Believe in children
Barnardo's
Training and Consultancy



Safeguarding and Child Protection SCP2

Day 2

Barnardo's Registered Charity Nos. 216250 and SC037605

Stonewall DIVERSITY CHAMPION
INVESTORS IN PEOPLE
British Quality FOUNDATION Member
CITY & GUILDS APPROVED CENTRE

The Area

Tadmill is a unitary authority which has a population of around 119,000 of whom around 32% comprise members of minority ethnic communities, largely of Indian and Pakistani heritage. The area is increasingly home to new arrivals, asylum-seekers and refugees from many different countries. Just over a 1/4 of the population are under the age of 18 (around 27,000). The borough is largely a compact urban environment. It is made up of a range of different types of neighbourhoods, including mixed communities, communities with high minority ethnic populations and communities that are predominantly white.

Deprivation varies neighbourhood by neighbourhood within the area but **Baywell** is one of the most deprived. According to the Index of Multiple Deprivation (2015), Tadmill ranked the 108th most deprived council out of 149. The pattern of ill health and disease in Tadmill is very typical of a deprived urban population, with high rates of circulatory diseases, diabetes and significant levels of mental health problems. Life expectancy is lower than the national average and the averages for other areas in the region.

Data about vulnerable children indicate a high incidence of substance misuse, mental health problems and domestic abuse within their families, issues which predominate in Baywell.

The Family

Karen	*25yrs old*	*Mother*
Mandy	*9 yrs old*	
Sarah	*6 yrs old*	
Simon	*13 mths old*	
John	*38yrs old*	*Father of all 4 children*
Jason	*14 years*	*son of John -*
Stephen	*32 years*	*P.Uncle*

- The three younger children have moved home with Karen six times in the last 2 years, but have been able to stay within the school catchment area. Karen now has the tenancy of a three bedroomed council property, nearby her sister and her mother in Baywell.

- Karen has ongoing mental health problems and is being treated for depression. .John is an ex heroin addict but has been 'clean' since Sarah was born 6 years ago. He is however a heavy drinker and more so when his brother, Stephen is around. Stephen is an alcoholic, recently released from prison following a violent assault on another man. John is currently living with Stephen. Jason alternates between the two homes

- Parents have an off/on relationship. They have been 'together' for over 11 years, Karen met John when she was 14 and subject to a Care Order following physical abuse from both parents. Karen has left John three times in the last 14 months as a result of domestic abuse, at these times she moved into a refuge but refused the advice of the housing link worker and the refuge workers to accept a tenancy away from Baywell.

- The extended family have been known to Children's Social Care for many years. Children's Social Care have been involved with Karen since she became pregnant at 16 years old. The two youngest children were made subject to child protection plans almost 6 years ago because of concerns about neglect. However, they were 'stepped down' at the first review meeting 10 weeks later. Simon was a premature baby and the Health Visitor has concerns about his fluctuating weight, although he appears to be reaching his developmental milestones.

- There are growing concerns about Jason and his offending behaviour exacerbated by substance misuse. He frequently goes missing from school and family

- Family have been referred to your service either because of concerns about.
    - Mandy (9) and Sarah (6) and/or
    - about Simon (13 mths) and/or
    - about Jason (14)

Day 2: Exercise 11

Cycle of Change: Case Studies/Statements:

Scenario 1

James (8 years) has been made the subject of a child protection plan following an incident when his mother hit him, causing bruising to his face. He is not attending school regularly. As part of the plan, James' mother has been told she must get James into school regularly and she must work with your service.

Scenario 2

Kayleigh is 16 years old. She has left school without any qualifications and doesn't have a job. She is 3 months pregnant and needs to find somewhere to live as she has run away from home. She has been referred to your service for support and help with accommodation.

7 Steps of Contemplation Case Studies/Statements:

Scenario 3

Amy (age 2), is significantly underweight. She has undergone tests and no organic cause has been found. Her mother has a mental health problem; she has never established regular mealtimes and has little knowledge about nutrition. She has denied there has been a problem until recently, but has now responded to professional's increasing concerns.

