis, then, the aim has been

adequately to reflect the cycles of learning and reflection experienced by the researcher throughout the project.

It will be evident from the research aims set out in the introduction that a principal objective of the research was to understand the process of assessment and the meanings that those involved in the assessment situations studied attributed to their actions and experiences. The epistemological stance, as we have seen, was to be an interpretive one. As a consequence, the main thrust of the strategy was qualitative rather than quantitative in nature. Bryman (1988) explores how these terms invariably say as much about the social science researcher's philosophical stance in relation to the study of people and human processes as they do about data-gathering techniques.

Addressing, for the moment, the technical level, face-to-face individual interviewing was selected from the available range of qualitative techniques as the main method of data collection. Interviews of this type were considered most appropriate for two reasons. Firstly, given the topics explored — mental ill-health and an area of social work practice — there was likely to be some sensitivity on the part of both clients and social workers. To use Lee's (1993) term, the research might be viewed by potential participants as a threat. Mental ill-health is generally regarded as a private matter. It is easy to see how talking about their mental health and its effects on their children could be experienced by parents as both intrusive and stressful. Encounters between social workers and their clients are, most often, actually quite private affairs. Again, it is easy to see how social workers might be wary of scrutiny, judgement and possible sanction. Especially given the sensitive nature of the topics to be explored, then, individual depth interviewing (as opposed to, say, using survey techniques) was considered an important means of maximising the validity of the data. Secondly and relatedly, the sensitive nature of the topics notwithstanding, this method was judged to have the most potential for success when it came to the teasing out and

understanding both of the process by which social workers made their assessments and plans and of the experience of that process by clients. In considering the range of options, it also made good sense to capitalise on the researcher's interviewing and 'people' skills developed through professional training and experience.

Despite the preferred emphasis on qualitative techniques overall, as others have observed (Allan, 1991; Powell, 1996), it was considered important to employ interlocking research techniques and a variety of types and sources of data in order to ensure a well-rounded and thorough study. Quantitative techniques were thus not entirely eschewed since data collected and represented in such a way was considered likely to provide additional useful information complementary to the qualitative data gathered. Addressing not only the technical level of 'triangulation' but also the philosophical level, Bryman (1988) cautions against depicting qualitative and quantitative research as mutually exclusive models of the research process. That said, he is not oblivious to the dilemmas involved for researchers in formulating their strategy and methods, noting that *"many writers tend to move uneasily back and forth between epistemological and technical versions of the debate"* (p174).

While noting Bryman's call for a less either-or debate both at the level of philosophy and of technique, the spelling out of the predominant philosophical assumptions upon which the research is based can only be helpful. A key commitment of this research has been to see the situations from the perspectives of those studied. How far this is truly possible may be arguable, but the research clearly subscribes in its fundamentals to a naturalistic/interpretive approach, as opposed to a rationalistic approach, to social science.

The overall conduct of the research, then, was intended to be in the spirit of open-minded and co-operative inquiry rather than being driven, and therefore bound, by the testing out of the researcher's previously-formulated hypotheses. The philosophical

approach was reflected at the level of methodology and, particularly in the early stages, the methodology was very much a developing one with each phase, as it unfolded, informing and shaping subsequent phases. The methodology, then, was as follows.

RESEARCH METHODS

REVIEW OF THE LITERATURE

Reviewing the literature was seen as an important part of the methodology in that it provided the documentary background against which the research was to be conducted and conclusions drawn. We saw in Chapters One and Two that three areas of literature were reviewed. These reviews were undertaken to identify themes and topics for detailed exploration and to ensure a sound basis for analysis of the research findings. The researcher's experience as a social work practitioner was identified as bringing considerable benefits to the task of reviewing the literature. A strong practice base would aid not only the identification of salient issues, but also the assessment of whether or not such issues were likely to 'ring true' for social work practice. A thorough grasp of the issues in the literature, combined with a view on their relevance to social workers and clients, was considered essential to ensure that the data was not collected in an unhelpful vacuum in terms of either theory or practice.

USE OF DIFFERENT SOCIAL WORK SETTINGS

It was judged that the situation of families with young children and parental mental ill-health was likely to present in a variety of social work settings, both in the statutory and voluntary sectors. To provide opportunity to consider a broad range of social worker and client perceptions and in acknowledgement of the possible impact of organisational context and, in particular, workplace setting on social work practice,

inclusion in the study of a variety of social work settings was considered important. Approaches to the voluntary sector were outside the scope of the project. More importantly, there appeared merit in keeping the research within the statutory sector where, arguably, issues of good-enough parenting and child development more clearly permeate the agency's wider social work agenda. In taking account of the likely impact of organisational context, the researcher was cognizant of social work as a profession that is, to a large extent, mediated by the state which *"both creates and seeks to constrain"* (Hugman, 1991 p27). Thus, where organisational factors and/or influences are referred to, the term 'organisational' is used in the wide sense of how matters pertinent to social work are currently being organised, in acknowledgement of the notion that social work is a profession that ultimately has relatively little control over the various aspects of its agenda (Howe, 1991) and is, therefore, particularly susceptible to the influence of context.

Within the statutory sector, then, it was considered that such family situations were most likely to present for a social work service in the settings of: area fieldwork office (parent or child or family presenting initially); family and child guidance (child presenting initially); and via hospital-based adult psychiatry (parent presenting initially). Although such families might also present for a social work service in a general health setting, this was considered less likely. Such reduced likelihood, particularly when combined with the practical constraints imposed by a small-scale project, led to the exclusion from the study of situations arising in the general health setting.

The research, therefore, was conducted in the following three settings:

- Area Team
- Child Guidance
- Adult Psychiatry

All of these settings offered (not necessarily exclusively) a social work service, with social workers employed by a local authority and thus working in the statutory sector.

GROUP DISCUSSIONS WITH SOCIAL WORKERS

Partly in order to ensure the incorporation of social workers' practice wisdom at an early stage in the process, and partly to engage their interest and co-operation, audio-taped group discussions with social workers were organised in the three different settings. (The term 'practice wisdom' is used throughout to mean knowing what to do in a social work situation based on training, experience and general know-how.) Five group discussions were held, including one pilot (three Area Team groups and one each in Child Guidance and Adult Psychiatry). An average of six social workers participated in each group.

When using group discussion as a research technique, great benefit is clearly derived from a free-flowing and flexible content. Considerable advance planning was necessary, however, both to maximise data generated in the groups and to ensure their smooth running in practical terms. Detailed design of the group discussions is set out in Appendix B.

The discussion groups were moderated by the researcher who aimed to adopt a neutral stance while at the same time promoting a non-judgmental atmosphere and encouraging the free exchange of ideas. The particular value of group discussion lies in providing opportunities for variations in perspective and attitude to be both revealed and challenged by the participants.

With this in mind, consideration was given to the relative merits of 'mixed' vis-à-vis peer group discussions. On balance, there was much to commend peer group discussions. A degree of commonality and homogeneity, such as would be the case

for social workers employed within a particular setting, was seen as important in facilitating disclosure of views. There are also, however, disadvantages in holding group discussions among peers. It was possible that social workers would not wish to air controversial ideas or voice particular opinions in case such views were attributed to them in the future. Conversely, among staff groups who knew each other well, it was possible that some views and attitudes may be so well known and aired as to be taken for granted and not openly stated. In either case, a less than accurate reflection of the group's views was possible, undermining the validity of the technique. Overall, the benefits of within-setting groups were seen as outweighing the disadvantages. Recognising such disadvantages was the first step towards overcoming them; it would fall to the skill of the researcher/moderator to ensure validity was maximised. Although not directly relevant for groups of peers, much general guidance about the use of groups as a research technique was gleaned from the literature on focus groups, whose principal purpose has been described as *"to collect information, to listen and to learn"* (Krueger, 1988).

The primary aim of this data collection technique was to explore with each of the social work groups issues identified from an initial review of the literature, with a view to clarifying areas of particular importance to be explored in relation to specific cases in the individual interviews that would follow. A twin aim was to identify, via collective practice wisdom, any additional topic areas for follow-up that had failed to emerge from the literature.

The main topic areas identified from the literature for exploration in this way were as follows:

1. Given the connections between issues of parental mental ill-health and its impact on children and/or relationship with matters of child care, whose needs are being assessed? how is the main focus arrived at?

2. What type and degree of knowledge and skills do social workers need for effective assessments in these sorts of family situations?
3. Related to (2), what is the place/purpose of 'specialist' and/or other consultation?
4. Do social workers have and/or need specialist knowledge regarding the impact of parental mental ill-health on children?
5. What less tangible influences might there be on the assessment process? What is the influence of, for example: the setting; the referral; the role of the supervisor; informal supports; resources; and issues of culture or race?
6. How are gatekeeping and intervention decisions arrived at? What range of services might typically be available for these types of families? What circumstances might prompt intervention, onward referral or no intervention?
7. To what extent do social workers incorporate parental perceptions of the situation into their assessments? To what extent are assessment and intervention decisions a joint enterprise? How are differences of view managed? What part does perceived level of risk play, given differing perspectives?

While seeking to retain, as far as possible, the benefits of discursiveness and flexibility, it was nevertheless important that there was a topic framework for use during the group sessions and within which the data gathered could be more readily compared and analysed. A suitable research instrument, based on the foregoing topic areas, was accordingly designed (Appendix B2). Group discussions were typically of approximately one hour's duration.

Through the group discussions, then, it was possible to begin to get from social workers active in the different settings a sense of the sorts of factor which might, in theory at least, inform and influence their assessments and plans in relation to families with a mentally disordered parent. In this way, as we shall shortly see, and in

line with the developing methodology, the group discussions served to clarify the issues to be explored in greater depth in the one-to-one interviews with social workers and parents which followed.

INTERVIEWS WITH SOCIAL WORKERS

The aim of the individual interviews with social workers was to explore in detail their views of what factors had informed and influenced their assessments, actions and plans given the particular context of parental mental ill-health. To this end, social workers who carried out initial assessment interviews of the relevant families referred to all three settings during the identified time span were contacted and all agreed to be interviewed (a total of 34 social worker interviews).

As already stated, the main body of data was gathered by means of one-to-one interviews. A research technique that enquired in an in-depth manner of those directly involved in that process was considered, on balance, to be more likely than, say a highly-structured interview of the survey type to achieve the required aim of seeking to understand process. In view of the researcher's practitioner background and skills base, it was considered that there would be little difficulty in establishing the necessary rapport with social workers and parents and thus an appropriate climate for the in-depth interviewing required to unpick and tease out process. That said, it cannot be overlooked that those commenting at an individual level may not be best placed to reveal interconnections on a grander scale. It was to maximise the validity of the data, therefore, that, as we shall see, a number of perspectives on the assessment situations were investigated.

We have seen that a number of issues and topics were identified from a review of relevant literature and that these were explored with social workers through the medium of group discussion. Following analysis of data from the group discussions

(of the style discussed under the heading *Data Analysis*), the following key themes of influence emerged:

- setting
- the referral
- consultation
- risk
- collaboration with clients

In relation to these themes, two aspects are of particular interest. Firstly, it will be noted that no new themes emerged beyond those already identified through the literature review. This may be construed as arising from the constraint imposed by a previously identified, albeit loose, framework or (and arguably more likely) may reflect the way practice at least informs theory, if not necessarily the other way round.

Secondly, and importantly, what is evident is the preponderance of organisational factors that came to light when groups of practitioners were asked to identify what was particularly important and influential for them when making assessments, plans and interventions. It might be considered that this was an artefact of the technique inasmuch as social workers were being asked to talk theoretically rather than specifically about a particular case. It is difficult to see, however, how areas of potential influence not related to the organisation, (such as, say, the importance of being knowledgeable in a particular realm or having a thorough background knowledge of the family) are necessarily excluded by this particular technique.

The emphasis placed by social workers, through the medium of group discussion and at this very early stage in the research, on organisational factors demonstrates the value of the method and the idea of a developing methodology. As a consequence, when the individual interviews began the researcher had been alerted still further to the potential importance of organisational influences vis-à-vis other influences and

was able to modify the topic frameworks being developed for use in the individual interviews accordingly.

Because the aim was to maximise exploration with the social workers of their views and perceptions rather than to impose too rigidly the researcher's own preconceptions, interviews were conducted in the style of a 'guided conversation' along the lines suggested by Petch (1988). The emphasis was on enabling and encouraging the respondents to air freely, for example, their own approach, style and knowledge base and what they considered important and relevant in their assessments. That said, issues and topics previously identified for further exploration within the scope of the individual interviews would ensure a framework for the comparison and analysis of data. In effect, then, interviews were semi-structured, with interviewees being encouraged to pursue lines of thought of interest and importance to them while at the same time being brought back, at some point within the interview, to discussion of previously identified topic areas. Interviews typically lasted 60-75 minutes. The topic framework developed for the social worker interviews is appended at C.

As with the group sessions, these interviews were audio-taped for later transcription. The purpose of audio-taping the one-to-one interviews was to free the research interviewer to promote discourse, to facilitate the conversational style of the interviews and to ensure a more accurate reflection of their content than note-taking was likely to achieve. Notes were made immediately after interviews in the rare instances of partial equipment failure.

INTERVIEWS WITH PARENTS

One-to-one interviews were also conducted with parents who had participated in the initial assessment interviews undertaken by the social workers. Following discussion

with the assessing social workers, parents were either approached directly by the researcher or, less frequently, through the social worker. The approach adopted is explored further under the heading of *Ethical Questions*. Twenty-four parents/families agreed to be interviewed.

Generally (21 instances) the research interviews were one-to-one encounters reflecting the initial assessment interviews, although in a single instance a partner who was present became keen to join in when the process was under way. There were three instances of joint research interviews. In two of these instances, both parents had been involved in the initial assessments undertaken by social workers; in the third, one parent had been the subject of a formal mental health assessment under the 1983 Mental Health Act and his wife was closely involved as Nearest Relative. In the case of joint interviews, attention was given to clarifying any differences of view. The extent to which the experience of being interviewed jointly with a partner may have distorted any individual's responses is unclear.

The aim of the parent interviews was to explore their perceptions both of the impact of their own or their partner's mental disorder on their child's development and of the social work assessment and intervention service they were offered. Again, interviews were conducted in a conversational style, based on a semi-structured format and were tape-recorded. With comparison of data in mind, a range of topics and issues similar to those covered with the social workers was also covered with the parents. Although the aim was to ensure topics and issues that overlapped and could therefore be compared, it was nevertheless acknowledged that there were likely to be differences between social workers and parents in, for example, the depth of interest in individual topic areas. Interviews typically lasted 45-60 minutes. The topic framework developed for the parent interviews is appended at D.

COMPARISON OF PERSPECTIVES

The aim, then, was to cover substantially the same range of topics and issues throughout all interviews with social workers and clients, with some additional areas (such as knowledge base, various organisational influences, etc.) likely to be discussed with the social workers alone. In this way it was possible to put the two sets of views alongside one another. The aim of this approach was twofold. Firstly, as we have seen, the comparison of perspectives increases the validity of the data overall. Secondly, the particular comparison of professional and lay perspectives enables evaluation of the degree to which the social workers were successful in incorporating their clients' perspectives into their assessments.

DATA FROM OTHER SOURCES

With a view, then, to gaining further perspectives on the process being investigated, the following additional data were collected to provide the situational context for the social workers' assessments, plans and proposed interventions:

A. CASE FILE INFORMATION

A variety of information was collected from departmental case files. This included information concerning the basic characteristics of the referred families, information concerning parental psychiatric status and any particular concerns relating to child development issues. Data relating to the particular assessment situations were also gathered. This included, for example, referral details, the assessments and plans as recorded, and what was known with regard to 'outcomes' three months after the initial assessment. Some of the information collected (for example, that relating to concerns previously noted about the children's development) turned out to be largely extraneous to the

research task at hand. The relevant data collection instrument is appended at E.

B. INFORMATION ABOUT SOCIAL WORKERS

As has already been stated, an original interest was the extent to which social workers' assessments were likely to be influenced not only by, for example, the setting in which they worked, but also by their professional and personal experiences and enthusiasms. With this aim in mind, a self-completion questionnaire was devised and completed by all social workers who participated in the study. Information collected in this way included, for example: basic characteristics; professional training and experience; expertise in either mental health and/or child care; current workload emphases; and work-related personal enthusiasms. With hindsight, this particular line of enquiry, taken in conjunction with others of over-riding importance, was, at best, overly ambitious and, at worst, ill-conceived in its execution. As a result, a considerable amount of material collected via the social worker questionnaires was later discarded. The relevant data collection instrument is appended at F.

C. POLICY DOCUMENTATION

The final data source relates to policy documentation. Information regarding the department's formal written guidance concerning the task of assessment and the related areas of planning and decision-making was collected from a policy and procedures manual of the standard typically available to social workers.

ETHICAL QUESTIONS

The dimension of ethics permeates all stages of research. Guidance of the type available to professional researchers is clearly important and generally informative (Social Research Association, 1992/3). The lay practitioner-researcher is in a different position to the professional, however and, in the researcher's experience, many of the ethical dilemmas raised during the course of the research process concerned the hybrid nature of this role. That said, resolution, as we shall shortly see, invariably lay in the direction of re-clarifying roles and responsibilities; having embarked upon such a project the practitioner-researcher is, in terms of research ethics, researcher first and practitioner second.

Edwards & Talbot (1994) list some useful general questions of the type that have exercised the researcher:

- *Will the data collection method cause pain or distress to participants?*
- *Am I satisfied that any conclusions reached are appropriately supported by enough evidence?*
- *Can I keep promises of confidentiality?*
- *Am I taking undue advantage of my position to gain information ...?*
- *Does the research raise false hopes amongst the participants?*
- *Can I reproduce my findings in ways that authentically represent the concern of participants?* (Edwards & Talbot, 1994 p13)

Ironically, an early ethical dilemma arose in relation to negotiating agreement to undertake the project. This was a determinedly lengthy process in itself, no doubt influenced by the fact that, in the context of a hard-pressed social services department, an individually inspired piece of practitioner research into a low priority area of practice was never going to receive top billing on any decision-maker's agenda. More to the point, however, the social services department concerned had no

guidelines regarding the undertaking of independent research within the borough, although the department was invariably generous in its approach to individual managers and (more rarely) practitioners who expressed such an interest. It seemed ethically dubious to take advantage of what might be termed an almost naive vacuum. Accordingly, the approach adopted was educational in part, with the researcher being in the position of suggesting standards and offering reassurances in relation to ethical questions that were not initially raised by the department. To act so — taking the ethically justifiable course for its own sake — must surely be at the heart of the resolution of all ethical dilemmas and, as such, was not unusual. What is perhaps unusual was to encounter a potentially powerful organisation (some of whose demands any researcher might reasonably have expected to need to resist on the grounds of ethics) adopting, unknowingly, a position more commonly associated with the powerless.

The hybrid nature of the researcher-practitioner role and its potential to raise ethical issues has already been mentioned. Especially given that the project was being carried out in the researcher's employing authority, the question of being at the same time both an 'insider' and an 'outsider' had frequently to be addressed. Being an insider was undoubtedly helpful overall. The credibility that came with being a known and respected practitioner facilitated access as a researcher both to the organisation itself and to individuals. At the organisational level, the view was taken that this known individual could be trusted to act appropriately. At the individual level, more than one social worker made the point that the fact that the researcher was also a practitioner had influenced their agreement to participate in the study. There were times, however (most commonly in relation to client — or, more accurately, other subject — confidentiality), when it was necessary to be very clear with social work colleagues about the extent to which, for the purposes of the study, the researcher was, in fact, an outsider. Such a line had always to be trodden with great tact and diplomacy.

This was not least because, as well as being the subjects of the researcher (and, as such, due particular obligations) social workers were also, in many ways, *de facto* gatekeepers. It was not uncommon for social workers to be protective of their clients and of their work and relationship with clients. Sometimes this concern for clients' welfare tipped unhelpfully over into lack of acknowledgement that clients too had the right to make certain decisions (for example, whether or not they wanted to be involved in a research project). Generally, a full airing of the issues was sufficient for any concerns about direct access to be overcome. Where social workers' concerns in relation to, for example, direct access and/or the timing of the approach remained, bearing in mind the need to avoid alienating people unnecessarily, these were honoured, and social workers trusted not to unfairly influence the clients and/or the process one way or another. Whether such trust was justified cannot be entirely clear. However, where social workers acted initially as intermediaries (11 instances) more clients agreed to be interviewed than refused (7 and 4 instances respectively).

Before moving on to consider the ethical questions raised in relation to parents who participated in the research, attention is directed first to those members of the families who did not participate. In terms of the research design, it will not have escaped notice that the perspectives of the children, both of the impact of parental mental disorder as experienced by them and of the social work assessment and intervention service they and their families were offered, are missing. After some deliberation, it was decided to exclude children as respondents in the study. This was partly because of the recognised limitation in the abilities of younger children to conceptualise and for other practical reasons, but also, more importantly, because of the ethical dilemma of asking children to voice their views in a very sensitive area and then, as a researcher, being relatively powerless to respond in any meaningful way, at the level of the individual, to their felt experiences. This dilemma was, of course, also apparent in relation to the parents — arguably particularly so given that they were made vulnerable by mental ill-health. With adults, however, there is at least a greater

realisable potential for the exercise of personal responsibility in relation to their views and demands than can be the case with children. For these reasons the perspectives of children were excluded from the study, but not, it is hoped, forgotten in the process.

Returning to the parents, as subjects involved in the research they were clearly due ethical obligations. Again, being a practitioner-researcher conducting a study in the researcher's own employing borough was a potential problem to be addressed. It was possible that the clients would have met, or would in the future meet, the researcher, not as researcher but as social worker. The approach adopted towards such difficulties (which were actually rare but could, in a sense, be seen as ongoing) was to give attention to clarifying boundaries and issues such as independence and confidentiality. By their nature, however, such issues remain problematic, particularly when those involved may well be, and be accustomed to being, relatively vulnerable and powerless.

To avoid making poorly thought-through decisions 'on the hoof', as it were, one safeguard adopted was to think through in advance ethical responses to a variety of hypothetical situations (for example, with regard to incidences involving child protection and mental health issues) that might come to light in the course of the research. Aside from the ethical considerations in such situations, social work knowledge and experience had the potential to be helpful in this regard, not least because the researcher had a clear sense of current social work referral standards in relation to these areas. More tricky were decisions centring on what to do in the face of sometimes glaringly evident gaps in the social work practice under examination as experienced by particularly vulnerable clients. The line adopted by the researcher was to keep the research focus in view, leaving responsibility for action with the client, tempered very occasionally by, at the end of the research interview, encouragement not to be passive or by the imparting of some readily available piece of information. The aim was to act upon what felt morally right once the relative aspects of being a

researcher, a social worker and having just experienced a human-to-human encounter had all been weighed in the balance.

The final area to be covered regarding ethical considerations is that of data analysis and the presentation of findings. In respect of the latter a prime aim has been to protect as far as possible the anonymity of those involved. With regard to the former, by definition, interpretation of data must be subjective. However, it does not need to be self-indulgently so. The starting point in designing the research was to 'see through the eyes of others'. It has been important not to lose sight of this aim — in other words, not to misrepresent the views of those involved — while, at the same time, holding an awareness of participants' accounts as both situated and 'perspectival' (Silverman, 1993). In such matters, as in all matters within the realm of ethics, there can be no substitute for a high level of rigour, honesty and personal integrity. To achieve such a level has certainly been the researcher's intention.

DATA ANALYSIS

We turn finally in this chapter to the approach adopted in relation to analysis of the data, in particular the more recognisably qualitative data resulting from group and individual interviews. The component parts of the various topic frameworks and other research instruments served as initial 'categories' and thus provided a base from which to begin analysis. The approach was one of seeking to identify themes coming up from the data. This was achieved by a thorough acquaintanceship with the data, a process that started with transcription by the researcher of all audio-taped material. The very nature of this immersion proved invaluable, enabling easy movement by the researcher both within and between blocks of data. The process of reading, sifting, testing out ideas against the data, re-reading and reflecting was continued to the point where the themes emerging from the body of data as a whole were fully identified and

developed. The approach to data analysis, and the rationale underlying it, are further expounded at the beginning of Chapter Five: Findings (I).

With the aim of achieving a detailed and illuminating picture of the areas which are the topic of this thesis, the research methodology sought to put knowledge as contained in the literature alongside the knowledge of social workers, and then to set the perspectives of social workers alongside the perspectives of clients, setting these perspectives, in turn, against additional contextual data. We turn now to Chapter Four: Design of the Study.

CHAPTER FOUR: DESIGN OF THE STUDY

In line with the developing methodology, the study was conducted in two phases: group discussions with social workers, followed by the study proper. How the group discussions were conducted has been described in outline already. Their detailed design is set out in Appendix B. Characteristics of the study participants and of the assessment situations, together with location of and timing of the study, are now described.

IDENTIFICATION OF SAMPLE

INCLUSION CRITERIA

Two criteria needed to be met for families (and thus social workers) to be included in the sample:

- at least one parent known to be recognised as mentally disordered
- referred and assessed for a social work service to any one of the three settings within the identified time span (details set out under the heading *Location and timing of the study*).

For the purposes of the study, a parent was deemed to have been recognised as mentally disordered if she or he fell within any of the following situations:

a. Letter of referral for a social work service from either general practitioner (GP) or psychiatrist which makes reference to mental disorder in a parent and/or partner;

b. Parent and/or partner presently receiving treatment for a mental disorder either from GP or psychiatrist, as identified at the time of referral or during the course of the initial assessment interview through information either on file or volunteered by client;

c. Parent and/or partner presently receiving mental health-related support (community psychiatric nursing, attendance at mental health day centre, psychotherapy etc.), as identified at the time of referral or during the course of the initial assessment interview through information either on file or volunteered by client;

d. Parent and/or partner referred to Adult Psychiatry by GP for assessment and/or treatment;

e. Parent and/or partner who self-refers to Adult Psychiatry for assessment and/or treatment;

f. Parent and/or partner who is the subject of a mental health assessment under the terms of the 1983 Mental Health Act or, following initial assessment, is referred to an ASW for the purposes of such a mental health assessment;

g. Parent and/or partner has formal psychiatric diagnosis or quasi-diagnosis, as identified at the time of referral or during the course of the initial assessment interview through information either on file or volunteered by client, whether or not presently receiving treatment or mental health related support. (Any in this category who, diagnosis notwithstanding, had not received treatment/support during the previous five years were excluded.)

Using Huxley's (1985) terms, parents were included in the study, then, if they experienced mental illness essentially at the level of 'conspicuous psychiatric morbidity' and beyond, that is, as detected and responded to by general practitioners and psychiatrists.

STUDY NUMBERS

A total of 34 referrals were identified. Initial assessment interviews (one-off assessment encounters or the first interview of a longer assessment) were the focus of the study. Twenty-three social workers undertook these initial assessment interviews. The maximum number of assessments allowed by any one social worker was three (14 social workers carried out one assessment, seven social workers carried out two assessments and two social workers carried out three assessments). All 23 social workers agreed to be interviewed in relation to each of the assessments they undertook (i.e. a total of 34 interviews). Twenty-four of the parents/families agreed to be interviewed. The total number of individual interviews, therefore, was 58.

LOCATION AND TIMING OF THE STUDY

The research was conducted within a single Outer London borough, a brief description of which is set out in Appendix G.

By far the majority of the data was gathered during the year 1990. Two of the five group discussions (including one pilot) were held at the end of 1989. The remaining three groups were completed prior to the main period of referral identification.

Three referrals were identified during March for the purposes of piloting the individual interviewing techniques and topic frameworks with social workers and parents. It was anticipated that the likely time span for collecting a suitable number of referrals would be three months. The main period of referral identification commenced in May and was due to finish at the end of July. In the event, in order to ensure sufficient numbers, the period was extended to include August. In addition, there were specific problems in relation to referrals from Child Guidance inasmuch as, for most of the main period of referral identification, staffing difficulties meant that very little work was being allocated to social workers. Therefore, further Child Guidance referrals were

identified during the period October to December with some interviews taking place during the early part of 1991.

Research interviews with social workers and parents were conducted over the following time-scale. 68% (23) of interviews with social workers took place within six weeks of the assessment encounter and 23% (8) within 12 weeks. Due to long-term sick leave (two instances) and a combination of annual leave and work pressures generally (one instance), the remaining three interviews (9%) took place at 13, 14 and 19 weeks respectively.

50% (12) of interviews with parents took place within nine weeks of the assessment encounter and 38% (9) within 14 weeks. The remaining three interviews (12%) took place at 17, 21 and 22 weeks respectively. Negotiations with social workers concerning direct contact with parents (started at the time of the social work research interviews and sometimes protracted), quite apart from parents' own constraints on availability, sometimes meant a considerable gap between the assessment encounter and the parent research interview. With regard to the three particularly long gaps, in all instances intervention/assessment continued beyond the initial assessment interview, none of the cases being treated as single-interview assessments.

The issue of people's ability to recall events, given the passing of time, is thus raised. It is undoubtedly true that some interviewees had a more ready recall than others. It was noticeable, however, that, having once located the specific event in the 'mind's eye', as it were, social workers and parents alike were able actively to re-engage with their recollection of the assessment, or, where contact exceeded a single interview, the initial assessment interview. Social workers, of course, had recourse if they wished (few did) to their written accounts; they invariably had no difficulty recalling the cases under discussion. With regard to parents, the impression gained was that the assessment encounter had been an event of some significance, often occurring at a

time of stress and difficulty. The social work assessment was an event sufficiently out of the ordinary to ensure, despite the passing of time, reasonable levels of recall on the part of parents as well as social workers.

THE ASSESSMENT SITUATIONS

The total number of assessment situations studied was 34. Thirty-one families were involved in the study, three families being referred twice during the study period.

SUMMARY

Clearly, to be included in the study parental mental ill-health needed to have been identified. That said, the parents were, in the main, substantially in contact with mental health supports and services. In addition, most of the referred cases were already known to the social services department. By far the majority were referred by a third party to an Area Team setting — most usually, specifically for assessment/ investigation — and were responded to in a duty situation.

The majority of families were headed by lone mothers who, by and large, suffered from depressive disorders. These mothers mainly had one or two children who were aged five years or under. The mothers themselves were generally young (that is, in their twenties) and Caucasian in terms of ethnic origin, as were their children.

FAMILY COMPOSITION

Two-thirds (22) of the families were single-parent families. Generally these families were headed by women, with the exception of one lone father. One-half of the lone parents (11) were divorced or separated (6 and 5 respectively), nine were never married and two widowed. The lone parents were the natural parents of the children

they cared for. In four instances the other parent had continuing involvement with the family, although was not living in the family home.

One-third (9) of the families were two-parent families. In the majority of cases (7), the couples were married and the natural parents of the children in the family. In the remaining two instances, couples were cohabiting with, in both cases, the mother being the natural parent of all the children in the family and her partner the birth parent of some child/ren and the *de facto* step-father of others.

THE PARENTS

AGE AND GENDER

Of the 40 parents involved in the study, 30 were female and 10 male.

The ages of parents were not always noted in case records. The ages of 17 of the 22 lone parents were recorded. Based on the available information, one-half of the total lone parent group (11) were in their twenties, with approximately one-quarter (6) being in their thirties and forties (2 and 4 respectively). The ages of 12 of the 18 individuals comprising the two-parent families group were recorded. Based on the available information, over one-half the parents in the total two-parent group (10) were in their twenties and thirties (5 and 5 respectively), the remaining two being over forty years of age.

ETHNIC ORIGIN

Ethnic origin was not systematically noted in case records unless the assessment was a formal mental health assessment by an ASW. If families were non-white, ethnic origin was likely to be referred to in case notes. Statements about ethnic origin are made based on available information, combined with the researcher's own

assumptions having met over seventy per cent of those assessed. The inadequacy of this information will be apparent. It is included to give at least a flavour of the likely breakdown of ethnic origin.

Breakdown by ethnic origin of the total number of parents was as follows:

Ethnic origin	*No. of parents*
Caucasian	30
Asian	6
Afro-Caribbean	2
South-East Asian	1
African	1
	40

Table 4.1: Ethnic origin of parents

Approximately two-thirds (16/22) of the lone parents were Caucasian. Ethnic origins of the remaining six lone parents were Afro-Caribbean (2), Asian (2), African (1), South-East Asian (1). The majority (14/18) of parents in the two-parent families group were Caucasian. The ethnic origin of the remaining four parents was Asian.

THE CHILDREN

AGE AND GENDER

Fifty-seven children were involved in the study — 36 boys and 21 girls.

Of the 38 children (22 boys, 16 girls) to be found in single-parent families, over one-half (21) were aged 5 years and under, two-thirds of these (14) being two years or less. Ten children were in age range 6-9 years and seven in the age range 10-14 years. Of the 19 children (14 boys, 5 girls) to be found in the two-parent families group, again approximately one-half (10) were aged 5 years and under, three-fifths of

these (6) being two years or less. Four children were in the age range 6-9 years, a further four in the age range 10-14 years and there was one 15 year old.

ETHNIC ORIGIN

Breakdown by ethnic origin was as follows:

Ethnic origin	*No. of children*
Caucasian	39
Asian	6
Afro-Caribbean	5
Mixed race	5
African	2
	57

Table 4.2: Ethnic origin of children

Of the 38 children to be found in single-parent families, 23 were Caucasian, five were Afro-Caribbean, a further five were of Mixed Race and two were African. Of the 19 children to be found in two-parent families, 16 were Caucasian and three were Asian.

PARENTAL MENTAL HEALTH

All the women (21) in the lone-parent group were said to be mentally disordered. By far the majority of these (17) were considered to have depressive disorders, plus — in six instances — evidence of suicide attempts and/or serious suicidal feelings and, in one instance, severe alcohol problems. Three of the four remaining lone mothers were considered respectively to have: manic-depression; unspecified mental illness (ASW assessment); and personality disorder. Concerns over the mental health of the fourth had warranted referral to a consultant psychotherapist. In the case of the lone father, his separated partner was diagnosed as schizophrenic.

Eight of the nine women in the two-parent families group were said to be mentally disordered. The exception was a woman whose husband was considered to be mentally disordered, having a diagnosis of manic-depression. In the majority of cases (6), the mothers alone were considered to be mentally disordered (although in one instance the father was known to have problems of alcoholism). Their mental disorder took the form of: depressive disorder (4 instances, including one with serious suicidal feelings); unspecified psychosis plus alcohol problems (one instance); and continuing mental health concerns sufficient to warrant psychiatric assessment (one instance). In the remaining two cases, both parents were said to be mentally disordered. One mother was diagnosed as schizophrenic, the other mother was considered to have a depressive disorder; both fathers were said to have unspecified psychiatric difficulties for which they had received treatment in the past.

PREVIOUS/ONGOING CONTACT WITH SOCIAL AND HEALTH SERVICES

In three-quarters of the referred cases (25/34) the families had had contact in the past and were known to social services. This number includes the three families that were re-referred during the study period, only one of whom had not been known previously. In the remaining nine instances the referred families were not known to social services.

As set out above under the heading *Inclusion Criteria*, families were included in the study if a parent was encompassed within a variety of situations where her/his mental health was accorded some prominence. Grouping those categories broadly, the picture is one of parents who were, in the main, substantially in contact with mental health supports/services:

	*No. of parents**
Subject to assessment/re-assessment	7
Current treatment/support	26
Past treatment plus ongoing concerns	24

*Some parents fall into more than one category

Table 4.3: Parental contact with mental health supports/services

REASON FOR REFERRAL

In over one-half of the cases (19) investigation/assessment of a situation was the stated reason for referral. This number includes four instances where the referral was specifically to request formal assessment under the mental health legislation. In the majority of these 19 cases, the emphasis of the referral was on the child/ren in the family (eight instances, including two where there were clear child protection issues). In six instances (including the four requests for formal mental health assessments) the emphasis of the referral was on the parent alone, and in five instances emphasis was on both parent and child.

In under one-third of the cases (10) the reason for referral was either to request a service or to seek advice. All self-referrals (7) fell into this group. In the remaining five instances, the reason for referral was to request ongoing social work support for the family, including two cases where there were clear child protection implications.

SETTING WHERE REFERRED AND REFERRAL SOURCE

By far the largest group of assessment situations identified for the study (24) emanated from two Area Teams (16 from one, eight from the other). The remainder emanated in equal numbers from the settings of Adult Psychiatry and Child Guidance (5 each).

The 34 referrals came from a variety of sources. The following shows referral sources broken down into settings — in other words, who referred to whom:

Referral source	*Setting to which referred*		
	Area Team	Adult Psychiatry	Child Guidance
Self-referral	6		1*
Voluntary organisation	4		
School/Education	4		
Health professional	4		
Psychiatric setting	2	3	
Another part of SSD	2	1	3
Medical setting/GP	2	1	1
	24	5	5

(* at the instigation of the school)

Table 4.4: Referral sources broken down by setting

A DUTY OR NON-DUTY RESPONSE TO REFERRALS

As a rule of thumb, 'duty' social workers provide the first point of contact for unallocated referrals, as well as back-up cover on allocated cases where social workers are absent. Approximately two-thirds of the initial assessments (21) were undertaken on such a duty basis. Included within this number were five formal mental health assessments carried out by ASWs (four of which had been specifically requested). The great majority (19) of the assessments handled via the duty system took place in the Area Team setting. Two duty assessments, both ASW assessments, took place in the Adult Psychiatry setting.

Just over one-third (13) of the initial assessments were undertaken in non-duty situations. Five (out of 24) Area Team assessments received a non-duty assessment. All five Child Guidance referrals were responded to on a non-duty basis, and the remaining three Adult Psychiatry referrals were responded to in this way.

In the Area Team setting the duty system was used, by and large, for initial assessments. In the Adult Psychiatry setting only a specifically ASW duty service was in operation. Non-duty responses occurred in a variety of situations. In the Area Teams where the duty system was bypassed it was either because there was such a clear ongoing role for the organisation that the cases went straight to allocation, or because the cases appeared to warrant a level of (mental health) specialism not available at that time through the duty system. No comparable duty system was in operation in either Child Guidance or Adult Psychiatry. Apart from assessments carried out via the Adult Psychiatry ASW duty system, therefore, in both the Child Guidance and Adult Psychiatry settings assessments were generally undertaken once cases had been either specifically allocated to, or identified as within the province of, individual social workers (the systems in Child Guidance and Adult Psychiatry respectively).

THE SOCIAL WORKERS

A total of 23 social workers undertook the 34 assessments.

SUMMARY

To be included in the study social workers were required to be professionally qualified, hence all were. All the social workers were white. By far the majority were women in their thirties and forties. Overall they were a group of considerably experienced practitioners, three-quarters having between six and twenty years experience. This level of practice experience was reflected in their job grading.

By and large, the social workers acknowledged that, in their own estimation, since qualifying they had built up expertise in child care and, to a lesser extent, in mental health. They were likely to have undertaken in-service training in both areas, although in the Area Team setting priority appeared to be given to training in child care. The majority of social workers were interested in the area of mental health to the extent that they were keen to do or had undertaken ASW training, although of the latter not all continued to practise as ASWs. To what extent such interest reflected wider career aspirations in combination with an interest in the area for its own sake is unclear. As a group the social workers appeared overall to be rather more enthused by mental health as a topic compared with child care.

WORKPLACE SETTING AND WORKLOAD EMPHASES

Seventeen of the social workers were based in two Area Teams (10 and 7 respectively); three were Child Guidance social workers and three were based in Adult Psychiatry at the general hospital.

Reflecting their setting base, the current emphases in the workloads of the social workers were described by them as follows:

Workload bias	*No. of social workers*		
	Area Team	Child Guidance	Adult Psychiatry
Emphasis on C/Fam			
Over 75%	7	3	-
50-75%	2	-	-
Emphasis on MH			
Over 75%	3	-	3
50-75%	1	-	-
'Generic' caseload	4	-	-
	17	3	3

Table 4.5: Social workers' workload emphases

QUALIFICATIONS

By far the majority of the social workers (20) held the Certificate of Qualification in Social Work. The three exceptions (two Child Guidance workers, one Area Team worker) were social workers of nineteen years' experience and over who held child care and mental health social work qualifications that were forerunners to the CQSW qualification.

Three-fifths of social workers (14) held educational or professional qualifications in addition to their social work qualification, first degrees and nursing qualifications respectively being the most usual.

ETHNIC ORIGIN

Based on their self-descriptions, all the social workers (with one silent exception) identified as 'White' and/or 'British' in terms of ethnic origin.

GENDER

All the male social workers in the study worked in the Area Team setting, overall distribution by gender being as follows:

	No. of social workers		
	Area Team	Child Guidance	Adult Psychiatry
Female	12	3	3
Male	5	-	-
	17	3	3

Table 4.6: Breakdown of social workers by gender

AGE

Breakdown by setting according to age was as follows:

Age range (yrs)	*No. of social workers*		
	Area Team	Child Guidance	Adult Psychiatry
20-29	2	-	-
30-39	8	-	1
40-49	3	1	2
50-59	4	1	-
60 and over	-	1	-
	17	3	3

Table 4.7: Breakdown of social workers by age

LENGTH OF PRACTICE EXPERIENCE

The following shows a breakdown of social workers' years of practice experience (excluding long breaks) according to setting. (No distinction is made between full- and part-time working.) Social workers with the least experience were to be found in the Area Team setting, although there were considerable numbers (two-thirds) with six years experience and over. Social workers in Adult Psychiatry were more experienced

(11 years experience and over) and Child Guidance social workers were more experienced again (16 years and over).

Experience	*No. of social workers*			
(years)	AT	CG	AP	Total
Up to 5	6	-	-	6
6-10	7	-	-	7
11-15	3	-	2	5
16-20	1	2	1	4
Over 20	-	1	-	1
				23

Table 4.8: Length of social workers' experience

JOB GRADING

The majority of social workers (18) were workers of significant experience and ability based on their job gradings. By far the majority of the lower graded social workers were to be found in the Area Team setting. They made up over half (9) of the Area Team social workers (17 in total). With one Adult Psychiatry exception who was graded in the mid-range, the Child Guidance and Adult Psychiatry social workers were the most highly graded.

Grade	*No. of social workers*			
	AT	CG	AP	Total
Level 2*	5	-	-	5
Level 3	4	-	1	5
Extended level 3/above	8	3	2	13
				23

(*entry point for qualified social workers is bottom of level 2)

Table 4.9: Job gradings of social workers

LEVEL OF EXPERTISE

Based on self-descriptions, the following shows the level of expertise built up by social workers since qualifying. As a group, Area Team social workers were more likely to

identify lack of expertise in mental health rather than in child care. All the Child Guidance social workers (3) considered they had child care expertise, with two considering they also had mental health expertise. All the Adult Psychiatry social workers (3) considered they had mental health expertise, again with two considering they had child care expertise as well.

'Felt expertise'	*No. of social workers*			
	AT	CG	AP	Total
Child care				
yes	13	3	2	18
no	4	-	1	5
				23
Mental health				
yes	9	2	3	14
no	8	1	-	9
				23

Table 4.10: Social workers' level of expertise

IN-SERVICE TRAINING

In the Area Team setting, child care training appeared to be given priority inasmuch as, although one-half (8) of the social workers had undertaken in-service training courses in the areas of both child care and mental health, a similar proportion (7) had undertaken only child care training, with only one social worker having undertaken only mental health training. In the Child Guidance setting priority appeared to be given to child care training, although two of the three social workers had undertaken training in both areas. All the Adult Psychiatry social workers had undertaken training in both areas, again reflecting the priority within the department to matters of child care irrespective of setting.

	No. of social workers		
	AT	CG	AP
Child care only	7	1	-
Mental health only	1	-	-
Both	8	2	3
Neither	1*	-	-
(*recently qualified worker)			

Table 4.11: In-service training undertaken by social workers

APPROVED SOCIAL WORKER TRAINING

One-half (12) of the total group of social workers had undertaken ASW training, with one-third (8) currently practising as ASWs, six of whom were based in the Area Team setting and two in Adult Psychiatry. The four social workers who were ASW trained were Area Team based. Of the remaining 11 social workers, five (4 Area Team, 1 Adult Psychiatry) expressed a positive interest in undergoing ASW training. The six social workers who did not express an interest in such training were based in equal numbers in the settings of Area Team and Child Guidance.

	No. of social workers			
	AT	CG	AP	Total
ASWs	6	-	2	8
ASW trained	4	-	-	4
Non ASWs	7	3	1	11
	17	3	3	23

Table 4.12: ASW training undertaken by social workers

ENTHUSIASMS AND SPECIAL INTERESTS

Taking the group as a whole, social workers were somewhat more likely to have a particular interest in or enthusiasm for mental health social work rather than child care. The following is a breakdown by setting of social workers' special interests in these areas.

Setting	*Area of Special Interest*			
	Mental Health		*Child Care*	
	Yes	No	Yes	No
AT	11	6	11	6
CG	3	-	3	-
AP	3	-	-	3

Table 4.13: Social workers' special interests

For the majority of social workers (17), however, these enthusiasms did not translate into membership of particular special interest groups. Of the one-fifth of social workers (6) who did belong to a special interest group, by far the majority of examples cited were mental health related.

Having looked in some detail at the situations studied and at those involved in the study, we turn now to an examination of the findings.

CHAPTER FIVE: FINDINGS (I)

OVERLAP BETWEEN ADULT MENTAL HEALTH AND CHILD CARE SOCIAL WORKERS' KNOWLEDGE BASE

The research findings are grouped around the previously identified areas of interest. Chapter Five sets out findings in relation to (1) social workers' and parents' perceptions of the interface between parental mental ill-health and the progress of children; and (2) the knowledge base of social workers.

In line with the aim of making transparent the cycle of reflection and learning that has been part of this project, at this point we revisit how the raw data were analysed and thus how the findings were arrived at.

The aim of data analysis is to make sense and meaning of research data in order that the resulting findings can be more easily communicated. In the process it is necessary for the researcher to *"reduce, reorganize and combine"* (Ely *et al.*, 1991 p140). As far as this project is concerned, this process began, in a sense, at the design stage, since the researcher was clearly interested in pursuing specific issues and aspects seen as germane to the research topic overall. Hence the use of a semi-structured interview format as detailed in Chapter Three. As noted, then, initial 'categories' were already in place and formed the basis for further analysis.

An alternative approach would have been to invite social workers and parents to talk in an unstructured way about the assessment process in which they had participated. The researcher would then identify themes arising, on the face of it, more spontaneously from such unstructured accounts. It might be argued that such an approach is more likely to head off the unwarranted imposition of pet themes by the researcher. However, this needs to be set against the potential for such an approach to fail to explore the specific issues and topics identified for the research.

Exploration of the assessment process with particular reference to parental mental health and the needs of children, and the place of knowledge within that, were specifically identified as research objectives. These, then, are some of the threads that run through the analysis of the data, along with others (such as the influence of organisational factors) whose genesis was more clearly in the literature or in the group discussions. In other words, it is acknowledged that the framework within which the data has been analysed is based on the aims and objectives of the research which, in turn, are linked to the researcher's particular and evolving interests.

While exploring these aspects has been given some priority, it is also the case that a premise of the research was a commitment to exploring the perspectives of those involved in the assessment process. In pursuing particular aspects, then, the aim has been that this should not be to the exclusion of social workers' and parents' understandings and perceptions; the researcher remained alert to other topics and aspects of relevance and importance in the assessment context.

One particular example of how this approach worked in practice is worth mentioning specifically since it relates to the learning spiral that occurred in relation to the topic of knowledge. A specific interest of the researcher was exploring the extent to which social workers called upon pertinent formal knowledge. It was in the process of making sense of respondents' statements in this area that the researcher deepened her understanding with regard to both the nature of knowledge and the nature of the assessment process, as it became clear from analysis of the social workers' responses that recourse to practice wisdom was as likely as the application of formal knowledge to guide practitioners' actions.

We might say, then, that the aim has been for creative interplay between the researcher's framework and the statements of respondents; within the framework of

topics and ideas imposed by the researcher, respondents' views have been sifted and weighed for emergent themes that illuminate the endeavour as a whole.

We turn now to the first area of findings.

THE INTERFACE BETWEEN PARENTAL MENTAL ILL-HEALTH AND THE PROGRESS OF CHILDREN

The first area of findings concerns lay and professional perceptions of the impact of parental mental ill-health.

PARENTS' PERCEPTIONS

From the parents' responses it was clear that they considered the impact of their own mental disorder and/or personal difficulties on them and their families was considerable. (Of the 24 parents interviewed, 23 were identified as having mental illness, the exception being a parent/client whose partner was identified as being mentally ill.) By far the majority of the parents interviewed (21) spoke with considerable feeling about their personal experiences concerning this aspect of their lives:

> *"I didn't want to do nothing, I didn't want to eat, I didn't want to sleep, I didn't want to drink, I didn't want a bath or nothing. I just sat there most of the time and did nothing at all. Wouldn't even go to the front door or answer the phone. I thought that's wrong, and then it got to the stage that I just didn't want to know [child], I just wanted to be left on my own, crying, not wanting to go out, I just didn't want to do nothing. ... I felt all of this and, at the same time, inside I knew that I had to do something about it. I knew, I just knew that I had to do something because if I didn't then [child] would have ended up hurt. ... I'd sit there and I'd be talking and all of a sudden I'd just start screaming and shouting. And that's when I thought to myself, when I was sitting there on my own, I sat there and thought this isn't right, that just is not me ... I honestly thought there were times when I was*

going to end up in the madhouse, and that's when I thought I need somebody else, I need somebody that knows what to do about it".[1]

"It took a lot out of me. I don't know how you explain it really, it's very difficult to explain. At the time I felt I was all right. It was the other people around me were saying that I was on a high and I wasn't, and I was trying to explain to them that I was all right ... but obviously they were right and I must have been wrong. So then they carted me off into hospital, but that's how I felt at the time. I felt all right in myself, I didn't feel ill." (ASW assessment)

"I've been living from day to day ... because I never knew what to expect, it's just a case of waiting for the fatal day, one could say. It's unfortunate because I'm still fond of my ex-wife and maybe she can't help doing what she does. We didn't get divorced because of adultery or anything along those lines, it was just basically due to her bizarre behaviour, I just couldn't cope with it. She went from bad to worse, so I had to get custody of [child] otherwise God knows what would have happened to him really. She wasn't really caring for him at that stage, or for herself for that matter."

In the remaining three cases, although the parents were identified as qualifying on mental health grounds for inclusion in the study, the parents did not see themselves as having mental health problems. Nevertheless, the difficulties as they understood them — due, respectively, to financial/practical considerations, reaction to separation/divorce and failing to cope with a child perceived as temperamentally difficult — clearly had significant impact on their functioning and/or well-being.

"I walked out two or three times with [baby] in my arms for about two hours and just walked the darn streets ... running away from the problem because it got to the stage that the problem's there day in and day out, we've tried everything we could think of, we've tried everything everybody else has suggested and we're getting nowhere and I said I can't take no more and actually walked out and left [husband] with the three boys because it got to the stage I couldn't take no more."

Parents appeared alert to the possibility of their children being adversely affected by parental mental disorder and were not fazed by questioning in this vein. Specifically

[1]With a view to maximising readability of the quoted material, speech 'fillers' and significant deviations from the point under discussion have been excluded from the quoted material.

regarding whether or not they considered their own mental health/personal difficulties had had some effect on their children, the majority of parents, over two-thirds (17), reported that, in their view, there had been some effect on the child. In seven instances, parents considered the effect to be clearly noticeable and directly linked to parental mental ill-health.

