

**A Systematic Audit and Evaluation of Archival Assessment Records in a Residential  
Assessment Service for Children, Adolescents, and Families**

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## Abstract

*“Actually we have it all wrong, when we say we look forward to the future.*

*The future is a void and we walk, so as to say, blindly with our backs towards it.*

*At best we see what we have left behind”.* (Fritz Perls, 1969).

*“We do not think ourselves into new ways of living, we live ourselves into new ways of thinking.”* (Richard Rohr, 2003).

This work is an evaluation of assessment work completed in my employment setting. I work as Senior Psychologist for Tusla, Child and Family Agency, (formerly Health Service Executive, H.S.E.), in a residential assessment service that provides multi-discipline assessment of children, adolescents, and families for community social work teams, located in counties Cork and Kerry, in the Republic of Ireland.

The service was established in 2000. Over the years there have been changes in the landscape of service provision, (in terms of: legislation; service configuration and provision; changes in the personnel of the assessment team, and among referring agents). During the existence of the service, there has been an apparently unlimited range of reasons for referral, with a large number of referrals lacking clear, specifically, stated reasons, (rather being stated in the form of a list, or history of problems within a family unit, or within a child/adolescent).

This mixed methods evaluation examines archival assessment Report records for the first 10 years of service operation. Data have been managed using MaxQDA qualitative analysis software.

Quantitative analysis of information about all completed assessments for the first ten years of operation of the service is undertaken, with qualitative content analysis of a smaller sample of electronic records from five selected annual cohorts.

I have discussed how findings from the research have supported the design, development, and implementation of a new model for practice within the service.

## Acknowledgements

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I have named those who have been most directly involved in supporting my efforts to complete all assignments, but many others, (my fellow students on the M5 Course and students and tutors whom I encountered on various elective courses modules have enriched my experience of the M5 Course.

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## **Introduction and context-setting**

### **1.1: What the research involves**

This work is an evaluation of the first ten years of operation of an assessment centre for children, adolescents and families (see Appendix 1 for the description of the service, which is provided in the assessment centre information booklet) through examination of archival data from the service in the form of team assessment reports.

This research was carried out in the context of my role (Senior Educational Psychologist) within a multi-discipline assessment team. Referrals to the assessment service have been made exclusively through the child protection social work services, which have traditionally been established within the Irish National Health Service (i.e., the “Health Service Executive”, known as “the H.S.E.”).

On 1<sup>st</sup> January 2014, all H.S.E. child protection social work services and the assessment centre were transferred en masse, in a pre-planned re-organisation, to a newly established agency, ‘Tusla, The Child and Family Agency’, established as, “*the dedicated State agency responsible for improving wellbeing and outcomes for children*” (Tusla website, homepage). This Minister with responsibility for this new agency is the ‘Minister for Children and Youth Affairs’, whereas, the Minister for Health continues to have responsibility for all H.S.E. services. Hereafter, I refer to this specific service (i.e., the multi-discipline residential assessment centre) as the ‘assessment service’, and I refer to the parent body as, ‘Tusla’ (see **Appendix 2** for the description of Tusla, which is provided on the website of the Agency).

I intend that the current research work will provide insight with regard to the workings of the ‘assessment service’ for colleagues on the assessment team, members of service and organisation management, referring agents, and service users.

I envisage that the work will, also, prove to be of wider relevance for interested parties in a national context and beyond, who are involved with services for young persons and their families, (particularly in the context of the process of the establishment of Tusla, which is intended to create a separation of child protection social work services and allied professional services from the national Health Service.

The data (selected from 144 team assessment reports) have been collated electronically and examined using qualitative analysis software (MAXQDA) and the research includes review of my experience of this tool for such work.

Quantitative analysis of data from the archival assessment report information have been undertaken and qualitative content analysis of the data (discussed further in the ‘Methodology’ section) have been completed.

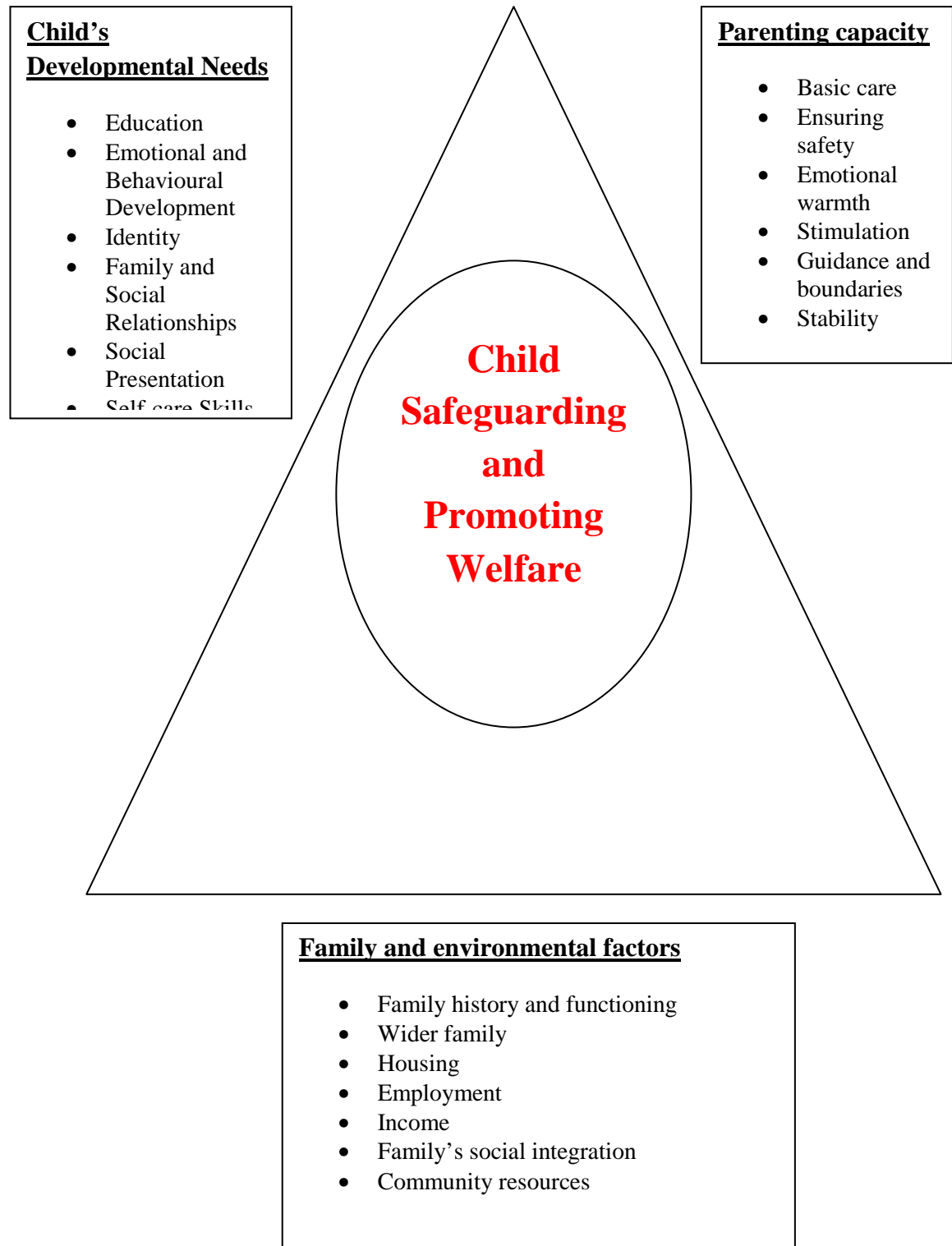
### **1.2: Description of the ‘assessment service’**

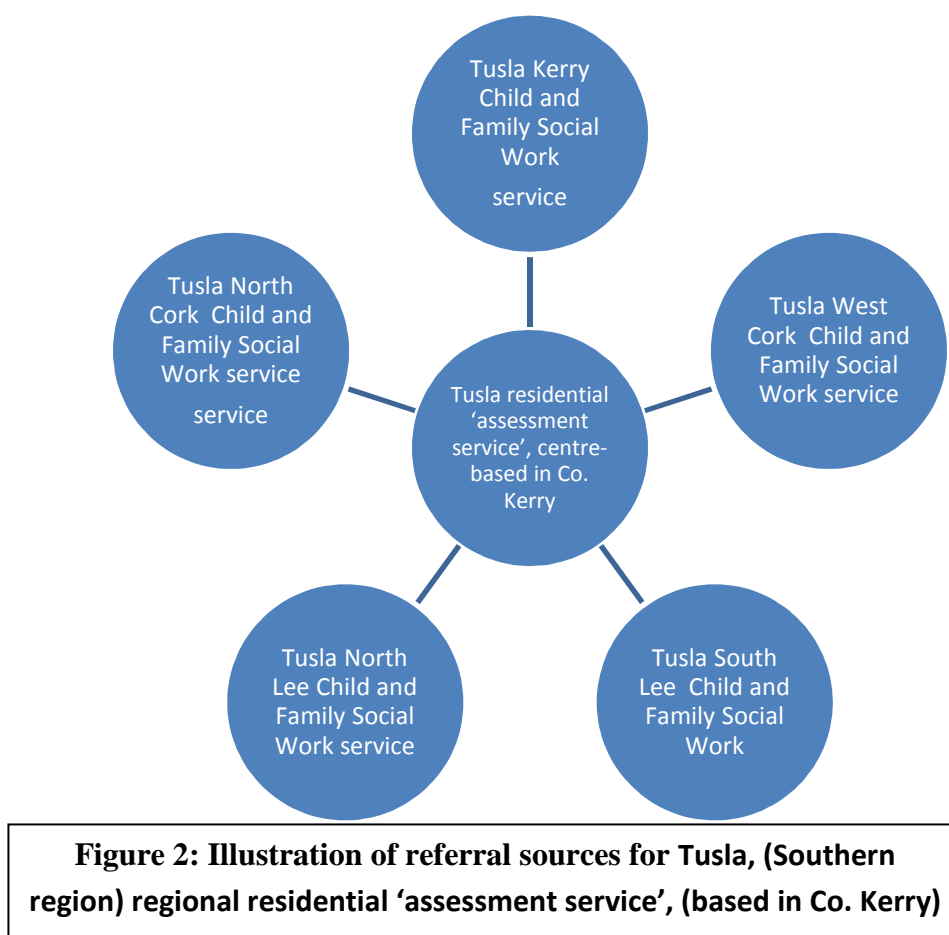
The multi-discipline assessment team within the ‘assessment service’ has responsibility to provide assessments, with reference to the Framework for Assessment (2006) (see **Figure 1**, next page) for statutory ‘Tusla’ “child protection and welfare” social work services with regard to referred children, adolescents, and/or families, (within the context of a residential childcare setting).



**Figure 1 Framework for the Assessment of Vulnerable Children and their Families**

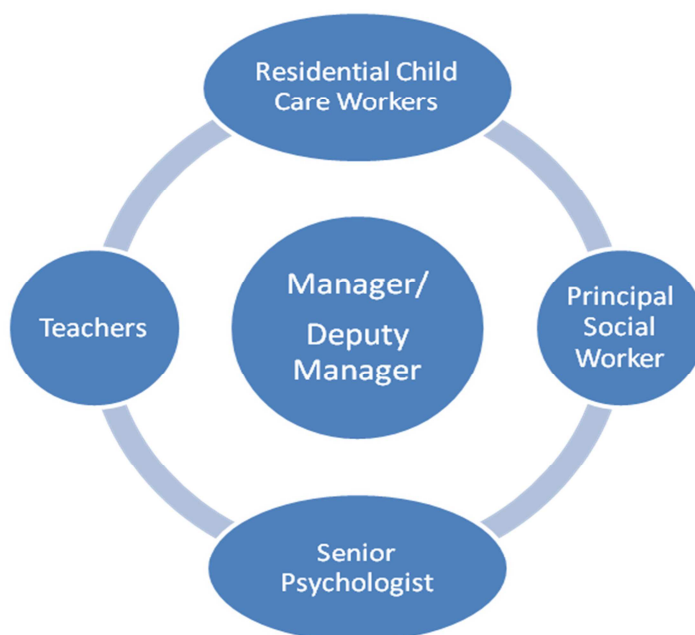
**(Buckley, Howarth, and Whelan, 2006)**





The 'assessment service' accepts referrals from the five area child protection social work teams, which cover counties Cork and Kerry (see **Figure 2**, above). Cork (population 420,346, and an area of 7457 km<sup>2</sup>) and Kerry (population 125,863, and an area of 4746 km<sup>2</sup>) are two of the largest counties in Ireland, and are largely rural areas (source:<http://www.wesleyjohnston.com/users/ireland/geography/counties.html>).

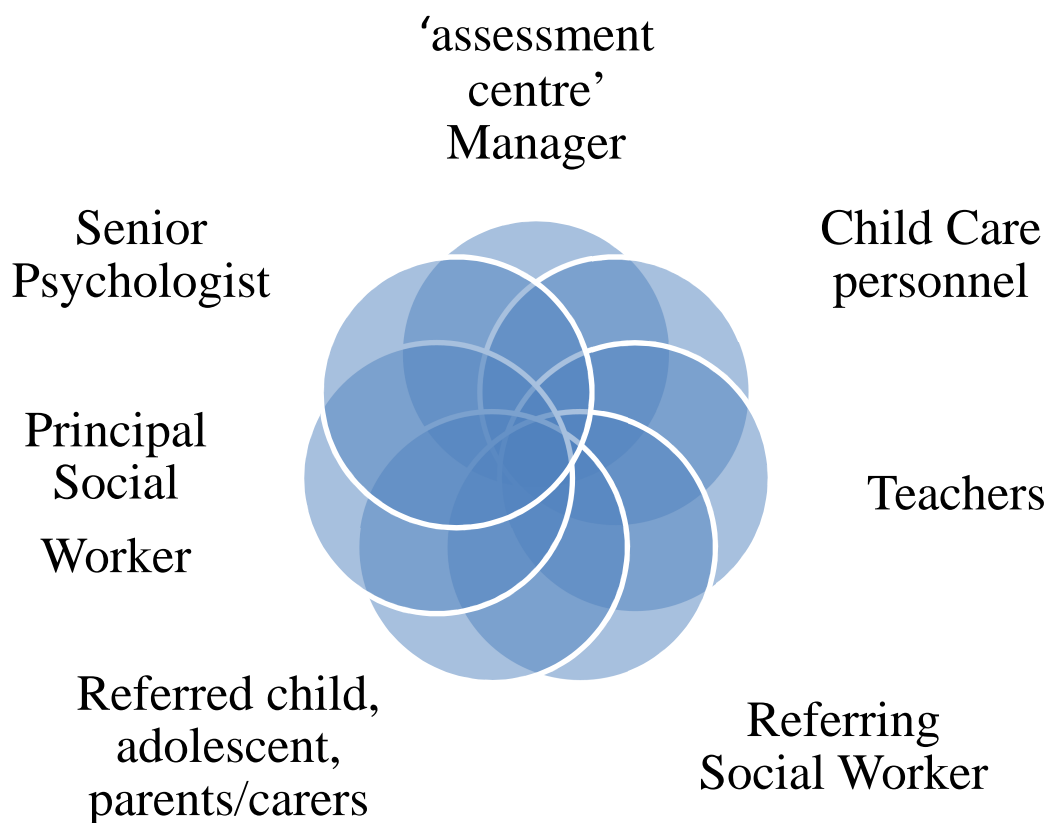
The assessment team consists of representatives of four professional disciplines: child care; teaching; social work; and, psychology (illustrated in **Figure 3** (next page) and **Figure 4**, on following page). **Figure 4** additionally, includes (as a members of a 'temporary organisation', which has been convened for purposes of a collaborative approach to assessment): (a) the referring Social Worker; and, (b) the referred child, adolescent, and/or parents/carers.



**Figure 3: Organisation of Multi-Discipline Assessment Team**

There is only one post each for the disciplines of psychology and social work, and as a consequence these practitioners tend to be involved with all assessment referrals. Each child, or adolescent (i.e., ‘client’) who has been accepted for assessment is assigned a separate “key-worker”, and a “deputy key-worker” (chosen by the assessment centre manager from among the residential child care workers).

Each client is, also, designated to work with one of the two teachers in the ‘assessment service’, and has assigned a “case manager” (either the manager, or the deputy manager of the ‘assessment service’). The assigned “case manager” has a co-ordinating role in relation to the proposed individual schedule of assessment, and acts as chairperson of: ‘Assessment Team Meeting’ (week 2); ‘Strategy Meeting Meetings’ (weeks 3 through to 5); ‘Internal Recommendations Meeting’ (week 7); and, ‘Final Recommendations and Feedback Meeting’ (week 8). The process and schedule for an eight-week assessment period is shown in **Figure 5** (on next page but one).



**Figure 4: Illustration of a view of the overlap of the constituent elements of the Tusla multi-discipline 'assessment service' assessment team, shown here in a model of collaborative assessment endeavour with the involvement of the assessment centre management, referring agent(s), and referred children, adolescents and families**

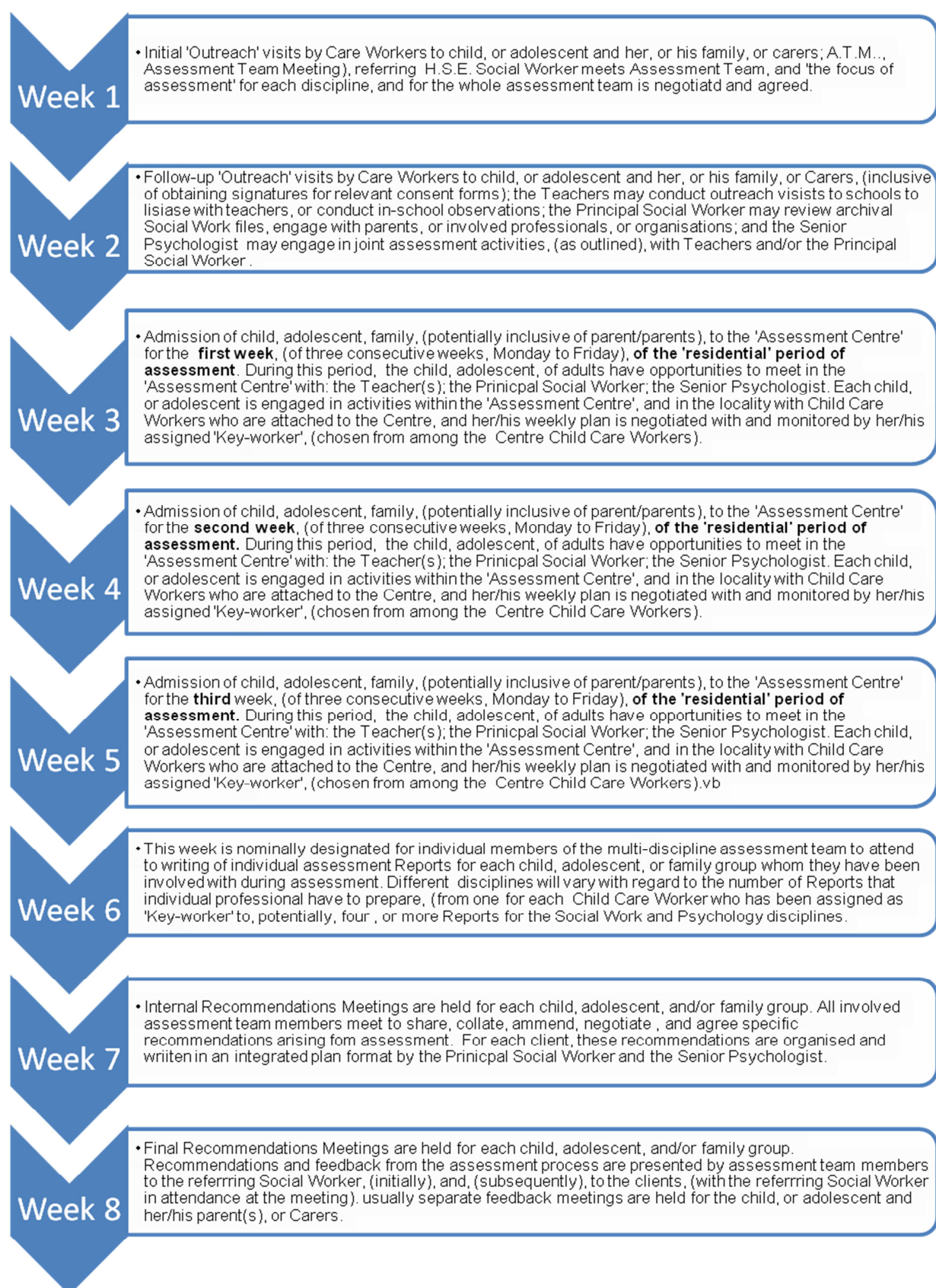
Members of the assessment team frequently liaise, in relation to assessment referrals, with representatives of: C.A.M.H.S.; Department of Education psychological services (N.E.P.S.); H.S.E. community psychological services; schools; and, various local, child, and/or family-focussed community services (such as Family Resource Centres, services provided through Area Partnerships, Neighbourhood Youth Projects, 'Springboard' services, Juvenile Liaison Officer services (J.L.O.) or private practitioners in the areas of play therapy, counselling, or psychological services.

On occasion, a pre-agreed 'choreography' of intervention is agreed with such services in advance of the assessment process, or at the time of feedback of conclusions, which have been arrived at through the assessment process.

A unique aspect of the 'assessment service' (within both the H.S.E. and Tusla) has been the synchronised, systematic, combined focus across within the assessment process of a single service that allows observation and assessment of clients within educational, clinical, family, residential, and community contexts.

Practitioners within the 'assessment service' attempt to operate on the basis of a child-centred approach, with attention to: the ecology of the child; her/his developmental progression; her/his engagement with life-tasks; her/his situation in relation to life-cycles and patterns; and reference to her/his relevant family and community systems.

During each assessment process it is explicitly stated that the 'assessment service' team-members intentionally seek to adopt a stance of seeking to systematically foster collaboration between all participants in the assessment process, in the service of inclusive, solution –focussed resolution of existing, or identified child protection and welfare concerns.



**Figure 5: Flow-chart type illustration of the existing eight-week assessment cycle within the Tusla 'assessment service'.**

### **1.3: Distinctive features of the ‘assessment service’**

During most of the period of its existence the ‘assessment service’ has been unique within the ‘public’ services in the Republic of Ireland, because of the combination of following features:

- the residential assessment aspect of the service, combined with the ‘outreach’ aspect of the service, and high levels of individualised encouragement of clients to engage with the service;
- the wide age-range covered by the service, from infancy to 18 years of age, (while most other children’s services operate with more restricted age-ranges);
- the service is not availed of through the juvenile justice system (unlike many other residential assessment services in the public service);
- referral to the service is exclusively through H.S.E. (now, ‘Tusla’) child protection social workers. It is important to note that no other psychology-related service has this referral route as an exclusive, or predominant feature of the service;
- a strong association of the service with H.S.E., (Tusla) children’s residential services and with foster-care services, (both the manager of the ‘assessment service’ and the psychologist are members of the ‘Admissions Panel’ for residential childcare services in the region, and many children who eventually avail of residential care, or foster-care have had assessments through this service);
- construction of a ‘de facto’ link between Health and Education services, through the presence of two teachers and an educational psychologist within the H.S.E. (Tusla) system. Health and Education services in the Republic of Ireland

tend to be segregated, with a dearth of formal links between respective bodies and personnel at both national and local services levels.

In this break with traditional boundaries of how services are organised at local and at national level a space is created for examining problems in a new way, for seeing a new aspect, for creating a different kind of narrative;

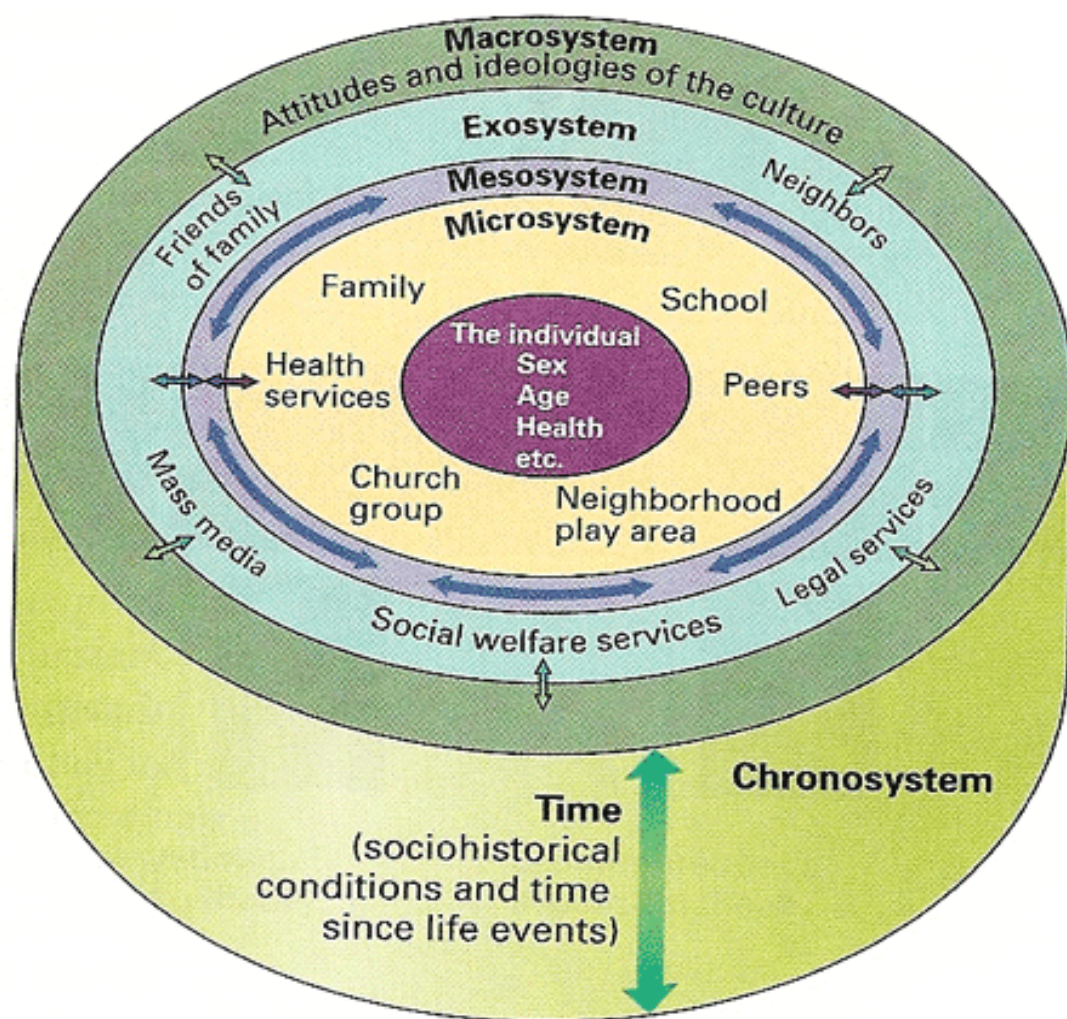
- construction of a collaborative, ‘de facto’ link between Health, Education, and Youth Justice services, (such a link is apparent where the child, adolescent, or family is involved with the Justice service). In the assessment centre, there is direct involvement of an educational psychologist in provision of an assessment, which is integrative of information that pertains to mental health, behaviour, developmental progress, family systems, identity, cognitive functioning, social adaptive functioning in academic, home and community settings, learning support needs, and identification of vocational guidance and psycho-therapeutic support needs. The scope of assessment and the frequency of involvement with Judges and legal services, (either through issues of youth justice, or child welfare), means that the educational psychology role is atypical, when compared with other examples of educational psychology practice in the Republic of Ireland.

#### **1.4: Brofenbrenner, (1979, 1989), ‘Ecological Systems Model’**

Within the ‘assessment service’ the “The Framework for Assessment of Vulnerable Young Children and their Families”, (Buckley et al., 2006), is considered together with the Brofenbrenner, (1979, 1989), ‘Ecological Systems Model’ for understanding human development in the context of interacting and overlapping environmental systems.



This model, (illustrated in Figure 6, on following page), has been found useful by team members in supporting maintenance of attention to the complexity of inter-related influences that parents, children, social workers, and team members can be subject to in making choices, and its visual representation allows for shared attention in assessment dialogues.



**Figure 6: Illustration of the Ecological Systems Model of Bronfenbrenner, (1979, 1989),**

(copied direct from the Internet document:

<http://nlyingst.iweb.bsu.edu/edpsy251/courseconcepts/251/bronfenbrenner.html>)

Kelly suggests, (2008, p. 26), "... *'The Ecological model is an example of a... Constructionist model... It is based largely on the work of Bronfenbrenner, (1979), who postulated the idea of an eco-system to explain complex processes contributing to differentiated developmental outcomes. The model looks at levels, or spheres of influence, moving from, and including, a child's individual characteristics to the characteristics, processes, values and beliefs associated with home, school, and community. The interaction of characteristics, factors, processes, and values is described as 'transactional', meaning that the child and his or her responses, characteristics, and developmental outcomes contribute to and are influenced and modified by dynamic, interactive processes. Potentially, the child influences the eco-system as much as it influences him or her'*".

### **1.5: Positions of 'neutrality' and 'inclusiveness, based on systemic practice'**

As a key asset of the "assessment service", the members of the assessment team intentionally seek to adopt a professional assessment position, which seeks to marry "neutrality" and independence of the referring agents, (in relation to received referral information), and inclusiveness of all parties who have direct involvement with the referred child, adolescent, or family.

In this context, a comment on the idea of "neutrality" from the work of Campbell and Draper, (p. 111), is particularly relevant. They are referring to an earlier article by Palazzoli et al., (1980), writing about family therapy, when they say, "*neutrality is not described as a quality is not described as in the therapist's personality or actions, but as an 'effect on the family'. In other words, neutral is not something that one "is" or "does", but the 'perceived effect' of one's actions*".

Members of the ‘assessment service’ continually emphasise to all parties that we are part of the ‘Tusla’ service child protection system, and that we endeavour to treat all participants in the assessment process in an authentic, transparent, respectful manner, and welcome each person’s, or agency’s contribution to the assessment process.

Inclusiveness in relation to the assessment process is manifest in the exhaustive attempts to contact as wide range of individuals and services who/which have been involved with clients, and in the nature of relationships formed with each party.

Considerable attention, thought, and reflection are pro-actively given to attempts to be respectful of separate viewpoints, and means of communication of information received from all parties/sources. Simultaneously, efforts are made to critically assess all information gathered, with awareness of how particular narratives in relation to the client may come to be dominant, or marginalised in relation to the assessment process. There is a focus on trying to understand: (a) how the information is used as currency in exchanges between parties; and, (b) how content is used to construct particular narratives and discourses in relation to each child, adolescent, or family, or service provider.

### **1.6: Position of the ‘assessment service’ in relation to the wider environment**

This research has occurred at a time when the ‘assessment service’ had been under imminent and ongoing threat of closure, (owing to a combination of severe funding limitations within public services as a result of a national monetary crisis, a shortage of residential child care staff within the associated H.S.E. residential services for the Southern region, and ongoing questions about the purpose, effectiveness, and perceived high cost of such a unique service).

Despite supportive advocates within social work services for the continued existence of the 'assessment service', the 'assessment service' has, also, been considered an unjustifiable luxury, (in terms of cost and numbers of clients seen), and as irrelevant, (in the context of poorly defined purpose and perceptions of a lack of transparency about admissions processes and decisions, assessment processes and methods).

Extant evidence for continuation of the 'assessment service' is based largely on quantitative information, (head-counts of numbers of completed assessments), combined with a positive reputation of the service held by some members of referring social work teams, based on individual anecdotal examples of 'successful outcome' in relation to individual higher profile problematic 'cases'. The same child care worker personnel who are involved with the 'assessment service', also, provide a separate respite care service for Tusla social work clients at weekends and holiday periods, and this has been seen to add to reasons for existence of the 'assessment service'.

A number of managers who are involved with the service have referred to how when the figures in relation to numbers of clients who have accessed the service are considered by senior management within the H.S.E. (Tusla) against the costs of running and staffing the 'assessment service', it is likely that the service could be viewed in a negative light, (owing to the apparent high costs of provision of assessment and childcare for a relatively small number of children with complex support needs, where identifiable outcomes and calibrated evidence of progression are not systematically collected, or available).

In this context, evaluation of the ‘assessment service’ has been seen by management as a relevant undertaking, and a key aspect of the research, therefore, is provision of organised and manageable descriptive data. Such information can afford persons who are outside of the ‘assessment service’, (such as, persons at senior management levels within Tusla, representatives of other services, referring social work services), grounded insight about what occurs within the ‘assessment service’.

### **1.7: A dual focus to the content of the data, and to the research methods used**

Issues, which relate to the utility, relevance, and credibility of the information provided in the current evaluation, (for persons who work within a system that tends to reduce evaluative data to costs, staff numbers, and client throughput), overlap with more general issues in relation to validity and reliability of qualitative research methods, and for this reason the work may be seen to have a dual focus.

This dual focus includes both:

- (a) attention to discovery of, and reflection on data about what has occurred within the ‘assessment service’ during its first ten years of operation; and
- (b) attention to the experiences of (i) conducting practice-based research within one’s own organisation with (ii) a mixed methods approach, and (iii) use of qualitative analysis software for handling of large data-sets.

### **1.8: The nature of ‘complex cases’ referred the ‘assessment service’ and the problems of fragmented service provision**

This ‘assessment service’ seeks to address the complex assessment and intervention needs of those children, adolescents, or families who are moving, or have already moved beyond the accepted societal boundaries of care, welfare, conduct, or healthy psychological development and self-regulation in contexts of home and family, school, or community.

The singular referral route, (through community child protection social work services (a service that operates across the borderlands of ‘mainstream’ society) means that clients who are selected for referral to the ‘assessment service’ tend to already be on the margins of society, in terms of exposure to identified developmental high-risk factors (such as domestic violence, parental substance abuse, or addiction, significant parental mental health issues, traumatic parental separation, significant limitations in parenting capacity, significant emotional distress and/or problematic behaviour patterns, poverty, neglect, physical abuse, emotional abuse, and/or sexual abuse, significant absence from school, educational failure, and/ or early school leaving).