Scenario 4

Ben (17) has left school without qualifications and doesn't have a job.

Prochaska and DiClemente's Stages of Change Model

Stage of Change	Characteristics	Techniques
Pre-contemplation	Not currently considering change: "Ignorance is bliss"	Validate lack of readiness Clarify: decision is theirs Encourage re-evaluation of current behavior Encourage self-exploration, not action Explain and personalize the risk
Contemplation	Ambivalent about change: "Sitting on the fence" Not considering change within the next month	Validate lack of readiness Clarify: decision is theirs Encourage evaluation of pros and cons of behavior change Identify and promote new, positive outcome expectations
Preparation	Some experience with change and are trying to change: "Testing the waters" Planning to act within 1month	Identify and assist in problem solving re: obstacles Help patient identify social support Verify that patient has underlying skills for behavior change Encourage small initial steps
Action	Practicing new behavior for 3-6 months	Focus on restructuring cues and social support Bolster self-efficacy for dealing with obstacles Combat feelings of loss and reiterate long-term benefits
Maintenance	Continued commitment to sustaining new behavior Post-6 months to 5 years	Plan for follow-up support Reinforce internal rewards Discuss coping with relapse
Relapse	Resumption of old behaviors: "Fall from grace"	Evaluate trigger for relapse Reassess motivation and barriers Plan stronger coping strategies

Pre-contemplation Stage

"Ignorance is bliss"
"Weight is not a concern for me"

Goals:

1. Help patient develop a reason for changing
2. Validate the patient's experience
3. Encourage further self-exploration
4. Leave the door open for future conversations

1. Validate the patient's experience:

"I can understand why you feel that way"

2. Acknowledge the patient's control of the decision:

"I don't want to preach to you; I know that you're an adult and you will be the one to decide if and when you are ready to lose weight."

3. Repeat a simple, direct statement about your stand on the medical benefits of weight loss for this patient:

"I believe, based upon my training and experience, that this extra weight is putting you at serious risk for heart disease, and that losing 10 pounds is the most important thing you could do for your health."

4. Explore potential concerns:

"Has your weight ever caused you a problem?" "Can you imagine how your weight might cause problems in the future?"

5. Acknowledge possible feelings of being pressured:

"I know that it might feel as though I've been pressuring you, and I want to thank you for talking with me anyway."

6. Validate that they are not ready:

"I hear you saying that you are nowhere near ready to lose weight right now."

7. Restate your position that it is up to them:

"It's totally up to you to decide if this is right for you right now."

8. Encourage reframing of current state of change - the potential beginning of a change rather than a decision never to change:

"Everyone who's ever lost weight starts right where you are now; they start by seeing the reasons where they might want to lose weight. And that's what I've been talking to you about."

Contemplation Stage

"Sitting on the fence"
"Yes my weight is a concern for me, but I'm not willing or able to begin losing weight within the next month."

Goals:

1. Validate the patient's experience
2. Clarify the patient's perceptions of the pros and cons of attempted weight loss
3. Encourage further self-exploration
4. Leave the door open for moving to preparation

1. Validate the patient's experience:

"I'm hearing that you are thinking about losing weight but you're definitely not ready to take action right now."

2. Acknowledge patient's control of the decision:

"I don't want to preach to you; I know that you're an adult and you will be the one to decide if and when you are ready to lose weight."

3. Clarify patient's perceptions of the pros and cons of attempted weight loss:

"Using this worksheet, what is one benefit of losing weight? What is one drawback of losing weight?"

4. Encourage further self-exploration:

"These questions are very important to beginning a successful weight loss program. Would you be willing to finish this at home and talk to me about it at our next visit?"

5. Restate your position that it is up to them:

"It's totally up to you to decide if this is right for you right now. Whatever you choose, I'm here to support you."

6. Leave the door open for moving to preparation:

"After talking about this, and doing the exercise, if you feel you would like to make some changes, the next step won't be jumping into action - we can begin with some preparation work."