> *"I think one physical sign of this is the fact that my son has hardly grown in the last year. I know that because his clothes more or less still fit him. Whereas other boys of his age I know are getting considerably taller than him, his pals, he hasn't grown much at all. So obviously ... it's affected him inwardly like that. It has affected him from the point of view, he was far happier when his mother wasn't here. He's not too bad at the moment while she's not too bad, she's not doing anything too bizarre, but, he's like me, he likes a regular sort of lifestyle, 'cos he's very much like me in nature, and so when it gets completely disorganised, you don't quite know what's going to happen next, or what time of day or night it's going to happen, it definitely worries him. And it's worried him inwardly from the point of view that he doesn't appear to be quite so happy, sometimes he used to sing round the house, which kids do, don't they, but you don't get much of that lately. ... I might be wrong, but it's an indication to me and I know he's not quite the same happy-go-lucky kid."*

In six instances parents considered the impact on their child had not been solely, or even mainly, due to their mental health difficulties but also to wider considerations, including separations due to hospitalisation.

> *"Although [child] hasn't got any major behavioural problems, he has changed since [husband] died, and I think quite naturally so, and he has become more aggressive and more disobedient, but I think that's a combination of the fact that he's had me unwell, he's had his father die and he's just a six-year-old who's just frustrated at the fact that he can't always do what he wants, and so it's just a combination of everything really. ... [He] doesn't actually know I tried to kill myself, he just knows ... I wasn't very well. ... He knows when I'm not feeling that well ... he'll say to me 'you feel sad today, don't you mummy?' and I say 'well, yes I do'. And he'll say to me 'that's all right'. ... I think it brings out a feeling of insecurity, but I think because I have got such a good relationship with [him] he's not as affected as he might be ... I think that he's conscious of the fact that if I'm not well it's a possibility I may go into hospital, so therefore it may seem to him that, like dad, I'm ill like [husband], but all the way through I've said that mummy hasn't got a serious illness like daddy, mummy will get better. I hope (laughs). ... I've tried to make it easy for him that way."*

In the four remaining instances, parents considered that children had been affected in a less marked, transitory way and were managing overall or were back to normal.

> *"I worry about my eldest child. I don't think it's very good for him, he seems to have to do so much to help me out. ... I don't feel like a proper mother, I can't do anything with the children 'cos we just can't get out and that's no exaggeration, I can't get the double push-chair and the children down the stairs, so we just don't go out. ... I honestly think it would drive anybody up the wall. ... I do worry what effect it'll have on them, but it doesn't last forever."*

The remaining parents — just under one third (7) — considered that their difficulties had had no appreciable effect on their children.

> *"No, they've accepted the fact that I've been ill and I'm in hospital ... really 'my mummy's not well and she needs help', which I think is very good of them, they've accepted it."*

THE SOCIAL WORKERS' VIEWS

In contrast to the parents' views, as an issue in its own right, the interface between parent mental ill-health and the progress of children did not loom so large for social workers. Approximately one-half of the social workers (16/31, a direct question on this aspect having been added following the three pilot interviews) did not consider any impact on the child(ren) of the parent's mental disorder to be serious enough to examine in depth in its own right.

> *"It didn't seem to be <u>that</u> important in this particular case. I may be wrong about that, it may have been very important, but it didn't seem to me that it was, she seemed more of a disorganised sort of person and that it was more to do with that and the way she viewed herself, which may be to do with her depression, but I didn't feel it was, that was the problem rather than the fact that she had a psychiatric disorder."*

In three of these instances this was in the light of what was judged to be sufficient support from the other parent and in a further two (one an ASW assessment) that

particular aspect was, in any event, considered to be outside the remit of the assessing social worker.

> *"No ... I had some intuitive faith in his father's ability to care for him, because his father was showing an awareness and an understanding ... and if he'd had concerns that that was having an impact on [child] then my feeling was that he would have come to us much earlier and maybe approached the school to see how [child] was doing at school ... That ... hadn't been presented before, so I felt it was okay."*

> *"I didn't consider it in depth. I just assumed that her emotional well-being must have an effect on the child, but I didn't actually know what that was and whether the child was used to it and how things normally were. ... I wouldn't be working on those problems in the future so it's almost pointless getting to involved and perhaps leading her to believe I might."* (ASW assessment)

An almost equal number of social workers (15) gave more consideration to the impact of the parent's mental disorder, regarding it as having greater significance. As we shall see in Chapter Six under the heading of *Case Characteristics*, while the mental health of the parent as an individual is by no means entirely overlooked, the issue that predominates for social workers is that of parenting and its related aspects. The majority of social workers (9) who accorded greater significance to the presence of parental mental ill-health considered the impact in terms of how it affected parenting and family relationships, in two instances in combination with concern about potential direct effects on the child(ren).

> *"Yes, I did, but even during all of this I felt that [the mother] was actually providing adequate parenting for this child, so yes I did, apart from that issue about the safety which we dealt with, but in terms of the emotional relationship with the child and so on I felt that was adequate in spite of the difficulties she was having."*

> *"What concerned me was ... primarily two things ...(1) that she might be so preoccupied with her internal world that she wouldn't notice what [child] was doing and he could of course have an accident, and, secondly that she might perceive in him things which ... weren't there, and react as if they were and so react inappropriately to him either physically or emotionally."*

In contrast, a smaller number of social workers (6) considered the parental mental illness and its associations predominantly in terms of its more direct effects on the child(ren).

> *"When I say we worried about how they were managing I mean ... potentially there was mental illness in this family, there was alcohol abuse in this family and there was violence in this family, and it seemed to me at the end of this conversation that there probably was all of that or had been at times ... it was really very concerning how the children managed."*

SOCIAL WORKERS' KNOWLEDGE BASE

We turn now to the next area of findings relating specifically to the knowledge base of social workers.

SOCIAL WORKERS' ARTICULATION OF THEIR KNOWLEDGE BASE

From the tenor of their responses it was clear that social workers were unfamiliar with the idea of articulating their knowledge base, although, with encouragement, they were able to do so:

> *"I must have been obviously 'cos I had a framework of a balance of norms that I was working with and it seemed to me that however extreme her outburst was it was in a normal range. So, if I logically think about where I'm getting that information from, then, yes, it must be from my awareness of human behaviour, i.e. adult behaviour and mental health."*

The majority of social workers (24) were able to conceptualise a place for formal knowledge in their assessments:

> *"Both ... a knowledge of good-enough parenting ... about how she actually was considering the children, whether she was using the children for her own purposes or whether she was considering their needs ... And also really how she was functioning, how she felt and ... how she talked about her husband ... talking to her to know whether she was depressed or suicidal or whatever or whether she was quite calm, so using some sort of knowledge of mental health there."*

A significant minority (10), however, while certainly giving a nod in the direction of formal knowledge, preferred what, on the face of it, were everyday conceptions as the backdrop for their judgements:

> *"Child development, yes I suppose I would say that ... I think at the stage when they start school they do all sorts of funny things really ... part of it I think when a child starts school is that they haven't quite got the idea of what's usual behaviour and what isn't. And they very quickly acquire it from being with their peer group and being in the outside world. ... I mean if it had been a 10 year-old hoarding food then I think that would have been another thing."*

It seems likely that the latter group highlights the importance to social workers of practice wisdom as a knowledge base, alongside more formal bodies of knowledge. Certainly the small number of social workers (4) who acknowledged bringing their own personal experience to bear supports the idea of practitioners reflecting on a range of experiences and using such knowledge to inform their practice:

> *"I haven't got much training at all in drink problems, but I've got a personal experience of a friend who had a severe drink problem and I suppose ... I was drawing on that a bit, more than any sort of training."*

Moreover, in approximately one-fifth (7) of the interviews social workers were reluctant to talk of formal knowledge as having overriding relevance and were keen to talk as much in terms of common sense:

> *"I think it went without saying that if she hadn't got any money, and with three children she needed some money, I think that that was obvious, you didn't need any special knowledge base there."*

> *"I don't know whether it's professional knowledge, to me it's fairly common sense that if [the client] was quite happy for the father to ... look after the child and ... he wanted to do it himself, then ... to me that's fairly common sense that ... he's the best person to look after him 'cos he's the closest person to [the child] after the mother basically."*

It is arguable, however, that far from social workers using a truly 'common' sense — an understanding shared by all — they have instead integrated and/or developed a knowledge base incorporating both practice wisdom and more formal knowledge and are applying it in a largely unconscious fashion. The following example illustrates where a social worker professed to be using common sense but actually followed up with statements suggesting specialist knowledge that incorporates a range of models for understanding emotional distress or mental illness:

> *"Fairly normative ideas of where to cook and do you always invite your neighbour to watch the barbecue burning in the front room fireplace. (Interviewer: So you don't need any specialist knowledge to know that's pretty odd?) No, no. The thing that bothered me about that was was it madness purely for its own sake, in its own right, or was it madness that was brought on by ... an anxiety about being evicted from the house and the Court appearance and, even more significantly, a history of drug and alcohol abuse that had disorientated this woman's idea of what was appropriate, and was she actually pissed and cooking something and she just got totally confused about it and uptight about it all and did it completely the wrong way around, and was that the main influencing factor?"*

In the above extract the social worker appears to be bringing considerably more than common sense notions to bear in the assessment process without being particularly aware of doing so. In contrast, however, — and particularly when speaking in generalised terms — a sizeable minority of social workers (13) did recognise that they brought a range of different sorts and levels of knowledge to bear in their assessments:

> *"I don't think I'd have been able to talk to her in an informed way without a knowledge of mental illness, without a knowledge of legislation and also without a knowledge of child development and the impact of parental mental illness on children."*

> *"I think some of it is just everyday experience, I think that the common person in the street can pick up when someone looks a bit down ... but I suppose ... the level of my assessment was more than that, so I would say that ... I was using specialist knowledge that I acquired through training."*

It is contended that the extent to which social workers are knowledgeable about knowledge — both their own and generally — is important if professional effectiveness is to be maximised. This point will be explored fully in Chapter Eight: Discussion of Findings.

APPLICATION OF DISCRETE AREAS OF KNOWLEDGE

Turning to the extent to which social workers drew on discrete areas of formal knowledge in their assessments, just under one-half of the social workers (16) considered themselves to be drawing on the full range of their knowledge and experience, in other words, on their accumulated practice wisdom. These social workers did not consider that discrete areas of formal knowledge, whether mental health or child development/good-enough parenting, proved particularly valuable in their own right during the assessments in question:

> *"I think there was a need to have a grasp of both and on that basis I don't think a greater focus on either one or the other would have been particularly productive."*

One of these social workers spoke of his awareness of the shifting sands of knowledge. Implicit here is the case for an approach based on practice wisdom:

> *"I think most knowledge is eclectic, you gather bits of information and you see which are the important bits ... and you try to put them all together and come up with some sort of coherent picture. ... You've got to be very careful you don't stick to one particular theory too often or you could come unstuck ... you could be going on the same track for years and it's the wrong track, so I'm wary ... things change, people change, circumstances change, theories change, ideas about social work training and practice, knowledge bases change, so I wasn't sticking to one theory, I was using a built up knowledge over ... years."*

As much a part of practice wisdom as knowing when to intervene is knowing when not to. By way of contrast, then, a small number of social workers (3) reflected on the fact

that, although 'waiting in the wings', as it were, the depth and scope of their knowledge bases had not appeared to be of immediate or constructive use given the particular situation with which they were faced:

> *"I have to be very careful here ... because I think I can say, in retrospect, thinking about it, that [knowledge of mental health] may have informed my decision. I think at the time because it was so framed in terms of a practical financial thing, I'm not sure I would have sat down this long and analysed it to that level."*

From here begins to emerge the idea of social workers applying different levels of assessment dependent upon the situation with which they are faced. This point is explored in Chapter Six under the heading of *The Managed Professional.*

In contrast to the above, approaching one-half of social workers (15) did feel able to identify one sphere of formal knowledge as being particularly helpful in the assessments undertaken. Here again, the overarching theme of parenting was highlighted inasmuch as the majority of social workers (12) gave prime importance either to their child development/good-enough parenting knowledge base, or to their mental health knowledge base, but primarily with a view to assessing the parent's functioning/impact as a parent (8 and 4 instances respectively):

> *"I think probably the good-enough parenting, at that particular stage when I went along in response to these concerns that she was leaving the baby."*

> *"I suppose I would think of the mental health as one factor that might affect her parenting. I suppose I would look at it in terms of her parenting abilities and skills and how her mental health will affect the way she looks after the children."*

The sub-theme of the mental health of parents as individuals in their own right was again also apparent inasmuch as a small number of social workers (3) (two undertaking ASW assessments and one Adult Psychiatry social worker) considered

their adult mental health knowledge base to be of prime importance in terms of informing their assessments:

> *"In this assessment, both are very important and, if I chose, it would be to go for the adult mental health. ... It's because the referral was from the consultant to me to work with this woman's distress, and, yes, there's a child, and there was no evidence in terms of the referral, there was some evidence that there were difficulties, but no evidence of a child being at risk or of there being real problems with the little girl. And whilst that was an important aspect to consider, if I had to choose between increased knowledge in one field or the other then it would be mental health."*

THE INTERFACE BETWEEN PARENTAL MENTAL ILL-HEALTH AND THE PROGRESS OF CHILDREN

The impact of parental mental disorder on children as a discrete body of formal knowledge appeared to hold little significance for social workers in terms of informing their work as they recounted it. This is perhaps unsurprising given that, as we saw earlier, social workers did not appear especially interested in the interface as such. Instead they regarded it as only one aspect of the overall situation with which they were presented. Any ramifications therefrom (as they perceived them, based not on specialist knowledge, but on practice and other relevant bodies of knowledge) were weighed in the general balance accordingly.

CHAPTER SIX: FINDINGS (II)

THE ASSESSMENT PROCESS

Findings relating to the assessment process, in particular the influences of case characteristics, of the organisational context and of social workers being managed professionals, are set out in Chapter Six.

CASE CHARACTERISTICS

A general question was asked of social workers inviting them to consider what factors they had taken into account in their assessments. An initial hesitancy was evident on the part of social workers in responding to this question, with only a few (3) being able to provide an explicitly articulated framework.

> *"I use an assessment framework which is taken from the McMasters school in Canada ... basically looking at ... five or six specific sections ... in terms of how relationships work within any family situation."*

In by far the majority of interviews (31), the social workers recounted an individualistic approach to their assessments, recalling factors taken into account haphazardly. That is not to say they did not aim to cover the appropriate ground, however. As one social worker put it:

> *"You go through the whole gambit in your mind as you're dealing with people."*

The factors noted by social workers as being influential in their assessments can broadly be divided into two: factors associated with the particular circumstances of the case ('case characteristics') and factors extrinsic to the case ('external factors'). A breakdown of the factors cited by social workers, with regard to factor type and number of times cited, is given at Appendix H.

Two-thirds of the social workers (22) identified case characteristics alone as being of importance in their assessments. All assessments undertaken by social workers in the Adult Psychiatry and Child Guidance settings were included in this group. The remaining one-third of social workers (12), all Area Team based, identified both case characteristics and external factors. The external factors identified as influences by social workers are presented under the heading *Organisational Influences*. For now, however, we look in more detail at the case characteristics that social workers considered influential in their assessments.

CASE CHARACTERISTICS WITH A THEME OF PARENTING

In relation to the case characteristics identified by social workers as important, while there are exceptions focusing on aspects of the mental health of the parent as an individual, the issue that predominates is that of parenting and its pivotal role in the context of family life.

Some of the case characteristics cited by social workers had a clear association with the issue of parenting and these are noted first. By far and away the key factor for social workers, cited in four-fifths of cases (27), was the level of parental functioning:

> *"She manages to look after the surroundings, after herself and her children, which shows me that she is taking care of her immediate environment and the children. She's not letting the place go, that shows me that she's coping. That she goes out, achieves, does washing, does shopping, carries on normal everyday tasks."*

The relationship between parent and child (13 instances), child development issues (9), and good-enough parenting issues (8) — all clearly associated with parenting — were also important factors for social workers:

> *"And mum's relationship with [child] which was also warm and caring and there was dialogue between them."*

"Just looking at the child generally, observing her, looking at her development, ... looking at her size, which was small, but was proportionately small, and her development was good, she was running round, talking, responding to questions."

"It was clear that she wasn't attempting to stimulate him at all, she didn't initiate any interaction with him personally or through the use of toys."

as were the factors of client requesting support in the parenting role (7), degree of risk to child(ren) (7) and impact on family relationships (6):

"She was coming up with real practical assistance that she needed, support she needed ... she's on a fixed income anyway, so she'd come in quite appropriately."

"I was concerned that the fact that she'd got children in her care, young children and therefore my underlying perspective as a social worker is, is this parent able to adequately care, look after and protect her children or is she a danger to them or is she likely to allow them to be at risk?"

"There was the emotional impact of father's illness on the children who were not sleeping at night ... wanting to be with mother all the time, including at night-time."

Although on the face of it the association is less clear, the following case characteristics, it is contended, also had the issue of parental functioning at their heart. So, for example, the support network available (cited in 10 instances) focused on the level of support for the parent both as an individual and in their parenting role/for the family. Similarly, the client's degree of insight (8 instances) included insight into parental difficulties and responsibilities:

"[Parent] happened to have a supportive family, [child] happens to go to nursery, the health visitor is also supportive with the baby ... that's one example of the sort of systems that I'm looking for."

"[Parent] was able to show a high degree of insight into her own problems. She was able to make statements such as 'I find it very difficult to ever be happy with [child], ... 'I realise [child] has taken on the adult's position in our family sometimes'."

And again, financial circumstances (6), environmental/living conditions (5) and general history (4) were characteristics seen by social workers very much in terms of the context of family life and functioning:

> *"Her main concern was to have the children back ... There was no way that she would be able ... to collect her children without having any money."*

> *"The state of the home, how she was managing practically."*

> *"The file ... it was a diminutive file ... we had very few other background concerns, if any."*

CASE CHARACTERISTICS FOCUSING ON THE MENTAL HEALTH OF THE PARENT AS AN INDIVIDUAL

Exceptions from the overarching theme of parenting focused on the mental health of the parent as an individual. Where this different emphasis was apparent, with the focus appearing to be more on (but, even so, rarely exclusively on) the parent as an individual, the case characteristic cited most often by social workers as having importance was what was known of the psychiatric history of the parent (10 instances).

> *"I was taking into account [client's] mental state because she'd been very unstable in the past and, because she'd been unstable then, the care of her children was a bit suspect. So I was assessing how she was feeling."*

A further characteristic of importance, albeit to only a small group of social workers (6 instances), was the degree of risk to the mentally disordered parent. Only one social worker carrying out a general assessment cited degree of risk to the parent in terms of their mental health as a factor important in their assessment, whereas this was a factor taken into account in all five of the ASW assessments.

> *"It was the risk to her just wandering around in the street being out of control ... the way she was and being very unpredictable, she could actually do anything to anybody or wander in front of a bus or whatever."* (ASW assessment)

The final case characteristic (cited in one instance), focusing as it does on cultural aspects of the case, might be considered not to fit the schema. However, to the extent that the thrust of the social worker's interest was concerned with questions of identity, here too the focus might be said to be the mental health of the parent as an individual in their own right.

> *"I have to work quite hard to understand what's the meaning of being Sikh for her, because she's coming to the meetings in Asian dress and giving out some information about fitting in with Sikh culture and religion, and in other ways she was making the very clear statement almost 'I'm English, I've been brought up in England, I didn't learn the language, I kept away from people who were Sikh, teased or commented on girls at school who were wearing Indian dress and behaving in a way which didn't fit in with the customs in this country'. So that I needed to really understand how to reconcile those different views, how she reconciled them."*

SOCIAL WORKERS' WRITTEN ACCOUNTS

Taking the body of data as a whole rather than on a case-by-case basis, the written records, as regards case characteristics, were largely confirmatory of the themes identified in the social workers' spoken accounts of their work. Once again, the theme of parenting/child care predominated, being mentioned in 21 instances including (in 6 instances) specifically risk to children. (In the social workers' spoken accounts parental functioning was mentioned in 27 instances; risk to children in 7 instances.)

The mental health of the parent as an individual appeared to warrant greater emphasis in the written record, being mentioned in 17 instances, including (in 5 instances, all ASW assessments) specifically risk to the parent. (In the spoken accounts psychiatric history was mentioned in 10 instances; risk to parent in 6 instances.) In addition, in a further 9 instances the parent's mental health was noted specifically in relation to their functioning as a parent. The direct linking by some social workers of parental mental health and parental functioning apparent from the case records was not so clearly in evidence from the social workers' spoken accounts

where concentration tended to be on level of parental functioning *per se*. This discrepancy is interesting inasmuch as the data is suggestive of the notion that the mental health of the parent appeared to warrant a somewhat greater emphasis in the written record than it did in social workers' spoken accounts or even (based on the parents' perspectives) during the assessment encounter itself. Why this might be so is discussed in Chapter Eight: Discussion of Findings.

FURTHER EXPLORATION OF THE INFLUENCE OF CULTURE AND RACE

We have seen that, with the one exception, social workers did not volunteer issues of culture and race as being of any significant influence in their assessments. Social workers were, however, asked directly about these aspects as potential influences.

Two-thirds of social workers (23) considered neither culture nor race had been influential for them in making their assessments. In five of these instances clients were from ethnic minorities or of mixed racial backgrounds. In these cases (together with an additional eight white clients, making 13 in total) the social workers acknowledged racial or cultural aspects, ranging from simple recognition to clearer statements about how the particular racial or cultural circumstances of the client might have played a part in relation to the social worker's assessment or within the case itself.

> *"No, it didn't actually, no, it didn't, even though she was Asian, it didn't"*

> *"She was Nigerian, I was certainly very aware of that and I think that sometimes with people who come from that background you have to be more aware of what they actually mean by voices, etc. ... But I think in this case I actually felt ... that really she was pretty sick, it was pretty obvious really. So although I think, although I was aware of it, I don't think that it influenced me to any great degree."*

One-third of the social workers (11) did consider that issues of race and/or culture had been of influence. In six instances clients were from black or ethnic minority backgrounds and social workers acknowledged that this played a part in their assessments. This was either in relation to the acknowledgement of the very particular circumstances of the client and/or evident in the way the social workers chose to intervene.

> *"I think I wanted to really ensure that she was getting the stuff that she was entitled to ... And as a representative of the social services department I certainly didn't want to give [her the impression] that there was racism. ... Which I don't think is the case, I think it's just 'oh, it's Mrs [client] again' 'cos she moans and groans. ... [Also] her feelings, her isolation ... I think that's why I'm saying really that she might have some short-term allocation just to work out what she feels about herself and how isolated she is and what's her support network and ... what her fear's about, she has a fear about going out in the evenings, lots of women do, particularly Asian women ... 'cos there's quite a bit of racism around in [the locality] anyway, and, so, yeah, there's all those issues."*

In the remaining five referrals where the clients were white, cultural factors rather than race were considered to have been taken into account in the assessment.

> *"That's interesting because she is, the mother is the daughter of Polish immigrants, so yes, I guess ... I was conscious, well, I think that the way she is is due to her parental background but also I see some of her characteristics as being characteristics of Polish people, certain kinds of Polish people ... and that has contributed to my assessment of how out of the normal she is for herself."*

The findings on this point have been presented here, not least because, with rare exception, issues of culture and race were seen as falling within the realm of case characteristics rather than as relating to the organisational framework. The significance of this finding in practice terms is for later discussion.

ORGANISATIONAL INFLUENCES

We turn now to an examination of organisational influences on the assessment process. As we shall see, a minority of social workers spoke readily of the influence of the organisation in relation to their assessments. Aside from the external factors identified spontaneously by these social workers, in an attempt to explore a variety of possible wider organisational and contextual influences, a number of direct questions were posed concerning the influence of, for example, setting, the referral, and resources. The influence of the organisational context, in these and other areas, was also apparent from the social workers' responses more generally.

EXTERNAL FACTORS IDENTIFIED BY SOCIAL WORKERS

We have seen that one-third of social workers (12) identified, in addition to case characteristics, external factors that were influential in their assessments. Put simply, the issue concerning social workers centred on questions such as: 'is this for us?' (both in terms of 'is this legitimately our concern?' and, linked to that, 'to what extent can this be relied upon as a referral?'); and 'have we/others got the resources to assist, especially in light of priorities?'. The theme that predominates, then, is that of the role and resources of the agency.

As has been mentioned, where external factors were cited (12 instances, all Area Team based social workers) these were always in association with case characteristics. For those who did cite external factors, the key external factor (cited in 10/12 instances) was concern or lack of concern on the part of other professionals.

> *"The doctor ... had spoken to duty, and that was after he'd seen her and had expressed anxiety about her and was she going to be all right for the weekend?"*

Further external factors cited were the credibility of the referrer in the eyes of the assessing social worker, whether or not another agency was in a position to assist, including practical considerations, and time constraints (4 instances each):

> *"The referral ... that this young woman was being referred by another social worker who'd done an assessment ... and had an understanding of this woman's history, who had known this woman for a long time."*

> *"We had a brief chat about ways and means that this may be financed by making application to the health service ... or by requesting money from DSS. But ... it was between half two and three in the afternoon and realistically speaking it wasn't really on for her to go to [the] DSS ... we're talking about £2.60 for a travelcard, it was really just impractical and unfair, I think, to suggest that she go and queue for that amount of money."*

> *"It's easy to justify paying out money when there's a sort of label attached to it and the clinically depressed bit was a quite easy label. ... Basically when it comes to making a financial request ... I think the fact that I could use — it is very much labelling — but it is a convenient label to say that somebody is depressed and they have an appointment to see a psychiatrist. You can easy justify it when one doesn't have enough time to go in depth into family background and look at family dynamics, which I wasn't going to have that sort of time that afternoon."*

Lastly, awareness of the Agency's child protection agenda was cited as an external factor in one instance.

> *"Because there'd been a lot of concern about her mental state in the past and thus concern about her treatment of the kids, the idea of a nursery place was a way into the family so the youngest child could actually be monitored in case there were continuing problems, so we would actually know about it. It was a way of us getting into the family."*

THE SETTING

In by far the majority of cases (29) social workers considered that the particular setting in which they worked had an impact upon and influenced the focus of their work with families, either directly or in the sense of providing a backdrop against which the assessments were carried out. In five interviews, setting was not considered to be an

influence, although contradictions are in evidence when the data is looked at more widely. Findings have been grouped according to each of the settings.

AREA TEAM

In 22 of the 24 Area Team social work interviews, social workers considered themselves to be influenced by setting. Its most significant effect was to make them greatly aware of their statutory obligations, specifically with regard to children (14 instances):

> *"Without doubt, yes. I mean in terms of the responsibility I feel and the legislation behind our work, obviously it does have an influence. Because the law says I have to be involved in this and have to ensure the child's safety and the various legal requirements in that area, and once a case is allocated to me obviously I taken on certain responsibility, both ethical and legal, to make sure that I carry out those requirements."*

mental health (7 instances):

> *"Well, yes, in terms of child care ... this is a child care agency really, but also it's a statutory agency too in terms of mental health ... and I could enforce that role. If I felt that she wasn't well enough to be going to her mother to collect the child, then I would have done something about that. If I felt that there was a possibility that she was not going to be able to look after her children ... I would have done something about that."*

the conflicts involved when statutory obligations were in competition (4 instances):

> *"In that I had to go and talk to the childminding development officer and therefore had to ring up [client] and tell her, but she said she didn't mind. That made it a bit difficult actually ... because I'm a mental health specialist and that's bringing in the heavy-handed bit which I don't normally have to do in this role, any child care."*

and as a 'helping agency' generally (4 instances):

> *"I think it probably does. We have an obligation to help families, if it's the appropriate thing to do, it isn't just our own personal feelings about it, so, yes ... if she can justify needing money then we should give her money."*

Area Team social workers noted also their awareness of the limitations imposed by the setting, including resource constraints, (8 instances):

> *"I don't feel I'm here to respond to human need just because it's human need. If a vagrant comes in off the street and wants money or wants some assistance, however much personal sympathy I may have for them as another human being, I don't feel that it's my role as a social worker employed by this council to resolve that or deal with that, but my job here is to pass them on to agencies or organisations that have been set up to help people in that situation."*

and remarked upon the pressures that were seen as part and parcel of Area Team work (6 instances):

> *"I do find that, generally speaking, the sheer pressure of child care work is so embracing and all-swamping that it's very difficult to actually make space for the mental health, and that this has to be slotted in with other, also very urgent commitments."*

In only two instances did Area Team social workers consider that the setting had not been of any great influence. Some ambiguity is apparent, however, when the overall data is taken into account. In the first instance, in a second interview the social worker had considered the setting to be an influential factor in the assessment process and indeed had made the trenchant observation *"you're defined by where you're coming from"*. In the second instance the social worker considered that setting had not been of influence in the assessment while at the same time noting elsewhere that the nursery service that she was assessing the child for would, in fact, automatically provide an element of potentially useful oversight.

CHILD GUIDANCE

The setting was considered to be of influence in all the Child Guidance social work interviews (5). Child Guidance social workers were particularly aware of the difference of being workers offering specialist expertise compared to the more global

responsibilities of Area Team social workers, as well as considering themselves 'here for the children' in a way that no other agency was.

> *"I think that we do try and hold an awareness of how the adult world and what's going on in the adult world is affecting children, which isn't always held in mind by other agencies, and I think that's part of our role."*

Beyond that, uniquely, Child Guidance social workers spoke positively of the multi-disciplinary aspects of their setting, noting the expansion of view that working with other disciplines brought to their work, combined with ready access to additional 'resources'.

> *"Extra resources really ... I think it's an extremely useful setting to work in. The EPs are child-oriented, [child psychiatrist] I suppose is child-oriented but will do family work ... we often do joint interviews with the parents and the children, so I get a psychiatric diagnosis and I get an educational, a child development input."*

ADULT PSYCHIATRY

Turning to the Adult Psychiatry based social workers, in two of the five interviews (two of the three social workers) it was considered that the setting had had an influence inasmuch as it ensured they were much more adult mental health focused in the work they undertook and the social workers were aware of specialist knowledge developed as a result of working in their particular setting.

> *"... for this lady the presentation was her inner difficulties ... that often does come up on a psychiatric unit. I think one of the differences is that in an Area Team there's usually another focus, so that it may be the parent-child relationship or it may be housing or maybe a child is in care ... It's that difference."*

> *"Certainly working in the hospital here and obviously having the input of psychiatric information and knowledge ... made a difference ... just because I've got a broader mental health base. ... It gave me an extra range of skills and knowledge to actually assess [client] with."*

The remaining three Adult Psychiatry interviews were with the same social worker who took the view that the setting where she worked was not influential in her assessments, although she acknowledged that she had worked within Adult Psychiatry for a long time, that this might in itself have clouded her view, and that others might disagree with her certainty. Once again, however, some ambiguity is apparent since from other comments made by this social worker it can be inferred that the setting is of some influence inasmuch as she is able to articulate a difference in the likely responses of the Area compared to that from her own setting.

> *"I can only say that because she was actually an in-patient and the fact that she might have been homeless ... the fact that the problem started within the hospital setting ... I don't think there's anything else that actually made it ... any different than if I'd been working in an area, mind you, I haven't worked in an area for years, so I don't really know what the difference is. It probably would have gone for allocation and would have taken 20 weeks to be allocated and by that time he probably would have committed suicide (laughs)."*

THE REFERRAL

From the perspective of parents, in the majority of instances (19) initial contact (referral) was mediated by a third party.

> *"I really was at an all-time low and I went to ask the doctor to take the children away and she got in contact with social services."*

In a minority of cases (5) the parents themselves made direct contact. In all instances of self-referral parents approached the local area social services office.

> *"I phoned up, 'cos I was in care from the age of 11 to 18 and I know that the social services do help ... so I went down there and I just asked if I could borrow some money because I had no money, no nappies, because the social security messed up my money."*

Over two-thirds of the social workers (24) considered they had been influenced in some way by the referral. This was either by its content (in all but four instances in various combinations with the following aspects) (18 instances):

> *"... there was the factor that she'd taken the overdose the week before and the social worker and people had been trying to support her to avoid hospital admission, but in spite of that they'd seen her that Monday morning and were concerned that it wasn't perhaps safe to continue."*

by its perceived urgency/the priority that it needed to be accorded (13 instances)

> *"It was the language used, '[client] is quite desperate, saying she's suicidal and her husband beats her, she hasn't eaten for 10 days, is incoherent and has been drinking' bla-bla-bla, is all indicative of something fairly critical, something that needs to be done fairly urgently and decisions have to be made."*

by various aspects of the referrer, such as their credibility or actions taken by them (12 instances):

> *"I'd had previous contact with [head teacher] and I felt that she wouldn't either make a fuss about nothing or alternatively that she wouldn't ignore something which was important. I had some faith in her in a sense I think."*

and, finally, by the referral's tone (5):

> *"... this is a very full and thorough [referral] from a health visitor ... so I suppose there's that in itself, and you think 'aha, here's somebody who knows what they're doing'. ... so that's why I gave that referral more weight than I suppose I would normally."*

Just under one-third of the social workers (10) considered that the referral in itself had not been of any particular influence. Seven of these 10 cases were self-referrals.

> *"It was a self-referral and she just appeared in reception and I didn't see her before I went out to talk to her, so I didn't have any preconceptions about her at all."*

In the remaining three instances, despite being referred by another agency, the referral was not considered to have any distinguishing features to justify being of any great influence in its own right.

"The referral was very bald really. ... the letter from the GP ... just said that he thought she was depressed but not suicidal but he was concerned 'cos she had three small children ... really I felt that I was going in with very little information. ... I don't think the GP's letter particularly influenced me. ... I just took it at face value just to go in and see what was what really."

Social workers appeared to take self-referrals very much more at face value than they did the referrals from other agencies who were by far the majority of referrers. As we shall see, it is argued that these findings have significance in terms of whose definition of need is likely to prevail within the assessment encounter.

RESOURCES

A number of contradictions emerged from the social workers' responses with regard to the influence of resources on the assessment process.

One-third of the social workers (11) considered that resources had been of influence in their assessments. With one exception which was to do with the quality of a resource, the influence was concerned either with the lack of suitable resources or with the pressure on resources. Such resource constraints led social workers to make less suitable responses or unconfident offers of assistance (6 instances):

"The only day centre we've got is the day hospital and if they'd been at an ordinary day centre ... it might actually suit her better."

"Yes, very much so, because whereas I said I would promise to enquire about the possibility of and so on, if I'd known there was a resource I would have ... reassured her properly instead of making vague promises."

or they led to very tight assessments and careful rationing of resources (2 instances):

"I also had to be very conscious that if this child did need psychotherapy it had jolly well got to need it to get it. ... One of my considerations was, before seeing them all, was to do with, if [child] needed work in her own right ... did she actually have to see a psychotherapist or would it be sufficient for her to be seen by a social worker ... that's to do with resources again."

or, paradoxically, (1 instance) lack of a suitable resource led to the client being offered what might be considered a much more precious resource:

> *"Yes, they did. ... the playgroups in that area are quite good. This lady told me they were full but I knew they were full anyway, they're full 'til September. ... If there had been a vacancy I would have suggested ... that she try to get her into a playgroup and ... I would have offered subsidy because she was on benefit. but there was no point in that because I knew there was no vacancy. ... It would have been good enough I think."*

Two-thirds of social workers (23) considered overall that resources had not been of influence in their assessments. By far the majority of this number (18) (including four ASW assessments where the clients involved were assessed as needing compulsory detention in hospital) considered that any resources required were readily available, either within the agency or from an outside agency:

> *"Not really that much at the moment, no ... there hasn't been that much of a problem in terms of resources."*

> *"I knew that there was a GP and I knew that the GP would be able to set up a [community psychiatric] nurse. I had no doubt about that and that was right. So, not in this particular instance, no."*

Of the remaining five of these 23 social workers, two were aware that, while resources had not influenced their assessments, their availability or lack of availability had influenced the intervention:

> *"I don't think they've influenced the assessment. They've certainly influenced the intervention, what's available to be offered and the assistance side of it."*

and three took the view that, as a matter of principle, assessments should be 'uncontaminated' by resource considerations:

> *"I don't think resources would ever influence my actual assessment of a family. I think I would always ... make my assessment and then look at what the shortfall is."*

One of this latter small group acknowledged that matters were rarely that clear-cut however:

> *"No, not really, because my attitude is that whatever it is that you need you'll have to find it if it's necessary or, if it's not entirely necessary, make do with what you've got. ... But you can only require resources that you know about ... I suppose you do work like that really [i.e. constrained by resource availability] but, as I say, it's all to do with your own imagination really, isn't it, as much as anything. What you could have if you looked for it."*

Indeed the view that, despite best practice, resources do somehow creep into the picture finds echoes in the comments of approximately one-half (11) of the social workers who considered themselves uninfluenced by resources, pointing to considerable evidence, if not to the contrary in these particular assessments, certainly to the fact that these social workers were very well aware of operating within a climate of considerable resource constraints:

> *"That's hard to say, I always feel that there is a need for a crash-pad, non-hospital place for two or three nights or something. I'm not sure whether she would have accepted that line, but, yes, she probably would have needed to be in hospital compulsorily anyway."* (ASW assessment)

> *"Not in the sense that we managed to get a ... foster placement, that felt quite positive that we could get a foster placement within the area, that felt good as a resource ... but I felt, in the long term, what were the resources that we could offer this woman. ... I feel quite negative about what we can really do as change-agents because of the limited resources that we have, and we could offer a placement at a nursery for her and a social worker to go in once a week ... but really what ... resources do we have for a lot of these people, and I think we don't really have enough."*

The following series of extracts (one of two such examples) is interesting in that it appears to demonstrate the insidious effect of a lack of resources on the assessment. The social worker's initial response was that resources had not been an issue:

> *"I don't think I thought of resources for these little boys except in terms of educational ones ... I wasn't getting too much alarm about these two boys, I was much more concerned about this mother and what she had to give."*

In discussion she goes on to reveal, however, how she had rapidly concluded that a potentially helpful resource was unlikely to be available so she ruled it out at an early stage:

> *"There was some talk with my senior ... of a family aide and I think when she was talking to me about that I thought that's such a scarce resource that I don't know if there's any point in asking for that, so yes ... that was an influence. If I'd thought it was more freely available and I wouldn't get snubbed, 'we've got more urgent cases than that' perhaps I might have rung them up."*

Getting into her stride the social worker recalls another support, the idea of which she again discarded because of the seemingly luxurious nature of what, translated into a social service resource, might be characterised as a home care assistant, befriender or even after-school play scheme:

> *"I think I did say to this girl she could have done with, I didn't use the word to her, but a surrogate granny and that was what I thought would be nice, if there was a granny figure that could meet them after school, take them over to tea, someone who could have them for the Saturday. That was the resource I would have liked (laughs)."*

In addition, the picture of resources being a significant influence in the assessment process is reinforced inasmuch as, when asked how they saw the influence of the political climate, approximately two-fifths of social workers (13) considered this to be manifest via the issue of resources:

> *"I suppose it did, because she had nowhere to go and also she was being turned away by the hospital, and the fact that you do feel that people like that are, haven't got a place, individuals, adults, haven't got anywhere to fall back on, the fact that the hospital was washing its hands of her ... must be political. ... I suppose if there had been some wonderful place that you could recommend that she do go when she's desperate, then that's what you would have pointed her at ... But there just isn't anything."*

With regard to the influence of resources, then, much of the data was contradictory. The overall picture gained was that the availability of resources was perhaps of

greater significance than many social workers were aware of, most notably when it came to discussing the particular rather than commenting upon resource constraints in general.

THE GATEKEEPING ROLE

It will be noted that the above organisational influences most apparent to social workers were the setting in which they operated (in terms of it dictating their agenda) and aspects of the referral (over and above its content). This underlines the fact that the findings reveal gatekeeping as a prime function of assessment. By definition, gatekeeping means that as well as ensuring the way is barred to some, others must not fail to be ushered through, most notably in situations of high risk. In the very particular context under consideration of children and families where there is parental mental ill-health, gatekeeping takes place where a plethora of needs, duties (not least to protect children and support families) and available resources coincide and definition of the agency role is thus at its starkest.

In the light of the priority accorded to gatekeeping, it is not surprising then that, where the agency role was not considered to be clear from the outset (six instances, four of which were self-referrals), the focus of the assessment was on establishing exactly what the problem was, who else was involved and generally clarifying the scope/need for agency involvement. In all of these cases the social workers reported that they had chosen their focus in order to establish the character of the difficulty and the extent of their brief:

> *"I just saw him on duty, he came in to ask advice, so I was just trying to establish what was the problem and what he wanted, and whether or not I could do anything for him."*

In by far the majority of cases (28), however, it was apparent that the social workers considered there to be a clear agency role from the outset. In the majority of these instances (21) the focus of the assessment was directly linked to the detail of what were seen as appropriate referrals:

> *"It was a request from a GP and the consultant psychiatrist to actually go out to do the assessment, so, it wasn't in the context of wider work with the family."* (ASW assessment)

In seven cases, however, social workers chose to focus somewhat differently than the referrals indicated, highlighting again the importance of the gatekeeping role. In all of these cases it is clear that the social workers were making professional judgements and extending their assessments to incorporate areas that, in their view, were likely to be of greater, or at least of equal, significance to the problem as referred, sometimes with the agency's child protection brief in mind:

> *"It was immediately apparent to me that ... the mother was actually very depressed ... I felt within the first five minutes that whatever was the matter with [child] was because of what was the matter with her."*

> *"... even though ... the actual focus was meant to be the mother ... if somebody's got children I always look at the child because, having done child care work myself, I know how important it is, the parenting, and I know that's part of the statutory duty, so I always do both, although in this job [mental health specialist] my focus is the mother."*

In the majority (21) of the 28 cases where the agency brief was already established, the social workers saw their focus primarily as investigating the circumstances of the referral, albeit pursuing different emphases, namely, the parent/parenting role (11 instances):

> *"I was assessing her ... to see whether she should be detained under the Mental Health Act in hospital, so I was assessing her mental state at the time of referral."* (ASW assessment)

both parent and child or the whole family unit (6 instances):

"I was assessing the mother's attitude to the boys, that was my first focus."

"I was assessing the whole family that lived in the flat."

or the child(ren) (4 instances):

"The initial reason for my seeing her was to make an assessment of whether [child] needed help in her own right or help could reach her through working with the family or mum."

In the remaining seven cases the gatekeeping role is again thrown into relief since the social workers saw their focus as assessing the client's eligibility for a service on offer by the agency, such as an Under Fives place or financial assistance:

"... whether we should give her the money or not. That was the actual focus."

Moving on to compare the responses of social workers and parents with regard to the focus of the assessment, the most striking difference is that the social workers invariably emphasised the task being undertaken whereas by far the majority of parents understood the focus in terms of the people involved. So, for example, even though social workers already acknowledged a clear agency role in the majority of cases (28/34), they remained task-centred in describing the focus for their assessment. A minority (7/28) did not mention the people involved at all as providing a focus for the assessment, seeing themselves as assessing for a requested service, whereas for the majority (21/28), who saw their focus as being to investigate the circumstances of the referral, the people involved were mentioned, but only in terms of where/on whom the social workers had chosen to focus down in their investigation of the circumstances. In other words, it was evident that social workers were task-based first and people-centred only in support of that. In the small number of cases (6/34) where there was not already perceived to be a clear agency role, the focus for social workers was on establishing exactly what the problem was and generally clarifying the scope/need for agency involvement, again indicating an approach which is task-centred rather than people-centred.

In contrast, the majority of the parents (20/23[2]) understood the focus of the assessment as being (and saw the social workers as being) focused on the people involved, specifically either on the child(ren) (9 instances):

"I think she was more interested in the children and the children's welfare."

on the parent themselves (7 instances):

"She was most interested in me. We tried to find out what was the problem."

or on both parent and child(ren) equally or on the family unit as a whole (4 instances):

"Finding out why we thought we were there and what we thought we wanted to get out of it, as a family, basically."

Only a small number of parents (3/23) reported the social worker as being solely task-focused, specifically establishing whether or not there was a role for the agency and/or advising on/solving the problem to hand:

"I came because I've got a problem, but the problem is somebody else ... She just advised me as to the situation with people like [ex-wife]. ...The second social worker ... was obviously interested in my problem from the point of view that ... there was a good chance that the house might have been burned down ... he was sympathetic in trying to help me to get something basically done about [ex-wife], ... but, as he went through it, he explained that basically that there was nothing he could actually do."

Despite the parents' majority perception of the social workers' emphasis on the people as opposed to the task, issues of eligibility and the provision of services as and when appropriate were nevertheless in the frame. Approximately two-thirds of parents (15/23) considered that the reasons underlying the social worker's chosen focus were either related to clarifying/investigating the situation (8 instances):

"They all seemed very concerned that there was no child abuse going on. I think this was what everyone suspected, that somewhere along the line a child was being abused."

[2]Equipment failed to record part of one interview; where data set is incomplete it is noted in the text.

or because the social worker was carrying out his/her role either generally (4 instances) or specifically in relation to the problem as referred (3 instances):

> *"I would have thought it was because it's their job and that. That is one reason why I phoned them, because I thought, well, they are in charge, they know what to do with kids and ... I just thought they're the only ones which could help me out."*

> *"Because the letter came from the school and it was about the boys."*

A further one-third of parents (8) considered that the social worker's focus was selected for supportive reasons and in order to move the problem forward in some way:

> *"Not 'cos they were worried about the children obviously ... probably to give me a break ... for me to get myself sorted out ... knowing that I need to be sorted out before I could sort the kids out and ... treat them the way they should be treated."*

The data indicates, however, that while parents do understand social workers are 'doing their job', in the main, their perceptions focus on social workers as people who provide support and help solve difficulties rather than being merely those who execute agency-appropriate tasks. There is indeed much in the data from the social workers to suggest that they *are* problem-solvers, but it cannot be overlooked that they are not just problem-solvers *per se*, they are solvers of problems as defined by the agency by which they are employed. Paramountcy of the agency remit — and the repercussions for clients — is a point for later discussion.

PROFESSIONAL/POLITICAL CLIMATE

Social workers generally found this a problematic question. There appeared to be varying perspectives regarding extent to which such influences might be in operation:

> *"Well, that's the thing about a climate, you don't know it's influencing you"*

"No, I don't think so ... and I'm thinking, had it taken place today, with the political climate that's recently changed in the office [child death], that I probably would have put more focus on the children than on her. So I think that, yes, I'm answering in two ways. I think in this instance, no, the political climate did not influence my assessment and I think that I am open, as we all are, to being influenced by political climates. And I think that had I done this assessment today, this week, then I may have taken more time in looking at the welfare of the children and not just been guided by her mental state."

In about one-third of instances (10) social workers considered without equivocation that they had not been influenced by professional/political considerations. Beyond this in 24 instances (approximately two-thirds), social workers considered that the professional/ political climates had been either actually (15 instances) or were potentially (9 instances) of influence. As we have seen, the issue mentioned most often in this connection was the political one of resources (13 instances):

"I think anything to do with money, you've got this sense all the time of shrinking resources and a hostile overall political climate to local government in general."

Apart from resources, which were seen as an essentially political issue, other issues mentioned concerned professional rather than political matters, for example, awareness of the demands/limits of the professional role (7 instances):

"My personal professional opinion ... is that it's not actually right for us to undertake a lot of these situations. When there's an immediate child care element of risk or hazard, yes, I think it's appropriate for us to take that on board, but when you're talking about situations with some little or no child care issues involved and it's purely a matter of somebody not getting ... their giro or not receiving a social fund payment and there's no other factors at all ... I do object to that and I don't think we should be giving our time or resources in that sort of situation."

heightened sensitivity to child protection issues (5 instances):

"Well, I knew that I had to satisfy myself that she wasn't saying that she couldn't stand the children any more or that she'd kill them or anything like that. I hope I would have always thought that really. However, we're all very conscious of that of course. So I suppose in that sense, yes, I suppose I was influenced by that. I mean we're all very careful, we're all very careful."

together with other issues of professional concern namely equal opportunities (2 instances) and evolving professional standards (2 instances):

> *"I think also any mental health assessment of anybody who's clearly non-ethnically British and white and local ... one just has to do a mental checklist with yourself that you're not unduly discriminating or prejudicing your views because of that. ... It's all about interviewing in an appropriate manner and so on."* (ASW assessment)

> *"With all the new stuff that we're bringing in on reviews and things, I think I recognise the need to be very clear when I first meet clients about why I'm going ... and what the purpose of it is, 'cos I recognise I haven't always been in the past. ... I think this case probably highlighted the things that have been developing in the office about being open and honest with clients."*

In a reflection of earlier findings, these findings are suggestive of a lack, on the part of the social workers, of any strongly held sense of the backdrop against which they operated.

FORMAL DEPARTMENTAL WRITTEN GUIDANCE

We turn now to a consideration of what was provided by the agency in the way of formal policy, procedures and practice guidance for the purpose of supporting and guiding social workers in relation to the task of assessment.

As we shall see in the section entitled *The Managed Professional*, social workers had recourse, as and when they considered it appropriate, to the advice and guidance of seniors and managers regarding the task of assessment. In addition, relevant formal guidelines and procedures, applicable at national level, both in relation to child care and mental health, were distributed within the department. Social workers also had the opportunity to consult local guidance contained in the departmental policy and procedures manual. Examination of a typical manual, however, revealed only a limited amount of formal written guidance pertaining specifically to the task of assessment

and the related areas of planning and decision-making across all client groups. In total, there were seven separate entries covering, variously, between two and thirty pages (see Appendix I).

Some of the written guidance available, particularly in the areas of child protection, child care planning and in relation to the assessment of older people, appeared up-to-date, typically reflecting the tenor of recent national guidelines and current professional thinking. Guidance of this standard contrasted with other guidance that was dated up to ten years previously but still current. While this was not necessarily problematic, the lack of recent review was notable inasmuch as some of the guidance had a distinctly antiquated flavour, a fact that arguably would have reduced its relevance for social workers (for example, an entry entitled 'The Social History' which *inter alia* made reference to 'immigrant families'). Guidance on assessment procedures was available in relation to both child care and mental health. However, no guidance specifically addressing the area of parental mental health vis-à-vis child care was in evidence.

It will be clear from the above that, at least in terms of written guidelines formulated with the local area in mind, assessing social workers operated in something of a vacuum. Moreover, while issues of practice were not entirely overlooked (particularly, for example, in some of the more detailed child protection guidance relating to comprehensive assessments as a basis for planning), a heavy concentration on procedural mechanisms was apparent in much of the guidance available. In terms of the written guidance, then, managerial priorities clearly prevailed over issues of professional practice. The implications for effective practice both of the paucity of departmental guidelines and of their bent towards managerial considerations are issues to be explored further in the later, more detailed discussion of the findings overall.