Many of the individuals and families who are referred for assessment are presented by referring Social Workers as:

- (a) barely, or not at all contained by their own internal systems of self-regulation in relation to societal norms; and/or as,
- (b) barely, or not at all, contained by engagement with, and the actions and influence of community Health, Welfare, Education, Justice, or child protection services.

Children and adolescents who are referred to the ‘assessment service’ often are identified by atypical patterns of emotional and behavioural presentation.

Such presentations are often seen by the referring agents to arise (at least in part) from exposure to significant (often multiple) traumatic factors during their formative years of development, and/or failure to have their developmental support needs adequately met through relationships with others in family, school, or community environments. Often such individuals may be accurately deemed by social workers to have ‘complex’ support needs, in the sense that interactions of a number of distinct problems, (such as, relationship difficulties, learning difficulties, experiences of abuse, or neglect, mental health problems, or disruption of optimal parenting), at the interface of the child/adolescent with her/his environment can give rise to complex profiles of support needs. Identification of such complex profiles of support needs at assessment engenders calls for integrated, supplementary interventions from a number of different professional services, in conjunction with parents/carers, and education services.

### **1.9: Fragmentation of services**

In contrast to what is recognised to be required for effective child, adolescent, and family services, my experience of having worked as a psychologist in the Republic of Ireland for over twenty-five years has given me personal evidence of how, generally, there has been, and continues to be, a problematic fragmentation in relation to delivery of child, adolescent, and family professional intervention and support services.

Over years of practice in a wide variety of service settings, I have, also, encountered examples of absence of connection and, occasional, examples of apparent inter-discipline rivalry between different types of ‘psychological’ services, pre-school and school-age services, between ‘Health’ and ‘Education’ services.

I have, also, experienced frequent examples of lack of integration and absence of cross-fertilisation, or sharing of knowledge-bases, or information between professional disciplines, (psychology, social work, teaching, psychiatry, speech and language therapy), within services which are often defined by common age-bands, or by domain of service provision.

I believe that a significant contributory aspect of such fragmentation in relation to delivery of services arises from a historical tendency to piecemeal development of single-profession, or disability-specific services. Until the recent drive to establish the Child and Family Agency, ‘Tusla’ (established at the beginning of January, 2014), there has not, generally, been recognition of the possibilities of professional disciplines working together in formally integrated ways, or in multi-discipline teams, nor opportunities to do so.

Clients with complex presentations are likely to be involved with multiple services, and I believe that a potential negative effect of engagement with multiple services and with a range of professional disciplines can be collateral fragmentation of a coherent understanding of client circumstances, such that relevant information about what factors sustain problem situations, and what factors could most usefully be considered in attempts to induce and sustain positive changes may be missed.



Assessment interventions, which are limited in focus and which are not linked to a designated professional role with responsibility to seek engagement of clients with appropriate services, carry with them a risk of becoming obstacles to change and obstacles to relevant service provision. A child/adolescent, or family may become defined in terms of not being eligible for a service, without guidance as to what services would be appropriate, and this can lead to a 'pinball' effect of clients being 'bounced' between services that are resolutely defending their contact boundaries with clients and with other professional services.

Alternatively, a client, or family may become exclusively defined in terms of a specific, context-neutral area of difficulty, or deficit, (e.g., a client is defined exclusively in terms of presenting with a "General Learning Disability", or as presenting with "a Mixed Disorder of Conduct and Emotions"). Such a label may lead to foreclosure of further, comprehensive professional evaluation of relevant environmental circumstances, and/or client/family narratives that could inform professionals about readiness to change, or relevant client/family personal world-views that could support development of a meaningful working alliance in the service of positive change.

In some instances, what appears to be, or is reported as, a failure by an assessment service to clearly explain the process of assessment, the assessment system used, and the diagnostic label to clients may, also, result in a lack of faith by other professionals and by clients and in the assessment service.

Potentially, 'multi-discipline' services, which are organised around a number of different professional disciplines, (such as C.A.M.H.S.), offer opportunity to address assessment in a more-multi-faceted and holistic way than is the case in single-profession assessment services. However, often, in many of the local C.A.M.H.

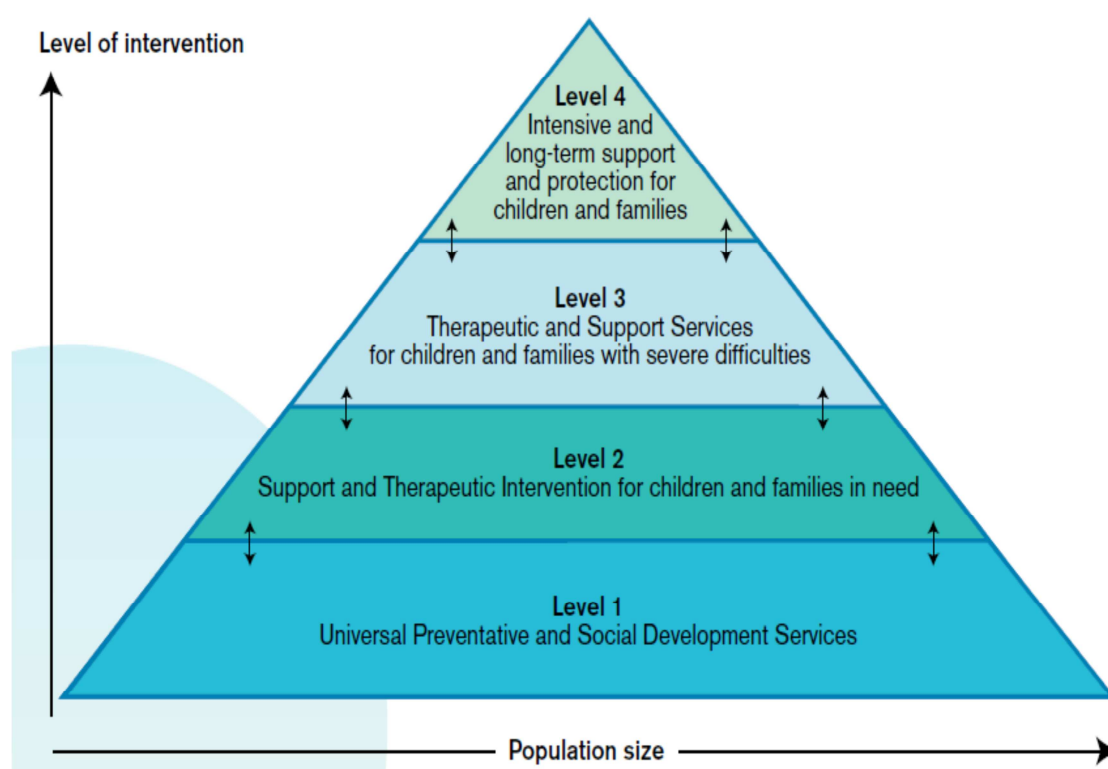
services it seems, that time-pressures, high service demand in combination with limited professional resources, a narrow threshold of eligibility for the service, and a focus on a ‘medical’ model, (which often seems to privilege ‘within-child’ explanations of ‘pathology’), leads to limited meaningful access to the resources and collective wisdom of the individual professionals.

**1.10: ‘Containment’ and ‘Reciprocity’ and attempts through the ‘assessment ‘service’ to address and redress fragmentation of assessment and intervention services**

During my tenure of the position of senior psychologist with ‘assessment service’ I have attempted to raise awareness with colleagues of the effects of fragmentation of services as contributory elements to development of problematic ‘complex cases’. In this case, it is useful to be able to summon up the visual representations of the Brofenbrenner “Ecological Systems” model of human development and the Hardiker model of levels of services to families (respectively, **Figure 6**, p. 24 and **Figure 7**, in Appendix 5).

Attention to the Brofenbrenner model prompts one to view clients and the problematic concerns, which are associated with them in the assessment referral information in the contexts of a dynamic interplay between individuals and their environments over time. Consideration of the Hardiker model encourages one to view the referral information from the perspective of regarding the client’s presentation as potentially related to and a factor of the nature of access to and involvement with child, adolescent, and family support services.

As outlined in the diagram (**Figure 7**, below, and further elaborated in Appendix 5) the ‘assessment service’ is most often concerned with referrals, which deal with children, adolescents, or families who need to access services at levels Three and Four (in addition to, or, perhaps, instead of those services that they may avail of/have already availed of at levels One and Two).



**Figure 7 - The Hardiker Model (1991) (diagram from Ferns Diocesan Youth Service (F.D.Y.S.), explanatory handout**

On the basis of such ‘maps’, (cf. Milner and O’Byrne, 2002), I have encouraged colleagues in the ‘assessment service’ to intentionally seek to offer an alternative approach, which in part aims to redress experiences and effects of fragmented service delivery.

This approach attempts to create a systemic and dynamic focus on individuals who are responding to environmental situations, individuals within patterns of relationships, and individuals within life-span contexts, (this is relevant both for issues of assessment and issues in relation to professional intervention).

In encouraging colleagues to respond in a pro-actively positive and individualised manner to clients (both children and parents) who are referred to the ‘assessment centre’, I have often been in the situation of ‘pushing an open door’, and we are able to agree strategic interventions in relation to assessments on the basis of shared ‘maps’ and perspectives..

The residential child care personnel in the ‘assessment centre’ are familiar from their initial training with concepts that are associated with pro-active positive care of children and families, with therapeutic factors to be considered in relation to emotional containment and processing, and with use of metaphors such as ‘journey’ and ‘story’ (for understanding the importance of attention to the dynamics of change processes and attention to personal meaning-making in relation to personal motivation, and in order to support adjustment to change and trauma). I return to these factors later in the ‘Discussion’ section of this work.

I believe that in terms of systems of assessment, fragmentation of services can be usefully considered to be a matter of lack of ‘containment’ at an organisational, or inter-organisational level, (where the idea of ‘containment’ is analogous to how this concept is used by Hazel Douglas in her 2007 work, “*Containment and Reciprocity*”).

Douglas, (2007, p.3), defines these terms as follows, “**Containment** is thought to occur when one person receives and understands the emotional communication of another without being overwhelmed by it and communicates this back to the other person. This process can restore the capacity to think in the other person”...

“**Reciprocity** initially describes the sophisticated interactions between a baby and an adult when both are involved in the initiation, regulation and termination of an interaction. Reciprocity applies to the interactions in all relationships”.

Douglas, (2007), continues, “Both containment and reciprocity are involved in the interrelationship between two people. However, within the mother/baby relationship, the mother is portrayed as much more active in the concept of containment, whereas both are portrayed as active within the concept of reciprocity”, and, (on p.13), “Both concepts highlight fundamental processes that enable us to relate to each other”.

Douglas, (2007, pp.24-44), links the idea of, “*containment*” with the work of Freud, Bion, Klein, Bick, and Daws, and concepts of, “*projection*” and, “*projective identification*”. These terms refer to hypothesised psychodynamic processes, whereby those experiences and associated feelings, which cannot be contained by the organism is projected into another as a form of communication of emotional experience.

In this context, the concept of “*containment*”, may be seen to refer to aspects of a professional-client relationship and processes associated with such a relationship.

I believe that the twin processes of “*containment*” and “*reciprocity*” are potentially inherent in the design and practice of the “assessment service”.

### **1.11 The ‘assessment service’ considered in terms of ‘Containment’ ‘Reciprocity’**

At present , the process has a definite beginning, with an initial ‘outreach’ meeting, where there is a gradual engagement with clients, and development of a collaborative working alliance through a process of ‘outreach’ visits, to the home setting, and ‘family visits’ to the residential assessment setting.

Clients are provided with written information, (in the form of client information booklets and spoken information, provided by child care workers, about the ‘assessment service’). Clients have a designated ‘key-worker’, (chosen from among the residential child care workers in the “assessment service”).

Parents/carers and children/adolescents know how long the assessment process will last, (i.e., 8 weeks), and are given a detailed schedule of assessment phases.

Clients know, in advance, that they will receive individual feedback of findings and recommendations from the assessment process.

Children or adolescents are ‘cared for’ and work with teachers in a nurturing environment, in an out-of-home and an out-of-school setting, (providing time and a different space for reflection on everyday situations and relationships). For many children and adolescents the effects such engagement with teachers in the context of a residential environment, which is intended to provide psychological, emotional, and behavioural containment and nurturance have appeared akin to a “Nurture Group” experience, (*“The aim of nurture work is to provide a restorative experience of early nurture in the children’s neighbourhood school”*, Boxhall and Lewis, 2010, p. xi).

The process has a definite end with a pre-scheduled ‘feedback’ meeting and in this sense, the clients have opportunity to have a sense of perspective and a sense of horizon in relation to the assessment process, in Gestalt terms, there is defined ‘closure’.

If my thoughts have some validity, or merit in relation to considerations about the relative ineffectiveness of many single-discipline and multi-discipline services, (owing to limitations in the levels of meaningful engagement with clients), it is worth attempting to translate the implications to the language of the market, management, and government.

I believe that failure to provide “*containment*”, and failure to recognise that assessment as an intervention is more than the systematic gathering of information from, or about a client, is likely to be costly to public services, in terms, of: resources; time; money, and ‘bad press’ as ineffective, and inadequate services. In relation to this research, I do not see that it is necessary to manipulate outcomes from the research to support these views of the effects of fragmentation and lack of integration of services on children and families. However, I would like to illustrate the subtleties of service provision by the ‘assessment service’, and the complexity of the task demands, which arise from the diversity and presenting high support levels of clients who are referred for assessment.

### **1.12: National developments in relation to children’s services**

The Irish General elections in early 2011, produced a change of government, and the incoming government announced through the Minister of Children, that it planned to remove Child Protection and Welfare services from the responsibility of the Health Service Executive, and to hold a referendum on children’s rights.

The Children's Rights Referendum was approved by the electorate on 10<sup>th</sup> November 2012 by a majority of 58% of the electorate, based on a national turn-out of 33.5% of the total electorate. Much of the opposition to the proposed constitutional amendments focused on suggested threats to the rights of parents, claims of excessive powers being allocated to Government and statutory, (social work), services, and criticisms of historical failures of government and State services to adequately provide for the support needs of children, adolescents, and families.

In a related development, the Report of the Task Force on the Child and Family Support Agency was published in May 2012, and the Government proposed the establishment of the new Child and Family Support Agency from 'early' 2013.

The Minister for Children and Youth Affairs stated in the Irish Parliament, ('Dáil Éireann'), that the new Child and Family Support Agency would have 4,000 staff and a budget of €590m, which would include the €26m budget of the existing Family Support Agency. She indicated that she had established a 'shadow agency' already within the H.S.E., and she said that the number of managers had been reduced from 34 to 16 and there was consideration of the potential for the further rationalisation of services for children under the new agency.

The Minister brought legislation before the Dáil in July 2013 for the establishment of the new Agency. On the 20<sup>th</sup> September, Minister Fitzgerald announced the appointment of members to the Board of the Family Support Agency, which was to become the Board of new Child and Family Agency on its establishment. The Child and Family Agency Bill has completed second stage in the Dáil and Committee Stage will be taken by the select committee on Health and Children in October.



In a statement issued on the occasion of the first meeting of this new Board, Ms. Norah Gibbons, (Chairperson of the Family Support Agency and Chairperson-designate of the Child and Family Agency), the following responsibilities of the new Agency were identified: *“the Child and Family Agency will assume responsibility for a range of services from Establishment Day. These services include:*

- *Child Welfare and Protection Services, including family support services;*
- *Existing Family Support Agency responsibilities;*
- *Existing National Educational Welfare Board responsibilities;*
- *Pre-school Inspection Services;*
- *Domestic, sexual and gender based violence services; and*
- *Services related to the psychological welfare of children.”*

Ms. Gibbons, also, stated that, *“The establishment of the Child and Family Agency, which brings together a wide range of child and family-centred services, represents very significant public service reform; involving 4,000 staff across three existing agencies and a budget of €570million approx.”*

The new agency came into being on the 1<sup>st</sup> of January, 2014, when many H.S.E. and N.E.W.B. personnel were transferred en masse, and without an opportunity to exercise any choice in relation to the transfer to the new agency. Approximately a dozen psychologists who were associated with residential care services were included in the transfer. At the time of writing, no additional dedicated psychological services have been allocated, or created for this new agency, although a Principal Psychologist position has been designated to explore development of such services.

*“Truth lies wrapped up and hidden in the depths”, Lucius Annaeus Seneca*

### **1.13: Relevance and the potential impact of the research**

This research is important, because it is the first systematic and comprehensive evaluation of a service that is unique as a model of service within the Republic of Ireland. The ‘assessment service’ is unique, because it is a multi-discipline assessment service, which contains a residential assessment component, and which is situated at the confluence of ‘borders’ of other ‘psychological’ and social work services.

Many children and families who are seen by this ‘assessment service’ seem to access the service at a time of actual, or potential transition of children from the care of their parents to voluntary, or compulsory placement into the ‘care of the Health Service Executive, (with possible options of respite care, foster-care, ‘shared-care’, or full-time residential care).

Referring agents, (at the time of making referral to the ‘assessment service’), also, often identify gaps in service provision, an absence of integrated and consistent professional practice, or an absence of informed reflective practice as reasons why their clients have reached a point of crisis in relation to Education, Justice, or out-of-home statutory ‘care’ services.

This research takes place in the early years of the second decade since the foundation of this child protection service, and it occurs against a backdrop of:

- (i) an intense focus on, reflection on, and criticism of past and current Residential Care provision in the country;
- (ii) an unprecedented National economic downturn with current and impending cut-backs and pressures on public services for children, adolescents and families;
- (iii) an apparent increase in environmental stressors on children, adolescents and families in the State, (i.e., cut-backs in public child and family services; increased financial pressures on families); and
- (iv) an apparent increased awareness within the country of psychological factors and risk factors with regard to child and adolescent development.

The research is important, because of the number of vulnerable children who are registered as within the ‘care’ of the H.S.E. (Tusla) A figure of 5,347 children in the care of the H.S.E. is stated by Clarke et al., (2010), and they note, (page iii), that, *“this represents a significant growth in the total number of children in care since 1990, when the figure was around 2,000. The Child Care Act, 1991 placed statutory responsibility on the then health boards for the protection and welfare of children and it is likely this had a bearing on the increase in the number of children in care”*. These children have been admitted to H.S.E. (Tusla) ‘care’ through the process of grant of a Care Order, sought by a H.S.E. (Tusla) social worker through the Court system. Research on the operation of this assessment service, which informs many such decisions in this region has potential to be used for development of systematic, child-centred practices throughout H.S.E. (Tusla) social work services nationally.

The research is important for the ‘assessment service’ at a service development level, as it offers an opportunity to systematically ‘take stock’ of the assessment practice over the ten-year period that has elapsed from the inception of the service.

The research is important, because its focus is at a point of interface and collaboration between professions which are associated with organisational involvement in the lives of children and families, (including the professions of psychology, social work, teaching, and child care worker). In particular the relationship between two key professions that are involved in child protection, welfare and development, namely psychology and social work is implicitly explored in this research.

The research is, also, important in the context of ongoing national responses to historical child protection and welfare concerns. There has been much recent public discussion and debate in relation to child protection services in popular media and political contexts in the Republic of Ireland since the presentation of the “Kilkenny Incest Inquiry” to government in May 1993, and in what is seen by many as the imminent culmination and outcome from a series of public scandals, investigations, and legislative and public service provision changes since that time.

#### **1.14: Framing the research questions**

In my experience, an integral part of the assessment process within the ‘assessment service’ has involved awareness of, and matching of disparate existing services with identified complex configurations of multiple support needs for children, adolescent, and families.

As an established, holistic assessment service, which has predated the recommendations of the Report of the Task Force on the Child and Family Support Agency by over ten years, the ‘assessment service’ has the potential to provide rich information with regard to ‘needs’ which present in Irish child protection services at all levels of the Hardiker model.

Qualitative evaluation and content analysis of archival data from the ‘assessment service’, thus, assumes a greater relevance for service planning and development, than would have been the case at the outset of my research endeavours.

When I consider the ‘assessment service’ and the development of the service in the context of the impending changes with regard to national child protection services, and against the backdrop of processes of wider cultural and organisational self-reflection in relation to delivery of child, adolescent, and family services, it seems relevant for me to quote someone whose writings moved me to apply for Doctoral training in Educational Psychology in the first instance. Tom Billington (2006) writes

*“How do we speak of children?*

*How do we speak with children?*

*How do we write of children?*

*How do we listen to children?*

*Additionally, how do we listen to ourselves*

*(when working with children)?”*



## **2. Literature Review**

### **2.1: Preface and proposed structure of this literature review**

The potential breadth of literature review that is possible, or relevant in relation to an mixed-methods evaluation of a multi-discipline, residential ‘assessment service’ for children (from pre-school ages upwards), adolescents (up to 18 years of age), parents, and family systems, (of any and every possible configuration and hue) is daunting and almost limit-less.

Therefore, for pragmatic purposes of balance within the word-limits of this thesis, manageability of completion of a task in a, hopefully, ‘good-enough’ manner, and in order to meaningfully support the rest of the work taken in this written record of a research endeavour, I have been selective and sparing about reporting the wide range of material attended to, and at the end of this review, I have included a listing of books, which I find useful in my practice and have used to share ideas with colleagues in efforts to create a constructive and shared “community of practice” within and associated with the ‘assessment centre’.

### **2.2: Introduction – children outside of the home and in the care of others**

Children spend considerable parts of childhood in the company of strangers (i.e., persons who are not member of their immediate family). It is the in the nature of childhood that as a developing person, each child is gradually exposed to social interactions with peers and adults who are part of a local community, but who are not necessarily family members. In some cases, such interactions are mediated by parents, in other cases, the interactions are mediated by professionals who work with children, those who are recognised by parents and by society as, “responsible adults” (i.e., responsible *for* the care and protection of children, and responsible *to* the children’s parents and to society for the care of the children).

Kemp, (2008), cites Parton, (1998, p. 11), as saying that, “*social work operates in the twilight zone between the private family world and the public world, and that this territory is ‘ambiguous, uncertain, and contested’*”. I believe that in the context of a multi-discipline assessment approach, which involves attention to a public space where experience of a child, or adolescent is shared between home and school, Educational Psychology can take a legitimate role in illuminating and exploring a “*territory*” that is seen as, ‘*ambiguous, uncertain, and contested*’.

School for most children offers a mandatory, formal, substantial, and observable, (therefore, assessable), experience outside of the home setting.

In relation to child protection, or welfare concerns, (a central concern of H.S.E. Social Work services, and the ‘assessment service’), there is great potential for soliciting reliable and verifiable observations from adults with professional expertise in relation to child development, (i.e., Teachers and/or Special Needs Assistants), with respect to a child’s, or adolescent’s daily presentation, his, or her emotional and inter-personal presentations with peers and with adults, his, or her life narratives, hopes, and concerns, and fears.

I believe that the contexts in which Educational Psychologist have traditionally practiced, (schools), encourage: attention to complex, rather than simpler causal factors, (eco-systemic and developmentally-focussed assessment practices, with reference to observed presentations of clients in context-specific settings – home, classroom, playground, etc.); engagement in collaborative assessment practices, (with teachers and with parents); engagement in child/adolescent-centred assessment practices, such as interview, dynamic assessment, evaluation of personal constructs, assessment of meta-cognition); and an awareness of the imperative for generation of formulations and recommendations, which are oriented towards fostering change, and which are practically implement-able by others, (child/adolescent, parents, or teachers).



School is a key theatre of life, where children are away from parents and in the care of persons, who are recognised as, “responsible adults”. Under the Education and Welfare Act (2000) parents are required to ensure that their children (from the age of 6 years to the age of 16 years) attend a recognised school, or receive certain minimum required types and standards of education. Enforcement of this requirement by the State is largely processed through representatives of the National Education and Welfare Board (N.E.W.B.) who are the Education Welfare Officers (E.W.O.s). The E.W.O.s have recourse to instigation of punitive legal proceedings with parents if they fail to ensure adequate minimum attendance and participation by their child in the education system. Although there is no absolute legal obligation on children to attend school, nor on their parents to send them to school, most parents opt to avail of education outside of their home setting.

Educational psychologists work in the same domains of practice as the Education Welfare Officers, and are often involve in assessment and problem-solving with E.W.O.s in relation to children and families who present as having problems in this area. This is one way in which educational psychologists may become involved with children who are identified as ‘at risk’ in terms of child protection, or welfare issues.

Intentionally placing one’s child in the care of other adults is premised on assumptions that both the individuals and the organisations concerned with the provision of such care are benign elements, and part of a benign system of care. This assumption is often explicitly addressed in public written statements about school ethos, mission statements, and policies.

It is clear that school is about more than education, it is about creation and maintenance of a safe environment for positive child development, and for modelling of appropriate adult relationships and appropriate responses to challenging life situations, and modelling of appropriate organisational/institutional codes of practice.

Insofar as school is a forum for processes of socialisation of children in line with a culture's ethical and moral standards, school affords children their first opportunity to be aware of the quality of a State's relationship with its citizens. In school, the State has an implicit relationship with a child as an individual citizen in a way, which is different to the State's relationship with that child as mediated through her, or his parents in her, or his home.

For at least ten years, parents are accountable for a child in the education system, (as per the parameters of the Education and Welfare Act, 2000), on a daily basis for almost 50% of each year. For those children who are educated outside of the home, in State-recognised schools, parents become accountable participants in a system of shared care with teachers, school organisations, and the government, (as represented by the Department of Education).

Accountability is mirrored in this two-way in this system of shared care, with other participants accountable to parents in terms of functioning optimally in relation to awareness of each child's care needs, and consistent demonstrable competencies in relation to knowledge, judgement, decision-making and actions for protection of children.

Educational psychologists have multiple opportunities to support development of each as school as a place of safety, which is responsive to changing environmental and societal circumstances and circumstances of individual pupils. Opportunities for provision of such support exist at organisational and systemic levels through delivery of in-service training for teachers, advice with regard to development of school policies and protocols, support for delivery of social, personal and health programmes, introduction of new programmes and approaches for pro-actively addressing issues, which may grouped under the terms "mental health and well-being", and extension of established protocols in relation to critical incident management to encompass child protection concerns about individual pupils.

## **2.3: Where child protection means that a child lives away from her, or his parents -**

### **Children in the care of the State – provision of professional services**

Tarren-Sweeney, (2010), focuses on provision of mental health services to children in care, (and those adopted from Care), highlighting the high numbers of children in care in the western world, (giving a figure of approximately one million), and indicating a doubling of numbers of children in care over the previous decade, which he states, *“is largely accounted for by a corresponding acceleration in the detection of child maltreatment”*.

A figure of 5,347 children in the care of the H.S.E. is stated by Clarke et al., (2010), and they note, (page iii), that, *“this represents a significant growth in the total number of children in care since 1990, when the figure was around 2,000. The Child Care Act, 1991 placed statutory responsibility on the then health boards for the protection and welfare of children and it is likely this had a bearing on the increase in the number of children in care”*.

Gilligan, (2009), speaking of residential childcare in Ireland, says, “Residential child care appears to be used, especially, to serve challenging or marginal populations within or on the edge of the child welfare system. A key function appears to be to absorb any slack left by foster care or family placement provision, which is the preferred mode of care in the Irish system...” He speaks of the evolution of residential childcare in Ireland as having had, *“three phases:*

- *institutionalisation and seclusion, (1850s to 1970s);*
- *professionalization and de-institutionalization, (1970s to 1990s); and,*
- *secualrization, specialization, and accountability, (1990s onward).*

*It can be argued that each of these phases reflected developments in wider Irish society and in the world more generally... Developments in residential child care in Ireland seem closely intertwined with the growth in Catholic female, and also new male) religious congregations, (residential communities), in the nineteenth century – there was an eightfold increase in the number of nuns in the period 1841-1901, (Clear, 1987, p.37). Most of these congregations began to pursue their mission through providing institution-based care to different groups seen as needy, including children with particular needs... Overall residential child care in this period might be said to mirror a broader and related tendency at that time in Ireland to rely on institutions to hide society's "outsiders" or to "bury" social problems."*

Gilligan, (2009, pp.15-16), writes of how, *"Residential child care currently embraces a number of models for different groups of children and young people, and operates under the auspices of a number of different sectors and legal arrangements"*.

Tarran-Sweeney (2010) says, *"It's time to re-think mental health service for children in care, and those adopted from care... Surveys have consistently found that a child in care is more likely than not to have psychological difficulties of sufficient scale or severity to require mental health services, regardless of their location... Around half of children in care are reported as having clinically significant mental health difficulties, while up to one quarter more have difficulties approaching clinical significance... recent findings suggest that a sizeable proportion manifest complex psychopathology, characterized by attachment difficulties, relationship insecurity, problematic sexual behaviour, trauma-related anxiety, inattention/hyperactivity, and conduct problems and defiance... Children in care also endure poorer physical health, higher prevalence of learning and language difficulties, and poorer educational outcomes than other children... studies carried out in England suggest as many as 60 per cent of children manifest mental health difficulties six years after being adopted from care."*

He gives the main focus of his article as, “*Standard child clinical conceptualization, assessment methods, and formulations miss the mark for these vulnerable populations in a number of critical ways. The present paper proposes 10 principles to guide the design of mental health services for children in care, and those adopted from care.*”

## **2.4 : Educational Psychology in the changed landscape of Irish Education**

Educational Psychology, as a profession, is intrinsically linked to work with children, parents, and organisations within the Education system. The profession has developed in Britain over the past fifty to sixty years, as an accepted essential element of the mainstream education system at pre-school, Primary and post-Primary levels.

Within the Republic of Ireland, the establishment of the National Educational Psychological Service (N.E.P.S.) in 2000, accompanied by employment of over 100 educational psychologists by that service within the following years marks a watershed in development of the profession within this State. The foundation of this service officially distinguished the profession from more established clinical psychological services and from psychological services, which were associated with general learning disability organisations. Psychological services within organisations that were providing services for children with general learning disabilities had often, hitherto, provided a de facto school psychological service to schools in the absence of a nation-wide educational psychology service. Establishment of the service, also, served to identify, (for the first time in many instances), the existence of the profession among teachers, children and parents at Primary and post-Primary levels.

The N.E.P.S. organisation defines itself as follows, "*NEPS mission is to support the personal, social and educational development of all children through the application of psychological theory and practice in education, having particular regard for children with special educational needs.*" This is a broad remit, which goes beyond narrow definitions and implicitly includes attention to and support for development of positive mental health, healthy relationships with others, and self evaluation.

To date, N.E.P.S. has had opportunity to be involved in the introduction and refinement of systematic and graduated assessment of individual pupils, and through involvement of parents in the referral and feedback elements of the assessment process have set a precedent and literally and metaphorically opened doors for home-school liaison and links. Often in network of communication, between pupil, psychologist, parents, school, other professionals/agencies, and the Department of Education, the educational psychologist may have roles in relation to advocacy and/or mediation, or “brokerage”. Establishment of expectations and habits of two-way communication and accountability between home and school are key elements of an effective child protection system. Given their accepted role in relation to critical incident management in schools, and their placement in a liminal space in relation to schools, educational psychologists, (subject to appropriate training), could be well-placed to an advocacy role in relation to individual children where child protection issues pertain. Educational psychologists have a designated responsibilities for assessment, for liaison with parents, for liaison with other professionals and agencies, and work is undertaken in collaborative and inclusive ways, which are child-centred, consensual, inclusive of family perspectives, and collaborative.

Individual assessments and pieces of consultative work, which have been undertaken by educational psychologists with N.E.P.S. have emphasised a systematic, phased, holistic and inclusive assessment approach, have specifically attended to explicit models of consultation, and have supported a move away from exclusive focus on problems as located “within-child” to examination of the “meaning” of a child’s behaviour and modes of emotional expression, and attempts to understand each child’s functioning in relation to family of origin, life experiences, developmental pathways, and views of the world, as well as her, or his competencies and potentials.

The foundation and development of N.E.P.S. over the past decade has, also, led to the establishment of the profession of educational psychology within the walls of schools, (thus, engendering systemic change by adding another element to support of teachers, pupils, and parents, and contributing to accountability and openness within schools and across the education system).

The establishment of the N.E.P. Service, pre-dated establishment of the National Education and Welfare Board, (N.E.W.B.), in 2002, with designated Education Welfare Officers, (E.W.O.s), and pre-dated establishment of the National Council for Special Education, (N.C.S.E.), in 2003, with designated Special Educational Needs Officers, (S.E.N.O.s).

Together with these services and their designated officers, N.E.P.S. is a feature of a new educational landscape in the Republic of Ireland, which was created and laid down during the first decade of the new millennium, and which promotes a potentially more differentiated and higher levels of engagement by statutory bodies in the lives of children and their parents, (at least in relation to those children who are identified by their teachers as experiencing problems and/or failing to benefit in normative ways with regard to ease of engagement with the formal education system).

## **2. 5: Role of Educational Psychologists, (E.P.s), in child protection processes**

German et al., (2000, p. 264), reviewed and outlined the views of the British Psychological Society in relation to the role of Educational Psychologists, (E.P.s), and child protection,

*“The BPS (1994) national commission of inquiry into the prevention of child abuse stated clearly that EPs have an important and varied role to play in child protection.*



*This, in addition to the government documents on multi-disciplinary roles and the Children Act (1989), outline the role for the EP, given EPs' regular contact with schools, children and families. The BPS (1994) report made a number of recommendations, stating that EPs are able to and should work with children and families during all the stages of the child protection process: pre-disclosure, investigation and assessment, post-disclosure, including further assessment, drawing up treatment plans, implementation, review and re-assessment. The report suggested that the EP has a responsibility to assess the risk to the child, family and perpetrator and, at a more individual level, should assess the psychological damage to the victim and formulate a treatment plan in conjunction with the victim and other agencies.”*

German et al. (2000, p. 264), also, identify two child protection packages, which they report have been designed by educational psychologists: (a) Evans, G. (1993) *Child Protection: A Whole Curriculum Approach*. Bristol: Avec Designs Limited, and, (b) Marsland, P. and Farrell, P. (eds.) (1989) *What's Different About This Child Today? Issues in Child Protection for Schools*. Manchester: NSPCC and University of Manchester.