Preparation Stage

"Testing the Waters"
"My weight is a concern for me; I'm clear that the benefits of attempting weight loss outweigh the drawbacks, and I'm planning to start within the next month."

Goals:

1. Praise the decision to change behavior
2. Prioritize behavior change opportunities
3. Identify and assist in problem solving re: obstacles
4. Encourage small initial steps
5. Encourage identification of social supports

1. Praise the decision to change behavior:

"It's great that you feel good about your weight loss decision; you are doing something important to decrease your risk for heart disease."

2. Prioritize behavior change opportunities:

"Looking at your eating habits, I think the biggest benefits would come from switching from whole milk dairy products to fat-free dairy products. What do you think?"

3. Identify and assist in problem solving re: obstacles:

"Have you ever attempted weight loss before? What was helpful? What kinds of problems would you expect in making those changes now? How do you think you could deal with them?"

4. Encourage small, initial steps:

"So, the initial goal is to try nonfat milk instead of whole milk every time you have cereal this week."

5. Assist patient in identifying social support:

"Which family members or friends could support you as you make this change? How could they support you? Is there anything else I can do to help?"

The Seven Steps of Contemplation

Morrison,T in Horwath (ed), *The Child's World* 2010

1) *"I accept there is a problem."* Understanding may be minimal and moving from Step 1 to 2 is the most difficult phase of the work. Research suggests an approach which is both "supportive and authoritative" and which recognises that both strengths and risks/needs can be helpful (as with Signs of Safety).

2) *"I have some responsibility for the problem."* Person may not accept full responsibility. It is important that the practitioner does not 'blame' the person and does not assume that acceptance of some responsibility reduces the risk to the child.

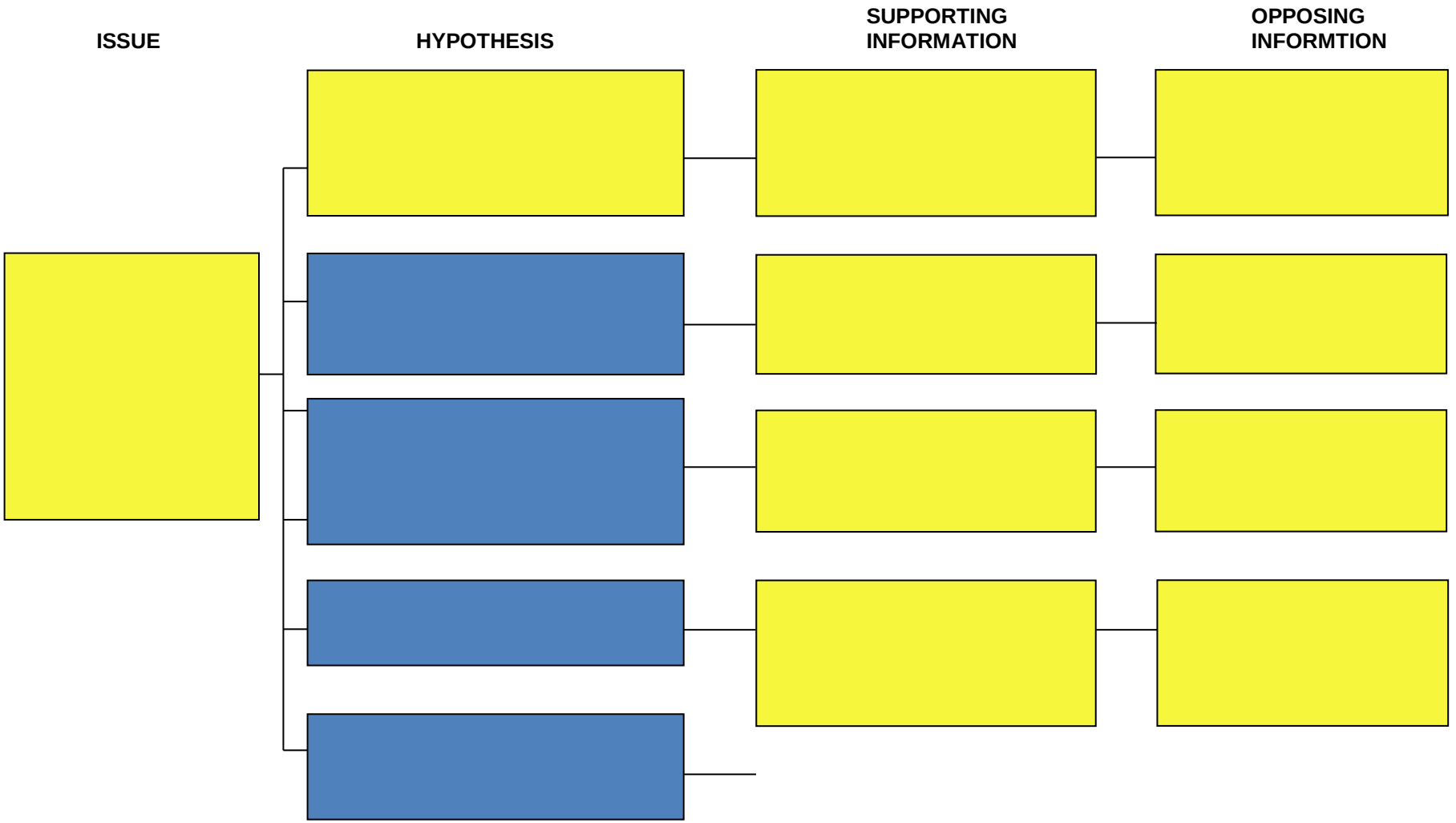
3) Person experiences some "*internal discomfort".* **Note**: this is distinct from "*external discomfort"* which results from external imposition of expectations, e.g. a child protection plan (England and Wales). The person becomes aware that their behaviour is incompatible with their beliefs/view of themselves. **Note**: it is important that, with parents, concern for the child is included in the discomfort.