THE MANAGED PROFESSIONAL

So far we have seen something of what is influential for social workers in undertaking the assessment process. Social work assessments, however, are not understandings of situations for their own sake; by definition, they beg outcomes. Assessment, then, is also defined by the need to arrive at a relevant and coherent response. Social workers are required to achieve such a response by drawing on their very particular professional knowledge, training, experience and skills while, at the same time, ensuring (and, indeed, being asked to account for the fact) that they have not lost sight of organisational aims and responsibilities. In this sense, then, they might be termed 'managed' professionals and their role imbued with all the complexities such a term conjures up.

THE EXERCISE OF PROFESSIONAL DISCRETION

We have seen how, as part of the gatekeeping function, social workers were required to exercise professional judgement with regard to gatekeeping decisions. Data both from social workers and from parents indicate support for the notion that social workers, mindful of their role and responsibilities, varied and, in particular, widened their assessments as and when they considered it appropriate. In other words, different levels of assessment were in operation, the level of assessment being subject to adjustment depending upon what the situation under investigation was seen to warrant.

About three-quarters of parents (17/23) considered that social workers displayed a wider interest over and above their primary focus. Areas of additional interest to social workers were <u>other family members</u> (10 instances):

> *"Yeah ... given [child] is a minor, his father's dead, his interests needed to be taken into consideration obviously, if I wasn't going to be able to look after him, then they would have to consider having him somewhere else."*

the family's domestic circumstances (4 instances):

> *"Yes ... she did want to help, she suggested that maybe it would be a good idea if they could write to the council to get me moved away."*

and, in three instances, the social worker's interest was perceived as being global in tone:

> *"She appeared pretty impartial and basically want to know ... the whole set-out."*

In approximately one-half of the social worker interviews (18) it was apparent from the social workers' spontaneous comments that the needs of both the parent(s) and child(ren) had been taken account of in the assessment. In the remaining 16 cases, however, social workers were additionally questioned specifically about the needs of either child(ren) or parent, as appropriate.

Taking first the social workers' responses in relation to the needs of the child(ren) (10 instances), the predominant theme (eight instances) centred on the view, often with the child's needs firmly in mind, that if the parent was functioning or could be supported to function well enough then the children were likely also to be faring well enough. In terms of the exercise of professional discretion, then, the overall approach here was very much to take situations at face value, doing some fine-tuning in the way of support/advice as appropriate, and probing that little bit extra where necessary. The following extract spells out this approach:

> *"I am loath to say too much more about how much I was assessing her capabilities as a mum, or how much I'd taken into account the kids' needs. Probably, at some level, yes I was, but I think I really have to go back and emphasise the fact that this was a short-term decision being made, I would guess I didn't interview her for more than 10 minutes, and in that time, obviously, I'm not going to get a detailed family history or much background. ... I think the focus would have been helping mum function (a) as an individual and thereby, as a secondary issue, functioning better as a mum for these kids, as far as I knew, with the information I had. ... If she'd have been obviously more distraught or making obviously inappropriate requests, I think at that point I would have been going a bit deeper, but*

because the pattern seemed to me to be quite rational in terms of a practical problem to which she'd come to an appropriate agency and had made an appropriate request, I think I pretty much went along with that, on the basis that it would help her and therefore help the kids. If anything out of the ordinary or a bit weird had come up in terms of anything she might have said about the kids or if she had made a slightly bizarre request to go somewhere that didn't seem particularly important or rational, then, yes, I would have gone a bit deeper. But the level it was at was fairly clear and fairly appropriate as far as I could make out, so I took it pretty much at face value."

In the two remaining instances, the social workers did consider the needs of the children but did not act to remedy potential perceived lacks, demonstrating considerable professional discretion:

"Yeah. That perhaps maybe they weren't getting as much emotional support as they perhaps needed, I don't know, but [client] was certainly trying to do her best to ensure that they got everything else, which included holidays, school uniforms, bus passes and stuff. ... In my mind the recommendation would be, if we had the resources, for short-term allocation."

The picture gained from the social workers' responses in relation to the needs of the parent (6 instances) similarly reflects considerable discretion on the part of social workers. Again, the predominant theme was that the social workers had not focused for any length of time on the needs of the parents since in the social workers' judgement they appeared to be managing well enough when interviewed (3 instances):

"No, not really ... I felt she has a capacity obviously from her past behaviour to get very depressed, suicidal if things go wrong in her life. I felt there was going to be that a capacity for that, but really ... it was a reaction to circumstances, that she's ... very influenced by circumstances, her mental state is up or down depending on what's happening, and that she's likely to have a fairly unstable existence, but not that it was a mental health problem that you could actually treat in any way."

In the remaining interviews (3) social workers demonstrated their discretion, firstly, by judging that, despite recognising that the parent had particular needs as an individual,

prime importance needed to be given to the parent/child relationship (two instances) and, secondly (one instance), by retaining a sceptical, 'wait and see' position regarding the mother's individual needs notwithstanding that the parent herself considered she had no mental health issues that needed addressing:

> *"I didn't consider her needs as an individual. I was trying to keep the focus on [referred child] and if we didn't stick entirely to [him] to look at the children. But inevitably I didn't railroad over her ... you can talk about the parents ad nauseam ... and you don't actually as a result improve very directly the relationship between parents and children."*

> *"I brought that up as an issue 'cos I didn't want it to be a hidden agenda ... she said that it had been a problem ... and that it was something she'd turn to when she was having a bad time. She'd recently split up from her husband ... and the drinking had all been around that, but that she was okay now ... I'd picked up from the file there had been a referral to [detoxification unit] which I think was when we brought up the query about the mental health. She said she'd never been and that she'd been to see the doctor in a very depressed state around when the marriage was breaking up and she was drinking and she did want help and he'd suggested this referral ... So I was picking up that alcohol was something she turned to when she was depressed or had problems and that would always be a potential for the future as well, while at the moment she was presenting as not drinking, there wasn't any evidence to show she was. ... But I was left with the feeling should this be something I'm doing?"*

The point about the exercise of professional judgement/discretion and different levels of assessment being in operation is reinforced by social workers' comments when talking about their use of knowledge. Emerging from that data was the idea of a 'negative' assessment, echoes of which were apparent in about one-third of the interviews (10). What this means, in effect, is that, instead of proactively or 'positively' assessing a situation in its entirety, the assumption is made that, in all respects other than the immediate problem to hand, the situation is fine. Aspects of such an assessment would be therefore almost by default.

> *"Probably I could put it in another way, if I could restate this, say, in a sort of negative way, that I think my knowledge of mental health issues ... if there had been, for me, warning bells there, would have come into play in a positive sense. If I'd seen warning bells about how mum interacted with me, about how she'd interacted with the duty officer, if I'd seen more on the file*

about past contacts and mental health concerns. So, from a negative point of view, the fact that alarm bells weren't there informed my decision, rather than the fact that anything was there that did inform my decision."

In such cases, rather than proactively assessing all aspects of a case, social workers would instead stay alert for the unusual, sometimes referred to as 'warning bells'. If warning bells were sounded social workers would probe to satisfy themselves or take some sort of action. In the following example the social worker stayed involved where she could reasonably have ceased contact because she sensed a warning bell and was not happy with the situation:

"... although it seemed reasonable, I wasn't a hundred per cent happy, and I knew that he was going to nursery in September and I really wanted to see how that would be used, because the health visitor had said about whether she had some involvement with drugs and ... although that's not grounds itself for us to be involved, if that was involved I just wondered how this would affect the situation. So what I wanted to do was go back, although probably I felt that things would be all right."

Most often, then, particularly in the duty situation, it was a case of social workers simply staying alert for warning bells. The watchword appeared to be 'you don't go looking for trouble', with the rider 'but you do stay alert for it'.

In relation to assessment work on duty, which is probably where there is the clearest dividing line between the negative and positive approaches to assessments, the most common approach of social workers, while it appears to be very procedural in style, suggests that social workers are always aware that their role encompasses duties and responsibilities over and above the rationing of and/or handing out of services. As we have seen, social workers are gatekeepers whose role is to usher some through and to bar the way to others.

The following extracts illustrate these two aspects of a common duty approach. The first is indicative of the gatekeeping role in the commonly understood sense of establishing service eligibility and the second highlights that gatekeeping takes place in the context of very particular statutory responsibilities:

> *"I think what I'm really coming round to saying is that this was basically only a two-way decision, it was either a 'yes' or a 'no' to the money that was being assessed and a number of factors would have informed the decision either way."*

> *"When I go to duty interviews I go very much with an open mind and just go to pick up and register whatever is there to register ... And if there is something that I pick up then, yes, I will probe it ... I will be looking for the unusual and the negative ... 'cos you're looking for trouble in a sense. If you don't find it, fine, close it and get on to the next one."*

The tensions in the process increased when the dimension of clients' rights was brought into the picture. In two instances, social workers put the case for not having the automatic right to probe more deeply than the presenting issue — unless, of course, there were statutory reasons for doing so:

> *"It was an ongoing [duty] case, she was presenting with odd symptoms, but I wasn't an ASW, I wasn't prepared to get into analysis ... she has a right to be odd if she wants to, as long as it doesn't affect her kids that's all, so I didn't pursue that."*

We have seen, then, that, as a matter of course, social workers exercise considerable professional discretion in order to make often finely-balanced assessment/ gatekeeping decisions. It is clear the social workers are aware of statutory responsibilities that they are duty bound to pursue if the situation demands. The parents' data appears to bear this out inasmuch as, as we shall see, assessing social workers sometimes pursue aspects which are not of interest/importance in the parents' eyes. Further, in a quarter of the parent interviews (6/24) the parents perceived the social worker as displaying no interest in anyone else in the family beyond the selected focus for the assessment:

"No. Just the children. ... I would have liked someone to talk to, because I'm on my own, and ... I need someone to talk to."

The absence (or indeed presence) of wider interest on the part of social workers was not necessarily problematic for parents, as we shall see when we look specifically at levels of agreement between parent and social worker in the section headed *Social Worker-Client Communication* in Chapter Seven: Findings (III). However, when the perceptions of the six parents who perceived the social worker as displaying no interest in anyone else in the family beyond the selected focus for assessment are compared with those of the social workers it is apparent that all these social workers did, in fact, also weigh the needs of others in the family during the course of the assessment. One of these social workers spontaneously reported taking into consideration the needs of both parent and children in her account of her assessment, whereas the specific question whether or not they had considered the needs of parent/child was asked of the remaining five. All these responses were in the vein that, since the social worker had judged that the parent appeared to be doing okay, the assumption had been made that all was well more generally. This picture is suggestive of the negative assessment approach — which has its roots both in the gatekeeping (in and out) function and in the notion of professional discretion — in action. Indeed, two of these social workers were ones who articulated adopting such an approach. It seems likely, however, that at least some social workers employ this approach in a less obtrusive and arguably more internalised way.

CONSULTATION AS AN AID TO THE ASSESSMENT PROCESS

Social workers were as likely to complete their initial assessments on the information presented to them as they were to make a point of consulting more widely. ASWs, on whom there is a statutory duty to consult, were the exceptions. Where social workers did consult, the emphasis was on gathering information and seeking opinions rather

than on communication as such. Consultation, then, appeared very much to do with tying up the social workers' own independent assessments and often the piece of work generally, any collaborative effort being frequently to that end.

Just over one-half of the social workers (18) considered that they had not needed to find out more information to complete their assessments. By far the majority of these (16) felt satisfied that they had sufficient information to complete their initial assessment, (although two social workers would ideally have liked more information):

> *"No ... I'd spoken to the school [referral source] and I knew she was going to the doctor and I think I was happy with that. And also, I'd checked the records here to make sure that somebody hadn't been there last week and taken a child out or anything like that."*

Just under one-half of the social workers (16) did seek out additional information before completing their initial assessments. This number included the five ASW assessments and a child protection referral. The social workers sought additional information for a variety of often intermingling purposes. The most commonly cited reasons were to gather information (10 instances):

> *"The purpose of going back to the school was to establish how the boy was, and whether he was displaying any other behaviour within the school that would lead me to want to interview him further."*

to check the views of other professionals in order to have their own views either confirmed or disconfirmed (10 instances):

> *"[The health visitor] was going in checking on the child so it was really to see if she had the same opinion as I did in terms of the child's development and the relationships."*

and for the purposes of communication generally (5 instances):

> *"I did phone the council. My primary motive in doing so was to inform them of what was happening and to ask them where they were in relation to trying to transfer [client]."*

To a lesser extent contact and consultation were for the purposes of informing another agency with a view to their monitoring the situation (2 instances):

> *"I shared my assessment ... What I said was that ... we wouldn't actually be offering her social work input at this time but if they had any concerns about the children ... please would they feel able to refer to us."*

checking factual information and liaising over a practical matter (1 instance each):

> *"I had to phone the DSS ... which was basically a confirmation of the situation which the mother told me."*

> *"And the other thing was ... [child] didn't have a school uniform ... so I rang the school to discuss [case] with them ... and I managed to get a uniform grant."*

CONSULTATION WITH SENIORS

The picture of social workers working to a large extent independently is reinforced by the type/level of consultation with seniors and peers as well as the extent to which and how they are influenced by these two groups.

Where social workers did consult with seniors, in the main, they were not influenced in their assessments. In addition, consultation with seniors was mainly concerned with issues of organisational accountability rather than with issues of practice.

In two-thirds of cases (22) the social workers had some discussion with a senior. The majority of social workers (14) considered that these discussions were not influential to their conclusions, with some 'discussions' being either cursory in the extreme and/or in the vein of 'reporting in', including authorisation of finance (9 instances):

> *"I discussed it with the senior and I think, again, there's discussion and there's discussion. It can very much depend on what's going on in the office at the moment. I'm not sure what the duty senior was involved in, but there was some work that was going on that was fairly involved and intense and so the limits of the discussion can be like 'this is what I've decided, on this basis' and that can be a matter of, it was, a matter of a couple of sentences."*

"It was just trying to negotiate the money really, presenting the case and negotiating the money."

While the remaining discussions (5) were of greater length and significance, they nevertheless remained uninfluential in terms of the assessment, the overall flavour of these responses indicating that they were rather longer reporting in sessions:

"Just my senior ... she just took on board that they might come into care. I didn't spend the whole supervision time on that case, I'd taken two or three, but there was an acknowledgement of how hairy it sounded really and how rejecting this mother sounded. I thought I'd keep her informed about developments in case they did have to come into care. It was that kind of pitch at that time ... the organisational bit."

For one-third of the social workers where discussions with a senior took place (8 out of 22) the discussions, albeit sometimes brief, had been influential in some way, either in relation to the assessment or in relation to the intervention:

"I did discuss it with my senior ... I went through what I'd done ... I think the one thing I took away was not to get into a collusive role with the mother ... And I think maybe there was a little bit of that perhaps in the first interview, that I had to be aware of for subsequent ones."

"I talked to [duty senior], that was all ... to give her money he had to sign the form, and I wanted to make sure that he ... agreed to a reasonable amount and so I explained what her state of mine was to him, and, yes, he was very sympathetic and ... I think that I might have thought £25 and he made it £30. I think he pushed it up rather than down, so that was what it centred around. It wasn't more than five minutes, if that."

In one-third of the total number of cases (12) there was no discussion with a senior of either the assessment or the proposed plan. The predominant reason for this was that, in the view of the social workers, the cases did not warrant it and were within their capacity to deal with without discussion:

"That doesn't happen on duty, does it? I don't discuss everything I do on duty with the duty senior, the only thing that gets discussed is the things like just child protection referrals. This is a very routine, as far as I'm concerned, a very routine referral and a very routine assessment."

As well as social workers taking the view that the cases did not warrant discussion, the pressures on their time and seniors not being readily available were mentioned in conjunction:

> *"Certainly there was a lot going on ... I had to make it fairly quick ... It was probably partly to do with that, but also because of what he'd been asking me, I think I'd tied it up as much as I could have done."*

> *"I didn't actually. I don't think it would have made me act any differently looking back ... and, yes, there are some mental health cases which I would discuss with them, but often, logistically, you're out there, you have to get on with it."* (ASW assessment)

This combination of the social workers considering that the work was within their capabilities and, in essence, to some extent enforced independence was perhaps most noticeable in relation to the ASW assessments. Of the five ASW assessments included in the study, four did not consult with a senior and the fifth had only the most cursory of initial discussions.

> *"No, I didn't discuss it with my senior back at the office, partly 'cos of the time element, but partly because ... you can debate whether one should, but, we tend not to, the practice is that I tend to make my decision and it's my decision and I only consult with a senior if I'm worried about something or bothered about something rather than automatically reporting, which would have spent further time on the phone trying to locate him, I can't remember if he was actually in that day or not. So as a matter of routine I don't normally consult my senior unless there's something I'm not sure about, I want advice or there's a legal thing somewhere".* (ASW assessment)

CONSULTATION WITH COLLEAGUES

Discussions with colleagues were more limited but tended to be more influential. Such discussions were as likely to be for the purposes of gathering information and gaining opinions regarding practical next steps as for the purposes of peer supervision as such. Any influence appears to be more connected to practical implementation of actions required rather than informing the social workers' conclusions.

In over one-half of the cases (19), no discussions with colleagues took place. Again, this was due to a combination of the cases not warranting discussion and time pressures:

> *"No ... [case] didn't warrant it."*

> *"I may have come back into the room and said something like 'I've got this poor lady in tears out here', but I didn't discuss it, no, not really. I think everybody was running in all directions and on the 'phone and I think there were other people in reception at the time as well."*

Discussions with colleagues took place in the remaining 15 cases and in the majority of instances (12) these discussions were influential in some way, either in relation to the planning and process of the assessment (8 instances):

> *"I think that was one of the reasons why [duty colleague] was getting in a flap ... rather than wait till 5.30 to see [mother] he was going to go tromping in to see the boy, and saying 'oh I don't need to see the mother, do I?'. Whereas that was entirely wrong ... I felt myself thinking I don't actually want these people to have to deal with all that, so I wanted to do it myself rather than to expose them to that."*

or in relation to alternatives for intervention (4 instances):

> *"It changed in the sense that [student] put forward an option that I wouldn't have thought of ... which I thought was a very good suggestion, so it did, yes."*

There were only a small number of instances (3) where discussions with colleagues had taken place where the social workers had not found these discussions to be of any particular influence. These were all cases where the social worker was continuing involvement beyond the initial assessment:

> *"I've discussed it with colleagues since I went on the visit ... it may influence my thinking in the future, but not at the time of the assessment, no."*

WEIGHING RISK

Being mindful of risk considerations is clearly part and parcel of the assessing social worker's gatekeeping role. The central role that the issue of risk has in the assessment process is now highlighted as we turn to the social workers' assessment conclusions. Risk considerations were a central element of these. In three-quarters of cases (25/34), the social worker's conclusions focused on the safety and risk elements in the situation, with these being addressed either explicitly (15 instances):

> *"The conclusions that I reached was that [client] had had ... quite a violent outburst which when looked at in the context of everything was justified and was a one-off release of her feelings ... I believed her when she said that she'd coped through the worst and that she didn't need any help at the moment. I thought that there had been significant changes inasmuch as that she was now well on her way to sorting things out, which I thought was maybe why the outburst had happened now. It was like the immediate pressure had begun to resolve, so now she could afford to have the outburst, and I agreed with her that she would contact us if she needed further help or support."*

or implicitly (10 instances):

> *"Now against all this background of a very short term precise administrative, financial sort of task, the one factor that probably stood out and might have suggested another problem was the statement by the health visitor in the past that mum had had post-natal depression. So that's going into the interview with me as something that I'm aware of, not all that heavy about, because it could mean so many things but it's there and something I'll be watching for. Didn't seem to be any evidence of major problems there and therefore I didn't take that on board as a factor which would lead me to make an immediate financial payment to this woman."*

A somewhat smaller majority (two-thirds) of parents (16/24), too, understood the social workers' conclusions at least partly in terms of risk assessment, statements such as *"he obviously thought I was coping"* and *"she says that the boys are all right"* being common. Whether or not parents understood the emphasis on coping in the same way as social workers (i.e. that not coping might have meant solving the problem in a way that involved the introduction of statutory powers) is not clear.

CONSIDERATION OF ALTERNATIVE ACTIONS/PLANS

In the overwhelming majority of cases (30) social workers responded that they had not given any consideration to alternative courses of action:

> *"No, I felt very much that I'd done my part and it was now left to the duty senior to dispose of as she thought fit."*

In only very few instances (4/34), then, had social workers actively considered doing anything else. In three instances, risk elements were being weighed in the balance to a greater or lesser extent, (for example, two of these cases were ASW assessments), with resources and practice considerations mentioned in one instance each:

> *"I considered ringing the hospital and discussing the whole thing, though I was pushed by then because it was towards the end of the Friday. I'd dropped other things to do this and ... that was a constraint, I needed to go back and see what else ... was needing tying up. ... We did consider referring her back to the refuge. We talked to her about how happy she was to go back home. The refuge were not happy about this, it has to be said, because I think they were just not sure that they could contain their own anxiety about whether she was suicidal or not. ... And we told her that ... she was aware of that and she was saying 'I want to go to hospital instead' and 'yes, I know that the hospital probably won't admit me but nevertheless I'll go and talk'."* (ASW assessment)

This picture of the consideration of alternative courses of action being influenced largely by risk factors is reinforced by the social workers' responses when (in 27 instances) they were asked about the consideration of alternative courses of action specifically in relation to the parent/child who was not the primary focus for attention. Here again, by far the majority of social workers (23/27) responded that they had not considered alternative actions, the majority (21) citing either <u>insufficient cause for concern or because they or another agency were continuing to be involved/monitoring the situation</u>:

> *"No ... I didn't think there was any need, I suppose I could have checked at the school that everything was all right. ... I didn't think of it ... And, it didn't sound as though it was a high priority. I think if dad had been coming*

in saying this child's really anxious and he's getting really wound up, then I would've, but that wasn't really the question, that wasn't what he was saying. He was saying that he and the boy were quite all right about it all ... I didn't think it was part of the problem."

"... she'd be monitored by the medical profession, and if she was on medication ... she's got her doctor there and her doctor could always refer, or CPN could refer, the psychiatrist could refer to us, if they felt that she needed social work support. ... there's a health visitor, then there's the clinics and the schools ..."

In the remaining two cases, social workers reported that consideration of alternatives was without point due to the lack of appropriate resources and practical considerations (one instance each):

"No, 'cos I felt that if she was asking for it there wasn't anything we could provide"

"No. ... at that stage I didn't even know where [client's children] were, so I did all that we felt we could do, the airline checking ..." (ASW assessment)

In four instances the social workers had considered (and in fact in two cases had additionally taken) alternative courses of action specifically in relation to the parent/child who was not the primary focus for attention. In all of these instances consideration of alternatives was connected with arriving at the most appropriate all-round intervention given the situation under investigation:

"I was a bit anxious about going through with that process when I felt this mother was so much needing something for herself and I was concerned that I was saying to her 'please wait' initially and she was getting ... desperate. ... Because she had been saying ... to me I desperately need to talk to someone, I need to see someone myself and I said 'well, one of the options that we're considering here at the clinic is that it maybe that you're going to be the person we see anyway so do you think you can wait three weeks?' ... and initially she said yes, but by the end of the second week she was saying, no ... and that was when ... we referred her between us to [consultant psychotherapist]."

Similarly, little consideration was given by social workers to possible alternative plans. Three-quarters of social workers (26) responded negatively in this regard:

> *"No, not really, there didn't seem to be anything else really. We don't give vouchers for food or anything like that and, in any case, I don't like doing things like that ... but, in any case, the option wasn't really open, so, no."*

The remaining social workers (8), however, did give consideration to an alternative plan, although in over half of these cases consideration was, in the social worker's estimation, fleeting. Again the predominant theme was risk, with resources and practice considerations being cited less frequently as influences:

> *"We briefly considered whether the children should be in care, yes, but it was brief. ... Again, had we had a warm and friendly foster home round the corner, we might have thought about it, but I think it's automatic with us not to consider reception into care unless things are a good deal iffier than this, 'cos we don't know what we're going to do with them."*

It is perhaps not surprising that social workers gave little overt consideration to alternative courses of action since, as we are about to see, social workers' assessment conclusions, instead of being accounts detailing their analysis and understanding of the situation, are, in effect, plans of action. Having already arrived at a plan of action the social worker then implements that particular plan. A conclusion of this type is, by definition, likely to exclude any great delineation of options, other than *en route* to finding the problem's solution. Where alternative courses of action were considered, the main influencing factor was the balance of safety/risk. Wider practice considerations were in evidence at this point for a relatively small number of social workers. Resource and practical constraints were little acknowledged by social workers as being of any significance in determining courses of action.

SOLUTION-BASED CONCLUSIONS, RUDIMENTARY PLANS

It is noteworthy that the social workers' conclusions were framed in terms of solutions and actions rather than being summations of the social workers' understandings of the situations with which they had been presented. Plans following from these initial assessments tended to be rudimentary, with the social workers' responses being reiterative of the solution decided upon. The overall picture gained is that the social workers were primarily inclined to adopt an *ad hoc* problem-solving approach rather than one that might be termed formulating a professional understanding with a view to more considered planning and action.

Any risk issues having been weighed in the balance, the social workers' conclusions and plans following assessment appeared to centre around three approaches as a basis for further action/inaction.

Approach 1 was where immediate resolution of the problem at issue, often practical in nature, was possible, leading therefore to an ultimate response (i.e. beyond the immediate resolution) of 'No Further Action'. A conclusion and plan centring on this approach was evident in approaching one-half of the interviews (15). Most often (11 instances) the situation was resolved in a way that had a positive outcome for the client and agency. In four instances, however, the situation was resolved in a way which might be construed as negative for the client inasmuch as the clients did not receive the help they were requesting, although on three occasions clients were referred on to an agency considered by the social worker to be more appropriate.

Example of a Conclusion

"[Client] was getting really no support from her husband. [She] was a fragile personality, clearly, and what needed to be done, she quite clearly explained to me what needed to be done in order to satisfy her that she was doing her best for her children, and that most of those things could be done by the education department, and what I did was re-route her to the education department, also telling that [the client] was finding it quite difficult to talk to tutors and would there be a way of getting round."

Example of a Plan

"None. To close it. ... I didn't feel there was any further social work action."

Conclusions and plans based on this first approach were all Area Team cases, with the exception of one Child Guidance case where the clients were offered the opportunity to think further about the service they required and then to re-approach the agency, a plan which had their full agreement.

Approach 2 was where the social worker concluded either that further assessment was necessary and/or that rapid follow-up work of some sort needed to be undertaken by them. A conclusion and plan centring on this approach was evident in over two-fifths of the interviews (14):

Conclusion

"I felt what I wanted to do was to do a more in depth assessment of herself as a person and my idea was to use the ... DHSS guidelines in terms of assessment of parents to actually help draw out more information."

Plan

"I've really got nothing to go on. I'll just have to continue monitoring, offering support as appropriate until the next case conference."

Conclusions based on this second approach included the five Adult Psychiatry cases, four of the five Child Guidance cases and five Area Team cases.

Approach 3 was where social workers concluded that cases needed to be passed to a worker other than themselves for attention. A conclusion and plan centring on this route was evident in one-sixth (5) of the interviews. In three instances, cases were to go forward for allocation to another social services worker. In one instance where an ASW assessment had been carried out on an allocated case, work was to be continued by the allocated worker and in the final instance (also an ASW assessment)

the case was considered to need further follow up by duty social workers. Conclusions based on this third approach were all Area Team cases:

Conclusion

"I thought the case should be allocated and I thought that a mixture of practical help needed to be given and also perhaps skills teaching, and also emotional support and ... that the social worker should also monitor it as well ... Monitor actually what was happening in this family."

Plan

"Certainly I wanted somebody to check out what contact she was having with this alcohol unit and whether there was a social worker there we could liaise with, because it seemed to me that that was central to her problems and that we should facilitate that if we could. ... And I suggest the social worker of [detoxification] unit may be involved and, if not — I write it as a question — 'should we check on the two children if they do appear to 'look after' each other?' " (ASW assessment)

ACTIONS TAKEN, INCLUDING WITH REGARD TO THE INTERFACE

Turning to the specific actions taken by social workers following on from their assessment conclusions, a range of actions was apparent with social workers typically taking a number of actions (up to four). The most common actions related to making contact either with another agency or with departmental colleagues (13 instances):

"When I finished the assessment, I did talk to the other professionals involved."

writing up and completing paperwork of some kind (11 instances):

"Here we just write it up and that's that and make recommendations."

arranging to see the client again for ongoing assessment/work (9 instances):

"Just to see her every so often and talk to her about if she's experiencing these problems and ... to offer support as the family require."

and speaking to a senior (8 instances):

"Just talked to my senior about it."

These were followed by implementation of the service agreed (7 instances):

> *"Gave her the money and she went."*

advice to the client (4 instances):

> *"That was the other thing ... we did which was to underline what they were doing already and hopefully also to bring dad in a bit more."*

organisation of a practical task (3 instances):

> *"I just made sure that I had people covering, to keep an eye, the health visitor would be going in while I was away for three weeks. [Client] had a hospital appointment and ... the family aide at the hospital agreed that she would take her to the development check."*

and reflecting upon the case (2 instances):

> *"Came back, had a long think about it. In fact, I'm still having a long think about it really."*

As we have seen, social workers did not appear especially interested in the interface as such, although quality of parenting was a consistent concern. The majority of social workers (18) did not seek to address this aspect directly in their actions/plans since, overall, they considered the impact to be of insufficient significance to act upon. A sizeable minority of social workers (13) considered, when asked the specific question, that the impact on the child(ren) of the parent's mental health difficulties was significant enough, or potentially significant enough, to take account of, with five social workers intending to continue their assessments and formulate future plans bearing this aspect in mind:

> *"Something that would be in the back of my mind would be that when we're talking about psychotherapy, you're talking about a very long term, gradual process, which isn't liable to make any sudden impact and therefore I wouldn't be expecting any overnight or dramatic changes. We're talking about gaining gradual insight over quite a long period of time, probably years we're talking about really. It's not as if, it's not like something like schizophrenia where someone's drug balance can be changed and might radically alter behaviour"*

a further five social workers aiming to take account of this in the immediate work/social work plan:

> *"I would see that by introducing a social worker into that environment, we would be able to give the mum some emotional support, that the mum wouldn't then be dependent solely on the child for support, the fact that the social worker could put practical input so that would lower the stress levels of the mum, so again she wouldn't be turning to the child for support, and that the social worker could give the mum information and training and knowledge about being a mum. So again, hopefully, by teaching the mum some skills, that the mum would be able to meet the child's needs better rather than the child trying to meet the mother's needs."*

and the remaining three social workers planning to offer a service (e.g. under fives place) which would directly support the child:

> *"The need for the nursery placement even if she hadn't been going to college, I think it was probably in that child's interests to have a two or three day placement to mix with other children, to be stimulated and in a way he would get it at the nursery."*

CASE FILE RECORDS

The written accounts of social workers in relation to their assessment conclusions, actions and plans shed little additional light on the assessment process. Taking the body of records as a whole, the written accounts reinforce the general picture given in the social workers' spoken accounts. We have seen something of the content of what is recorded. How it is recorded and to what purpose is also noteworthy, however.

Apart from the ASWs (5) who were required by the department to write their assessment conclusions on a standard form (and were therefore required to note particular areas), the recording of social workers varied widely in style. The most usual approach (14 instances) was for social workers to record a short summarising statement, sometimes using the client's own words, of the immediate problem to hand. This approach was evident in all settings (10 Area Team, 2 Adult Psychiatry, 2 Child Guidance).

In a similar number of instances (13, including the five ASW assessments), the approach adopted by social workers was to give a more comprehensive exposition of the problematic situation including (usually) not only concerns but also any strengths in evidence. The ASWs in addition gave background on social, family and personal circumstances as well as spelling out the risk factors as they saw them. This approach was evident in the settings of Area Team and Adult Psychiatry (11 and 2 instances respectively).

In the remaining seven instances (3 Area Team, 3 Child Guidance, together with one Adult Psychiatry case where direct access to file was denied) there was no record of any summarising or concluding remarks on the part of the assessing social worker, although in three instances (all Child Guidance cases where work was to continue) descriptive accounts of the interviews and/or history/information gathered therefrom were recorded.

With regard to social workers' actions, the written accounts confirmed the social workers' spoken accounts, with no significant discrepancies regarding the range of actions involved pursuant to social workers' assessments. Discussions/contact with a variety of colleagues were mentioned in 17 instances, advice/discussions with clients (including arrangements to meet again) were noted in 15 instances, the undertaking of some sort of practical task (including in four instances ASWs arranging for hospital admission) was mentioned in 11 instances and, finally, completion of specific paperwork (i.e. over and above general recording) was mentioned in seven instances.

Social workers' plans, as recorded, accurately mirrored those given in their spoken accounts, with 15 instances of 'No Further Action' being recorded, followed by 14 instances where the social worker planned to undertake further assessment and/or work themselves and, finally, 5 instances where the social worker recommended allocation/further work to be carried out by another social services worker.

The social workers' written records, then, including records of their conclusions, were, for the most part, descriptive in tone. The lack of analysis in evidence suggests that, during this initial assessment stage at least, social workers' main concern was not with elucidating a professional summation of the situation with which they had been presented as a basis for considered action with fundamental change at its heart. Rather, their emphasis was on recording 'the facts' of the situation for accountability purposes and/or as justification for the more immediately problem-solving line they were inclined to pursue. The written records, then, underline the point that the overriding approach adopted by the social workers was a reactive one whereby the emphasis was on finding solutions to the immediate problems as presented.

CHAPTER SEVEN: FINDINGS (III)

THE CLIENTS' PERSPECTIVE

Chapter Seven sets out findings related to the assessment process as viewed largely from the client perspective, in particular with regard to social worker-client communication and the clients' experience.

SOCIAL WORKER-CLIENT COMMUNICATION

COMMUNICATION AND PARTNERSHIP FROM THE PARENTS' PERSPECTIVE

PERCEPTIONS OF THE SOCIAL WORKER'S ASSESSMENT CONCLUSIONS

Approximately two-thirds of parents (15/23) responded either in the vein of not particularly knowing what the social worker's conclusion might have been (although all were prepared to go on and, at best, articulate what they supposed to be the case or, at worst, hazard a guess) (10 instances):

> *"I've got no idea. ... My personal view is that she thinks oh, she's okay and the kids are fine, they just need time to settle and that's it because they've only just started the school as well, so they hadn't been given any time at all to settle into the school. She didn't give no indication that, well, I'll be calling back on this date or anything like that, she went off quite cheerfully and I left her quite cheerfully and that was it really. She seemed quite satisfied."*

or seeing it solely in terms of problem-solution (5 instances):

> *"I just asked for some money and they gave it to me, and asked how the kids were and that was it. They didn't say are you all right for other things or anything ... they just asked how the kids were and if you had enough money, and that was it."*

The remaining parents (8/23) had a clear view of the conclusion they believed the social worker had reached and this was presented in terms of the parent having at least an idea of the thinking behind the social worker's conclusion:

"Basically that [child] had been through some very traumatic and upsetting scenes and [her] being upset was actually part of a normal child, in fact it would have been abnormal for her not to have shown any signs of reaction to what she'd been through. So it was basically how to help a perfectly normal child who's having some perfectly normal reactions to some very nasty incidents that occurred, how to help the child come to terms with that, to help her understand it and to help her accept what she went through and to cope with it."

PERCEPTIONS OF THE SOCIAL WORKER'S VIEW REGARDING THE IMPACT OF THE PARENT'S MENTAL HEALTH DIFFICULTIES

In less than one-third of cases (7/24), parents were able to express a view on what the social worker's thinking had been in relation to the impact of their illness/difficulties on the child:

"All she said to me was obviously it's going to affect the children to a certain extent, but I don't think she was too worried, she didn't appear to be too worried. I think if she was she would have said."

The remaining just over two-thirds of parents (17/24), however, considered that they were unable to say what the social worker's view on this aspect might have been. In eight instances (one-third of the total number), this was because, in the parent's view, this aspect had not been covered to any great extent with the assessing social worker:

"That's a very difficult question. I'm sure she had or she has, but I can't answer that."

"Not the first ones, no, 'cos they wasn't involved in that part. The recent social worker that I've got now does. ... They wasn't allocated as my social worker, that's why. This one has been allocated for me personally."

PERCEPTIONS OF THE SOCIAL WORKER'S ACTIONS/INTERVENTIONS

By far the majority of parents (20) indicated that, in their view, the social worker had taken action or intervened in some way, either at the time or following the interview. In

11 instances the actions/interventions were essentially discussions either with the clients themselves or with others:

> *"The first time all she did was ... put down what I'd said ... on record more or less 'cos on the first occasion I mentioned about there might be a need for accommodation in the future. And also I mentioned that I might need some assistance with an access problem, I think that probably went on record as well. On the second occasion ... he offered me the advice to go and see the ... duty probation officer."*

> *"Afterwards she contacted ... the nursery, I found out. [Child]'s key worker told me that she'd been in touch with them. ... She also spoke to my health visitor and I think my health visitor knew her and they'd come to some arrangement that the health visitor was going to call in once a week to see how I was and how the children were."*

and in 9 instances the social workers had taken some sort of concrete action — for example, either providing financial assistance or making representations on the client's behalf within the agency or to an outside agency:

> *"She contacted my doctor, she is writing a letter for housing. She doesn't think it'll have a lot of clout with them."*

> *"She just took down an application form, she took down details, she asked a lot of questions about my personal life ... and she said that she was going to put [child]'s name forward for the allocation meeting. And I got a letter after that ... saying that at that point there wasn't a space but [child] would be considered at the end of June."*

In the remaining one-sixth of cases (4), parents considered that the social worker had taken no action of any kind that they knew of:

> *"I don't know if she did. She must have done I suppose."*

> *"No, she just said she'd see me in a couple of weeks time, and that was it."*

PERCEPTIONS OF THE SOCIAL WORKER'S PLAN/FUTURE INTENTIONS

In by far the majority of cases (21) the parents' responses indicated that social workers had conveyed their plans or, at the very least, something of their future

intentions even if they were not presented or seen in terms of formal plans as such. This number includes nine instances where the social worker had simply indicated that there should be future contact only as and when necessary:

> *"Yeah, that she would recommend another social worker. ... I would hear from someone as soon as there was someone to take it, but if there was any problems or anything to do meanwhile, then to just phone for the duty social worker."*

> *"They didn't say that much ... I didn't know until about two weeks afterwards ... that I should be allocated a social worker. Nobody said. ... I think the agreement for the kids was to be there for four weeks, with the foster mother ... and then after that they'll review the situation again I think. And then decide whether, depends on how I was coping, with myself and my situation and the treatment I was getting, and whether I was happy to have the kids back and whether I could cope or whether I couldn't cope, then they'd decide, and review it and see how I felt."*

> *"No, she didn't mention that they'd want to have contact in the future or anything of that sort. It was really just left as if you need any help you can call us because we can see that you're managing on your own. That was basically it."*

In relatively few cases (3), the parents' responses indicated that in their view the social workers conveyed nothing about future plans/intentions (two of these cases were to be closed; one (an ASW assessment) was to have ongoing work by an already allocated social worker):

> *"No. He didn't say anything like that."*

The above data is suggestive of parents perceiving social workers as people who, by and large, adopted an active, problem-solving stance, either in terms of their interactions with them as clients or with others, as necessitated by the immediate situation with which they were faced. However, when it comes to parents having a clear view of social workers' conclusions it does appear that parents were left more in the dark than good practice would dictate. On a more positive note, where parents were clearer about conclusions they often had an idea of the thinking underlying the

conclusion. Parents appeared also to have a general understanding of plans and future intentions, but the data is not indicative of any great sense of involvement on the part of the client in anything other than an essentially passive, dependent role. This finding is reinforced by the parents' responses when they were asked specifically about the extent to which actions and plans were discussed.

DISCUSSION OF ACTIONS AND PLANS

Just over two-thirds of parents (17) considered they had been involved sufficiently regarding actions although, in an echo of the above, their responses have an overriding flavour of their being informed rather than involved to the extent of working in partnership:

> *"She told me that I'd hear from her within the next two weeks, which I did, and she also explained that if the letter was a refusal, then the following month when they have another allocation meeting [child] would get a place then."*

> *"She asked me how I felt about that and I can't remember what I said to be totally honest, but I know that I did agree to it. ... She asked me about the doctor and whether I'd mind ... if they'd was to get in touch with the GP and they'd all have a discussion or something or other. And I said ... I didn't mind because the doctor knew half of what was going on, so I didn't mind."*

Just under one-third of parents (7) considered they had not been informed about the social worker's intended actions. This number includes all the parents who were the subject of ASW assessments (4 instances, three of which ended with compulsory admission to hospital) where the client's memory of any consultation regarding actions was often hazy or it may be that a combination of the client's mental state and the circumstances of the actual admission were not conducive to protracted discussion between social worker and client:

> *"She didn't suggest what she was going to do."*

"[Social worker] explained to us at the first interview we had that if the two doctors, she did explain to us that they were going to put a section on but they would have to get the authority of a social worker as well. I remember her explaining that to us ... the pair of us were there." (partner) *"What so that she was having some sort of opinion on my mental state? ... I don't remember that."* (client) (ASW assessment)

"I don't think so, but she did explain in the beginning why she was there. I don't think she actually said to me 'I've spoken to the doctors and I agree for [husband] to go into hospital', but when she did come with the doctor she did introduce herself and say 'I am here for [husband]'s benefit and my part is to oversee that [husband] is ill and needs to go into hospital' ... She explained why she was here." (partner) (ASW assessment)

Parents recalled varying levels of discussion about future plans. Seven parents were simply in agreement with the plans proposed and did not venture a view with regard to the extent to which they were involved with their formulation. Approximately two-fifths of parents (9) either expressed some uncertainty about the extent to which matters were aired and actions agreed upon (6 instances):

"I don't think I was actually asked. ... Looking back on it now ... I would have liked the opportunity to be asked 'what do you think?', which I wasn't ... I think quite possibly because it was coming out in conversation anyway."

or were not in agreement with the social worker's plans and considered discussion to be inadequate or unsatisfactory (3 instances):

"Well, I've got to get some help. I could go back down there, but I don't know if I'll get anywhere. At the moment. ... As I said to the girl, I said I try hard ... I keep on telling you, ... it just don't seem like you're helping at all. 'Cos I went down and tried and she just said ... I've got other people to see and ... you haven't got a proper social worker and once you get a proper social worker she can sort your problems out. But I just think to myself, what's that, a waste of time. But I didn't know [where] to go even ... I don't know what to do, either to go back down to them or to the Advice Bureau ... would they help?"

In the remaining eight instances (one-third), it is evident from the responses that agreement with the social worker's plan/future intentions on the part of the parent had

been reached following some discussion of the possibilities, in other words, there was a greater sense of partnership:

> *"She asked if I'd mind, and I said no, not at all, I would appreciate that, just in case I couldn't cope at all, with [child] more than anything else ... I need someone to talk to, I need some help."*

As we saw previously, parents appeared, in the main, to have a reasonable idea of what the social worker's intentions were with regard to actions and plans, although parents' responses indicated that such information was relayed in a relatively informal fashion. As we shall shortly see, whereas parents were, more frequently than not, in agreement with social workers' actions and future intentions, the data suggests that parents tended to end up in the role of passive recipient and were not as involved in the active formulation of plans and courses of actions as might reasonably be expected from full partners in the process.

COMMUNICATION AND PARTNERSHIP FROM THE SOCIAL WORKERS' PERSPECTIVE

DISCUSSION OF ACTIONS/PLANS

The social workers saw themselves as being communicative of their work with clients; certainly their aim appeared to be so. By far the majority of social workers considered they had discussed their intended actions and plans with parents (30 and 26 respectively out of 31, direct questions on this aspect having been added following the three pilot interviews). Reasons cited for doing so varied, covering common courtesy and a preference for a naturally informative style of working:

> *"Well, yes, I don't like to just disappear and give people no idea if I'm going to come back (laughs) or what I'm going to be doing."*

'discussions' which were perhaps, more accurately, explanations:

> *"Yes. ... she knew for example that we talked to the refuge again, she knew that we would take her to hospital, she knew that we were taking the children home, she was happy for all of that to happen."*

and in order to work collaboratively and keep the client well-informed, especially in the context of ongoing work:

> *"Yes. ... Because I thought she should know exactly what was involved, why and what the expected time limits would be. So that, as far as possible, I was ... sharing knowledge of the process with her and the intentions, even though I don't kid myself that that's the same as her having equal power, she hasn't, it is a situation in which power is inevitably unequal. ... We talked, yes, of being involved with the social worker, of contributing to the decision to be made about what would happen with [child]."*

Where discussions did not take place, the exceptions were, with regard to actions, one instance where compulsory admission to hospital was involved:

> *"No, we said that ... the doctors felt she should stay in and ... I said it looks as though at least for the short term you probably ought to stay in. I didn't actually tell her I was going to compulsorily keep her there because I was going to do that having actually made the admission, go back and tell her, and then of course she vanished. So I didn't tell her prior to the admission because then she could have walked out before I'd handed the papers in and she was actually admitted. So I normally don't commit myself to saying that you will be kept here or whatever until after I've actually arranged the admission and the papers have been accepted. But she would probably know."* (ASW assessment)

and, with regard to plans, five instances: in two where compulsory admission to hospital had taken place and the plans were unclear:

> *"I didn't discuss it with [client] no, no ... I can't remember whether I went over that with the wife. I'm not sure I did."*

in a further two where there was to be no further action and the social worker thought it unhelpful to labour the point given that the duty system was in place:

> *"No, no, 'cos it wasn't left that we would take no further action, in the sense that we would take further action if he came back and presented something."*

and in one instance where the social worker admitted to taking an autocratic stance which was not open to discussion:

> *"No ... I won't be discussing it, I'm going to be autocratic, I've made that decision."*

PERCEPTIONS OF CLIENTS' VIEWS

When asked their views of how parents had viewed the actions/plans, approximately two-thirds of the social workers (20/31) considered clients had an essentially positive view:

> *"I think he was pretty accepting of it in a way ... it was really just reinforcing what he already knew. He wasn't particularly fed up about it, he was really coming in saying 'I don't know whether there is anything, I just want to find out whether there is?' and then when I said 'Well, no, there isn't', he wasn't particularly surprised. ... As I say, accepting of it. Pleased to have seen somebody, even though there wasn't a lot we could do."*

Less than one-third of social workers (9) thought clients had displayed more ambivalence/uncertainty about what was being offered (including one instance of a couple whose views were considered to differ):

> *"She didn't comment a lot. I think it was only later her anger towards the other social worker came out and towards me, and also turning up late indicated to me that she didn't want to be here. But her manner was that this was yet another hoop to go through, which I could understand."*

> *"Well, the father was very clearly saying that he wanted to go and finish off what they were doing with their social worker. The mother was saying that she wanted help with [child] and she didn't want to leave it too long because she was quite frightened of her ability to cope once he reached adolescence if they didn't get help before then, but she wasn't saying it as strongly as he was saying what he was saying."*

and in the remaining two instances, both ASW compulsory admissions, the social workers considered their clients had negative reactions to the actions/plans:

> *"Just that no, she's not staying and she's got all these important things to do at home ... And that she'd be all right."* (ASW assessment)

LEVELS OF AGREEMENT BETWEEN PARENT AND SOCIAL WORKER AS REGARDS THE ASSESSMENT (FROM THE PARENTS' PERSPECTIVE)

It will be noted in the forthcoming data that there is a fairly consistent breakdown (2:1) between parents who, for ease, might respectively be termed 'more contented' and 'discontented'. There is, in fact, some cross flow between these groups, with the number of parents who expressed discontent at some point during the process totalling 14, or over one-half of the parents interviewed. Breakdown by setting is 11 Area Team cases, two Child Guidance cases and one Adult Psychiatry case. Taking the most discontented one-third of parents (all Area Team cases with the exception of one Child Guidance case) as a guide, the predominant theme where parents experienced a sense of discontent was a lack of convergence between social worker and parent. In other words, the issue and/or perspective of greatest importance to the client was somehow missed by the social worker. We turn now to examine levels of agreement in specific areas and the themes that emerge where lack of agreement is in evidence.

With regard to the focus of the assessment, approximately two-thirds of parents (15/23) were in agreement regarding the social worker's primary focus inasmuch as the area selected by the social worker was also of prime importance to them, there being nothing of greater importance:

> *"To me it was, that was the reason I went ... [child] had started bedwetting again and having nightmares."*

In just under one-third of cases (7) the perspective of the parent diverged from that of the social worker. Four parents held a different opinion from that of the social workers regarding what was considered to be the matter of greatest importance:

> *"All the time she was talking to me she was playing with [child]. It was really quite distracting ... she was watching the children play together ... which wasn't helping because I know how the children play together ... I wanted help with what I was feeling and not what was going on with the children ... How I felt."*

whereas for a further three parents what was considered to be problematic by the social worker was not considered a problem at all by the client and neither was anything else:

> *"I wasn't worried about [child], but I wasn't really worried about myself at the time either, but I realise that I should've worried about myself 'cos I'm the one that's got to look after her. But you don't think of that at the time, you just grin and bear it, just get on with it."*

The remaining parent offered contradictory responses. Exploration of these contradictions follows shortly.

Where social workers were perceived by parents as displaying an interest wider than their primary focus (17 instances), in the majority of these cases (12) parents were in agreement with social workers about the inclusion of this additional focus:

> *"Well, this was the whole thing, it was becoming quite a strain, obviously on me, because I get it first-hand, and not knowing what was going to crop up next ... Although my son didn't see everything or hear everything, he'd been involved in a hell of a lot of it, the police have been here on so many occasions and that sort of thing over different affairs. And he can't cope with too much more, it's got to the point when he doesn't like his friends coming round when his mother's in that sort of state."*

In the remaining five of these 17 instances, however, parents were not in agreement with social workers about the inclusion of wider issues over and above matters judged by the client to be of prime importance:

> *"Everyone's interested and everybody wants to know what's going on and everybody wants to know 'well, why were you in hospital and why did you take the overdose?' and whatever. But no-one can actually turn round and say to me, well, I've got this much power with [housing] and I can actually push your case forward. ... Everyone just wants to know what's going on, and ... to tell you the truth, I am getting freaked out just telling everyone the same story over and over again because no-one can do anything."*

With regard to the parents' own views of the situations with which they were faced, again approximately two-thirds (15/23) held substantially the same view of the situation as the conclusion they believed had been drawn by the social worker:

> *"I think he probably made a fair assessment."* (ASW assessment)

> *"I just felt it was perfectly normal ... for [child] to feel like that ... but at the same time knowing that [she] was bedwetting and having nightmares and so on, it's obviously a situation that needs to be sorted out and [she] needs to be helped through, and I felt it was all getting a bit beyond me and ... I wanted very much to help [child] ... and I felt I needed help in order to do so. So it was a mutual conclusion that was reached really."*

And, again, approximately one-third of parents (7) disagreed with the view they believed the social worker had formed, such divergence being based on a straightforward difference of perceptions around either the conclusion reached, or, the advice proffered:

> *"I disagreed with it at the time [Decision was 'No further action required']. It was very nice actually her coming and talking to her and I felt as if I could've talked to her about it, talked to her about the problems that I was having if she'd given me more time."*

> *"We thanked her for her help and everything but we turned round and said sorry but we found in the end it was no help and we're back to square one again ... it's just one of those things."*

The remaining parent (as before) gave contradictory responses inasmuch as she first said she disagreed with the social worker's essentially low-key assessment of the situation but was unable clearly to articulate why. Her initial response is suggestive of her wanting and needing more help (Extract A). Fear of having her children removed (she had had two children adopted fifteen years previously) appears to have got in the way of fully sharing her situation with the social worker which would have provided a better chance of obtaining the level and/or type of help she realistically needed (she was hospitalised following a breakdown a few days later). She eventually opted

(Extract B) for coming down more clearly on the side of agreement with the social worker's low-key approach, although indicating that, at the time, she did not comprehend the seriousness of her situation:

> *Extract A: "I sort of disagreed, but I didn't say, because I was worried about the children. ... I didn't say anything to her, just in my mind, I thought, I don't know really what I thought. It's hard to explain, I just had that feeling she was going to take them off me, that was the only feeling that I had. I just, I get paranoid about people, I've been like this every since I got ill, that they're going to take the children off me. I know they're not, but I can't get it through to my brain that they're not going to touch them. I could've been wrong, but that's the feeling that I got."*
>
> *Extract B: "I just needed to sort myself out. I didn't realise I was headed for a breakdown."*

The above extracts exemplify in an overt way the understandable ambivalence that was often experienced by parents about the process of assessment. As we shall see, the adjustment by clients of their needs and expectations, for a variety of reasons including, as in this case, issues of fear and control, is a point soon to be explored more fully.