They go on to highlight the specific contributions, which Educational Psychologists could make to the child protection process, citing the work of Nissim and Peake, (1992), stating that they, “commented on the distinct areas of expertise that EPs can offer to the area of child protection and also to the work of social services departments. Primarily, EPs have a specialist knowledge base and are familiar with normal and abnormal child development throughout the full age range 0-19 years. EPs also have knowledge of different theories of human development, growth and behaviour, and have a range of specialist assessment skills, techniques and tools. They are able to offer assessment at individual, group, and family level. Additionally, some EPs can offer appropriate forms of intervention. EPs can also offer training and consultancy skills and Nissim and Peake (1992) see this as a central role in their work for Oxfordshire Social Services.”

For any who may be unclear about a role for educational psychologists in relation to child protection processes, Nugent et al, (1999, p. 33), in a paper that addresses child sexual abuse and the role of educational psychologists, argue that, “... *the experience of child sexual abuse can often have a negative effect on learning, behaviour, attendance and socialisation in school. Therefore, EPs have an important role to play in addressing these needs. It is well recognised that the number of children identified as having been sexually abused is relatively low, (Maher, 1987; Renvoize, 1993). When identification of child sexual abuse does take place, the response from educationalists, very often, is to delegate the responsibility for intervention to social services and the police. The investigative process is often lengthy and traumatic for a child and it is important to be aware of the NCH Action for Children, (1994), finding that at least one in four children are not offered therapy. Whether or not a child receives therapy, he or she will be expected to attend school. If the experience of sexual abuse has a negative impact on schooling, then it is the teachers and EPs who have the primary responsibility for identifying and meeting those needs.*” The key points here are the recognition of the centrality of a school environment to the life-experience of most children, and the impact of abuse on key aspects of a child’s functioning, (learning). In this context, it is appropriate to choose to interpret “learning” in school from a broader perspective than academic learning, the impact of abuse on a child is likely to affect her, or his learning about her, or his personal boundaries, her, or his intra-personal world, (including identification and expression of emotions, moral reasoning, and sense of self and identity), relationships with peers and relationships with and trust in adults. In terms of knowledge-bases, skills sets, relevant professional training, assigned primary tasks in relation to designated roles, and professional support structures, (supervision and membership of a relevant professional community), Educational Psychologists are likely to be better-placed than most professionals in the Education sphere to constructively and competently address child protection issues.

## **2.6 : “The Munro Review of Child Protection Final Report – A Child-centred system”**

In 2010, the Minister for Education in England requested Professor Eileen Munro to conduct an independent review of child protection. The Final Report, (from a total of three Reports), from this review process was published in May 2011. Professor Munro states early in the Report, (p. 6), that, *“The review began by using ‘systems’ theory to examine how the current conditions had evolved”*. In the first of the three Reports she, *“described the child protection system in recent times as one that has been shaped by four key driving forces:*

- *the importance of the safety and welfare of children and young people and the understandable strong reaction when a child is killed or seriously harmed;*
- *a commonly held belief that the complexity and associated uncertainty of child protection work can be eradicated;*
- *a readiness, in high profile public inquiries into the death of a child, to focus on professional error without looking deeply enough into its causes; and*
- *the undue importance given to performance indicators and targets which provide only part of the picture of practice, and which have skewed attention to process over the quality and effectiveness of help given.”*

She concluded, (p. 6), that, *“These forces have come together to create a defensive system that puts so much emphasis on procedures and recording that insufficient attention is given to developing and supporting the expertise to work effectively with children, young people and families.”*

Professor Munro, (p. 6), states that the second report from the review process, *“considered the child’s journey through the child protection system – from needing to receiving help – to show how the system could be improved”*. She concluded that, *“instead of “doing things right”, (i.e. following procedures), the system needed to be focused on doing the right thing, (i.e., checking whether children and young people are being helped)”*.

The third Report incorporates the two earlier Reports and makes wide-ranging and specific recommendations, informed by a systems analysis perspective and consultation with children, as well as consultation with relevant professionals who are involved in child protection. The whole Final Report is worth consideration by professionals in the Irish context who are involved in education of children, in the care of children, and/or in child protection services, and Professor Munro reflects clearly on lessons to be learned from earlier generations of child protection initiatives. The following comments from the Final Report by Professor Munro recognise the complexity of child protection processes, warn against assumptions that the work is finished when a new initiative has been launched and suggests constructive ways of “thinking outside of the box” in relation to child protection.

Professor Munro, (p. 14), notes that, *“Determining how to improve the child protection system is a difficult task as the system is inherently complex. The problems faced by children are complicated and the cost of failure high. Abuse and neglect can present in ambiguous ways and concerns about a child’s safety or development can arise from myriad signs and symptoms. Future predictions about abusive behaviours are necessarily fallible.*

*The number of professions and agencies who have some role in identifying and responding to abuse and neglect means the coordination and communication between them is crucial to success.”*

She observes, (p. 15), that, *“There have been determined efforts to improve the child protection system over many decades. The reforms made have been well-informed and substantial progress has been made. Despite this, the problems revealed in inquiries and Serious Case Reviews (SCRs) into child deaths and serious injuries are of a repetitive nature. The cumulative impact of reforms has contributed to a heavily bureaucratised, process-driven system that frontline professionals experience as creating obstacles to the timely and effective provision of help to children and families. To understand better why reforms have not always had the intended effect, the review has undertaken a systems analysis. Before making further recommendations for reform, systems thinking has helped the review form a deeper understanding not only of ‘what’ has been going wrong but ‘why’ the system has evolved this way.”*

The following comment, (p. 15), gives a flavour of how creative use of systems thinking from other professional areas may contribute to promotion of dynamic, enduring, and consistently effective systems of child protection, *“The review has also drawn on the lessons learned from other high risk areas of work such as healthcare and aviation. These sectors share a similar history to child protection of mistakes and tragic outcomes leading to reform efforts that not only produced a disappointing level of improvement but also created new complications. By looking at the wider context in which professionals work, these industries have developed new methods of understanding what contributes to the quality of performance. These lessons are now leading to more effective reforms that raise the quality of work.”*

As a profession, Educational Psychology in Britain, and subsequently in Ireland, has often used ideas and approaches from systems thinking, systems analysis, and family systems therapy in work with children, parents, and schools, in order to facilitate understanding of

complex issues and situations, and in order to choose the most effective and efficient point(s) and mode(s) of intervention. The following section briefly reviews some relevant contributions from a systems thinking perspective.

### **2.7: Educational Psychology, systemic thinking and practice**

Working in a designated role within schools, in a context, which affords opportunity for access to observations of children over extended periods, across a range of situations with different tasks demands, and across a diverse range of peer relationships and relationships with different adults outside of the home situation distinguishes the work of educational psychologists who work directly with schools, from the work of clinical, or counselling psychologists, and from the work of professions, such as social work, (with a focus on home situations), or from the work of what tend to be clinic-based, or centre-based professions, (such as psychiatry, speech and language therapy, or paediatric occupational therapy).

Opportunity for such observation, potentially, increases the validity of reliability of any assessment work undertaken with children, offers opportunities for multiple perspectives on a child's presentation, (individual face-to-face work with a child, observation of child in a variety of situations, elicitation of opinion from adults who have daily familiarity with a child, inclusive of elicitation of opinions from parents, elicitation of opinions from teachers and other school personnel, such as Special Needs Assistants).

Similarly, the context of the work affords possibilities for constructive therapeutic intervention at diverse levels and multiple levels. Intervention may be considered: with groups of teachers, at an organisational, (school), level; with groups of teachers, across a number of organisations, (working with clusters of schools); working with an individual teacher; at the level of an individual pupil; working conjointly with a child and her, or his

parents; working with parents, or groups of parents; and/or working with a triadic combination of child-parents-teachers in the context of a particular school culture.

In making sense of the complexity of the territory within which educational psychology operates, educational psychologists have often utilise the Ecological Systems theoretical model of Bronfenbrenner, (1979). A key feature, which distinguishes this model from many other theories of child development is the emphasis placed on environmental influences on development.

The model allows one to contextualise the individual experiences and functioning on an individual child within her, or his naturally occurring family, social, community, cultural and historical systems. In the context of child protection and welfare, the model has potential (similar to model used in the Buckley et al., 2006 “Framework for Assessment of Vulnerable Children and their Families”) to encourage awareness of the complexity of interaction of multiple aspects of risk and multiple protective factors in relation to each child.

Bronfenbrenner’s levels of systems analysis include:

- **Micro-system:** Referring to the immediate environment that an individual interacts with, including an individual's family, peers, school, neighbourhood, and organised religious experiences.
- **Meso-system:** Referring to relations between micro-systems, or connections between contexts, such as the relation of family experiences to school experiences, school experiences to organised religious experiences, and family experiences to peer experiences.
- **Exo-system:** Referring to links between a social setting in which the individual does not have an active role and the individual's immediate context, such as, a child's

experience at home may be influenced by a parent's experiences at work, (e.g., employment, change of work location, change of work hours).

- **Macro-system:** Referring to the culture in which individuals live, such as, socio-economic status, poverty, and ethnicity. Members of a cultural group tend to share a common identity, heritage, and values. The macro-system evolves over time, because each successive generation may change the macro-system, leading to their development in a unique macro-system.
- **Chrono-system:** The patterning of environmental events and transitions over the life course, as well as socio-historical circumstances. For example, parental separation, death of a parent, recession, or a boom economy.

Dowling and Osborne (1994) proposed what they called “a joint systems approach” for work by educational psychologists with children in schools. This approach aimed, (p. xv) “*to provide a bridge between theory and practice, and to draw together separate advance in the application of systems theory to the fields of family therapy and of consultative work in schools, in order to suggest a model for working jointly with both families and schools*”.

The work of Dowling and Osborne, (editors), and other contributors to their book provides a relevant starting point for understanding the potential contribution of this way of working to Educational Psychology practice, and one can see the relevance of this to the material discussed in “The Munro Review of Child Protection Final Report – A Child-centre system”, (2010).

Fox, (2009), has reviewed the development of and integration of systemic thinking with Educational Psychology practice in Britain from the 1950s until recent years, with a focus on



how systemic thinking has been utilised for, and has shaped approaches to work with children and families and with schools as organisations. He charts a view of development of streams of professional thought and practice throughout the latter half of the twentieth century and the early years of the current century, which conveys a sense of occasionally shared and often diverse roads taken by the epistemologies of systemic thinking and practice and Educational Psychology. Fox's paper is likely to be helpful in thinking about future directions for the profession. It complements the earlier work of Dowling and Osborne, (1994), and provides a panoramic view of professional practice within the context of systems thinking, which can helped to calibrate one's own position in relation to ways of working ,and supports a sense of distinct sense of professional identity, (whether one chooses to practice within this approach, or not), in relation to other branches of the applied psychology and in relation to other professions, which are involved with children and families.

Early in my thinking about my own reasons for undertaking this research and reflecting on the nature of the 'assessment service' for me in my practice as an educational psychologist within this service, I was drawn to work, which has been a source of both personal and professional inspiration for me, namely the creative nexus of the "Crane Bag".

This was an intellectual journal founded in 1977 by Richard Kearney and Mark Patrick Hederman with the support of the poets, Seamus Heaney and Seamus Deane, and the concept of 'Fifth Province' thinking (as espoused by Byrne, N., Kearney & McCarthy I.C., (2002) in relation to systemic thinking and social work services).

What prompted my turn to this material was reading Milner and O'Byrne (2002) while seeking to better understand the perspectives of social workers to assessment of children, adolescents, and families. These writers give a useful insight into the complexity of the

information, which social workers are expected to hold and process, when they speak (pp.68-69) of how, *“Social workers are introduced to and familiar with, a wide range of theory from the sociological... to the psychological... There exist a plethora of research findings concerning specific aspects of people’s lives, including psychological research findings relating to such aspects as attachment and loss, stages of human development, personality development theories, the hierarchy of human needs, intellectual development and moral development. Sociology offers theoretical insights into social strata, power, oppression, while social psychology looks at, e.g., groups and decision-making, and the dynamics of formal organisations. The cycles of development in family life are studied, as are deviance and crime, and mental illness. On top of these, there is a knowledge of the law and rights”*.

They posit the question (p.69) *“How do all these fit together?”*

To answer this question, they begin to consider (p. 80) five theoretical approaches, which they call “maps”, based on derivation from the work of Bateson (1972).

They identify (pp. vi-vii and p.81) the five theoretical “maps” of assessment as:

- *“the “map of the ocean” : Psychodynamic approaches”;*
- *“the “ordnance survey map” : Behavioural approaches”;*
- *“the “handy tourist map” : Task-centred approach”;*
- *“the “navigator’s map” : Solution-focussed approaches”;*
- *“the “forecast map” : Narrative approaches”.*

Hederman (1985, Vol. 9, Number 1, p. 110) in explaining the title of the *“The Crane Bag”* journal, (as follows) also, outlines how “Fifth Province” is relevant and can be applied in situations of debate and judgement about complex, ephemeral matters, where conflict with

recourse of participants to tenaciously held value, and antagonistic systems and ideologies are at play.

*“A bag not a book, a container, rather than a content in itself was what it was meant to be.*

*‘The Crane Bag is really a place... no-man’s land, a neutral ground, where things can detach themselves from all partisan and prejudiced connection...*

*Does such a place exist? Can such a place exist?’ This was the question we tried to answer within the pages of our journal... It was within this context that the notion of the fifth province was first suggested.*

*We maintained the following description: ‘Modern Ireland is made up of four provinces, whose origin lies beyond the beginning of recorded history. And yet, the Irish word for province is ‘coiced’, which means ‘a fifth’. This fivefold division is as old as Ireland itself, yet there is disagreement about the identity of the fifth. Some claim that all the provinces met at the ‘Stone of Divisions’ on the Hill of Uisneach, believed to be the mid-point of Ireland. Others say that the fifth province was Meath, (‘Mide’), ‘the middle’. Although they disagreed about the location of this middle, or ‘fifth’, province...*

*Although Tara was always the political centre of Ireland, this middle, or fifth province acted as a second centre, which, although non-political, was just as important, acting as a necessary balance, it was sometimes described as a secret well, known only to the druids and fili, (poets) these two centres acted like two kidneys in the body of the land. The balance between the two was guarantor of peace and harmony in the country as a whole... Uisneach, the secret centre, was the place where all oppositions were resolved...*

*The constitution of such a place would require that each person discover it for himself within himself... The purpose of The Crane Bag is to promote the excavation of such un-actualized spaces within the reader, which is the work of constituting the fifth province’*

*“The Fifth Province is a metaphor taken from Irish Celtic mythology and represents a ‘space’ wherein different and often opposing realities might meet and engage. As such, it also stands as a metaphor for an approach wherein the realities of individuals are voiced, heard, accepted and respected in a disposition of love. When we listen to the storied lives of our clients we are constantly challenged to place our ‘selves’, our stories and our constructs at risk so that we can be open to receive their gift of soul baring. To open space for another, we are called on to be present and to let go of our personal prejudices and agendas.”*

This metaphor, aside from its utility in explanation of aspects of systemic thinking is appropriate to the ‘assessment service’, which has a reporting relationships to the child care manager of North Lee child, adolescent and family services, (in county Cork), while having a physical location in the neighbouring county Kerry. It, also, belongs as an ‘assessment service’ to all five Tusla Social Work teams, while not being a defined, permanent feature of any single tea. As such, the ‘assessment service’ occupies on many levels a liminal space in child protection and welfare services, which is similar in essence to the transient, yet significant position of the metaphorical “*Fifth Province*”.

## **2.8: A guiding template for Tusla social work assessment services**

Over the past decade, a guiding template for H.S.E. social work assessment services has been the British ‘Framework for Assessment’ (2000) which uses a three-perspective approach that is focussed on: the child’s developmental needs; parenting capacity (i.e., the capacity of parents, or caregivers to respond appropriately to those needs, including their capacity to keep the child safe from harm) and, family and environmental factors (i.e., the impact of wider family and environmental factors on the parents and child).

**Appendix 3** of this document gives further details of the key elements of this framework. The document is a useful reference point for psychologists as: it has currency with existing Tusla child protection social work services; it has a stated explicit aim of provision of “*a systematic basis for collecting and analysing information to support professional judgements about how to help children and families in the best interests of the child*”; and its simple framework of three domains of assessment, allows opportunity for clear engagement with social work and other professions with respect to what psychological services could offer in the context of child protection and welfare services.

### **Appendix 9 Listing of resources**

In the context of assessment work, which is undertaken in relation to child protection, and mental health promotion, **Appendix 9** contains a brief listing of resources that I have found to be worth consideration.

### **3. Methodology**

#### **3.1: Introduction and research metaphor**

I am interested in exploring and seeking to understand more of the complexity of the ‘assessment service’ in ways, which are inclusive and representative of the views of those who have been participants in the assessment.

I do not believe that any single participant account, (or collection and amalgam of individual participants accounts), of the workings of the service will serve as the “truth” about the service.

At the same time, I value and I want to capture a comprehensive sense of the operation of the service over its lifespan in a way, which includes the richness of voices of participants, and which moves beyond quantitative data about the service, such as might be contained in ‘annual report statistics.

Awareness of how the influence of personal relationship context could affect efforts to gain perspectives and insights about the service from persons who have had previous experience of the service, moves me away from an approach that would be largely reliant on interviews about recollections of historical experiences.

Given awareness about the limitations of alternative sources of research data, and methods of research, I was fortunate in the course of supervision with my assigned course tutor to become aware of a potentially rich seam of untapped data, which could match with my personal curiosity about the assessment service. Electronic records exist for all assessment team reports, which have been compiled across the complete lifespan of the assessment service. I have been able to negotiate access to this extant contemporaneous electronic data.

Research metaphors, which fit for me in relation to the possibility of research using this naturally occurring data, (i.e., data, which arose organically from the function, purpose, and work of employees of the organisation, and which remained as a trace of past client-professional relationships and work completed), are the metaphors of “archaeology”, or “forensic anthropology”.

The narratives/perspectives, which arise for me in relation to these metaphors, are of beginning work at present-day ground-level, (i.e., in consideration of the present-day status of the ‘assessment service’, knowing from the existing topography and from the oral history of *muintir-na-háite*, (i.e., literally the people of the palace, or the ‘locals’ – those persons who are currently employed in the ‘assessment service’, or those social workers who still employed by the local child, adolescent, and family services and who have referred clients to the ‘assessment service’), that the site has been inhabited in previous generations, (i.e., previous incumbents of roles within the ‘assessment service’, and clients who have previously availed of the ‘assessment service’), with each generation building on, or close to the original site of habitation, (the ‘assessment service’).

Changes in personnel have obviously occurred, the profile of the inhabited site has changed, individual life-cycles in relation to the site have overlapped, affected, and helped to shape the presence of the current inhabitants.

Much is implicitly ‘known’ about the customs, culture, values, and practices of previous inhabitants. Evidence of their presence is available from written records, and oral tales handed down by the “*seanacháí*”, (story-tellers), of the culture, and some artefacts and physical constructions of earlier times still exist and endure in current usage.

However, all who are involved with the service recognise that what is visible, audible, and evident on ‘the surface’ is only a degraded part of greater whole, which could be further explored by systematic analysis of ‘the site’, in this case through systematic analysis of the archived records of the professionals who have plied their professions across previous ‘generations’ of the ‘Assessment service’, and who are represented in its operation today.

The underlying research philosophy is grounded in the research paradigms of pragmatism, and critical realism. The research has been focussed on producing information, which is relevant to the specific ‘real-world’ context of development of an existing ‘assessment service’. This service, historically, has been unique within the Health services in Ireland. The research has involved working with archival assessment report data, which has been generated from assessment work completed by the ‘assessment service’.

A mixed methods approach is used, which includes quantitative analysis of patterns of all assessments completed by the ‘assessment service’ on a year-by-year basis, (in terms of information such as, age of child referred, gender, details of referral source), and a qualitative content analysis approach to examination of the content of the assessment Reports in a smaller selected sample, (representing 42% of completed reports for the period), that I have chosen from archives of all completed assessment reports for the first ten years of operation of the service.

The data was ‘collected’, (having initially obtained permission from the relevant management representatives within the Health Service Executive, H.S.E.), from extant assessment report archives, which are held by the ‘assessment service’.

I converted the electronic records of these reports to “rich text” format, and entered the converted records in their respective annual data-sets for ease of further examination, management, and analysis using MAXQDA software.



The research is both ‘exploratory’ and ‘evaluative’.

The research has involved:

- (i) comprehensive quantitative analysis of the assessment reports for children, adolescents, and families who have been assessed by the service over a ten- year period (i.e., data about ages, gender, geographical area); and,
- (ii) content analysis of a chosen sample assessment reports, which were completed for the period 2000 to 2009 (i.e., the first ten years of the service).

### **3.2: The Research Philosophy**

A foundation of this research for me has been efforts to establish clarity for myself with regard to the position, which I have adopted as researcher in conducting the research.

In my everyday practice as a psychologist, I have identified myself as choosing to work within social constructionist and personal constructionist frames of reference.

My viewpoints are consistent with assumption that in any context, there exist multiple and dynamic valid views of reality, rather than a single fixed form of reality, which is available to be discovered, or known.

von Glasersfeld has summarised such a viewpoint as follows, (1991, p. 17), as, “*As a constructivist, I have never said, (nor would I ever say), that there is no ‘ontic’ world, but I keep saying that we cannot ‘know’ it. I am in agreement with Maturana when he says: ‘an observer has no operational basis to make any statements or claim about objects, entities or relations as if they existed independently of what he or she does’ (1988: 30)*”.

However, in preparing this research, I have struggled to match my self-perceived inclination to ‘social constructionism’ as a core element of and basis for my professional practice and the transference of such a position to an epistemology that is consistent with research interests, research questions, and chosen research voice and methodology. In my professional practice as a psychologist, I have been convinced that a social constructionist outlook has provided me with flexibility and open-mindedness in daily interchanges with other professionals and clients (allowing me the creativity to draw on a wide range of different theoretical perspectives, knowledge-bases, and methods in a constructive, integrative, and containing manner when working with colleagues and clients). From a personal construct perspective, Kelly’s (1955) “*fundamental postulate*” that, “*A person's processes are psychologically channelized by the ways in which he anticipates events*” affords permission to question and challenge one’s own perceptions and assumptions and those of others, and appears to be almost an invitation to consider alternative versions of reality and theoretical positions.

In the context of this research endeavour, I have felt confused and conflicted with such a position, which has seemed too flimsy, fickle, and intangible in the context of a necessary ‘concrete-ness’, tangibility and robustness for the realm of research.

*“All research beyond the banal begins in uncertainty, where action is unanticipated and anticipations are unrequited. We enter slippery, uncertain ground. Paths grow faint, the footing unsound. In real beginnings, we nearly always stumble, are misunderstood, and lose our confidence or our way some of the time. The awkwardness seems unsightly and unprofessional, so we rarely tell beginning tales”.*

(Charmaz, K. and Mitchell, R.G. Jr., 1987, p.209).

These words of Charmaz et al. resonate for me, (given my own laborious attempts to produce quality written material during this research), when I reflect on my choice to engage in mixed methods quantitative and qualitative research. The array of qualitative research approaches, which were potentially available in relation to evaluation of the ‘Assessment service’ were dazzling and confusing.

Dovona-Ope, D.R., (2012, writing in Midgely et al., 2012, pp.27-33), explores, “*Determining a Voice to Use in Writing about Mixed Methods Research*”, and she speaks of “*binaries*” that influence a choice of author’s voice, inclusive of dichotomy that has traditionally existed between “quantitative” and “qualitative” research methods with associated voices ranging, respectively, from an “*impersonal*” voice to a “personal” voice.

In relation to making sense of such “*binaries*”, I have found the Table, by Wahyuni, D. (2012, p. 70), which is presented here, (on following page) as **Figure 8**, to be of great assistance in structuring my thinking about my research position and research methodology, following feedback received at my Viva. The clear structure and visual-spatial layout of this grid, combined with clear definitions of facets of research paradigms provided me with tangible and enduring clarity about my own research position and helped me find a coherent research voice.

<b>Table 1: Fundamental Beliefs of Research Paradigms in Social Sciences Research Paradigms</b>				
<b>Fundamental Beliefs</b>	<b><i>Positivism (Naïve realism)</i></b>	<b><i>Post-positivism (Critical Realism)</i></b>	<b><i>Interpretivism (Constructivism)</i></b>	<b><i>Pragmatism</i></b>
<b><i>Ontology: the position on the nature of reality</i></b>	External, objective and independent of social actors	Objective. Exist independently of human thoughts and beliefs or knowledge of their existence, but is interpreted through social conditioning (critical realist)	Socially constructed, subjective, may change, multiple	External, multiple, view chosen to best achieve an answer to the research question
<b><i>Epistemology: the view on what constitutes acceptable knowledge</i></b>	Only observable phenomena can provide credible data, facts. Focus on causality and law-like generalisations, reducing phenomena to simplest elements	Only observable phenomena can provide credible data, facts. Focus on explaining within a context or contexts	Subjective meanings and social phenomena. Focus upon the details of situation, the reality behind these details, subjective meanings and motivating actions	Either or both observable phenomena and subjective meanings can provide acceptable knowledge dependent upon the research question. Focus on practical applied research, integrating different perspectives to help interpret the data
<b><i>Axiology: the role of values in research and the researcher's stance</i></b>	Value-free and Etic Research is undertaken in a value-free way, the researcher is independent of the data and maintains an objective stance	Value-laden and etic Research is value-laden; the researcher is biased by world views, cultural experiences and upbringing	Value-bond and Emic Research is value bond, the researcher is part of what is being researched, cannot be separated and so will be subjective	Value-bond and etic-emic Values play a large role in interpreting the results, the researcher adopting both objective and subjective points of view
<b><i>Research Methodology: the model behind the research process</i></b>	Quantitative	Quantitative or qualitative	Qualitative	Quantitative and Qualitative (mixed or multi-method design)
<i>Based on Saunders et al.(2009, p.119), Guba and Lincoln (2005), and Hallebone and Priest (2009)</i>				

**Figure 8: Beliefs of Research Paradigms in Social Sciences Research Paradigms**

I have been concerned to create a coherent personal integration of insight, which I have accrued from diverse sources, (rather than merely stitching a theoretical ‘patchwork quilt’ of personally attractive ideas). Often the most challenging aspect of this process has been making sense of the background, or embedded epistemological underpinnings of the expressed ideas of authors. This has especially been the case, where the viewpoints of authors have seemed to me to be closely related, although in practice offering quite divergent understandings of way of knowing.

The following discussion of relevant sources is illustrative of the material, which has informed my research approach and is illustrative of dilemmas, which I encountered with regard to integration of knowledge.

### **3.3: The research paradigms of “pragmatism”, and “critical realism”**

Robson explores what it means to be scientific in the context of ‘real world research’, (2002, p. 3, “*investigation involving people in ‘real life’ situations*”).

He considers ‘quantitative’ and ‘qualitative’ methods, and ‘fixed’ and ‘flexible’ research designs, and he critiques both ‘positivist’ and ‘relativist’ belief systems in research.

Robson, quotes Byrne, (1998, p. 37), “*Positivism is dead. By now it has gone off and is beginning to smell*”, as a widely accepted view of current attitudes to positivism, but he is careful to distinguish quantitative research practices from their traditional positivist underpinnings and warns against throwing “*the scientific baby out with the positivist bath-water*”.

Robson, (p. 6), advocates for combination of qualitative and quantitative approaches. He promotes, (p. 29), ‘Critical Realism’ as a research philosophy that “*can provide a model of scientific explanation which avoids both positivism and relativism*”.

He points out, (p. 33), that, *“There is much more to the realist view than simply asserting that an external reality exists... it provides a coherent model of for science, which is very different from that of positivism. Nevertheless, at the heart of realism is the assumption that there is a reality, which exists independently of our own awareness of it.”*

I have grounded the underlying research philosophy of the current research in the research paradigms of “pragmatism”, and “critical realism”, and some explanation is required of these terms.

Robson, (2002, p. 29) speaks of, “realism” and “critical realism” in the same context, and states, *“Realism can provide a model of scientific explanation which avoids both positivism and interpretivism”*. In his advocacy of a “critical realism” philosophy and approach to social science research, Robson, (2002, p. 42), refers to, *“... our relatively primitive understanding of what is happening in many real-world situations”*.

This perspective of the limitations of knowledge of the dynamics complex life phenomena, is consistent with views in relation to the inadequacy of research methodology, which were expressed by Sayer, (2000, p. 5), when he spoke of his realisation that, *“... the goal of finding rough regularities, let alone laws, to describe social systems, was a pipe dream. At the same time, realist philosophy was beginning to challenge the regularity or successionist theory of causation, and to analyse the explanation of change in open systems, so that it became clear that abandoning the hopes of finding regularities in no way led to abandoning explanation”*.

In respect of “critical realism”, Sayer, (2000, p. 13), talks of how, *“One of the most distinctive features of critical realism is its analysis of causation, which rejects the standard Humean ‘successionist’ view that it involves regularities among sequences of*

events". In relating this research philosophy to research methods, Sayer, (2000, p. 19), says that, *"Compared to positivism and interpretivism, critical realism endorses or is compatible with a relatively wide range of research methods, but it implies that the particular choices should depend on the nature of the subject of study and what one wants to learn about it"*.

Robson, (2002, pp. 42-43), writes, in a similar vein as he endorses a view that, *"the qualitative/quantitative debate, while it might have been necessary in the 1980s and 1990s, has now become increasingly unproductive"*. Among a number of alternatives to what he calls *"paradigm wars"*, he puts forward, (2002, p. 43), *"a pragmatic approach"*, which he defines as, *"whatever philosophical or methodological approach works best for a particular research problem at issue. This leads to mixed method studies where both quantitative and qualitative approaches are adopted"*.

Onwuegbuzie and Leech, (2005), articulate the position of a pragmatic research paradigm well by suggesting that this perspective can be understood as juxtaposed on one end of a continuum with other research perspectives. They credit Rossman and Wilson, (1985), with original formulation of this idea, and say, (p. 376), that, *"three major schools of thought have evolved from the quantitative-qualitative paradigm wars, namely: 'purists, situationalists, and pragmatists'". The difference between these three perspectives relates to the extent to which each believes that quantitative and qualitative approaches can co-exist and can be combined. These three camps can be conceptualised as lying on a continuum, with purists and pragmatists lying on opposite ends, and situationalists lying somewhere between the purists and pragmatists"*.

These authors present as strong advocates of a pragmatic research paradigm and quite stridently conclude with the recorded opinions, (pp. 384-385), that, “*relying on one type of data, (i.e., numbers or words), is extremely limiting. As such, mono-method research is the biggest threat to the advancement of the social sciences*”, while claiming that, “*By utilising quantitative and qualitative techniques within the same framework, pragmatic researchers can incorporate the strengths of both methodologies*”.

They, also, suggest that, “*pragmatic researchers are more likely to be cognisant of all available research techniques and to select methods with respect to their value for addressing the underlying research questions, rather than with regard to some preconceived biases about which paradigm is a hegemony in social science research*”.

In making distinction between the “*three major schools of thought*”, Onwuegbuzie and Leech, (2005, pp. 376-377), provide a useful condensed overview of the relationship between these research outlooks on a continuum. I paraphrase their commentary here, as it has proved to be a relevant reference point for me in my efforts to navigate with a range of not-quite compatible maps of research methodology, which vary in relation to the scale used, level of detail provided and perspective chosen –

*“Proponents of both camps (i.e. purists)... posit that quantitative and qualitative methodologies stem from different ontologic, epistemologic, and axiologic assumptions about the nature of research... for purists, the assumptions associated with both paradigms are incompatible regarding how the world is viewed and what it is important to know.*

*Purists... contend that quantitative and qualitative approaches cannot and should not be mixed... they advocate mono-method studies...*



*Situationists maintain the mono-method (paradigmatic) stance held by purists, but also contend that both methods have value. However, they believe that certain research questions lend themselves more to quantitative approaches, whereas other research questions are more suitable for qualitative methods...*

*Pragmatists, unlike purists and situationists, contend that a false dichotomy exists between quantitative and qualitative approaches... pragmatists advocate integrating methods within a single study... both approaches have inherent strengths and weaknesses, researchers should utilise the strengths of both techniques in order to understand better social phenomena... pragmatists ascribe to the philosophy that the research question should drive the method(s) used... research methodologies are merely tools that are designed to aid our understanding of the world”.*

Consideration of these meta-perspectives in relation to research paradigms and methodology has been personally insightful in relation to understanding how a critical realist position is more tenable and consistent with the research voice that I envisage having when speaking about this research.

### **3.4: The research is ‘exploratory’**

The research may be seen as ‘exploratory’ in that it seeks to address what appears to a chimera quality in relation to the image of the ‘assessment service’, with an existing lack of a clear, consistent, and comprehensive picture of the service from the viewpoints of:

- a) a coherent, robust, shared vision of service within the assessment team;
- b) the perspectives of professionals who commission the service, (i.e., H.S.E. social work team members);

- c) the perspectives of children, adolescents, and families who are clients of the service;
- d) the perspectives of professionals in related areas who interact with the service, such as, teachers, members of C.A.M.H.S., ‘community care’ psychologists, other ‘community care’ professionals, (such as public health nurses, speech and language therapists, or paediatric occupational therapists), Department of Education psychologists, and representatives of community-based support groups, (such as Family Resource Centres, or “Springboard” initiatives); and,
- e) the perspectives of professionals who are involved in the Legal system with regard to child protection, Care, and Welfare issues, (such as, Gardaí, legal representatives, Judges, and representatives of Probation services).

My experience has been that when members of the assessment team, or management of the service reflect on experiences of work completed by the service, the service tends to be exclusively referred to through anecdotes about specific individuals who have been assessed, or through tales about personalities and professional styles of referring agents, or personalities and professional styles of particular team members, who have worked with the ‘assessment service’.

Although this may be a typical, informal process and occurrence within many services, there does not appear to me to be available a more tangible, evidence-based repository of knowledge for informing perspectives about the nature and worth of the service.