4) *"I believe that things must change."* The person may not know how to change. It is important not to rush into the Action stage but to build the person's confidence and ability to change.

5) "*I can see that I can be part of the solution*." The person may experience fear, anxiety and contradictory emotions. It is important to encourage them and build their self-efficacy and confidence by, for example, exploring previous successful attempts to change, personal resources.

6) *"I can make a choice."* The person has some power to choose and a range (possibly limited) of choices. At this stage it is important that people feel supported and their ability to make and sustain change is encouraged.

7) *"I can see the next steps towards change."* This is the *preparation-for-action* stage. People have an understanding of the impact of the problem/s on their child/themselves, the change/s they need to make, and the possible consequences. It can be helpful to focus on specific goals: who will contribute what, what the results will be and a written contract such as a Child Action Plan or Pathway Plan (England and Wales) may be helpful. It's important to be aware of contingencies and consequences and to continue with support.



Getting to change – Tips for Practice

Kinds of change talk:

Desire: Statements parents might make about wanting to change

- I would like to..
- I wish....
- I really want to
- If only…

Ability: Statements parents make about self-capability

- I think I could
- I could probably…
- What I can do ….

Reasons: Statements parents make are specific arguments for change

- I know I would feel better if ..
- I would be able to manage if
- I would worry less if …

Need: Statements parents make about feeling an obligation to change

- I know I should….
- If their behaviour was better then..
- I should do this for their sakes..
- If it would stop all the hassle then…

Commitment: Statements parents make about the action(s) they will take to change.

Intention or low level commitment: Statements parents make related to an intention to take action to change.

- I hope to...
- I plan to..
- I will try to..

Higher level commitment statements:

- I will ….
- I am going to ….
- I will make an appointment
- I will make sure that..