The potential for social workers to become agents of unwelcome control was one of the reasons parents gave in order to account for the differences in their own and social workers' perceptions about what should properly take priority in assessments. Seven parents held a different view from the social worker with regard to what was important in terms of focus and saw the social worker as primarily interested in an area/course of action which was not of prime (or any) concern to them. The parents considered the reasons for this difference of approach to be connected with, essentially, an agency remit that did not coincide with the parent's preferred requirements. Four extracts will serve to illustrate the differing aspects.

In the first example the social worker was perceived by the client as having too little authority to act. In the second the social worker was perceived as being able to exercise statutory powers, thus overriding the parent's immediate wishes. In the third example the client perceived herself as being excluded from access to a service due to insufficient child care concerns. And in the fourth example the client perceived herself as being unnecessarily subjected to a service she saw no need for:

> *"The whole point about social services is you can't force anything on anybody, really, not by yourselves ... let's say somebody's living in really deprived conditions or something on those lines, maybe you'd call a doctor in or a couple of doctors in to get something done about it ... but you need other people in to enforce different orders. ... Social workers by themselves don't necessarily do anything, it's the other people that, mainly thinking about medical officers or psychiatrists or whatever, that will get involved in the real nitty-gritty situations ... So, as I said, he offered me as much advice as he could but I knew that there wouldn't be too much he could do, but I thought maybe there might be a chance. So, because there might be a chance, I went, it was as simple as that."*

> *"I just didn't want to be here full stop. At that particular day, I can remember it, it was in my mind, I was going to do it no matter what happened or where I was. ... It seemed more important to me because I wasn't able to cope with the situation at home at the time and the only way out of the situation was not to be around."* (ASW assessment)

> *"I don't know, she just seemed to be more interested in the children. She just seemed to want to make sure that the children were all right, which they were, but I needed to be all right for the children to be all right ... I needed help for the children to be more happier, but there was nothing she could do to help me in the end ... I wanted something that was for me, something that perhaps didn't involve the children, have a cup of coffee with someone, someone to talk to about me and not about the children."*

> *"I just wanted to clear it up for her really, 'cos I was actually going to cancel the visit 'cos I didn't think it was necessary, but it slipped my mind ... anyway then she came and I've got nothing to hide."*

THE CLIENTS' EXPERIENCE

UNMET EXPECTATIONS

There are clear examples, in relation both to the actions social workers took and to the plans they made, of parents' expectations remaining unmet. One-third of parents (8) would have liked the social worker to have done something different in terms of actions/interventions:

> *"I would have liked them to have found me a social worker a lot sooner than what they did. I was very disappointed in that respect. ... Because I did need one sooner, I didn't need to wait three weeks before I was actually ... allocated one. Whereas I had to keep going down there and reminding them that I'm still here and I'm still needing someone to take on my case and help me through it and help me get the support that I need. ... I didn't like the fact of going down there and talking to loads of different people. I like to talk on a one-to-one basis where I can relate to one person, ... not having to explain the whole situation to somebody else and somebody else."*

With regard to the actions/interventions of social workers, themes which emerged (often overlapping) from the parents' responses in relation to their experience of having unmet expectations were the need for more support (mentioned in 5 instances):

> *"I think while I was in hospital and while I was getting better ... I think it might have been a good idea for [ASW] to come ... to chat with me to see how things were going to be in the future. 'Cos obviously that couldn't go on, me getting so down and wanting to kill myself, ... it's not right. And I think that might have been better for me and I would have been quite happy to chat with him. That might have been of some benefit ... in case I didn't get as well as I am now."*(ASW assessment)

an awareness of resource constraints (4 instances):

> *"I wish there was a service for them to come out just to see how you are. ... I wish there was some person [whose] job was aftercare, for kids that have been out of care and that need somebody to talk to. ... There isn't a lot of staff, they've had so many cutbacks and they're just limited to what they've got. And they've got so many kids per person, haven't they? ... I understand that ... and I accept that. I just wish there was somebody there ... to come round just for half an hour or something."*

the desire for better communication (4 instances):

> *"I'd have liked her to have come back and explain ... why she felt there was no need for her to come and see me again instead of writing me just a letter, or I would have preferred her to have rung so we could have discussed it ... just to tell me, well, why. ... I couldn't see the purpose of her visit really, because she didn't do nothing. I was under the impression from the doctor that when she'd come she'd talk to me and help me."*

and, in two instances, a failure to provide the exact solutions/answers wanted by clients:

> *"I would have liked them to get me a house, to get in touch with the council and put my case forward. ... I think they could have helped if they'd wanted to. ... But no-one said that they would."*

In terms of the future plans envisaged by the social worker, one-half of parents (12) considered that they would have liked something different to happen:

> *"I would have liked a lot more than what I got. ... I was hanging on a string for quite a while and ... that made me very annoyed and very frustrated as well because I didn't know what was happening and ... whether I was going to get allocated a social worker."*

> *"I would, yes ... if she'd told me definitely one way or another. I don't know how that side of things works."* (child protection investigation)

With regard to the social workers' plans/future intentions, two key (sometimes overlapping) strands emerged from the parents' responses in relation to their experience of having unmet expectations. In nine instances, what was required was a more flexible, negotiable, client-centred service including, specifically, higher levels of support and/or advocacy:

> *"In an ideal world there would have been ... a person on some phone twenty-four hours a day, so that if you really, really had problems and that you felt my God, I'm really going out of my mind now or I'm going to hurt my baby or I'm going to hurt myself, whatever ... it's a number. It might be engaged but if you keep calling you'll get through, and that there is a kind of acute service. ... Just to know that there was somebody that didn't have to know you or anything, but I think, as myself, most people would not call unless you had to."*

"Like I say she's not been allocated to me as a full-time social worker ... I would like to know [she] is there for me. She said that I can always phone her but she can't guarantee she'll always be there but I can always phone her and she'll try her best. ... She can only do what she's told to do really by her superiors."

In five instances better communication and involvement were what was required:

"She did mention in passing about [local mental health project] ... she did say she would find out more information about that for me, and she said there was a crèche there, which I thought might be helpful if I didn't have the children around. But we never heard any more of that. I did tell her at the time that it did sound like a good idea, but we didn't see her again after that."

"I would have liked the opportunity to have been able to go to the conference. I don't like decisions being made over my head which I feel are affecting me and the family without having an input into. ... Looking back on it. ... As it is, it worked out and everything's fine, so I've no complaints on that score, but supposing it hadn't and I hadn't been consulted, then I would have not have felt very happy."

ADJUSTED EXPECTATIONS

The above is relatively straightforward inasmuch as parents were clear about what they would have liked or expected and what they failed to get. However, turning to an examination of what the more contented parents said, the picture becomes more murky. The data is indicative of some parents at least being prepared to adjust their expectations and requirements in the light of their perceptions of the agency and the services it either offers or enforces.

Two-thirds of parents (16) did not think there was anything else that they would have liked the social worker to have done regarding actions/interventions:

"No, not really. If my child was being abused in any way, then, yes, I probably would have wanted something more to be done. But there's no indication that anything's happening."

In five of these instances, however, (approximately one-fifth of the total number) parents added qualifying statements that were suggestive of their wanting something more. The predominant theme was that, ideally, the service/resources could be better-tailored to the full-range of the clients' needs as they saw them:

> *"Not really. The only thing I would have liked is for my daughter to get a full-time place, but this borough's totally different from [neighbouring] borough, everything's just part-time."*

> *"No, I would have liked to go on for two or three months. I wouldn't have liked to have stopped right now, but it has done a lot anyway, and I am very pleased, it helped me and I'm really grateful for the counselling."*

> *"Nothing I could blame her for. I would have liked her to have asked about the furniture but I couldn't ask her ... they've done so much for me already, so I feel a bit guilty."*

With regard to the social worker's proposed plan, one-half of the parents (12) considered overall that they would not have liked anything different to have happened:

> *"No, not really, I think they've done everything they can."*

Examples of adjusted parental expectations in relation to the social worker's plan are fewer (3 instances) and more complex. Interestingly, in each case the parent had her/his own preconceptions about what was likely to be on offer. If anything their expectations of the service were worryingly low. These preconceptions seem not to have been disabused nor parents' expectations raised through the process of assessment, the original low expectations being ultimately fulfilled. In the first extract the client considers that resource constraints mean he is unlikely to receive the help he ideally would like, especially given the essentially unwilling participation of his wife (who was in the throes of a mental health crisis), whereas in the two extracts that follow the demands of both mothers are influenced, at least partly, by their previous

negative experiences of social work intervention, as well as in one of the cases by lack of clear information about the service:

> *"No, it all comes back to the same thing ... you've only got certain resources ... and there is only certain ways of attacking a problem ... my wife, my ex-wife being the example, she's one of those persons you can't help unless they're prepared to help themselves."*

> *"I don't think there's nothing much anybody could do. Maybe it was just a little counselling I needed ... somebody to listen to my story that I needed, and the kind I got, and I don't think there was any help they could really give me, not unless regarding maybe a couple of items of furniture for maybe the kids or something, but I dunno, in this case I suppose a little talking helped regarding my boys, [daughter] got a nursery placement out of it. ... I've got terrible views of social services in the past 'cos I was in care myself a couple of years. It's best they stay clear, or you stay clear of them 'cos normally once they dabble into your affairs it's difficult to get them out again."*

> *"I don't think so, because I don't really know what else she could have done at the time. I think most people — and even me to a certain degree, we had dealings with social workers when I was a child — are under the impression that you don't get too involved because they're the sort of people that come and take the kids away in the end and things like that. I suppose I just didn't feel, if I was going to contact anyone, she was the person I would contact. ... I suppose I don't really ... know a hundred per cent what they fully do ... what they could have done for me afterwards and what good it would do me just to moan and groan at them about how I felt. ... Most people I know that have had dealings with social workers are either women that are on their own with their kids and they want them solely so as they can get free rides for their kids to school or things like that ... or they are needed because they are arguing over the custody of the kids. ... I don't know anybody that's basically had a social worker to help them through emotional problems rather than ... to do with something like illness. 'Cos it's not me that's ill, it's [husband]."* (partner) (ASW assessment)

Finally in relation to the adjustment of parental expectations, we have seen the proportion of parents (approximately one-third) holding a different perception from the social worker to be stable across aspects of the assessment such as focus, secondary focus and overall view of the situation. However, when parents were asked directly whether or not they agreed with the social worker's actions and plans, the level of divergence decreases, parents appearing to become more content, as it were,

with the outcome. Actions based on compulsory admissions to hospital aside (where strong dissent might be anticipated), only two parents ultimately strongly disagreed with the social worker in relation to actions/interventions and only three parents strongly disagreed in relation to the social worker's future plans. The data, then, suggests that the majority of the parents who held substantially different views from social workers on a range of aspects went on to make adjustments to their requirements and expectations when faced with the reality of the actions/plans as proposed by social workers.

In contrast, what the small group of 'dissenting' parents express is a keen awareness of the relative powerlessness of their position:

> *"It's unsettling when they say well I'm going to have to go back to the office and discuss it with such and such ... it wasn't him that was actually making the decision. ... I didn't voice anything, a lot of it went internally. ... I just thought he's going to present the case back there and they're going to get a care order on him. ...I suppose [social worker]'s got to talk to somebody. ... But it just feels that the more people are getting involved ... decisions are going to made and I don't think I've got a word. My words won't be heard, I don't think. Or they hear them but they won't take notice of them. They've got all the power."*

EXTENT TO WHICH PARENTS FELT LISTENED TO AND HELPED BY SOCIAL WORKER

The majority of parents, three-quarters (18), thought they had been listened to by the social workers and that their views had been taken into account. This number includes the three parents who had a view of the situation that differed from the conclusion they understood the social worker to have drawn:

> *"Oh yes, most certainly that, they're very attentive in that respect, yes. ... They weren't blasé or anything on those lines, no, no, they sat and listened and they asked what I would call pertinent questions. I would say they were professional, at least the two I spoke to were anyway."*

> *"Yeah ... she listens to everything. She's just terrific. I look forward to her coming round."*

The remaining six parents (one-quarter), three of whom were the subject of ASW assessments, were either unsure or ambivalent about whether or not the social worker had listened to and taken notice of their view or considered that they had not:

> *"I'm not really sure 'cos I spent half my time with my head down so I didn't really ... take on board whether he was listening to me or not."* (ASW assessment)

> *"It was just a waste of time going because ... it's come to a blank book, what you've explained to them must have just gone in one ear and out the other ... well, she listened but ..."*

With regard to how helpful or otherwise parents had found the social worker's interventions, the majority of parents, just over two-thirds (17) saw the course of action taken by the social worker as being helpful:

> *"It has, because I'm here [temporary accommodation] ... I think the first social worker started the ball rolling and ... I don't know, she just made things come to light more. There was just someone there I could talk to, tell them everything. And I suppose, if I was to be totally honest, in one way I ... wanted to tell someone ... hoping that someone else could sort out this quite a big mess out for me, 'cos I tried, but I just got deeper in it. ... All right, I'm in one room with a baby, pregnant, but it's actually got me somewhere. ... That's what I wanted more than anything, someone just to be on my side to understand me and know what I meant. And at home I wasn't getting that, not before the social worker, I wasn't getting that."*

in one-quarter of the interviews (6) parents expressed some doubts about aspects of how helpful the social worker's actions and interventions had been, leading them to give responses laced with uncertainty (including one example where parent and partner were divided in their opinions):

> *"I spoke outside in the hall, near where the kids' play stuff is. ... She did ask me if I wanted to go into a little room, but she knew that I had a double buggy so how could I get into the small room ... I felt uncomfortable talking, 'cos there were people outside. ... When I got all my food and the kids' nappies I didn't have nothing left ... £25 doesn't get much, does it? But I was grateful to get it, because if I didn't have it, then I wouldn't have had anything. It was lucky ... the social services are there, because anything you need help with, you just phone up and ask."*

"She found out a few things we didn't know but a lot of things she told us we already knew about anyway. But she did find out a few things that we never thought that could be bugging him [child]." (parent) *"It never worked."* (partner)

and in only one instance did the parent consider that the course of action taken by the social worker had not been helpful to her at all:

"I couldn't understand why she contacted the nursery school as the problems were with me and not with the children. The nursery school is there purely for [child]'s benefit. Even though she got the place because I had post-natal depression, her key-worker is there to help her ... they're not working on my depression. She's just there to give me a break. They don't know that much about me as a person. I couldn't understand why she'd contacted the nursery, and it worried me a bit ... because I thought perhaps she'd found that there was something wrong with [child] and that's why she needed to contact [her] key worker. ... Everything she wanted to do was really for the children and not for me."

EXTENT TO WHICH PARENTS FELT LISTENED TO IN RELATION TO THE IMPACT OF THEIR MENTAL HEALTH DIFFICULTIES

With regard to whether or not parents considered the social worker had listened to their views about the impact of their mental health difficulties, one-half of the parents (12) considered that the issue had not been addressed specifically (this number includes the three parents who did not consider their difficulties to come within the mental health realm in any case).

In the remaining one-half of the interviews (12) where this aspect was considered to have been covered specifically, in the majority of instances (10) the parents felt that their views in this regard were listened to:

"Yeah, she listens ... I dunno how she listens ... she must get really sick and tired of it and think 'I've got to go round [there] again' (laughs), but she just takes it all in."

whereas the remaining two parents felt unheard:

"I know they do listen, but I don't really know that they know how I feel".

We have seen that active partnership between social workers and parents was limited. Despite this lack of active involvement in the process, however, parents did, for the most part, feel their ideas and views were listened to by social workers and generally social workers' interventions were seen as helpful. Where parents did not feel heard or see interventions as helpful, the data is indicative of social workers pursuing essentially gatekeeping priorities that conflicted with parents' wishes and/or failing to take a sufficiently client-centred approach. In this, the parents' data around communication and partnership had clear similarities with the earlier data focusing on the content and outcome of the assessment. Nowhere was this 'missing' of parents by social workers more apparent than in relation to the interface between parental mental ill-health and the progress of children. Notwithstanding the process of assessment and despite its clear significance for parents, the issue failed to be identified by social workers as a matter of any great professional concern.

THE PICTURE THREE MONTHS ON

Three months after the date of assessment outcomes relating to the 34 situations as recorded in case files were as follows:

WORK CONTINUING

In 14 cases work was continuing with clients three months later. This number includes one case which had been held by the initial assessing social worker on duty and was now awaiting allocation, and two cases which were closed after three months continuous work by the social worker who did the initial assessment. In all these cases the plan had been for ongoing work of some sort, with one (Child Guidance) exception where the plan had been to close the case while the clients considered whether or not to proceed.

Work continuing after three months was more likely to be the situation for Child Guidance and Adult Psychiatry clients rather than Area Team clients:

Area Team	Child Guidance	Adult Psychiatry	Total
7	4	3	14
(out of 24)	(out of 5)	(out of 5)	(out of 34)

Table 7.1: Cases continuing three months on

In the ten cases where parents agreed to research interviews, the majority (8) were either satisfied or very satisfied with the service they received (7 (3 Area Team, 3 Child Guidance, 1 Adult Psychiatry) and 1 (Area Team) respectively), with the remaining two expressing dissatisfaction (1 Area Team (due to service considerations, in particular having to wait so long for an allocated worker which was exacerbated by poor communication) and 1 Child Guidance (due to not getting desired outcome/type of service deemed helpful)).

CASES CLOSED

In 12 instances the cases were closed following assessment and/or an immediate short period of work and remained closed to the assessing agency thereafter for the rest of the three month period. In seven of these cases the plan had been to take no further action. In the remaining five had been for further assessment/work.

Cases closed either immediately after assessment or following a very short-term piece of work were more likely to be those presenting in the Area Team setting rather than the settings of Adult Psychiatry or Child Guidance, although only marginally so in the latter case. Two of the Area Team cases and the one Child Guidance case continued to have support from other social services workers:

Area Team	Child Guidance	Adult Psychiatry	Total
9	2	1	12
(out of 24)	(out of 5)	(out of 5)	(out of 34)

Table 7.2: Cases closed three months on

In the ten cases where parents agreed to research interviews, one-half (5) were either satisfied or very satisfied with the service they received (3 (Area Team) and 2 (1 Area Team, 1 Adult Psychiatry) respectively), a further three were uncertain about how satisfied they had been with the service (all Area Team), whereas the remaining two were dissatisfied (both Area Team, neither got the desired outcome, one was also dissatisfied with the level of communication).

RE-REFERRALS

In eight instances, cases which had been closed following assessment were re-referred during the following three months. This number includes further re-referrals from two of the three families that were assessed, closed and re-referred during the study period (the third case remained closed following one re-referral, the family having moved in any case to an adjoining borough). The plan in all these instances was to take no further action, with one exception where the case had been put forward for a decision on allocation (and was not allocated).

All cases where there were instances of re-referral were Area Team cases:

Area Team	Child Guidance	Adult Psychiatry	Total
8	-	-	8
(out of 24)	(out of 5)	(out of 5)	(out of 34)

Table 7.3: Cases re-referred during the three months that followed initial assessment

We turn first to the two cases where there were further re-referrals from families who had already been re-referred during the study period. In the first instance the client re-referred on one occasion in the following three months, the case again being closed. This parent when interviewed had expressed dissatisfaction with the service (due to not getting the type of support deemed helpful).

In the second of these families (the case that had been forwarded for allocation but not allocated) the parent made a total of five contacts with the duty service during the following three months. According to records, she was often unable to articulate the help she required and gained a variety of responses including expressions of concern over her mental health and about how she might be coping with her children. Apart from the granting of financial help to enable the children to attend a Saturday club, the case remained closed. This parent declined to be formally interviewed but had sought out the researcher expressly to record her extreme dissatisfaction with the service.

A further case that re-referred during the following three month period was again closed, although an under fives place was allocated to one of the children on the recommendation of the health visitor. This parent when interviewed had not felt heard and had disagreed with the social worker's plan for closure of the case, wanting more in the way of support than the financial assistance she received. She had nevertheless reported that she was very satisfied with the service. As an ex-child in care who had, in her words, been 'rescued' from an untenable home situation, she remained eternally grateful to social services and social workers despite any current shortcomings.

In the remaining two instances where there were re-referrals during the following three months, both cases went to allocation for ongoing work, one on a statutory child protection basis. This parent when interviewed had been satisfied with the service she had received at the time (she had been referred as a result of concerns by the school

who were the source of the later referral, again expressing concerns about the children). The other parent when interviewed had not got the outcome she wanted at the time (which was more general assistance, and particularly allocation to a social worker) and had been uncertain about the service she had received.

It is noteworthy that there is a preponderance of dissatisfaction on the part of parents in connection with these cases that were closed and re-referred, in at least one instance a clearly disturbing number of times. The exceptions to this marked level of dissatisfaction were two cases where parents had either no current pressing demands of their own or considerable gratitude for services received in the past.

It is noteworthy also that it was only in the Area Team setting that social workers appeared to operate in this way. Child Guidance and Adult Psychiatry social workers were more likely to continue working for longer periods with clients, compared to Area Team social workers, and clients were most likely to be satisfied when work did not cease immediately following a one-off assessment and/or very short-term piece of work.

SATISFACTION COMPARED

Half the parents (14/28 including partners) were satisfied with the social work service they had received including two with qualified satisfaction. Equal numbers were very satisfied and dissatisfied (five in each case) and four parents were uncertain. Desired outcome was the predominant influence with regard to level of satisfaction/ dissatisfaction, followed by the quality of service as perceived by the client. Distinctions were made between the quality of individual social workers and the quality of the service overall; good social workers did not offset inadequate service provision in the eyes of the parents.

In contrast, the social workers had a rather higher level of satisfaction overall. The majority of social workers, two-thirds (22/34) considered themselves satisfied with the piece of work they had undertaken including six with qualified satisfaction. Eight social workers were very satisfied with their work. None were dissatisfied, although four were uncertain. Influences on the social workers' level of satisfaction were the extent to which they felt they had been able to get to grips with the issue as presented, followed equally by the outcome for the client and the achievement of good practice/professional standards and, finally, the resources climate in which they operated.

Having looked in detail at the findings of the research, we turn in the following chapter to discussion of the findings.

CHAPTER EIGHT: DISCUSSION OF FINDINGS

The findings are discussed under the following main headings: *(1) The place of knowledge; (2) What informed social workers; (3) Other influences on the process; (4) Being a managed professional; (5) The role of the client.* The place of knowledge — social workers' and clients' — within the assessment process is explored in the context of further consideration of the nature of professional knowledge. What informed and the influences on social workers in their assessments is discussed, with particular reference to the dominance of managerial/organisational considerations and the relative lack of focus on issues of professional concern. The need for a redressing of this balance via the route of reflective practice is argued. The current and potential role of clients within the initial assessment process is discussed, particularly with regard to issues of client empowerment and partnership.

THE PLACE OF KNOWLEDGE

THE SOCIAL WORKERS' KNOWLEDGE BASE

A particular objective of the research was to explore the extent to which social workers called upon pertinent formal knowledge. The findings indicate that the majority of social workers could conceptualise a place for formal knowledge and approaching one-half of social workers were able to identify a specific sphere of formal knowledge as having overriding relevance for the particular assessment they had undertaken. However, when account is taken of other findings in this area — that a slightly higher number of social workers were unable to identify one sphere of knowledge over another as having particular significance; and that significant minorities preferred everyday conceptions and/or common sense notions as a basis for their judgements and recognised that they brought a range of different sorts and levels of knowledge to bear in ways that they judged appropriate to the situation in hand — in line with the findings of others (Pithouse, 1987; Higginson, 1989; Hill *et al.*,

1992; Waterhouse & Carnie, 1992), the indications are that the approach of social workers was significantly underpinned by a knowledge base of practice wisdom rather than by the application of formal knowledge.

The inclination of social workers to adopt an approach based on practice wisdom — which, by its nature, involves, in greater or lesser degree, the incorporation of formal bodies of knowledge — was further exemplified by the social workers' responses in the area of interface between parental mental ill-health and the progress of children. Social workers invariably took account of the interface inasmuch as they responded to it as an aspect of the situation with which they were presented and about which they needed to make decisions. What they did not do, however, was to understand the interface in terms of a specific body of applicable knowledge (as set out, for example, in Chapter One). Instead the social workers' assessments were informed by other less specific and/or less formal knowledge. These findings echo the observations of others (DHSS, 1985; Isaac *et al*, 1986; Sheppard, 1994a).

While such an approach is understandable, even essential, in the context of the life of a busy practitioner, it is argued that, with regard to the specific interface under discussion here, there is nevertheless a significant downside to the total bypassing of a body of relevant formal knowledge. Payne (1996) points out the essential interconnectedness of knowledge and skills in a practical activity such as social work, commenting: *"skill which cannot use knowledge is less skilled than it might be"* (p53). As we saw in Chapter One, specific aspects of the difficulties faced by a parent experiencing mental ill-health — such as symptomatology, prognosis, precipitating factors and/or any consequent effects — warrant particular attention in their own right. It is argued that, when social workers fail to take account of such mental health-related aspects, their assessments — however skilled otherwise — are likely to be poorer and, ultimately, less effective.

Taking the above findings together, then, it is argued that the approach adopted by the social workers implicitly indicated the primacy for them of the knowledge base of practice wisdom over and above an approach which emphasised the application of specific bodies of formal knowledge. Faced with situations for assessment (in these instances involving the interface between parental mental health and the needs of children), social workers were informed by their own variously accumulated banks of knowledge and experience alongside the observations and intuitions generated by the circumstances. This knowledge and experience was largely professional/ organisational but sometimes, in addition, personal and/or based on everyday notions of common sense. By way of illustration, we might say that social workers carried a knowledge base/practice wisdom 'tool bag' containing a variety of tools. They might bring out for use any of these depending upon the situation that presented. Different workers' tool bags might be filled with a greater or lesser range of tools (with perhaps, occasional significant gaps considering the job in hand), with tools that were likely to be more or less suited and/or adaptable to the task, and with tools that were more or less sophisticated. Nevertheless, whatever situation presented itself, social workers would get on and do something with the tools they had. In other words, whatever the make-up of their particular knowledge base, when faced with a given situation to assess, social workers, as befitted their role, invariably went on to form a view. Moreover, the social workers clearly considered their approach and the views gained to be valid. In this connection, as Eraut (1985, 1994) points out, practitioners are in an environment where the aim is not knowledge for its own sake but action — action for which they bear responsibility. Since practitioners need, then, to believe in, rather than undermine, the views formed and actions taken, Eraut (1985) contends a pragmatic approach, based largely on experience as applied to the individual situation, is invariably likely to hold sway.

THE NATURE OF PROFESSIONAL KNOWLEDGE

The incremental and evolving nature of theoretical knowledge, as illustrated in Chapter One, gives a clue as to the difficulties facing social workers who do seek to apply formal knowledge as a basis for practice. Shot through with as yet unanswered questions and uncertainties, the body of literature highlights the problematic nature of formal knowledge vis-à-vis its relevance to the professional context of social work. Hard-pressed practitioners might legitimately ask how relevant, on balance, any of it is to the sort of individual, uncertain, problematic situations with which they are faced. That a learning spiral was undergone by the researcher in relation to the topic of knowledge has already been indicated. At the outset, the model of professional knowledge and practice subscribed to was broadly, using Schön's (1983) term, that of 'technical rationality' whereby *"professional activity consists in instrumental problem solving made rigorous by the application of scientific theory and technique"* (p21). The responses gained from the social workers, however, made it clear that this was far from the whole story. What had been overlooked was that professional activity — and perhaps especially an activity such as social work assessment — is as much about problem *setting* as problem *solving*. Schön describes problem setting as an interactive 'naming and framing' process whereby professionals *"define the decision to be made, the ends to be achieved [and] the means which may be chosen"* (Schön, 1983 p40). Given that practice situations are frequently characterised by their uniqueness, uncertainty and complexity, the process might be said, at least in the early stages, to be the antithesis of technicality. It is, then, the essentially non-technical work of 'naming and framing' that creates the conditions required for the exercise of any technical expertise that may ultimately be brought into the process.

Eraut (1985; 1994) expands our understanding of how professionals use knowledge in a practice context, in particular aiming to tease out the links between mode of knowledge use and professional judgement. Citing Broudy *et al.* (1964), he contends

that to use knowledge 'applicatively' requires having an awareness of what would be the professionally 'right' prescription for action in any given situation and, fine-tuning to individual circumstances notwithstanding, essentially implies reference to accepted rules or procedures. The ability to employ other modes of knowledge use alongside the mode of application is what sets the professional apart from the technician. The concepts, theories and intellectual disciplines associated with their sphere of expertise provide practitioners with their professional perspectives, or ways of construing situations; thus, *"understanding is shaped by the interpretative use of such theoretical knowledge"* (Eraut, 1985 emphasis added). Such interpretative mode of knowledge use is not the whole story when it comes to making sound judgements, however. Good professional judgement relies as much on the professional having an intuitive sense of what would be an appropriate, workable course of action taking all the circumstances into account. This mode of knowledge use — referred to by Eraut (1985) as 'associative' — is usually based on a wealth of professional experience. As will be discussed in more detail shortly, the findings revealed that assessing social workers exercised a high degree of professional judgement/discretion. Again, the indications were that any understanding of the process that placed undue emphasis on the application of formal knowledge or on technical solutions would be sadly lacking.

Reflecting on the data and aiming to make sense of the findings in the light of further reading in the area of professional knowledge enabled the researcher to see that an epistemology of practice that relies solely on ideas such as the application of knowledge and technical problem solving denies concerns central to professional practice. Arguably this is particularly so of social work since it is in the nature of the beast that there will be relatively few clear-cut situations where technical solutions can be satisfactorily applied. Noting the ability of professionals to 'reflect-in-action' — broadly to have a feel for what will probably work in a given situation, making adjustments as necessary — as well as to reflect on their actions, Schön (1983)

proposes instead an epistemology of practice that emphasises ongoing reflective inquiry, such that the implicit and tacit are made explicit, with technical problem solving viewed as only one aspect of professional knowing.

Commentators note that a characteristic of social work is that it relies on the bringing together of a number of different types and areas of knowledge (Curnock & Hardiker, 1979; Davies, 1994; Payne, 1996):

> *Widely agreed areas of social work knowledge cover understanding of the organisational and legal contexts of work, social scientific knowledge about human beings and their interactions, and social work practice methods.* (Payne, 1996 p55)

In light of this, it might be argued that use of the term 'practice wisdom' — with its somewhat homespun connotations — does the profession something of a disservice. In the belief that social workers use knowledge in a more systematic way than is generally recognised, Curnock & Hardiker (1979) aimed to conceptualise and codify the practice of assessment. The authors make the distinction between bodies of knowledge culled from, for example, the human and social sciences (which they call 'theories of practice') and knowledge that is to do with the active process of how social workers conceptualise their day-to-day task and the frameworks they use to help them make sense of the wealth of detail they sift. They term the latter 'practice theory', making the point that, not only is much of it implicit, but, as yet, such practice theory has not been codified or documented to any great extent. The two, of course, interweave, with the (sometimes) explicit theories of practice forming only one part of practice theory: *"It is the process of using many types of knowledge within a purposeful relationship which forms the kernel of practice theory"* (Curnock & Hardiker, 1979 p9).

As Eraut (1985, 1994) notes, however, some kinds of experience-derived practical knowledge — 'reading' the set of a face or the tone in a voice, for example — are essentially uncodifiable. Here the term 'wisdom' may well be more appropriate than 'theory'. Essentially, however, the various aspects of practical know-how are borne out of the sort of reflection-in-action process propounded by Schön (1983). We are brought back at this point, then, to the different conceptions of ways of professional knowing.

THE CASE FOR PRACTITIONERS BEING KNOWLEDGEABLE ABOUT KNOWLEDGE

Although the findings overall indicated that their approach was one significantly underpinned by a knowledge base of practice wisdom, the social workers did not appear to conceptualise knowledge in this way. Where social workers did make explicit a concept of knowledge it was understood in terms of formal bodies of knowledge. Generally they did not appear to be aware of different conceptualisations of knowledge. It might be asked, then, whether it matters that social workers do not recognise the make-up of their own particular sort of 'knowledgeableness', encompassing as it does elements both of technical knowledge and practical know-how, or the variety of ways it may be brought to bear on the professional task? It matters in a number of important ways. Firstly, being informed in a theoretical way about the professional task is likely to enhance its execution in practice (Utting, 1989) (although some may fear a loss of social work's more 'artistic' elements will be the result). It has long been acknowledged that a gulf exists between theory and practice within the discipline of social work. It is argued that such a state of affairs is likely to continue until social workers acknowledge their own particular and specific practice-derived knowledge base, allowing themselves to conceptualise the relationship between theory and practice differently (Schön, 1983; Eraut, 1985). If social workers conceptualise their knowledge only in terms of formal bodies of knowledge — themselves often derived from other disciplines — they are likely to remain largely

unconvinced about the relevance of a concern to relate theory to practice. This is because, as we have seen, as practitioners they 'know' that such theory is not really what they base their work on. Thus, as Paley (1987) suggests, relating theory to practice is likely to be seen as something of a technical exercise — demanding a different 'interpretive repertoire' or mode of accounting — to be undertaken from time to time if particular situations (for example, appearance at Court, practice teaching, etc.) warrant it, but otherwise viewed as largely irrelevant to the everyday task and the everyday mode of accounting. At practitioner level, then, the conceptual leap that has, as yet, to be made, entails social workers acknowledging the particular 'way of knowing' that informs their social work task, making it explicit, and arguing its validity vis-à-vis alternatives. One of the more accessible ways for practitioners to pursue this end is via the route of research-minded practice (Everitt *et al.*, 1992).

Secondly, there is the question of professional identity. Based on their responses regarding the influence of the professional climate, this was far from strong in the social workers studied. Although clearly a matter for debate, a delineated area of technical/applied knowledge is often cited as one of the hallmarks of a profession (Howe, 1991; Hugman, 1991). Given the nature of social work's expertise and the public forum in which it is practised, such delineation will always be (arguably, should always be) problematic. It is not uncommon, however, for social workers to talk of their profession as not having its own knowledge base and to refer to the necessity of drawing upon the knowledge bases of other disciplines, psychology, sociology, psychiatry etc. being cited as obvious examples. Such a simplistic understanding of the nature of knowledge on the part of social workers can only be unhelpful and undermining of social work as a discipline. A better understanding of what constitutes knowledge generally, in other words, of the concerns of epistemology and how such concerns relate to social work in particular, might go a long way towards increasing professional identity and cohesiveness. Opinions will, of course, vary as to whether the promotion of social work as a profession is desirable (Glastonbury *et al.*, 1980;

Hugman, 1991), not least in terms of what a professional (if translated into 'expert') model can mean in terms of power imbalances in the client-worker relationship (Smale *et al*, 1993). Being knowledgeable about knowledge is, in any event, likely to increase social workers' sense of being professionals in the colloquial understanding of the term — that is, paid, talented and high-quality performers (Glastonbury *et al.*, 1980; Smale *et al.*, 1993).

The pros and cons of encouraging social workers to identify more strongly as a professional group aside, however, it is argued that an increased understanding of the nature of knowledge can only enhance social workers' sense of professionalism, leading to a more (consciously) informed approach and thus to more effective execution of the essentially 'emancipatory' social work task (Everitt *et al.*, 1992). In other words, it is by being knowledgeable about their own (and others') knowledge that social workers can first empower themselves. This is vital for a number of reasons. The first relates directly to clients. If social workers fail to make explicit and apply their knowledge in a conscious way, meaningful communication and partnership with clients will be hindered. On the other hand, the more social workers are able to do this, the more the task will be enhanced (Schön, 1983). To work successfully in partnership with clients, to clarify and negotiate meanings both ways, to ensure interventions empower wherever possible, aside from listening to the difficulties clients bring, social workers need to become more skilled at articulating their professionally informed understandings and rationales in relation to the assessment process. This acknowledges that communication is a process of convergence, involving the sharing of information by participants in order to gain mutual understanding (Smale *et al.*, 1993). Secondly, more conscious ownership of the particular knowledge base of the profession, and thus well-argued promotion of the social work perspective, will similarly serve only to enhance the inter-professional communication and partnership demanded by the current-day legislative climate (Lloyd & Taylor, 1995) and changing local authority structures (Siddall, 1997). Thirdly, as a grouping within the profession

(Howe, 1991), the practitioner arm of social work does itself, and the profession as a whole, a disservice if practitioners do not expound their particular perspective and engage in the ongoing debate about what issues, at any one time, rightly warrant professional concern. This latter point is discussed further in the concluding remarks.

Of relevance at this point is the social workers' level of articulacy. In general terms, the social workers appeared unused to articulating the basis for their work, including their knowledge base, but they could do so with encouragement. Lack of articulacy on the part of social workers has been noted by others (DHSS, 1978; Jones, 1990; Hill *et al.*, 1992). Whether the issue at bottom is, however, actually one of social workers' lack of skill/practice in articulation or professional weakness when it comes to analytical skills is less clear. In line with other research (Clegg, 1992/3; Clifford, 1992/3; Hill *et al.*, 1992), there might be said to be worrying indications that this is so, inasmuch as social workers framed their assessment conclusions in terms of practical solutions to clients' problems rather than as professional summations of their understandings of clients' situations together with the rationale underlying the decisions arrived at. In an echo of this, social workers' written accounts were descriptive rather than analytical in tone. Since, however, there is likely to be an interrelationship between articulacy and analysis, to address the former (in, for example, the forum of practice supervision — more of which later) will, in any case, demand a honing of the latter.

A PLACE FOR CLIENTS' KNOWLEDGE?

Arguably, if social workers are to analyse successfully and fully the sorts of situation that are presented for assessment, they need to ensure account has been taken of all pertinent aspects. What is or is not considered pertinent to the social work task is, of course, to some extent, a matter of professional judgement. In any negotiated assessment process, however, we might legitimately expect clients as well as social

workers to have a say regarding pertinence. An aim of the research was to explore the informal knowledge of clients specifically with regard to the interface between parental mental ill-health and the needs of children. It was clear from their responses that parents' own mental health and well-being had tremendous significance for them. No parent failed to have a view about the impact of their mental health and/or personal difficulties on them and on their children. Many parents spoke at length, eloquently and movingly. It is clear from the findings, then, that clients had a great deal of informal knowledge about the area of interface. We might even describe them as experts in their own right on the subject. Yet, to the extent that two-thirds of parents felt unable to venture a view as to the social worker's opinion with regard to such impact (one-third expressly because the aspect had not been covered to any great extent), it seems an area little discussed between parents and social workers either in any great depth or in terms of the interface specifically, despite parents' alertness to the actual and potential impact of their mental health difficulties on their children.

Of course, it cannot be assumed that every parent would automatically have welcomed greater concentration by a social worker on their mental health difficulties (Hugman & Phillips, 1992/3; Read & Baker, 1996). The point at issue here, however, is that, within the assessment process, social workers appear to have overlooked a significant aspect of the 'knowing' of their clients in a major way. We are brought back at this point to the importance of social workers being better versed in epistemology. That there is a link between knowledge and power has become something of a cliché. Worrall (1990) reminds us, however, that:

> *"knowledge of itself does not give power. On the contrary, it is those who have power who are authorised 'to know' and whose 'knowledge' is afforded privilege".* (Worrall, 1990, cited in Everitt *et al.*, 1992 p17)

As welfare professionals, social workers are often in undeniably powerful positions vis-à-vis their clients. Noting that all too often the ways of knowing associated with professionals have ultimately objectified and controlled those they aimed to serve, Everitt *et al.* (1992) expound the view that it is precisely because of the power dimension arguably inherent in the social worker-client relationship that a firm grasp of epistemological theory is crucial as a basis for social work practice. They argue that for social work to be emancipatory, social workers need to be knowledgeable about, not only the many varied and evolving theories that might inform assessment, intervention, services and the effectiveness of those, but also about the differing approaches to becoming and laying claim to be knowledgeable. The point about social workers being knowledgeable about theories of knowledge in particular is that this is likely to enhance their critical thinking. This is vital if encounters between practitioners and clients are to be based on ideals such as equality and social justice that are not merely notional:

> *"Different ways of knowing and understanding the world make different assumptions about the individual and society, and about their interrelationships. Unless these assumptions are teased out, they may be adopted unknowingly and uncritically by practitioners. And yet these assumptions have implications for practice."* (Everitt *et al.*, 1992 p 17)

The role of the clients in the assessment process will be discussed in more detail shortly. Specifically as regards the place of knowledge/ways of knowing in the process, however, it is argued here that social work practitioners need to attend more closely to their skills and abilities to think critically and reflexively if the assessment process is to be experienced by clients as truly participatory. A consideration of the nature of knowledge is undoubtedly a good place to start.

As well as exploring specifically the place of formal and informal knowledge, the study aimed to explore more generally what informed and influenced the assessment process. We turn now to a discussion of these more general findings.

WHAT INFORMED SOCIAL WORKERS

THE PREDOMINANCE OF PARENTING

We have seen that, in their recounting of factors that were influential in their assessments, a recurrent and predominating theme for social workers was that of parenting. Case records similarly reflected this focus. Social workers' emphasis on the issue of parenting undoubtedly says something about the primacy for social workers, at least in the statutory sector and certainly where children are in any way involved, of children and issues of child-care. In a review of recent literature concerning the effectiveness of interventions to prevent or respond to child abuse, Gough (1993, cited in DoH, 1995) noted that such emphasis, to the exclusion of other important dimensions of child and family support, was common:

> *Since the whole concept of child abuse was largely based on parental responsibility for the distress of their children ... the service response was likely to be concerned with perceptions of the adequacy of the parents as carers.* (DoH, 1995 p93)

Such priority setting is perhaps unsurprising and can be viewed as a reflection of legislation, which itself reflects current political and societal concerns.

At first glance, it is hard to argue against the rectitude of parenting being given priority and, of course, ultimately, most would consider it undesirable to do so. This is notwithstanding that, in acknowledging the primacy given to issues of child-care, we are brought four-square into the arena of gender politics and, thus, face to face with the uncomfortable notion that social work, unless specifically informed by feminist

thinking, may reinforce the unequal position of women within an essentially patriarchal society (Dominelli, 1991; Everitt *et al.*, 1992). Putting this issue (despite its importance) to one side, however, a closer look at the social workers' emphasis on parenting raises further important questions about the productiveness overall of such discounting of parents as individuals — individuals with their own particular mental health difficulties who are also parents.

On the one hand, overlooking the parent's individual mental health as an aspect worthy of significant attention in its own right can be seen in the context of wider mental health debates centring on, for example, the often stigmatised position of mentally ill people in society and the 'Cinderella' character of the services they frequently receive. On the other hand, it can be viewed as a corollary of what appears to be the pivotal role of the parent (in effect, the mother) in the family as viewed by social workers. We might say that, in effect, the chief question being addressed was 'is this a good-enough parent?'. As others have found (Hugman & Phillips, 1992/3), it was clear that, to a very great extent, the parent was related to as 'holder of the parental role' rather than as an individual person who, as one of many facets, held the particular role of parent. It is easy to see how such an approach would be unlikely fully to meet the needs of the individual adult/parent as a whole person and, further, to form the view that parents' needs were being downplayed in order that their children's might be met.

Interestingly enough, though, in a sense, the social workers' emphasis on parenting also overlooked the needs of individual children, since for these to be addressed the question 'what is the impact on this child?' would need to be asked. Emphasis by social workers on children in this more direct way, rather than on parenting, was considerably rarer. (There is an echo here of DeChillo *et al.* (1987), although in that study the psychiatric social workers' concentration was on mentally ill adults to the exclusion of their children.) We are back, then, to the pivotal role of the parent and the

working assumption frequently held by social workers that, if the parent was coping, as a parent, the children would probably be coping too.

In the context of social services assessment, implicit in the question 'is this a good-enough parent?' is the rider 'or do we need to intervene?'. Assessing and establishing quality of parenting (notably as part of the child protection agenda) are, of course, concerns central to the work of social services (DoH, 1988). What we might well be seeing reflected, then — via the social worker's emphasis on parenting at the level of the individual assessment encounter — is the influence of a key aspect of the agency's agenda.

Undoubtedly, in such situations, a variety of needs will be present and the meeting of differing needs will need to be negotiated. In partnership with those involved, the social work task is to facilitate this negotiation (Lloyd & Taylor, 1995). It is difficult to see, however, how the accent by social workers on parenting *per se*, as opposed to on the person as an individual first, together with acknowledgement of their particular facets of mental ill-health and the role of parent, can be supportive of the professional/ organisational ideal of working in partnership to maximise the potential for effective social work encounters. To the contrary, such a discounting approach is likely to work against the notion of partnership with parents. Rather than being responded to as individuals potentially requiring a service (that might or might not include support with parenting), it was as if the rights of the mentally ill parent to such a service, over and above the rights of children to be parented adequately (or even, arguably, over and above the 'rights' of the agency to pursue its child protection agenda, given that they reflect the overriding 'needs' of the State (Johnson, 1972 cited in Hugman, 1991 p19)), lacked legitimacy, unless and until the mental health of the parent was problematic to the extent that it clearly warranted an agency response in its own right.

MENTAL HEALTH OF THE INDIVIDUAL

The findings indicate that, where social workers did focus specifically on the mental health of the individual, this was most likely to be in the context of a statutory assessment of risk — that is, where the needs of/concerns for the mentally ill parent had become high profile in their own right. Social workers were less likely, then, to respond to lower-profile individual mental health needs or to keep in mind psychiatric/mental health risk in its widest sense. This response contrasted with the responses of social workers to the needs of children, it clearly being common (exemplified by their emphasis on parenting) for social workers to be mindful of the possibility of risk to children over and above the formal child protection context. It seems likely that the reasons for such different responses once again relate to the relative status of mental health as an issue in its own right vis-à-vis what is seen as the particular and overriding vulnerability of children in comparison with adults (even mentally ill/vulnerable adults). In addition, despite recent well-publicised breakdowns in the mental health care/protection system (for example, as detailed in the Christopher Clunis Inquiry Report, (Ritchie *et al.*, 1994)), it is probably still the case that it is failures in the child protection system that draw the greatest public criticism, the ever-present possibility of which, in turn, ensures, greater professional caution/ defensiveness.

The findings indicate that the aspect of individual mental health most likely to be of particular interest to social workers was that of the individual's psychiatric history. It appeared that, given the context of assessment, this had particular relevance for social workers inasmuch as, aside from being a factor in its own right, such historical information also served as a useful yardstick by which to judge the current state/progress of the mentally ill parent. In response to the question posed by Isaac *et al.* (1986) referred to in the introduction we can see, then, that this is at least one way in which knowledge of psychiatric status is used by social workers.

The discrepancy between the extent to which the parent's mental health was discussed directly with the parent and the far greater extent to which information that a parent was experiencing mental health difficulties was recorded in case files is particularly interesting and, sadly, not without irony. We have seen in the findings that an approach familiar to social workers was one whereby they operated on the basis of staying alert to any warning bells. In line with this approach, it is arguable that the emphasising by social workers of parental psychiatric status in case records might have aimed to serve as, in effect, a form of written early warning to colleagues who would come later. The usefulness or otherwise of such an approach, especially from the particular perspective of the labelled client, is, of course, open to debate.

AGENCY ROLE AND RESOURCES

The findings indicate that, when it came to the identification of factors that informed specific assessments, social workers were much more likely to mention characteristics internal to the case than external, contextual factors. As we have seen, the theme arising from the responses of the minority of social workers who did volunteer external factors was that of the role and resources of the agency. Having an understanding of agency, professional and societal definitions of, and constraints upon, the assessment task — what might be termed organisational (in its widest sense) knowledge — is clearly a facet of the process. Despite the fact, then, that external factors were volunteered by only a minority of social workers, it would be surprising if understandings in this vein did not form part of social workers' practice wisdom. Indeed, when social workers were asked specifically about organisational factors they were invariably able to articulate the extent of the influence of such factors as perceived by them.

Why, then, should there be this tendency for social workers to exclude from their initial analyses the part played by organisational factors? Certainly, when speaking in

abstract terms, social workers readily acknowledged the part played by external factors in the shaping of assessments, as the findings from the group discussions indicated. It seems, then, that the social workers knew in theory that their assessments were open to influence by such factors, but the majority held to the belief that somehow in this *individual* case they had screened them out, had risen above them. It is easy to see how the juxtaposition of human need and organisational constraint might be difficult for assessing social workers to tolerate at the level of the individual. In addition, it appears likely that there is a cultural belief within social work that the best assessments 'should' be needs-based and uncontaminated by external considerations. Indeed, a small number of social workers voiced this view explicitly.

Perhaps unsurprisingly, the social workers most likely to acknowledge the influence of external factors were Area Team social workers, most often carrying out their assessments in a duty situation. For these social workers, operating where the gatekeeping role is at its starkest, the part played by the agency role and resources in shaping their assessments was clearly apparent alongside the individual characteristics of the cases themselves.

On the face of it, then, when examining what the majority of social workers initially considered had informed their assessments, the organisational theme of agency role and resources, although identifiable, was less dominant, notably vis-à-vis the theme of parenting. The theme of parenting has been understood as relating largely to the characteristics of individual cases. It is arguable, however, that even though the majority of social workers considered that case characteristics alone informed their assessments, since their emphasis in the context of these sorts of families was so clearly on *parenting,* this emphasis, of itself, implies an underlying (although unacknowledged) awareness of agency role. There is, of course, a clear link between issues of good-enough parenting and the assessment of risk as it relates to child

protection. The importance of risk as an organisational influence in the assessment process will be discussed shortly.

OTHER INFLUENCES ON THE PROCESS

SETTING

The organisational context was certainly accounted for by social workers, however, when it came to the influence of setting. By far the majority of social workers considered that the setting in which they operated had the effect of providing the focus on/slant to their work, although subtle differences were in evidence about the way this worked as between the two specialist settings and the more general Area Team setting. So, for example, Child Guidance social workers and the majority of Adult Psychiatry social workers were aware that working within their settings ensured a focus on children and adult mental health respectively, whereas the effect for Area Team social workers of their more general setting was that they had a heightened awareness of the agency's emphasis on the carrying out of a range of statutory obligations.