There have been previous evaluations of the service and whole-service inspections by monitoring agents, but information from such sources does not seem to be used in understanding or communicating about what the identity and workings of the service. I believe that absence of a knowledge-base implies lack of clarity about the nature and identity of the service, which for me is further exemplified:

- (i) within the ‘assessment service’ team, by frequent disagreement across team members/professional disciplines about a coherent, specific model of the assessment process, (aside from broad consensus that assessment occurs within the templates of: (a) the *“Framework for Assessment of Vulnerable Young Children and their Families”*, (Buckley et al., 2006), and (b) an associated document from the British Department of Health, *“Assessing Children in Need and their Families: Practice Guidance”*, 2000);
- (ii) within the ‘assessment service’ team, by a history of willingness to accept referrals without consistent, explicit reference by assessment team members to a clear model of assessment, which could give transparent, accountable guidance in relation to demarcation between this ‘assessment service’ and other community-based services, (such as C.A.M.H.S., or ‘community’ psychological services);
- (iii) external to the ‘assessment service’ team, by a history of wide-ranging, indiscriminate, and often vaguely stated reasons for referral for assessment that have been provided by referring H.S.E. social workers, in referral documents, or at recorded referral meetings; and,
- (iv) external to the ‘assessment service’ team, by a history of mis-understandings, (requiring explanation by assessment tea-members), of the nature of the service, which have occurred with referred clients, and with representatives of other services, or agencies.

### **3.5: The research is ‘evaluative’**

The research may be seen as ‘evaluative’, in the sense that I seek to critically comment on the nature of the information, which is available in the assessment reports with regard to:

- a) what has been sought by the service users, in terms of the stated reasons for referral of children, adolescents, and families for assessment. (Note that in this instance, I have designated H.S.E. (now, ‘Tusla’) social workers, as the ‘service users’. Limiting the definition of ‘service users’ in this instance to ‘referring H.S.E. social workers’ is in line with a point made by Butler, (2002, p. 9, “... *the literature cautions against evaluators trying to address the needs of too many stakeholders at once, such that the evaluation questions and findings become too diluted to be of significant practical value to anyone*”); and,
  
- b) what appears to have been provided by the assessment team in relation to completed assessments. I have commented, elsewhere, that the stated reasons for referral have often appeared to be lacking in specificity and embedded in descriptions of the life histories and/or life circumstances of clients.  
  
Therefore, it is relevant to attend to critically exam what has been delivered in terms of assessment, and explore how this seems to be justified by the available referral information; and
  
- c) a view of ‘evaluation’ as conceptualised by Stake and Easley (1978). Matthews, (2002), has stated that these authors “*take the view that evaluation is not so much about judging worth as providing information from which insiders can understand their actions and influence the future course of events*”; and,

- d) consideration of the worth and place of the service both in the context of development of child and family services nationally within this period, and in the context of espoused future directions and needs for such services.

### **3.6: Evaluation**

Among the relevant definitions of “Evaluation”, which have I have considered in relation to this research, the following capture aspects of focus that I would hope to incorporate in the current research:

- *“Evaluation attempts to assess the worth, or value of some innovation, or intervention, some service, or approach”, (Robson, 1993, p. 171);*
- *“The purpose of evaluation research is to measure the effects of a programme against the goals it sets out to accomplish as a means of contributing to subsequent decision making”, (Weiss, 1990, p.21);*
- *“Program evaluation is the systematic collection of information about the activities, characteristics, and outcomes of programs for use by specific people to reduce uncertainties, improve effectiveness, and make decisions with regard to what those programs are doing and affecting”, (Patton, 1986: 14).*
- *“Evaluation examines our effectiveness and can help us to improve it, can increase our accountability to users and clients, develops our knowledge and identifies gaps in our knowledge, and helps us to identify new models of practice and service delivery”, (Lishman, 1998, p. 101).*

These definitions provide insights in relation to the links between practice, estimations of worth, relevance, and effectiveness, and they emphasise the systematic gathering of information as evidence that can inform choices, and decisions about practice.

In the context of the Irish Health Service Executive, (my employing organisation), the following discussion of “evaluation”, from Butler, (2002, p.6), is, also, directly relevant, *“Evaluation has a vital role to play in enabling health service planners and managers to attain the highest standards of effectiveness, efficiency, equity, quality and value for money in the services that they provide, and to demonstrate that attainment for accountability purposes. Evaluation has the potential to provide the evidence required for effective decision making at all levels of the health system and across all areas of health care provision. The important role of evaluation and the need to enhance evaluation demand and capacity is underpinned in recent policy documents... In addition, recent legislative changes aim to enhance accountability, further endorsing the importance of monitoring and evaluation in health care management”*.

From this listing of definitions of evaluation, both the definition by Robson, (2003), and the definition by Lishman, (1998), are consistent my own intentions in conducting this research.

These two definitions encompass ideas of evaluation of the worth of a service and a focus on examination of the effectiveness of one’s practice, with a view to addressing accountability to service users and intentions to improve service quality.

### **3.7: Pilot study**

Initially, I read and analysed printed copies of three reports of assessment, which had been selected at my request by the deputy manager of the service from available reports for

years one to seven of the ‘assessment service’. These files were selected in order to provide me with examples from assessments, which had been completed by three separate previous incumbents of the role of psychologist within the assessment team.

I examined each file in order to see historically what sort of format, information, and patterns appeared to me in the written narratives, and to get a sense of how assessments were approached prior to my time with the service.

A key aspect of this initial review of these reports was examination of whether there appeared to be enough commonality of content, and assessment approach over time and different practitioners in order to justify approaching the ten years of assessment reports as a functionally unitary phenomenon. I wanted to establish whether I could justifiably make meaningful comparison of content across reports. There seemed to me to be sufficient commonality of content, types of referral, clients, and approaches to assessment to allow such comparison across time-spans and practitioners.

### **3.8: Choice of overall samples for quantitative analysis and qualitative analysis**

A data-set of reports from the first ten years of the ‘assessment service’ was chosen, as the period held meaning for local management and frontline service-providers as an obvious ‘anniversary’ for the service. It seemed to me that this period of operation of the ‘assessment service’, also, coincided with an exceptional era within the short history of the State, an era which has seen significant changes in the development of children’s services in Ireland, (as discussed in the ‘Introduction’ to this work). I began work with the ‘assessment service’ in mid-2007, and, thus, the period of work under review covered the initial two and half years of my own tenure with the organisation, as well as the periods of tenure of all previous incumbents of the post of senior psychologist with the service.

All of the reports for this ten-year period were examined, (please note that the figure of 147 children is a slightly larger figure than the total number of assessment reports for this period, as in some instances, siblings were discussed in single assessment report), and were used for the relevant quantitative analyses, which were undertaken and which are presented in the 'Results' section of this thesis.

A smaller sample, (i.e., five annual cohorts of assessments from this overall ten-year cohort), was chosen for a process of qualitative content analysis. These five sets of data involved consideration of assessments for sixty-one children, (from an overall total of one hundred and forty-seven children, who were seen for assessment by the 'assessment service' during this period, (i.e., 42% of the available assessment records).

I intentionally decided not to sample a quota of assessment reports from each year, or from selected years as I was concerned that this would nullify the possibility of substantively examining patterns of practice within year-periods and would prohibit any meaningful and reliable examination of any trends with regard to patterns of sources of referrals seen, and/or patterns in relation to age-groups, in conjunction with patterns in relation to gender-groups.

I chose these five cohorts in order to provide substantive coverage of assessment practices across the full range of the ten-year time-period under consideration, and because the numbers of children seen in any one year did not overly dominate the numbers seen in the other years under consideration.

In the context of this point, The average number of clients for whom assessments were completed on an annual during the first ten years of this service was, approximately 15.,



In the other years, which were not chosen for such qualitative analysis, the numbers of reports completed for each year, ranged from two years with 14 reports, one year with 17 reports, a year with 20 reports, and a year with 21 reports.

The numbers seen in the relevant years under consideration for qualitative content analysis were: Group 1 ( $n = 8$ ); Group 2 ( $n = 10$ ); Group 6 ( $n = 17$ ); Group 9 ( $n = 12$ ); and, Group 10 ( $n = 14$ ).

With regard to the overall ten-year period sample, for six of the total ten years under consideration, the number of completed assessment reports ranged from 12 to 17 reports.

Two years recorded notably higher numbers than this range, (i.e., 20 reports and 21 reports, respectively), and two years recorded lower numbers, (i.e., 8 reports and 10 reports, respectively).

The years chosen for qualitative content analysis were:

- the first two years of the ‘assessment service’, i.e., 2000 (‘Group 1’), and 2001 (‘Group 2’);
- a year from the middle of the ten-year period under consideration, i.e., 2005 (‘Group 6’);
- the final two years of the ten-year period of operation of the ‘assessment service’, that was under consideration in this work i.e., 2008 (‘Group 9’) and 2009 (‘Group 10’).

This selection seemed to me to be a representative sample of the total available body of records on a number of counts in terms of: (i) the number and percentage of records chosen; (ii) the range of time periods covered by the sample; and (iii) the range of different practitioners within the assessment team who featured in the preparation of the reports across these annual cohorts.

### **3.9: Content analysis**

*“Content analysis is a systematic coding and categorising approach which you can use to unobtrusively explore large amounts of textual information in order to ascertain the trends and patterns of words used, their frequency, their relationships and the structures and discourses of communication... The researcher’s creation of coding frames highlights certain aspects of the text, providing the reader with one particular view, but others are possible and different researchers may achieve different results because of different protocols developed and imposed”* (Grbich, 2009, p. 112).

The content analysis used in this work is based on a coding system, which I have formulated from categories (described below) that are, respectively, brought to the data (i.e., categories ‘A’ and ‘B’) or drawn from the data (i.e., category ‘C’).

**Category A** - based on “The Framework for Assessment of Vulnerable Young Children and their Families” (Buckley et al., 2006, p. 65) see Appendix 3.

This framework presents an integrated, multi-faceted categorisation of, *“Three Dimensions of a Child’s Life”*, which (p. 65) *“should be considered concurrently in order to understand their mutual interaction and impact on the child”*.

According to Buckley et al. (2006, p. 66), the “Framework” has been organised, thus, in order to encourage practitioners to take *“a **parallel and integrated** view of the different ways in which factors in a child’s family and environment constantly interact in order to meet his or her needs”*.

The respective categories are outlined in diagrammatic form (Figure 1, on next page).

- (i) **“Child’s Developmental Needs”** (pp. 66) *“Whether and How the Child’s Needs are met. The Assessment Tool identifies the child’s need for **relationships, attachments, affections and resilience**”;*
- (ii) **“Parenting Capacity”** (pp. 66) *“Parent/Carer Capacity to Meet the Child’s Needs; parental capacity must be considered in relation to each of the child’s identified needs”;*
- (iii) **“Family and Environmental Factors”** (pp. 65) *“Extended Family and Community’s Capacity to Meet the Child’s Needs and/or Support Parent/Carers to Meet those Needs”.*

**Category B** – based on dimensions, or phenomena, which I have identified as relevant for organisation and cross-reference within the data-set, such as, age, gender, identification of referring agent/team, identification of assessment team discipline/member (see ‘Method’ section); and,

**Category C** - based on dimensions, or phenomena, which I have identified as arising from the data-set, based on frequency counts of words, terms, or phrases (see ‘Results’ section and Appendix 6).

### **3.10: Aspirations for the research**

My intentions in undertaking this research are that an up-to-date, comprehensive and systematic evaluation of the service (based on both quantitative analysis of referral information from completed assessment reports, and qualitative content analysis of archival assessment report data), will clarify what the nature of the ‘assessment service’ has been over the first ten years of its operation.

I believe that the research will give fresh and clear direction and impetus for development of my own professional practice, through greater awareness of the history of the service, and opportunity to systematically review and learn from the work of colleagues and predecessors in the role of psychologist within the assessment team.

The research is intended to generate hypotheses about the stance, the approach, the limitations, and the future potential of the ‘assessment service’, which might be deduced from the archival data. I expect that the evaluation will capture what functions the ‘assessment service’ has served within the Child and Family Agency, (‘Tusla’)/H.S.E. (South), region.

The research allows opportunity to see how psychological and social work services within the Child and Family Agency, (Tusla), and the H.S.E. may constructively work together in assessment contexts. I anticipate that such information and explicit explanation of a model of service could have relevance beyond the specific situation of this child, adolescent, and family assessment service, and could afford insight for development of services such as C.A.M.H.S, general learning disability services, and adult mental health services.

### **3.11: The research is an opportunity for a holistic approach to service evaluation**

The research offers opportunity to envisage how child, adolescent and family services may be meaningfully evaluated in terms other than expenditure on service and ratios of numbers of clients seen within fixed time-spans by each professional, or service.

A more holistic approach to service evaluation is particularly relevant for a tertiary service, which works with much smaller numbers of clients than services at secondary levels, and yet is often compared directly with such services, in terms of crude cost-benefit, or value-for-money evaluations. This research has involved systematic exploration of an existing corpus of written documentary archival material, (which has been generated as a key product of the primary task of the service), in order to help define the role and functions of the service, and support its future development.

I systematically explore quantitative information from the archival records; I explain and justify of the choice of codes, which are used to analyse the content of assessment records; I interpret qualitative material, and relate it to the quantitative data; and, I attempt to integrate and relate all data to implications for future professional practice and development of the service.

In the context of the establishment of a new national, multi-discipline Child and Family Agency, the research has potential to inform professional disciplines, service management, and Government about those children, adolescents, and families with complex developmental support needs who particularly require integrated service provision, and who are at high risk of avoidable developmental impairment, or harm, as a consequence of not having their assessment needs adequately addressed within models of single-discipline ‘community’ services, or the ‘medical’ mental health model of C.A.M.H.S.

Such Community services are already under severe pressure in terms of long waiting-lists for access to services, and in the case of C.A.M.H.S., often appear to limit the scope of their assessment work to screening assessment as to whether the child, or adolescent presents with what is defined by the service as “significant mental health problems”.

Exclusionary criteria tend to operate with regard to engagement with C.A.M.H.S. if the child is deemed to present with: “conduct” problems/disorder; A.S.D.; a general learning disability; or, situations where C.A.M.H.S. have noted that there is a “lack of stability” with regard to the child’s, or adolescent’s home and family circumstances.

In the case of referral for assessment to H.S.E. ‘community’ services, children and adolescents who are referred from Child and Family Agency, (‘Tusla’), social work services must ‘compete’, (in the sense of placement on long waiting-lists), for access to separate professional services with children who are referred from other sources.

In this context, the focus of assessment is often limited to consideration of a narrow range of circumstances and phenomena that are seen by the practitioner directly pertain to the area of interest of the relevant individual discipline, (e.g., speech and language therapy services), and individual pieces of assessment work by separate professional disciplines often occur in an unsynchronised way, with notable gaps of elapsed time between assessments, and often with limited liaison between professionals about a child, or a family, and with limitations of perspective, in terms of oversight of disparate pieces of assessment information.

While such selectivity of focus may be necessary and appropriate for these services in most circumstances, the system of service delivery in relation to both C.A.M.H.S. and H.S.E. 'community' services mitigates against adequately addressing the complex assessment and intervention planning needs of many, (if not most), of the children, adolescents, and families who present with any complex constellation of multi-faceted professional support needs.

An intended outcome from the current research is to capture the richness and complexity of the assessment process with regard to the referred clients who have been seen by the service, and to create opportunity for greater awareness and debate among front-line professionals in such services and among management personnel of such services about the existence of, extensiveness of, and the complexity of service provision for such clients of public child, adolescent, and/or family services.

I suspect that the 'assessment service' meets a distinctive service need for referring agents and for particular client types that are seen by the 'Assessment service', and that the service needs of such client-types tend to be overlooked and/or inadequately addressed in part, because of lack of awareness and understanding by planners and deliverers of professional public services in this realm, (i.e., child, adolescent, and family assessment services, which attend to mental health, and/or developmental progress, and/or psychological functioning, and/or functioning within family units).

I am stating my views in relation to these matters here in an attempt to be ethical and clear about what might be seen as a personal agenda in undertaking this research.

The work is not intended to be unfairly partisan and critical, nor is it intended to be unintentionally naïve, or ignorant about the challenges of service provision faced by service providers and planners for potentially infinite client needs, while operating within fiscal and budgetary limitations.

However, the work is intended to provide food for thought for service providers where tenacity in maintenance of simplicity of viewpoint can lead to ignoring attention to needs for complex and integrated service provision, and where the absence of adequate and integrated resources and services can masquerade as a ‘one-size-fits-all’, closed system of service provision.

### **3.12: The Research Questions**

In approaching this body of data, using a mixed-methods approach, I distinguished the following questions:

- (a) “Who does the assessment service provide assessment for, (i.e., what appear to be the defining features of the clients who have been referred to the service)?”**
- (b) “What does each professional discipline within the assessment team appear to focus on and do as part of the assessment process?”**
- (c) “What is evident from what has been gathered and what has been saved, (in the assessment Reports), with regard to how children, adolescent, and families have come to be have been referred to the ‘Assessment service’?”**
- (d) “How does the ‘assessment service’ appear to address the concerns of the referring agents, (from the information available in the assessment Reports)?”**
- (e) “What information characterises the types and nature of recorded recommendations that have been made by the ‘Assessment service’ for future directions and professional interventions with assessment clients?”**

**(f) “How does the assessment service appear to ‘add value’ to referred from the information available in the assessment Reports?”**

In other words, is it possible to see in the Reports what are ‘new’, or more developed professional perspectives in relation the clients, (compared to information and views of the referring agents that were available at the time of the referral for assessment)?

Related questions to any exploration of ‘added value’ are questions **(g)** and **(h)** (below)

**(g) “What has been assessed through referrals to this service?”**

(i.e., from systematic analysis of the recorded information in the assessment Reports – the end-products of the assessment process – “What are the most salient characteristics and categories of information that are discernible to me for the ten-year period of initial operation, which is under consideration?”).

**(h) “What could be recommended for future development of the assessment service?”**

Additionally, and subordinate to these underlying research questions, I recognise that the following specific questions are relevant to consider:

- What forms of assessment were requested through referral to this service?
- Have there been any notable trends with regard to changes in the nature of referrals to the service, assessment focus for the assessment team, or changes in assessment approaches, or practices?
- How useful is a qualitative analysis of archival data as a means for service evaluation, and in what ways might such an approach be useful?
- How useful is qualitative analysis software, (in particular, in this instance, MAXQDA software), for management and analysis of complex narrative archival data, and in what ways might such software be useful?



I record these questions here as reference points for future analysis and discussion of data.

I had initial intentions to interview groups of social workers from the five referring social work teams, (using a questionnaire, which was specifically designed for the purpose), but I abandoned this endeavour as both ineffective and too time-consuming, (after an initial ‘pilot’ session with one social work team).

Similarly, my initial intention to systematically analyse in a qualitative manner all available assessment report records proved too unwieldy, (in terms of available time for me), even with the use of electronic records and qualitative analysis software.

However, the use of electronic records and the nature of the qualitative analysis software has meant that the data is available for ongoing exploration and the material has, thus, become an integral part of my practice in the ‘assessment service’.

Rather than having a literal “shelf-life” of the duration of the research, the encoded assessment reports are available as a foundation for future entries of data and for further exploration in a way that does not go out of date.

In itself, the action of making available electronic records within the framework of a qualitative analysis software package has been important, as it makes available a corpus of work that has been largely unattended and inaccessible, and which can now be shared easily with others and readily worked with in meaningful ways. A key-aspect of my own current practice has been to recognise the central relevance on completion of chronologies in relation to clients as part of assessment practice with clients, and, in a similar way, it seems relevant to utilise historical information about the ‘assessment service’ to understand and communicate the complex facets of the identity of service in a coherent and consistent way.

### **3.11: Ethical Issues**

Application for consent to carry out this research was processed through application to the formal, written H.S.E. Ethical Approval process.

The research did not involve direct access to any vulnerable clients of the service. The main material used in the research and the main focus of the research is an audit of existing data, (Assessment team Reports), which have been stored electronically by the 'Assessment service'.

Any assessment data accessed during the research is not recorded in the research by individual name, or by inclusion of any personal features that would allow for individual identification.

All data that was collected has been recorded and maintained using codes for features such as gender, age, location, status. Individual assessment data, (such as test, or check-list scores), are analysed only in relation to data cohorts, (e.g., 'persons seen for assessment in 2007'), and individual assessment records are not re-evaluated, or reviewed in the written research report to be produced. Data are examined on a yearly cohort basis. The competencies of individual professionals are not evaluated, or questioned.

All data, (both written and electronic has been handled and managed in accordance with prescribed H.S.E. 'best practice' guidelines).

## **Results**

The initial part of this section provides contextual quantitative information about all assessments, which were completed by the ‘assessment service’ during its first ten years of operation, from its establishment in 2000.

In relation to the body of work, which has been completed by the ‘assessment service’, ‘explorative’ analysis has not previously been systematically undertaken. Such research is relevant for understanding how the service has been used during this period by the five area Tusla social work teams.

The latter part of this section provides illustrative qualitative information arising from content analysis of the assessment reports.

The total available ‘population’ for consideration during this research consisted of 147 assessment reports, which comprised the complete assessment output of the ‘assessment service’ from the time of its establishment in 2000 over the following ten-year period to the end of 2009.

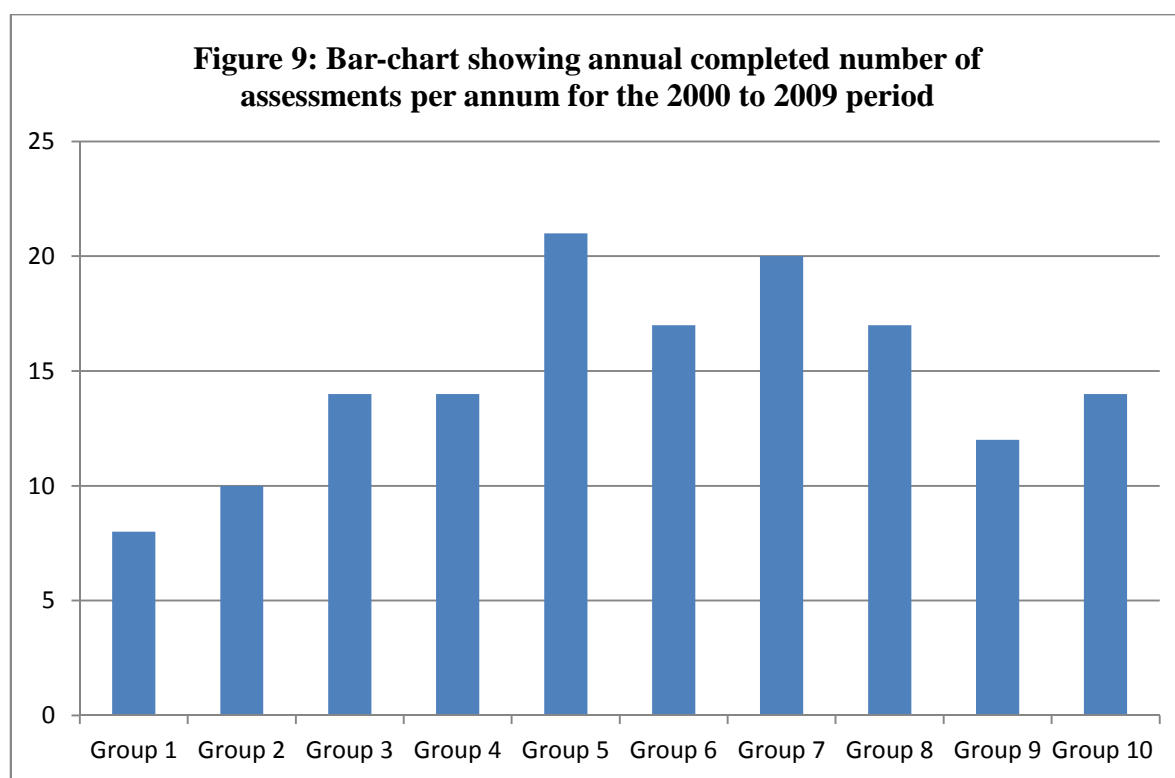
**Table 1, (on the following page), provides an overview of number of assessment reports completed per annum for this period.** It should be noted that in some cases, the year of completion of report may be in a different year from the year in which the individual’s assessment period occurred, (attendance for assessment may have been in the final months of a preceding year, while the report has been completed in the early months of the subsequent year).

**Table 1 Total ‘population’ of assessment reports, organised by year of report**

<b>Year</b>	<b>Data-set Group no. and no. of assessments per annum</b>	<b>Referral sources, (recorded as name of area Social Work team)</b>	<b>No. of Males, (expressed as a % of total no. of assessments p. a., with age-range for each year)</b>	<b>No. of Females, (expressed as a % of total no. of assessments p. a., with age-range for each year)</b>
<b>2000</b>	<b>Group 1 (n =8)</b>	North Lee 3, (38%); South Lee 0, (0%); Kerry 4, (50%); North Cork 0, (0%); West Cork 1, (12%).	<b>5 males (63%)</b> (8 years 3 months to 16 years 6 months)	<b>3 females (37%)</b> (14 years 9 months to 16 years 6 months)
<b>2001</b>	<b>Group 2 (n = 10)</b>	North Lee 3, (30%); South Lee 4, (40%); Kerry 3, (30%); North Cork 0, (0%); West Cork 0, (0%);.	<b>9 males (90%)</b> (7 years 8 months to 15 years 4 months)	<b>1 female (10%)</b> (15 years 0 months)
<b>2002</b>	<b>Group 3 (n = 14)</b>	North Lee 4, (29%); South Lee 1, (7%); Kerry 8, (57%); North Cork 1, (7%); West Cork 0, (0%).	<b>8 males (57%)</b> (8 years 9 months to 16 years 0 months)	<b>6 females (43%)</b> (7 years 7 months to 15 years 1 month)
<b>2003</b>	<b>Group 4 (n = 14)</b>	North Lee 10, (72%); South Lee 2, (14%); Kerry 2, (14%); North Cork 0, (0%); West Cork 0, (0%).	<b>9 males (64%)</b> (9 years 6 months to 15 years 9 months)	<b>5 females (36%)</b> (13 years 0 months to 16 years 11 months)
<b>2004</b>	<b>Group 5 (n = 21)</b>	North Lee 10, (48%); South Lee 6, (28%); Kerry 3, (14%); North Cork 2, (10%); West Cork 0, (0%).	<b>9 males (43%)</b> (13 years 1 month to 17 years 7 months)	<b>12 females (57%)</b> (12 years 7 months to 17 years 0 months)
<b>2005</b>	<b>Group 6 (n = 17)</b>	North Lee 4, (23%); South Lee 4, (23%); Kerry 4, (23%); North Cork 3, (18%); West Cork 2, (12%).	<b>12 males (71%)</b> (9 years 6 months to 15 years 9 months)	<b>5 females (29%)</b> (13 years 0 months to 16 years 11 months)
<b>2006</b>	<b>Group 7 (n = 20)</b>	North Lee 5, (25%); South Lee 3, (15%); Kerry 7, (35%); North Cork 2, (10%); West Cork 3, (15%).	<b>16 males (80%)</b> (9 years 6 months to 15 years 9 months)	<b>4 females (20%)</b> (13 years 0 months to 16 years 11 months)
<b>2007</b>	<b>Group 8 (n = 17)</b>	North Lee 5, (29%); South Lee 2, (12%); Kerry 3, (18%); North Cork 5, (29%); West Cork 2, (12%).	<b>11 males (65%)</b> (9 years 6 months to 15 years 9 months)	<b>6 females (35%)</b> (13 years 0 months to 16 years 11 months)
<b>2008</b>	<b>Group 9 (n = 12)</b>	North Lee 6, (50%); South Lee 4, (34%); Kerry 1, (8%), (33%); North Cork 0, (0%); West Cork 1, (8%).	<b>9 males (75%)</b> (8 years 11 months to 16 years 3 months)	<b>3 females (25%)</b> (13 years 3 months to 15 years 5 months)
<b>2009</b>	<b>Group 10 (n = 14)</b>	North Lee 3, (21%); South Lee 0, (0%); Kerry 3, (21%); North Cork 7, (50%); West Cork 1, (8%).	<b>6 males (60%)</b> (4 years 5 months to 16 years 3 months)	<b>8 females (40%)</b> (4 years 5 months to 16 years 3 months)

**Table 1** (on previous page) provides the following information:

- identifies the year of completion of assessment reports (column 1);
- identifies the number of Reports completed for each year (column 2);
- gives a breakdown of the number of completed assessments in relation to each of the five referring social work teams (column 3);
- gives separate analysis of the number of males and females who were seen for assessment within each yearly cohort, with these figures expressed as a percentage of the total number of assessments that were completed for each year (columns 4 and 5); and, finally,
- gives age-ranges for males and females who were assessed are provided separately.



**In Figure 9, (above), the total numbers of individuals, which were seen for assessment for each year during the period 2000 to 2009 are represented in a bar-chart format.**

Examination of the records in the final row of **Table 1**, indicate that the numbers of assessments, which have been completed for this period for each year has varied considerably from ten, or less assessments per annum, which occurred on two occasions, to 20, or more

assessments per annum, which, also, occurred on two occasions. The period 2004 to 2007, (represented by groups 5, 6, 7, and 8), seems to show a greater throughput of completed assessments, with 75 assessments, (i.e., an average of approximately 19 completed assessments per annum during this period. This maybe compared to an overall average for the ten-year period that is closer to approximately 15 completed assessments per annum).

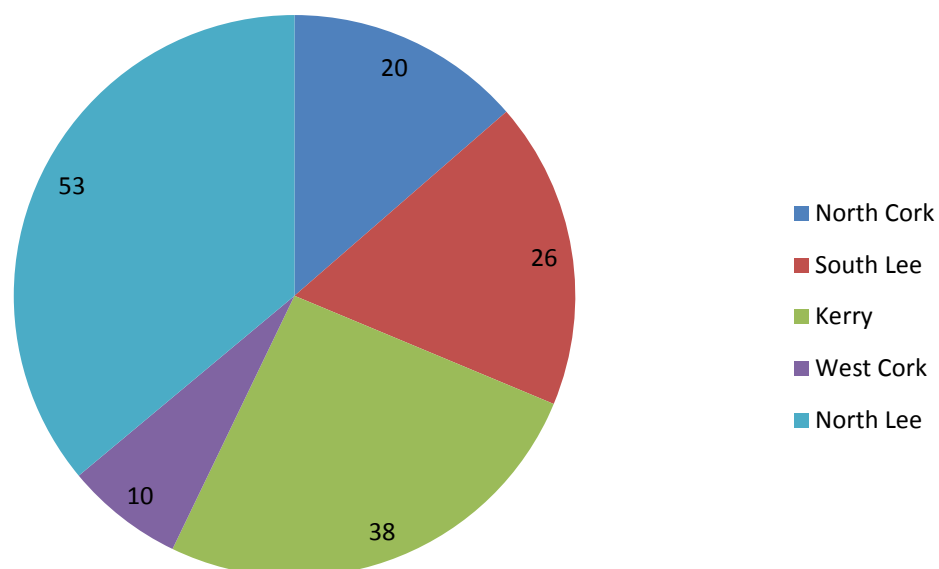
**In Table 2, (below), the total numbers of individuals, who were seen for assessment from each area social work team, (i.e., the sum of the figures in column three from Table 1), are expressed as percentages of the total figure for the period.**

Examination of the records in the final row of **Table 2** indicate that the numbers of assessments, which have been completed for this period for each referring social work team form definite patterns. In turn, these figures are represented in two separate pie-charts on the following page (see **Figure 10** and **Figure 11**).

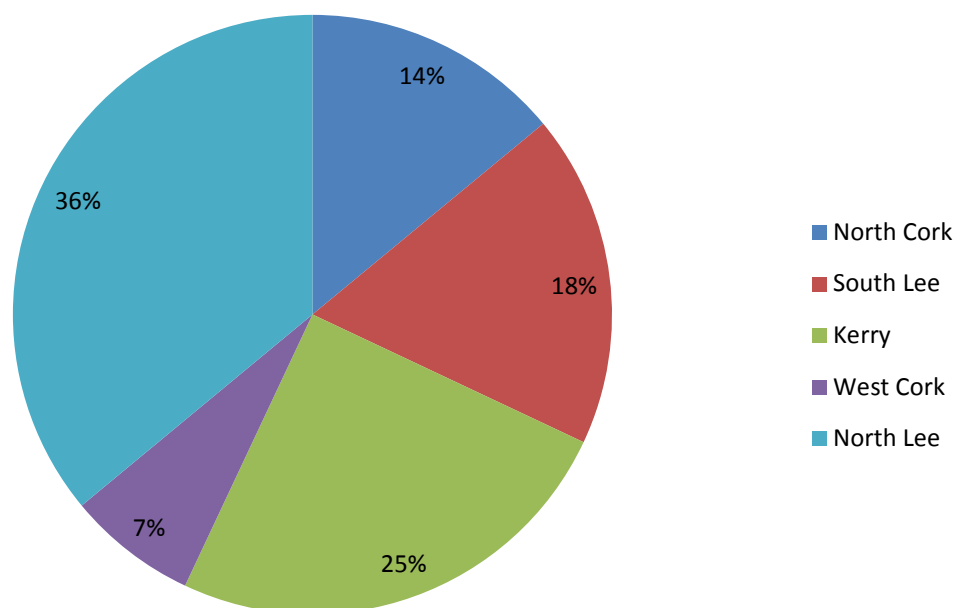
**Table 2: Total ‘population’ of assessment reports, overall figures for 2000-2009 period**

<b>Data-set group no. and no. of assessments for the entire period 2000-2009</b>	<b>Referral sources, (recorded as name of area social work team)</b>	<b>No. of males, (expressed as a % of total no. of assessments per annum, with age-range for each year)</b>	<b>No. of females, (expressed as a % of total no. of assessments per annum, with age-range for each year)</b>
<b>N = 147 (100%)</b>	North Lee 53, (36%); South Lee 26, (18%); Kerry 38, (25%); North Cork 20, (14%); West Cork 10, (7%).	<b>94 males (64%)</b> (4 years 5 months to 17 years 7 months)	<b>53 females (36%)</b> (4 years 5 months to 17 years 0 months)

**Figure 10: Pie-chart showing total number of assessments carried out for each area social work team, (2000 to 2009 period), expressed as a percentage of the overall total number for the period, (N = 147)**



**Figure 11: Pie-chart showing proportion of total number of assessment reports completed for each area social work team, (2000-2009 period), expressed as actual numbers**



Over one-third, (i.e., 36%), of the total number of the completed assessment reports are associated with clients of the North Lee social work team.

Approximately one-quarter, (25%), of the total number of the completed assessment reports are accounted for by clients of the Kerry social work team.

Approximately one-fifth (18%) accounted of the total number of the completed assessment reports were referred clients of the South Lee social work team.

The West Cork social work team referred a figure of less than 10% (i.e., 10 individuals = 7%) of the total number of completed assessments for this period, while the North Cork social work team accounted for double this number and proportion (i.e., 14%) of the assessments completed for this overall period.

**Table 3** (on the following page), compares numbers and percentage figures for completed assessment reports, (for each area social work team), with the numbers of social workers who had were involved in making the referrals for these assessments, (for each area social work team) and these numbers expressed as a percentage of the total number of referring social workers for these completed assessments.

It is noteworthy that there appears to a direct correspondence between the percentage figures for the number of social workers who referred from each social work department, (as a percentage of the total number of referring social workers for the period), and the total number of assessments, which were completed for each social work department.

It is important to note that these figures refer to assessment reports, which were completed by the assessment team, and these proportions may differ from the total number of requests for assessment, (accurate figures were not available for this period).

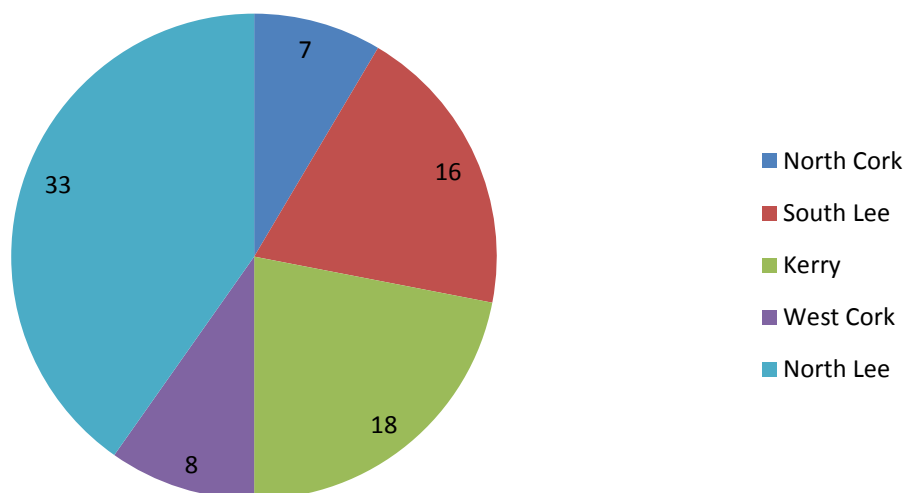


It is, also, important to note that the different area teams may be represented quite differently if figures of referral for assessment, (i.e., total figures for all referrals, which have been made to the service, inclusive of those referrals, which were not accepted for assessment, or which did not culminate in participation in the assessment process), or use of the “Respite Care” aspect of the service were examined. This was not part of the brief for the current study, but it is a separate area of service provision, which should be examined at a future date, in order to give a clearer picture of the role and worth of the service to the Health Service Executive, (in particular Child Protection Social Work services), in this region.

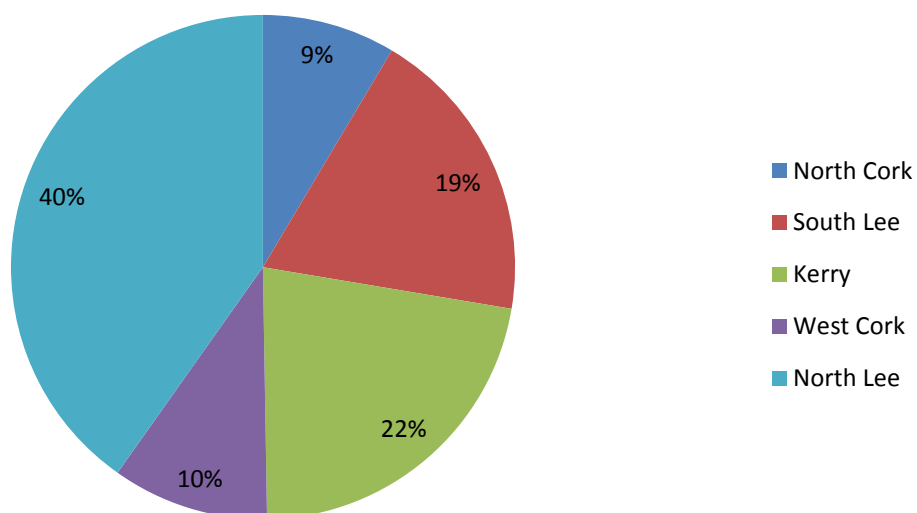
**Table 3 Comparison of numbers and percentage figures for completed assessment reports, (for each area social work team), with the numbers of social workers who were involved in making the referrals for these assessments, (for each area social work team), with these numbers expressed as a percentage of the total number of referring social workers for these completed assessments**

<b>Social Work Department</b>	<b>No. of assessments 2000 to 2009</b>	<b>% of total no. of assessments 2000 to 2009</b>	<b>No. of social workers who were involved in referral for assessments 2000 to 2009, (N = 82)</b>	<b>% of total number of social workers who were involved in referral for assessments 2000 to 2009</b>
<b>North Cork</b>	20	14%	7	9%
<b>South Lee</b>	26	18%	16	19%
<b>Kerry</b>	38	25%	18	22%
<b>West Cork</b>	10	7%	8	10%
<b>North Lee</b>	53	36%	33	40%

**Figure 12: Pie-chart showing numbers of social workers N = 82) from each social work department, that have referred for completed assessments for the period 2000 to 2009**



**Figure 13: Pie-chart showing percentage figures from the total number of social workers who are identified in the reports as referral agents, for each social work department, who have referred for completed assessments for the period 2000 to 2009**

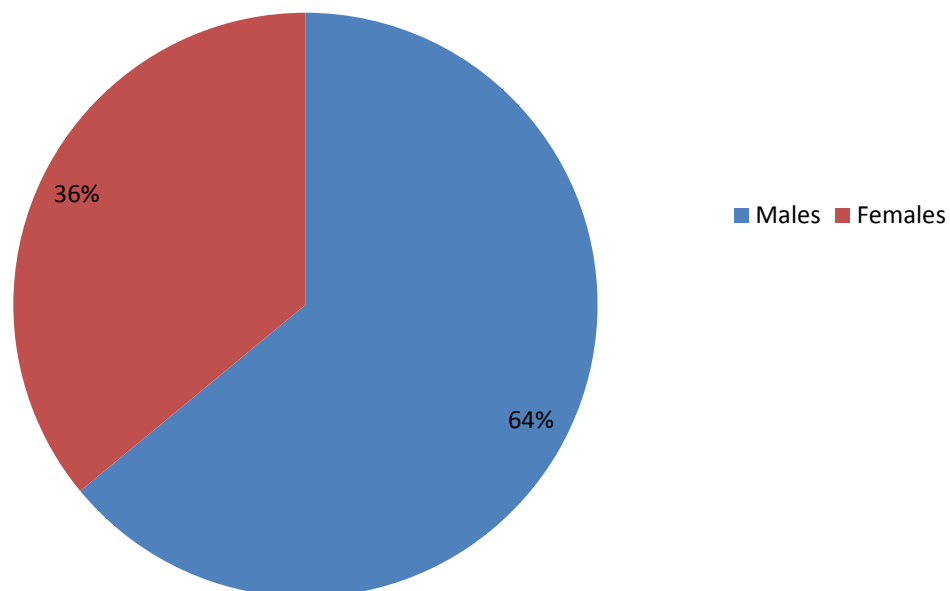


Notwithstanding the caveats, which I have expressed in relation to figures in **Table 3** and the following **Figure 12** and **Figure 13**, it is relevant for those who are involved with the 'Assessment service' to consider what such differences in relation to ratios of assessments, which have been completed for separate area Social Work teams in the region may mean, and to examine whether reasons for different levels of completed assessments have changed over time. It is relevant to ask if the figures:

- reflect differing levels of population density in the different areas;
- reflect different needs for, and/or use of such a tertiary service across area Social Work teams;
- reflect differing rates of referrals to the 'assessment service' across separate area social work teams;
- represent higher 'success rates' for some area social work teams, over other teams, in having referrals accepted by the 'assessment service', (and if this is the case, what identifiable factors within the service can be seen to influence such trends); or,
- reflect differing levels of awareness of the service across area social work teams?

It is possible that a number of these factors may operate, and interact, but it would be difficult to forensically unpick the relative influences at work. It seems to me that what is important is that the possibilities of such factors are used to inform dialogues with representatives of the referring area Social Work teams in relation to future development of the service.

**Figure 14: Pie-chart showing the proportion of total number of clients for the assessments completed, which were Males (64%), or Females (36%) for the 2000 to 2009 period**



Examination of the records in the **Table 2**, also, show that when the total number of assessments is broken down by gender, there is a strong preponderance, (a ratio of almost two-to-one; 64% to 36%; represented in **Figure 14**, above), of males who have been seen for assessment, compared to the number of females who have been seen during this period. The considerably higher number of males, compared to females who have been seen for assessment, is of interest as it may be indicative of recognised trends for males to ‘externalise’ problematic experiences and feelings, while females are seen to tend to ‘internalise’ such experiences and emotions. This figure should be considered by and be of concern to Child Protection Social Work services as it may indicate a need to more carefully evaluate observations of and judgements about girls in relation to child protection issues, (i.e., a need to systematically look beyond the obvious, particularly in relation to girls).

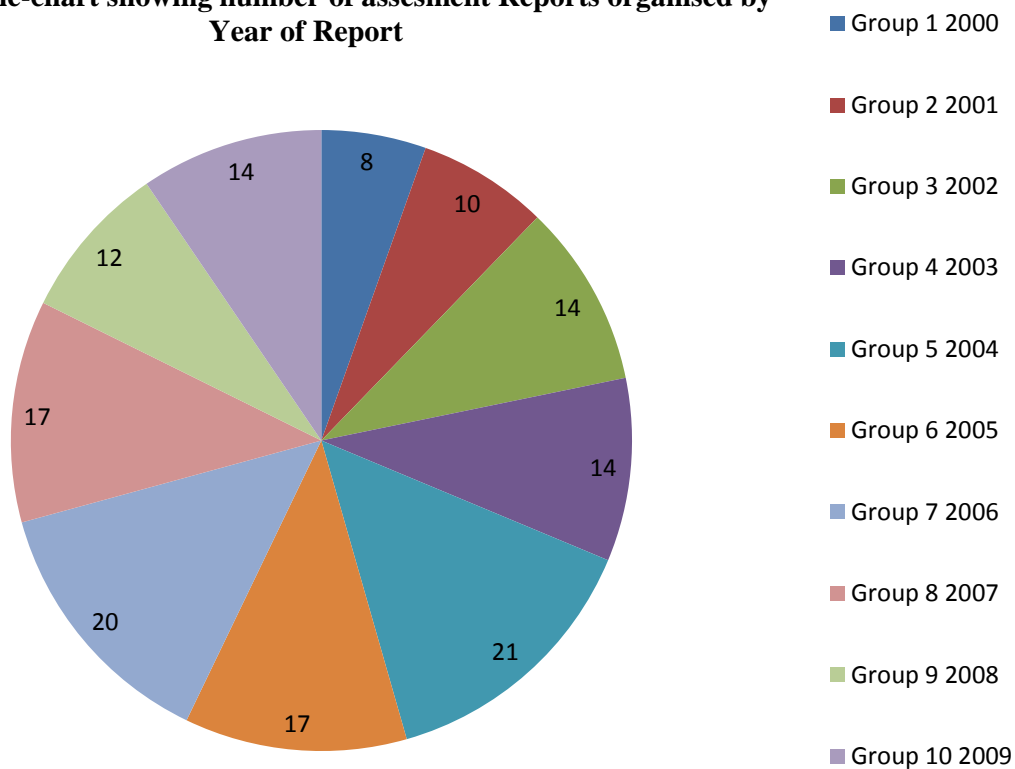
The age-ranges for each gender are similar, covering a range from four years of age to seventeen years of age. This is quite a wide age-range when one considers that the 'assessment service' is asked to consider, assess, and comment on issues such as developmental progress, parenting capacity, and child-environment interactions.

The assessment issues, which are likely to arise for children at such varied age-levels are likely to vary considerably and require notably diverse professional knowledge-bases and skill-sets from assessment team members. The wide age-range of clients when considered in conjunction with the nature of the reasons for referral, and the nature of assessment work undertaken has implications for staff selection, training and professional development.

The average number of clients for whom assessments were completed on an annual during the first ten years of this service was, approximately fifteen, (ranging from a lowest figure of eight completed assessments in the first year of operation, to a highest figure of twenty-one completed assessments, in the fifth year of operation of the service, (see **Table 4**, and **Figure 15**, on following page). Given the costs of the service, the demands for the service, the extent of waiting-lists for the service, and the seriousness of the assessment issues, which are addressed by the service, it is difficult to explain why there should exist such variation in the numbers of children and adolescents who are seen by the service on a year-by-year basis. At opposite extremities of the numbers of completed assessments on a yearly basis, for every two reports of assessment completed in 2000, five were completed in 2004, (with figures varying across a range from a low figure of 8 assessments completed in 2000, i.e., 5% of the available assessment records, to a high figure of 21 assessments completed in 2004, i.e., 14% of the available assessment records for this period).

**Table 4: Number of assessment reports, organised by year of report**

Year	Number of assessment Reports completed
2000	Group 1 (n = 8)
2001	Group 2 (n = 10)
2002	Group 3 (n = 14)
2003	Group 4 (n = 14)
2004	Group 5 (n = 21)
2005	Group 6 (n = 17)
2006	Group 7 (n = 20)
2007	Group 8 (n = 17)
2008	Group 9 (n = 12)
2009	Group 10 (n = 14)
<b>Total</b>	<b>All groups (N = 147)</b>

**Figure 15: Pie-chart showing number of assesment Reports organised by Year of Report**

How the service has been delivered has changed over the years, but such changes have not resulted in any trend to increased numbers of assessment reports, and for six of the four years under consideration, the number of completed assessment reports ranged from 12 to 17 Reports, (with two years recording notably higher numbers, and with two years recording lower numbers).

It is important for future planning of the service that such variation is accounted for, in order to ensure that maximum effective use is made of the service and that there is predictability with regard to the time allocated for completion of assessments. In turn, such predictability could help to address with more specific information the concerns of referring agents about how long they will have to wait for completed assessment reports, and how long they will be waiting for a client to be seen by the 'Assessment service', once she/he has been referred.

Given that the service currently operates an eight-week 'assessment cycle', (with an "average" of four clients in a cohort for each 'assessment cycle'), potentially, the number of assessment reports for each year should be closer to twenty-four, (on the basis of six completed assessment 'cycles' per annum), a figure, which is greater than even the highest recorded number for this ten-year assessment period.

If it is the case, that it is not practicable to complete such a high number of completed assessment reports, then reasons for limitations should be identified and realistic targets, specified, and set for the assessment team, and adhered to.

In reality, sections of any year are accounted for by periods of primary use as a respite care service, (rather than as an assessment service), holiday periods, and limitations of operation due to availability of child care worker personnel within existing budgetary constraints.

The service does not operate as smoothly in practice, as would appear possible from schedules, which are prescribed on paper, owing to involvement of key members of the assessment service in other time-consuming activities, (such as: within-service Internal Admissions Panel meetings; Central Admissions Panel meetings (for admission of children and adolescents to residential care provision); Child Protection Case Conferences; ‘core-group meetings’, or ‘professionals meetings’; staff training; or service development meetings. In practice, the specialise nature of each assessment undertaken often involves key assessment team members in considerable research of local available resources, specialised assessment issues, specialised treatment, or intervention issues, which involve work beyond the bounds of time allocated for completion of individual assessment work. I suggest that it is important, for efficiency and development of the service, (and associated services, such as the referring social work teams), that there would be allocated time and dedicated systems for reflection on, and integration of such experiences and acquired knowledge.

In this study, although quantitative analysis includes attention to all ten cohorts of assessments, I actively selected and considered only five of the ten available data-sets for the purposes of qualitative research. This reduced group of five data-sets was chosen in order to make qualitative analysis of large a mounts of complex narrative information more manageable, while still qualitatively reviewing a substantial number of records from across the ten-year time-span, which is under consideration.

The five data-sets chosen represent five annual cohorts of assessments, which were undertaken by the ‘assessment service’. These five sets of data involved consideration of assessments for sixty-one children, from an overall total of one hundred and forty-seven children, who were seen for assessment by the ‘assessment service’ during this period (i.e., 42% of the available assessment records).



Please note that the figure of 147 children is a slightly larger figure than the total number of assessment reports for this period, as in some instances, (in earlier years of the ‘assessment service’), siblings were discussed in one assessment report

Five cohorts, rather than the complete set of ten cohorts, were considered in order to make the task more manageable, and 42% seemed a reasonably representative sample in this context.

The numbers of children for whom assessment reports were completed was not a constant figure across years. Such inconsistency in terms of the number of assessments completed within years meant that it was difficult to choose data-sets, which might not significantly affect, or skew the representativeness of the overall sample, owing to the influence of undetected, or unquantifiable factors, (such as mind-sets, practices, or styles of particular constellations of the assessment team, or broader time-specific societal, or environmental factors).

I intentionally decided not to sample a quota of assessment reports from each year, as I was concerned that this would nullify the possibility of substantively examining patterns of practice within year-periods and would prohibit any meaningful and reliable examination of any trends with regard to patterns of sources of referrals seen, and/or patterns in relation to age-groups, in conjunction with patterns in relation to gender-groups.

I chose these five cohorts in order to provide substantive coverage of assessment practices across the full range of the time-period under consideration, and because the numbers of children seen in any one year did not overly dominate the numbers seen in the other years under consideration. The years chosen were:

the first two years of the ‘Assessment service’, i.e., 2000 (‘Group 1’) and 2001 (‘Group 2’);  
a year from the middle of the ten-year period under consideration, i.e., 2005 (‘Group 6’);  
the final two years of the ten-year period of operation of the ‘Assessment service’, that was under consideration in this work i.e., 2008 (‘Group 9’) and 2009 (‘Group 10’).

The numbers and the percentage figures for children/adolescents seen for assessment for these five year-groups are presented in the following table, (**Table 5**). Percentage figures are expressed as a percentage of the overall number of available assessment Reports for this ten-year period, (i.e., 147 assessment Reports).

**Table 5: Total ‘sample’ of assessment reports, organised by year of report**

Year	Data-set	Referral sources	No. of Males and age-range	No. of Females and age-range
2000	Group 1 (n = 8; 5% of total)	North Lee 3; South Lee 0; Kerry 4; North Cork 0; West Cork 1.	5 males (3%) (8 yrs. 3 mths. to 16 yrs. 6 mths.)	3 females (2%) (14 yrs. 9 mths. to 16 yrs. 6 mths.)
2001	Group 2 (n = 10; 7% of total)	North Lee 3; South Lee 4; Kerry 3; North Cork 0; West Cork 0.	9 males (6%) (7 yrs. 8 mths. to 15 yrs. 4 mths.)	1 female (less than 1%) (15 yrs. 0 mths.
2005	Group 6 (n = 17; 12% of total)	North Lee 4; South Lee 4; Kerry 4; North Cork 3; West Cork 2.	12 males (8%) (9 yrs. 6 mths. to 14 yrs. 10 mths.	5 females (4%) (13 yrs. 0 mths. to 16 yrs. 11 mths.
2008	Group 9 (n = 12; 8% of total)	North Lee 6; South Lee 4; Kerry 4; North Cork 0; West Cork 2.	9 males (6%) (8 yrs. 11 mths. to 16 yrs. 3 mths.)	3 females (2%) (13 yrs. 3 mths. to 15 yrs. 5 mths.)
2009	Group 10 (n = 14; 10% of total)	North Lee 3; South Lee 0; Kerry 3; North Cork 7; West Cork 1.	6 males (4%) (7 yrs. 3 mths. to 15 yrs. 8 mths.)	8 females (6%) (4 yrs. 5 mths. to 16 yrs. 3 mths.)

**Table 6** and **Table 7**, (below), respectively, provide summaries of the information available for: (a) the total population; and for (b) the sample chosen for content analysis.

**Table 6: - Summary of total ‘population’ of assessment reports**

Total	N = 147 (100%)	North Lee 52, (35%); South Lee 26, (18%); Kerry 38, (26%); North Cork 21, (14%); West Cork 10, (7%).	94 males (64%) (4 yrs. 5 mths. to 17 yrs. 7 mths.)	53 females (36%) (4 yrs. 5 mths. to 17 yrs. 0 mths.)
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**Table 7: - Summary of total ‘sample’ of assessment reports**

Total for five year- groups	N = 61 (42%)	North Lee 19 (31%); South Lee 12 (20%); Kerry 18 (30%); North Cork 10 (16%); West Cork 6 (10%).	41 males (67%) (4 yrs. 5 mths. to 16 yrs. 6 mths.)	20 females, (33%) (4 yrs. 5 mths. to 16 yrs. 11 mths.)
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(Note that the percentage figure in the second column of **Table 7** is the percentage relative to the total number of reports for the ten-year period, while percentages in the final three columns refer to the relative proportions for the five years of the sample in question.)

Comparison of the data in **Table 6** and **Table 7** shows reasonably good matches across ‘sample’ and ‘population’ for dimensions such as: proportion of referrals from each Social Work Department area; proportion of males and females who were seen for assessment; and overall age-ranges for each gender of the children and adolescents who were seen for assessment.

The following sections present break-downs of assessment reports for each year of the 'sample', and for the remaining years of the overall available 'population'.

**Description of cohort of 14 children assessed during 2009, (Group 10)**

**Table 8: - Cohort of 14 children assessed during 2009, (Group 10)**

Year of assessment 2009, (Group 10, Total number = 14 children/adolescents)						
<u>6 Males</u> identified by age	Referring Social Worker	Area of referral		<u>8 Females</u> identified by age	Referring Social Worker	Area of referral
13-11	N.C. 1	North Cork		11-0	N.C. 1	North Cork
15-3	W.C. 8	West Cork		9-8	N.C. 1	North Cork
15-8	N.L. 33	North Lee		5-5	N.C. 1	North Cork
				4-5	N.C. 1	North Cork
7-3	N.C. 1	North Cork				
9-11	KY 18	Kerry		7-0	N.C. 1	North Cork
13-8	KY 18	Kerry		16-1	KY 1	Kerry
				14-1	N.L. 15	North Lee
				16-3	N.L. 15	North Lee

A total of fourteen children/adolescents were seen for assessment during 2009 (six males and eight females) (see Table 8, above). Within this cohort were three separate family groupings of; four siblings; and two separate two-sibling groups). In the case of two of these three family groupings a younger sibling was informally considered by the assessment team, although they were not formally referred for assessment, owing to their young ages (pre-school level). This was, also, the case for one of the individual referrals.

The gender ratio for the overall year-group of fourteen assessment referrals, is atypical, (compared to the other nine years of assessment activities for the ‘assessment service’, which were considered), as more females than males were seen for assessment (a ratio of 4 females to 3 males).

Seven of the fourteen children/adolescents who were seen for assessment were referred by the North Cork social work team, (all referred by the same social worker, see below), three adolescents were referred by the North Lee social work team, three children/adolescents were referred for assessment by the Kerry social work team, and one adolescent was referred by the West Cork social work team. No referrals from the South Lee social work team were seen for assessment by the ‘assessment service’ during 2009.

The age-range for females who were seen for assessment ranged from a child of 4 years 5 months to an adolescent who was aged 16 years 3 months at the time of their assessments. The age-range for males who were seen for assessment ranged from a child of 7 years 3 months to an adolescent who was aged 15 years 8 months at the time of their assessments. These relatively wide age-ranges for both genders are typical of the profile of relatively wide age-ranges for the overall population of children who are referred for assessment with the ‘assessment service’.

Five of the eight girls who were seen for assessment were attending ‘mainstream’ Primary school at the time of their assessments. One of the children who were attending Primary school, had been recorded as presenting with notable ‘Emotional and/or Behavioural Difficulties’ (consistent with the Department of Education ‘disability’ category) prior to assessment, and was at imminent risk of exclusion from the school environment, owing to difficulties, which teachers were experiencing in management of her behaviour in school.

Of the three girls who were of an age to attend post-Primary school, two were attending ‘mainstream’ post-Primary school, and one of these two girls was resident in a H.S.E. foster-placement at the time of her assessment. The other one of these two girls would, later, (following the outcomes of her assessment with the ‘assessment service’), transfer to a ‘special school’ for pupils with “Mild General Learning Disability” (with integrated professional support services). This girl would, also, subsequently (following the outcomes of her assessment with the ‘Assessment service’) transfer from the care of her mother to a full-time H.S.E. residential care placement in a H.S.E. ‘group home’.

The third girl of this sub-group was attending an alternative educational provision for pupils who had ‘dropped out’ from ‘mainstream’ post-Primary school. This service provides individual and small-group tuition to Junior Certificate level (i.e., Third Year) for pupils who are at risk of early school-leaving. This girl (prior to attending the ‘assessment service’) had been presenting with notable ‘Emotional and/or Behavioural Difficulties’, (consistent with the Department of Education ‘disability’ category), prior to assessment, and was at imminent risk of exclusion from the school environment, owing to difficulties, which teachers were experiencing in management of her behaviour in school settings. Following the outcomes of her assessment, this girl would later transfer to from the care of her mother to a full-time H.S.E. residential care placement in a H.S.E. ‘group home’.

One female Social Worker, (‘N.C. 1’, North Cork social work team), referred a total of seven of the fourteen children, (i.e., 50% of the children who were seen by the ‘assessment service’ during 2009).

These children were referred as part of two family groups (respectively, four female siblings, and two siblings - an adolescent male, and his adolescent female sibling), plus one, separate, individual (male) referral.

In the case of both the grouping of four siblings and the individual referral, the assessment team was involved in attending to/observing the parental care and development of a younger sibling of the referred child/children. In both of these cases, the younger child had not been formally referred for assessment to the 'assessment service', but the referring H.S.E. social worker held concerns about the suitability of the home placement for the children and the adequacy of the available parental care and stimulation.

Referrals by Ms. 'KY 18' (Kerry social work department) accounted for a family group of two boys who were seen for assessment. Both of these children/adolescents were in the care of their mother and remained so after the assessment. Both of these children were attending 'mainstream' Primary school and continued to do so after the assessment.

Referrals by Ms. N.L. 15 (North Lee social work department) accounted for two of the adolescent girls who were seen for assessment. Both of these girls (as a result of the outcomes of their respective assessments) later transferred from living at home (in the care of their respective mothers) to full-time H.S.E. residential 'care' placements, in separate H.S.E. 'group homes'. Prior to these assessments, both of these girls had presented with problematic and 'at-risk' behaviour patterns in home, school, and community settings, and both girls had required alternative, rather than 'mainstream' post-Primary education provision. One girl was identified at assessment as presenting with "Mild General Learning Disability", while the second girl was identified through assessment as presenting with significant specific impairment of her spoken language processing abilities, (scoring a 'Full-scale I.Q. score', which was within the "Borderline Mild General Learning Disability" range.

### **Description of cohort of children seen for assessment during 2008, (Group 9)**

A total of twelve children/adolescents were seen for assessment during 2008 (nine males and three females) (see **Table 9**, below). Within this cohort were three separate family groupings of separate two-sibling groups). The gender ratio for the overall year-group of fourteen assessment referrals, is typical (compared to the other nine years of assessment activities for the 'Assessment service', which were considered) as more males than females were seen for assessment (a ratio of 3 males to 1 female for this year).

**Table 9: - Cohort of 12 children seen for assessment during 2008, (Group 9)**

Year of assessment 2008, (Group 9, Total number = 12 children/adolescents)						
<u>9 Males</u> identified by age	Referring Social Worker	Area of referral		<u>3 Females</u> identified by age	Referring Social Worker	Area of referral
14-4	N.L. 15	North Lee		13-3	N.L. 30	North Lee
16-3	N.L. 15	North Lee				
15-11	KY 4	Kerry		15-5	W.C. 7	West Cork
14-8	S.L. 14	South Lee		14-3	N.L. 32	North Lee
13-5	S.L. 15	South Lee				
9-11	S.L. 15	South Lee				
12-0	S.L. 16	South Lee				
8-11	N.L. 30	North Lee				
15-4	N.L. 31	North Lee				

Six of the twelve children/adolescents who were seen for assessment during 2008 were referred by the North Lee social work team (referred by four separate social workers, two of



whom referred pairs of siblings) four children/adolescents were referred by the South Lee social work team, one adolescent was referred for assessment by the Kerry social work team, and one adolescent was referred by the West Cork social work team. No referrals from the North Cork social work team were seen by the 'assessment service' during 2008.

The age-range for females who were seen for assessment ranged from an adolescent of 13 years 3 months to an adolescent who was aged 15 years 5 months at the time of their assessments. The age-range for males who were seen for assessment ranged from a child of 8 years 11 months to an adolescent who was aged 16 years 3 months at the time of their assessments. The age-range for the female group is quite narrow, while the wide range for the male group is more typical of the age-range profile of the overall population during the 10-year period.

One of the three girls who were seen for assessment was attending 'mainstream' post-Primary school at the time of her assessment.

A second girl of this sub-group was attending an alternative educational provision for pupils who had 'dropped out' from 'mainstream' post-Primary school.

This service provides individual and small-group tuition to Junior Certificate level, (i.e., Third Year), for pupils who are at risk of early school-leaving. Following the outcomes of her assessment, this girl would later transfer to from the care of her mother to a full-time H.S.E. residential care placement in a H.S.E. 'group home'.

The third girl had been refusing to attend school for an extended period.

**Description of cohort of children seen for assessment during 2005, (Group 5)****Table 10: - Cohort of 17 children seen for assessment during 2005, (Group 6)**

Year of assessment 2005, (Group 6, Total number = 17 children/adolescents)					
<u>12 Males</u> by age	Referring Social Worker	Area of referral	<u>5 Females</u> by age	Referring Social Worker	Area of referral
13-10	N.L. 10	North Lee	15-11	N.C. 5	North Cork
13-9	S.L. 9	South Lee			
15-9	N.L. 27	North Lee	13-0	N.C. 6	North Cork
9-6	S.L. 12	South Lee			
13-9	W.C. 5/S.L.6	West Cork	14-0	S.L. 2 and S.L. 5	South Lee
13-10	KY 7	Kerry			
11-5	KY 3	Kerry	14-7	W.C. 5/S.L.6	West Cork
14-10	N.C. 7	North Cork			
10-5	KY 17	Kerry	16-11	N.L. 28/N.C. 2	North Lee
14-1	N.L. 2	North Lee			
10-8	N.L. 2	South Lee			
11-0	KY 4	Kerry			

A total of seventeen children/adolescents were seen for assessment during 2005, (twelve males and five females) (see **Table 10**, above). Within this cohort were three separate family groupings of separate two-sibling groups.

The gender ratio for the overall year-group of fourteen assessment referrals, is typical (compared to the other nine years of assessment activities for the ‘assessment service’, which were considered) as more males than females were seen for assessment (a ratio of over 2 males to 1 female).

Four adolescents of the seventeen children/adolescents who were seen for assessment were referred by the North Lee social work team, (referred by four separate social workers), four children/adolescents were referred by the South Lee social work team, (referred by five separate social workers – one referral was jointly made by two social workers on that team), four children/adolescents

were referred for assessment by the Kerry social work team (referred by four separate social workers), two adolescents were referred, separately, by one social worker the West Cork social work team, and three adolescents were referred by three separate social workers from the North Cork social work team.

The age-range for females who were seen for assessment ranged from an adolescent of 13 years 0 months to an adolescent who was aged 16 years 11 months at the time of their assessments. The age-range for males who were seen for assessment ranged from a child of 9 years 6 months to an adolescent who was aged 14 years 10 months at the time of their assessments. These relatively narrow age-ranges for both genders are somewhat atypical of the profile of wider age-ranges the overall population.

### **Description of cohort of children seen for assessment during 2001, (Group 2)**

A total of ten children/adolescents were seen for assessment during 2001, (nine males and one female) (see **Table 11**, on following page). Within this cohort was one two-sibling group.

**Table 11: - Cohort of 10 children seen for assessment during 2001, (Group 2)**

Year of assessment 2001, (Group 2, Total number = 10 children/adolescents)						
<u>9 Males</u> identified by age	Referring Social Worker	Area of referral		<u>1 Female</u> identified by age	Referring Social Worker	Area of referral
10-0	S.L 12	South Lee		15-0	S.L.6/W.C. 5	South Lee
13-10	S.L. 12	South Lee				
10-2	N.L. 25	North Lee				
11-6	KY 16	Kerry				
10-2	N.L. 14	North Lee				
15-4	S.L. 13	South Lee				
8-8	KY 15	Kerry				
7-8	KY 15	Kerry				
14-10	N.L. 26	North Lee				

The gender ratio for the overall year-group of fourteen assessment referrals, is atypical (compared to the majority of the other years of assessment activities for the ‘Assessment service’, which were considered) as far more males than females were seen for assessment (a ratio of 9 males to 1 female).

Three of the ten children/adolescents who were seen for assessment were referred by the North Lee social work team (referred by three separate social workers), four children/adolescents were referred by the South Lee social work team (referred by three separate social workers), and three children/adolescents were referred for assessment by two separate social workers from the Kerry social work team (including one sibling pair).

No referrals from the North Cork social work team, or from the West Cork social work team were seen for assessment by the 'assessment service' during 2001.

The one female who was seen for assessment was 15 years 0 months at the time of her assessment. The age-range for males who were seen for assessment ranged from a child of 7 years 8 months to an adolescent who was aged 15 years 4 months at the time of their assessments. The age-range for male gender is relatively typical of the profile of wide age-range for the overall population of children/adolescents who were assessed during the 10-year period.

#### **Description of cohort of children seen for assessment during 2000, (Group 1)**

A total of eight children/adolescents were seen for assessment during 2000, (five males and three females) (see **Table 12**, below).

**Table 12: - Cohort of 8 children seen for assessment during 2000, (Group 1)**

Year of assessment 2000, (Group 1 Total number = 8 children/adolescents)						
<u>5 Males</u> identified by age	Referring Social Worker	Area of referral		<u>3 Females</u> identified by age	Referring Social Worker	Area of referral
8-3	KY 12	Kerry		15-10	KY 13	Kerry
15-6	N.L. 22	North Lee		16-6	KY 13	Kerry
13-2	N.L. 14	North Lee		14-9	N.L. 24	North Lee
15-11	KY 14	Kerry				
16-6	W.C. 6	West Cork				

The gender balance for the overall year-group of eight assessment referrals recorded slightly more males than females seen for assessment (a ratio of almost 2 males to 1 female for this relatively small grouping). Three adolescents of the eight children/adolescents who were seen for assessment were referred by the North Lee Social Work team, (referred by three separate Social Workers, four children/adolescents were referred by the Kerry social work team, and one adolescent was referred by the West Cork social work team.

No referrals from the South Lee, or North Cork social work teams were seen for assessment by the 'assessment service' during 2000.

The age-range for females who were seen for assessment ranged from an adolescent of 14 years 9 months to an adolescent who was aged 16 years 6 months at the time of their assessments. The age-range for males who were seen for assessment ranged from a child of 8 years 3 months to an adolescent who was aged 16 years 6 months at the time of their assessments. The age-range for male gender is relatively typical of the profile of wide age-range for the overall population, while the age-range for female gender is narrower and relatively atypical of the profile of wider age-range for the overall population.

**Tables 13 to 18: - five annual cohorts, which were not part of the chosen sample**

The five tables on the following pages give details of clients of the 'Assessment service' for those five years, which were not chosen as part of the sample for this piece of research. The years involved are: 2002; 2003; 2004; 2006; and, 2007.

I have repeated **Table 4** here (see following page) from an earlier section of this section, and I have juxtaposed the information in this table with the information in **Table 13** (see following page), which summarises similar information for these five years of assessment reports.

**Table 4: - Summary of total ‘population’ of assessment Reports**

Total	N = 147  (100% of total)	North Lee 52, (35%); South Lee 26, (18%); Kerry 38, (26%); North Cork 21, (14%); West Cork 10, (7%).	94 males (64%)  (4 yrs. 5 mths. to 17 yrs. 7 mths.)	53 females (36%)  (4 yrs. 5 mths. to 17 yrs. 0 mths.)
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**Table 13: - Summary of total ‘remainder’ of assessment Reports**

Total for five year- groups	N = 86  (58% of total)	North Lee 33 (39%); South Lee 14 (16%); Kerry 23 (27%); North Cork 11 (13%); West Cork 4 (5%).	53 males (62%)  (4 yrs. 5 mths.to 17 yrs. 7 mths.)	33 females, (38%)  (7 yrs.7 mths. to 17 yrs. 0 mths.)
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Comparison of the data in **Table 4** and **Table 13** shows reasonably good matches across ‘sample’ and ‘population’ for dimensions such as: proportion of referrals from each social work department area; proportion of males and females who were seen for assessment; and overall age-ranges for each gender of the children and adolescents who were seen for assessment.

**Table 14 - Cohort of 14 children seen for assessment during 2002, (Group 3)**

Year of assessment 2002, (Group 3 Total number = 14 children/adolescents)						
<u>9 Males</u> identified by age	Referring Social Worker	Area of referral		<u>5 Females</u> identified by age	Referring Social Worker	Area of referral
12-11	N.C. 1	North Cork		13-9	N.L. 15	North Lee
16-0	S.L. 11	South Lee				
13-2	KY 10	Kerry		12-10	N.L. 21	North Lee
11-7	KY 10	Kerry		13-1	KY 6	Kerry
9-11	KY 10	Kerry				
14-4	N.L. 16	North Lee		11-1	KY 6	Kerry
8-9	KY 6	Kerry		7-7	KY 6	Kerry
10-9	N.L. 22	North Lee		15-1	KY 11	Kerry



**Table 15 - Cohort of 14 children seen for assessment during 2003, (Group 4)**

Year of assessment 2003, (Group 4, Total number = 14 children/adolescents)						
<u>9 Males</u> identified by age	Referring Social Worker	Area of referral		<u>5 Females</u> identified by age	Referring Social Worker	Area of referral
17-0	N.L. 15	North Lee		14-3	KY 9	Kerry
13-0	N.L. 16	North Lee				
14-7	S.L. 10	South Lee		14-9	N.L. 19	North Lee
15-3	N.L. 17	North Lee		15-9	N.L. 19	North Lee
13-9	KY 8	Kerry				
15-6	N.L. 18	North Lee		15-0	N.L. 12	North Lee
15-8	N.L. 19	North Lee		14-7	S.L.6/W.C. 5	South Lee
15-6	N.L. 20	North Lee				
11-1	N.L. 21	North Lee				

<b><u>Table 16 - Cohort of 21 children seen for assessment during 2004, (Group 5)</u></b>						
Year of assessment 2004, (Group 5, Total number = 21 children/adolescents)						
<u>9 Males</u> by age	Referring Social Worker	Area of referral		<u>12 Females</u> identified by age	Referring Social Worker	Area of referral
16-7	N.L. 9	North Lee		13-6	KY 7	Kerry
17-7	N.L. 14	North Lee		15-4	N.C. 3	North Cork
13-10	N.L. 13	North Lee		16-5	KY 7	Kerry
15-0	KY 6	Kerry		17-0	N.L. 9	North Lee
13-9	N.L. 12	North Lee		16-4	N.C. 4	North Cork
15-7	N.L. 11	North Lee		13-5	S.L. 9	South Lee
16-7	N.L. 10	North Lee		15-1	S.L. 6	South Lee
13-11	S.L. 6	South Lee		16-8	S.L. 8	South Lee
13-1	N.L 7	North Lee		15 -6	N.L. 9	North Lee
				12-7	N.L.8	North Lee
				13-9	S.L. 7	South Lee
				15-0	S.L. 6	South Lee

<b><u>Table 17 - Cohort of 20 children seen for assessment during 2006, (Group 7)</u></b>					
Year of assessment 2006, (Group 7, Total number = 20 children/adolescents)					
<u>16 Males</u> by age	Referring Social Worker	Area of referral	<u>4 Females</u> by age	Referring Social Worker	Area of referral
9-10	W.C. 5	West Cork	15-9	N.L. 7	North Lee
14-4	S.L. 5	South Lee			
14-11	W.C. 4	West Cork	14-10	N.C. 3	North Cork
9-3	N.L. 6	North Lee			
16-2	N.L. 6	North Lee	16-5	N.L. 2	North Lee
9-5	KY 3	Kerry			
13-2	N.C. 3	North Cork	16-8	KY 2	Kerry
14-6	S.L. 4	South Lee			
14-3	KY 5	Kerry			
11-5	N.L. 3	North Lee			
12-6	KY 4	Kerry			
13-9	KY 3	Kerry			
14-8	S.L. 3	South Lee			
13-6	KY 2	Kerry			
15-9	W.C. 3	West Cork			
15-5	KY 1	Kerry			

<b>Table 18: Year of assessment 2007, (Group 8, Total number = 17 children/adolescents)</b>
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<b><u>11</u></b> <b><u>Males</u></b> identified by age	Referring Social Worker	Area of referral		<b><u>6</u></b> <b><u>Females</u></b> identified by age	Referring Social Worker	Area of referral
4-5	N.C. 1	North Cork		13-4	N.C. 1	North Cork
15-5	S.L. 1	South Lee		7-8	N.C. 1	North Cork
16-7	W.C. 1	West Cork		12-5	N.C. 1	North Cork
17-4	N.L. 1	North Lee		16-0	N.C. 1	North Cork
15-0	KY 1	Kerry		11-9	N.L. 4	North Lee
10-4	KY 1	Kerry		13-5	KY 1	Kerry
13-2	N.L. 28/N.C. 2	North Cork				
14-8	N.L. 2	North Lee				
13-8	S.L. 2	South Lee				
14-5	W.C. 2	West Cork				
15-3	N.L. 3	North Lee				

## **Discussion**

This research process has acted as a vehicle for me to develop knowledge and skills in relation to: what Denzin and Lincoln, (1998), refer to as a “landscape” of qualitative research. The choice of an implicitly three-dimensional metaphor is apt, as it suggests a level of engagement with surface and “ground” that is richer and more complex than is conjured up by oft-used references to a “road-map” for quantitative research and analyses of numerical information.

The process of engagement with the data has called me to interact with and rely on colleagues along the way, in a way that previous research, (within a more quantitative framework), has not. I found that I could no longer rely on acquired knowledge, as the “landscape” changed with each step of the journey, and, as a result, colleagues who moved in the same “landscape” found themselves in the position of being asked for direction by me, pushed to give knowledge that they didn’t realise they had, (rich feedback in relation to ideas that I shared, or dilemmas that I faced).

Similarly, the support of a supervisor who had travelled similar paths before, and who was comfortable with following a path that evolved, rather than a research route, which was known in advance has been important. Presence of such a companion provided containment of anxiety about being lost, and furnished faith in perseverance with making a trail through this landscape.

Use of MaxQDA offered a more obvious type of containment. With the exception of occasional glitches in the computer, this qualitative analysis software ensured that I could always return to the trail, and know exactly where I had left off when I had last engaged with the data. It has been an incredible experience to find such a user-friendly and reliable tool for management of large amounts of complex data.

The MaxQDA software has become an integral part of my practice, and my intention is to continue to use it with colleagues as a routine element of ongoing evaluation of service.

Discussion with management and colleagues of the quantitative information, which has arisen from analysis of the archival records has already led to: a clearer vision of the service provided; a plan to proactively engage with referring agents and promote a clearly-defined model of service, (inclusive of clearer boundaries and links with other professional assessment services in the region).

The proposed new model of service has allowed for re-defined roles within the assessment team, and I have included these in the following pages, (allowing comparison with earlier examples, in **Appendix 8**).

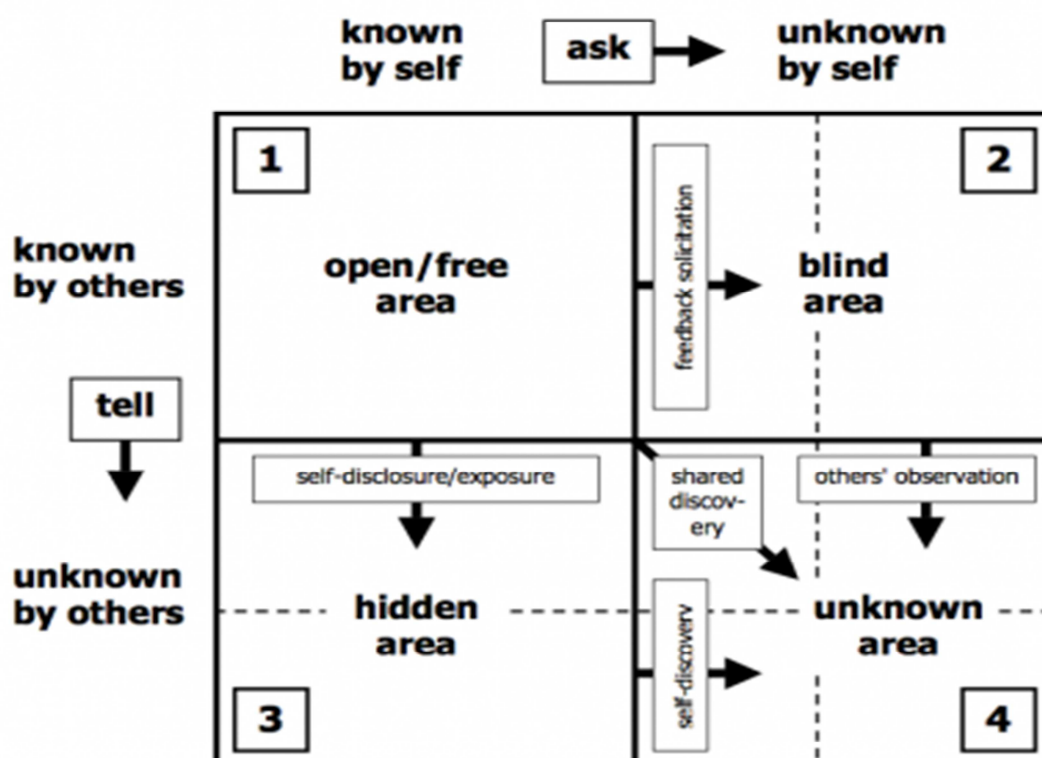
This model has, also, involved a re-definition of levels of engagement with referring agents, and “consultation meetings” are now often offered in advance of assessment.

These meetings help to: clarify the psychological and other questions to be answered at assessment, limit expectations of referrers within a transparent formulation for assessment; support the process of collating all relevant previous assessment Reports in advance of the assessment process; help time-management in relation to assessment; and foster development of a collaborative working alliance with the referring agent.

Permission has been given by management of the ‘assessment service’ to take a period of some ten weeks out from the fixed eight-week assessment schedule in order for the senior psychologist and the principal social worker who are attached to the service to formally develop a new model of service, which will form the basis for future operation of the service.

The impetus for this development has come from my own reflection and research in relation to the service, and is based on a gradual shift in awareness among stakeholders within the management of the service and among the professional disciplines which form the multi-disciplinary team.

The Johari Window model of awareness is relevant for understanding of how this process of change has come about. This image (Figure 1, below) named after the first names of its two inventors **Joseph** Luft and **Harry** Ingham), uses the visual metaphor of a four-paned 'window', where the window blinds can move separately, (in response to changes in awareness/ knowledge/insight as a result of communication in any context, or relationship.



**Figure 16: Jo-Hari window**

I use this model here to illustrate how as a result of undertaking research about the 'assessment service' (i.e., asking questions, shown by the 'ask' arrow pointing right, at the top), I discovered new information about the service. In turn this has helped me to give back new information about the 'assessment service' to members of the assessment team and management team (i.e., reporting the research findings, shown by the 'tell' arrow pointing down, at the left). From the perspective of service stake-holders, this may be seen to have reduced the 'hidden' and 'blind' areas, and to have, conversely, expanded the 'open', or 'known' area in relation to the 'assessment service'.























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## **Appendices**

**Appendix 1: Anonymised – ‘Assessment and Resource Centre’ Information Booklet****Assessment Service**

Assessment conducted through a multi-disciplinary team process. The assessment team consists of the following disciplines: Social Work, Education, Psychology and Child Care. The focus of assessment is to develop an understanding of the young person and the family's situation in order to formulate a plan of intervention to meet both the needs of the young person and the family.

Each discipline engages in assessment activities from their own professional perspective. The assessment involves both a residential and outreach component, which aims to achieve a comprehensive insight into the family situation. Throughout the process of assessment, the multi-disciplinary team members meet to share and explore the information gathered in order to generate hypotheses on the presenting difficulties. During the final stage of the process, each discipline draws conclusions regarding the results of their assessment activities, (which formulate the overall team recommendations). From these conclusions, the overall Team Recommendations are formulated.

**Assessment Process**

Our Assessment service is an 8-week process, broken down into three Phases:

**Phase One (two weeks) consists of:**

- Assessment Team Meeting
- Outreach Visits to the young person in their place of residence.
- Family visit to the Unit.

Phase Two (three weeks) consists of:

- Three-week Residential Placement (Sunday/Monday – Friday), depending on the young person's individual needs.
- Multi-disciplinary Team Meetings
- Respective disciplines engage in information-gathering activities.

Phase Three (three weeks) consists of:

- Opportunity for further Outreach Visits/meetings with family, if necessary
- Compiling Final Assessment Team Report
- Recommendations Meeting
- Feedback to the young person, parents/carers and referring Social Worker.

**Role of Assessment Team**

Roles within the Assessment Team include:

- Childcare/Keyworking
- Social Work
- Psychology
- Education

Keyworker

The Keyworker is a member of the Child Care staff and forms the primary relationship with your child within the unit and engages with your child in both formal and informal settings to assess your child's presentation, as is informed by the focus of assessment.

Social Worker

The unit Social Worker engages with your family to assess the strengths within the family and the impact of the wider environment on your child.



*Psychologist*

The unit Psychologist will work with your child in a formal setting and analyse the presenting concerns, seeking to place them into context.

*Teacher*

The unit Teacher has regular sessions with your child and seeks to determine your child's level of attainment and educational functioning, focusing on the strengths that your child brings to the learning process.

**Appendix 2: Page from the Tusla Child and Family Agency website, describing the Agency: “About Us - Welcome to the Child and Family Agency website”**

**Who we are**

On the 1st of January 2014 the Child and Family agency became an independent legal entity, comprising HSE Children & Family Services, Family Support Agency and the National Educational Welfare Board as well as incorporating some psychological services and a range of services responding to domestic, sexual and gender based violence.

The Child and Family Agency is now the dedicated State agency responsible for improving wellbeing and outcomes for children. It represents the most comprehensive reform of child protection, early intervention and family support services ever undertaken in Ireland. It is an ambitious move which brings together some 4,000 staff and an operational budget of approximately €600m.

The Agency operates under the Child and Family Agency Act 2013, a progressive piece of legislation with children at its heart, and families viewed as the foundation of a strong healthy community where children can flourish. Partnership and co-operation in the delivery of seamless services to children and families are also central to the Act.

The establishment represents an opportunity to think differently, where appropriate to behave differently and to seek a wide range of views regarding the most effective way of working together to deliver a wide range of services for children and families. An approach which is responsive, inclusive and outward looking.

## **New Beginnings**

Prior to establishment date, widespread consultation with all stakeholders sought to capture the hopes, and indeed fears, which key influencers had regarding the new Child and Family Agency. Many held the view that a mere realignment of services and the amalgamation of a number of bodies would not be enough to deliver on the fresh start so much called for throughout the sector. It was felt that what was required was a new identity which captures a new sense of purpose shared by all those who together will deliver children and family services going forward.

Consideration was given to the aspirations for the agency and many themes emerged – A new beginning, an opportunity, a challenge. From debate and conjecture, the name Tusla emerged as a fitting logo for the Child and Family Agency. While the word borrows from the Irish words ‘tus’ + ‘lá’, Tusla is a completely new word reflecting a shared desire for a new beginning, forging a new identity. A new word, a new way of working.

## **Our Remit**

Under the Child and Family Act, 2013 the Child and Family Agency is charged with:

- supporting and promoting the development, welfare and protection of children, and the effective functioning of families;
- offering care and protection for children in circumstances where their parents have not been able to, or are unlikely to, provide the care that a child needs. In order to discharge these responsibilities, the Agency is required to maintain and develop the services needed in order to deliver these supports to children and families, and provide certain services for the psychological welfare of children and their families;

- responsibility for ensuring that every child in the State attends school or otherwise receives an education, and for providing education welfare services to support and monitor children's attendance, participation and retention in education;
- ensuring that the best interests of the child guides all decisions affecting individual children;
- consulting children and families so that they help to shape the agency's policies and services;
- strengthening interagency co-operation to ensure seamless services responsive to needs;
- undertaking research relating to its functions, and providing information and advice to the Minister regarding those functions; and
- commissioning services relating to the provision of child and family services

### **Our Services**

The Child and Family Agency's services include a range of universal and targeted services:

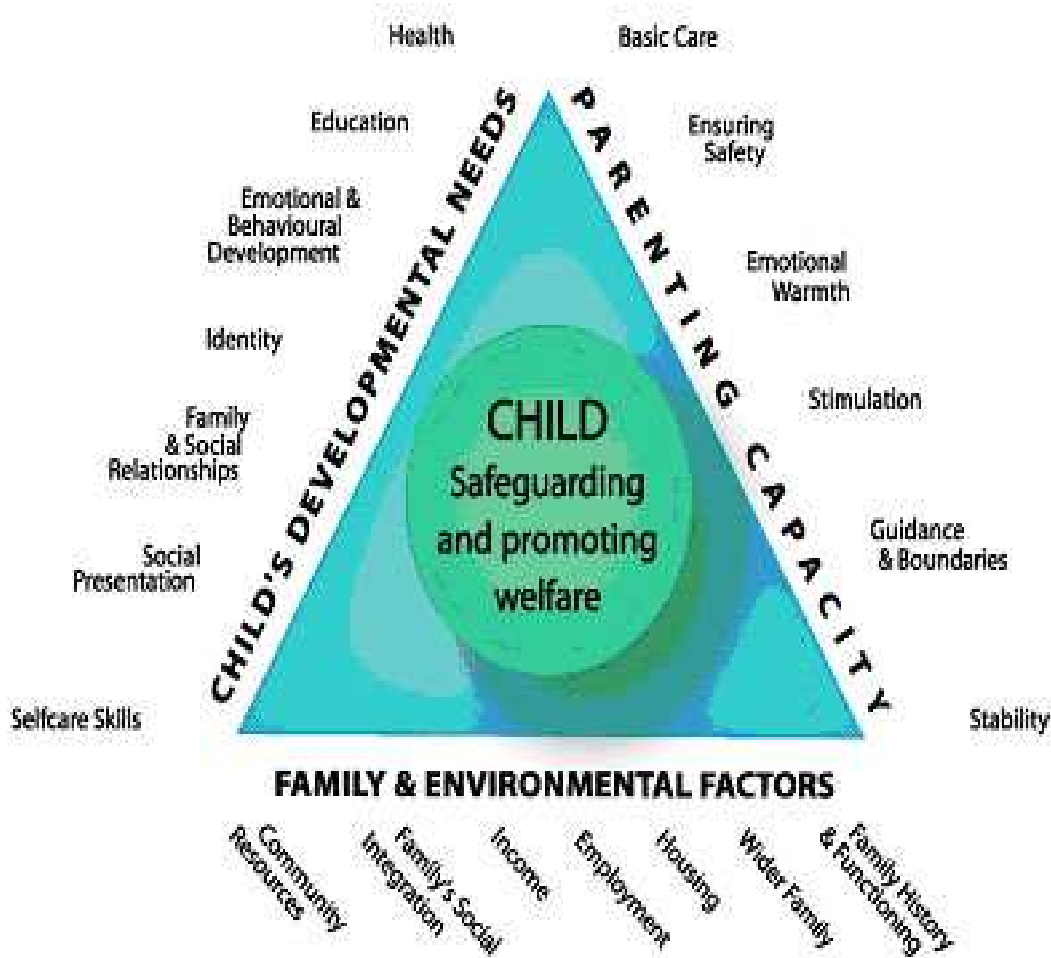
- Child protection and welfare services
- Educational Welfare Services
- Psychological Services
- Alternative care
- Family and Locally-based Community Supports
- Early Years Services
- Domestic, Sexual and Gender-based Violence Services

### **Appendix 3: Framework for the Assessment of Children in Need and their Families**

This information is sourced from the following on-line web-site -

<http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eorderingdownload/00305-2010dom-en-v3.pdf>

The following section reproduces excerpts from Appendix 2 of Working Together to Safeguard Children – A guide to inter-agency working to safeguard and promote the welfare of children, (2010) as a summary of the guidance, which is encapsulated in the “Assessment Triangle” diagram, (see below).



1. *The Framework for the Assessment of Children in Need and their Families* provides a systematic basis for collecting and analysing information to support professional judgements about how to help children and families in the best interests of the child. Practitioners use the framework to gain an understanding of the following domains:
  - a child's developmental needs;
  - the capacity of parents or caregivers to respond appropriately to those needs, including their capacity to keep the child safe from harm;
  - the impact of wider family and environmental factors on the parents and child.
  
2. The Framework is to be used for the assessment of all children in need, including those where there are concerns that a child may be suffering **Significant Harm**. The process of engaging in an assessment should be viewed as being part of the range of services offered to children and families. Use of the Framework should provide evidence to help, guide and inform judgements about children's welfare and safety from the first point of contact, through the processes of initial and more detailed core assessments, and then services. The provision of appropriate services need not and should not wait until the end of the assessment process, but should be determined according to what is required, and when, to promote the welfare and safety of the child.
  
3. Evidence about children's developmental progress – and their parents' capacity to respond appropriately to the child's needs within the wider family and environmental context – should underpin judgements about:
  - the child's welfare and safety;
  - whether - and if so how - to provide help to children and family members
  - what form of intervention will bring about the best possible outcomes for the child
  - the intended outcomes of intervention

**A: DIMENSIONS OF CHILD'S DEVELOPMENTAL NEEDS****Health**

Includes growth and development as well as physical and mental well-being.

**Education**

Covers all areas of a child's cognitive development which begins from birth. Includes opportunities:

- for play and interaction with other children;
- to have access to books;
- to acquire a range of skills and interests;
- to experience success and achievement.

Involves an adult interested in educational activities, progress and achievements, who takes account of the child's starting point and any special educational needs.

**Emotional and Behavioural Development**

Concerns the appropriateness of response demonstrated in feelings and actions by a child, initially to parents and caregivers and, as the child grows older, to others beyond the family.

Includes nature and quality of early attachments, characteristics of temperament, adaptation to change, response to stress and degree of appropriate self-control

**Identity**

Concerns the child's growing sense of self as a separate and valued person. Includes the child's view of self and abilities, self-image and self-esteem, and having a positive sense of individuality. Race religion, age, gender, sexuality and disability may all contribute to this.

**Family and Social Relationships**

Development of empathy and the capacity to place self in someone else's shoes. Includes a stable and affectionate relationship with parents or caregivers, good relationships with siblings, increasing importance of age appropriate friendships with peers and other significant persons in the child's life and response of family to these relationships.

**Social Presentation**

Concerns child's growing understanding of the way in which appearance, behaviour, and any impairment are perceived by the outside world and the impression being created. Includes appropriateness of dress for age, gender, culture and religion; cleanliness and personal hygiene; and availability of advice from parents or caregivers about presentation in different settings.

**Self Care Skills**

Concerns the acquisition by a child of practical, emotional and communication competencies required for increasing independence... Special attention should be given to the impact of a child's impairment and other vulnerabilities, and on social circumstances affecting these in the development of self care skills.

**B:     DIMENSIONS OF PARENTING CAPACITY****Basic Care**

Providing for the child's physical needs, and appropriate medical and dental care. Includes provision of food, drink, warmth, shelter, clean and appropriate clothing and adequate personal hygiene.



**Ensuring Safety**

Ensuring the child is adequately protected from harm or danger. Includes protection from significant harm or danger, and from contact with unsafe adults/other children and from self-harm. Recognition of hazards and danger both in the home and elsewhere.

**Emotional Warmth**

Ensuring the child's emotional needs are met giving the child a sense of being specially valued and a positive sense of own racial and cultural identity. Includes ensuring the child's requirements for secure, stable and affectionate relationships with significant adults, with appropriate sensitivity and responsiveness to the child's needs. Appropriate physical contact, comfort and cuddling sufficient to demonstrate warm regard, praise and encouragement.

**Stimulation**

Promoting child's learning and intellectual development through encouragement and cognitive stimulation and promoting social opportunities. Includes facilitating the child's cognitive development and potential through interaction, communication, talking and responding to the child's language and questions, encouraging and joining the child's play, and promoting educational opportunities. Enabling the child to experience success and ensuring school attendance or equivalent opportunity. Facilitating child to meet challenges of life.

**Guidance and Boundaries**

Enabling the child to regulate their own emotions and behaviour. The key parental tasks are demonstrating and modelling appropriate behaviour and control of emotions and interactions with others, and guidance which involves setting boundaries, so that the child is able to

develop an internal model of moral values and conscience, and social behaviour appropriate for the society within which they will grow up. The aim is to enable the child to grow into an autonomous adult, holding their own values, and able to demonstrate appropriate behaviour with others rather than having to be dependent on rules outside themselves. This includes not over-protecting children from exploratory and learning experiences. Includes social problem solving, anger management, consideration for others, and effective discipline and shaping of behaviour.

### **Stability**

Providing a sufficiently stable family environment to enable a child to develop and maintain a secure attachment to the primary caregiver(s) in order to ensure optimal development.

Includes: ensuring secure attachments are not disrupted, providing consistency of emotional warmth over time and responding in a similar manner to the same behaviour. Parental responses change and develop according to child's developmental progress. In addition, ensuring children keep in contact with important family members and significant others.

## **C: FAMILY AND ENVIRONMENTAL FACTORS**

### **Family History and Functioning**

Family history includes both genetic and psycho-social factors. Family functioning is influenced by who is living in the household and how they are related to the child; significant changes in family/household composition; history of childhood experiences of parents; chronology of significant life events and their meaning to family members; nature of family functioning, including sibling relationships and its impact on the child; parental strengths and difficulties, including those of an absent parent; the relationship between separated parents.

**Wider Family**

Who are considered to be members of the wider family by the child and the parents? ... What is their role and importance to the child and parents and in precisely what way?

**Housing**

Does the accommodation have basic amenities and facilities appropriate to the age and development of the child and other resident members?.... Basic amenities include water, heating, sanitation, cooking facilities, sleeping arrangements and cleanliness, hygiene and safety and their impact on the child's upbringing.

**Employment**

Who is working in the household, their pattern of work and any changes? What impact does this have on the child? How is work or absence of work viewed by family members? How does it affect their relationship with the child?

**Income**

Income available over a sustained period of time. Is the family in receipt of all its benefit entitlements? Sufficiency of income to meet the family's needs. The way resources available to the family are used. Are there financial difficulties which affect the child?

**Family's Social Integration**

Exploration of the wider context of the local neighbourhood and community and its impact on the child and parents. Includes the degree of the family's integration or isolation, their peer groups, friendship and social networks and the importance attached to them.

**Community Resources**

Describes all facilities and services in a neighbourhood, including universal services of primary health care, day care and schools, places of worship, transport, shops and leisure activities. Includes availability, accessibility and standard of resources and impact on the family, including disabled members.

## **Appendix 4: ‘assessment service’ documents relating to 8-week assessment cycle**

### **Appendix 4.1: First Assessment Team Meeting**

#### **Phase 1 Week 1 , (i.e., the 1<sup>st</sup> week of the 8-week schedule)** (Time: 2 Hours)

##### **Agenda:**

##### **Pre- Planning Stage** (Internal assessment team members to attend) (45 minutes)

- Feedback on First Outreach Visit.
- Share initial thoughts/generate hypotheses.
- Clarify team focus and identify methods and disciplines primarily responsible for this. Outline child/carers focus of assessment, (as discussed with family at First Outreach Visit).
- Identify core members to access and circulate documentation/literature relevant to presenting issues (e.g. A.D.H.D., O.C.D. etc.), where applicable.
- Discussion in relation to the young person’s ‘Portfolio’, (to be completed during assessment).

##### **Planning Stage** (Internal assessment team members and referring Social Worker to attend) (1 hour)

- Get an update from the referring Social Worker, (S.W.), on any developments relating to the child/family since the Admissions Panel Meeting.
- Give feedback to the referring Social Worker on engagement process to date and initial Outreach Visit.
- Seek clarity on referring Social Worker’s preferred focus of assessment and contract focus based on the priorities of referring Social Worker /child/Carers/‘Assessment Centre’ assessment team members.
- Confirm who constitutes the family and identify significant others involved with the child, or family/Carers who may be able to contribute to the assessment.
- Identify for the referring Social Worker the necessary documentation required from them where applicable, (i.e., copy of Care Order, or Voluntary Consent to Care form, copy of Birth Certificate, copy of Care Plan, Statement of Care).
- Ensure all reports requested at the Admission Panel stage have been submitted, including Information Access Consent form.

- Ensure that the young person's school/educational placement has been informed of the commencement of assessment. Obtain name of Principal, address and phone number of school, where applicable.
- Clarify the role and expectations of the referring Social Worker in the assessment, and agree levels of communication and contact between him/her and the 'Assessment Centre' team throughout the assessment. Confirm that the referring Social Worker can attend identified meetings during the assessment process. Invite the referring Social Worker to read all relevant Log Books/Child's File during the child's stay.
- Complete 'risk assessment' in relation to "Absence Management Plan".
- Decide on practical arrangements re: travel, directions, appointments, etc.
- A.O.B.

### **Scheduling Stage**

(Internal assessment team members and 'Placement Co-ordinator' to attend) (15 minutes)

- Plan family visit, (e.g., clarify activities for family visit to Unit/identify what assessment team members are available to attend).
- Plan residential component having consideration for group compatibility/levels of risk/needs of young person.

## **Appendix 4.2: Second Assessment Team Meeting**

### **Phase 2 Week 2, (i.e., the 2<sup>nd</sup> week of the 8-week schedule)** (Time: 1½ - 2 hours)

(Internal Assessment Team Members to attend)

#### **Agenda:**

- Matters arising from minutes of First Assessment Team Meeting, including amendments, if applicable.
- Individual professional disciplines share thoughts in relation to themes/focus for assessment.
- Review/generate hypotheses with reference to information shared, identify findings and possible implications of these.
- Identify the core issues for further assessment and the specific activities to be engaged in during the remainder of the assessment, (e.g., planning for further family assessment days).
- Designate member(s) of the assessment team to feedback to the young person, carers, referring Social Worker and the larger staff team as appropriate.
- Advise assessment team members who will not be available to attend Internal Recommendations Meeting that they will need to forward their recommendations to another member of the assessment team.
- Confirm dates of outstanding meetings/family days, etc.
- State date of completion of Final Assessment Team Report.
- A.O.B.

(Phone call re.: assessment update to be made by the 'Assessment Centre' Social worker to referring Social Worker following Second A.T.M., and minutes of the meeting to be forwarded).

### **Appendix 4.3: Strategy Meeting**

#### **Phase 2, weeks 1 to 3, (i.e., the 3<sup>rd</sup>, 4<sup>th</sup>, and 5<sup>th</sup> weeks of the 8-week schedule)**

(Time: Approximately 1 hour 15 minutes per young person) (To be held each week during Phase 2 of assessment period, therefore: the meeting in Phase 2, Week 1 is recorded as 'First Strategy meeting'; the meeting in Phase 2, Week 2 is recorded as 'Second Strategy meeting'; and the meeting in Phase 2, Week 3 is recorded as 'Third Strategy meeting').

#### **Purpose and Function of a Strategy Meeting:**

Provides the multi-disciplinary team with an opportunity to collaborate on findings of assessment to date, review focus of assessment and agree any outstanding assessment activities. **Manager/Deputy Manager to 'chair' meeting. 'Rotating' minute taker**

#### **Agenda:**

1. Matters arising from minutes of First Assessment Team Meeting, including amendments if necessary, **(at Strategy Meeting in Phase 2 Week 1)**.
2. Extremely limited 'handover' of information to be provided, **(last 24 hours)**.
3. Review focus of assessment if applicable / analyse the information we have to date.
4. The following questions to be considered if applicable:
  - Are the findings between each discipline consistent?
  - Are there any further assessment tools, or tasks to be completed to add to the findings?
5. Identify the core issues for further assessment and the specific activities to be engaged in during the remainder of the assessment, (e.g., planning for further family assessment days).
6. Review 'Voluntary Agreement', if necessary.
7. Discussion in relation to the young person's assessment 'Portfolio'.
8. Discuss if it is necessary for the referring Social Worker to attend the Third Strategy Meeting. Designate a member of the assessment team to contact the referring Social Worker, **(at Strategy Meeting in Phase 2 Week 2)**.
9. Advise assessment team members who will not be available to attend Internal Recommendations Meeting that they will need to forward their recommendations to another member of the assessment team, **(at Strategy Meeting in Phase 2 Week 3)**.
10. Confirm dates of outstanding meetings/family days, etc.
11. State date of completion of Final Assessment Team Report, **(at Strategy Meeting in Phase 2 Week 3)**.
12. A.O.B.

### **Appendix 4.4: Strategy meeting record-form**



**‘Assessment Centre’ Assessment & Resource Unit**

**Strategy Meeting Record Form**

**PHASE 2:**    **WEEK** \_\_\_\_\_ **DATE:** \_\_\_\_\_ **Time:** \_\_\_\_\_

<b>NAME:</b>	<b>D.O.B:</b>	<b>KEYWORKER:</b>	<b>DATE OF NEXT STRATEGY MEETING:</b>
<b>Person’s Present:</b>			
<b>Agreed Strategies/Outcomes/Decisions made (if applicable):</b>			

**Signed:** \_\_\_\_\_

**Minute Taker**

**Appendix 4.5: Report-writing week**

### **Phase 3 Week 1, (i.e., the 6<sup>th</sup> week of the 8-week schedule)**

This week is nominally designated for individual members of the multi-discipline assessment team to attend to writing of individual assessment Reports for each child, adolescent, or family group whom they have been involved with during assessment.

Thus, each Child Care Worker ‘Key-worker’ will have one assessment Report to write; Reports for individuals within each cohort for assessment will be allocated between the two teachers who are attached to the services; the Principal Social Worker may have one, or more Reports to write, (depending on whether individual children, or adolescents are the focus of assessment, or whether a specific assessment cohort relates to a “family assessment”; while, the Senior Psychologist will usually have at least four individual assessment Reports, sometimes more than one type of assessment Report per individual child, or adolescent, (e.g., a separate “psycho-educational Report of assessment” for school services, and may have a Report, or Reports relating to a parent(s), or the family as a whole.

### **Appendix 4.6: Internal Recommendations Meeting, (I.R.M.)**

#### **Phase 3 Week 2, (i.e., the 7<sup>th</sup> week of the 8-week schedule)** (Time: 2 hrs.)

(Internal assessment team members to attend – ‘client manager’, where necessary)

#### **Agenda:**

- Each professional discipline shares their likely individual recommendations.
- Agree and write up Team Recommendations.  
(The person who writes up Team Recommendations is responsible for ensuring they are typed and circulated to the assessment team prior to Recommendations meeting, as they need to be given to referring Social Worker at that meeting).
- Advise that any additional recommendations arising outside of this meeting need to be checked with each professional discipline prior to being added to list of Team Recommendations.
- Agreement on designated team members to give feedback to the child/family/Carers.

### **Appendix 4.7: Final Recommendations Meeting and ‘Feedback’ Meeting (see below)**

**Phase 3 Week 3 (i.e., the 8<sup>th</sup> week of the 8-week schedule)(Time: 1½ hours)**

(Internal team members and referring Social Worker to attend)

**Agenda:**

- Each professional discipline to provide brief update to the referring Social Worker on new information only and outline assessment findings and provisional recommendations.
- List of assessment Team Recommendations to be given to the referring Social Worker.
- Agreement on feedback to be given/who gives the feedback to the young person and family/Carer following this meeting. (Discuss how feedback can be given if family/Carer and young person cannot attend meeting).

**Appendix 4.8: Feedback Meeting**

(Representatives of internal assessment team and referring Social Worker to attend)

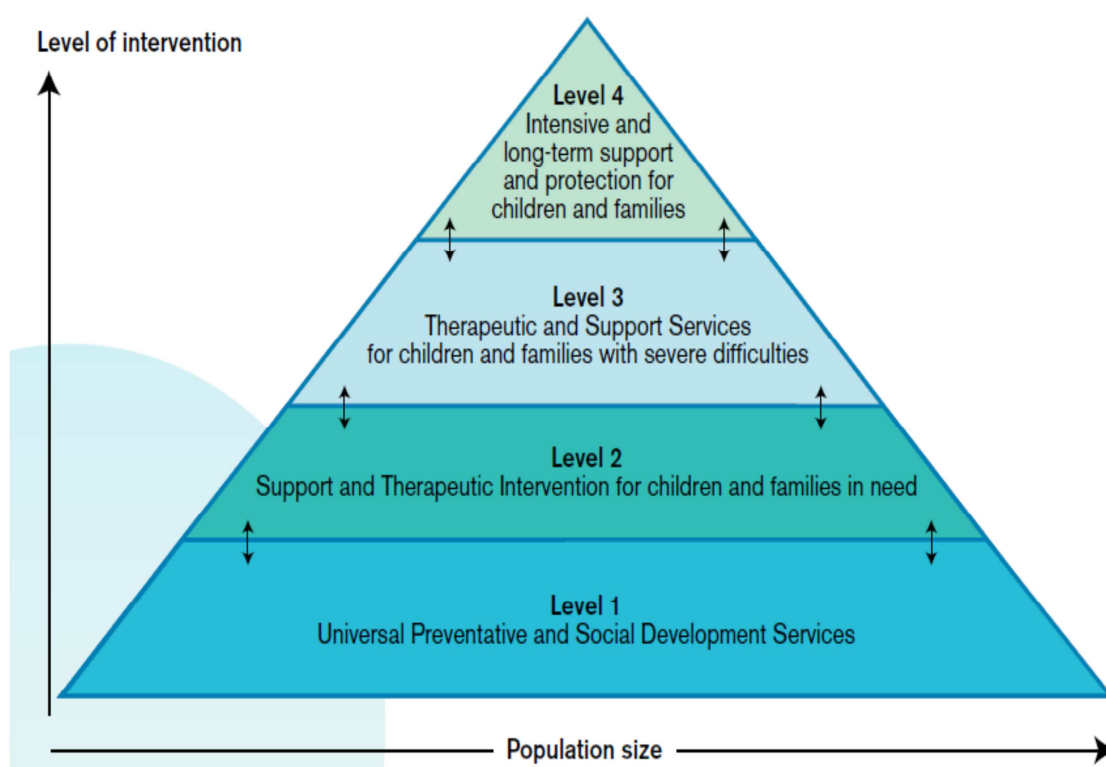
**Agenda:**

- To inform the young person and family/Carers on the findings of assessment and recommendations made.
- To provide an opportunity for the young person and family/Carers to seek clarification on any points of information.
- To provide an opportunity for the young person and family/Carers to voice their experiences of the assessment process.
- To outline to the young person's family/Carers what happens now regarding the recommendations.

## **Appendix 5: The Hardiker Model of levels of need for services to families**

The Hardiker Model (based on the work of Pauline Hardiker, 1991) is described by Mc Kittrick, (2010, p.2) as *“The Hardiker model differentiates between the level of need. It is a model designed to describe the level and nature of services that best fit the range of needs of families.”* She goes on to say that, *“In Ireland today there are 6,122 children in care (April 2011) – level 4. We have more than 12,000 that are known to the care system – that is, where an expression of concern has been made to the HSE about their wellbeing. We know there are many other children where there are concerns held by family members and/or professionals, but have not as yet been communicated to the HSE – level 3.”*

The Hardiker Model (1991) (diagram from Ferns Diocesan Youth Service, (FDYS) explanatory handout on this model.



**Figure 7 - The Hardiker Model (1991) (diagram from Ferns Diocesan Youth Service (F.D.Y.S.), explanatory handout**

As outlined in the diagram, (above), the ‘assessment service’ is most often concerned with referrals, which deal with children, adolescents, or families who need to access services at levels Three and Four, (in addition to, or, perhaps, instead of those services that they may avail of at levels One and Two). The levels are explained in the F.D.Y.S. document, and I provide an abbreviated interpretation of this explanation here, (drawn in large part from the original document).

### **Level One:**

represents ‘mainstream’ services –available to all children. The document highlights that consideration of service provision at this level offers the potential for delivering resources through community development initiatives. Examples of such initiatives could include, ‘parent-toddler groups’, ‘women’s groups’, or resources, which are focussed on whole populations within ‘disadvantaged areas’, such as, Family Resource Centres, or ‘Springboard’ initiatives.

### **Level Two:**

represents services to children who have some additional needs. Such services are described as, “*characterised by referral, and full parental consent and negotiation*”. Examples of such services could include referral to N.E.P.S, to Community Psychological, Speech and Language, or Occupational Therapy services, or to C.A.M.H.S.

(Note that: In school settings, referral to ‘Learning Support Teaching’, linked to the Department of Educational and Skills category of “High Incidence Disabilities” could be seen as a ‘Level One’ service; while designation as eligible to access ‘Resource Teaching’, of ‘Special Needs Assistant’ allocation, linked to the Department of Educational and Skills category of “Low Incidence Disabilities” could be seen as a ‘Level Two’ service).

**Level Three:**

represents support to families or individual children and young people “*where there are chronic or serious problems or children at risk. Support is often provided through a complex mix of services which usually need to work together well in order to provide the best support. State intervention can have a high profile at this level*”. Examples of how services are provided at this level include children, or adolescents with allocated H.S.E. Social Workers, or children, or adolescents who have an assigned “Juvenile Liaison Officer” from the Gardaí, or an assigned Probation Officer, or who are before the Courts.

**Level Four:**

represents “*support for families and individual children or young people where the family has broken down temporarily or permanently where the child, or young person may be in out of home care. It can also include young people in detention or as an in-patient due to disability or mental health problems.*

“*Services at Level 1 are supported by preventative services at Level 2 where all difficulties are dealt with by mainstream education, health and community services. The more needs addressed at levels 1 and 2 the better. Level 2 services are essentially preventative, many provided by community and voluntary agencies. The effectiveness of Level 2 services will often determine the threshold for entry into Level 3. Similarly, effective intensive targeted services at Level 3 will affect thresholds for Level 4. But children in care including high support and special care or in detention at Level 4 are also dependent on access to effective services at Levels 3, 2 and 1 on the journey back to the community.*”

## **Appendix 6: Code-book for content analysis of archival assessment report records**

I have chosen the dimensions (distinguished here as ‘codes’) for content analysis of the archival assessment report data. As noted in the ‘Introduction’ to this work, the content analysis used in this work is based on a coding system, which I have formulated from the following categories:.

**Category A** - based on “The Framework for Assessment of Vulnerable Young Children and their Families” (Buckley et al., 2006) inclusive of three broad sub-categories (as follows) each with subsidiary dimensions.

- (iv) “Child’s Developmental Needs”;
- (v) “Parenting Capacity”; and
- (vi) “Family and Environmental Factors”.

**Category B** – based on dimensions, or phenomena, which I have identified as relevant for organisation and cross-reference within the data-set, such as, age, gender, identification of referring agent/team, identification of assessment team discipline/member (see ‘Method’ section); and,

**Category C** - based on dimensions, or phenomena, which I have identified as arising from the data-set, based on frequency counts of words, terms, or phrases (see ‘Results’ section and Appendix 6).

The following headings identify separate coding dimensions, with descriptors of how each code is applied to the archival report data, and some comments on the relevance of particular codes.

### **Address of child**

This category records the address of each child, or adolescent who is the subject of the assessment at the time of her/his assessment with the residential assessment centre.

*Purpose: being able to identify patterns of where children who have referred to the assessment service live, and provide a profile of geographic spread and areas of concentrations of referrals. In turn this information could inform the Centres identification of relevant schools and services for particular areas, inclusive of development of professional links with individual professionals, and preparation of information-packs to assist with recommendations from assessments, (e.g., referral for a particular service, such as play therapy, or recommendations relating to leisure-sampling in a particular area, e.g., available leisure-pursuits, employment opportunities in Cobh, a naval/seaside town would differ considerably from Kanturk, an inland, rural town. Information from this category could, also, help to inform service development with Tusla social work, H.S.E. psychology, and C.A.M.H. services within a broader H.S.E. context, with regard to proactive “resource” work, which is part of the brief of the ‘assessment service’ centre (e.g., “Incredible Years” programmes, which could be delivered in conjunction with local community-based projects).*

### **Age of child**

This category records the age of each child, or adolescent who is the subject of the assessment at the time of her/his assessment with the residential assessment centre. *Purpose: being able to identify patterns of age in relation to children, (broken down by gender), who have been referred to the assessment service, and provide a profile of age-range spread and focus in relation to patterns of age-group referrals in relation to male and female referrals.*



*Potentially, this information could be cross-referenced with coding categories relating to: (a) reasons for referral and background factors; (b) activities undertaken by each discipline; and, (c) the nature of recommendations made from the assessment process.*

#### **‘assessment service’ assessment team**

This category is divided into four sub-categories, which represent the respective professional roles within the assessment team: psychologist; social worker; teacher; and, “key-worker” (child care worker). Each professional is identified by her/his name. *Purpose: being able to relate individual practitioners with identified patterns of activities undertaken by each discipline; and, the nature of recommendations made from the assessment process.*

#### **Aspects of self**

This category is divided into two sub-categories:

**“Aspects of self”** - this code includes specific references to the term, “self”, (e.g., “self-esteem”, or “self-concept”).

**“Personality Disorder”** - this code includes specific references to the term, “personality disorder”.

#### **Aspirations of child/young person**

This category is a unitary code (i.e., not sub-divided into other categories) and includes specific references, where the assessment report has recorded that the child, or young person has expressed aspirations for her/his future life circumstances (inclusive of educational placement, residential placement, relationships, change in self, or vocational aspiration).

**Attachment**

This category is a unitary code (i.e., not sub-divided into other categories) and includes specific references (if the assessment report has recorded specific comment on the nature, or quality of “attachment” relationship between the subject(s) of the report, (usually the child, or young person who is the main subject of the report, but possibly between other key figures in the world of child, or young person) and others. The word “attachment” must be used in the context of explicit, or implied reference to evaluation of the quality of the relationship.

**Behavioural, or emotional problems during the assessment**

**This category is divided into multiple sub-categories:**

**Absconding**

This category is used where there is comment by a member(s) of the assessment team on the child, or adolescent absconding from the residential assessment centre.

**Discharge**

This category is used where there is comment by a member(s) of the assessment team on the child, or adolescent being discharged prior to completion of assessment from the residential assessment centre.

**Emotional distress**

This category is used where there is comment by a member(s) of the assessment team on the child, or adolescent showing notable emotional distress the residential assessment centre.

**Oppositional behaviour and verbal abuse**

This category is used where there is comment by a member(s) of the assessment team on the child, or adolescent showing notable oppositional behaviour and/or verbal abuse in the residential assessment centre.

**Physical aggression**

This category is used where there is comment by a member(s) of the assessment team on the child, or adolescent showing physical aggression in the residential assessment centre.

**Property damage**

This category is used where there is comment by a member(s) of the assessment team on the child, or adolescent engaging in property damage while attending the residential assessment centre.

**Relationship, or communication difficulties**

This category is used where there is comment by a member(s) of the assessment team on the child, or adolescent showing physical aggression in the residential assessment centre.

**Self-regulation difficulties**

This category is used where there is comment by a member(s) of the assessment team on the child, or adolescent showing physical aggression in the residential assessment centre.

**Sexual behaviour**

This category is used where there is comment by a member(s) of the assessment team on the child, or adolescent showing sexual, or sexualised behaviour while she/he was attending the residential assessment centre.

**Stealing**

This category is used where there is comment by a member(s) of the assessment team on the child, or adolescent engaging in stealing while she/he was attending the residential assessment centre.

**Substance abuse**

This category is used where there is comment by a member(s) of the assessment team on the child, or adolescent engaging in substance abuse while she/he was attending the residential assessment centre.

**Child care, or key-worker activities**

This category is divided into sub-categories, which seem to me to represent distinct categories of function and focus in relation to the written narrative of this profession's engagement in the assessment team process.

**Focus of assessment**

This category is used where there is comment by a child care member(s) of the assessment team about her/his focus of assessment in relation to the child, or adolescent who is the subject of assessment.

**Home, or Family access observations**

This category is used where there is comment by a child care member(s) of the assessment team about observations in home, or family access situations in relation to the child, or adolescent who is the subject of assessment.

**Initial Outreach meetings**

This category is used where there is comment by a child care member(s) of the assessment team about undertaking 'initial outreach' visits, (i.e., visits to meet the child prior to her/him attending the residential assessment centre), to the child, or adolescent who is the subject of assessment.

**Key-worker meetings with child**

This category is used where there is comment by a child care member(s) of the assessment team about undertaking scheduled assessment-related meetings with the child, or adolescent who is the subject of assessment, while she/he is attending the residential assessment centre.

**Leisure, Social, or Shopping Outings**

This category is used where there is comment by a child care member(s) of the assessment team about undertaking scheduled assessment-related leisure, social, or shopping outings with the child, or adolescent who is the subject of assessment, while she/he is attending the residential assessment centre.

**Observation in assessment settings**

This category is used where there is comment by a child care member(s) of the assessment team about undertaking assessment-related observation of the child, or adolescent who is the subject of assessment, while she/he is attending the residential assessment centre.

**Vocational visits, work-sampling, or work experience**

This category is used where there is comment by a child care member(s) of the assessment team about undertaking scheduled assessment-related vocational visits, work-sampling, or work experience with the child, or adolescent who is the subject of assessment, while she/he is attending the residential assessment centre.

**Diagnosis**

This category is used where there is comment in the report of the assessment team about the existence of, (or proposed existence of), a formal mental pathology “diagnosis” in relation to the child, or adolescent who is the subject of assessment.

**Duration of assessment**

This category is used where there is comment in the report of the assessment team about the duration of the assessment period in relation to the child, or adolescent who is the subject of assessment.

**Extended family and Social networks**

This category is used where there is comment in the report of the assessment team about the relevance and nature of relationships of her/his extended family and social networks in relation to the child, or adolescent who is the subject of assessment.

**Health**

This category is used where there is comment in the report of the assessment team about the relevance and nature of some aspect of, or general physical health of the child, or adolescent who is the subject of assessment.

**Independent living skills**

This category is used where there is comment in the report of the assessment team about the nature and quality of the “independent living abilities” of the child, or adolescent who is the subject of assessment.

**Language difficulties**

This category is used where there is comment in the report of the assessment team about the existence of a specific spoken language processing disorder with regard to the child, or adolescent who is the subject of assessment.

**Leisure**

This category is used where there is comment in the report of the assessment team about the nature and quality of the ‘independent living abilities’ of the child, or adolescent who is the subject of assessment.

**Parental involvement in the assessment**

This category is used where there is comment in the report of the assessment team about the nature and quality of engagement with and involvement in the assessment process of the parents, foster-parents, or step-parents of the child, or adolescent who is the subject of assessment.

**Personal hygiene and presentation**

This category is used where there is comment in the report of the assessment team about the nature and quality of the personal hygiene and presentation of the child, or adolescent who is the subject of assessment.

**Psychologist activities**

This category is divided into multiple sub-categories, which seem to me to represent distinct categories of function and focus in relation to the written narrative of this profession's engagement in the assessment team process:

**Academic abilities assessment**

This category is used where there is record of formal assessment of the core academic abilities, (i.e., core literacy abilities and/or core numerical-mathematical abilities), of the child, or adolescent who is the subject of assessment.

**Adaptive functioning assessment**

This category is used where there is record of formal assessment of the 'social adaptive' abilities, (i.e., core independent living abilities), of the child, or adolescent who is the subject of assessment.



**Behaviour ratings**

This category is used where there is record of formal assessment of the emotional and/or behavioural patterns of the child, or adolescent who is the subject of assessment, (through completion of formal emotional and/or behavioural rating scales).

**Clinical assessment methods**

This category is used where there is record of formal assessment using ‘clinical’ assessment methods, (i.e., methods, which rely on systematic interpretation of responses, based on psychological and/or psychotherapeutic training of the Psychologist, inclusive of: ‘therapeutic board games’; drawing activities; ‘sand play’; role-play; play activities; counselling sessions; and/or clinical interview), with the child, or adolescent who is the subject of assessment.

**Collation/integration of assessment information**

This category is used where there is record of formal collation of assessment information, which was already extant at the time of the assessment of the child, or adolescent who is the subject of assessment.

**Family assessment measures**

This category is used where there is record of formal assessment methods in order to explore the perceptions of her/his family relationships with the child, or adolescent who is the subject of assessment.

**Home visits**

This category is used where there is record of home visits by the psychologist to the home of the child, or adolescent who is the subject of assessment.

**Intellectual functioning assessment**

This category is used where there is record of the psychologist undertaking formal assessment of intellectual functioning with the child, or adolescent who is the subject of assessment.

**Number and focus of sessions**

This category is used where there is record of the number of 'sessions', which were provided by the psychologist with the child, or adolescent who is the subject of assessment.

**Observation**

This category is used where there is record of formal assessment through processes of systematic observation of the child, or adolescent who is the subject of assessment.

**Psychometric measures, (other)**

This category is used where there is record of formal assessment with the child, or adolescent who is the subject of assessment using psychometric assessment methods other than those, which are already addressed under such categories as: academic abilities, adaptive functioning, behaviour ratings, family relationships, intellectual functioning, or observation.

Examples of measures included in this category are those, which are intended to measure phenomena such as: 'self-concept'; 'anxiety'; 'locus of control'; personal adjustment' and written projective measures, (such as an 'incomplete sentences' task).

### **Parental interview/observation**

This category is used where there is record of formal interview undertaken by the psychologist with a parent/the parents of a child, or adolescent who is the subject of assessment.

### **Risk assessment**

This category is used where there is record of formal assessment of 'risk' having been undertaken by the Psychologist with the child, or adolescent who is the subject of assessment.

### **School visits**

This category is used where there is record of a visit to her/his school having been undertaken by the psychologist with the child, or adolescent who is the subject of assessment.

### **Social Worker – joint work**

This category is used where there is record of assessment work having been undertaken by the psychologist specifically in collaboration the assessment team Social Worker in relation to the child, or adolescent who is the subject of assessment, (examples of such work include interviews with parents).

**Video use**

This category is used where there is record of assessment work having been undertaken by the psychologist in relation to the child, or adolescent who is the subject of assessment, which involved video-taped review of observations of the child, or adolescent, and/or her/his parents, and/or her/his siblings.

**Recommendations**

This category is divided into multiple sub-categories, which seem to me to represent distinct categories of recommendations from assessment in relation to the written narrative of the assessment reports:

**Adult Psychiatry assessment/intervention**

This category is used where there is recommendation for referral to adult psychiatric services for assessment and/or intervention for a parent/the parents of a child, or adolescent who is the subject of assessment.

**‘Assessment service’ intervention**

This category is used where there is recommendation for an intervention from some aspect of the ‘assessment service’ for a child, or adolescent who is the subject of assessment.

**C.A.M.H.S. assessment/intervention**

This category is used where there is recommendation for referral for an intervention from C.A.M.H.S. assessment and/or intervention for a child, or adolescent who is the subject of assessment.

**Couple counselling**

This category is used where there is recommendation for referral 'couples counselling' intervention for the parents of a child, or adolescent who is the subject of assessment.

**Educational placement**

This category is used where there is recommendation in relation to her/his educational placement for a child, or adolescent who is the subject of assessment.

**Family access regulation**

This category is used where there is recommendation in relation to professional regulation of family access arrangements for a child, or adolescent who is the subject of assessment.

**Family therapy**

This category is used where there is recommendation for referral for family therapy intervention for the family of a child, or adolescent who is the subject of assessment.

**Family tracing/re-unification with parent**

This category is used where there is recommendation for family tracing and/or family re-unification supports in relation to a child, or adolescent who is the subject of assessment.

**Gaurdian ad litem**

This category is used where there is recommendation for 'Gaurdian at litem' supports in relation to a child, or adolescent who is the subject of assessment.

**Group therapy**

This category is used where there is recommendation for referral for group therapy intervention for a child, or adolescent who is the subject of assessment.

**Health/Medical intervention/support**

This category is used where there is recommendation some form of health and/or medical intervention for the family of a child, or adolescent who is the subject of assessment.

**Leisure**

This category is used where there is recommendation for supports in relation to leisure options exploration and/or participation with regard to a child, or adolescent who is the subject of assessment.

**Occupational Therapy assessment/intervention**

This category is used where there is recommendation for occupational therapy assessment and/or intervention supports in relation to a child, or adolescent who is the subject of assessment.

**Out-of-home placement**

This category is used where there is recommendation for out-of-home placement in relation to a child, or adolescent who is the subject of assessment.

**Parent support/guidance**

This category is used where there is recommendation for parental guidance and/or supports in relation to parents of a child, or adolescent who is the subject of assessment.

**Parental counselling**

This category is used where there is recommendation for parental counselling in relation to parents of a child, or adolescent who is the subject of assessment.

**Probation, or Court services**

This category is used where there is recommendation for referral for Probation service supports, or for some form of Judicial Court intervention in relation to a child, or adolescent who is the subject of assessment.

**Psychotherapeutic relationship/support**

This category is used where there is recommendation for referral for some form of psychotherapeutic relationship and/or counselling support/intervention for a child, or adolescent who is the subject of assessment.

**Social Work involvement**

This category is used where there is recommendation for referral for some form of social work support and/or intervention for a child, or adolescent who is the subject of assessment.

**Speech and Language Therapy assessment/intervention**

This category is used where there is recommendation for referral for some form of speech and language therapy support and/or intervention for a child, or adolescent who is the subject of assessment.

**Structure and intervention**

This category is used where there is recommendation for some form of professional intervention with regard to providing structure in relation to daily activities and/or systematic activation for a child, or adolescent who is the subject of assessment.

**Training**

This category is used where there is recommendation for referral for some form of support/intervention with regard to employment and/or training for employment for an adolescent who is the subject of assessment.

**Referral and background factors**

This category is divided into multiple sub-categories, which seem to me to represent distinct categories of focus for provided referral information and background factors in relation to the written narrative of the assessment reports:

**Absent parent**

This category is used where there is clear reference in the referral information to the absence from her/his life of a/the parent(s) of a child, or an adolescent who is the subject of assessment.



**Attitude to assessment**

This category is used where there is clear reference in the referral information to the attitude(s) to the assessment process, which are held, or assumed to be held by a child, or an adolescent who is the subject of assessment.

**Bullying**

This category is used where there is clear reference in the referral information to an experience(s) of bullying, which has been experienced by a child, or an adolescent who is the subject of assessment.

**Court/Justice services**

This category is used where there is clear reference in the referral information to involvement of a child, or an adolescent who is the subject of assessment with Court, and/or Justice services.

**Emotional distress, and emotional regulation**

This category is used where there is clear reference in the referral information to observed, or anticipated emotional distress and/or problems with emotional regulation exhibited by a child, or an adolescent who is the subject of assessment.

**Extended family and Social networks**

This category is used where there is clear reference in the referral information to the extended family and/or social networks of a child, or an adolescent who is the subject of assessment.

**Financial factors**

This category is used where there is clear reference in the referral information to the financial circumstances of the family, or parent of a child, or an adolescent who is the subject of assessment.

**Fire-setting**

This category is used where there is clear reference in the referral information to previous attempts at fire-setting by a child, or an adolescent who is the subject of assessment.

**Frequent moves**

This category is used where there is clear reference in the referral information to previous frequent moves of residence by a child, or an adolescent who is the subject of assessment.

**Gambling**

This category is used where there is clear reference in the referral information to previous gambling by a child, or an adolescent who is the subject of assessment and/or by her/his parent(s).

**Learning abilities**

This category is used where there is clear reference in the referral information to learning abilities in relation to a child/ adolescent who is the subject of assessment.

**Learning difficulties**

This category is used where there is clear reference in the referral information to identified and/or suspected learning difficulties in relation to a child, or an adolescent who is the subject of assessment.

**Limits/Boundaries problems**

This category is used where there is clear reference in the referral information to issues of limit/boundary setting with regard to a child, or an adolescent who is the subject of assessment, (references may be either 'positive', or 'negative' in tone and may relate to either a focus on self-regulation, or a focus on relationship between the child, or adolescent and her/his parent(s).

**Lying**

This category is used where there is clear reference in the referral information to previous incidences of lying by a child/ adolescent who is the subject of assessment.

**Multiple parental partners**

This category is used where there is clear reference in the referral information to multiple parental partners in relation to a/the parent(s) of a child, or an adolescent who is the subject of assessment.

**Needs/Supports identification**

This category is used where there is clear reference in the referral information to identification of needs and/or supports and/or formulation of a plan of intervention in relation to a child, or an adolescent who is the subject of assessment.

**Out-of-home**

This category is used where there is clear reference in the referral information to a child, or an adolescent who is the subject of assessment being, or having been in an out-of-home placement.

**Parent in prison**

This category is used where there is clear reference in the referral information to a/the parent(s) of a child, or an adolescent who is the subject of assessment being in prison, or having been in prison.

**Parental capacity, including neglect and emotional abuse**

This category is used where there is clear reference in the referral information to parental capacity and/or demonstration of emotional neglect and/or abuse in relation to a/the parent(s) of a child, or an adolescent who is the subject of assessment.

**Parental conflict/separation**

This category is used where there is clear reference in the referral information to previous and/or current parental conflict and/or separation in relation to a child, or an adolescent who is the subject of assessment.

**Parental employment**

This category is used where there is clear reference in the referral information to some aspect of parental employment in relation to a child, or an adolescent who is the subject of assessment.

**Parental mental health**

This category is used where there is clear reference in the referral information to previous and/or current parental mental health issues in relation to a child, or an adolescent who is the subject of assessment.

**Personality disorder**

This category is used where there is clear reference in the referral information to 'personality disorder' in relation to a child, or an adolescent who is the subject of assessment.

**Physical abuse and/or Domestic violence exposure**

This category is used where there is clear reference in the referral information to previous frequent or current experience of and/or exposure to physical abuse and/or domestic violence by a child, or an adolescent who is the subject of assessment, and/or experience of such phenomena by one, or other of the parents of a child, or an adolescent who is the subject of assessment.

**Physical aggression**

This category is used where there is clear reference in the referral information to demonstration of physical aggression and/or abuse by a child, or an adolescent who is the subject of assessment.

**Pre-school behaviour problems**

This category is used where there is clear reference in the referral information to pre-school behaviour problems shown by a child/adolescent who is the subject of assessment.

**Prescribed medication**

This category is used where there is clear reference in the referral information to prescribed medication being, or having been prescribed and/or used by a child, or an adolescent who is the subject of assessment.

**Problem behaviour**

This category is used where there is clear reference in the referral information to 'problem' and/or 'challenging' behaviour patterns shown by a child, or an adolescent who is the subject of assessment, (where such behavioural patterns are not otherwise identified in more specific terms, (such as 'physical aggression', or 'self-harm').

**Professional services**

This category is used where there is clear reference in the referral information to previous, and/or current, and/or pending professional interventions, and/or referral for such interventions in relation to a child, or an adolescent who is the subject of assessment, and/or her/his family.

**Property damage**

This category is used where there is clear reference in the referral information to previous property damage by a child, or an adolescent who is the subject of assessment.

**Relationship with parents**

This category is used where there is clear reference in the referral information to the nature and/or quality of her/his relationship(s) with her/his parent(s), which has been demonstrated, or observed for a child, or an adolescent who is the subject of assessment.

**Residential/Voluntary/Foster-Care**

This is a broad category, which is used where there is clear reference in the referral information to residential/foster care (i.e., statutory care) and/or voluntary care experiences in relation to a child, or an adolescent who is the subject of assessment.

This category may, also, be used in relation to behaviour, or factors, which have been observed and recorded in relation to the context of such 'care' arrangements (e.g., problematic behaviours, which have been observed in the 'care' setting).

**School attendance problems**

This category is used where there is clear reference in the referral information to previous and/or current significant school attendance problems shown by a child, or an adolescent who is the subject of assessment.

**School problems**

This category is used where there is clear reference in the referral information to previous and/or current significant school behaviour problems shown by a child, or an adolescent who is the subject of assessment.

**Self-harm**

This category is used where there is clear reference in the referral information to previous frequent incidences and/or threats of self-harm by a child, or an adolescent who is the subject of assessment.

**Sexual abuse**

This category is used where there is clear reference in the referral information to previous experiences, or alleged experiences by a child, or an adolescent who is the subject of assessment of sexual abuse.

**Sexualised language and/or behaviour**

This category is used where there is clear reference in the referral information to sexualised language and/or behaviour demonstrated by a child, or an adolescent who is the subject of assessment.

**Sibling references**

This category is used where there is clear reference in the referral information to the siblings of a child, or an adolescent who is the subject of assessment.



**Soiling/Wetting**

This category is used where there is clear reference in the referral information to incidences of soiling and/or wetting herself/himself shown by a child, or an adolescent who is the subject of assessment.

**Stealing**

This category is used where there is clear reference in the referral information to previous incidences of stealing shown by a child, or an adolescent who is the subject of assessment.

**Substance abuse**

This category is used where there is clear reference in the referral information to previous incidences of substance abuse shown by a child, or an adolescent who is the subject of assessment.

**Substance abuse, (parent)**

This category is used where there is clear reference in the referral information to previous incidences of substance abuse shown by a/the parent(s) of a child, or an adolescent who is the subject of assessment.

**Referring agent and area team**

This category is a unitary code, (i.e., not sub-divided into other categories). This category consists of the name of the referring social worker and identification of her/his area social work team.

**Safety and risk evaluation**

This category is a unitary code, (i.e., not sub-divided into other categories). This category is used where there is specific comment by a member(s) of the assessment team on identified risk, and/or risk-taking behaviour in relation to, the child's, or adolescent's behavioural patterns.

**School attended**

This category is used where there is specific reference to and identification of the school attended by the child, or adolescent who is the subject of the assessment.

**Self-concept**

This category is a unitary code, (i.e., not sub-divided into other categories). This category is used where there is specific comment by a member(s) of the assessment team on the nature and quality of the child's, or adolescent's 'self-concept' and/or her/his identity status.

**Social and relationship skills**

This category is a unitary code, (i.e., not sub-divided into other categories). This category is used where there is comment by a member(s) of the assessment team on the nature and quality of the child's, or adolescent's interactions with peers, and/or her/his style of communication with peers, her/his quality of relationships with peers, and/or her/his emotional and behavioural self-regulation in relation to interactions with her/his peers.

**Social Worker activities**

This category is divided into sub-categories, which seem to me to represent distinct categories of function and focus in relation to the written narrative of this profession's engagement in the assessment team process.

**Family meetings**

This category is used where there is reference to the assessment team social worker engaging in a 'family meeting' in relation to the child, or adolescent who is the subject of the assessment.

**Joint work with psychologist**

This category is used where there is reference to the assessment team social worker engaging in a collaborative piece of work in relation to the child, or adolescent who is the subject of the assessment.

**Liaison with G.P.**

This category is used where there is reference to the assessment team social worker engaging in liaison with the general practitioner (G.P.) of the child, or adolescent who is the subject of the assessment.

**Liaison with social worker**

This category is used where there is reference to the assessment team social worker engaging in liaison with the assigned H.S.E. ('Tusla') social worker (i.e., the referring agent) of the child, or adolescent who is the subject of the assessment.

**Nature and number of sessions**

This category is used where there is reference by the assessment team social worker to the number of sessions of work that she undertook in relation to assessment of a child, adolescent, or family who is/are the subject of the assessment, and/or description of the nature of the work, which was undertaken in such sessions.

**Parent meetings**

This category is used where there is reference to the assessment team social worker engaging in meeting a parent(s) in relation to the child, or adolescent who is the subject of the assessment.

**Teacher activities**

This category is divided into sub-categories, which seem to me to represent distinct categories of function and focus in relation to the written narrative of this profession's engagement in the assessment team process:

**Art and Craft activities**

This category is used where there is reference to a teacher within the assessment team working with the child, or adolescent, using 'Art', and/or 'Craft' activities.

**Assessment of core academic abilities****(i) Mathematics**

This category is used where there is reference to assessment of some aspect of the numerical-mathematical reasoning ability, or skills of the child, or adolescent, by the teacher, and/or commentary on some aspect her/his academic, or functional numerical-mathematical abilities.

**(ii) Reading**

This category is used where there is reference to assessment of some aspect of the reading ability of the child, or adolescent, by the teacher, and/or commentary on her/his reading abilities.

**(iii) Spelling/Writing**

This category is used where there is reference to assessment of some aspect of the reading ability of the child, or adolescent, by the teacher, and/or commentary on her/his spelling abilities.

**(iv) Unspecified core academic abilities**

This category is used where there is reference to assessment of, and/or commentary on of some unspecified aspect of 'educational attainment' and/or 'academic abilities'.

**Attitude to school/learning**

This category is used where there is reference to an observation made by a teacher about the child's, or adolescent's 'motivation' for academic learning, or her/his attitude(s) to school and/or learning, or an observed value judgement made by the child, or adolescent about some aspect of formal learning, or schooling.

**Career choice investigation**

This category is used where there is reference to an observation made by a teacher within the assessment team about the child's, or adolescent's vocational interests, and/or reference to undertaking, or the prospect of undertaking exploration and clarification of her/his vocational interests.

**C.V. preparation**

This category is used where there is reference by a teacher within the assessment team about assisting the adolescent in preparation of curriculum vitae.

**Domestic Science activities**

This category is used where there is reference to an observation made by a teacher within the assessment team about the child's, or adolescent's participation in food preparation activities and/or observation of her/his knowledge, skills, or attitude in relation to such activities.

**Educational history collation**

This category is used where there evidence of an attempt made by a teacher within the assessment team to collate information previous educational history data, or provide a chronology in relation to the child's, or adolescent's history of schooling, examinations, or qualifications.

### **Educational visits**

This category is used where there is comment made by a teacher within the assessment team about the child's, or adolescent's participation in an 'educational visit', which was arranged by the teacher.

### **Emotional distress**

This category is used where there is reference to an observation made by a teacher within the assessment team about emotional distress in relation to the child's, or adolescent's vocational presentation in educational activities.

### **Focus of assessment**

This category is used where a teacher within the assessment team has specified her focus of assessment in relation to the child, or adolescent who is being assessed.

### **Games**

This category is used where there is reference to an observation made by a teacher within the assessment team about the child's, or adolescent's engagement with and/or participation in games, or imaginative activities.

### **Handwriting/work preparation**

This category is used where there is reference to an observation made by a teacher within the assessment team about the quality of the child's, or adolescent's handwriting and/or presentation of written work.

### **Home visits**

This category is used where there is reference to participation by a teacher within the assessment team in a 'home visit' to the child's, or adolescent's residence.

### **Homework activities**

This category is used where there is reference to an observation made by a teacher within the assessment team about the child's, or adolescent's engagement with 'homework' activities, or where there is a recommendation made by a teacher about participation in a homework activity.

### **Language processing evaluation**

This category is used where there is reference to an observation made by a teacher within the assessment team about the nature, or quality of a child's, or adolescent's engagement receptive, or expressive spoken language abilities, and/or the nature, or quality of a child's, or adolescent's spoken articulation.

### **Learning style assessment**

This category is used where there is reference to an observation made by a teacher within the assessment team about the nature, or quality of a child's, or adolescent's learning style(s), or her/his observed presentation in relation to generic learning skills and attitudes in the assessment setting.



**Leisure participation evaluation**

This category is used where there is reference by a teacher within the assessment team about the nature of a child's, or adolescent's awareness of, engagement with, and/or participation in available leisure options.

**Library use/visits**

This category is used where there is reference to an observation made by a teacher within the assessment team about a child's, or adolescent's use of Library services.

**Number of sessions**

This category is used where there is reference to an observation made by a teacher within the assessment team about the number of formal assessment sessions, which the teacher conducted with a child, or adolescent.

**Observation**

This category is used where there is reference to an observation made by a teacher within the assessment team of a child's, or adolescent's behavioural presentation either in a naturalistic setting, (where such observation is not couched within another framework such as, 'learning style', or participation in 'domestic activities'), or in a 'small-group' context, (with peers in the assessment setting, or with peers in some other setting).

**Peer relationships evaluation**

This category is used where there is reference to an observation made by a teacher within the assessment team about the nature, or quality of a child's, or adolescent's peer relationships, or comment on information about such relationships, which is based on interview with the child, or adolescent, or with others who know her/him.

### **Personal hygiene grooming evaluation**

This category is used where there is reference to an observation made by a teacher within the assessment team of a child's, or adolescent's presentation in terms of the nature, or quality of her/his personal hygiene and personal grooming in the assessment setting.

### **Poetry and song**

This category is used where there is reference to an observation made by a teacher within the assessment team of a child's, or adolescent's engagement in singing, and/or reading, or writing poetry.

### **Portfolio preparation**

This category is used where there is reference made by a teacher within the assessment team with regard to a child, or adolescent engaging in 'portfolio' preparation in the assessment setting.

### **Recommendations**

This category is used where there is reference specific recommendation has been made by a teacher within the assessment team in relation to a child, or adolescent.

The range of areas of recommendations made covered recommendations in relation to: ‘respite care’; ‘behaviour management’; ‘allocation of child care personnel’; ‘family access arrangements’; ‘residential placement’; ‘leisure participation’; ‘parenting guidelines’; ‘personal development, or counselling intervention’; ‘school placement’; and, ‘vocational, or training placement’.

### **School placement exploration**

This category is used where there is reference by a teacher within the assessment team to exploration, which was undertaken with a child, or adolescent behavioural presentation in the assessment setting with regard to a suitable school placement for her/him, or a comment was made in the Report with regard to the teacher raising a question as to what might be a suitable school placement for her/him.

### **School report/liaison**

This category is used where there is reference by a teacher within the assessment team to recording reports of a child’s, or adolescent’s presentation in school settings.

### **Self-concept assessment**

This category is used where there is reference to by a teacher within the assessment team to engaging in the assessment setting in formal assessment, interpretation and reporting of assessment a child’s, or adolescent’s ‘self-concept’, through use of a formal measure designed for this purpose.

**Support services identification**

This category is used where there is reference to by a teacher within the assessment team to engaging in sourcing information about she believes are relevant support services for a child, adolescent, or family, who is/are the subject(s) of assessment.

**Teaching/assessing computer skills**

This category is used where there is reference to by a teacher within the assessment team to engaging in teaching and/or assessing computer skills with a child, or adolescent.

**Traveller background/identity**

This category is a unitary code, (i.e., not sub-divided into other categories). This category is used where there is explicit reference to “Traveller” identity, or family background in relation to the person, or persons who are the subject(s) of the assessment report.

**Appendix 7: Roles of Disciplines in ‘assessment service’ , (as recorded in a June 2008 assessment centre document)**

**Appendix 7 (a): Child Care Worker/Key-worker role**

- Outreach
- More focus – re: planning at ATM stage
- Using tools such as ‘Turning Points’
- Develop the primary relationship with child/family – often the ‘link’ in
- Responsibility with bringing back initial feedback and sometimes the sense of not being received
- Completing the Family History – in absence of Social Worker
- Provision of 24-hour Assessment and Respite care
- Contact with Social Worker, attendance and preparation for meetings
- Flexibility re: Outreach assessments
- Meeting with other relevant professionals
- Advocate for young person at meetings
- More active around realistic recommendations and follow through if possible
- Planning for residential
  - - Individual Programme Plan, (IPP) - Structures
  - Individual Client Management Plan, (ICMP) - Boundaries
  - Files - Focus and ‘Key-worker’ sessions preparation
- Four days to write report
- Responsibility for sharing hypothesis with assessment team during residential
- Feedback to young person from meetings
- Key-worker Sessions
- Facilitate family visit - Travel; Organising; Supporting as the ‘link in’

### **Appendix 7 (b): Psychologist role**

- Team member at Áirne Villa and Team member of Psychology, HSE
- Participation and contribution to Assessment Planning Meetings, (A.P.M.)
- Review existing info, identify gaps and formulate psychology approach
- Liaise with any professionals involved with family prior to assessment
- Provide expertise re: models of human function and development, also, models of dysfunction.
- Expertise re: measurement of aspects of function i.e., intelligence/personality
- Models of change and therapeutic intervention
- Carry out assessments
- Synthesising recommendations
- Use of: Psychometric measures; developmental scales; projective techniques; intentional use of relationship
- Write reports
- Design and maintain record system, (i.e., files)
- Involvement / delivery of staff training
- Service Development, (generally)
- Providing tools/resources to other team members
- Provide supervision to other Psychologists and any trainees on placement
- Carry out research/design/statistic analysis
- Responsibility for critical incident management – internally or wider within the H.S.E.
- Liaising with other disciplines
- Judgements around need for any kind of further diagnostic assessment
- Advice on assessment of and judgement of risk in relation to children/families – availability to support

**Appendix 7 (c): Teacher role**

- Focus - Looking at real issues grounded at Assessment Team Meetings, (ATM)
- Meeting family and child
- School visits (joint sometimes) and phone contact – useful to bring a different discipline
- Scheduling sessions and content
- Attendance at meetings – Strategy, (ATM etc.)
- Reports – governed by what initial focus was
- Assessing educational baselines i.e. reading; numbers; group participation; concentration capacity; response to correction/praise
- Catalogue of educational services available
- Considering onward placements and assessing suitability of young person
- Look at child's perception / interpretation of education
- Liaison with schools
- Preparation for future placement
- Careers and aspirations for the future
- Consider recommendations in context of other disciplines sometimes
- Liaison with assessment team throughout
- Come to joint consensus between both teachers re: glitches / lesson notes / sharing
- Extended tools used – now for younger ages
- Reports - timeframe

**Appendix 7 (d): Social Worker role**

- History of developmental milestones
- Expertise on child protection and legislation
- Exploring parenting capacity, family dynamics, attachment
- Meet relevant professionals
- Family tree
- Explore Social Work / Service intervention history – with family and other professionals
- Parent's history (re: childhood)
- Risk assessment
- Exploring child's view of present situation and future (from Social Work perspective)
- Practical and realistic idea of families' capacity to engage / change
- Structured interviews
- Knowledge / links / access to services
- Specific link with parents during assessment
- Exploring strengths within family and wider family
- Specific role in feedback to Social Worker
- Attendance at meetings – Strategy, ATM, APM, 'Feedback' meetings
- Family visits
- Exploring environmental factors - housing; poverty; crime; employment
- Systems approach
- Reports
- Training support to unit.



**Appendix 8: Proposed responsibilities in relation to the four professional disciplines in the 'assessment service', (following completion of current research)**

**(a) Responsibilities for the role of 'Senior Psychologist' in the assessment team:**

1. Liaison with referring Tusla, Child and Family Agency social worker;
2. Analysis of all existing assessment and 'background' information at the time of referral for each child, adolescent, or family who is/are referred to the assessment service, for the purpose of formulation of an integrated assessment focus and assessment strategy for the assessment team;
3. Formulation of an integrated assessment focus and assessment strategy for the assessment team in relation to each child, adolescent, or family who is/are referred to the assessment service;
4. Liaison with all relevant professionals who have previously been involved with each child, adolescent, or family who is/are referred to the assessment service, or who are currently involved, or shortly to be involved with such clients of the service. This liaison function is especially appropriate to the role where there are issues to be discussed in relation to mental health diagnoses, psycho-educational assessments, social-emotional assessments, queries about quality of "attachment" in relationships, addiction issues, developmental delays, or impairments, and/or psychotherapeutic interventions;
5. Interviews with parents and/or carers in relation to family history, family narratives, or 'scripts', patterns of interaction within family and between 'nuclear' family and extended family and wider community and services, and with regard to nature and quality of current and previous couple relationship(s);

6. Interviews with parents and/or carers in relation to developmental history for each child, adolescent, or family who is/are referred to the assessment service;
7. Provision of information to family and/or carers, and to assessment team members about relevant child-related services and organisations to be considered in relation to the assessment process;
8. Provision of relevant training to assessment team members;
9. Supervision of psychology and/or counselling trainees, (as assigned/negotiated);
10. Undertake relevant “risk assessment” procedures, (as relevant and required), in conjunction with the principal social worker, with manager/deputy manager of the assessment service, and with such other community-based professionals as are relevant to the circumstances;
11. Undertake relevant client “group”, or “family” assessment activities/procedures, as relevant (inclusive of use of: psychometric measures; developmental scales; projective techniques; intentional use of relationship);
12. Advise about any need for further diagnostic assessment in relation to each child, adolescent, or family who is/are referred to the assessment service;
13. Provide expertise re: models of human function and development, and about models of psychological dysfunction;
14. Provide expertise re: measurement of aspects of function (i.e., intelligence; personality; mental health; social adaptive functioning; and relationships).
15. Provide expertise re: models of change and psychotherapeutic assessment of needs, and forms of intervention;
16. Provide expertise re: assessment of “attachment” patterns and dysfunction, and undertake such assessment, where relevant;

17. Provide expertise re: re: assessment of “parenting capacity” and dysfunction, and undertake such assessment, where relevant;
18. Prepare a written assessment report in relation to each child, adolescent, or family who has been accepted for assessment (in line with the designated role, responsibilities and degree of involvement of the psychologist) in each assessment;
19. Provide spoken and written contributions to the written “team recommendations” from the assessment process;
20. Provide “feedback” to relevant parties at ‘final recommendations’ meeting;
21. Attend follow-up “professionals meetings”, “Family Welfare Conferences”, “Case Conferences”, or Court proceedings (as appropriate);
22. Undertake relevant research in relation to the service;
23. Contribute to the development and design of assessment frameworks, policies, assessment approaches, and methodology;
24. Maintain relevant records in relation to the designated professional role;
25. Engage in professional supervision appropriate to the role;
26. Engage in relevant C.P.D. activities appropriate to the role;
27. Participate as a professional colleague in endeavours of local Psychology teams;
28. Carry out research/design/statistic analysis;
29. Hold responsibility for “critical incident” de-briefing and management – internal to the service, or within wider Tusla, Child and Family Agency services, and provide such services, as requested.

**(b) Responsibilities for the role of ‘Child Care’ personnel in the assessment team**  
**(inclusive of “Key-worker” role):**

1. Source and collate assessment referral information and documents;
2. Ensure provision of a safe environment for residents and staff;
3. Be aware of, adhere to and implement all relevant residential care standards;
4. Ensure that each child, or adolescent is safe from harm, in and outside of the assessment centre, during her/his residence in the assessment centre;
5. Consistently maintain awareness of safeguarding issues with regard to vulnerable children, or adolescents who are involved with, or attending the assessment centre;
6. Consistently maintain own awareness, skills, and practice standards in relation to Therapeutic Care Intervention (T.C.I.) protocols;
7. Ensure provision of a warm, caring, nurturing relationship between residential child care staff and each child, or adolescent;
8. Ensure attention to and monitoring of each child’s, or adolescent’s health, hygiene, comfort, and nutrition needs by residential child care staff during the residential assessment;
9. Engage with each child, or adolescent in management of her/his time before, between , and after scheduled appointments with assessment team members;
10. Facilitate for each child, or adolescent regular contact with her/his family;
11. Help each child, or adolescent understand the reasons why she/he is “in care”, and the impact this may have on her/him;
12. Observe interactions with each child, or adolescent in the group home setting;
13. Observe interactions with each child, or adolescent in all other relevant settings that are agreed with the assessment team as a part of the assessment process, (including the child’s, or adolescent’s own home , community settings, leisure, or school settings;

14. Manage children's and/or adolescent's interactions in the group home setting to ensure physical, and psychological safety and health of each person;
15. Schedule and facilitate each child's/adolescent's attendance at scheduled appointments;
16. Provide safe transportation for each child to and from her/his residence;
17. Provide information about the assessment process, and her/his progress in relation to this process to each child/adolescent;
18. Liaise and provide information to each child's/adolescent's parents and/or Carers;
19. Liaise and provide information to each child's/adolescent's referring Tusla, Child and Family Agency social worker;
20. Observe and record each child's, or adolescent's behaviour on a daily basis, in relation to dimensions, or systematic, structured protocols for observation that have been agreed by the assessment team;
21. Observe and record each child's, or adolescent's functional independent living skills on a daily basis, in relation to dimensions, or systematic, structured protocols for observation that have been agreed by the assessment team;
22. Collation of information gathered through liaison with others, or through observations of the child, or adolescent during his time attending for assessment, and "feedback" of such information to assessment planning meetings with other disciplines;
23. Provide relevant "handover" details to colleagues and to other disciplines;
24. Provide personal and professional protection information to colleagues and to other disciplines, as relevant for each child, or adolescent, (mood, sensitivities, critical incidents, contagious illnesses, allergies, relevant personal history);
25. Observe each child's/adolescent's family dynamics as is agreed by the assessment team to be relevant to the child's/adolescent's assessment;

26. Implement behaviour modification strategies with each child, or adolescent as agreed by the assessment team;
27. Provide specific “feedback” to each child, or adolescent in relation to her/his personal hygiene, dress, behaviour, communication, progress, achievements;
28. Support each child, or adolescent in all reasonable ways to complete her/his personal “assessment portfolio”, and liaise with other team-members to ensure completion of an adequate “assessment portfolio”;
29. Provide (as required) T.C.I. behavioural interventions and associated “life-space” interview for any child, or adolescent during her/his attendance at assessment;
30. Observe and record each child’s, or adolescent’s self-esteem presentation;
31. Provide relevant advocacy on behalf of the child, or adolescent within the assessment team, or assessment process, where necessary, and as agreed with the assessment team;
32. Explore and record with each child, or adolescent her/his current, previous, and desired interests, or hobbies;
33. Explore and record with each child, or adolescent her/his current, previous, and desired participation in social groups, organisation, or societies;
34. Explore and record with each child, or adolescent her/his current, previous, and desired interests and participation in physical exercise, games or sports;
35. Provide systematic, structured leisure sampling activities, and provision and recording of assessment and guided reflection in relation to these activities;
36. Provide systematic, structured vocational/occupational sampling activities, and provision and recording of assessment and guided reflection in relation to these activities;

37. Assess each child's, or adolescent's engagement with, and persistence with the assessment process, generally, and with other dimensions that might be specifically agreed as worth observation by the assessment team;
38. Explore and record each child's, or adolescent's motivation for participation in activities and processes, (including degree of, consistency of, and nature of such participation)
39. Explore and record each child's, or adolescent's strategies for dealing with conflict, and explore and record for each child, or adolescent the patterns of and nature of conflicts experienced;
40. Explore and record for each child, or adolescent the patterns of and nature of power struggles experienced;
41. Explore and record for each child, or adolescent the nature of her/his reactions to "peer-pressure"
42. Explore and record for each child, or adolescent her/his abilities for identifying, naming, managing, and/or expressing emotions;
43. Explore and record for each child, or adolescent the patterns of and nature of her/his responses to interventions in relation to experienced stress, or distressful emotions;
44. When in a designated "key-worker" role, ensure provision of relevant "care-plan", all relevant consent forms, completion of all proactive and written care measures and approaches to be used by child care worker personnel with the relevant child;
45. When in a designated "key-worker" role, contribute to assessment design and formulation of assessment for each child, or adolescent;
46. When in a designated "key-worker" role, prepare a written assessment report in relation to the designated role, responsibilities, and degree of involvement in each assessment;

47. When in a designated “key-worker” role, provide spoken and written contributions to “Team Recommendations” from the assessment process;
48. When in a designated “key-worker” role, provide “feedback” at Final Recommendations meeting;
49. Attend follow-up “professionals meetings”, “Family Welfare Conferences” or “Case Conferences”, (as requested by the manager/deputy manager of the assessment centre).



(c) **Responsibilities for the role of ‘Principal Social Worker’ in the assessment team:**

1. Liaison with referring Tusla, Child and Family Agency social worker;
2. Construction, or sourcing of a “genogram” in relation to each child, or adolescent who is referred to the assessment service;
3. Construction (possibly in conjunction with other assessment team members) of relevant ‘chronologies’, (e.g.,: in relation to patterns of engagement with social work services;;
4. Interviews with parents and/or carers in relation to family history, patterns of interaction within family and between ‘nuclear’ family and extended family and wider community and services and with regard to nature and quality of current and previous couple relationship(s);
5. Sourcing and collation of information about relevant cultural, or “special” family characteristics, nationality, or religious needs factors to be considered in relation to each child, or adolescent;
6. Systematic evaluation of home environment in relation to each child, adolescent, or family.
7. Systematic evaluation of parental stressors, and coping capacities in relation to each parent, carer, or family.
8. Systematic evaluation of parental life history, and life experiences in relation to each parent, or carer, with systematic consideration of how such life history, and life experiences may be relevant to the care and parenting of each child, or adolescent.
9. Systematic evaluation of parental life styles, and patterns of daily living in relation to each parent, or carer, with systematic consideration of how such life styles, and patterns of daily living may be relevant to the care and parenting of each child, or adolescent.

10. Provision of information to family and/or carers, and to assessment team members about relevant child protection and welfare-related legislation to be considered in relation to the assessment process;
11. Provision of information to family and/or carers, and to assessment team members about relevant child-related services and organisations to be considered in relation to the assessment process;
12. Provision of information to family and/or carers, and to assessment team members about relevant child-related financial supports, which could be considered in relation to the assessment process;
13. Provision of relevant training to assessment team members;
14. Supervision of social work trainees, (as assigned/negotiated);
15. Undertake relevant “risk assessment” procedures, (as relevant and required), in conjunction with the senior psychologist, with the manager/deputy manager of the assessment centre, and with such other community-based professionals as are relevant to the circumstances;
16. Undertake relevant client “group”, or “family” assessment activities, procedures, as required, in conjunction with the senior psychologist;
17. Contribute to assessment design and formulation of assessment for each child, or adolescent;
18. Prepare a written assessment report in relation to each child who has been accepted for assessment, (in line with the designated role, responsibilities, and degree of involvement of the principal social worker), in each assessment;
19. Provide spoken and written contributions to the written “team recommendations” from the assessment process;
20. Provide “feedback” to relevant parties at ‘final recommendations’ meeting;

21. Attend follow-up “professionals meetings”, “Family Welfare Conferences” or “Case Conferences”, (as requested by the manager/deputy manager of the assessment centre);
22. Undertake relevant research in relation to the service;
23. Contribute to the development and design of assessment frameworks, policies, assessment approaches, and methodology.
24. Maintain relevant records in relation to the designated professional role.

**(d) Responsibilities for the role of ‘Teacher’ in the assessment team:**

1. Assessment, and exploration, of each assigned child’s/adolescent’s educational history and learning experiences;
2. Assessment, and exploration, of each assigned child’s/adolescent’s educational, and vocational interests and goals;
3. Assessment, and exploration, of each assigned child’s/adolescent’s family history of education, learning and employment;
4. Assessment, and exploration, of parental learning styles in relation to each assigned child’s/adolescent’s , and levels of literacy and numerical competence;
5. Assessment, and exploration, of each assigned child’s/adolescent’s family and environmental supportive and limiting factors in relation to education and vocational training opportunities;
6. Assessment, and exploration, of the relevance of cultural factors to each assigned child’s/adolescent’s engagement with education, or vocational training opportunities;
7. Assessment, and exploration, of the relevance of school cultural factors to each assigned child’s/adolescent’s engagement with education, or vocational training opportunities;
8. Gathering and collation of information from previous educational providers in relation to each assigned child, or adolescent;
9. Assessment of functional auditory attention for each assigned child, or adolescent in a learning setting;
10. Assessment of each assigned child’s, or adolescent’s functional auditory working memory in a learning setting;
11. Assessment of each assigned child’s, or adolescent’s functional visual attention in a learning setting;

12. Assessment of each assigned child's, or adolescent's functional visual working memory in a learning setting;
13. Assessment of each assigned child's, or adolescent's functional awareness and ability in relation to self-regulation in learning settings;
14. Assessment of each assigned child's, or adolescent's functional speed of processing of information;
15. Assessment of each assigned child's, or adolescent's degree of cognitive organisation, planning, and efficiency in relation to academic reasoning and problem-solving;
16. Assessment for each assigned child, or adolescent of relevant emotional factors in learning settings;
17. Assessment of each assigned child's, or adolescent's mental/emotional "blocks" to learning;
18. Assessment of each assigned child's, or adolescent's functional levels of insight with regard to self-assessment in formal learning settings;
19. Assessment of each assigned child's, or adolescent's self-expectations in relation to academic learning, and/or formal training;
20. Assessment of each assigned child's, or adolescent's functional phonological awareness and processing skills;
21. Assessment of each assigned child's, or adolescent's functional core literacy knowledge and skills, (word analysis, word recognition, spelling);
22. Assessment of each assigned child's, or adolescent's functional core literacy deficits and impairments, (word analysis, word recognition, spelling);
23. Assessment of each assigned child's, or adolescent's functional applied literacy knowledge and skills, (reading comprehension and written composition);

24. Assessment of each assigned child's, or adolescent's functional awareness and use of grammar and punctuation;
25. Assessment of each assigned child's, or adolescent's functional core numerical-mathematical knowledge and skills;
26. Assessment of each assigned child's, or adolescent's functional core numerical-mathematical deficits and impairments;
27. Assessment of each assigned child's, or adolescent's functional "mental" arithmetic skills;
28. Assessment of each assigned child's, or adolescent's functional numerical and mathematical awareness, knowledge and skills, including –
  - money identification and counting;
  - reading time, estimating elapsed time, and using timetables;
  - use of calendar, diary, schedules;
  - money recognition, calculation of relative value, and calculation of change;
  - budgeting and estimation of value;
  - measurement in all forms, (metric and Imperial);
  - applied use of fractions, ratios, percentages.
29. Assessment of each assigned child's, or adolescent's functional verbal processing abilities;
30. Assessment of each assigned child's, or adolescent's functional subject-specific knowledge and skills;
31. Assessment of each assigned child's, or adolescent's functional spoken language skills;
32. Assessment of each assigned child's, or adolescent's functional "practical" skills in relation to educational, training and independent living contexts;

33. Assessment of each assigned child's, or adolescent's awareness with regard to choice of subjects;
34. Assessment of each assigned child's, or adolescent's awareness, knowledge, skills, and habits/practice in relation to leisure options;
35. Assessment of each assigned child's, or adolescent's vocational interests and awareness;
36. Support and ensure systematic relevant leisure sampling, and guided reflection and recording by each assigned child, or adolescent, as agreed with the assessment team;
37. Support and ensure systematic relevant vocational sampling, and guided reflection and recording by each assigned child, or adolescent, as agreed with the assessment team;
38. Assessment of each assigned child's, or adolescent's degree of awareness and practice of core work skills;
39. Assessment of each assigned child's, or adolescent's degree of self-organisation in relation to learning;
40. Assessment of each assigned child's, or adolescent's self-responsibility in relation to learning;
41. Assessment of each assigned child's, or adolescent's motivation in relation to learning;
42. Assessment of each assigned child's, or adolescent's learning styles;
43. Assessment of each assigned child's, or adolescent's responses to different teaching styles;
44. Assessment of each assigned child's, or adolescent's attitude to authority and "rules" in relation to academic, or training contexts;
45. Assessment of each assigned child's, or adolescent's degree of awareness of relationship between education and other life-settings;

46. Dynamic assessment of learning potential;
47. Assessment of each assigned child's, or adolescent's response to different types of strategies for mediation of learning
48. Assessment of each assigned child's, or adolescent's level of moral reasoning;
49. Assessment of each assigned child's, or adolescent's word processing and information technology knowledge and skills;
50. Exploration of the relevance of alternative educational providers;
51. Exploration of the relevance of educational legislation;
52. Exploration of the relevance of educational agencies and support services, (such as: the National Council for Special Education (N.C.S.E.); the National Council for Curriculum and Assessment (N.C.C.A.); the Special Education Support Service (S.E.S.S.); the Special Educational Needs Officer (S.E.N.O.) role; the Educational Welfare Officer (E.W.O.) role; C.E.C.D.E, 'Inclusion Ireland'; 'Integrate Ireland'; the Irish Association of Teachers in Special Education (I.A.T.S.E.); the Irish Vocational Educators Association I.V.E.A.); the National Disability Authority (N.D.A.); the National Education and Welfare Board (N.E.W.B.); the Primary Curriculum Support Programme (P.C.S.P.); the School Development Planning Service (Primary) S.D.P.S.; the School Development Planning Initiative, (post-Primary), S.D.P.I.; the National Parents' Council (Primary) N.P.C.; the National Centre for Technology in Education (N.C.T.E.); the Irish Learning Support Association (I. L.S.S.); the Educational Research Centre (E.R.C.) (Ireland) St. Patrick's College; the Junior Certificate Mathematics Support Service; the Junior Certificate Science Support Service; the (post-Primary) (S.P.H.E.) Support Service.
53. Development of short-term, medium-term, and long-term individual education plans;
54. Use of frameworks such as S.M.A.R.T., or B.M.W. for target-setting with clients;



55. Exploration of the relevance of application for Learning Support Teaching;
56. Use of V.A.K.
57. Use of Kolb's Learning Styles;
58. Use of Donald L. Kirkpatrick's training evaluation model – 'the four levels of learning evaluation';
59. Use of Bloom's Taxonomy of Learning Domains;
60. Provision of information on the Junior Certificate Programme and the Junior Certificate Schools Programme;
61. Provision of information on the Leaving Certificate Programme, the Leaving Certificate Vocational Programme, and the Leaving Certificate Applied Programme;
62. Provision of information on the School Completion Programme;
63. Provision of information on Innovative Department of Education and Skills programmes;
64. Provision of information on the Further Education and Training and Awards Council (FETAC) and the Irish National Framework of Qualifications;
65. Provision of information on SOLAS (Seirbhísí Oideachais Leanúnaigh agus Scileanna) vocational training opportunities, and alternative by national training organisations, and/or specialist training organisations, (inclusive of private providers of training; occupational-specific providers of training; and, training, which is provided through specialist and/or national disability-focussed training organisations.

## **Appendix 9: Listing of resources**

In the context of assessment work, which is undertaken in relation to child protection, and mental health promotion, the following brief listing of resources are worthy of consideration:

- Burns, K., and Lynch, D. (Eds.) (2008) *Child protection and welfare social work – Contemporary themes and practice perspectives*. Dublin: A.A. Farmar Ltd.
- Barker, J., and Hodes, D. (2007), “*The child in mind: A child protection handbook*”, (3rd Edition). Routledge, London.
- Calder, C. and Hackett, S., (2003), “*Assessment in child care – Using and developing frameworks for practice*”. Russell House Publishing, Dorset.
- Greenhalgh, P. (1994). *Emotional growth and learning*. London: Routledge.
- Hill, M. (Ed.) (1999). *Effective ways of working with children and their families*. London: Jessica Kingsley Publishers.
- Howarth, J., (2005), “*The child’s world: Assessing children in need*”. Jessica Kingsley Publishers, London.
- Iwaniec, D., (2006), “*The emotionally abused and neglected child: Identification, assessment and intervention: A practice handbook*”, (2nd Edition). Chichester: John Wiley and Sons.
- Iwaniec, D., (2004), “*Children who fail to thrive: A practice guide*”. London: John Wiley & Sons.

- Iwaniec, D., (1995), “*The emotionally abused and neglected child: Identification, assessment, and intervention.*” Chichester:
- Parker, J., and Bradley, G. (). *Social work practice: Assessment, planning, intervention, and review. (Second edition).* Exeter, U.K.: Learning Matters Ltd.
- Pughe, B., and Philpot, T, (2007). *Living alongside a child’s recovery: Therapeutic parenting with traumatized children.* London: Jessica Kingsley Publishers.
- Rose, R., and Philpot, T, (2005). *The child’s own story: Life story work with traumatized children.* London: Jessica Kingsley Publishers.
- Rymaszewska, J, and Philpot, T, (2006). *Reaching the vulnerable child: Therapy with traumatized children.* London: Jessica Kingsley Publishers.
- Schmidt-Neven, R. (2010), “*Core principles of assessment and their therapeutic communication with children, parents, and families*”. Routledge, Cornwall.
- Smith, M. (2011). *Rethinking residential child care: Positive perspectives.* Bristol, U.K.: Policy Press.
- Ward, A., and McMahon, L. (1998). *Intuition is not enough: Matching learning with practice in therapeutic child care.* London: Routledge.
- Weare, K., (2000), “*Promoting mental, emotional, and social health: A whole school approach*”, Routledge, London.