Parents also need to

1) recognize the disadvantages of the status quo,

2) recognize the advantages of change,

3) hold some optimisim about change,

4) have an intention to change,

5) and make a commitment to change

1. Recognize the disadvantages of status quo

- I never really thought about how.....
- I didn't understand that.....
- I can see if I don't....
- If things don't change then…

Ways to evoke change talk about the disadvantages of status quo

- What concerns you about your current situation?
  What makes you think you need to do something about your weight?
- What concerns you about not checking your blood glucose on a regular basis?
- What do you think might happen if you don't change your diet?

2. Recognize the advantages of change

- If I kept the appointments then
- Mebbe they would stop hassling me if
- Life would easier if..
- I might enjoy playing with my children
- Their behaviour might be easier to maanger
- I would have less stress

Ways to evoke change talk about the advantages of change

- How would life be different for you if.....?
- If you could wake up tomorrow and things changed by magic, how would things be better for you?
- What are the main reasons you see for .....?
- What would be the benefits of..... for you?

3. Expressing optimisim about change

- I think I could manage
- I did manage to do this a couple of years ago
- If I make my mind up about something I can usually follow it through

- If I have some support that might help

Ways to evoke change talk about expressing optimisim

- What do you think would work if you decided to change...?
- How confident are you that you can make this change?
- What kind of support would be helpful in making this change?
- What encourages you to change if you want to do it?

4. Expressing intention to change

- I think I need to do something..
- I don't want things to be like for the next …..
- I don't know how I will manage but I must..

Ways to evoke change talk about intention to change

- I can see you are feeling stuck right now. What is going to have to change?
- How important is it for you to .....?
- What do you intend to do?
- What do you think you might be able to do?
- What are you thinking about how to check their weight?
- What are you thinking about changing their diet?
- You mentioned some good ideas about…..which ones sound like they might work for you?

5. Making a Commitment to change

Ask scaling questions to help parents determine how important a change is and how confident they are in making that change:

- On a scale from zero to ten how important is it for you to.....?
- Tell me why you chose that number?
- What could happen that would move you to higher number?
- On a scale from zero to 10, how confident are you that you can make this change?
- Tell me more why you chose that number for your confidence level?
- What do you think might help become more confident in making a change?

Other ideas to help parents change is to use elaboration with questions such as:

- How much, when, where
- Ask for an example
- Describe what happened last time you....
- Tell me about a typical day

If parents show little desire to change you might try asking the extreme questions

- What concerns you the most about.....?
  Suppose you do nothing about....., what do you imagine is the worst thing that will happen?
  How much do you know about the impact of children not being taken for medical appointments and what can happen if their condition worsens?
- What might be the best results you could imagine if you.....?
  If you were completely successful in making changes you want, how would things be different for you? Looking at past experiences
- Do you remember a time when things were better for you? What was it like then?
- What are the differences between the [John]of 10 years ago and the John today?
- If you make a change in how you care for the children, what do you hope to be different?
- How would you like things to be 10 years from now?
- It seems like you are anxious about how things are with you now,
- How would you like things to be different?
- Suppose you don't make any changes and just continue as you are now, what do you think your life will be in 5 years from now?
- Given how you feel now, if you don't make any changes, how do you think you will feel a year from now?

Ways to reinforce the change talk

- It sounds like a good idea
  It sounds like that could work
- You make a good point
- I can see you gave this a lot of thought
- It's important for you to.....

Rolling with resistance:

Resistance behaviors may include making excuses, blaming others, minimizing importance or significance, challenging, hostile language (verbal and non-verbal), and ignoring. **Parents who are resistant are not ready to change.**

Ways to roll with resistance:

Acknowledge the person's perception or disagreement

You don't see a need to check your blood glucose when your hemoglobin HBA1C is always at 6.5

You don't think taking your medication everyday is really necessary. o You're rather discouraged about trying to exercise again.
You think it is better to eat whatever is available any time you are hungry

You think you will die anyway and smoking won't make any difference how or when that happens.
You think in the long run losing weight will make a difference in how much medicine you have to take and at the same time it is really a hard thing to do.
On one hand you know there are some problems that can happen if you don't montior your blood glucose and the information I suggested is not acceptable to you.