In addition, whereas social workers from both the specialist settings were aware that their setting required and/or gave them opportunity to develop specialist knowledge and become experts, Area Team social workers (expert generalists being something of a contradiction in terms) were more aware of the *de facto* limitations and pressures that required management as part and parcel of their daily workload. In a sense, it was as if the expertise of being an Area Team social worker was the skill of managing a variety of conflicts and competing needs on a daily basis, set always against the backdrop of statutory obligation.

Of course, it cannot be overlooked that all three settings came within the larger organisational structure of social services and there were indications that this larger

structure was itself an influence. Despite being experts in their respective fields, there was an extent to which the Child Guidance and Adult Psychiatry social workers nevertheless held the priorities of Area Team social work very much in their awareness, albeit in different ways. Top priority work in social services is statutory work. The top priority client group is children. Typically, the Area Team setting is where these two priorities interweave. There is little doubt that statutory child care work — the province of the ostensibly generalist Area Team social worker — is given top priority in social work. The indications were that, to some extent, Child Guidance social workers experienced the luxury of practising in the knowledge that they focused on the highest priority group and also had the security of knowing that they offered a specialist and expert service to this group, over and above what hard-pressed Area Team social workers, with myriad other calls on their time, were able to provide. These indications were backed up to a certain extent by the Child Guidance social workers' views about the positive benefits of working in a multi-disciplinary setting. Colleagues from other professional groups were viewed in terms of providing extra resources with which to tackle any difficulties as work progressed. In the Child Guidance setting, professionals from whatever discipline had the child as their primary focus. To this extent, conflicts of interest (at least around who the primary client should be) were minimised. In effect, then, Child Guidance social workers saw themselves as experts within a team of experts whose paramount and ongoing focus was the child.

Within Adult Psychiatry, a multi-disciplinary approach to formal mental health assessments was clearly the norm. However, in contrast to Child Guidance social workers, Adult Psychiatry social workers were silent about multi-disciplinary aspects when discussing the influence of setting at the individual case level. Beyond ensuring a clear mental health focus for their work, the indications were that Adult Psychiatry social workers had to tolerate more tension than Child Guidance social workers around the priorities set by the organisation to which they were ultimately

accountable, that is, social services. In group discussion, Adult Psychiatry social workers spoke of having another social work hat or of their ultimately overriding responsibilities to children. Unlike their Child Guidance colleagues, therefore, Adult Psychiatry social workers were in the position of having to practise in the knowledge that, the adult mental health focus of their setting notwithstanding, they may well, at some point, have to put the needs of their clients (if parents) second to the needs of their clients' children.

GATEKEEPING

While setting was a widely acknowledged example of the influence of the organisation with regard to assessment, there can be little doubt about the significance of the organisational context as an influence on social workers' assessments, albeit in sometimes more subtle ways. It has been argued that, on the whole, social workers were inclined to downplay the extent of such organisational factors at the level of the individual assessment. We are left wondering what/whose purpose is served if the reality of the situation is distorted in such a way? To use the resources climate as only one example, whose ends are helped or hindered if social workers fail to acknowledge the nature and significance of the impact of available resources at the individual case level?

One answer to these questions may lie in the fact that, as the findings indicate, gatekeeping stood out as a prime function of initial assessment. Boundary-setting and rationing needed to take place and much of social workers' effort was directed to this end. In the small number of cases where the agency role was not considered clear from the outset, the chosen focus for the assessment by social workers was establishing the character of the difficulty and the extent of their brief. In by far the majority of cases, however, the agency role was considered clear from the outset. The focus of social workers here was either on investigating the circumstances of the

majority of cases, however, the agency role was considered clear from the outset. The focus of social workers here was either on investigating the circumstances of the referral generally in order to form a view of the situation or, in a smaller number of cases, specifically on assessing clients' eligibility for an identifiable service provision. The latter suggests adoption of a more standardised approach although, as the findings revealed, negative style assessments by social workers looked more procedural than they were. Glastonbury *et al.* (1980) draw the distinction between social work *"where the main emphasis is on a whole view of both client(s) and practitioner as people"* and social service *"where the main emphasis is on the client's eligibility for certain services, and on the use of standardised procedures and roles to provide those services"*, noting that, at times, work with clients might focus on either and indeed may include both (p74).

Parents, by far the majority of whom perceived the assessment process as people rather than task oriented (in contrast to social workers), nevertheless understood that a sorting out process was under way. We saw, in addition, that in their gatekeeping role social workers were concerned not only with establishing clients' eligibility for or the rationing of services, but also, at times, with ensuring that those clients others (society) deem in likely need of services (usually protective) were not overlooked.

Undoubtedly, gatekeeping is an inevitable and appropriate part of the assessment process, particularly in the initial assessment phase. Arguably this aspect of the process is of particular interest if an organisational/managerial perspective is taken. It is, however, only one aspect of assessment. It is contended that where heavy, even crude, emphasis on the gatekeeping function significantly overshadows other vital aspects of the process (both analytical and in terms of intervention), social workers do their clients, themselves, and the service overall a considerable disservice. The distorting effect of the 'managerial imperative' (Hughes, 1993) will shortly be explored further.

RISK

That the organisation of social services provides the context and thus sets the tone for the assessment process is not in doubt and this is surely nowhere more apparent than when considering the central part played by risk. As others have noted, risk is a factor that weighs heavily in the assessment process both generally (Lloyd & Taylor, 1995) and, unsurprisingly, specifically in the child protection arena (Waterhouse & Carnie, 1992). Findings from the study revealed that risk was a theme running through the majority of social workers' assessment conclusions and appeared to be the main motivator for consideration of alternative possibilities where this occurred. The majority of parents, too, understood that there was heavy accent on assessing the risks in their situations, notably the extent to which they were 'coping'. In addition, we saw how the possibility of unacceptable risk ensured that a small number of mentally ill parents warranted greater attention in their own right than they are likely otherwise to have received.

Other than providing evidence for the importance of risk for social workers undertaking assessments, the findings shed little light on this important area. We are left with more questions than answers, obvious ones being: what is meant by risk management in social services? and whose needs are being served? What social workers focused upon primarily was ensuring that the risk of an unacceptable outcome did not get too great. In some ways this begs the question since we might ask: unacceptable for whom? and who defines the acceptability/unacceptability of various risks, and how? It was apparent that the full range of risk in any one situation was not delineated by social workers (Carson, 1995). Despite, then, the centrality of risk in the process, we are left wondering if judgements in this area, when it comes down to it, are really rather crude and reactive. On the other hand, this may be unnecessarily harsh. Most social workers were very experienced. As we have seen, they operated from a basis of practice wisdom and were unused to articulating their

work in detail. Quite apart from how well equipped social workers were to make high-quality judgements about risk or how sound their judgements were, it is worth considering whether social services departments actually want sophisticated judgements about risk, judgements that take proper account of, for example, psychiatric/mental health risk in other than the statutory mental health assessment context. Ramifications in terms of, for example, the pattern of service provision could be considerable. The 'fudging' that occurs in relation to this issue may well relate to the fact that, ultimately, social services/social work does not set its own boundaries (Howe, 1991). What constitutes the risk goal-posts are, therefore, moveable. A current example of this occurrence relates to the change of emphasis within the child care arena from child protection to family support. As a result of this policy change, the whole area of risk management will need to be revisited and may be profoundly affected (see, for example, Masson, 1992).

RESOURCES

In the context of social work assessment it is impossible to consider questions of risk in anything other than an academic way without fairly quickly coming up against the issue of resources. The findings relating to resources as an influence on the assessment process were contradictory at times and all the more revealing for being so. Social workers were more likely to acknowledge the influence of resources at the abstract level (for example, in group discussion) or to talk of their influence in a generalised way (resources were the most commonly cited political issue of influence).

When asked about the influence of resources specifically at the individual case level, a third of social workers considered that resource constraints had influenced their assessments, the remaining two-thirds holding the view that resources had not been of influence. Other responses of half these social workers, however, indicated that

matters were not quite so clear-cut. There were some contradictory statements by social workers but, more often, indications that they operated in a context of unremitting awareness of the resources climate. A further small sub-group made their view explicit that, whatever the influence of resources with regard to intervention, assessments, at least, should be uncontaminated by questions about resources.

These last provide an interesting key to understanding an important further finding with regard to the influence of resources, inasmuch as there appears to be professional disquiet with the notion that assessment might, in reality, be service-driven instead of needs-led. Whatever the intentions of social workers may be, the findings indicate an insidious effect whereby they ceased to focus on the delineation of need and the consideration of a full and imaginative range of responses thereto. Instead, the problem tended to be framed in terms of the solutions they knew to be available, if not actually understood in those terms. Best practice, it would appear, was likely to get lost in the hurly-burly of carrying out the job, with social workers failing, by and large, to delineate between the needs to be met and the interventions chosen.

As we saw from the research interviews with social workers, the part played by resources in their assessment decisions came more clearly into focus when they were given the opportunity to talk through their assessments at greater length. The extent to which social workers operated independently, with significant discretion and relative lack of supervision/consultancy on a day-to-day basis, is relevant here and is a point that will be returned to shortly. Notwithstanding how analysis by social workers of the situations they face is to be facilitated, it is argued that, in terms of the professional task, failing to acknowledge the part played by resource issues is unhelpful. In contrast, increased acknowledgement by social workers of such aspects of the equation has the potential to shift the ground of assessment away from an arguably paternalistic handing out of whatever is available and towards a negotiation between

partners concerning not only identification of unmet needs, but also about what is possible given *all* the circumstances, needs and constraints.

BEING A MANAGED PROFESSIONAL

PROFESSIONAL DISCRETION

We return now to the issue of social workers' independent professional discretion and its influence on the assessment process. As others have found (DoH, 1995), there were many examples within the data of social workers exercising professional discretion. This was so for even relatively inexperienced practitioners. Perhaps the most vivid example for our immediate purposes was the evidence for negative style assessments. This style of assessment was most common in the duty situation. While it appeared very procedural in style, it was clear that the social workers never lost awareness that their role encompassed duties and responsibilities that were over and above the rationing and/or handing out of services. As gatekeepers in a statutory context, the social workers' role was as much to usher some through to services as to bar the way to others. The findings indicate that in approximately a third of cases this balance was achieved by social workers via a negative style assessment approach, on the one hand taking situations at face value and assuming 'no news is good news', while, on the other hand, staying alert for the odd, the unusual — the warning bells.

Aside from the above particular illustration, social workers typically had discretion over: what to pursue or not pursue within the assessment interview; the tenor and level of the intervention response; whether or not to gather additional information in connection with the assessment; what to bring to the attention of senior staff and/or consult over more widely; and, not least of course, whether families warranted further social work contact or closure.

It would be misleading, however, not to acknowledge that the exercise of such professional discretion took place within the particular ethos and culture of the agency and was undoubtedly informed by this backdrop, not least by the guidance that was on offer, both formal and informal, verbal and written. In addition, organisational checks and balances were clearly in operation, for example, via the routine check of case records by duty seniors and oversight of social workers' cases through the medium of formal periods of supervision. These factors and their wider influence notwithstanding, the extent of professional discretion exercised by the individual assessing social workers was considerable. To approach the point from a different angle, the findings also indicate a relatively low level of direct influence by seniors, since by far the majority of social workers either did not consult senior staff or thought their views uninfluential.

We might reasonably conclude, therefore, that the assessing social workers were rather powerful individuals — gatekeepers not just by virtue of role but in actuality. Certainly parents frequently viewed them as exercising considerable individual discretion regarding, for example, what was covered in the assessment interview as well as its outcome. The impression gained, however, was that the power inherent in the exercise of such considerable professional discretion went largely unrecognised by social workers. We saw, for example, that social workers were not readily articulate about their professional knowledge base and how that was brought to bear in their work. Nor was there evidence for social workers having a strong sense of belonging to a professional community as such, although they clearly saw their job as being social work.

INDEPENDENCE

That is not to say, however, that social workers were unaware of the extent to which they worked (and, in some senses, were required to work) independently. With regard

to the extent to which social workers sought to consult with others as an aid to the assessment process, with the exception of ASWs (who have a statutory duty to consult), the findings indicate that social workers were as likely to complete their initial assessments on the information presented to them as they were to make a point of consulting more widely. Where social workers did consult, the emphasis was on gathering information and seeking opinions rather than on communication as such. Hence, consultation as part of the assessment process appeared very much to do with tying up the social worker's own independent assessment and often the piece of work generally, with any collaborative effort being frequently to that end.

The views of other professionals were not totally uninfluential, however, particularly when it came to questions of risk. We saw, for example, that for the one-third of social workers who did volunteer external factors as being influential in their assessments, in the main, it was degree of concern on the part of other professionals that they cited. Nevertheless, how helpful independence of this order might be overall is open to question in the face of, for example, the notions of partnership and the sharing of assessments as promoted in the Orange Book (DoH, 1988) and other guidance. Certainly, in the context of multi-disciplinary assessments, social workers need to be both alert to the potential for inter-professional power struggles and skilled in taking a co-operative, co-ordinating stance if comprehensive assessments informed by a variety of professional perspectives are to be achieved (Lloyd & Taylor, 1995).

CONSULTATION

It is worth considering, however, whether, viewed from another perspective, the independence of social workers might, in fact, have been masking a worrying degree of isolation, an aspect of social work practice noted in other research (DoH, 1995 p49). The picture of social workers working to a large extent independently was reinforced by the level and type of consultation with senior staff and peers as well as

the extent to which social workers were influenced by these two groups. As we have seen, one-third of social workers did not discuss their assessments with senior staff. In the two-thirds of cases where social workers did consult with senior staff, these (often quite brief) discussions were not, in the main, influential in the process of arriving at assessment conclusions, centring as they did on issues of organisational accountability rather than on issues of practice.

Peer discussion was more limited with only two-fifths of social workers discussing the cases with their colleagues. Although these discussions were somewhat more influential, they focused heavily on practicalities rather than informing the assessment process as such. We are left to ponder how and where the social workers obtained their practice supervision/consultancy? It is argued that, by and large, this aspect was missing from the process, edged out by the organisation's need for accountability and, moreover, to the detriment of best practice (Vernon & Fruin, 1986; Gadsby Waters, 1992; Stevenson, 1992). However, as Fisher & Cohen (1989/90) noted following their study of the implementation of a mental health consultation programme within two area offices, provision of consultation alone will not necessarily improve practice:

> *"Consultation appears of limited value when used in isolation from other ways of changing practice and is unlikely to be effective without the appropriate organizational and policy context".* (Fisher & Cohen, 1989/90)

The sheer dominance of organisational context as an influence on practice, then, needs to be fully accounted for.

MANAGERIAL CONSIDERATIONS TAKE PRECEDENCE

Social workers clearly exercised a high degree of independence and professional discretion in their work. They did so, however, in a context that was dominated by the concerns of management; risk, gatekeeping and finance being obvious examples. Thus, the professional discretion of social workers was not purely (or even primarily)

concerned with matters of professional practice; instead such discretion was inextricably linked with the notion of organisational accountability. Practitioners were in the position of being liable to be called to account for their actions not only (arguably rarely) in terms of professional standards/priorities, but also (much more commonly, if not invariably) in terms of managerial and organisational priorities (Minty, 1995). In this way, social workers experienced at first hand the tensions associated with being a managed profession (in Johnson's (1972) terms a 'mediated' profession, cited in Hugman, 1991 p4). In particular, they were required to exercise so-called *professional* discretion in a context where *managerial* priorities took precedence.

There can be little doubt that issues of managerial accountability were of great importance within the organisation and were given priority over and above matters of practice. The absence of discussion between assessing social workers and their seniors where cases 'didn't warrant' it, the emphasis social workers placed on 'reporting in', the fact that in only one-quarter of the total number of cases were seniors in any way influential in relation either to the assessment or intervention, for example, all suggest that what was given priority in contacts between social workers and senior staff were not questions of practice whereby the social worker's emerging view of the situation might be expanded, but matters primarily concerned with organisational accountability.

To some extent, this view is reinforced by the findings arising out of casefile data collected in respect of the assessments. As we have seen, the emphasis in the written record was on recording 'the facts' of the case by way of justification for the immediate actions to be taken, which were themselves recorded. In some ways, then, casefile information about the assessments was an almost exclusively administrative record aimed at meeting managerial, rather than professional, requirements. (The purpose and ownership of records are, of course, matters for debate — see, for example, Raymond, 1989; Doel & Lawson, 1986.) One way of construing the

discrepancy between the recording of the fact of parental mental health and its discussion with the parent is that parental mental health was seen primarily as a risk factor that needed to be recorded for two reasons — with an eye on organisational accountability and to provide a written warning bell for those who came later. Indeed, the emphasis placed on risk generally by social workers arguably reflects the high priority given to risk assessment by the organisation.

The picture of managerial considerations being in the ascendancy is reinforced when the findings relating to formal departmental written guidance are taken into account. As we have seen, locally-derived formal departmental written guidance pertaining to the task of assessment and related areas of planning and decision-making was limited, with no guidance specifically addressing the area of overlap between parental mental health and child care. Moreover, while it would be overstating the case to say that issues of practice were overlooked completely, the heavy emphasis on procedural mechanisms indicated, once again, that managerial priorities took precedence over the needs of professional practice in local guidance provided by the department.

The obvious question at this juncture is: what does it mean for social work practice, and ultimately for clients, if professional concerns are consistently squeezed out by managerial considerations which, although undoubtedly important, cannot of themselves provide the whole answer when it comes to the provision of an effective social work service? The short answer is that it is likely to mean impoverished practice, less effective service provision and less effective encounters between clients and social workers. This point will be expanded in the concluding discussion.

THE NEED FOR SUPERVISION THAT ENCOMPASSES A FOCUS ON PRACTICE/ PROFESSIONAL CONCERNS

The question has been asked: where do social workers obtain their practice supervision? This takes as read the need for staff supervision encompassing issues of practice and covering professional concerns. In a consideration of the place of supervision in the current-day 'turbulent environment' of the health and welfare services, Hughes & Pengelly (1997) contend:

> *Staff supervision is a means of developing and controlling the quality of service, taking account of the needs and rights of users and the quality of staff performance. The needs and rights of staff must also be attended to, in order to get the best from them as the major resource of the organisation. The functioning of supervision is thus inextricably linked to the way the organisation manages the tension between needs, resources and rights.* (Hughes & Pengelly, 1997 p6)

It is, then, surely an article of faith that social work practice and, thus, the service to clients is enhanced by the input of supervision that encompasses a focus on practice/ professional concerns — and yet we see it edged out by other considerations at a crucial point in the process.

That a better balance needs to be achieved between the several bases — administrative/managerial, professional, educational, supportive (Gadsby Waters, 1992) — to be covered in supervision is clear when we are reminded of, for example, the findings regarding the articulacy of social workers. The social workers, by far the majority of them very experienced, were clearly unused to articulating the basis for their assessments. They were, of course, ready and able to say *what* it was they had done but were much less used to articulating, at anything other than a superficial level, *why* they had taken those actions — their underlying rationale. Reference has already been made to the possibility that lack of adequate analysis on the part of social workers may have sat underneath their lack of articulacy. While the two do not

by any means necessarily go together, it is noteworthy that very few social workers referred to explicitly articulated frameworks in connection with their assessments. Again, while a systematic approach does not of itself ensure rigorous thinking/analysis (indeed, used unthinkingly it may well constrain), common sense dictates that a framework is more likely to be helpful than not, not least as an aid to the communication of one's thinking. What better place to practise some of the range of skills required in the assessment process — starting with the communication of what sense a social worker has made of a situation — than in supervision? As a body, social workers need to be able to explain and confidently assert their professional thinking, to clarify for themselves what their knowledge base is — in other words, to be clear about what their particular professional contribution is.

In addition, practitioners have a responsibility, indeed a professional obligation, to ensure they are not simply operating out of their own prejudices (Everitt *et al.*, 1992). Supervision that takes better account — in deed as well as word — of practice issues and professional development, alongside the requirement for managerial accountability, must surely be a vital part of the process. It is argued that attention to such balance would mean less likelihood of factors that, in fact, have great significance in the assessment equation, being effectively 'screened out' and their importance overlooked. In this regard, by way of example, the disparity between the extent to which social workers acknowledged the influence of the resources at the individual case level and their views on the influence of resources when speaking in general terms has already been mentioned.

A further notable gap between what social workers purport to do and what they do in practice concerns the influence of culture and race. With one exception, such issues were not initially volunteered. This was despite the fact that 25% of the parents and 32% of the children in the study were from ethnic minorities. When asked specifically about the role of culture and/or race, two-thirds of social workers did not consider

these issues had been of significant influence in their assessments. For the third of social workers who did identify the issues of culture and/or race as influential, the issues were much more likely to be viewed at the level of individualised cultural difference rather than understood and analysed in structural terms (Rhodes, 1991; Clifford, 1992/3).

It is true that the majority of the population in the locality was Caucasian (see Appendix G). To this extent, the social workers might be said to have been more attuned to dealing with the majority ethnic group rather than with minority groups. Nevertheless this finding is clearly unsettling, both in its own right and because it appears to be significantly at odds with the professional value system, legislation and guidance and with the considerable emphasis placed on such issues during professional and subsequent workplace training. Ready awareness of the impact of race/culture supports an actively anti-oppressive stance which itself is viewed by many as a key element of empowering practice (Mullender & Ward, 1991, cited in Everitt *et al.*, 1992 p38). The findings in this area alone provide an eloquent argument for supervision that addresses professional as well as organisational priorities.

This need is further highlighted by the social workers' responses to the interface between parental mental ill-health and the progress of children. We have seen that social workers formed judgements in this area largely without reference to a body of formal knowledge that had particular relevance. What does it mean that social workers formed judgements in the absence of what we might imagine to be vital background knowledge? Can social workers make *informed* judgements if they are not familiar with a body of knowledge that has particular relevance? In such circumstances, are their judgements valid at all? We might observe that such potential inadequacies occur all the time, in one sense or another, since no social worker can keep up to date at all times with areas of knowledge that may or may not be relevant to their daily work. Further, it might be argued that such questions, on the one hand,

deny the complexity of knowledge as a concept and, on the other, undermine the validity of practice wisdom as a knowledge base in its own right and thus social work itself. Uncomfortable as they are, these are nevertheless important questions. In response it is argued that, as long as well-rounded supervision which takes account of professional needs is in place, they are entirely answerable. Supervision is undoubtedly a demanding task in its own right (Rushton & Nathan, 1996). At its best it provides a system of supports, checks and balances that are not only organisational but also professional/educational. The opportunity to explain what sense one has made of a situation, to answer the pertinent questions of a professional colleague, to clarify one's thinking and identify the gaps of information and knowledge that must not go unfilled — in short, to have one's view expanded — must go a long way towards instilling the sort of confidence that is essential if social work aims to gain acknowledgement as a mature profession.

The view has already been advanced that social work practitioners need to attend more closely to their skills and abilities to think critically and reflexively about their work. It is argued here that the medium of staff supervision provides an important forum for the development of the sort of reflective practice described by Schön (1983). Hughes & Pengelly (1997) describe a 'triangle' of supervisory functions — managing service-delivery, focusing on the practitioner's work and facilitating the practitioner's professional development. Reflecting on and evaluating assumptions and actions in relation to particular pieces of work and developing understanding and knowledge more generally about the social work role and social work's way of knowing both fit comfortably within this definition. Having said that, there will also, of course, be other forums in which reflective practitioners can explore and develop such issues. Reflective practice is, at bottom, an attitudinal attribute and, as such, can never be entirely dependent on the quality of supervision provided. In this latter respect, Hughes & Pengelly, citing Clare (1988), caution against harbouring the notion of a lost 'golden age' of social work supervision (Hughes & Pengelly, 1997 p29).

THE MISSING OF AN ASPECT NOT DIRECTLY RELATED TO ORGANISATIONAL PRIORITIES

As it is, it is hard not to be left with a feeling of disquiet, even dismay, that the social workers so clearly lacked interest in the interface as the parents understood it. It is not that social workers were uninterested in aspects of the subject. By far the majority of social workers (three-quarters) expressed interest and enthusiasm for mental health as a topic, to the extent that they either had undergone or were keen to undergo ASW training. It is a short step to pondering whether consultation to a greater degree and professional purpose might have made a considerable difference with regard to social workers' response to parental mental ill-health. Their own mental health, its impact for them and their children was clearly a major issue in the lives of parents. As we have seen, the main emphasis for social workers in relation to the assessment of these families was on the adequacy of parenting. Parental mental ill-health (unless it posed sufficient risk to warrant attention in its own right) was viewed as, at best, an aspect of that adequacy and, at worst, a side-issue. Around this issue at least, social workers failed to be sufficiently client-centred. Given the heavy emphasis on parenting to the exclusion of an issue so prominent for clients, it seems likely that organisational priorities — crudely, the protection of children above all else — got in the way of effective communication between social worker and client.

THE ROLE OF THE CLIENT

SOCIAL WORKERS' COMMUNICATION WITH CLIENTS

What makes it all the more surprising that social workers should miss an issue of such major importance in clients' lives is that the social workers clearly intended to be good communicators. For example, by far the majority of social workers considered they had discussed their intended actions and plans with parents. When these perceptions are compared with those of parents, however, it is clear that the parents felt less well-informed than the social workers' views might suggest. The findings further indicate

that while clients were, for the most part, kept informed by social workers about pertinent aspects of the assessment, there was little evidence of their being *actively* involved in the process. So, for example, with regard to the social worker's view regarding the impact of the parent's mental health difficulties, two-thirds of parents were unable to say what the social worker's view on this aspect might have been. Similarly, with regard to the social worker's general conclusions the majority of parents (three-quarters) had either no idea of what the social worker concluded or could voice the solution offered but without any idea of the thinking underlying it. We also saw examples where parents with worryingly low expectations of the service failed to have such expectations disabused by the assessment process. Middleton (1997) notes a general tendency on the part of potential service users to hold low expectations, commenting that assessment therefore needs to encompass *"unstitching preconceived and limited ideas about services available"* (Middleton, 1997 p52).

While the findings certainly indicate that, by and large, parents felt that their views were listened to and taken account of in the process (the exceptions usually being when statutory considerations prevailed), all the indications are that, as others have found, parents were passive rather than active in the process (Rhodes, 1991; Day, 1994). An assessment where the client is actively involved cannot fail to be very different in character — and very possibly in outcome — from one where the client is passive in the process. What, then, are the ramifications that arise from such a difference?

WHO DEFINES NEED?

The first and most obvious ramification relates to the definition of need and, in particular, to who, within the assessment encounter, defines need. It is not difficult to conclude that, other than in the most simplistic sense, the views of clients who remain passive in the process are unlikely to hold sway when it comes to definition of their

needs. It has been argued that social workers exercised considerable professional discretion within the process. We might reasonably conclude, therefore, that it is primarily practitioners' definitions of need that prevail, particularly in the light of how relatively little social workers seemed open to the influence of others once the process was under way. On the other hand, we have seen that social workers' frames of reference are considerably influenced by organisational context. Given that assessment is such an organisationally valued activity, Middleton (1997) suggests it would be naive not to acknowledge potential mismatches between organisational, professional and service user agendas. She argues that it is part of the professional task to understand such mismatches and to manage them effectively to ensure the best outcome for services users. This task becomes further complicated where assessments are based on a multi-disciplinary ethos and the agendas of more than one agency are involved.

In this latter connection, what bears particular examination in relation to the question of who defines need in the initial assessment context is the extent to which social workers are open to influence early on in the process, notably at the point of referral. The findings indicate that by far the majority of referrals were instigated by other professionals, relatively few parents referring themselves. In some senses, then, we might say that, inasmuch as they were the prime instigators of referrals, professionals from other agencies had considerable influence when it came to the definition of need, at a general if not a specific level. Certainly, particularly with regard to decisions about priorities, the views of referring professionals and the ways in which they presented both themselves and their referrals were accorded considerable weight. In contrast to self-referrals, which social workers took very much at face value (none being of influence over and above their content), referrals from other agencies engendered far greater consideration and scrutiny beyond the case details alone. This is perhaps not so surprising given the primacy of gatekeeping. By definition, in making the referral, professional referrers have already determined to their own satisfaction

that the referral is appropriate, that is, it 'fits' with the agency role. In order therefore to guard against social work's boundaries being established by other (sometimes poorly informed) professionals, we have seen that, in sifting the many factors which present as part of the initial assessment process, the social workers made judgements concerning, for example, the credibility and actions of referring professionals. In this way the referrals of professionals took on a status that was not matched by the self-referrals which, by definition, came with less 'baggage'. As such not only could they be taken, quite legitimately, by social workers much more at face value, but, by virtue of their relative lack of complexity vis-à-vis organisational and professional boundaries, they were also accorded low status.

THE POWER DIMENSION

The picture that emerges — social workers failing to relate to clients first and foremost as individuals whose situations nevertheless are likely to reflect complex relationships to social structures and divisions; organisational priorities consistently edging out professional needs; the relative status accorded to professional as opposed to self-referrals; and clients who are passive and uninvolved in the assessment process to the extent that a major issue in their lives is overlooked — says a lot about the power imbalances in the process. We are reminded of how easy it is for clients to be rendered powerless, of how little the system supports them to be powerful in the process and to speak with authority on, indeed to define, their own needs (Smale *et al.*, 1993).

We know that parents undergoing the assessment process do allow others to define their needs inasmuch as the findings indicate that significant numbers of parents had expectations that went unmet (one-half in terms of the social worker's plan/future intentions and one-third in terms of actions/interventions). It seems likely that, in contrast to those parents who were clear about the gaps in the service as they saw

them, the remaining parents, presumably knowing no different and by all accounts grateful for the help on offer, found themselves settling for others' definitions and solutions. Where there were unmet expectations it was noteworthy that, first and foremost, clients were seeking services that were more flexible, were tailored more to their needs and offered higher levels of support. Close on the heels, however, of these particular unmet expectations (which in themselves say something about deficiencies in service provision) was the desire for better communication and involvement in the process. The extent to which social workers failed to involve parents actively in the process has already been commented upon.

On the basis that resources are finite and that meeting all needs at all times is impossible, it might seem foolhardy to seek to involve people more actively in a process of decision-making around access to services from which it may ultimately be necessary to exclude them. Hence, it might be argued that, taking a wider perspective and given that a major thrust of initial assessment is gatekeeping, the passive client is somehow helpful to the overall process. We certainly know that, through the process of assessment, parents do, in the main, come to modify their expectations and indeed to settle, relatively happily in the end, for the service they are offered. To a very great extent, then, by far the majority of clients come to the assessment situation with goodwill and leave content enough.

It is argued, however, that it is possible to reach this same end-point via two distinct routes. The first, as we have seen, involves, at its best, grateful passivity on the part of the client and, at its worst, disillusionment and a keen sense of powerlessness. The alternative involves the client being a full and active partner in a process wherein conflicting issues, needs, perspectives and realities are aired, examined and worked through to the point where both client and social worker are fully conversant with the decision reached and satisfied, if not always with the outcome, certainly with the process. Successfully maximising the possibility for such convergence of perspectives

demands considerable and particular skills on the part of the social worker. Certainly it demands a shift of attitude and focus on the part of social workers, away from their being *ad hoc* problem-solvers and towards the empowerment of their clients. Of course, in order to achieve this practitioners need also to feel sufficiently empowered. An approach which centres on reflective practice will be of particular importance in this regard. In contrast, too heavy an accent on the organisational agenda is likely to be experienced by practitioners as disempowering in itself (Middleton, 1997).

EMPOWERMENT AND PARTNERSHIP

Social work assessment is not concerned purely with understanding for its own sake. It is also defined by the need to arrive at a relevant and coherent response. The findings indicate that, in the initial assessment phase, social workers were most inclined to focus on coming up with an immediate solution to the problem that presented itself and to take actions to this end as necessary while, at the same time, being constantly aware of potentially overriding statutory responsibilities. The findings also indicate that, in the main, parents perceived assessing social workers as people who adopted an active, problem-solving stance, willing to address the immediate difficulties in the lives of parents. We saw, however, that, although 'helped' in this way, parents were relatively passive in the process. Crudely, the scenario is thus: at the suggestion of some professional person, you (parent) bring along an immediate problem. If it fits with what the social worker (as representative of the agency) is able to do, the problem is sorted out, probably pretty quickly. There is always the risk that the social worker may get interested in something she considers a problem but which you probably do not. Either way, you will not have a lot of say, but then making the approach is, almost certainly, something of a last resort. Anyway you are grateful that someone is willing to take the difficulty on, and for any help you can get.

Put this way it is easy to see how the experience for clients is the antithesis of empowerment. What seems to be the immediate problem is solved, but whose problem? Certainly, the gatekeeping function appears to be served, although perhaps not as well as it might be. On the surface, then, it is easy to conclude that the needs of the agency have prevailed. Taking a wider perspective, however, it is a short step to querying whether an initial assessment service based on an ethos of *ad hoc* problem solving, quite apart from the disempowering effect on clients, really is the best use of social work time and agency resources.

Significant difficulties ensue if, in the assessment encounter, the function of gatekeeping is over-emphasised to the detriment of other aspects of the process. We have seen, for example, how important facets in the lives of clients are likely to be overlooked. Thus, it may be that effective gatekeeping is in any case ultimately undermined in this way. More importantly, where the emphasis is on reactivity and *ad hoc* problem solution — that is, working *on* the problem as opposed to *with* the client — clients learn nothing new through the process about how to be active in the solution and prevention of their own problems (Fisher *et al.*, 1984). What seems now to be missing is what might be termed the 'therapeutic' element of the work — in other words, any attempt to undertake work with the client based on the premise that, even in the brief encounter which is initial assessment, clients can be assisted to maximise and develop abilities in order that they may retain a sense of self-direction and autonomy in their lives. It is argued here that a partnership approach, wherein priority is given to establishing a working relationship between client and social worker (Middleton, 1997) is ideally suited to the achievement of such an objective. Although clearly central, in theory at least, to current-day notions of best practice in social work (DoH, 1995), such an approach might nevertheless seem overly ambitious in the context of initial assessment, especially where the work takes place in one-off sessions. We saw, in any case, that work that was of somewhat longer duration was likely to be experienced by clients as more satisfying, perhaps because having rather

more time facilitated the sort of convergence of perspectives that is beneficial to the process. Ambitious or not, while making assessments social workers will, in any event, be encountering clients. It seems not unreasonable then, from all points of view, that the potential of such an encounter be maximised through a shift in emphasis. Parents need to be more actively involved in both the assessment and the resolution of their difficulties if they are to feel empowered in their lives as a result of the process. Social workers need to use their skills differently as well as to a more consciously different end. They need, in effect, not only to assess during the assessment encounter, but also to use the opportunity to intervene — that is, to engage with the client — in a way likely to promote change within the client at least as much as in their most immediate circumstances. The agency needs to honour the possibility for growth within the assessment process and to provide support for such a change of emphasis in the expectation of an improved, dynamic service in which the needs, knowledge and capacities of clients are properly accounted for and the potential for satisfaction all round is maximised. How such ends might be achieved is explored in the concluding discussion that now follows.

CHAPTER NINE: CONCLUDING DISCUSSION

The final chapter first explores the question of how knowledge in all its complexity may be accessed and developed, with particular reference to the area of overlap between adult mental health and child care. The assessment process more generally is then considered and the changing nature of assessment examined. The view is advanced that social workers need to develop clearer understandings of the aim of the assessment task and its context from a professional perspective, and that, if this is to be achieved, the balance between organisational/managerial imperatives and professional/practice concerns needs to be redressed. The honouring of different ways of knowing and working in partnership with clients are issues that coalesce in the context of current understandings of the assessment task. It is contended that such matters of practice and professionalism demand reflective practitioners.

An interest in the impact on children of parental mental ill-health was the starting point for the study which aimed to explore, from different perspectives, the process of assessment in families where parental mental ill-health was apparent. An important aspect of that exploration concerned the place of knowledge within the assessment process and, in particular, the use by social workers of pertinent formal knowledge. The view has been advanced that significant benefits would accrue if practitioners were to adopt a social work methodology emphasising reflective practice. The consideration that follows of how social workers might better access knowledge specific to the parental mental health/child care overlap needs, therefore, to be viewed in the reflective practitioner context.

It was apparent from the study that, by and large, social workers operating in the area of overlap were not informed by a body of specific, formal knowledge that, on the face of it, has great relevance for their assessments. It is argued that social work assessment in the area of overlap between parental mental health and child care is

likely to be the poorer for such a lack, not least because some acquaintanceship with the relevant body of formal knowledge on the part of social workers, as well as being directly informative in its own right, is likely to expand thinking horizons. Arguably this is of particular importance where a social worker's usual focus, for whatever reason, is on either adult mental health or child care. A pertinent question, then, at this juncture is: why is knowledge that is relevant to the adult mental health/child care overlap not used by social workers?

There are a number of possible reasons. The first concerns the nature of the body of knowledge under discussion. Reference has already been made to its lack of subtlety, its evolving character, its puzzles and uncertainties and the many unanswered questions it poses. Practitioners looking for guidance when dealing with families where there is parental mental ill-health may well feel discouraged by this lack of completeness, querying the usefulness of such a body of knowledge over their own wider experience- and practice-derived, albeit less specific, knowledge base. Moreover, as we saw, since by no means all children are adversely affected by parental mental ill-health, the requirement for interventions that centre on children in these families is variable. In these circumstances, then, it is arguable that, from the point of view of the busy practitioner, the acquisition of specialist knowledge — especially in light of its indeterminate character — has limited value. It is contended here, however, that, particularly in the assessment context, awareness on the part of social workers of, at the very least, the current research consensus would significantly inform and thus 'add value' to the social work task.

Secondly, it seems likely that the area suffers from neglect simply *because* it is viewed as an area of overlap between specialisms. The move within social work away from genericism and towards specialisation compounds this difficulty, particularly as older, generically-trained/experienced social workers leave the profession. Moreover, it is an area that falls between stools across disciplines, not just within the discipline of

social work. So, for example, adult psychiatrists and community psychiatric nurses deal with parents who are mentally ill, but they are not necessarily attuned to the needs of their patients' children. The same may be true for general practitioners and others in any adult mental health support network. Similarly, child psychiatrists and psychologists deal with children who are significantly disturbed, but by no means all of these have parents with needs relating to their own mental ill-health. Areas of overlap, by definition, lack centrality. At first glance, then, interest and expertise — in any formal sense — are likely to be limited. On the other hand, the event of parental mental ill-health impacting child and family life is not in itself an unusual phenomenon and it may well be, therefore, that there is considerable informal knowledge, understanding and experience of the overlap held on the margins of a number of disciplines, including social work.

If we are concerned to ensure relevant knowledge is 'used', we are brought back at this point to the need for reflective practice. An approach that solidly encompasses ongoing reflective inquiry about the nature of the task and the implicit assumptions that underpin it will help prevent social workers' assessments being too narrowly focused because of a specialist base or because organisational priorities squeeze out other considerations. It is in the nature of reflective practice that knowledge pertinent to the task at hand will be sought out and/or gathered as practitioners pursue their professional agenda. Significantly, as Eraut (1994) (citing Cronbach *et al.*, 1980) points out:

> *"research findings and new ideas affect decision-making indirectly rather than directly ... They get used interpretatively rather than applicatively and influence people by changing the nature of discussion about a problem or by introducing new perspectives ..."* (Eraut, 1994 p52)

In light of this, it is important, at this point, to recall the complex nature of professional knowledge. Knowledge pertinent to the social work task, in this area as any other, is

not limited to a body of formal knowledge accessed solely by reference to its literature. Pertinent knowledge will also be accessed and — as importantly — *developed* via, for example, consultation and collaboration with a variety of knowledgeable others, including those whose knowledge may be informal in kind. Practitioners will, in addition, develop knowledge and understanding, in this area of overlap as in other areas, both through reflection on the task at hand and its context and through the type of reflection-in-action process described by Schön (1983). For, as Eraut (1994) points out, the distinction between knowledge use and knowledge creation is, in the end, not so clear-cut: *"The interpretative use of an idea in a new context is itself a minor act of knowledge creation ..."* (Eraut, 1994 p54).

The question remains: how, then, can knowledge pertinent to the area of overlap between adult mental health and child care be accessed and developed by practitioners to a satisfactory degree? Undoubtedly, an approach grounded in the type of reflective practice that has been under discussion here is a good starting point. But, of itself, it cannot be the whole answer. It seems clear that what is also needed are structures provided by the organisation to support those practitioners who, from time to time, encounter families with young children where there is parental mental ill-health in order that they may have opportunities to develop their knowledge and understanding of the overlap.

The case for staff supervision encompassing greater focus on practice/professional concerns has already been made and is pertinent in this regard. There are, however, a variety of additional possibilities. The first and most obvious example is training for social workers that specifically addresses the area of overlap. Provision of such training by social services departments would, as it were, put the overlap between parental mental health and the needs of children 'on the map'. Practitioners would gain the opportunity to review their knowledge, familiarise themselves more fully with the subject area, consider issues raised by the overlap and reflect on the complexities

involved with regard to, for example, assessment and decision-making. Such training would be enhanced if it were multi-specialism (for example, mental health and child care social workers training together) and/or multi-disciplinary (for example, a mixture of health and social services personnel) in character. Practitioners would then have increased opportunities to meet others with relevant knowledge and resources, to share and compare ideas and perspectives and to hone consultation skills, as well as generally to network and establish useful contacts for the benefit of future work.

Formal training apart, and in acknowledgement of the fact that knowledge is also built and developed in more informal ways, there is a need also for structures to support regular opportunities for consultation and collaboration with colleagues, again particularly across specialisms and disciplines. Such 'cross-fertilisation' encounters often take the form of special interest groups. Frequently such groups are generated by enthusiastic practitioners; however, in the experience of the researcher, few such groups survive to maximise their usefulness unless they are actively supported and thus legitimised by the agency.

Legitimisation by the wider organisation is crucial; as the study revealed, organisational priorities have a way of asserting themselves. What would be helpful, then, with regard to the area of overlap between parental mental health and the needs of children, is policy, procedures and practice guidelines specific to the area. Given that the area crosses health and social services boundaries, joint locally-devised guidelines would be of particular benefit and, in this way, appropriate multi-disciplinary consultation could be ensured. Although experience tells us that the emphasis of any such formal written guidelines may well be on the procedural aspects of contact with families where there is parental mental ill-health rather than oriented towards practice, an important part of their value would be in conferring organisational validity on the area.

Indeed, it is possible to envisage all of the above organisational supports, not just the written guidelines, being put in place with an essentially managerial perspective predominating. It is worth repeating that what is being advocated here are organisational structures that support practitioners in the development of their practice in relation to the parental mental health/child care overlap, with specific emphasis on gaining access to and the development of pertinent knowledge and understanding.

And what of clients' knowledge? Discussion about how practitioners might access knowledge and deepen their understanding in this area should not overlook the reservoir of knowledge held by mentally ill parents about the impact of their mental health difficulties both for themselves and for their children. As others (Middleton, 1997; Smale *et al.*, 1993) have noted, it is the situations within which individuals/families find themselves which are the proper focus for assessment. From such a perspective, parental mental ill-health and its ramifications *will* be pertinent to the analytical process by which are made decisions that we term assessment (Middleton, 1997). The extent, however, to which such issues are on the assessment agenda and form the basis for planning what needs to be done in response to the client's situation should be a matter for negotiation between social worker and client. What is crucial is that — in pursuing an 'off the shelf' agenda dictated by the agency — practitioners do not overlook the ways of knowing and knowledgeableness of clients in relation to a major aspect of their lives. The adoption by social workers of such an approach and the sort of collaboration with other professionals regarding knowledge development that has been called for are linked inasmuch as they both require the ability successfully to negotiate perspectives — that is, to gain an understanding of the other's perspective while conveying, adjusting but maintaining the integrity of one's own. The challenge for social workers lies in honouring the ways of knowing of others and allowing such knowledge to inform the assessment process.

Such an assertion is, in many ways, predicated upon an essentially modern-day conception of social work assessment. At this point, then, it is important to acknowledge the changing nature of the assessment task in recent years, not least because it is against this backdrop that the research data have been collected and analysed. In light of important legislative changes the stature of assessment has undeniably increased. It has become a high profile activity as never before. As Middleton (1997) remarks, assessment has acquired a capital A.

Arguably, now is a particularly good time for front-line assessment practice to be revisited. Indeed, there are many indications that social services departments are reviewing assessment procedures and seeking to re-train those who undertake assessments accordingly. Again, however, the concern is that issues of practice — as opposed to procedure — are slipping too far from view. From the point of view of professional practice, assessment demands not only considerable knowledge of the nature of the task and its context, but also significant skills, particularly if, as here, assessment is viewed as an interventionist, change-promoting activity. In such circumstances, practitioners are likely to need practice-related training opportunities in order that they can explore not only the vital 'what' of assessment but also the equally vital 'how'.

The study sought to explore the process of assessment within a specific area. Serendipitously, focusing on the specific brought an additional dimension to exploration of the general. The approach highlighted the tensions present in the assessment process, thus illuminating an important area of practice. That there are many tensions in the process of assessment cannot be in doubt. Typically, the picture is one of differing perspectives, potentially conflicting needs, the requirement to balance rights with responsibilities, self-evident power imbalances, the ideal of client empowerment and the enabling of choice — unless and until questions of risk and

scarce resources rear their heads. The essential role of the social worker is holding and managing the tensions inherent in the assessment situation.

Of course, social work assessment takes place in a context; in this study, the context was that of a local authority social services department. A number of authors have commented on the particular challenges facing practitioners in mediated professions (Glastonbury *et al.*, 1980; Hugman, 1991; Johnson, 1972). As Howe (1991) has shown us, it is likely, within any profession, that there will be continual bid and counter-bid for the advancement of the knowledge perspective of one arm of the profession over another. Although, on the face of it, this might sound like an undesirable power struggle, so long as respect for differing views and a sense of perspective are embedded within the process, such ebb and flow is in itself far from negative. On the contrary, it has the potential to be energising and expanding and speaks of dynamism.

Within current-day social work, however, there are signs that the organisational and managerial perspective — widely acknowledged to have been in the ascendancy for some time — needs now to have reached its apogee. The study revealed how the tensions inherent in the assessment situation were shadowed by an extrinsic factor, that of the interplay between managerial and professional (strictly speaking, practitioner-arm) concerns. Such additional tensions are played out in the assessment situation with significant ramifications for clients, social workers and the effective provision of social service. It is argued, therefore, that the current lack of balance between professional and managerial concerns needs to be redressed, with the aim of according higher profile and value to professional concerns and professional accountability, in the belief that this will maximise the potential for all-round satisfaction.

In acknowledgement of the systemic nature of the beast, change will, of course, be required at different levels. Crucially, however, changes are needed in the approach of social workers to their role and tasks in relation to assessment. (It will not escape notice that, although such changes are here being proposed specifically in the area of assessment, the ideas are arguably applicable in terms of social work practice more generally.) In particular, social workers need opportunities to develop clearer understandings of the professional aims of the assessment task, in contrast to aims likely to be given prominence from a managerial perspective (such as financial control, statutory requirements and procedural correctness).

Everitt *et al.* (1992) put forward the view that the principal values of social work are empathy and empowerment. Others have spoken of fairness (Jordan, 1990) and the requirement for balance between the individual and social aspects of social work (Parsloe, 1986). Such values demand attitudes that are congruent when it comes to, for example, the assessment of clients and their situations. That most social work activity today takes place among the poorest and most disadvantaged sections of society needs not to be overlooked either (Jones, 1996). To tease out the professional aims of the process will often mean, then, in the first instance, a return to fundamentals, a reacquaintanceship with the question: 'what are we here for?' A large part of that for social workers is about aiming to understand what things look like from the client's perspective, taking full account of issues of power and oppression, and then to work alongside the client(s) while they resolve their difficulty in a way that validates, supports and fosters an increased sense of autonomy and self-direction. This is far from the whole story, though, and is where the particular challenge of holding the tensions comes into play, arguably most notably in the assessment situation. Although, when they present for assessment, clients are ostensibly centre-stage, it is undeniable that a major part of what social workers are here for is, by definition, every bit as much about the 'noises off' of the wider organisational, societal, legal and political context. Thus, in order to clarify the totality of their professional

aims, practitioners also need a highly developed understanding of the context within which assessment takes place.

How is such redressing of the balance between professional and managerial concerns to be achieved? As befits their role of advancing the purpose of the organisation, social services managers are understandably keen to keep control of the working environment through the mechanisms of rules, routines and procedures. Social work, however, is not so easy to pin down absolutely. In many areas, it rests on the practitioner's willingness to engage with a purpose in complex areas of human need and social requirement:

> *Because professionals involved in child protection are influential, it is clear that their competence is more than a matter of simply adhering to rules and following guidance; they need to display sensitivity and discretion combined with forceful curiosity.* (DoH, 1995 p48)

In addition, as Howe notes:

> *Clients do not always succumb to the organisation's definition of who they are and what they are. To the extent that they remain unpredictable in critical areas, the ways of the expert practitioner are more effective than the inflexible prescriptions of the administrator.* (Howe, 1991 p219)

Professional discretion and judgement, then, cannot ultimately be divorced from the process. This fact is, of course, widely acknowledged (a cynic might note, while yet more forms are being devised). Given this, managers, too, will have an interest in ensuring the enhancement of practice skills. However, because of their primary focus, it is perhaps unrealistic to expect that they alone take the lead in this regard.

Who, then, should take the lead in putting the perspective of practitioners higher on the social work agenda? It would not be unreasonable to consider that the social work educational system might play an important role in this regard. The educator/

academic arm of the profession has its own perspective which undoubtedly encompasses an interest in and attention to professional performance and standards. Certainly, it is a quarter in which the increasing proceduralisation of social work has hardly gone unnoticed (Sheppard, 1995; Dominelli, 1996; Ford, 1996).

It is noticeable, however, that the managerial perspective, with its preference for a largely technical approach to the work, is being steadily advanced when it comes to the training of social workers (Howe, 1991; Ford, 1996; Jones, 1996). There are those who consider that the way to make research relevant to practice is to ensure that findings are packaged 'in the form of tools that are useful' (White in Gibbons (ed), 1992 p174). The danger of proceeding too far along a management-influenced competence route with regard to social work education is that an important facet of the dynamic within the profession will be lost. Instead of reflective social workers who are skilled in their ability to think critically and knowledgeably and to intervene accordingly: *"the practitioner, through her training, simply learns to think and practise as the manager would wish her to."* (Howe, 1991 p218). Passive social workers who have been drilled to respond in programmed ways to 'standard' situations ultimately do favours to no-one, least of all their clients.

In contrast to a narrowly conceived competence-based approach, others in the field of social work education advance the view that educating social workers to become skilled in the medium of reflective practice is the way forward (Yelloly, 1994). Everitt *et al.*, in like vein, advocate the reclaiming of social work from the dominance of managerialism, calling for 'research-minded' practice. Again, the emphasis is on critical reflection:

> *Research-minded practice is concerned with the analytical assessment of social need and resources, and the development, implementation and evaluation of strategies to meet that need. ... The taken-for-granted becomes subject to critical scrutiny.* (Everitt *et al.*, 1992 p4)

It is argued here that a social work methodology based on the practice of critical reflection of the process is more likely to ensure the sort of high quality professionalism that is needed if a better balance of managerial/organisational and professional concerns is to be restored. Clearly, then, the practitioner arm of the profession will itself have an active part to play in such a restoration.

In line with other studies (Pithouse, 1987; Higginson, 1989; Hill *et al.*, 1992; Waterhouse & Carnie, 1992), the study revealed the importance of practice wisdom as the basis for the social workers' *modus operandi*. In other words, in engaging with clients, the practitioners knew their role, they knew their task, they knew what was expected of them (from a variety of quarters), they listened to and talked with their clients, they judged the situation as they went along, and they did things appropriate, on balance, to the situation as they saw it. In Schön's (1983) terms, we might say that they demonstrated both 'knowing-in-action' and 'reflecting-in-action'. By definition, social work practice involves elements of repetition; similar sorts of human and social dilemmas arise. This is how professional expertise is built up (Schön, 1983). Knowing becomes increasingly tacit, actions are guided by an internalised feel for the situation. However, potentially within this increasing professional competence are the seeds of a move towards decreased effectiveness, apparent when acknowledgement of the unique and unusual within the everyday is overlooked. A strategy of regular *conscious* reflection on the role and on the task in hand is vital to continuing maximum effectiveness:

> *Through reflection, [the practitioner] can surface and criticize the tacit understandings that have grown up around the repetitive experiences of a specialized practice, and can make new sense of the situations of uncertainty or uniqueness which he may allow himself to experience.* (Schön, 1983 p61)

As Schön further notes, when practitioners reflect in and on their practice, the possible focus for such reflection is likely to be wide and varied, including, for example, reflection on *"the tacit norms and appreciations which underlie a judgment"* (Schön, 1983 p62). It is argued, then, that greater accent by practitioners on undertaking such consciously reflective practice would enable them, for example, to clarify the distinct professional concerns of the assessment process. That is not by any means to say that the aim should be for managerial concerns to be edged out or superseded by purely professional concerns. That would clearly be a nonsense. Professional concerns do, however, need to be set prominently alongside organisational aims. It is argued here that practitioners themselves have a professional responsibility to work towards this end.

It is useful to remember at this point that it is common still within social services organisations for managers to be qualified social workers; often they have been experienced social work practitioners before moving into team management and supervisory roles. Whether or not managers themselves are able to provide a direct resource for the reflective practitioner, there is undoubtedly common cause between the organisation, managers and practitioners when it comes to high quality practice and effective service delivery. If the will is there, managers and practitioners working together can ensure the types of structured practice-focused opportunities (supervision that concentrates on these ends, consultancy, peer supervision, for example) that are necessary to breathe life into the idea of reflective practice.

In the event, there are likely to be positive benefits for social workers and clients alike. With regard to social workers, from time to time to make the implicit explicit, to re-evaluate and clarify the professional task, its context, formal and informal theory and knowledge base, would be a fruitful means of validating the unique contribution of practice to the development of the profession, and thus a potent avenue to self-empowerment. In the client-social worker encounter that is the assessment situation,

by virtue of their role practitioners undoubtedly hold power in a way that is unavailable to clients. Social workers do not necessarily experience themselves as powerful, however. In the same way that clients can be rendered powerless and passive in the process of assessment, practitioners can, in their own terms, be cast in the role of the passive agent of the organisation. To seek to empower clients effectively, practitioners must first empower themselves. It is argued here that a vital way forward in this regard is the medium of critical, reflective practice, with all that means with regard to, for example, re-viewing the nature of professional knowledge and the relationship between research and practice.

The benefits of reflective practice for the clients of assessing social workers are likely to be experienced in the realm of client empowerment. In recent years it appears that assessment practice has become more and more driven by concerns high on the organisational agenda, although the needs-led rhetoric has frequently provided effective camouflage of this. Clients are not merely fodder for a gatekeeping process however. They have a right to expect something more from the process of assessment, even though finite resources dictate that sorting out who gets what must take place and even though they may, in the end, get nothing more than the experience of a one-off interview with a social worker to whom they have brought (or, more likely, were asked to bring) a problematic situation. It is argued that that 'something more' is the experience of a satisfying process, whatever the outcome.

To talk of empowerment is to talk of intervention. There have long been debates centring around questions such as: when does assessment end and intervention begin?; to what extent do the two overlap?; does assessment ever end?; and so on. Those debates usually focus on the continuing need for an element of assessment once intervention has begun. It is argued here that intervention needs to be reintroduced into the assessment process. If, in line with their professional aims, social workers are to pursue a strategy of client empowerment, they need to take a

more actively interventionist, change-promoting stance with clients within the assessment encounter.

One potentially effective way of making the required shift is through the notion of partnership. We saw a number of examples in the findings of the often glaring gap within social work between what theoretically happens and what happens in practice. The notion of partnership seems currently at the stage of being a good idea in theory — one to which any right-thinking social worker would subscribe. We saw, though, (and other research (for example, Thoburn *et al.*, 1995; Sharland *et al.*, 1995) has also found) that the reality is rather different. It needs not to be. Working in true partnership with clients has empowerment at its heart. For social workers undertaking assessments the process will, first and foremost, be one of acknowledging and owning their own power (both as individual professional and as representative of the agency), together with the 'privileged' position of their knowledge base (Worrall, 1990). To consciously own one's power is to have the option not to act it out to the detriment of others, but instead to allow the other the space to locate their own power and to know what they know. With that consciousness, then, social workers can bring their knowledge and skills to bear in ways that will enable their clients' active engagement in an assessment process wherein needs and potential needs are identified; understandings, realities and perspectives are shared; ways forward are negotiated; feelings, satisfactions and dissatisfactions acknowledged. It will not go unnoticed that the ability to communicate well — to put one's own perspective coherently as well as hearing others' perspectives — needs to be an integral part of this process. Partnership is a two-way street. Essentially, it is about being prepared to contemplate a shift in the balance of power in order to maximise the possibility for good outcomes. In the micro-situation that is the assessment encounter, supported by their reflective practice, practitioners are in a position to point the way for clients and the profession alike.

On the basis of the study, it is argued that the professional task of social workers is being distorted by an over-emphasis on organisational/managerial concerns to the detriment of best practice. A re-balancing of organisational/managerial and professional concerns would have beneficial implications for social work practice, for service delivery and for clients. Practice cannot fail to be enriched by a process that puts more clearly on the agenda professional aims encompassing not only an awareness of the requirements of the agency but also the ideal of client empowerment. Undeniably, social work is a difficult and pressured job, often carried out in the most testing of circumstances in a far from ideal world. There is nevertheless something sadly impoverishing about social work skills being used chiefly to 'soften the blow' for clients while the agency's prime concerns of rationing and risk are sorted out. Vitally important as these considerations are, they need not to be the only ones in the professional frame.

Apart from the goal of enriching social work practice and all that is likely to spring from that, it is contended that service delivery too will be improved by such a change of emphasis. To establish the notions of partnership and empowerment more firmly within the assessment process will be to change the tenor of the service. A social service that seeks to engage its users fully, actively *and with reciprocity* in the delivery of that service cannot but be enhanced. Of course, from the organisation's point of view, finite resources and being the agency of the state's protective powers will always colour its perspective. There will be mismatches of needs and desires, and curbs on some in the face of what society deems to be a greater good. Embodied in the opportunity for client empowerment and a partnership approach, however, reciprocity can always be part of the process. Client and agency remain in fairer balance.

At the behest of the agency, clients and social workers will continue to encounter one another: *"When social worker and client meet, words are said, things are done,*

decisions are made." (Howe, 1991 p214). The most effective service will come about when the agency acknowledges that what social workers do needs not to be solely concerned with pursuing the direct concerns of management, but that, quite properly, practitioners have a specifically professional agenda to pursue. The highest professional practice by social workers can only enhance the quality and effectiveness of services. In this way, ultimately, professional and organisational concerns are squared. The character of such a service is radically different, however.

In some ways, the benefits that would accrue to clients from the proposed change of emphasis would be intangible since they are as much to do with process as with outcome. In the assessment context, the goal of empowerment is to validate clients' knowledge and understandings of situations that are problematic and, in searching for solutions, to acknowledge and/or foster client qualities of autonomy and self-direction. The means, then, are active, participatory processes wherein differing perspectives are aired and negotiated, shared assessment reached and satisfactory resolution of problematic situations achieved. Reiterated starkly in this way, the notion begins to take on an almost fairy tale-like quality, absurdly at odds with the 'real world' of social work in the local authority context. If clients are to be the ultimate beneficiaries of reflective practice and a regaining of the balance between professional and managerial concerns, however, it is important for social workers not to be put off by the stretching nature of the professional goal. Not least because, based on the evidence of this study, clients are likely to meet social workers more than half way. Clients valued good communication and, as we saw, more often than not, came to assessment encounters with openness and great goodwill.

A changed emphasis towards reflective practice, the reclaiming of assessment from the current overweening influence of managerialism, will undoubtedly involve significant challenges to all as well as many potential benefits. The backdrop is, of course, a changing and uncertain future for social work. Today's provision of social

services, where the accent is on a mixed economy of care and ever closer supervision of aspects of social work by the courts, is already radically different from that envisaged during the era of Seebohm (Langan, 1993). Given the almost universal public criticism of the profession over the last twenty years, some will be surprised that social services departments and social work have survived at all. Certainly, in response to such disaffection, their roles have been rewritten, boundaries redrawn, autonomy restricted; undeniably the world of social work looks very different.

It is necessary at this point, then, to confront the uncomfortable notion that the ideas being advanced here are merely some sort of rearguard action on behalf of social work as we have known it, a sentimental harking back to rosier times past. It is not, though, a going back that is being proposed here, but a going forward. A thoughtful going forward for the profession as a whole that takes full account of where social work has got to and allows itself to be informed and enhanced by the knowledge and experience gained in the past.

As far as the function of assessment is concerned, where social work has got to is fairly clear. The current (and likely ongoing) residualist climate within which social work operates ensures a vital role for assessment in the provision of social services. Long seen as an important first step in social work intervention, in today's context the activity of assessment has become increasingly important as an intervention in its own right (Lloyd & Taylor, 1995; Langan, 1993). Indeed, it is enshrined within some of the most recent welfare legislation (notably the 1989 Children Act and the 1990 NHS & Community Care Act) that the process of assessment as carried out by social services is to concern itself not only with who will get what and who will provide what, but also with addressing the power imbalances (or, probably more accurately, the balance of client dependence/independence) that experience has shown are likely to be engendered within the process. In the social work of the future, then, assessment will arguably play an even more key role than good practice has dictated hitherto.

No doubt practitioners who carry out the task of assessing clients and their situations are more aware than most of the new and particular expectations being laid upon them. For, as Howe (1986, 1991) unflinchingly reminds us, social work does not set its own boundaries:

> *Social workers define neither the purpose of their work nor the means by which it is carried out. Except in matters of style, all the substantive elements of their work are determined by others, either directly in the form of managerial command or indirectly through the distribution of resources, departmental policies and procedures, and ultimately the framework of statutes and legislation that create both welfare clients and welfare agencies.* (Howe, 1991 p204)

It is argued here that it is precisely because of the moving nature of the target that social work practice calls out for a reflective approach from its practitioners. Although, in contrast with other professional groups, the scope for social workers to determine what they do is significantly constrained, there is nevertheless considerable scope for critical, reflective practice that is aimed at two complementary levels. At the macro level, reflective practitioners will have much to contribute to what will undoubtedly be an ongoing debate about what properly constitutes the role and tasks of social work. Certainly, this will involve practitioners in meeting the challenge of owning and promoting their particular perspective — indeed, fighting their professional corner — in a way that has become uncommon since the rise of managerialism. At the micro level, the challenge will be redefinition of the professional agenda to include not only awareness of the entirely proper concerns of management, but also renewed commitment to an assessment process that is truly participatory with client empowerment at its heart. In some senses (and perhaps this has been the downfall of social workers), change at this level may well be easier to achieve. For, as Howe (1991) also points out, within the 'privacy' of individual social worker-client encounters there is much scope for social workers to choose how they conduct themselves.

Undeniably, however, it is both levels that need to be addressed if the particular perspective of the practitioner-arm of the profession is to be advanced overall.

The aim of this study has been to explore the topic of social work assessment where two areas of great importance to social work practice overlap. It is in the nature of things that, to a greater or lesser extent, there will always be such areas of overlap to confront (but hopefully not confound) practitioners who undertake assessments. Lloyd & Taylor (1995) sum up well what is required of social workers by this demanding and complex sphere of work:

> *Good practice in social work assessment demands that practitioners be competent, knowledgeable, consistent and accountable, in situations which are frequently chaotic, irrational, hopeless or just plain messy. To do so and remain as human beings is a complex and risky enterprise. ... Social workers must hold on to the distilled understanding of what social work assessment is all about, if they are to meet new challenges within a holistic rather than reductionist framework.* (Lloyd & Taylor, 1995)

For the foreseeable future, assessment will remain a vitally important task within social work and social services. As yet the direction of social work in the twenty-first century is unclear. An active body of thoughtful, reflective — yet vociferous — practitioners would undoubtedly make a valuable contribution to its development.

THE IMPACT OF PARENTAL MENTAL ILL-HEALTH ON CHILDREN

AIDE-MEMOIRE FOR ASSESSING SOCIAL WORKERS

The consensual view is that there is no doubt that a link exists between parental mental disorder and psychopathology in children. One influential study (Rutter & Quinton, 1984) shows that one-third of children are seriously affected, but by no means all children are. Those who are do not necessarily present with the same sort of disorder as the parent.

The presence of a parental mental disorder is a significant potential indicator of poor outcome for the child. How a parent is classified psychiatrically seems relatively unimportant. In contrast, severity of the disorder, its chronicity and the presence of hostility and discord within the family may be more significant in terms of child outcome.

ASPECTS TO CONSIDER

Direct effects

Do the parent's symptoms impinge upon/involve the child directly? For example, do delusions focus on the child, is the child involved directly in obsessive-compulsive behaviour, or subject to emotional unavailability and/or irritability on the part of the parent?

Effects via parenting

The parenting of a mentally disordered parent may be affected, although not necessarily. Quality of parenting — in various dimensions, for example: interest; involvement and stimulation on the part of the parent; attunement to child needs; and a balance of positive/negative affect — is likely to be more significant with regard to child outcome than one diagnosis over another. With regard to very young children, is the presence of parental depression affecting security of attachment?

Effects via the correlates of parental mental ill-health

Bear in mind the likely impact for the child of the wider psychosocial picture, for example: chronicity of parental mental ill-health (ongoing strain for child); family disruption and separations from parent and/or home; and discord and hostility within the family, including marital discord. The extent of such discord may be especially important.

Child characteristics

Children are individuals and differ in their vulnerability. All ages are vulnerable to the impact of parental mental ill-health although the developmental considerations differ. The part played by the child's gender is unclear. Keep in mind that it is a 'two-way street' — children also have an impact upon the well-being or otherwise of mentally disordered parents.

Protective factors

Stay alert to the potential strengths in the situation. Likely 'protective' factors are: a good relationship with one or more parent; good peer/sibling relationships; some source of consistent parenting (if mother is mentally ill, the father will be an important figure); and access to well adults and independent sources of feedback for the child, including recognition by other members of the family that a parent is unwell.

THE GROUP DISCUSSIONS

1. Aim

The aim of the group discussions was to invite social workers to consider and articulate what factors inform and influence their assessments, plans and interventions in relation to young families where there is parental mental disorder, with particular reference to the perceived needs of the child.

In line with the concept of a developing methodology, it was intended that information gleaned through the group discussions should clarify the issues to be explored in greater depth in the one-to-one interviews with social workers and parents that were to follow.

2. Design of the approach

2.1 Why groups?

The particular value of group discussion lies in the opportunity they give for variations in perspective and attitude to be both revealed and challenged by participants. Group interaction can thus provide greater insight into why particular views are held.

2.2 Why groups within settings?

It was decided that group discussions would be held within each of the settings used in the project. Since a major benefit of group discussion is the opportunity for a variety of perspectives to be aired and debated, consideration was given to inviting social workers from different settings to participate in a mixed discussion group. The logistics of this were beyond the resources of a part-time researcher. More importantly, the benefits of holding group discussions within settings could not be

discounted. A degree of commonality and homogeneity, such as would be the case for social workers employed within a particular setting, was seen as an important factor in facilitating the disclosure of views and opinions.

Certain disadvantages in holding group discussions among peers were also acknowledged. Social workers might not wish to air controversial ideas or to voice particular opinions in case such views were attributed to them in the future. Conversely, among staff groups who knew each other well, it was possible that some views and attitudes may be so well known and aired that much would be taken for granted and not openly stated. In either case a less than accurate reflection of the group's views was possible, undermining the validity of the technique.

Overall, it was considered that the benefits of within-setting groups outweighed the disadvantages. Recognising such disadvantages was the first step towards overcoming them. It would fall to the researcher/moderator to ensure maximum validity. This point is addressed in more detail at a later stage.

2.3 Who would participate in the group sessions?

Ideally, groups should be small enough for views to be shared comfortably but large enough to provide diversity of opinion. Unlike in the area teams, the social work staff groups at the child guidance clinic and the adult psychiatric unit were small, numbering five and six respectively (includes full- and part-time posts). In relation to these two settings, therefore, the aim was to include all members of the social work team who practised as social workers in order to maximise the scope for diversity of views. In both cases this therefore meant the inclusion of a senior social worker with additional line management and supervisory responsibilities. The drawback of including senior social workers in this way primarily centred on the potential for social workers to feel inhibited in the expression of their true views and opinions. The benefits of the seniors' inclusion, however, were judged to outweigh the

disadvantages, inasmuch as they were presently practising social workers and in both settings were seen to be part of small, relatively cohesive staff groups used to meeting regularly to discuss social work issues.

Within the area teams (of which there were four borough-wide) the numbers of social work staff were obviously considerably greater, averaging approximately 20. The aim was to hold group discussion sessions in each the four areas, one of which would serve as the pilot. In order to keep the group discussion sessions in the areas manageable, numbers were limited to a maximum of eight. Selection of participants was both informed by the pilot and a matter for discussion during negotiations with the individual area teams.

2.4 Location

Each group session was to be held in the team's own offices. The benefit of this was that the discussion groups would take place in a familiar, 'safe' environment with no additional travelling time. This was seen as likely to maximise participation. It was acknowledged that the disadvantage of holding the groups in different locations was that there was no continuity of environmental conditions. Once again, particularly taking practical considerations into account, the benefits were judged to outweigh any disadvantages in not having a single, neutral location.

2.5 Moderator

All discussion groups were to be moderated by the researcher to ensure a degree of consistency across the groups. It was also acknowledged as important that the researcher adopt a neutral stance while at the same time aiming both to promote a non-judgmental atmosphere and to encourage the free exchange of ideas. Apart from in one area team where the researcher was known in a social work role, it would more often than not be the case that the researcher would not be known to participants other than as a researcher.

2.6 The format of the groups

It was anticipated that the group sessions would last for approximately one hour. This was because concentration often wanes after about this length of time and also because social workers are unlikely to have a more lengthy period of time available for such an activity. It was further anticipated that the timing of each group would be by arrangement and was thought most likely to be during a regular 'special interest' or social workers group meeting slot.

All group discussions were to be tape-recorded. It was acknowledged that this would need to be made clear to all participants at the outset of the session, with the emphasis being placed on the tape-recorder as an essential tool allowing everyone's comments to be captured.

Each group would begin with the moderator making a brief statement giving the aim of the session, how long it would last, stressing that there was no 'right' point of view and that all ideas, however tentative, were welcome. The actual wording of this introductory statement is reproduced at Appendix B1.

Group sessions were to be concluded by choosing a natural break when the time allotted had run its course. Social workers were to be thanked at that time for their participation, followed by the written thanks of the researcher.

2.7 Topics to be covered

In order that the data gathered through the discussion groups could be effectively compared and analysed, it was important that there be a uniform framework of topics to be covered during the course of all the group sessions. To this end the moderator would aim to explore issues of likely importance with each of the groups. These topics had been previously identified by the researcher by means of a review of relevant literature. They were then itemised on a single sheet of paper to

provide an aide-memoire for the moderator's use during each of the group discussion sessions (see Appendix B2). The aim was to cover the entire range of topics during the group sessions, but in a flexible and imaginative way which would take its lead from the flow of discussion in any particular group.

3. The group discussion sessions

3.1 The pilot

The purpose of a pilot group discussion session was threefold: (1) to see if the technique was effective in achieving the stated aim; (2) to see if it was feasible for the range of topics identified to be covered in the allotted time; and (3) to enable the researcher to practice the skills required of a moderator.

It was decided to hold the pilot in the area where the researcher was known in a social work role. It was further decided that all invitees would be participants in the duty service offered by the office. In this way it was hoped that the group participants would both see the discussion as relevant and useful to them as practitioners and feel that they had some up-to-date knowledge and skills to share in relation to the function of assessment.

Given the area team chosen for the pilot, the researcher was in a position to know the background and roles of many members of staff and was therefore able to invite a range of participants offering a mix of experience and views. The aim was to have a group of social workers who together would provide a range of experience in terms of child care and mental health (including Approved Social Workers), and level/length of experience (i.e. some 'level 3' workers and some newly qualified) and a mix of sexes.

Eight participants were invited and all attended. (See Appendix B3 for the invitation). Undoubtedly such good attendance was influenced by the fact that the

researcher was known and, therefore, people were personally supportive. In addition, the opportunity had been taken to publicise the research project at an area meeting and social workers' and seniors' individual queries had been answered as and when they arose. Social workers also appeared to be enthused professionally and, as a result, keen to participate in the project.

The pilot served three useful purposes. Firstly, experience in conducting the pilot showed that the group discussion was indeed a useful vehicle for getting social workers to articulate the factors which informed and influenced their assessments, plans and interventions in families where there is mental disorder in the parents. In addition, group dynamics appeared to be working in the way anticipated.

Secondly, the pilot clarified the amount of information and scope of views that could be covered in the time allotted. It was possible to cover the range of topics identified within the time span, although the idea of making sure that all 'prompts' were precisely covered (for example, the question 'is diagnosis important?') was dropped on the basis that it was more important to cover a particular general topic area and to see what emerged from the group.

Thirdly, the pilot increased the researcher's confidence with regard to such effective moderating abilities as being able to link one topic area with another smoothly to keep discussion moving and bringing people back to the point if they strayed away from the focus of the session. Care needed to be taken that the researcher consistently limited herself to the role of moderator (that is, not slipping into joining in the discussion as a participant) and, allied to this, making sure that enough time was allowed for participants to speak up before making a comment or moving the discussion on to a related point. Overall, however, sufficient confidence was experienced in relation to the approach. In addition, the pilot gave useful practice in handling the tape-recording equipment.

The feedback received after the pilot group discussion was by and large positive and, once again, this boosted confidence in the technique. The great majority of participants said that they had enjoyed the session and found it a welcome opportunity to reflect with colleagues on their practice. One participant commented that, in addition to the positive aspects, the experience made him feel anxious with regard to practice issues.

3.2 The Other Groups

In addition to the pilot, four further group discussion sessions were held — two in area teams, one with Child Guidance social workers and one in an Adult Psychiatry social work office. A further area team within the borough declined to participate in the research.

3.3 Child Guidance

The Child Guidance group discussion was held during a regular two-weekly slot set aside for social workers to meet. Initial discussions about participation in the research had been held with the Clinic's senior social worker. She was enthusiastic about the project, enlisting support for it both from the Head of the Clinic and the multi-disciplinary team and from the social workers working within the Clinic.

Following these initial soundings, the researcher attended a social workers group meeting to explain the research in more detail and to agree with the social workers their participation in the project beginning with the setting up of a group discussion session, the aims and parameters of which were fully explored during that first meeting.

Five social workers, the full complement of social work staff, took part in the Child Guidance group discussion. This number included two social workers permanently seconded to the Schools Psychological Service but who nevertheless

worked in close conjunction with the Clinic and were very much part of the multi-disciplinary team. It also included the senior social worker who, apart from line management and supervisory responsibilities, continued to practice as a social worker and carried a small caseload. All were very experienced social workers of many years standing and all were female. As mentioned previously, given the relatively small size of the social work team, it was considered appropriate to include all team members in order to maximise the diversity of view.

The group discussion technique worked well with the Child Guidance team of social workers who participated co-operatively and fully in the task at hand.

3.4 Second Area Team

This area team responded very positively to the research and to the possible involvement of the area team social workers in the project.

Again, the researcher attended an area meeting in order to explain in more detail about the research and to enlist co-operation both in the project as a whole and in a social workers' group discussion. As a result, agreement to the participation of the area was received.

Despite the commitment of this area team to the research, the group discussion session which was held subsequently worked less well, in some senses, than some of the other discussion groups. It was agreed with management that all social workers who would be in an intake role following a forthcoming reorganisation (a total of 10) would be invited to attend the group discussion and an invitation similar to that at Appendix B3 was sent out. What appeared to be a suitable time of the week was selected, although this did not coincide with a regular meeting slot as such. Following a poor response to the first invitation (the date picked was during school

half-term with the consequence that a higher than usual number of social workers were on leave), a second invitation was sent out.

In the event, there were only three participants in the second area group discussion. Following reorganisation, all were to be intake social workers (two were currently); one participant was an Approved Social Worker. The group comprised two women and one man. With hindsight, despite considerable negotiations with management and with the area team as a whole, the researcher had failed to make sufficient direct contact with those workers likely to be invited to participate in the group discussion and thus to engender their interest in the face of competing pressures on their busy time schedules. This was so both for those who attended as well as those who did not and the impression gained was that participants were less well briefed than those in other group discussions.

The social workers who did attend the group discussion were undoubtedly co-operative, but the small number meant that the technique worked rather less well. It is probably true to say that, given their small number, the participants, for at least part of the proceedings, felt, to some extent, obliged to speak up rather than spontaneously to volunteer the views and insights most important to them. This is not to say that the views they did put forward are less valid but, at least to some extent, the group dynamic element of the technique appeared to be less in operation. Moreover, the small size of the group affected the moderating role and, unlike in the other groups, the researcher decided that it was appropriate to be more personally participatory in order to ensure the free-flow of debate.

3.5 Third Area Team

In relation to the setting up of the group discussion in this area, apart from initial soundings with a management representative (senior social worker), there was much more direct contact with the social workers themselves. It was clear from a fairly

early stage that, given the low rate of referral of the type of families which were the subject of the research, this area would not be involved in the later stages of the project (that is, the individual interviews with social workers and parents). What remained, then, was to engage the social work staff group's interest in participating in a group discussion. The researcher attended two social work group meetings to discuss the research generally and, in particular, to explain the aim and parameters of the group discussion session, in addition to having a number of conversations with individually interested social workers.

As a result of these negotiations, five social workers participated in the third area team group discussion which was held during a regular social workers group meeting slot. All those who attended participated in the area's duty system; three were Approved Social Workers. The group comprised three women and two men.

The group participants were well briefed and there had been sufficient personal contact with the majority to gain their confidence and enthusiasm. In addition, they gave the impression, perhaps partly because they knew they would not be involved in the later study and there would be no further demands on their time, that they were keen to contribute their time and energy to the research through the medium of such a group discussion.

The overall result was a successful session with an enthusiastic and co-operative group of social workers with whom the technique worked very well. The feedback from this group was particularly positive, with comments that they had found the session 'helpful' and that such discussion helped 'sharpen us up'. Interestingly, the comment was also made that 'of course, we say this and then do something completely different', an observation that hopefully would be illuminated as the research progressed.

3.6 Adult Psychiatry

Despite an initially positive response to the research from the senior social worker, gaining the participation of this team proved to be the most difficult.

Having eventually negotiated successfully to involve the Adult Psychiatry social workers in the research, there remained the task of engendering their personal interest and enthusiasm. Again, the researcher attended a social workers' group meeting in order to explain about the research in more detail, to answer questions and to enlist assistance and co-operation in the project.

Despite the initial difficulties at an organisational level in enlisting their co-operation, as a group by and large the social workers appeared willing to participate in the research generally and in the group discussion in particular. It was apparent, however, that this group of social workers saw themselves very much as adult-focused in their work and were at considerable pains to stress that they very rarely had referrals which involved them with young children. As a consequence of this, their concern was that they would have nothing of any great relevance to contribute to such a group discussion.

This group discussion comprised seven participants, the full social work team including the senior social worker who held a small caseload. Two were also Approved Social Workers. One worked solely in the realm of psychogeriatrics. Six participants were female, one male.

The discussion had been scheduled for a regular social workers group meeting slot. Due to other business, the session was late starting, there was a late change of accommodation, and use of the room was time-restricted. This meant that the session lasted only 45 minutes and it was not possible to cover the full range of topics in the time available. Also, given the social workers' expressed opinions about the low

referral rate of suitable families, it was less than clear at that stage that there would be a sufficient number of suitable referrals from which to draw any valid conclusions. In these circumstances, special emphasis was given during the group discussion to inviting the social workers to consider, at least in a hypothetical sense, the influence of multi-disciplinary work in a hospital setting on their assessments, plans and interventions.

This was the only group discussion session in which not all the participants expressed views. Two participants did not contribute to the discussion; one was a social worker working solely within the realm of psychiatry of old age and the other had previously voiced her view that she felt she had nothing to contribute. That said, though shorter than other group discussion sessions, the hospital group discussion produced a lively debate around the topics that were covered.

4. Themes emerging from the group discussions

Following the five group discussion sessions, all tape-recordings were transcribed by the researcher. Analysis (of the style discussed in the thesis proper) was undertaken with a view to the group discussion material informing the developing methodology of the project. From this emerged a number of themes that appeared to have a bearing on how social workers formulated their assessments, plans and interventions in the type of family situation under consideration.

The main themes emerging that appeared to warrant further investigation in the individual interviews as to their influence on social workers' decision-making were:

- setting
- the referral
- consultation
- risk
- collaboration with clients

It was ensured, therefore, that these themes were incorporated into the drawing up of the individual interview frameworks to be used with social workers and parents in the later stages of the research.

INTRODUCTION TO THE GROUP DISCUSSION SESSIONS

I would like to start by thanking you all for attending this group discussion in connection with my research project. The session will last for about an hour.

It is [the first/one] of a number of group discussion sessions, the aim of which is to invite social workers to consider and articulate what factors inform and influence their assessments, plans and interventions in relation to young families where there is mental disorder in the parents, with particular reference to the perceived needs of the child.

It is important that you give your own views and not those you believe to be 'typical' of an [area team/child guidance/psychiatric] social worker and I do want to stress that there are no right or wrong answers. Please feel free to share your point of view, however tentative, and even if it differs from what others have said.

I am tape-recording the session because I don't want to miss any of your comments - so please speak up! It will also be helpful if only one person speaks at a time. When I come to write up the research, no names will be attached to comments made in this session so you can be assured of confidentiality and anonymity.

I'd like to begin, then, by asking you to cast your mind back to the last time you were carrying out an initial assessment interview in a family where one of the parents had a mental disorder, or to imagine such a situation. What was on your agenda during that assessment, in other words, whose needs were being assessed? [Perhaps, to start us off, we could go round and respond to that in turn.]

TOPICS FOR DISCUSSION

WHAT IS ON THE AGENDA FOR SOCIAL WORKERS WHEN THEY ARE MAKING ASSESSMENTS OF FAMILY SITUATIONS WHERE THERE IS PARENTAL MENTAL DISORDER?

Whose needs are being assessed? child / parent / both / depends on setting/referral, etc.?
Mental health of parent? Do you need to know anything of mental disorder or is it straight good-enough parenting?
Welfare of the child?
Are you cognisant of the wider social work agenda to promote the welfare of children? always / sometimes / rarely?

WHAT DEGREE OF KNOWLEDGE AND SKILLS DO SOCIAL WORKERS NEED TO CARRY OUT EFFECTIVE ASSESSMENTS IN THIS SORT OF FAMILY SITUATION?

Do you need to know about mental disorder? What level of knowledge? Is diagnosis important?
Do you need to know about child development and good-enough parenting? What level of knowledge?
Which of the above is more or less important? Is experience in and/or training in assessment necessary?

Do you always consult when making assessments in this situation? always / when / why not? Who with? Psychiatrist / GP / Health Visitor / School / ASW / Child care social work expert / Senior / Other?
To what purpose(s)? To check satisfactory progress / gather knowledge re symptoms/impact?

WHAT DEGREE OF KNOWLEDGE DO SOCIAL WORKERS HAVE OF THE IMPACT OF PARENTAL MENTAL DISORDER ON CHILDREN'S DEVT.?

What sorts of factors do you take into account in this sort of assessment? Are there particular features (in the parent / child / family relationships) you would find worrying? What prompts that view?
Are there any particular ameliorating factors you would look for? What prompts that view?

ANYTHING TO ADD?

WHAT OTHER INFLUENCES ARE THERE ON SOCIAL WORKERS' ASSESSMENTS AND ACTIONS / PLANS?

What less tangible factors might influence you when making assessments / plans / interventions in this type of family situation? For example -
setting - ethos / aims / local definition of need / perceived sphere of work / commitment to multi-disciplinary approach
referral - source / persistence of referrer / problem as referred, presenting / previous knowledge (i.e. re-referral) or its lack
role of supervisor - degree/type of supervision / how supervision used in duty situation
role of informal supports - scope for discussion with colleagues
resources - relationship between assessment and action based on available resources / pressure to act / not to act
cultural/race issues - do stereotypes / lack of knowledge of issues stand in the way of assessment?

HOW DO SOCIAL WORKERS ARRIVE AT THEIR GATEKEEPING AND INTERVENTION DECISIONS?

What range of service are you likely to offer such a family? what prompts this view?
What range of service is typically available to this type of family from your setting? what prompts this view?
When might a family be referred on to a different social work setting? what prompts a different type of response? What prompts no further intervention?
What are the pressures to act / intervene in the usual way or differently? What are the constraints on acting / intervening in the usual way or differently?

TO WHAT EXTENT DO SOCIAL WORKERS INCORPORATE PARENTAL PERCEPTIONS OF THE SITUATION INTO THEIR ASSESSMENTS?

Is it important to incorporate parental perceptions of the situation into your assessment?
How do you get at what the parents' views are of the situation and at the response they would find most helpful?
What do you do is their views are different? What do you do if their views are diametrically opposed to your own?
Does perceived level of risk (to parent / child) alter your course of action given differing perspectives?
What level of consultation is there with parents regarding alternative interventions?

RESEARCH PROJECT

Dear

As you know, I am presently undertaking a research project within the social services department. The aim of the research is to explore how social workers make their assessments and plans, with particular reference to good-enough parenting and child development, set in the context of young families where there is parental mental disorder, alongside an exploration of parental perceptions of the same issues.

In connection with my research, I am holding a number of group discussion sessions. The aim of these sessions is to invite social workers to consider and articulate what factors inform and influence their assessments, plans and interventions in relation to young families where there is parental mental disorder, with particular reference to the perceived needs of the child. Information gleaned in this way will serve to clarify the issues to be explored in greater depth in later one-to-one interviews with social workers and parents.

You are therefore invited to attend the Area __ group discussion session, which will be held in the conference room on _____ at _____ for about one hour. I do hope you will be able to participate. Your co-operation will be greatly appreciated. Please return the tear-off slip below indicating your availability. If you have any questions, please do not hesitate to contact me.

Yours sincerely,

Sue Beresford

To: Sue Beresford

I am/am not able to attend the group discussion session on (date) at (time).

_____ (Name)

TOPICS FOR DICUSSION AT SOCIAL WORKER INTERVIEW

ASSESSMENT

Focus
Who or what were you assessing?
**Why? Why did you think that was important?

REFERRAL

Factors
What factors did you take into account?
Why? Why did you think that was important

Own knowledge
What made you think that factor was significant?

[Are you saying that factor was important given your knowledge of child development and good-enough parenting, adult mental health, or the impact on children of parental mental disorder? Which?]

How important was that knowledge in this assessment?

Additional information
Did you need to find out more information to complete your assessment? What was that? What did you do? Did you talk to anyone? Who? To what purpose?

CONSULTATION

Other influences
Do you think anything else might have influenced your assessment?

(then):
REFERRAL
SETTING
was there anything about the *referral* that might have influenced you?
did the *setting* where you work have an influence?
did you *discuss the case with a senior or colleagues* and might this have influenced you?
did *resources* influence your assessment?
did either the *professional or political climate* influence you?
did issues of *culture or race* have an influence?

Conclusions

What conclusions did you reach about what was happening and what needed to be done?
(If not mentioned) Did you consider the needs of [either parent or child]? Yes — backtrack to ** No — why not?

Did you consider the impact on child of parental mental disorder? Why / Why not?
What conclusion did you reach? How was this aspect incorporated into your actions / plans?

ACTIONS / INTERVENTIONS

What did you do? Why? Why did you think that was important?
Did you consider doing anything else?
Why not? or Why didn't you do that?

RISK

Did you consider doing anything in relation to [either parent or child]?
Why not? or Why didn't you do that?

Did you discuss with the clients what you were going to do?
Why / Why not? What was their view?

PLAN

What was your recommended plan of future action?
Why? Why did you think that was important?

COLLABORATION

Did you consider any other plan? Why didn't you decide on that plan?

Did you discuss the plan with the client?
Why / Why not? What was their view?

ANYTHING ELSE?

Overall satisfaction with piece of work? Very satisfied / Satisfied / Uncertain / Dissatisfied / Very dissatisfied

Would you be willing to be interviewed again in relation to another family?

TOPICS FOR DISCUSSION AT PARENT INTERVIEW

ASSESSMENT

Social worker's primary focus
Can you tell me how you came to have contact with the social worker?

Who or what was the social workers most interested in? [e.g. parent/child]
-- can you tell me why you think that?
-- why do you think the social workers was interested in that?

Did that seem most important to you? Why? / Why not?

Parent's view
Were there other things that seemed more important to you?
-- what were they?
-- why did you think they were more important?

Why do you think the social worker didn't think those things were the most important?

Secondary focus
Did the social worker appear interested in anyone else in your family? [e.g. parent/child]
-- can you tell me why you think that?
Yes -- why do you think that social worker was interested in that?

Did that seem important to you? Why? / Why not?

Social worker's conclusion
What conclusions do you think the social worker reached about your family or your situation?
[What do you think the social worker thought about you and your family after talking to you?]
-- can you tell me why you think that?
-- do you agree or disagree with that view?

Parent's view
What is your view of the situation?
Do you think the social workers listened to and took notice of your view?
-- what makes you think that? [how did that happen?]

PARENT'S VIEW OF PARENTAL MENTAL DISORDER

How has being ill/having problems affected you and your family?
Do you think your being ill/having problems has had an effect on your child(ren)?
-- can you say some more about that?
[how has it? or why do you think it hasn't]

What do you think the social worker's view on this was?
Do you think the social worker listened to and took notice of your view?
-- what makes you think that? [how did that happen?]

ACTIONS / INTERVENTIONS

Did the social worker do anything as far as you know?
[either when s/he was here or afterwards?]
What did s/he do? How do you know?

Did s/he talk to you about what s/he was going to do?
[tell you about it? ask you view?]
Did you agree or disagree with the idea?

Did you find what s/he did helpful or not?

Would you have liked her/him to have done something else?
What was that?

PLAN

Did the social worker say anything about what might happen in the future? [whether s/he or someone else would have contact in the future?]

What was that?

Did s/he talk to you about it? [tell you about it? ask your view?]
Did you agree or disagree with her/his idea?

Would you have liked something different to happen?

ANYTHING ELSE?

Overall satisfaction with the social work service? Very satisfied / Satisfied / Uncertain / Dissatisfied / Very dissatisfied

SCHEDULE OF INFORMATION TO BE COLLECTED FROM CASE RECORDS

Research Reference No. _____

1) BASIC DETAILS

Name: _____

Address: _____

_____

_____

_____

Family composition:

	Name	DOB/Age	Marital status	Rel to children
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____

	Name	DOB/Age	Sex
Child 1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____

N.B. INDICATE WITH (M) WHO IS MENTALLY DISORDERED
INDICATE WITH (R) WHO IS REFERRED CLIENT

Ethnic origin: _____

(see separately for categories)

2) REFERRAL DETAILS:

Referred on _____ by (desig.)_____

Problem as referred _____

_____

_____

_____

Family previously known to agency and/or area team? Y/N

If yes, which _____ and for how long _____

3) BASIC INFORMATION RE PARENTAL MENTAL DISORDER:

Who is said to be mentally disordered - mother? (1)_____

father? (2)_____

By whom?(eg GP/Psych.) (1)_____

(2)_____

What is form of disorder and/or diagnosis?

(1) _____

(2) _____

Under which category does family fall within sample

i.e. (a) - (g) _____

Give details and note if falls into more than one (i.e. when/how mental disorder apparent)_____

_____

_____

_____

4) CHILDREN

Note any concerns expressed about the children's development (in addition to referral, if child referred)

Referred child (if applicable) Within last year

Name	Concern expressed	By whom	Date

(Other) children (note if also referred)

Name	Concern expressed	By whom	Date

5) ASSESSMENT:

Initial assessment carried out by _____

on _____ in what capacity? (duty sw, ASW,etc) _____

Who was present at initial interview?_____

_____

_____

Date of write up _____

Assessment of family situation as recorded by social worker__

_____

_____

_____

_____

_____

_____

_____

Initial action(s) taken by social worker _____

_____

_____

_____

_____

_____

_____

Proposed plan regarding future intervention _____

_____

_____

_____

_____

_____

Social worker who interviewed continuing to be involved? Y/N

Any other social worker involved/to be involved? Y/N

If yes, give details _____

Secondary assessment being called for at this stage? Y/N

If yes, give details _____

Outcome 3 months after initial assessment (give date) _____

_____

_____

_____

_____

_____

(as either checked with social worker if allocated, or recorded on file if not allocated/closed, noting particularly references to child's development or mental condition of parent)

NB To social workers - To what extent were you able to carry out the initial plan?; If not, why not?

STRICTLY CONFIDENTIAL Research Ref. No. _____

SOCIAL WORKER QUESTIONNAIRE FOR SELF-COMPLETION

I BASIC INFORMATION

1. Please give your current post/job description

_____

2. What is your age? (please tick)

20-29	☐	50-59	☐
30-39	☐	60 & over	☐
40-49	☐		

3. What is your sex? (please tick)

Male	☐	Female	☐

4. How would you describe your ethnic origin?

_____

5. What is your present social work level? (please tick)

Level 2	☐	Level 3	☐
Extended Level 3	☐	Other	☐

If other, please specify _____

6. What does your current workload comprise? (please tick)

(Time spent)	Less than 25%	25-50 %	51-75 %	Over 75%
Children and families	☐	☐	☐	☐
Mentally disordered adults	☐	☐	☐	☐
Other	☐	☐	☐	☐

If other, please specify _____

_____

_____

II KNOWLEDGE BASE THROUGH WORK

7. Since qualifying do you consider yourself to have developed particular expertise in either (please tick)

	Yes	No
Child care	☐	☐
or		
Mental health	☐	☐

Please indicate which and expand on how this has arisen, for example giving details of previous posts held_____

_____

_____

_____

_____

8. Since working as a social worker, have you attended courses in relation to either (please tick)

	Yes	No
Child care	☐	☐
or		
Mental health	☐	☐

Please indicate which and give details, if possible_____

_____

_____

_____

_____

9. Are you an Approved Social Worker (whether or not presently authorised) or in training to be one? (please tick)

Yes ☐ No ☐

10. If you are <u>not</u> an Approved Social Worker, do you want to undergo training to be an Approved Social Worker in the future? (please tick)

Yes ☐ No ☐

11. Are you aware of any social services departmental policy, procedures or practice guidelines regarding assessment, planning and intervention, either in relation to specific client groups or generally? (please tick)

Yes ☐ No ☐

If yes, please specify _____

_____

_____

_____

III QUALIFICATIONS AND TRAINING

12. In which year did you qualify as a social worker? _____

13. How many years have you practised since qualifying? (e.g. excluding long breaks, such as maternity leave, 'sabbaticals')

_____

14. What social work qualification do you hold? (please tick)

CQSW ☐ CSS ☐ Other ☐

If other, please specify _____

15. What format of course was it? (please tick)

Non-graduate ☐ Post-graduate ☐

1 yr ☐ 2 yr ☐ 4 yr(degree) ☐ Other ☐

If other, please specify _____

16. Do you have any other qualifications? (please tick)

Yes ☐ No ☐

If yes, please specify _____

17. Did you have formal teaching on your course in relation to families and children? (please tick)

Yes ☐ No ☐

Please comment on the emphasis, or otherwise, given on your course to this topic _____

_____

_____

18. Did you have formal teaching on your course in relation to mental health? (please tick)

Yes ☐ No ☐

Please comment on the emphasis, or otherwise, given on your course to this topic _____

_____

_____

19. Did you have a placement or placements that involved working in the area of families and children? (please tick)

Yes ☐ No ☐

If yes, please indicate how many and specify setting(s)

_____

_____

_____

_____

20. Did you have a placement or placements that involved working in the area of mental health? (please tick)

Yes ☐ No ☐

If yes, please indicate how many and specify settings(s)

_____

_____

_____

_____

21. Before qualifying did you work in the field of either (please tick)

	Yes	No
Child care	☐	☐
or		
Mental health	☐	☐

Please detail, giving previous posts held (paid or voluntary) _____

_____

_____

IV OTHER INFLUENCES

22. Do you consider you have a particular interest in or enthusiasm for child care social work? (please tick)

Yes ☐ No ☐

Please indicate possible reasons _____

_____

_____

_____

23. Do you consider you have a particular interest in or enthusiasm for mental health social work? (please tick)

Yes ☐ No ☐

Please indicate possible reasons _____

_____

_____

_____

24. Do you currently belong to any special interest groups (within the work setting, CPAG, MIND, etc)? (please tick)

Yes ☐ No ☐

If yes, please specify _____

_____

25. Do you read any professional or related journals and/or articles/books? (please tick)

Yes ☐ No ☐

If yes, please give details _____

_____

_____

26. Are you following a work-related course of study or pursuing a special interest presently, either in or out of work time? (please tick)

Yes ☐ No ☐

If yes, please give details_____

_____

_____

27. Please include any additional thoughts or comments of your own if you care to (continue overleaf if necessary)_____

_____

_____

_____

_____

28. Please check you have completed answers to all the questions. Many thanks indeed for your time and effort. I shall collect this questionnaire when we meet for our interview.

Sue Beresford

(Extension No. _____)

BRIEF DESCRIPTION OF THE BOROUGH WHERE THE STUDY TOOK PLACE (BASED ON PROFILE INFORMATION ISSUED BY THE BOROUGH)

One of the larger outer London boroughs, the borough is a heterogeneous area with a number of distinct localities, each having its own characteristics and identity. Towards one end of the borough the local area resembles inner London. At the other end, there are areas that retain rural characteristics.

Total population is in the region of 204,000 (1991 Census figures). The oldest and the youngest in the population tend to concentrate in different localities. Both ends of the age spectrum are currently increasing in numbers. The population is racially and culturally diverse. At least one person in six in the borough is from an ethnic minority, the main minority ethnic groups being people of Pakistani, Indian and Bangladeshi origin.

Unemployment is around the average for an outer London borough (approximately 4%). Based on Department of Environment figures, the borough was ranked sixth among outer London boroughs in terms of deprivation. With regard to the social class structure, the borough's residents closely resemble the national picture.

In 1988 over 250 referrals of people with mental health difficulties were made to the social services area teams. This was recognised to be an underestimation of need since poor mental health can often contribute significantly to other difficulties experienced by an individual or family without in itself being given as the reason for seeking assistance. As regards children's services, in 1988 there were 280 children in the care of the borough and in August 1989 there were 120 children (from 58 families) on the borough's child protection register.

FACTORS CITED BY SOCIAL WORKERS AS INFLUENTIAL IN THEIR ASSESSMENTS

Factor	*Number of times cited*	*Case Characteristic (CC)/ External(E)*
Level of functioning of parent	27	CC
Relationship between parent(s) and child	13	CC
Parental psychiatric history	10	CC
Support network available	10	CC
Concern or its lack by other professionals	10	E
Child development issues	9	CC
Good-enough parenting issues	8	CC
Client's degree of insight	8	CC
Client requesting support in parenting role	7	CC
Degree of risk to child(ren)	7	CC
Degree of risk to mentally disordered parent	6	CC
Impact on family relationships	6	CC
Financial circumstances	6	CC
Environmental/living conditions	5	CC
General history or its lack	4	CC
Credibility of referrer	4	E
Whether another agency able to help (including practical considerations)	4	E
Time constraints	4	E
Cultural aspects of case	1	CC
Agency's child protection agenda	1	E

FORMAL DEPARTMENTAL WRITTEN GUIDANCE COVERING ASSESSMENT AND THE RELATED AREAS OF PLANNING AND DECISION-MAKING

(AS PERTAINING DURING 1990, THE MAIN STUDY PERIOD)

Title of Guidance	*Year of Issue*
The Social History	1980
Guidelines for dealing with reception into care	1980
Mental Health Act 1983 — Procedures and practice for assessment / action if compulsory admission to hospital is necessary	1983
Assessment procedure re residential care for elderly people	1988
Social Workers (Elderly People) — operational policy	1988
Child protection procedures (including specific guidelines on assessment and planning)	1989
Planning for children in care	1990

LIST OF REFERENCES

Adcock, M. with Lake, R. and Small, A (1988) 'Assessing Children's Needs' in Aldgate, J. and Simmonds, J. (eds) *Direct Work With Children*, London, Batsford

Adcock, M. and White, R. (eds) (1985) *Good-Enough Parenting: A Framework for Assessment*, London, British Agencies for Adoption and Fostering

Alaszewski, A. and Manthorpe, J. (1991) 'Literature Review: Measuring and Managing Risk in Social Welfare', *British Journal of Social Work*, Vol. 21, pp. 277-290

Aldgate, P.J. (1977) *Identification of Factors Influencing Children's Length of Stay in Care*, unpublished PhD thesis, University of Edinburgh

Allan, G. (1991) 'Qualitative Research' in Allan, G. and Skinner, C. (eds) *Handbook for Research Students in the Social Sciences*, London, The Falmer Press

Anthony, E.J. (1976) 'How Children Cope in Families with a Psychotic Parent' in Rexford, E.N., Sander, L.W. and Shapiro, T. (eds) *Infant Psychiatry: A New Synthesis*, New Haven, Yale University Press

Anthony, E.J. (1983) 'An Overview of the Effects of Maternal Depression on the Infant and Child' in Morrison, H.L. (ed) *Children of Depressed Parents: Risk, Identification and Intervention*, New York, Grune & Stratton

Atkinson, R.L., Atkinson, R.C., Smith, E.E., Bem D.J., Nolen-Hoeksema, S. (1996) *Hilgard's Introduction to Psychology*, Fort Worth, Texas, Harcourt Brace

Barford, R. and Wattam, C. (1991) 'Children's Participation in Decision-Making', *Practice*, Vol. 5, No. 2, pp. 93-102

Barmby, P.J. (1991) 'In the Beginning: Initial Investigations of Non-Accidental Injury', *Practice*, Vol. 5, No. 4, pp. 265-273

Bauman, Z. (1992) *Intimations of Postmodernity*, London, Routledge

Beardslee, W.R., Bemporad, J., Keller, M.B. and Klerman, G.L. (1983) 'Children of Parents with Major Affective Disorder: A Review', *The American Journal of Psychiatry*, Vol. 140, No. 7, pp. 825-832

Beardslee, W.R., Keller, M.B., Seifer, R, Lavori, P.W., Staley, J., Podorefsky, D. and Shera, D. (1996) 'Prediction of Adolescent Affective Disorder: Effects of Prior Parental Affective Disorders and Child Psychopathology', *Journal of the American Academy of Child and Adolescent Psychiatry*, Vol. 35, No. 3, pp. 279-288

Belle, D. (ed) (1982) *Lives in Stress: Women and Depression*, Beverley Hills, California, Sage

Bettes, B.A. (1988) 'Maternal Depression and Motherese: Temporal and Intonational Features', *Child Development*, vol. 59, pp. 1089-1096

Billings, A.G. and Moos, R.H. (1983) 'Comparison of Children of Depressed and Non-Depressed Parents: A Social Environmental Perspective', *Journal of Abnormal Child Psychology*, vol. 11, pp. 483-486

Birtchnell, J. (1988) 'Depression and Family Relationships: The Study of Young, Married Women on a London Housing Estate', *British Journal of Psychiatry*, Vol. 153, pp. 758-769

Birtchnell, J., Masters, N. and Deahl, M. (1988) 'Depression and the Physical Environment: A Study of Young Married Women on a London Housing Estate', *British Journal of Psychiatry*, Vol. 153, pp. 56-64

Blackburn, I. (1987) *Coping with Depression*, Edinburgh, Chambers

Boyd, J.H. and Weissman, M.M. (1981) 'Epidemiology of Affective Disorders: A Re-examination of Future Directions', *Archives of General Psychiatry*, Vol. 38, pp. 1039-1046

Brearley, P. (1982) *Risk and Social Work*, London, Routledge and Kegan Paul

Breznitz, Z. and Sherman, T. (1987) 'Speech Patterning of Natural Discourse of Well and Depressed Mothers and their Young Children', *Child Development*, Vol. 58, pp. 395-400

Broad, B. and Fletcher, C. (eds) (1993) *Practitioner Social Work Research in Action*, London, Whiting and Birch

Broudy, H.S., Smith, B.O. and Burnett, J. (1964) *Democracy and Excellence in American Secondary Education*, Chicago, Illinois, Rand McNally

Brown, G.W. and Harris, T. (1978) *Social Origins of Depression — A Study of Psychiatric Disorder in Women*, London, Tavistock

Bryman, A. (1988) *Quantity and Quality in Social Research*, London, Routledge

Bullock, R., Hosie, K. and Millham, S. (1984) *Predicting Children's Length of Stay in Care and the Relevance of Family Links*, Bristol, University of Bristol, Dartington Social Research Unit

Burbach, D.J. and Borduin, C.M. (1986) 'Parent-Child Relationships and the Etiology of Depression: A Review of Methods and Findings', *Clinical Psychology Review*, Vol. 6, pp. 133-153

Butler, A. and Pritchard, C. (1983) *Social Work and Mental Illness*, London, Macmillan

Butler-Sloss, E. (1988) *Report of the Inquiry into Child Abuse in Cleveland 1987. Short Version Extracted from the Complete Text* (Cm 413), London, HMSO

Cadoret, R.J. (1983) 'Discussion' in Guze, S.B., Earls, F.J. and Varrett, J.E. (eds) *Child Psychopathology and Development*, New York, Raven Press

Cantwell, D.P. and Baker, L. (1984) 'Parental Mental Illness and Psychiatric Disorders in "At Risk" Children', *Journal of Clinical Psychiatry*, Vol. 43, pp. 503-507

Caplan, H.L., Cogill, S.R., Alexandra, H., Robson, K.M., Katz, R. and Kumar, R. (1989) 'Maternal Depression and the Emotional Development of the Child', *British Journal of Psychiatry*, Vol. 154, pp. 818-822

Carson, D. (1995) 'Calculated Risk', *Community Care*, 26 October, pp. 26-27

Cassell, P. (1993) *The Giddens Reader*, London, Macmillan

Central Council for Education and Training in Social Work (1995) *Assuring Quality in the Diploma in Social Work — 1: Rules and Requirements for the DipSW*, London, CCETSW

Children Act 1989

Clare, M. (1988) 'Supervision, Role Strain and Social Services Departments', *British Journal of Social Work*, Vol. 18, pp. 480-507

Cleaver, H. and Freeman, P. (1995) *Parental Perspectives in Cases of Suspected Child Abuse*, London, HMSO

Clegg, S. (1992/93) 'A Study of Usage of Section 1 Money in a Large City Social Services Department', *Practice*, Vol. 6, No. 2, pp. 87-101

Clifford, D. (1992/93) 'Towards an Anti-Oppressive Social Work Assessment Method', *Practice*, Vol. 6, No. 3, pp. 226-238

Cohler, B.J., Grunebaum, H.U., Weiss, J.L., Gamer, E. and Gallant, D.H. (1977) 'Disturbance of attention among schizophrenic, depressed and well mothers and their young children', *Journal of Child Psychology and Psychiatry*, Vol. 18, pp. 115-135

Cohler, B.J., Gallant, D.M., Grunebaum, H.U, Weiss, J.L. and Gamer E. (1980) 'Child Care Attitudes and Development of Young Children of Mentally Ill and Well Mothers', *Psychological Reports*, Vol. 46, pp. 31-46

Cohn, J.F., Campbell, S.B., Matias, R. and Hopkins, J. (1990) 'Face-to-Face Interactions of Postpartum Depressed and Nondepressed Mother-Infant Pairs at Two Months', *Developmental Psychology*, Vol. 26, pp. 15-23

Cohn, J., Matias, R., Tronik, E., Connell, D., and Lyons-Ruth, K. (1986) 'Face to Face Interactions of Depressed Mothers and Their Infants' in Tronik, E. and Field, T. (eds) *Maternal Depression and Infant Disturbance*, San Francisco, California, Jossey-Bass

Collins, P. (1990) *Black Feminist Thought*, Boston, Unwin Hyman

Colton, M., Drury, C. and Williams, M. (1995) 'Children in Need: Definition, Identification and Support', *British Journal of Social Work*, Vol. 25, No. 6, pp. 711-728

Cooper, J. (1989) 'From Casework to Community Care: 'The End is Where We Start From' (T.S. Eliot)', *British Journal of Social Work*, Vol. 19, pp. 177-188

Coulshed, V. (1991) *Social Work Practice: An Introduction*, London, Macmillan

Coyne, J., Kahn, J. and Gotlib, I. (1987) 'Depression' in Jacob, T. (ed) *Family Interaction and Psychopathology: Theories, Methods and Findings*, New York, Plenum Press

Cox, A.D., Puckering, C., Pound, A. and Mills, M. (1987) 'The Impact of Maternal Depression in Young Children', *Journal of Child Psychology and Psychiatry*, Vol. 28, No. 6, pp. 917-928

Cronbach, L.J., Ambron, S.R., Dornbusch, S., Hess, R.D., Hornik, R.C., Phillips, D.C., Walker, D.F. and Weiner, S.S. (1980) *Toward Reform of Program Evaluation*, San Francisco, California, Jossey-Bass

Cummings, E.M. and Davies, P.T. (1994) 'Maternal Depression and Child Development', *Journal of Child Psychology and Psychiatry*, Vol. 35, No. 1, pp. 73-112

Curnock, K. and Hardiker, P. (1979) *Towards Practice Theory: Skills and Methods in Social Assessments*, London, Routledge and Kegan Paul

Davenport, Y.B., Zahn-Waxler, C., Adland, M.L. and Mayfield, A. (1984) 'Early Child Rearing Practices in Families with a Manic-Depressive Parent', *American Journal of Psychiatry*, Vol. 141, pp. 230-235

Davies, M. (1994) *The Essential Social Worker: An Introduction to Professional Practice in the 1990s*, Aldershot, Arena

Day, P.R. (1994) 'Ambiguity and User Involvement: Issues Arising in Assessments for Young People and their Carers', *British Journal of Social Work*, Vol. 24, pp 577-596

DeChillo, N., Matorin, S. and Hallahan C. (1987) 'Children of Psychiatric Patients: Rarely Seen or Heard', *Health and Social Work*, Vol. 12, pp. 296-302

Department of Health (1988) *Protecting Children: A Guide for Social Workers undertaking a Comprehensive Assessment*, London, HMSO

Department of Health (1989) *An Introduction to The Children Act 1989*, London, HMSO

Department of Health (1990) *The Care of Children: Principles and Practice in Regulations and Guidance*, London, HMSO

Department of Health (1991) *Patterns & Outcomes in Child Placement: Messages from current research and their implications*, London, HMSO

Department of Health (1995) *Child Protection: Messages from Research*, London, HMSO

Department of Health and Social Security (1978) *Social Service Teams: The Practitioner's View*, London, HMSO

Department of Health and Social Security (1982) *Child Abuse: A Study of Inquiry Reports 1973-1981*, London, HMSO

Department of Health and Social Security (1985) *Social Work Decisions in Child Care: Recent Research Findings and their Implications*, London, HMSO

Department of Health and Social Security (1985a) *Review of Child Care Law*, London, HMSO

Department of Health and Social Security, Home Office, Lord Chancellor's Department, Department of Education and Science, Welsh Office, Scottish Office (1987) *The Law on Child Care and Family Service*, London, HMSO

Department of Health and Social Security and the Welsh Office (1988) *Working Together: A guide to arrangements for inter-agency co-operation for the protection of children from abuse*, London, HMSO

Dingwall, R. (1989) 'Some Problems about Predicting Child Abuse and Neglect' in Stevenson, O. (ed) *Child Abuse: Public Policy and Professional Practice*, Hemel Hempstead, Harvester Wheatsheaf

Dingwall, R. and Eekelaar, J. (1979) 'Social and Legal Perceptions of Child Neglect: Some Preliminary Considerations', *Child Abuse and Neglect*, Vol. 3, pp. 303-314

Dingwall, R., Eekelaar J. and Murray, T. (1983) *The Protection of Children*, Oxford, Blackwell

Dodge, K.A. (1990) 'Developmental Psychopathology in Children of Depressed Mothers', *Developmental Psychology*, Vol. 26, No. 1, pp. 306

Doel, M. and Lawson, B. (1986) 'Open Records: The Client's Right to Partnership', *British Journal of Social Work*, Vol. 16, pp. 407-430

Dominelli, L (1991) ' 'Race', Gender and Social Work' in Davies, M. (ed) *The Sociology of Social Work*, London, Routledge

Dominelli, L. (1996) 'Deprofessionalizing Social Work: Anti-Oppressive Practice, Competencies and Postmodernism', *British Journal of Social Work*, Vol. 26, No. 2, pp. 153-175

d'Orban, P.T. (1979) 'Women Who Kill Their Children', *British Journal of Psychiatry*, Vol. 134, pp. 560-571

Downey, G. and Coyne, J.C. (1990) 'Children of Depressed Parents: An Integrative Review', *Psychological Bulletin*, Vol. 108, No. 1, pp. 50-76

Downey, G. and Walker, E. (1989) 'Social Cognition and Adjustment in Children at Risk for Psychopathology', *Developmental Psychology*, Vol. 25, pp. 835-845

Earls, F. (1987) 'Annotation on the Familial Transmission of Child Psychiatric Disorder', *Journal of Child Psychology and Psychiatry*, Vol. 28, No. 6, pp. 791-802

Edwards, A. and Talbot, R. (1994) *The Hard-pressed Researcher: A Research Handbook for the Caring Professions*, London, Longman

Ekdahl, M., Rice, E. and Schmidt, W. (1962) 'Children of Parents Hospitalized for Mental Illness', *American Journal of Public Health*, Vol. 52, pp. 428-435

Ely, M. with Anzul, M., Friedman, T., Garner, D. and McCormack Steinmetz, A. (1991) *Doing Qualitative Research: Circles within Circles*, London, The Falmer Press

Emery, R., Weintraub, S. and Neale, J. (1982) 'Effects of Marital Discord on the School Behaviour of Children of Schizophrenic, Affective Disordered, and Normal Parents', *Journal of Abnormal Child Psychology*, Vol. 16, pp. 215-225

Eraut, M. (1985) 'Knowledge Creation and Knowledge Use in Professional Contexts', *Studies in Higher Education*, Vol. 10, No. 2, pp. 117-133

Eraut, M. (1994) *Developing Professional Knowledge and Competence*, London, The Falmer Press

Erlenmeyer Kimling, L., Wunsch-Hitzig, R.A. and Deutch, S. (1980) 'Family Formation by Schizophrenics' in Robins, L., Clayton, P. and Wing, J. *The Social Consequences of Psychiatric Illness*, New York, Brunner/Mazel

Everitt, A., Hardiker, P., Littlewood J. and Mullender A. (1992) *Applied Research for Better Practice*, London, Macmillan Press

Farmer, E. and Owen, M. (1995) *Child Protection Practice: Private Risks and Public Remedies — Decision Making, Intervention and Outcome in Child Protection Work*, London, HMSO

Feldman, R.A., Rubin Stiffman, A. and Jung, K.G. (1987) *Children at Risk: In the Web of Parental Mental Illness*, New Brunswick, Rutgers University Press

Field, T.M. (1987) 'Affective and Interactive Disturbances in Infants' in Osofsky, J.D. (ed) *Handbook of Infant Development*, New York, Wiley

Field, T., Healy, B., Goldstein, S. and Guthertz, M. (1990) 'Behavior-state Matching and Synchrony in Mother-Infant Interactions of Nondepressed vs. Depressed Dyads', *Developmental Psychology*, Vol. 26, pp. 7-14

Field, T.M., Healy, B., Goldstein, S., Perry, S., Bendell, D., Schanberg, S., Zimmerman, E.A. and Kuhn, C. (1988) 'Infants of Depressed Mothers Show "Depressed" Behaviour Even With Non-Depressed Adults', *Child Development*, vol. 59, pp. 1569-1579

Field, T., Sandberg, G., Garcia, R., Vega-Lahr, N., Goldstein, S. and Guy I. (1985) 'Prenatal Problems, Postpartum Depression, and Early Mother-Infant Interactions', *Developmental Psychology*, Vol. 12, pp. 1152-1156

Fisher, M. (1983) 'The Meaning of Client Satisfaction' in Fisher, M. (ed) *Speaking of Clients*, Sheffield, Joint Unit for Social Services Research at Sheffield University in collaboration with *Community Care*

Fisher, M. and Cohen, J. (1989-90) 'The Effectiveness of Mental Health Consultation with Area Social Work Teams', *Social Work and Social Sciences Review*, 1 (2), pp. 94-108

Fisher, M., Marsh, P. and Phillips, D. with Sainsbury, E. (1986) *In and Out of Care — The Experiences of Children, Parents and Social Workers*, London, Batsford

Fisher, M., Newton, C. and Sainsbury, E. (1984) *Mental Health Social Work Observed*, London, George Allen and Unwin

Ford, P. (1996) 'Competences: Their Use and Misuse' in Ford, P. and Hayes, P. (eds) *Educating for Social Work: Arguments for Optimism*, Aldershot, Avebury

Fox, S. and Dingwall, R. (1985) 'An Exploratory Study of Variations in Social Workers' and Health Visitors' Definitions of Child Mistreatment', *British Journal of Social Work*, Vol. 15, pp. 467-477

Frankel, K.A. and Harmon, R.J. (1996) 'Depressed Mothers: They Don't Always Look as Bad as They Feel', *Journal of the American Academy of Child and Adolescent Psychiatry*, Vol. 35, No. 3, pp. 289-298

Gadsby Waters, J. (1992) *The Supervision of Child Protection Work*, Aldershot, Avebury

Gardner, R. (1989) 'Consumer Views' in Kahan, B. (ed) *Child Care Research, Policy and Practice*, London, Hodder and Stoughton in association with the Open University

Garmezy, N. and Masten, A. (1991) 'The Protective Role of Competence Indicators in Children at Risk' in Cummings, E.M., Greene, A.L. and Karraker, K.K. (eds) *Life-span Developmental Psychology: Perspectives on Stress and Coping*, Hillsdale, New Jersey, Erlbaum

Gershon, E.S., Hamovit, J., Guroff, J., Dibble, E., Leckman, J.F., Sceery, W., Targum, S.D., Nurnberger, J., Goldin, L.R. and Bunney, W.E. (1982) 'A Family Study of Schizoaffective, Bipolar I, Bipolar II, Unipolar Probands and Normal Controls', *Archives of General Psychiatry*, Vol. 39, pp. 1157-1173

Gibbons, J., Conroy, S. and Bell, C. (1995) *Operating the Child Protection System: A Study of Child Protection Practices in English Local Authorities*, London, HMSO

Gibbons, J.S., Horn, S.H., Powell, J.M. and Gibbons, J.L. (1984) 'Schizophrenic Patients and Their Families: A Survey in a Psychiatric Service Based in a DGH Unit', *British Journal of Psychiatry*, Vol. 144, pp. 70-77

Gizynski, M.N. (1985) 'The Effects of Maternal Depression on Children', *Clinical Social Work Journal*, Vol. 13, No. 2, pp. 103-116

Glastonbury, B. (ed), Cooper, D.M. and Hawkins, P. (1980) *Social Work in Conflict: The Practitioner and the Bureaucrat*, London, Croon Helm

Goodman, S.H., Brogan, D., Lynch, M.E. and Fielding, B. (1993) 'Social and Emotional Competence in Children of Depressed Mothers', *Child Development*, Vol. 64, pp. 516-531

Goodman, S.H. and Brumley, H.E. (1990) 'Schizophrenic and Depressed Mothers: Relational Deficits in Parenting', *Developmental Psychology*, Vol. 26, No. 1, pp. 31-39

Goodman, S.H., Radke-Yarrow, M. and Teti, D. (1993) 'Maternal Depression as a Context for Child Rearing' *Zero to Three*, Vol. 13, No. 5, pp. 10-15

Gopfert, M., Webster, J., Pollard, J. and Nelki, J.S. (1996) 'The Assessment and Prediction of Parenting Capacity: A Community-oriented Approach' in Gopfert, M., Webster, J. and Seeman, M.V. (eds) *Parental Psychiatric Disorder: Distressed Parents and Their Families*, Cambridge, Cambridge University Press

Gordon, D., Burge, D., Hammen, C., Adrian, C., Jaenicke, C. and Hirito, D. (1989) 'Observations of Interactions of Depressed Women with their Children', *American Journal of Psychiatry*, Vol. 146, pp. 50-55

Gotlib, I.H. and Hooley, J.M. (1988) 'Depression and Marital Functioning: Current Status and Future Directions' in Duck, S. (ed) *Handbook of Personal Relationships: Theory, Research and Interventions*, Chichester, Wiley

Gough, D. (1993) *Child Abuse Interventions: A Review of the Research Literature*, London, HMSO

Graham, P. (1986) *Child Psychiatry: A Developmental Approach*, Oxford, Oxford University Press

Gutek, B.A. (1978) 'Strategies for Studying Client Satisfaction', *Journal of Social Issues*, Vol. 34, No. 4, pp. 44-56

Hammen, C., Gordon, D., Burge, D., Adrian, C., Jaenicke, C. and Hiroto, D. (1987) 'Maternal Affective Disorders, Illness, and Stress: Risk for Children's Psychopatholgy', *American Journal of Psychiatry*, Vol. 144, No. 6, pp. 736-741

Hardiker, P., Exton, K. and Barker, M. (1989) *Policies and Practices in Preventive Child Care*, Report to the Department of Health, Leicester, University of Leicester

Hardiker, P. Exton, K. and Barker, M. (1991) 'The Social Policy Contexts of Prevention in Child Care', *British Journal of Social Work*, Vol. 21, pp. 341-359

Hendry, E. and Lewis, P. (1990) 'Risk and Child Abuse', *Practice*, Vol. 4, No. 3, pp. 146-155

Higginson, S. (1989) 'Predicting Abuse', *Social Work Today*, 8 June, pp. 16-17

Hilgendorf, L. (1981) *Social Workers and Solicitors in Child Care Cases*, London, HMSO

Hill, M., Lambert, L., Triseliotis, J. and Buist, M. (1992) 'Making Judgements about Parenting: The Example of Freeing for Adoption', *British Journal of Social Work*, Vol. 22, pp. 373-389

Home Office, Department of Healtn, Department of Education and Science and the Welsh Office (1991) *Working Together Under the Children Act 1989: A guide to arrangements for inter-agency co-operation for the protection of children from abuse*, London, HMSO

Howe, D (1986) *Social Workers and their Practice in Welfare Bureaucracies*, Aldershot, Gower

Howe, D. (1991) 'Knowledge, Power and the Shape of Social Work Practice' in Davies, M. (ed) *The Sociology of Social Work*, London, Routledge

Howe, D. (1992) 'Child Abuse and the Bureaucratisation of Social Work', *The Sociological Review*, Vol. 40, No. 3, pp. 491-508

Hughes, B. (1993) 'A Model for the Comprehensive Assessment of Older People and Their Carers', *British Journal of Social Work*, Vol. 23, pp. 345-364

Hughes, L. and Pengelly, P. (1997) *Staff Supervision in a Turbulent Environment: Managing Process and Task in Front-Line Services*, London, Jessica Kingsley

Hugman, R. (1991) *Power in Caring Professions*, London, The Macmillan Press

Hugman, R. and Phillips, N. (1992/93) ' 'Like Bees Round the Honeypot': Social Work Responses to Parents with Mental Health Needs', *Practice*, Vol. 6, No. 3, pp. 193-205

Huxley, P. (1985) *Social Work Practice in Mental Health*, Aldershot, Gower

Huxley, P. and Fitzpatrick, R. (1984) 'The Probable Extent of Minor Mental Illness in the Adult Clients of Social Workers: A Research Note', *British Journal of Social Work*, Vol. 14, pp. 67-73

Huxley, P., Korer, J. and Tolley, S. (1987) 'The Psychiatric 'Caseness' of Clients Referred to an Urban Social Services Department', *British Journal of Social Work*, Vol. 17, pp. 507-520

Isaac, B.C., Minty, E.B. and Morrison, R.M. (1986) 'Children in Care: The Association with Mental Disorder in the Parents', *British Journal of Social Work*, Vol. 16, No. 3, pp. 325-339

Jaenicke, C., Hammen, C., Zupan, B., Hiroto, D., Gordon, D., Adrian, C. and Burge D. (1987) 'Cognitive Vulnerability in Children at Risk for Depression', *Journal of Abnormal Child Psychology*, Vol. 15, pp. 559-572

Janet, P. (1925) *Psychological Healing* (Vol. 1; E.C. Paul, Trans.), London, Allen and Unwin

Johnson, T.J. (1972) *Professions and Power*, London, Macmillan

Jones, C. (1996) 'Dangerous Times for British Social Work Education' in Ford, P. and Hayes, P. (eds) *Educating for Social Work: Arguments for Optimism*, Aldershot, Avebury

Jones, M. (1990) 'Understanding Social Work: A Matter of Interpretation', *British Journal of Social Work*, Vol. 20, pp. 183-187

Jones, R.M. (1996) *Mental Health Act Manual*, London, Sweet and Maxwell

Jordan, B. (1990) *Social Work in an Unjust Society*, Hemel Hempstead, Harvester Wheatsheaf

Kahan, B. (1989) 'Introduction' in Kahan, B. (ed) *Child Care Research, Policy and Practice*, London, Hodder and Stoughton in association with the Open University

Kashani, J.H., Shekim, W.O., Burk, J.P. and Beck, N.C. (1987) 'Abuse as a Predictor of Psychopathology in Children and Adolescents', *Journal of Clinical Child Psychology*, Vol. 16, No. 1, pp. 43-50

Kauffman, C., Grunebaum, H., Cohler, B. and Gamer, E. (1979) 'Superkids: Competent Children of Psychotic Mothers', *American Journal of Psychiatry*, Vol. 136, pp. 1398-1402

Keller, M., Beardslee, W., Dorer, D., Lavori, P., Samuelson, H. and Klerman, G. (1986) 'Impact of Severity and Chronicity of Parental Affective Illness on Adaptive Functioning and Psychopathology in Children', *Archives of General Psychiatry*, Vol. 43, pp. 930-937

Kelly, G. (1990) *Patterns of Care: Child Care Careers and the Patterns That Shape Them*, unpublished report for the DHSS (Northern Ireland), The Queen's University of Belfast, Department of Social Studies

Klein, D., Clark, D., Dansky, L. and Margolis, E.T. (1988) 'Dysthymia in the Offspring of Parents with Primary Unipolar Affective Disorder', *Journal of Abnormal Psychology*, vol. 94, pp. 115-127

Klein, D., Depue, R.A. and Slater, J.F. (1985) 'Cyclothymia in the Adolescent Offspring of Parents with Bipolar Affective Disorder', *Journal of Abnormal Psychology*, Vol. 94, pp. 115-127

Kochanska, G., Kuczynski, L., Radke-Yarrow, M., and Welsh, J.D. (1987) 'Resolution of Control Episodes between Well and Affectively Ill Mothers and their Young Children', *Journal of Abnormal Child Psychology*, Vol. 15, pp. 441-456

Kraeplin, E. (1921) *Manic-Depressive Insanity and Paranoia*, Edinburgh, Livingstone

Krueger, R.A. (1988) *Focus Groups: A Practical Guide for Applied Research*, London, Sage Publications

Langan, M. (1993) 'New Directions in Social Work' in Clarke J. (ed) *A Crisis in Care? Challenges to Social Work*, London, Sage Publications in association with The Open University

LaRoche, C. Chiefetz, P., Lester, E., Schibuk, L., DeTomasso, E. and Engelsmann, F. (1985) 'Psychopathology in the Offspring of Parents with Bipolar Affective Disorders', *Canadian Journal of Psychiatry*, Vol. 30, pp. 337-343

LaRoche, C., Sheiner, R., Lester, E., Benierakis, C., Marrache, M., Engelsmann, F. and Cheifetz, P. (1987) 'Children of Parents with Manic-Depressive Illness: A Follow-Up Study', *Canadian Journal of Psychiatry*, Vol. 32, No. 7, pp. 563-569

Lee, C.M. and Gotlib, I.H. (1989) 'Clinical Status and Emotional Adjustment of Children of Depressed Mothers', *American Journal of Psychiatry*, Vol. 146, No. 4, pp. 478-483

Lee, R.M. (1993) *Doing Research on Sensitive Topics*, London, Sage Publications

Leigh, D. (1991) *A Practical Approach to Group Training*, London, Kogan Page

Lishman, J. (ed) (1984) *Evaluation*, Research Highlights No. 8, University of Aberdeen

Lloyd, M. and Taylor, C. (1995) 'From Hollis to the Orange Book: Developing a Holistic Model of Social Work Assessment in the 1990s', *British Journal of Social Work*, Vol. 25, No. 6, pp. 691-710

Lyons-Ruth, K., Connell, D., Grunebaum, H., Botein, S. and Zoll, D. (1984) 'Maternal Family History, Maternal Caretaking, and Infant Attachment in Multiproblem Families', *Preventive Psychiatry*, Vol. 2, pp. 403-425

Lyons-Ruth, K., Zoll, D., Connell, D. and Grunebaum, H.U. (1986) 'The Depressed Mother and her One-Year-Old Infant: Environment, Interaction, Attachment and Infant Development' in Tronick, E. and Field T. (eds) *Maternal Depression and Infant Disturbance*, San Francisco, California, Jossey-Bass

Mandel, D.R., Lehman, D.R. and Yuille, J.C. (1994) 'Should This Child Be Removed From Home? Hypothesis Generation and Information Seeking as Predictors of Case Decisions', *Child Abuse and Neglect*, Vol. 18, No. 12, pp. 1051-1062

Margison, F.P. and Brockington, I. (1982) 'Psychiatric Mother and Baby Units' in Brockington, I. and Kumar, R. (eds) *Motherhood and Mental Illness*, London, Academic Press

Masson, J. (1992) 'Managing Risk Under the Children Act 1989: Diversion in Child Care?', *Child Abuse Review*, Vol. 1, pp. 103-122

Mednick, S.A., Schulsinger, F. and Griffith, J.J. (1981) 'Children of Schizophrenic Mothers: The Danish High Risk Study' in Schulsinger, F., Mednick, S.A. and Knop, J. (eds) *Longitudinal Research: Methods and Uses in Behavioural Science*, Boston, Martin Nijhoff Publishing

Mental Health Act 1993

Mies, M. (1983) 'Towards a Methodology for Feminist Research' in Bowles, G. and Klein, R. (eds) *Theories of Women's Studies*, London, Routledge and Kegan Paul

Middleton, L. (1997) *The Art of Assessment*, Birmingham, Venture Press

Millham, S., Bullock, R., Hosie, K. and Haak M. (Dartington Social Research Unit) (1986) *Lost in Care: The Problems of Maintaining Links between Children in Care and their Families*, Aldershot, Gower

Mind (1991) *Understanding Schizophrenia*, London, Mind (Mental Health Charity)

Mind (1995) *Mental Health Statistics*, London, Mind (Mental Health Charity)

Minty, B. (1995) 'Social Work's Five Deadly Sins', *Social Work & Social Sciences Review*, Vol. 6, No. 1, pp. 48-63

Mullender, A. and Ward, D. (1988) 'What is Practice-led Research into Groupwork?' in P. Wedge (ed) *Social Work — A Third Look at Research into Practice, Proceedings of the Third Annual JUC/BASW Conference held in London, September 1987*, Birmingham, BASW

Munk, B.D. (1993) 'Providing Integrated Treatment for Parent/Infant Dyads at Risk because of Parental Emotional and Mental Illness', *Zero to Three*, Vol. 13, No. 5, pp. 29-35

Munn-Giddings, C. (1993) ' "A Different Way of Knowing": Social Care Values, Practitioner Research and Action Research', *Educational Action Research*, Vol. 1, No. 2, pp. 275-285

Murray, L. (1992) 'The Impact of Postnatal Depression on Infant Development', *Journal of Child Psychology and Psychiatry*, Vol. 33, No. 3, pp. 543-561

National Health Service and Community Care Act 1990

O'Hara, M. (1986) 'Social Support, Life Events and Depression during Pregnancy and the Puerperium', *Archives of General Psychiatry*, Vol. 43, pp. 569-573

OPCS Surveys of Psychiatric Morbidity in Great Britain (1994) Bulletin No. 1: *The Prevalence of Psychiatric Morbidity Among Adults Aged 16-64 Living in Private Households in Great Britain*, OPCS

Orvaschel, H., Walsh-Allis, G. and Ye, W. (1988) 'Psychopathology in Children of Parents with Recurrent Depression', *Journal of Abnormal Child Psychology*, Vol. 16, No. 1, pp. 17-28

Packman, J. and Jordan, B. (1991) 'The Children Act: Looking Forward, Looking Back', *British Journal of Social Work*, Vol. 21, pp. 315-327

Packman, J., Randall, J. and Jacques, N. (1986) *Who Needs Care? Social Work Decisions about Children*, Oxford, Basil Blackwell

Paley, J. (1987) 'Social Work and the Sociology of Knowledge', *British Journal of Social Work*, Vol. 17, pp. 169-186

Panaccione, V. and Wahler, R. (1986) 'Child Behavior, Maternal Depression, and Social Coercion as Factors in the Quality of Child Care', *Journal of Abnormal Child Psychology*, Vol. 14, No. 2, pp. 263-278

Parsloe, P. (1986) 'What Skills Do Social Workers Need?' in Marshall, M., Preston-Shoot, M. and Wincott, E. (eds) *Skills for Social Workers in the 80s'*, Birmingham, British Association of Social Workers

Parton, C. and Parton, N., (1989) 'Child Protection, The Law and Dangerousness' in Stevenson, O. (ed) *Child Abuse: Public Policy and Professional Practice*, Hemel Hempstead, Harvester Wheatsheaf

Paykel, E.S. (1974) 'Recent Life Events and Clinical Depression' in Gunderson, E.K. and Rahe, R.H. (eds) *Life Stress and Illness*, Springfield, Illinois, Charles C. Thomas

Payne, M. (1996) *What is Professional Social Work?*, Birmingham, Venture Press

Pelligrini, D., Cosisky, S., Nackman, P., Cytryn, L., McKnew, D.H., Gershon, E, Hamovit, J. and Cammuso, K. (1986) 'Personal and Social Resources in Children of Patients with Bipolar Affective Disorders and Children of Normal Control Subjects', *American Journal of Psychiatry*, Vol. 143, pp. 860-861

Pelligrini, D.S., Masten, A., Garmezy, N. and Ferrarese, M.J. (1987) 'Correlates of Social and Academic Competence in Middle Childhood', *Journal of Child Psychology and Psychiatry*, Vol. 28, pp. 699-714

Petch, A. (1988) 'Answering Back: Parental Perspectives on the Children's Hearings Systems', *British Journal of Social Work*, Vol. 18, pp. 1-24

Phillips, D. (1983) 'Mayer and Timms Revisited: The Evolution of Client Studies' in Fisher, M. (ed) *Speaking of Clients*, Sheffield, Joint Unit for Social Services Research at Sheffield University in collaboration with *Community Care*

Phillips, E.M. and Pugh, D.S. (1987) *How To Get A PhD: Managing the Peaks and Troughs of Research*, Milton Keynes, Open University Press

Pilgrim, D. and Rogers, A. (1993) *A Sociology of Mental Health and Illness*, Buckingham, Open University Press

Pithouse, A. (1987) *Social Work: the Organisation of an Invisible Trade*, Aldershot, Avebury

Powell, J. (1995) 'Researching Social Work and Social Care Practices in *Understanding Social Research: Perspectives on Methodology and Practice*, Faculty of Social Sciences and Faculty of Educational Studies, University of Southampton

Powell, J. (1996) 'The Social Work Practitioner as Researcher: Learning about Research' in Ford, P. and Hayes, P. (eds) *Educating for Social Work: Arguments for Optimism*, Aldershot, Avebury

Preston-Shoot, M. and Agass, D. (1990) *Making Sense of Social Work: Psychodynamics, Systems and Practice*, Basingstoke, Macmillan Education

Puckering, C. (1989) 'Annotation: Maternal Depression', *Journal of Child Psychology and Psychiatry*, Vol. 30, No. 6, pp. 807-817

Radke-Yarrow, M., Cummings, E.M., Kuczynski, L. and Chapman, M. (1985) 'Patterns of Attachment in Two- and Three-Year-Olds in Normal Families and Families with Parental Depression', *Child Development*, Vol. 56, pp. 884-893

Radke-Yarrow, M., Richters, J. and Wilson, W.E. (1988) 'Child Development in the Network of Relationships' in Hinde, R.A. and Stevenson-Hinde, J. (eds) *Relationships within Families: Mutual Influences*, Oxford, Clarendon Press

Raymond, Y. (1989) 'Empowerment in Practice. Clients' Views to Seeing Records: themes emerging from twelve interviews with clients', *Practice*, Vol. 1, pp. 5-23

Read, J. and Baker, S. (1996) *Not Just Sticks and Stones: A Survey of the Stigma, Taboos and Discrimination Experienced by People with Mental Health Problems*, London, Mind (Mental Health Charity)

Reid, W.H. and Morrison, H.L. (1983) 'Risk Factors in Children of Depressed Parents' in Morrison, H.L. (ed) *Children of Depressed Parents: Risk, Identification and Intervention*, New York, Grune and Stratton

Rhodes, P. (1991) 'The Assessment of Black Foster Parents: The Relevance of Cultural Skills — Comparative Views of Social Workers and Applicants', *Critical Social Policy*, Vol. 11, No. 2, pp. 31-51

Rice, E.P., Ekdahl, M.C. and Miller, L. (1971) *Children of Mentally Ill Parents: Problems in Child Care*, New York, Behavioural Publications

Rist, R. (1984) 'On the Application of Qualitative Research to the Policy Process: An Emergent Link' in Barton, L. (ed) *Social Crisis and Educational Research*, London, Croon Helm

Ritchie, J. *et al* (1994) *Report of the Inquiry into the Care and Treatment of Christopher Clunis*, London, HMSO

Rowe, J., Cain, H., Hundleby, M. and Keane, A. (1984) *Long Term Foster Care*, London, Batsford/BAAF

Rushton, A. and Nathan, J. (1996) 'The Supervision of Child Protection Work', *British Journal of Social Work*, Vol. 26, No. 3, pp. 357-374

Rutter, M. (1966) *Children of Sick Parents: An Environmental and Psychiatric Study*, London, Oxford University Press

Rutter, M. (1989) 'Intergenerational Continuities and Discontinuities in Serious Parenting Difficulties' in Cicchetti, D. and Carlson, V. (eds) *Research on the Consequences of Child Maltreatment*, New York, Cambridge University Press

Rutter, M. (1990) 'Commentary: Some Focus and Process Considerations Regarding Effects of Parental Depression on Children', *Developmental Psychology*, Vol. 26, No. 1, pp. 60-67

Rutter, M. and Quinton, D. (1984) 'Parental Psychiatric Disorder: Effects on Children', *Psychological Medicine*, Vol. 14, pp. 853-880

Sainsbury, E. (1987) 'Client Studies: Their Contribution and Limitations in Influencing Social Work Practice', *British Journal of Social Work*, Vol. 17, pp. 635-644

Sameroff, A.J., Barocas, R., and Seifer, R. (1984) 'The Early Development of Children Born to Mentally Ill Women' in Watt, N., Anthony, E.J., Wynne, L. and Rolf, J. (eds) *Children at Risk for Schizophrenia*, New York, Cambridge University Press

Schön, D.A. (1983) *The Reflective Practitioner: How Professionals Think in Action*, Aldershot, Arena

Sharland, E., Jones, D., Aldgate, J., Seal, H. and Croucher, M. (1995) *Professional Intervention in Child Sexual Abuse*, London, HMSO

Shaw, I.F. (1984) 'Literature Review. Consumer Evaluations of the Personal Social Services', *British Journal of Social Work*, Vol. 14, pp. 277-284

Sheppard, M. (1990) *Mental Health: The Role of the Approved Social Worker*, Sheffield, Joint Unit for Social Services Research at Sheffield University in collaboration with *Community Care*

Sheppard, M. (1991/92) 'Client Satisfaction, Brief Intervention and Interpersonal Skills', *Social Work and Social Sciences Review*, Vol. 3, No. 2, pp. 124-149

Sheppard, M. (1993) 'Maternal Depression and Child Care: The Significance for Social Work and Social Work Research', *Adoption and Fostering*, Vol. 17, No. 2, pp. 10-16

Sheppard, M. (1994a) 'Maternal Depression, Child Care and the Social Work Role', *British Journal of Social Work*, Vol. 24, pp. 33-51

Sheppard, M. (1994b) 'Childcare, Social Support and Maternal Depression: A Review and Application of Findings', *British Journal of Social Work*, Vol. 24, No. 3, pp. 287-310

Sheppard, M. (1995) 'Social Work, Social Science and Practice Wisdom', *British Journal of Social Work*, Vol. 25, No. 3, pp. 265-293

Siddall, R. (1997) 'Who Pulls the Strings?', *Community Care*, 29 May, pp. 16-17

Silverman, D. (1993) *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*, London, Sage Publications

Silverman, M.D. (1989) 'Children of Psychiatrically Ill Parents: A Prevention Perspective', *Hospital and Community Psychiatry*, Vol. 40, No. 12, pp. 1257-1265

Simic, P. (1995) 'Help I Need Someone: Care Management and Family Carers of People with Mental Health Problems', *Practice*, Vol. 7, No. 2, pp. 23-34

Smale, G. and Tuson, G. with Biehal, N. and Marsh, P. (1993) *Empowerment, Assessment, Care Management and the Skilled Worker*, London, HMSO

Sobel, D.E. (1961) 'Children of Schizophrenic Patients: Preliminary Observations on Early Development', *American Journal of Psychiatry*, Vol. 118, pp. 512-517

Social Research Association (1992/3) *Social Research Association Ethical Guidelines*, Social Research Association, Directory of Members 1992/3 (quoted in Shakespeare, P., Atkinson, D. and French, S. (eds) (1993) *Reflecting on Research Practice: Issues in Health and Social Welfare*, Buckingham, Open University Press)

Social Services Inspectorate (1986) *Inspection of the Supervision of Social Workers in the Assessment and Monitoring of Cases of Child Abuse When Children, Subject to a Court Order, Have Been Returned Home*, Department of Health and Social Security

Social Services Inspectorate (1989) *A Sense of Direction: Planning in Social Work with Children. A Review of Social Services Inspectorate Reports*, Department of Health

Social Services Inspectorate (1996) *Children in Need: Report of an SSI Inspection of Social Services Departments' Family Support Services 1993/95*, Department of Health

Spieker, S.J. and Booth, C. (1988) 'Family Risk Typologies and Patterns of Insecure Attachment' in Belsky, J. and Nezworski, T. (eds) *Clinical Implications of Attachment*, Hillsdale, New Jersey, Erlbaum

Stein, A., Gath, D.H., Bucher, J., Bond, A., Day, A. and Cooper, P.J. (1991) 'The Relationship between Post-natal Depression and Mother-Child Interaction', *British Journal of Psychiatry*, Vol. 158, pp. 46-52

Stevenson, O. (1992) 'Social Work Intervention to Protect Children: Aspects of Research and Practice', *Child Abuse Review*, Vol. 1, pp. 19-32

Stiffman, A.R., Jung, K.G. and Feldman, R.A. (1986) 'A Multivariate Risk Model for Childhood Behavior Problems', *American Journal of Orthopsychiatry*, Vol. 56, pp. 204-211

Stock Whitaker, D. and Archer, J. L. (1989) *Research by Social Workers: Capitalizing on Experience*, London, Central Council for Education and Training in Social Work

Teti, D., Gelfand, D. and Messinger, D. (1992) 'Maternal Depression, Maternal Behaviour, and Security of Infant Attachment: Does Depression Make A Difference? in Campbell, S (Chair) *Maternal Depression, Parenting, and Young Children's Development: A Longitudinal Perspective*, Symposium conducted at the Annual General Meeting of the American Psychological Association, Washington, D.C.

Teti, D.M., Gelfand, D.M. and Pompa, J. (1990) 'Depressed Mothers Behavioural Competence with their Infants: Demographic and Psychosocial Correlates', *Development and Psychopathology*, Vol. 2, pp-259-270

Thoburn, J., Lewis, A. and Shemmings, D. (1995) *Paternalism or Partnership? Family Involvement in the Child Protection Process*, London, HMSO

Thomas, A. and Chess, S. (1984) 'Genesis and Evolution of Behavioural Disorders: From Infancy to Adult Life', *American Journal of Psychiatry*, Vol. 141, pp. 1-9

Thompson, D. (1993) *Mental Illness: The Fundamental Facts*, London, Mental Health Foundation

Trad, P.V. (1986) *Infant Depression, Paradigms and Paradoxes*, New York, Springer-Verlag

Tronik, E.Z. (1989) 'Emotions and Emotional Communication in Infants', *American Psychologist*, Vol. 44, pp. 112-119

Tronik, E.Z. and Giuanino, A.F. (1986) 'The Transmission of Maternal Disturbance to the Infant' in Tronik, E.Z. and Field, T. (eds) 'Maternal Depression and Infant Disturbance', *New Directions for Child Development*, Vol. 34, pp. 61-82

Tuson G. (1996) 'Writing Postmodern Social Work' in Ford, P. and Hayes, P. (eds) *Educating for Social Work: Arguments for Optimism*, Aldershot, Avebury

Utting, B. (1989) 'Foreword' in Kahan, B. (ed) *Child Care Research, Policy and Practice*, London, Hodder and Stoughton in association with the Open University

Vernon, J. and Fruin, D. (1986) *In Care: A Study of Social Work Decision Making*, London, National Children's Bureau

Waterhouse, L. and Carnie, J. (1992) 'Assessing Child Protection Risk', *British Journal of Social Work*, Vol. 22, pp. 47-60

Watt, N. (1984) 'In a Nutshell: The First Two Decades of High-Risk Research in Schizophrenia' in Watt, N., Anthony, E.J., Wynne, L. and Rolf, J. (eds) *Children at Risk for Schizophrenia*, New York, Cambridge University Press

Watt, N. Anthony, E.J., Wynne, L. and Rolf, J. (eds) (1984) *Children at Risk for Schizophrenia*, New York, Cambridge University Press

Webster, J. (1990) 'Parenting for Children with Schizophrenic Mothers', *Adoption and Fostering*, Vol. 14, No. 2, pp. 37-42

Webster, J. (1992) 'Split in Two: Experiences of the Children of Schizophrenic Mothers', *British Journal of Social Work*, Vol. 22, No. 3, pp. 309-329

Webster-Stratton, C. and Hammond, M. (1988) 'Maternal Depression and Its Relationship to Life Stress, Perceptions of Child Behaviour Problems, Parenting Behaviours, and Child Conduct Problems', *Journal of Abnormal Child Psychology*, Vol. 16, No. 3, pp. 299-315

Weintraub, S. (1987) 'Risk Factors in Schizophrenia: The Stony Brook High-Risk Project', *Schizophrenia Bulletin*, vol. 13, pp. 439-449

Weissman, M.M. (1983) 'The Depressed Mother and Her Rebellious Adolescent' in Morrison, H.L. (ed) *Children of Depressed Parents: Risk, Identification and Intervention*, New York, Grune and Stratton

Weissman, M. (1987) 'Advances in Psychiatric Epidemiology: Rates and Risks for Major Depression', *American Journal of Public Health*, Vol. 77, pp. 445-451

Weissman, M.M., Gammon, G.D., John, K., Merikangas, K.R, Warner, V., Prusoff, B.A. and Sholomskas, D. (1987) 'Children of Depressed Parents', *Archives of General Psychiatry*, Vol. 44, pp. 847-853

Weissman, M. and Paykel, E.S. (1974) *The Depressed Woman: A Study of Social Relationships*, Chicago, Illinois, University of Chicago Press

White, I. (1992) 'A Director's Perspective' in Gibbons, J. (ed) *The Children Act 1989 and Family Support: Principles into Practice*, London, HMSO

Williams, F. (1989) *Social Policy: A Critical Introduction*, London, Polity Press

Worrall, A. (1990) *Offending Women: Female Lawbreakers and the Criminal Justice System*, London, Routledge

Wynne, L., Cole, R. and Perkins, P. (1987) 'University of Rochester Child and Family Study: Risk Research in Progress', *Schizophrenia Bulletin*, Vol. 13, pp. 403-476

Yelloly, M. (1994) 'Professional Competence and Higher Education' in Yelloly, M. and Henkel, M. (eds) *Learning and Teaching in Social Work: Towards Reflective Practice*, London, Jessica Kingsley

Zajicek, E. and DeSalis, W. (1979) 'Depression in Mothers of Young Children', *Child Abuse and Neglect*, Vol. 3, pp. 833-835

BIBLIOGRAPHY

Adcock, M. with Lake, R. and Small, A (1988) 'Assessing Children's Needs' in Aldgate, J. and Simmonds, J. (eds) *Direct Work With Children*, London, Batsford

Adcock, M. and White, R. (eds) (1985) *Good-Enough Parenting: A Framework for Assessment*, London, British Agencies for Adoption and Fostering

Alaszewski, A. and Manthorpe, J. (1991) 'Literature Review: Measuring and Managing Risk in Social Welfare', *British Journal of Social Work*, Vol. 21, pp. 277-290

Aldgate, J. and Simmonds, J. (eds) (1988) *Direct Work With Children*, London, Batsford

Aldgate, P.J. (1977) *Identification of Factors Influencing Children's Length of Stay in Care*, unpublished PhD thesis, University of Edinburgh

Allan, G. (1991) 'Qualitative Research' in Allan, G. and Skinner, C. (eds) *Handbook for Research Students in the Social Sciences*, London, The Falmer Press

Allan, G. and Skinner, C. (eds) (1991) *Handbook for Research Students in the Social Sciences*, London, The Falmer Press

Anthony, E.J. (1976) 'How Children Cope in Families with a Psychotic Parent' in Rexford, E.N., Sander, L.W. and Shapiro, T. (eds) *Infant Psychiatry: A New Synthesis*, New Haven, Yale University Press

Anthony, E.J. (1983) 'An Overview of the Effects of Maternal Depression on the Infant and Child' in Morrison, H.L. (ed) *Children of Depressed Parents: Risk, Identification and Intervention*, New York, Grune & Stratton

Atkinson, R.L., Atkinson, R.C., Smith, E.E., Bem D.J., Nolen-Hoeksema, S. (1996) *Hilgard's Introduction to Psychology*, Fort Worth, Texas, Harcourt Brace

Bagley, C. (1988) 'Day Care, Maternal Mental Health and Child Development: Evidence from a Longitudinal Study', *Early Child Development and Care*, Vol. 39 (October), pp. 139-161

Barford, R. and Wattam, C. (1991) 'Children's Participation in Decision-Making', *Practice*, Vol. 5, No. 2, pp. 93-102

Barmby, P.J. (1991) 'In the Beginning: Initial Investigations of Non-Accidental Injury', *Practice*, Vol. 5, No. 4, pp. 265-273

Barton, L. (ed) (1984) *Social Crisis and Educational Research*, London, Croon Helm

Bauman, Z. (1992) *Intimations of Postmodernity*, London, Routledge

Beardslee, W.R., Bemporad, J., Keller, M.B. and Klerman, G.L. (1983) 'Children of Parents with Major Affective Disorder: A Review', *The American Journal of Psychiatry*, Vol. 140, No. 7, pp. 825-832

Beardslee, W.R., Keller, M.B., Seifer, R, Lavori, P.W., Staley, J., Podorefsky, D. and Shera, D. (1996) 'Prediction of Adolescent Affective Disorder: Effects of Prior Parental Affective Disorders and Child Psychopathology', *Journal of the American Academy of Child and Adolescent Psychiatry*, Vol. 35, No. 3, pp. 279-288

Belle, D. (ed) (1982) *Lives in Stress: Women and Depression*, Beverley Hills, California, Sage

Belsky, J. and Nezworski, T. (eds) (1988) *Clinical Implications of Attachment*, Hillsdale, New Jersey, Erlbaum

Bettes, B.A. (1988) 'Maternal Depression and Motherese: Temporal and Intonational Features', *Child Development*, vol. 59, pp. 1089-1096

Billings, A.G. and Moos, R.H. (1983) 'Comparison of Children of Depressed and Non-Depressed Parents: A Social Environmental Perspective', *Journal of Abnormal Child Psychology*, vol. 11, pp. 483-486

Birtchnell, J. (1988) 'Depression and Family Relationships: The Study of Young, Married Women on a London Housing Estate', *British Journal of Psychiatry*, Vol. 153, pp. 758-769

Birtchnell, J., Masters, N. and Deahl, M. (1988) 'Depression and the Physical Environment: A Study of Young Married Women on a London Housing Estate', *British Journal of Psychiatry*, Vol. 153, pp. 56-64

Blackburn, I. (1987) *Coping with Depression*, Edinburgh, Chambers

Bowles, G. and Klein, R. (eds) (1983) *Theories of Women's Studies*, London, Routledge and Kegan Paul

Boyd, J.H. and Weissman, M.M. (1981) 'Epidemiology of Affective Disorders: A Re-examination of Future Directions', *Archives of General Psychiatry*, Vol. 38, pp. 1039-1046

Brearley, P. (1982) *Risk and Social Work*, London, Routledge and Kegan Paul

Breznitz, Z. and Sherman, T. (1987) 'Speech Patterning of Natural Discourse of Well and Depressed Mothers and their Young Children', *Child Development*, Vol. 58, pp. 395-400

Broad, B. and Fletcher, C. (eds) (1993) *Practitioner Social Work Research in Action*, London, Whiting and Birch

Brockington, I. and Kumar, R. (eds) (1982) *Motherhood and Mental Illness*, London, Academic Press

Broudy, H.S., Smith, B.O. and Burnett, J. (1964) *Democracy and Excellence in American Secondary Education*, Chicago, Illinois, Rand McNally

Brown, G.W. and Harris, T. (1978) *Social Origins of Depression — A Study of Psychiatric Disorder in Women*, London, Tavistock

Bryman, A. (1988) *Quantity and Quality in Social Research*, London, Routledge

Bryman, A. and Burgess, R.G. (eds) (1994) *Analyzing Qualitative Data*, London, Routledge

Bullock, R., Hosie, K. and Millham, S. (1984) *Predicting Children's Length of Stay in Care and the Relevance of Family Links*, Bristol, University of Bristol, Dartington Social Research Unit

Burbach, D.J. and Borduin, C.M. (1986) 'Parent-Child Relationships and the Etiology of Depression: A Review of Methods and Findings', *Clinical Psychology Review*, Vol. 6, pp. 133-153

Burgess, R.G. (1984) *In the Field: an Introduction to Field Research*, London, George Allen and Unwin

Butler, A. and Pritchard, C. (1983) *Social Work and Mental Illness*, London, Macmillan

Butler-Sloss, E. (1988) *Report of the Inquiry into Child Abuse in Cleveland 1987. Short Version Extracted from the Complete Text* (Cm 413), London, HMSO

Cadoret, R.J. (1983) 'Discussion' in Guze, S.B., Earls, F.J. and Varrett, J.E. (eds) *Child Psychopathology and Development*, New York, Raven Press

Cantwell, D.P. and Baker, L. (1984) 'Parental Mental Illness and Psychiatric Disorders in "At Risk" Children', *Journal of Clinical Psychiatry*, Vol. 43, pp. 503-507

Caplan, H.L., Cogill, S.R., Alexandra, H., Robson, K.M., Katz, R. and Kumar, R. (1989) 'Maternal Depression and the Emotional Development of the Child', *British Journal of Psychiatry*, Vol. 154, pp. 818-822

Carson, D. (1995) 'Calculated Risk', *Community Care*, 26 October, pp. 26-27

Cassell, P. (1993) *The Giddens Reader*, London, Macmillan

Central Council for Education and Training in Social Work (1995) *Assuring Quality in the Diploma in Social Work — 1: Rules and Requirements for the DipSW*, London, CCETSW

Children Act 1989

Cicchetti, D. and Carlson, V. (eds) (1989) *Research on the Consequences of Child Maltreatment*, New York, Cambridge University Press

Clare, M. (1988) 'Supervision, Role Strain and Social Services Departments', *British Journal of Social Work*, Vol. 18, pp. 480-507

Clarke J. (ed) (1993) *A Crisis in Care? Challenges to Social Work*, London, Sage Publications in association with The Open University

Cleaver, H. and Freeman, P. (1995) *Parental Perspectives in Cases of Suspected Child Abuse*, London, HMSO

Clegg, S. (1992/93) 'A Study of Usage of Section 1 Money in a Large City Social Services Department', *Practice*, Vol. 6, No. 2, pp. 87-101

Clifford, D. (1992/93) 'Towards an Anti-Oppressive Social Work Assessment Method', *Practice*, Vol. 6, No. 3, pp. 226-238

Cohler, B.J., Grunebaum, H.U., Weiss, J.L., Gamer, E. and Gallant, D.H. (1977) 'Disturbance of attention among schizophrenic, depressed and well mothers and their young children', *Journal of Child Psychology and Psychiatry*, Vol. 18, pp. 115-135

Cohler, B.J., Gallant, D.M., Grunebaum, H.U, Weiss, J.L. and Gamer E. (1980) 'Child Care Attitudes and Development of Young Children of Mentally Ill and Well Mothers', *Psychological Reports*, Vol. 46, pp. 31-46

Cohn, J.F., Campbell, S.B., Matias, R. and Hopkins, J. (1990) 'Face-to-Face Interactions of Postpartum Depressed and Nondepressed Mother-Infant Pairs at Two Months', *Developmental Psychology*, Vol. 26, pp. 15-23

Cohn, J., Matias, R., Tronik, E., Connell, D., and Lyons-Ruth, K. (1986) 'Face to Face Interactions of Depressed Mothers and Their Infants' in Tronik, E. and Field, T. (eds) *Maternal Depression and Infant Disturbance*, San Francisco, California, Jossey-Bass

Collins, P. (1990) *Black Feminist Thought*, Boston, Unwin Hyman

Colton, M., Drury, C. and Williams, M. (1995) 'Children in Need: Definition, Identification and Support', *British Journal of Social Work*, Vol. 25, No. 6, pp. 711-728

Cooper, J. (1989) 'From Casework to Community Care: 'The End is Where We Start From' (T.S. Eliot)', *British Journal of Social Work*, Vol. 19, pp. 177-188

Coulshed, V. (1991) *Social Work Practice: An Introduction*, London, Macmillan

Coyne, J., Kahn, J. and Gotlib, I. (1987) 'Depression' in Jacob, T. (ed) *Family Interaction and Psychopathology: Theories, Methods and Findings*, New York, Plenum Press

Cox, A.D., Puckering, C., Pound, A. and Mills, M. (1987) 'The Impact of Maternal Depression in Young Children', *Journal of Child Psychology and Psychiatry*, Vol. 28, No. 6, pp. 917-928

Croft, S. and Beresford, P. (1990) *From Paternalism to Participation: Involving People in Social Services*, London, Open Services Project and Joseph Rowntree Foundation

Cronbach, L.J., Ambron, S.R., Dornbusch, S., Hess, R.D., Hornik, R.C., Phillips, D.C., Walker, D.F. and Weiner, S.S. (1980) *Toward Reform of Program Evaluation*, San Francisco, California, Jossey-Bass

Cummings, E.M. and Davies, P.T. (1994) 'Maternal Depression and Child Development', *Journal of Child Psychology and Psychiatry*, Vol. 35, No. 1, pp. 73-112

Cummings, E.M., Greene, A.L. and Karraker, K.K. (eds) (1991) *Life-span Developmental Psychology: Perspectives on Stress and Coping*, Hillsdale, New Jersey, Erlbaum

Curnock, K. and Hardiker, P. (1979) *Towards Practice Theory: Skills and Methods in Social Assessments*, London, Routledge and Kegan Paul

Davenport, Y.B., Zahn-Waxler, C., Adland, M.L. and Mayfield, A. (1984) 'Early Child Rearing Practices in Families with a Manic-Depressive Parent', *American Journal of Psychiatry*, Vol. 141, pp. 230-235

Davies, M. (1994) *The Essential Social Worker: An Introduction to Professional Practice in the 1990s*, Aldershot, Arena

Davies, M. (ed) (1991) *The Sociology of Social Work*, London, Routledge

Day, P.R. (1994) 'Ambiguity and User Involvement: Issues Arising in Assessments for Young People and their Carers', *British Journal of Social Work*, Vol. 24, pp 577-596

DeChillo, N., Matorin, S. and Hallahan C. (1987) 'Children of Psychiatric Patients: Rarely Seen or Heard', *Health and Social Work*, Vol. 12, pp. 296-302

Department of Health (1988) *Protecting Children: A Guide for Social Workers undertaking a Comprehensive Assessment*, London, HMSO

Department of Health (1989) *An Introduction to The Children Act 1989*, London, HMSO

Department of Health (1990) *The Care of Children: Principles and Practice in Regulations and Guidance*, London, HMSO

Department of Health (1991) *Patterns & Outcomes in Child Placement: Messages from current research and their implications*, London, HMSO

Department of Health (1995) *Child Protection: Messages from Research*, London, HMSO

Department of Health and Social Security (1978) *Social Service Teams: The Practitioner's View*, London, HMSO

Department of Health and Social Security (1982) *Child Abuse: A Study of Inquiry Reports 1973-1981*, London, HMSO

Department of Health and Social Security (1985) *Social Work Decisions in Child Care: Recent Research Findings and their Implications*, London, HMSO

Department of Health and Social Security (1985a) *Review of Child Care Law*, London, HMSO

Department of Health and Social Security, Home Office, Lord Chancellor's Department, Department of Education and Science, Welsh Office, Scottish Office (1987) *The Law on Child Care and Family Service*, London, HMSO

Department of Health and Social Security and the Welsh Office (1988) *Working Together: A guide to arrangements for inter-agency co-operation for the protection of children from abuse*, London, HMSO

Dingwall, R. (1989) 'Some Problems about Predicting Child Abuse and Neglect' in Stevenson, O. (ed) *Child Abuse: Public Policy and Professional Practice*, Hemel Hempstead, Harvester Wheatsheaf

Dingwall, R. and Eekelaar, J. (1979) 'Social and Legal Perceptions of Child Neglect: Some Preliminary Considerations', *Child Abuse and Neglect*, Vol. 3, pp. 303-314

Dingwall, R., Eekelaar J. and Murray, T. (1983) *The Protection of Children*, Oxford, Blackwell

Dodge, K.A. (1990) 'Developmental Psychopathology in Children of Depressed Mothers', *Developmental Psychology*, Vol. 26, No. 1, pp. 306

Doel, M. and Lawson, B. (1986) 'Open Records: The Client's Right to Partnership', *British Journal of Social Work*, Vol. 16, pp. 407-430

Dominelli, L (1991) ' 'Race', Gender and Social Work' in Davies, M. (ed) *The Sociology of Social Work*, London, Routledge

Dominelli, L. (1996) 'Deprofessionalizing Social Work: Anti-Oppressive Practice, Competencies and Postmodernism', *British Journal of Social Work*, Vol. 26, No. 2, pp. 153-175

d'Orban, P.T. (1979) 'Women Who Kill Their Children', *British Journal of Psychiatry*, Vol. 134, pp. 560-571

Downey, G. and Coyne, J.C. (1990) 'Children of Depressed Parents: An Integrative Review', *Psychological Bulletin*, Vol. 108, No. 1, pp. 50-76

Downey, G. and Walker, E. (1989) 'Social Cognition and Adjustment in Children at Risk for Psychopathology', *Developmental Psychology*, Vol. 25, pp. 835-845

Duck, S. (ed) (1988) *Handbook of Personal Relationships: Theory, Research and Interventions*, Chichester, Wiley

Earls, F. (1987) 'Annotation on the Familial Transmission of Child Psychiatric Disorder', *Journal of Child Psychology and Psychiatry*, Vol. 28, No. 6, pp. 791-802

Edwards, A. and Talbot, R. (1994) *The Hard-pressed Researcher: A Research Handbook for the Caring Professions*, London, Longman

Ekdahl, M., Rice, E. and Schmidt, W. (1962) 'Children of Parents Hospitalized for Mental Illness', *American Journal of Public Health*, Vol. 52, pp. 428-435

Ellis, K. (1993) *Squaring the Circle: User and Carer Participation in Needs Assessment*, York, Joseph Rowntree Foundation

Elrod, J. M. Jr. (1981) 'Improving Employee Relations with Focus Groups', *Business*, Vol. 31, Pt. 6, pp. 36-38

Ely, M. with Anzul, M., Friedman, T., Garner, D. and McCormack Steinmetz, A. (1991) *Doing Qualitative Research: Circles within Circles*, London, The Falmer Press

Emery, R., Weintraub, S. and Neale, J. (1982) 'Effects of Marital Discord on the School Behaviour of Children of Schizophrenic, Affective Disordered, and Normal Parents', *Journal of Abnormal Child Psychology*, Vol. 16, pp. 215-225

England, H. (1986) *Social Work as Art: Making Sense for Good Practice*, London, George Allen and Unwin

Eraut, M. (1985) 'Knowledge Creation and Knowledge Use in Professional Contexts', *Studies in Higher Education*, Vol. 10, No. 2, pp. 117-133

Eraut, M. (1994) *Developing Professional Knowledge and Competence*, London, The Falmer Press

Erlenmeyer Kimling, L., Wunsch-Hitzig, R.A. and Deutch, S. (1980) 'Family Formation by Schizophrenics' in Robins, L., Clayton, P. and Wing, J. *The Social Consequences of Psychiatric Illness*, New York, Brunner/Mazel

Everitt, A., Hardiker, P., Littlewood J. and Mullender A. (1992) *Applied Research for Better Practice*, London, Macmillan Press

Fahlberg, V. (1982) *Child Development*, London, British Agencies for Adoption and Fostering

Farmer, E. and Owen, M. (1995) *Child Protection Practice: Private Risks and Public Remedies — Decision Making, Intervention and Outcome in Child Protection Work*, London, HMSO

Feldman, R.A., Rubin Stiffman, A. and Jung, K.G. (1987) *Children at Risk: In the Web of Parental Mental Illness*, New Brunswick, Rutgers University Press

Field, T.M. (1987) 'Affective and Interactive Disturbances in Infants' in Osofsky, J.D. (ed) *Handbook of Infant Development*, New York, Wiley

Field, T., Healy, B., Goldstein, S. and Guthertz, M. (1990) 'Behavior-state Matching and Synchrony in Mother-Infant Interactions of Nondepressed vs. Depressed Dyads', *Developmental Psychology*, Vol. 26, pp. 7-14

Field, T.M., Healy, B., Goldstein, S., Perry, S., Bendell, D., Schanberg, S., Zimmerman, E.A. and Kuhn, C. (1988) 'Infants of Depressed Mothers Show "Depressed" Behaviour Even With Non-Depressed Adults', *Child Development*, vol. 59, pp. 1569-1579

Field, T., Sandberg, G., Garcia, R., Vega-Lahr, N., Goldstein, S. and Guy I. (1985) 'Prenatal Problems, Postpartum Depression, and Early Mother-Infant Interactions', *Developmental Psychology*, Vol. 12, pp. 1152-1156

Fisher, M. (ed) (1983) *Speaking of Clients*, Sheffield, Joint Unit for Social Services Research at Sheffield University in collaboration with *Community Care*

Fisher, M. (1983) 'The Meaning of Client Satisfaction' in Fisher, M. (ed) *Speaking of Clients*, Sheffield, Joint Unit for Social Services Research at Sheffield University in collaboration with *Community Care*

Fisher, M. and Cohen, J. (1989-90) 'The Effectiveness of Mental Health Consultation with Area Social Work Teams', *Social Work and Social Sciences Review*, 1 (2), pp. 94-108

Fisher, M., Marsh, P. and Phillips, D. with Sainsbury, E. (1986) *In and Out of Care — The Experiences of Children, Parents and Social Workers*, London, Batsford

Fisher, M., Newton, C. and Sainsbury, E. (1984) *Mental Health Social Work Observed*, London, George Allen and Unwin

Ford, P. (1996) 'Competences: Their Use and Misuse' in Ford, P. and Hayes, P. (eds) *Educating for Social Work: Arguments for Optimism*, Aldershot, Avebury

Ford, P. and Hayes, P. (eds) (1996) *Educating for Social Work: Arguments for Optimism*, Aldershot, Avebury

Fox, S. and Dingwall, R. (1985) 'An Exploratory Study of Variations in Social Workers' and Health Visitors' Definitions of Child Mistreatment', *British Journal of Social Work*, Vol. 15, pp. 467-477

Frankel, K.A. and Harmon, R.J. (1996) 'Depressed Mothers: They Don't Always Look as Bad as They Feel', *Journal of the American Academy of Child and Adolescent Psychiatry*, Vol. 35, No. 3, pp. 289-298

Gadsby Waters, J. (1992) *The Supervision of Child Protection Work*, Aldershot, Avebury

Gardner, R. (1989) 'Consumer Views' in Kahan, B. (ed) *Child Care Research, Policy and Practice*, London, Hodder and Stoughton in association with the Open University

Garmezy, N. and Masten, A. (1991) 'The Protective Role of Competence Indicators in Children at Risk' in Cummings, E.M., Greene, A.L. and Karraker, K.K. (eds) *Life-span Developmental Psychology: Perspectives on Stress and Coping*, Hillsdale, New Jersey, Erlbaum

Gershon, E.S., Hamovit, J., Guroff, J., Dibble, E., Leckman, J.F., Sceery, W., Targum, S.D., Nurnberger, J., Goldin, L.R. and Bunney, W.E. (1982) 'A Family Study of Schizoaffective, Bipolar I, Bipolar II, Unipolar Probands and Normal Controls', *Archives of General Psychiatry*, Vol. 39, pp. 1157-1173

Gibbons, J. (ed) (1992) *The Children Act 1989 and Family Support: Principles into Practice*, London, HMSO

Gibbons, J., Conroy, S. and Bell, C. (1995) *Operating the Child Protection System: A Study of Child Protection Practices in English Local Authorities*, London, HMSO

Gibbons, J.S., Horn, S.H., Powell, J.M. and Gibbons, J.L. (1984) 'Schizophrenic Patients and Their Families: A Survey in a Psychiatric Service Based in a DGH Unit', *British Journal of Psychiatry*, Vol. 144, pp. 70-77

Gizynski, M.N. (1985) 'The Effects of Maternal Depression on Children', *Clinical Social Work Journal*, Vol. 13, No. 2, pp. 103-116

Glastonbury, B. (ed), Cooper, D.M. and Hawkins, P. (1980) *Social Work in Conflict: The Practitioner and the Bureaucrat*, London, Croon Helm

Goodman, S.H., Brogan, D., Lynch, M.E. and Fielding, B. (1993) 'Social and Emotional Competence in Children of Depressed Mothers', *Child Development*, Vol. 64, pp. 516-531

Goodman, S.H. and Brumley, H.E. (1990) 'Schizophrenic and Depressed Mothers: Relational Deficits in Parenting', *Developmental Psychology*, Vol. 26, No. 1, pp. 31-39

Goodman, S.H., Radke-Yarrow, M. and Teti, D. (1993) 'Maternal Depression as a Context for Child Rearing' *Zero to Three*, Vol. 13, No. 5, pp. 10-15

Gopfert, M., Webster, J., Pollard, J. and Nelki, J.S. (1996) 'The Assessment and Prediction of Parenting Capacity: A Community-oriented Approach' in Gopfert, M., Webster, J. and Seeman, M.V. (eds) *Parental Psychiatric Disorder: Distressed Parents and Their Families*, Cambridge, Cambridge University Press

Gopfert, M., Webster, J. and Seeman, M.V. (eds) (1996) *Parental Psychiatric Disorder: Distressed Parents and Their Families*, Cambridge, Cambridge University Press

Gordon, D., Burge, D., Hammen, C., Adrian, C., Jaenicke, C. and Hirito, D. (1989) 'Observations of Interactions of Depressed Women with their Children', *American Journal of Psychiatry*, Vol. 146, pp. 50-55

Gotlib, I.H. and Hooley, J.M. (1988) 'Depression and Marital Functioning: Current Status and Future Directions' in Duck, S. (ed) *Handbook of Personal Relationships: Theory, Research and Interventions*, Chichester, Wiley

Gough, D. (1993) *Child Abuse Interventions: A Review of the Research Literature*, London, HMSO

Graham, P. (1986) *Child Psychiatry: A Developmental Approach*, Oxford, Oxford University Press

Gunderson, E.K. and Rahe, R.H. (eds) (1974) *Life Stress and Illness*, Springfield, Illinois, Charles C. Thomas

Gutek, B.A. (1978) 'Strategies for Studying Client Satisfaction', *Journal of Social Issues*, Vol. 34, No. 4, pp. 44-56

Guze, S.B., Earls, F.J. and Varrett, J.E. (eds) (1983) *Child Psychopathology and Development*, New York, Raven Press

Hammen, C., Gordon, D., Burge, D., Adrian, C., Jaenicke, C. and Hiroto, D. (1987) 'Maternal Affective Disorders, Illness, and Stress: Risk for Children's Psychopatholgy', *American Journal of Psychiatry*, Vol. 144, No. 6, pp. 736-741

Hardiker, P. and Curnock, K. (1984) 'Social Work Assessment Processes in Work with Ethnic Minorities — the Doshi Family', *British Journal of Social Work*, Vol. 14, pp. 23-47

Hardiker, P., Exton, K. and Barker, M. (1989) *Policies and Practices in Preventive Child Care*, Report to the Department of Health, Leicester, University of Leicester

Hardiker, P. Exton, K. and Barker, M. (1991) 'The Social Policy Contexts of Prevention in Child Care', *British Journal of Social Work*, Vol. 21, pp. 341-359

Hendry, E. and Lewis, P. (1990) 'Risk and Child Abuse', *Practice*, Vol. 4, No. 3, pp. 146-155

Higginson, S. (1989) 'Predicting Abuse', *Social Work Today*, 8 June, pp. 16-17

Hilgendorf, L. (1981) *Social Workers and Solicitors in Child Care Cases*, London, HMSO

Hill, M., Lambert, L., Triseliotis, J. and Buist, M. (1992) 'Making Judgements about Parenting: The Example of Freeing for Adoption', *British Journal of Social Work*, Vol. 22, pp. 373-389

Hinde, R.A. and Stevenson-Hinde, J. (eds) (1988) *Relationships within Families: Mutual Influences*, Oxford, Clarendon Press

Home Office, Department of Health, Department of Education and Science and the Welsh Office (1991) *Working Together Under the Children Act 1989: A guide to arrangements for inter-agency co-operation for the protection of children from abuse*, London, HMSO

Howe, D (1986) *Social Workers and their Practice in Welfare Bureaucracies*, Aldershot, Gower

Howe, D. (1991) 'Knowledge, Power and the Shape of Social Work Practice' in Davies, M. (ed) *The Sociology of Social Work*, London, Routledge

Howe, D. (1992) 'Child Abuse and the Bureaucratisation of Social Work', *The Sociological Review*, Vol. 40, No. 3, pp. 491-508

Hughes, B. (1993) 'A Model for the Comprehensive Assessment of Older People and Their Carers', *British Journal of Social Work*, Vol. 23, pp. 345-364

Hughes, L. and Pengelly, P. (1997) *Staff Supervision in a Turbulent Environment: Managing Process and Task in Front-Line Services*, London, Jessica Kingsley

Hugman, R. (1991) *Power in Caring Professions*, London, The Macmillan Press

Hugman, R. and Phillips, N. (1992/93) ' 'Like Bees Round the Honeypot': Social Work Responses to Parents with Mental Health Needs', *Practice*, Vol. 6, No. 3, pp. 193-205

Humphries, S. (1984) *The Handbook of Oral History: Recording Life Stories*, Interaction Trust

Huxley, P. (1985) *Social Work Practice in Mental Health*, Aldershot, Gower

Huxley, P. and Fitzpatrick, R. (1984) 'The Probable Extent of Minor Mental Illness in the Adult Clients of Social Workers: A Research Note', *British Journal of Social Work*, Vol. 14, pp. 67-73

Huxley, P., Korer, J. and Tolley, S. (1987) 'The Psychiatric 'Caseness' of Clients Referred to an Urban Social Services Department', *British Journal of Social Work*, Vol. 17, pp. 507-520

Isaac, B.C. (1984) *The Relationship between Mental Disorder in the Parents and the Length of Stay of Children 'in Care'*, unpublished MSc thesis, Faculty of Medicine, University of Manchester

Isaac, B.C., Minty, E.B. and Morrison, R.M. (1986) 'Children in Care: The Association with Mental Disorder in the Parents', *British Journal of Social Work*, Vol. 16, No. 3, pp. 325 - 339

Jacob, T. (ed) (1987) *Family Interaction and Psychopathology: Theories, Methods and Findings*, New York, Plenum Press

Jaenicke, C., Hammen, C., Zupan, B., Hiroto, D., Gordon, D., Adrian, C. and Burge D. (1987) 'Cognitive Vulnerability in Children at Risk for Depression', *Journal of Abnormal Child Psychology*, Vol. 15, pp. 559-572

Janet, P. (1925) *Psychological Healing* (Vol. 1; E.C. Paul, Trans.), London, Allen and Unwin

Johnson, T.J. (1972) *Professions and Power*, London, Macmillan

Jones, C. (1996) 'Dangerous Times for British Social Work Education' in Ford, P. and Hayes, P. (eds) *Educating for Social Work: Arguments for Optimism*, Aldershot, Avebury

Jones, M. (1990) 'Understanding Social Work: A Matter of Interpretation', *British Journal of Social Work*, Vol. 20, pp. 183-187

Jones, R.M. (1996) *Mental Health Act Manual*, London, Sweet and Maxwell

Jordan, B. (1990) *Social Work in an Unjust Society*, Hemel Hempstead, Harvester Wheatsheaf

Kahan, B. (ed) (1989) *Child Care Research, Policy and Practice*, London, Hodder and Stoughton in association witn the Open University

Kahan, B. (1989) 'Introduction' in Kahan, B. (ed) *Child Care Research, Policy and Practice*, London, Hodder and Stoughton in association with the Open University

Kashani, J.H., Shekim, W.O., Burk, J.P. and Beck, N.C. (1987) 'Abuse as a Predictor of Psychopathology in Children and Adolescents', *Journal of Clinical Child Psychology*, Vol. 16, No. 1, pp. 43-50

Kauffman, C., Grunebaum, H., Cohler, B. and Gamer, E. (1979) 'Superkids: Competent Children of Psychotic Mothers', *American Journal of Psychiatry*, Vol. 136, pp. 1398-1402

Keller, M., Beardslee, W., Dorer, D., Lavori, P., Samuelson, H. and Klerman, G. (1986) 'Impact of Severity and Chronicity of Parental Affective Illness on Adaptive Functioning and Psychopathology in Children', *Archives of General Psychiatry*, Vol. 43, pp. 930-937

Kelly, G. (1990) *Patterns of Care: Child Care Careers and the Patterns That Shape Them*, unpublished report for the DHSS (Northern Ireland), The Queen's University of Belfast, Department of Social Studies

Klein, D., Clark, D., Dansky, L. and Margolis, E.T. (1988) 'Dysthymia in the Offspring of Parents with Primary Unipolar Affective Disorder', *Journal of Abnormal Psychology*, vol. 94, pp. 115-127

Klein, D., Depue, R.A. and Slater, J.F. (1985) 'Cyclothymia in the Adolescent Offspring of Parents with Bipolar Affective Disorder', *Journal of Abnormal Psychology*, Vol. 94, pp. 115-127

Kochanska, G., Kuczynski, L., Radke-Yarrow, M., and Welsh, J.D. (1987) 'Resolution of Control Episodes between Well and Affectively Ill Mothers and their Young Children', *Journal of Abnormal Child Psychology*, Vol. 15, pp. 441-456

Kraeplin, E. (1921) *Manic-Depressive Insanity and Paranoia*, Edinburgh, Livingstone

Krueger, R.A. (1988) *Focus Groups: A Practical Guide for Applied Research*, London, Sage Publications

Langan, M. (1993) 'New Directions in Social Work' in Clarke J. (ed) *A Crisis in Care? Challenges to Social Work*, London, Sage Publications in association with The Open University

LaRoche, C. Chiefetz, P., Lester, E., Schibuk, L., DeTomasso, E. and Engelsmann, F. (1985) 'Psychopathology in the Offspring of Parents with Bipolar Affective Disorders', *Canadian Journal of Psychiatry*, Vol. 30, pp. 337-343

LaRoche, C., Sheiner, R., Lester, E., Benierakis, C., Marrache, M., Engelsmann, F. and Cheifetz, P. (1987) 'Children of Parents with Manic-Depressive Illness: A Follow-Up Study', *Canadian Journal of Psychiatry*, Vol. 32, No. 7, pp. 563-569

Lee, C.M. and Gotlib, I.H. (1989) 'Clinical Status and Emotional Adjustment of Children of Depressed Mothers', *American Journal of Psychiatry*, Vol. 146, No. 4, pp. 478-483

Lee, R.M. (1993) *Doing Research on Sensitive Topics*, London, Sage Publications

Leigh, D. (1991) *A Practical Approach to Group Training*, London, Kogan Page

Lishman, J. (ed) (1984) *Evaluation*, Research Highlights No. 8, University of Aberdeen

Lloyd, M. and Taylor, C. (1995) 'From Hollis to the Orange Book: Developing a Holistic Model of Social Work Assessment in the 1990s', *British Journal of Social Work*, Vol. 25, No. 6, pp. 691-710

Lyons-Ruth, K., Connell, D., Grunebaum, H., Botein, S. and Zoll, D. (1984) 'Maternal Family History, Maternal Caretaking, and Infant Attachment in Multiproblem Families', *Preventive Psychiatry*, Vol. 2, pp. 403-425

Lyons-Ruth, K., Zoll, D., Connell, D. and Grunebaum, H.U. (1986) 'The Depressed Mother and her One-Year-Old Infant: Environment, Interaction, Attachment and Infant Development' in Tronick, E. and Field T. (eds) *Maternal Depression and Infant Disturbance*, San Francisco, California, Jossey-Bass

Maitland, P. and Nickalls, J. (1985) *Questionnaire Design in the Probation Service: A Beginners Guide*, London, Inner London Probation Service/Avon Probation Service

Mandel, D.R., Lehman, D.R. and Yuille, J.C. (1994) 'Should This Child Be Removed From Home? Hypothesis Generation and Information Seeking as Predictors of Case Decisions', *Child Abuse and Neglect*, Vol. 18, No. 12, pp. 1051-1062

Margison, F.P. and Brockington, I. (1982) 'Psychiatric Mother and Baby Units' in Brockington, I. and Kumar, R. (eds) *Motherhood and Mental Illness*, London, Academic Press

Marshall, M., Preston-Shoot, M. and Wincott, E. (eds) (1986) *Skills for Social Workers in the 80s'*, Birmingham, British Association of Social Workers

Masson, J. (1992) 'Managing Risk Under the Children Act 1989: Diversion in Child Care?', *Child Abuse Review*, Vol. 1, pp. 103-122

Mayer, J.E. and Timms, N. (1970) *The Client Speaks: Working Class Impressions of Casework*, London, Routledge and Kegan Paul

Mednick, S.A., Schulsinger, F. and Griffith, J.J. (1981) 'Children of Schizophrenic Mothers: The Danish High Risk Study' in Schulsinger, F., Mednick, S.A. and Knop, J. (eds) *Longitudinal Research: Methods and Uses in Behavioural Science*, Boston, Martin Nijhoff Publishing

Mental Health Act 1993

Mies, M. (1983) 'Towards a Methodology for Feminist Research' in Bowles, G. and Klein, R. (eds) *Theories of Women's Studies*, London, Routledge and Kegan Paul

Middleton, L. (1997) *The Art of Assessment*, Birmingham, Venture Press

Millham, S., Bullock, R., Hosie, K. and Haak M. (Dartington Social Research Unit) (1986) *Lost in Care: The Problems of Maintaining Links between Children in Care and their Families*, Aldershot, Gower

Mind (1991) *Understanding Schizophrenia*, London, Mind (Mental Health Charity)

Mind (1995) *Mental Health Statistics*, London, Mind (Mental Health Charity)

Minty, B. (1995) 'Social Work's Five Deadly Sins', *Social Work & Social Sciences Review*, Vol. 6, No. 1, pp. 48-63

Morgan, D.L. (1988) *Focus Groups as Qualitative Research*, London, Sage Publications

Morrison, H.L. (ed) (1983) *Children of Depressed Parents: Risk, Identification and Intervention*, New York, Grune and Stratton

Mullender, A. and Ward, D. (1988) 'What is Practice-led Research into Groupwork?' in P. Wedge (ed) *Social Work — A Third Look at Research into Practice, Proceedings of the Third Annual JUC/BASW Conference held in London, September 1987*, Birmingham, BASW

Munk, B.D. (1993) 'Providing Integrated Treatment for Parent/Infant Dyads at Risk because of Parental Emotional and Mental Illness', *Zero to Three*, Vol. 13, No. 5, pp. 29-35

Munn-Giddings, C. (1993) ' "A Different Way of Knowing": Social Care Values, Practitioner Research and Action Research', *Educational Action Research*, Vol. 1, No. 2, pp. 275-285

Murray, L. (1992) 'The Impact of Postnatal Depression on Infant Development', *Journal of Child Psychology and Psychiatry*, Vol. 33, No. 3, pp. 543-561

National Health Service and Community Care Act 1990

O'Hara, M. (1986) 'Social Support, Life Events and Depression during Pregnancy and the Puerperium', *Archives of General Psychiatry*, Vol. 43, pp. 569-573

OPCS Surveys of Psychiatric Morbidity in Great Britain (1994) Bulletin No. 1: *The Prevalence of Psychiatric Morbidity Among Adults Aged 16-64 Living in Private Households in Great Britain*, OPCS

Orvaschel, H., Walsh-Allis, G. and Ye, W. (1988) 'Psychopathology in Children of Parents with Recurrent Depression', *Journal of Abnormal Child Psychology*, Vol. 16, No. 1, pp. 17-28

Osofsky, J.D. (ed) (1987) *Handbook of Infant Development*, New York, Wiley

Packman, J. and Jordan, B. (1991) 'The Children Act: Looking Forward, Looking Back', *British Journal of Social Work*, Vol. 21, pp. 315-327

Packman, J., Randall, J. and Jacques, N. (1986) *Who Needs Care? Social Work Decisions about Children*, Oxford, Basil Blackwell

Paley, J. (1987) 'Social Work and the Sociology of Knowledge', *British Journal of Social Work*, Vol. 17, pp. 169-186

Panaccione, V. and Wahler, R. (1986) 'Child Behavior, Maternal Depression, and Social Coercion as Factors in the Quality of Child Care', *Journal of Abnormal Child Psychology*, Vol. 14, No. 2, pp. 263-278

Parry, G. and Watts, F.N. (eds) (1989) *Behavioural and Mental Health Research: A Handbook of Skills and Methods*, Hove, Lawrence Erlbaum

Parsloe, P. (1986) 'What Skills Do Social Workers Need?' in Marshall, M., Preston-Shoot, M. and Wincott, E. (eds) *Skills for Social Workers in the 80s'*, Birmingham, British Association of Social Workers

Parton, C. and Parton, N., (1989) 'Child Protection, The Law and Dangerousness' in Stevenson, O. (ed) *Child Abuse: Public Policy and Professional Practice*, Hemel Hempstead, Harvester Wheatsheaf

Paykel, E.S. (1974) 'Recent Life Events and Clinical Depression' in Gunderson, E.K. and Rahe, R.H. (eds) *Life Stress and Illness*, Springfield, Illinois, Charles C. Thomas

Payne, M. (1996) *What is Professional Social Work?*, Birmingham, Venture Press

Pelligrini, D., Cosisky, S., Nackman, P., Cytryn, L., McKnew, D.H., Gershon, E, Hamovit, J. and Cammuso, K. (1986) 'Personal and Social Resources in Children of Patients with Bipolar Affective Disorders and Children of Normal Control Subjects', *American Journal of Psychiatry*, Vol. 143, pp. 860-861

Pelligrini, D.S., Masten, A., Garmezy, N. and Ferrarese, M.J. (1987) 'Correlates of Social and Academic Competence in Middle Childhood', *Journal of Child Psychology and Psychiatry*, Vol. 28, pp. 699-714

Petch, A. (1988) 'Answering Back: Parental Perspectives on the Children's Hearings Systems', *British Journal of Social Work*, Vol. 18, pp. 1-24

Phillips, D. (1983) 'Mayer and Timms Revisited: The Evolution of Client Studies' in Fisher, M. (ed) *Speaking of Clients*, Sheffield, Joint Unit for Social Services Research at Sheffield University in collaboration with *Community Care*

Phillips, E.M. and Pugh, D.S. (1987) *How To Get A PhD: Managing the Peaks and Troughs of Research*, Milton Keynes, Open University Press

Pilgrim, D. and Rogers, A. (1993) *A Sociology of Mental Health and Illness*, Buckingham, Open University Press

Pithouse, A. (1987) *Social Work: the Organisation of an Invisible Trade*, Aldershot, Avebury

Powell, J. (1995) 'Researching Social Work and Social Care Practices in *Understanding Social Research: Perspectives on Methodology and Practice*, Faculty of Social Sciences and Faculty of Educational Studies, University of Southampton

Powell, J. (1996) 'The Social Work Practitioner as Researcher: Learning about Research' in Ford, P. and Hayes, P. (eds) *Educating for Social Work: Arguments for Optimism*, Aldershot, Avebury

Preston-Shooi, M. and Agass, D. (1990) *Making Sense of Social Work: Psychodynamics, Systems and Practice*, Basingstoke, Macmillan Education

Puckering, C. (1989) 'Annotation: Maternal Depression', *Journal of Child Psychology and Psychiatry*, Vol. 30, No. 6, pp. 807-817

Radke-Yarrow, M., Cummings, E.M., Kuczynski, L. and Chapman, M. (1985) 'Patterns of Attachment in Two- and Three-Year-Olds in Normal Families and Families with Parental Depression', *Child Development*, Vol. 56, pp. 884-893

Radke-Yarrow, M., Richters, J. and Wilson, W.E. (1988) 'Child Development in the Network of Relationships' in Hinde, R.A. and Stevenson-Hinde, J. (eds) *Relationships within Families: Mutual Influences*, Oxford, Clarendon Press

Raymond, Y. (1989) 'Empowerment in Practice. Clients' Views to Seeing Records: themes emerging from twelve interviews with clients', *Practice*, Vol. 1, pp. 5-23

Read, J. and Baker, S. (1996) *Not Just Sticks and Stones: A Survey of the Stigma, Taboos and Discrimination Experienced by People with Mental Health Problems*, London, Mind (Mental Health Charity)

Reason, P. (ed) (1988) *Human Inquiry in Action*, London, Sage Publications

Reason, P. and Rowan, J. (eds) (1981) *Human Inquiry: A Sourcebook of New Paradigm Research*, London, Wiley and Sons

Reid, W.H. and Morrison, H.L. (1983) 'Risk Factors in Children of Depressed Parents' in Morrison, H.L. (ed) *Children of Depressed Parents: Risk, Identification and Intervention*, New York, Grune and Stratton

Rexford, E.N., Sander, L.W. and Shapiro, T. (eds) (1976) *Infant Psychiatry: A New Synthesis*, New Haven, Yale University Press

Rhodes, P. (1991) 'The Assessment of Black Foster Parents: The Relevance of Cultural Skills — Comparative Views of Social Workers and Applicants', *Critical Social Policy*, Vol. 11, No. 2, pp. 31-51

Rice, E.P., Ekdahl, M.C. and Miller, L. (1971) *Children of Mentally Ill Parents: Problems in Child Care*, New York, Behavioural Publications

Rist, R. (1984) 'On the Application of Qualitative Research to the Policy Process: An Emergent Link' in Barton, L. (ed) *Social Crisis and Educational Research*, London, Croon Helm

Ritchie, J. *et al* (1994) *Report of the Inquiry into the Care and Treatment of Christopher Clunis*, London, HMSO

Robins, L., Clayton, P. and Wing, J. (1980) *The Social Consequences of Psychiatric Illness*, New York, Brunner/Mazel

Rowe, J., Cain, H., Hundleby, M. and Keane, A. (1984) *Long Term Foster Care*, London, Batsford/BAAF

Rushton, A. and Nathan, J. (1996) 'The Supervision of Child Protection Work', *British Journal of Social Work*, Vol. 26, No. 3, pp. 357-374

Rutter, M. (1966) *Children of Sick Parents: An Environmental and Psychiatric Study*, London, Oxford University Press

Rutter, M. (1989) 'Intergenerational Continuities and Discontinuities in Serious Parenting Difficulties' in Cicchetti, D. and Carlson, V. (eds) *Research on the Consequences of Child Maltreatment*, New York, Cambridge University Press

Rutter, M. (1990) 'Commentary: Some Focus and Process Considerations Regarding Effects of Parental Depression on Children', *Developmental Psychology*, Vol. 26, No. 1, pp. 60-67

Rutter, M. and Quinton, D. (1984) 'Parental Psychiatric Disorder: Effects on Children', *Psychological Medicine*, Vol. 14, pp. 853-880

Sainsbury, E. (1987) 'Client Studies: Their Contribution and Limitations in Influencing Social Work Practice', *British Journal of Social Work*, Vol. 17, pp. 635-644

Sameroff, A.J., Barocas, R., and Seifer, R. (1984) 'The Early Development of Children Born to Mentally Ill Women' in Watt, N., Anthony, E.J., Wynne, L. and Rolf, J. (eds) *Children at Risk for Schizophrenia*, New York, Cambridge University Press

Schön, D.A. (1983) *The Reflective Practitioner: How Professionals Think in Action*, Aldershot, Arena

Schulsinger, F., Mednick, S.A. and Knop, J. (eds) (1981) *Longitudinal Research: Methods and Uses in Behavioural Science*, Boston, Martin Nijhoff Publishing

Shakespeare, P., Atkinson, D. and French, S. (eds) (1993) *Reflecting on Research Practice: Issues in Health and Social Welfare*, Buckingham, Open University Press

Sharland, E., Jones, D., Aldgate, J., Seal, H. and Croucher, M. (1995) *Professional Intervention in Child Sexual Abuse*, London, HMSO

Shaw, I.F. (1984) 'Literature Review. Consumer Evaluations of the Personal Social Services', *British Journal of Social Work*, Vol. 14, pp. 277-284

Sheppard, M. (1990) *Mental Health: The Role of the Approved Social Worker*, Sheffield, Joint Unit for Social Services Research at Sheffield University in collaboration with *Community Care*

Sheppard, M. (1991/92) 'Client Satisfaction, Brief Intervention and Interpersonal Skills', *Social Work and Social Sciences Review*, Vol. 3, No. 2, pp. 124-149

Sheppard, M. (1993) 'Maternal Depression and Child Care: The Significance for Social Work and Social Work Research', *Adoption and Fostering*, Vol. 17, No. 2, pp. 10-16

Sheppard, M. (1994a) 'Maternal Depression, Child Care and the Social Work Role', *British Journal of Social Work*, Vol. 24, pp. 33-51

Sheppard, M. (1994b) 'Childcare, Social Support and Maternal Depression: A Review and Application of Findings', *British Journal of Social Work*, Vol. 24, No. 3, pp. 287-310

Sheppard, M. (1995) 'Social Work, Social Science and Practice Wisdom', *British Journal of Social Work*, Vol. 25, No. 3, pp. 265-293

Siddall, R. (1997) 'Who Pulls the Strings?', *Community Care*, 29 May, pp. 16-17

Silverman, D. (1993) *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*, London, Sage Publications

Silverman, M.D. (1989) 'Children of Psychiatrically Ill Parents: A Prevention Perspective', *Hospital and Community Psychiatry*, Vol. 40, No. 12, pp. 1257-1265

Simic, P. (1995) 'Help I Need Someone: Care Management and Family Carers of People with Mental Health Problems', *Practice*, Vol. 7, No. 2, pp. 23-34

Smale, G. and Tuson, G. with Biehal, N. and Marsh, P. (1993) *Empowerment, Assessment, Care Management and the Skilled Worker*, London, HMSO

Sobel, D.E. (1961) 'Children of Schizophrenic Patients: Preliminary Observations on Early Development', *American Journal of Psychiatry*, Vol. 118, pp. 512-517

Social Research Association (1992/3) *Social Research Association Ethical Guidelines*, Social Research Association, Directory of Members 1992/3 (quoted in Shakespeare, P., Atkinson, D. and French, S. (eds) (1993) *Reflecting on Research Practice: Issues in Health and Social Welfare*, Buckingham, Open University Press)

Social Services Inspectorate (1986) *Inspection of the Supervision of Social Workers in the Assessment and Monitoring of Cases of Child Abuse When Children, Subject to a Court Order, Have Been Returned Home*, Department of Health and Social Security

Social Services Inspectorate (1989) *A Sense of Direction: Planning in Social Work with Children. A Review of Social Services Inspectorate Reports*, Department of Health

Social Services Inspectorate (1996) *Children in Need: Report of an SSI Inspection of Social Services Departments' Family Support Services 1993/95*, Department of Health

Spieker, S.J. and Booth, C. (1988) 'Family Risk Typologies and Patterns of Insecure Attachment' in Belsky, J. and Nezworski, T. (eds) *Clinical Implications of Attachment*, Hillsdale, New Jersey, Erlbaum

Stein, A., Gath, D.H., Bucher, J., Bond, A., Day, A. and Cooper, P.J. (1991) 'The Relationship between Post-natal Depression and Mother-Child Interaction', *British Journal of Psychiatry*, Vol. 158, pp. 46-52

Stevenson, O. (ed) (1989) *Child Abuse: Public Policy and Professional Practice*, Hemel Hempstead, Harvester Wheatsheaf

Stevenson, O. (1992) 'Social Work Intervention to Protect Children: Aspects of Research and Practice', *Child Abuse Review*, Vol. 1, pp. 19-32

Stiffman, A.R., Jung, K.G. and Feldman, R.A. (1986) 'A Multivariate Risk Model for Childhood Behavior Problems', *American Journal of Orthopsychiatry*, Vol. 56, pp. 204-211

Stock Whitaker, D. and Archer, J. L. (1989) *Research by Social Workers: Capitalizing on Experience*, London, Central Council for Education and Training in Social Work

Teti, D., Gelfand, D. and Messinger, D. (1992) 'Maternal Depression, Maternal Behaviour, and Security of Infant Attachment: Does Depression Make A Difference? in Campbell, S. (Chair) *Maternal Depression, Parenting, and Young Children's Development: A Longitudinal Perspective*, Symposium conducted at the Annual General Meeting of the American Psychological Association, Washington, D.C.

Teti, D.M., Gelfand, D.M. and Pompa, J. (1990) 'Depressed Mothers Behavioural Competence with their Infants: Demographic and Psychosocial Correlates', *Development and Psychopathology*, Vol. 2, pp-259-270

Thoburn, J., Lewis, A. and Shemmings, D. (1995) *Paternalism or Partnership? Family Involvement in the Child Protection Process*, London, HMSO

Thomas, A. and Chess, S. (1984) 'Genesis and Evolution of Behavioural Disorders: From Infancy to Adult Life', *American Journal of Psychiatry*, Vol. 141, pp. 1-9

Thompson, D. (1993) *Mental Illness: The Fundamental Facts*, London, Mental Health Foundation

Trad, P.V. (1986) *Infant Depression, Paradigms and Paradoxes*, New York, Springer-Verlag

Tronik, E.Z. (1989) 'Emotions and Emotional Communication in Infants', *American Psychologist*, Vol. 44, pp. 112-119

Tronik, E.Z. and Field, T. (eds) (1986) *Maternal Depression and Infant Disturbance*, San Francisco, California, Jossey-Bass

Tronik, E.Z. and Giuanino, A.F. (1986) 'The Transmission of Maternal Disturbance to the Infant' in Tronik, E.Z. and Field, T. (eds) *Maternal Depression and Infant Disturbance*, San Francisco, California, Jossey-Bass

Tuson G. (1996) 'Writing Postmodern Social Work' in Ford, P. and Hayes, P. (eds) *Educating for Social Work: Arguments for Optimism*, Aldershot, Avebury

Utting, B. (1989) 'Foreword' in Kahan, B. (ed) *Child Care Research, Policy and Practice*, London, Hodder and Stoughton in association with the Open University

Vernon, J. and Fruin, D. (1986) *In Care: A Study of Social Work Decision Making*, London, National Children's Bureau

Waterhouse, L. and Carnie, J. (1992) 'Assessing Child Protection Risk', *British Journal of Social Work*, Vol. 22, pp. 47-60

Watt, N. (1984) 'In a Nutshell: The First Two Decades of High-Risk Research in Schizophrenia' in Watt, N., Anthony, E.J., Wynne, L. and Rolf, J. (eds) *Children at Risk for Schizophrenia*, New York, Cambridge University Press

Watt, N. Anthony, E.J., Wynne, L. and Rolf, J. (eds) (1984) *Children at Risk for Schizophrenia*, New York, Cambridge University Press

Webster, J. (1990) 'Parenting for Children with Schizophrenic Mothers', *Adoption and Fostering*, Vol. 14, No. 2, pp. 37-42

Webster, J. (1992) 'Split in Two: Experiences of the Children of Schizophrenic Mothers', *British Journal of Social Work*, Vol. 22, No. 3, pp. 309-329

Webster-Stratton, C. and Hammond, M. (1988) 'Maternal Depression and Its Relationship to Life Stress, Perceptions of Child Behaviour Problems, Parenting Behaviours, and Child Conduct Problems', *Journal of Abnormal Child Psychology*, Vol. 16, No. 3, pp. 299-315

Weintraub, S. (1987) 'Risk Factors in Schizophrenia: The Stony Brook High-Risk Project', *Schizophrenia Bulletin*, vol. 13, pp. 439-449

Weissman, M.M. (1983) 'The Depressed Mother and Her Rebellious Adolescent' in Morrison, H.L. (ed) *Children of Depressed Parents: Risk, Identification and Intervention*, New York, Grune and Stratton

Weissman, M. (1987) 'Advances in Psychiatric Epidemiology: Rates and Risks for Major Depression', *American Journal of Public Health*, Vol. 77, pp. 445-451

Weissman, M.M., Gammon, G.D., John, K., Merikangas, K.R, Warner, V., Prusoff, B.A. and Sholomskas, D. (1987) 'Children of Depressed Parents', *Archives of General Psychiatry*, Vol. 44, pp. 847-853

Weissman, M. and Paykel, E.S. (1974) *The Depressed Woman: A Study of Social Relationships*, Chicago, Illinois, University of Chicago Press

White, I. (1992) 'A Director's Perspective' in Gibbons, J. (ed) *The Children Act 1989 and Family Support: Principles into Practice*, London, HMSO

Williams, F. (1989) *Social Policy: A Critical Introduction*, London, Polity Press

Winnicott, D.W. (1965) *The Family and Individual Development*, London, Tavistock Institute

Wolcott, H.F. (1990) *Writing Up Qualitative Research*, London, Sage Publications

Worrall, A. (1990) *Offending Women: Female Lawbreakers and the Criminal Justice System*, London, Routledge

Wynne, L., Cole, R. and Perkins, P. (1987) 'University of Rochester Child and Family Study: Risk Research in Progress', *Schizophrenia Bulletin*, Vol. 13, pp. 403-476

Yelloly, M. (1994) 'Professional Competence and Higher Education' in Yelloly, M. and Henkel, M. (eds) *Learning and Teaching in Social Work: Towards Reflective Practice*, London, Jessica Kingsley

Yelloly, M. and Henkel, M. (eds) (1994) *Learning and Teaching in Social Work: Towards Reflective Practice*, London, Jessica Kingsley

Zajicek, E. and DeSalis, W. (1979) 'Depression in Mothers of Young Children', *Child Abuse and Neglect*, Vol. 3, pp. 833-835