Reframing

Parent: 'They just won' t behave I have tried so many times and nothing improves'
Practitioner: "You are very persistent, even though you are discouraged. This change must be important to you"

Parent: 'I tried to sort out bedtimes a few months but nothing changed and I gave up
Practitioner: 'It seems to me that you have given this a lot of effort already.' Everytime you try, you get closer. How can I help?'

Parent: 't just doesn't work! They just wind me up! '

Practitioner: 'Whether this works or not is up to you. You are in the best position to know what ideas are most likely to work for you'.

Parent: 'What if I tell you we are not going to work with you and do as you say?
Practitioner: That is a decision you need to make. I can give you information about the risks of ……. and what will happen if ….. but the decision as to what you do is yours…

Extracts from

Five General Principles of Motivational Interviewing:

1. Express empathy
2. Develop discrepancy
3. Avoid argumentation
4. Roll with resistance
5. Support self efficacy

Responses that are NOT Reflective Listening:

1. Ordering, directing, or commanding
2. Warning or threatening
3. Giving advice, making suggestions or providing solutions
4. Persuading with logic, arguing, or lecturing
5. Moralising, preaching, or telling clients what they should do
6. Disagreeing, judging, criticizing, or blaming
7. Agreeing, approving, or praising
8. Shaming, ridiculing, or labelling
9. Interpreting or analysing
10. Reassuring, sympathising, or consoling
11. Questioning or probing
12. Withdrawing, distracting, humouring, or changing the subject

Assumptions to Avoid:

1. This person OUGHT to change
2. This person WANTS to change
3. This person's children should be the prime motivating factor for change
4. If he or she does not decide to change, the consultation has failed
5. Individuals are either motivated to change, or they're not
6. Now is the right time to consider change
7. A tough approach is always best
8. I'm the expert He or she must follow my advice
9. A negotiation approach is always best

Signs of Resistance:

Arguing

- Challenging
- Discounting
- Hostility ß Interrupting

Denying

- Blaming
- Disagreeing
- Excusing
- Claiming impunity

- Minimizing
- Pessimism
- Reluctance
- Unwilling to change

Interrupting

- Talking over
- Cutting off

Ignoring

- Inattention
- Nonanswer
- No response
- Sidetracking

Strategies for Handling Resistance:

1. Simple Reflection: simple acknowledgement of the client's disagreement, emotion, or perception
2. Doublesided Reflection: acknowledge what the client has said and add to it the other side of the client's ambivalence
3. Clarification: verify your understanding matches the client's perspective
4. Shifting Focus: shift the client's attention away from what seems to be a stumbling block
5. Emphasizing Personal Choice and Control: assure the person that in the end, it is the client who determines what happens

Specific MI Strategies:

1. Ask open-ended questions
2. Listen reflectively
3. Affirm
4. Summarise
5. Elicit self motivational statements

Negotiating a Plan:

1. Set Specific (shortterm) Goals
2. Consider Your Options
    1. Discuss with the individual the different choices are for approaches to making changes
    2. Try to match the individual to the optimal behaviour change strategy
    3. Recognise that the person may not choose the "right" strategy
    4. Prepare the individual for this possibility
3. Establish a Plan
    1. Goals/Strategies/Tactics
    2. Summarise the plan with the patient
    3. Make sure to assess if the person is now ready to commit to the plan

Specific MI Tools:

1. List of Pros and Cons (Benefits/Costs) for and against behavior change
2. Assess Importance and Confidence
3. Looking Back – client reflects on effective strategies used with past successes; have them think back to time in life when things were going well describe this and what has changed now
4. Looking Forward – have client think about their hopes for the future if they make this change; how would they like things to be different; what are realistic options now – what could you do now; what are the best results you could imagine if you make this change
5. Exploring Goals – assess match between client's current behavior and future goals; explore how realistic goals are (trying to explore and develop discrepancies between current behavior and client's goals for the future)

Safeguarding is Everyone's Responsibility

20 things for practitioners to consider

A tool to prompt discussion and identify areas for development

Barriers to Recognising, Responding and Reporting		
Organisational Responsibilities		
•	Providing safeguarding training opportunities.	
•	All staff and managers understanding their responsibility to undertake supervision as outlined in a Supervision Policy.	
•	Developing a culture where fellow professionals offer supervision.	
•	Changing the way organisations manage frontline staff will have an impact on how they interact with children and families. There is evidence that workers tend to treat the service user in the same way as they themselves are treated by their managers.	
Practitioner Responsibilities and Self Assessment Questions (not an exhaustive list)		
1	How do I get through the front door and create a relationship where the family/parent is willing to tell me about the child and family?	
2	How do I ask challenging questions about very sensitive matters?	
3	How do I develop the expertise to sense that the child or parent or adult is being evasive? Do you reflect on the times when they have been evasive?	
4	How do I work directly with children and young people, vulnerable adults and their families, to understand their experiences, worries, hopes and dreams, and to help them change?	
5	Do I recognise my intuitive skills (essentially derived from experience) 'Gut feelings are neither stupid nor perfect? They take advantage of the evolved capacities of the brain and are based on rules of thumb that enable us to act fast'. Gut instinct or feelings are part of your tool kit.	
6	Have I had time to reflect to mull over the experience and learning from it, in supervision, for example, or in discussions with colleagues?	
7	Do I have the necessary skills to communicate with children and vulnerable adults with communication difficulties?	
8	Do I have knowledge of the development of children aged 0 -18 years?	
9	How do I assess the level of communication and engagement with the men in the family?	

With thanks to Leicestershire and Rutland Safeguarding Board

Practitioner Responsibilities and Self Assessment Questions (not an exhaustive list)		Notes
10	Are the men associated with the family 'visible'? Is their impact being assessed? Look for signs of 'hidden' partners, big shoes, coats etc. Ask the children! Talk to neighbours.	
11	What is life really like for the children or vulnerable adult in this family?	
12	Am I putting the needs, views and wishes of the vulnerable adult or children at the forefront of interaction and enquiry, or is the adult agenda dominating?	
13	Am I recognising barriers that inhibit engagement and implications for practice?	
14	Has my caseload repeatedly exposed me to intractable and long term problems contributing to a normalisation in my response? Is this a barrier to me recognising/understanding the significance of deviant or risky behaviour?	
15	Has my caseload not exposed me to intractable and long term problems contributing to a possible lack of recognition in my response? Is this a barrier to me recognising understanding the significance of deviant or risky behaviour?	
16	Do I have the knowledge and skills to recognise bruising that may be indicative of a non-accidental injury?	
17	Do I understand my role and responsibilities within the child/adult improvement protection plan?	
18	Do I understand the responsibilities of other members of the core/ multi agency group?	
19	Have I communicated with all other agencies involved in delivering the plan?	
20	Am I feeling confident and comfortable working with this family? If not why not? Is this a gut instinct telling you something?	

With thanks to Leicestershire and Rutland Safeguarding Board

Building confidence and developing best practice

We need to continually develop our understanding of the complexities of safeguarding children and adults.

'R' for remember (and much more)

Recognition – Do you know what abuse looks like? What are the thresholds for concern?

Report – Do you know who to share this information with? Do you feel confident to talk to that person? What will you do if you are not listened to? Do you know how to escalate concern? Do you know how to whistle blow?

Risk – Do you know what makes some situations more risky? If not do you feel confident to ask? Do you know what 'safe' looks like? Acknowledge the resiliant factors.

Relevance – Do you understand the relevance of the information you have? Does it matter if you don't? It may be relevant to the bigger picture and another agency may think it is critically relevant.

Resistance – Do you feel confident to challenge families or colleagues? Can you recognise when people are being evasive?

Relationships – Are you clear about the boundaries of your relationship with children, adults, families and carers? How do you avoid collusion? Are you clear what your Role is?

Recording – Is your recording clear, evidenced based, with agreed actions and timescales? Can you state 'in my professional judgement' with confidence?

Representing – Is the voice of the child or adult heard? How do you ensure they have every opportunity to be part of the process? Can you 'walk in their shoes'?

Review – What are your contingency plans? How do you cope with change?

Responsive - How do you manage optimism and pessimism as completely natural human responses to complex situations?

Reflection - Do you have space personally and professionally to learn? How do you challenge your own judgements?

All underpinned by CLEAR CREATIVE ACCESSIBLE COMMUNICATION

With thanks to Leicestershire and Rutland Safeguarding Board

Overall Plan Date: ***14.09.2015*** Time Period for Change : ***3 months*** Review of Overall Plan: ***13.12.2015***

Name of Child: Kylie **Age:** **19 weeks**

What we are worried about	**What is working well**
• Jackie does not agree that Kylie is underweight and this might be dangerous for Kylie and could be stopping her from growing properly • Kylie sleeps on the settee in the front room and when Jackie's friends comes round or the TV is on, she doesn't sleep properly. This can make her grumpy the next day and Jackie then finds it hard to settle her. • Jackie does not seem to understand how important it is to keep Kylie clean and to change her nappies regularly so her bottom and legs don't get sore. • Jackie has missed three important medical appointment for Kylie and this is not OK . Jackie does not understand why this matters. • Kylie is not doing lots of things that babies around her age should be doing and we need to understand why this is.	• Jackie is good at telling workers how she feels and how tough it can be for a single mum • Jackie has some nice play things for Kylie • Jackie understands that she needs time for herself and is good at asking for help from her sister when she needs a break. • Jackie is unhappy about social workers calling around but has agreed to work with them for Kylie's' sake

What we want to happen for Kylie in the longer term: **Within** ***3 months***	• **Kylie gradually puts on weight** • **Kylie's goes to sleep in a cot, somewhere safe so she is not disturbed by Jackie's friends when they come round at night** • **Kylie's hair and skin are kept clean and she is not left in dirty or damp clothes/nappies.** • **Kylie has special time with Jackie and they spend time together every day playing with toys from the Toy Library.** • **For Jackie to keeps the medical appointments for Kylie and if she has to rearranges any appointments she will tell SW1** • **If Jackie is struggling to care for Kylie, she will tell [name] and also SW1 so they can help as soon as possible.**

We know things can't get better for Kylie overnight, so the [detailed] plan below is what we have all agreed to do in the next [12]weeks. We will review progress every 4 weeks at a meeting. If what we all agreed doesn't happen, then professionals will have to look carefully at why things didn't get better for Kylie. If Jackie doesn't keep to the agreement then professionals may have to decide whether Jackie is the best person to care for Kylie.

Linda Richardson/December 2015

Case Study – Jamie & Meg

Your service works with secondary age children who are at risk due to school non-attendance. You are working with Jamie, aged 13. He lives with his mum, Sandra, and her boyfriend Paul. Paul is not Jamie's dad but has taken on a good supportive role with Sandra in parenting Jamie. Paul works nights in a factory and does not get in until 10am. Sandra and Paul have a child called Meg (18 months) through their relationship. Jamie has informed you that he gets up early every morning and feeds and changes Meg whilst mum sleeps in. This makes him late for school most days and, when mum "can't get up," he stays off to look after Meg. Paul doesn't know what is going on and believes Jamie is just truanting from school. This week Meg nearly choked when Jamie was feeding her and this frightened and upset him.

Believe in children
Barnardo's

A signs of safety© assessment and planning form

What are we worried about?	What's working well?	What needs to happen?
On a scale of 0 to 10 where 10 means everyone knows everything is fine for (child) and is safe enough for professionals not to get involved or get out of the family's life and 0 means things are so bad for (child) where do we rate the situation?		

On a scale of 0-10; what are the risks for both Meg & Jamie. Using the signs of safety model.

Remember; Strengthening Families Model: