'OUT OF HOURS'

SOCIAL WORK:

A STUDY OF LOCAL AUTHORITY

EMERGENCY DUTY

GLEN WILLIAMS

A Thesis submitted in partial fulfilment of the requirements of the Liverpool John Moores University for the Degree of Doctor of Philosophy

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ABSTRACT

'OUT OF HOURS' SOCIAL WORK:

A STUDY OF LOCAL AUTHORITY EMERGENCY DUTY

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Glen Williams   March 2004

Throughout the United Kingdom it is likely that 'out of hours', the smallest number of social workers is covering the largest geographical areas, the highest proportion of referrals, the most hours per week with the least support and in some of the most dangerous situations. For nearly thirty years, the majority of the working week has been staffed by out of hours social workers, and yet no systematic research has ever been undertaken into any aspects of this social work service.

The focus of this research then is local authority emergency duty team (EDT) social work. From a variety of perspectives and using a range of methods the researcher examines the past, present and potential future nature of out of hours social work.

As an EDT worker and researcher simultaneously, the author highlights the types and variability of his own assessments and those made by colleagues locally and nationally. Having established that EDT social work deals with significant occurrences after hours, this research questions whether conventional expectations of social work assessment are applicable in circumstances that are radically different from day-time work.

Employing statistical surveys, questionnaires, interviews and autobiographical commentary, this research collates and analyses EDT social work practice issues seeking to establish an assessment framework that can be applied to the generic, urgent and statutory demands that EDT and daytime social workers frequently face. The framework combines the qualitative and the quantitative, academic with practitioner, the personal and the political and reflects the nature of EDT social work.

Addressing a research void, this study clarifies and attempts to improve out of hours social work practice, including that of the researcher. This research presents a systematic analysis of the risk assessments, the decision-making processes and the crisis work undertaken by the most experienced group of social workers in Britain. The findings of this research should be of interest to those involved in out of hours social work, but may also have relevance to (social) workers undertaking (risk) assessments of service users.

PREFACE.

Social work's very existence, its *raison d'être* depends on the turmoil, tragedies and crises that beset many families and communities in our society. This research could not have been undertaken without the wealth of experience that has been gained during encounters with such families. Anonymous and 'invisible' to the reader of this thesis, these service users are to be recognised for their critical role in this work.

Thanks to Derek Clifford for all his timely advice, patience and focused comments; to Michael Preston-Shoot and Beverley Burke for sharing their guidance and knowledge; to all the much maligned and, all too often forgotten, EDT workers that took part in the exercise and to all those social workers and student social workers for regularly simply asking 'are you still doing that research?!'

I am grateful to my friends and extended family for their sustained interest in this work, their well-concealed incredulity at the time it took to complete and to my Mum for being so proud of her son, even if, as was usually the case, it was never entirely deserved!

Above all thanks to Liz, my partner who has been the 'extra academic mile' for me, put up with my research moods and coped with the two important 'little people' in my life Jack and Sophie (who arrived during Phase 2 of this research!).

Glen Williams 2004

INTRODUCTION.

I receive a phone call at 8 pm on a Thursday evening from the family

G.P. requesting a mental health assessment on a father of four children,

all under 10 years of age. Father said by the doctor, to be 'very drunk',

'volatile', 'actively suicidal', and 'in need of psychiatric admission.'

Mr. A., the father answered the door, half-naked, weighing about 20

stones, and over 6' tall. The doctor was still in the house, but in another

room with other relatives of the family, and the children.

Mr. A. was definitely drunk and spoke of the death of his wife who he

"lived for and adored". He went on to tell me that his best man at their

wedding had hung himself recently and last week his mother had been

killed in a road traffic accident. Throughout the interview, Mr. A's wrists

were visibly bleeding as he had cut them earlier that evening. Mr. A.

continued to express active suicidal thoughts as he sat hugging a

photograph of his wife on their wedding day, and sobbed throughout our

discussion. <u>*February 1997 Diary Entry.*</u>

The details above regarding *Mr A* are taken from this researcher's 'autobiographical diary' that records real events that I encountered as an Emergency Duty Team (henceforth EDT) social worker. The examples are anonymous and attempts have been made to ensure confidentiality is respected by altering the details of some of the families, but otherwise they represent actual events and my contemporaneous responses to them.

There is a range of potential social work responses to *Mr A* that are informed by a series of complex, inter-related personal, psychological, professional, practical, ethical, legal,

political and organisational factors. Social workers throughout the country regularly face similar dilemmas.

This research however, attempts to adopt a different perspective and examines some of the critical factors that exist for the 'out of hours' social worker who is called to assess, in this case, *Mr* A. This research explores the process that exists for the EDT social worker when all the daytime staff have gone home and their offices are closed. For the lone EDT worker with *Mr A*, the circumstances are different to those which might be encountered by the daytime social worker:

1. Having to visit without another social work colleague,

2. Not having any background information on *Mr A* or his family,

3. Limited access, if any, to a manager with whom to consult,

4. Taking a 'generic' [1] view on the presenting problems,

5. Having to prioritise other referrals being received whilst interviewing *Mr A*. and

6. Possibly having to take greater risks to self and service users[2]

20/2/97 (continued).

Why do I feel that I have been 'dumped on' by the daytime social workers (no lone visits for them!) that beat a hasty retreat as soon as I arrived at Mr. A.'s (they had been waiting outside the house!)?

I am frightened that Mr.A. will assault me, but at the same time feel dreadfully sorry for him.

Is my assessment being guided by the feeling that I would possibly be in a similar state if I had experienced such loss over such a short period of time? Is there

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[1] 'generic' means that EDT workers work with the full range of service users, in contrast to the daytime counterparts who 'specialise' with one group such as children and families, or older persons, or adults with mental health problems.

[2] 'service user' is the term used in this research to represent the recipient of a social service. This term is used whether the person wished to be a 'user' or not.

something stubborn within me that refuses to be frightened by Mr.A? Is the focus of my risk assessment on the children, the relatives or Mr.A? I feel certain that this man is drunk, but at the same time I believe I have a relatively libertarian view towards 'drinking parents'. A final complication is that I am a person that seeks to challenge authority, in this case, the perceived authority of the visiting doctor who thinks I should merely turn up and complete the 'section' papers. I know that to commit this man to the particular psychiatric hospital available would intensify his distress and force his 'suicidal hand', but neither are the alternatives queuing up to be selected!

Thoughts of the dangers and the risks, my role, statutory duties and powers, the children's welfare and an undirected anger that this practical dilemma has happened on my shift, all invade my mind, whilst simultaneously trying to listen what Mr.A. is saying to me.

Throughout the whole of the United Kingdom it is likely that 'out of hours', the smallest number of social workers are covering the largest geographical areas, the highest number of referrals, the most hours per week, with the least support and in some of the most dangerous situations.

'Out of hours' covers about seventy-six per cent of the time a social work service is provided, 365 days per year (Etherington & Parker 1983). '*We know little about how certain social patterns change or alter at various times during the day and yet we have concentrated most of our social work resources between the hours of nine and five.*' (Etherington & Parker, 1983 p.47). For nearly thirty years, the majority of the social work week has been staffed by out of hours workers, and yet most of their activities have rarely had a high profile, been largely undeveloped and, as the recent Social Services Inspectorate Report concluded: 'the out of hours service has been out of sight and out of mind.' (DoH, 1999a).

The focus of this research then, is Local Authority Emergency Duty Team social work. Part of the function of this study is to explore, from a range of perspectives, (autobiographical and theoretical for example) an aspect of social work which, to date, has received little, if any, detailed research. The researcher has been an EDT social worker with the same Local Authority (Part and Full Time) for over 10 years, and, since November 2002 has been the Manager/Practitioner of the same team. The intention was to combine these experiences with a more systematic examination of what takes place outside of 'normal' office hours both in my own employing authority and local authorities across Britain.

The work of the 'out of hours' or Emergency Duty Team social worker usually involves relatively long shifts, 12 - 15 hours being the normal weekday evening duration, with some Authorities opting for 24-hour shifts at the weekend. Given that in many local authorities, there is usually only one worker on duty at any one time, (for detailed breakdown see Chapter 7), it could be argued that, in many respects EDT social work is a 'crisis' waiting to happen, yet it seems to have escaped the degree of 'scrutiny' that daytime social work has experienced. This apparent lack of research has been the case since EDT's appeared within the social service departments in the early 1970's shortly after the Local Authority Social Services Act 1970. From 1996 – 2003 the author researched aspects of EDT and sought, in part, to address some of this apparent research gap.

Justification of the Research

It is argued within this research that EDT has a crucial role within the social work service, but that its contribution has been largely ignored by researchers, policy makers, politicians and daytime social work professionals alike. This study examines not only this apparent absence of attention to out of hours, but also what the positive and negative elements of EDT work are. This research presents a critical study of some key aspects of EDT as it

now operates, illuminating a vital aspect of social services provision for the very first time. As occurs during the day, difficult decisions are taken affecting the complexities of individual and family life concerning 'risk' and 'harm'. Unlike during the day however, EDT workers often make similar decisions without recourse to discussion with anyone. In other words, critical decisions, such as the removal of a child to a place of safety, an adult being placed in a psychiatric hospital, or a vulnerable older person being moved to residential care, are being made against contrasting organisational/professional backgrounds depending on the time and the day.

This research has importance from the perspective of the service user because it examines the processes via which a response is provided, or not, after hours. It should be of interest to EDT workers and managers alike because it explores the assessment and prioritisation processes that operate consciously or unconsciously when deciding what, if any, response is appropriate to a particular referral. This study also examines the various factors that impact upon this decision making process and the range of risks that are taken, or not, by various workers for a range of reasons.

At the time of writing policy changes are being introduced that are intended to make (social) welfare services more available, more accessible at any time of day or night, (DoH 2001b; DoH 1998b; and DoH 1999b). It seems appropriate therefore that this research should endeavour to examine social welfare provision out of hours providing an historical, academic and practice context to the government's '24/7/365' vision for the future of welfare provision.

It is hoped that the material will be of interest and some use to other social work professionals whether they operate at night or not. It is the view of this author that there may be lessons for social work 'in the dark' that are applicable to that undertaken during the weekday daylight hours. It is hoped that by examining the lessons to be learned from the majority of the week, social work practice from the rest of the (minority of the) week may also benefit.

Finally it is hoped that this research may provide initial thoughts on a generic assessment framework that might be employed specifically by EDT workers throughout the country, but also be of some use to daytime social workers irrespective of their specialism, who are involved in assessment of risk and potential significant harm.

Outline of the Research

Chapter One briefly describes the origins of Social Work generally and EDT specifically, examining the varying models of EDT that exist across the country and the nature of the work today. This first chapter concludes by introducing the reader to the specific aspects of EDT to be the subject of this research, and a brief outline of the manner in which this was carried out.

Chapter Two reviews the literature that already exists which relates to the work of EDT. Given the apparent paucity of EDT related material, this Chapter examines literature from the 'daytime' that has application to social work in the 'night-time'. Some of the Inquiries into social work tragedies are examined from an EDT perspective in order to try and establish potential lessons that might be learned. Aspects of all social work practice, such as 'crisis intervention', 'risk assessment' and social work skills that are applicable to day and night time practice are also discussed in this chapter.

Chapter Three details some of the methodological issues relevant to this research. This Chapter explores some of the debates current in research generally and social work specifically and tries to establish which research methods are most appropriate for this study. Using *triangulation* (Campbell and Fiske, 1959; Webb et al., 1966; Denzin, 1978) and seeking to *bridge* the 'academic' and the 'practical', the personal and the political, this

research combines different studies within the one research programme, such as participative interviews, questionnaires and longitudinal studies. As such, this study adopts the concept of *methodological triangulation.* In this Chapter, the researcher details, and seeks to justify, the methodological pluralist approach that has been adopted for this thesis.

Having sought to identify and justify the methodological basis of the work and the methods of 'data' collection, the researcher then, in Chapter Four, discusses the hypotheses underpinning the work and the manner in which the study progressed, i.e. the research process. This Chapter explains the chronology of the research process and divides the work into two 'Phases' that examine the researcher's own local authority (Phase One), and the nature of EDT's throughout the United Kingdom (Phase Two).

Phase 1 focuses on the researcher's own local authority and comprises questionnaire, interviews, an autobiographical diary and longitudinal study. Chapter 5 presents the process, findings and analysis of the 'data' collected over the six-year period of this study in the form of the longitudinal study.

Chapter 6 explains the questionnaire and interview details of Phase 1 respondents presenting and analysing in detail their responses. These findings were then applied to a much broader group of EDT workers from teams throughout Britain. Chapter 7 records and analyses their responses focusing specifically on assessment and prioritisation.

Chapter 8 seeks to draw together some of the key themes of the research and seeks to address the hypotheses that underpinned the research. The final chapter also attempts to present an EDT Assessment Framework that can be applied by all EDT workers as well as daytime workers. Various documents appear in the Appendix that supported this research and provide reference points and supplementary information for the reader.

Definitions

'EDT' (Emergency Duty Team) is used throughout the thesis as an interchangeable term: It refers to the team, the workers and the type of work undertaken. It is also a reference to 'out of hours' social work, but this is not intended to suggest that only EDT workers operate outside of the 'normal' working day, 9-5 pm.

'normal' is presented with the apostrophes to indicate a genuine recognition that many daytime social workers work late into the night, often without any support, or thanks, and very often accumulate so much Time Off In Lieu that they are unable to take it. In no way is the term 'normal' meant to indicate that daytime workers stop working at their allotted 'end of the day'.

'Emergency Service' v 'Out of hours service' This refers to two different approaches. The first is an emergency only service that responds to 'life and limb', statutory referrals that cannot safely be left until the following weekday. The 'out of hours' service is a broader provision that seeks to provide a social work service that is an extension of and similar to that which is provided during the day. At the time of writing, the former represents the majority of EDT provision in Britain, and the latter more of a governmental aspiration, albeit that a small minority of out of hours teams have already begun to move towards an extension of daytime social work provision.

'Service user' It is acknowledged that there does not seem to be a universally accepted term for the 'recipients' (with or without consent) of a social service. 'Client', 'Customer', and 'Service User' are the more common. For the purposes of this research I will use service user as I believe it has less connotations than the other two, although I accept it is far from ideal as it implies some degree of acceptance and choice, involvement, power and partnership. Sadly, in my experience, these are not always in evidence in some of the pieces of social work practice in which I have been involved.

Delimitations of the Scope of the Research and Key Assumptions

Service User Feedback.

A possible weakness of this research is the decision not to attempt to directly gather 'data' from the service users who encounter EDT's. The hypotheses set out below (see1.6) reflect a deliberate decision to concentrate on EDT aspects other than service users directly. The focus of this research is on such matters as:

      1/ Patterns and types of referrals to EDT,

      2/ Consistencies of responses and prioritisation by the EDT worker(s),

      3/ The theoretical framework of EDT workers.

The findings of all three areas of study may be of value or interest to the service users, but do not necessarily require their input at this stage. The fourth hypothesis of the research, 'can EDT and the author's own social work practice be more effective?', and the findings thereof, should be presented to service users for their input to explore organisational, personal, practical and political notions of what constitutes 'efficiency'. This may well be the subject of a further research project, indeed it makes sense that service users should be asked to comment on data collected about a service that effects them (potentially or actually), that they pay for via their council tax, and a service that may have to be altered. For the purpose of this study though, and for the following reasons I have not directly contacted service users to participate in this research study:

A/ I would contend that the nature of the focus of this research does not require it at this stage. Given the stated aims and objectives of this study described above, it is reasonable to suggest that service user participation would be tangential to the research problem. It is

not argued here that such input would be irrelevant, only that, at the time of writing it did not neatly fit into the plan of study, or the research problem.

B/ There are complicated practical, ethical and professional difficulties with an employee seeking the views of a service user that may well be 'subjected' to statutory intervention by the researcher in the future. There are also difficulties in gathering information from service users that are the casework responsibility of another, daytime social worker. There are also particular problems when the researcher goes outside his employing authority to question the service user's perspective of another team's EDT input.

C/ At the time of undertaking this research there are a range of questionnaires and surveys being sent out to service users for such purposes as Best Value, Internal Reviews, SSI inspections and local audits. Where possible and appropriate, this research will review such feedback and incorporate the findings into this research, aware of the limitations of such usage.

D/ Restrictions to this research existed, in that there was limited time and all the interviews and questionnaires were being co-ordinated by the researcher alone. To include service users, as part of the sample, would have extended this research beyond the means of one person and unnecessarily slowed down the process, potentially elongating the 6 years that the research process had already taken.

E/ A final reason for not specifically involving service users as part of this broad piece of research is that their input is too important to be fitted into an organisational, professional and personal examination of the subject. This may appear contradictory on first reading, but what is meant, is that the service users who have contact with EDT are more than likely to have only had one contact with them and no follow up service from the EDT worker.

This could mean therefore, that they are more prepared to be critical. The nature of the service provided by EDT (emergencies and urgent) more often than not means that either a person is removed, sometimes to the relief of carers and the distress of the service user, or, the service user remains in the home to the horror of the carer and the relief of the service user. In order to fairly gather information regarding the nature, effectiveness and quality of the EDT service received means that the process of collecting that information would need to be undertaken with much sensitivity and awareness of the risks. For example if I had completed the application for *Mr A* and he was 'sectioned' and placed in a psychiatric ward, with the resultant impact this may have had on his children (who also may have had to be accommodated), it would make for some interesting dynamics if I were to visit as the researcher seeking to gather feedback from the father or the children regarding the nature of EDT service. Their comments would have been extremely valuable, but the process would need to be handled with great sensitivity. In essence then, what I am arguing is that service user feedback is too important to be sidelined to one part of this research, and that if it is to be done justice, it could be the subject of a separate study.

The absence of direct service user feedback is not intended to minimise the importance of such research, nor to demean the value of information gathered from those often receiving an EDT service when, in the main, they do not request such input. It is acknowledged that the absence of such information may limit the value, applicability and relevance of this research, but it is hoped that service user feedback gathered by other means as indicated above, will inform the findings of this work. Reference is made in this study to service user feedback collated in reports produced by such as the SSI, Best Value officers and Local Authority Internal Reviews.

<u>United Kingdom.</u>

Throughout this research, reference is made to feedback from 'Britain', this 'country' and the 'United Kingdom'. It should be noted for purposes of accuracy that feedback was received from Scotland, Wales, the Isle of Man and England, but no responses were received from northern or southern Ireland. Discussions though, regarding the service in Belfast and the developing service in Dublin have taken place with EDT workers from both areas, and are incorporated into this study.

The researcher has also co-written a paper 'Important But Ignored' that examines problems of expertise in assessment and intervention out of hours, (see Appendix 1), this was published in the British Journal of Social Work, (Clifford and Williams, April 2002.) and is placed in the Appendix as required by the University regulations.

This research therefore sought to examine social work 'out of hours' qualitatively and quantitatively, objectively and subjectively. Whilst acknowledging its limitations, it is suggested that this 'local' and 'national' study is the first of its kind and will, hopefully, inform the current debate regarding daytime and night-time social care services.

CHAPTER ONE.

The Background

1.1 The Changing Nature of Social Work

Sheppard argues that:

> *'State social work may be considered a socially constructed profession, in the sense that it has been created as a means for working with certain individuals who have been defined as socially problematic. Its focus is one on individual-environment interaction and its orientation is towards these individuals as subjects. It is in the combinations of these elements of concern, focus and orientation that social work may be most clearly 'marked out'. This formulation helps both define social work and to distinguish it from other activities' (Sheppard, 1995 p.321).*

The central focus of state social work practice therefore, whether this be at the faceless organisational level, or that of the more human interface, should be concerned with humans and their relations with themselves and their environment. In many respects the nature of social work has been altered by the differing political and ideological positions of central government. There has been the development towards a market forces mentality within social work that has broken the perceived monopoly of 'public' care which was said to have existed within the local government Town Halls. Welfare pluralism is an extension of this dismantling of the Local Authority monopoly of care, and is promoted as the more 'honest' way of ensuring that the 'consumer' is offered more choice. The consumer, or 'service user' is expected to have an increased choice regarding the 'mixed economy of

care' that will need to be purchased by the care manager following a 'needs-led assessment'.

The separation of the role of purchasing rather than providing services, the contracting out of various services to compulsory competitive tendering, promotion of the independent sector, the introduction of Quality Assurance, and the so-called Anti-Trade Union legislation, have led some to despair at the perceived erosion of the Welfare State. It has also led to a reduced resistance to change and the radically altered role of the social services as co-ordinators, purchasers and care managers, or 'Lighter Touch' partners in child abuse investigations.

It is the belief of this author however, that the New Right diversion into market forces and cost effectiveness has still not altered the fundamental focus of social work, or EDT practice, namely working with people and their environment. Changes in social work have occurred however, with an increasing statutory emphasis being placed on the 'people' as individual consumers, and a decreased focus on the 'environment'. The 'Thatcher years' saw a 'meritocratic' system flourish in which individual ability determined success or failure. Failure to gain employment, for example, was caused by insufficient effort on the part of the individual to 'get on their bike' and find work, rather than the collapse of the traditional industries - coal, steel, cloth. In other words, individual weaknesses, not environmental failures were, according to this system, the root cause of unemployment. Similarly in welfare provision, the promotion of individual/private health care, reduced spending on a National Health Service and the introduction of competitive tables (waiting lists and waiting times for example), created a two-tier health service. One could be accessed publicly, the other purchased privately. This was mirrored within the social services by a substantial expansion of the private/independent care sector, established under the guise of giving individual citizens more choices. This changing nature of social

work has impinged on the research process and is clearly reflected in the autobiographical diary that was maintained throughout the duration of this study [1].

Despite ongoing shifts in focus, values and politics, what remain a constant are the inherent difficulties that exist when attempting to research the complex set of dynamics and processes that are 'Social Work'.

Lyons (1999a) suggests that social work is difficult because the subject matter is difficult as it is impacted upon not only the values, knowledge and skills of the individual worker, but also but the demands of government and the perceptions of other professionals, members of the public and the media.

There can be little doubt that social work operates within a complex social, political and ethical context that is changing rapidly. This transformation is reflected in different ways within social work/care, such as the move away from post war welfarism (that included public sector monopolies, nationalized industries and community identity), to a promotion of market forces (evidenced by the increased use of the 'private' or independent sector for service provision and notions of 'best value). Notwithstanding the confusing array of legislative and organisational changes, for example, the National Health Service, 1990, The Children Act 1989, The Criminal Justice Act, 1991, The Health Act 1999, The Health & Social Care Act 2001, The Care Standards Act 2000, The Protection of Children Act 1999, The Race Relations (Amendment) Act 2000, Local Government reorganisation 1996, the Modernising agenda of 'Modernising Social Work Services' (1998) and 'Aiming For Excellence'(1999), social work practice remains a difficult and complex task. Social work still has to deal with uncertainty, ambiguity and complex activity that involves an ethical base, legal accountability, responsibility for complex assessment and decision

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[1] Throughout the seven year period of this research (1996-2003) an 'autobiographical diary' was maintained, (for a detailed explanation see Chapter 4, 4.11). References to this diary are included throughout the thesis in an attempt to make relevant the data, but also to identify the subjective experiences of the author of social work practice as well as the research process itself.

making about relative risks, competing priorities, safety, harm and protection, and intervening in the lives of people who are in crisis, conflict, distress or trouble.

In addressing what he considers an essential characteristic of social work, Parton (1999) describes the ambiguity arising from the dual commitment to service users and families and their needs on the one hand, and legislation and statutory requirements of the state on the other. Social work practice is required to provide care, protection and control and to ration resource allocation. It is also expected both to work in partnership with users (Marsh and Fisher, 1992, The Children Act, 1989) and to promote the empowerment of individuals, groups and communities to take control of their own lives (Braye and Preston-Shoot, 1995).

1.2 The Origins of Emergency Duty Social Work.

Whilst it is not within the remit of this research to examine the history of social work in any great detail, it is relevant to note the way in which the provision of services outside of 'normal' office hours has changed little since the early 1970's. This is despite the many significant alterations that have been made to the way in which social workers operate during the day.

Following the Government Report' in 1946 (Curtis, 1946), 'social workers' began to be employed in large numbers in Local Authorities, especially in the child care service. These newly appointed, largely unqualified, workers were in addition to the local authorities that already employed mental health workers. Both groups of workers acted alongside the voluntary organisations, but tended to work to their own area of 'expertise' or 'specialism'. At this stage in the development of the profession, there was no recognised social service provision 'out of hours'.

The committee on Local Authority and Allied Personal Social Services, or Seebohm Report, (1968), recommended that 'specialisation' in social work should be radically altered. Essentially, what was being recommended, was that the then separate groups of 'social welfare' officers, medical and psychiatric social workers, child care officers and mental welfare officers should drop their distinctions and become 'generic' (i.e. general) social workers. The principle behind this proposed change was the social worker would be able to bring to the family or individual a far more comprehensive, holistic approach to their difficulties. Thus the family with a range of difficulties such as the 'elderly' grandparent, the grandson with the disability and the mother with the mental illness, could be visited by an individual, generically trained social worker, rather than by a succession of so-called 'specialist' social workers.

The legislation, which stemmed from the Seebohm Report (The Local Authority Social Services Act, 1970), abolished the specialist children's departments and created district based personal social services departments. At this stage, many Local Authorities established an 'out of hours', generic social work service.

The newly created, generic, district based, social work teams underwent major upheaval caused by the reform of local government in 1974, but the foundation for an out of hours service had been laid.

It is important to recognise that this generic mode of service delivery continued for almost three decades throughout the profession of social work, although it was punctuated by the Barclay Report (1982) and, in some areas, the emergence of Community Social Work in which social workers and their agencies are exhorted to create, stimulate and support networks in the community, (for a much more detailed and more accurate explanation of this see Hadley et al, 1987).

Over the past 25 years, a very complex set of systems for social welfare provision after hours have been at play. The significant changes in political ideology and political party in

power, particularly from 1979 onwards, numerous 'official' inquiries into the nature of social work provision, many tragedies where social services were involved, and much tighter (budgetary) constraints on local government, to name a few. The resultant public outcries, government sponsored research and funding initiatives meant that a new type of welfare provision would be legislated for. This, largely, became reality in legislation such as The N.H.S. & Community Care Act (1990), and The Children Act (1989). It could be argued that these two pieces of legislation alone have revolutionised the whole notion of personal social services. They have required changes in philosophy, outlook and practice: the people needing and using social services are no longer the objects of any Town Hall 'charity', but are to be seen as 'partners' in a joint enterprise. These partners have very specific rights, but also responsibilities and they are to be offered genuine choices from services that will have to attain certain standards and be inspected to ensure value for money. Another ideological shift is reflected in the Mental Health Act White Paper (DoH 2001) that suggests the introduction of increased restricted rights and limited responsibilities with an increase in the medicalised focus on mental disorder. This may be further compounded by the introduction of Mental Health workers (other than Approved Social Workers) who might be employed in a hospital, by the Health Authority, part of whose role will be to consider applications to 'section' patients, but independent of the recommending doctors. Other examples of the perceived erosion of a social model in preference for the medical one is the increase in Primary Care Trusts, Care Trusts, Community Mental Health Teams and the full range of 'partnership' arrangements that exist between social work service providers and 'health' providers.

All the above changes, which have not been dealt with here in any detail, have meant for the majority of daytime social workers, a return to a 'specialist' mode of service delivery within social services. In this system there are 'specialist' social workers who work with identified service user groups; these can be grouped by such labels as:
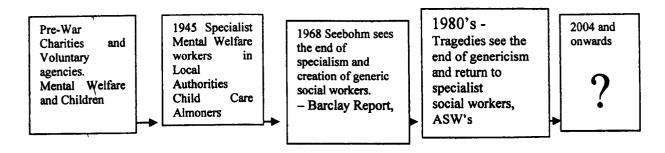
Adults with Mental Health Problems	Children & Families
Older Persons	Elderly Mentally Ill
Adults with Physical Difficulties	Adults with Learning Difficulties
Children with Disabilities	Youth Offenders

Each set of workers from the above specialist teams, will be sent on relevant specialist training to support their work with these identified individuals and families. Specialist teams of specialist social workers, as in the pre-Seebohm era referred to above, have once again become the norm rather than the exception in 21st century social work departments.

The two-year training for the professional qualification for prospective social workers has similarly altered, with the result that those undertaking the course over the past ten years will have been expected to opt for their chosen specialism before entering their second and final year. At the time of writing, the proposal is for a three-year qualifying course that, whilst including a generic introduction to the foundations of social work is, in my view likely to remain largely evidence (competency) based and may require students to specialise early in their degree course.

Against this backdrop of radical changes, and the fluctuation between specialism and genericism, EDT has remained fairly constant. In the author's own local authority the service has always been generic and has always had to respond to the changes in the department's statutory responsibilities. This research suggests that this has also been the case for the vast majority of EDT's throughout the U.K.

EDT's have functioned in their present form since the mid 1970's. Prior to 1978, 'out of hours' work was carried out by generic social workers on a rota basis as an extension of

their daytime contractual duties. As a result of, amongst other things, increasing workload demands during the day and night, pressure from the larger local government trade unions, and increasing awareness of contractual and health and safety duties and responsibilities, full-time, dedicated 'out of hours' teams were set up throughout the country. In the specific authority, that is the subject of Phase 1 of this research, a full-time team was established in 1978. Interestingly, in the report requesting the creation of this team that went to the relevant social services committee, provision was specifically included to review the service and to make recommendations as to whether the 'team' was of sufficient size to meet the demands upon it. This review has to date never properly been completed, and, up until the recent (2002) appointment of the author as a manager/practitioner, the original size, status, location, and generic nature of the 'team' had remained unaltered. This consistency is in direct contrast to the seemingly ever-changing face of daytime social work service provision as indicated, albeit briefly, above, and in the diagram below.

Pre-War Charities and Voluntary agencies. Mental Welfare and Children	1945 Specialist Mental Welfare workers in Local Authorities Child Care Almoners	1968 Seebohm sees the end of specialism and creation of generic social workers. – Barclay Report,	1980's - Tragedies see the end of genericism and return to specialist social workers, ASW's	2004 and onwards ?

The beginnings of social work can be found in the work of charitable organisations that specialised in providing help and assistance to children and families that were destitute, or hospital treatment for those deemed to have psychiatric difficulties. This service became formalised in 1945 when local governments set up specialist children's departments and a mental welfare service, and was radically altered by Seebohm whose report brought about the creation of generic social workers (the founder of EDT's in many ways). Since the mid 1980's however, we have witnessed the return to the specialist departments culminating in the Mental Health social work service returning to 'hospital's in the form of Care Trusts,

whilst the children's department is divided into sub specialisms such as 'Family Placement', 'Assessment' and 'Permanence' with an emphasis upon the split between purchaser and provider. There is some weight in the suggestion that the service is returning from whence it came given the recent increase in the Voluntary and Independent sector and the emphasis upon specialism. It remains to be seen whether EDT's will 'survive' such changes or if the entire service provision will come full circle and return to the days of generic workers that view 'problems' holistically.

The current nature of EDT in this country (see also Chapter 7, Phase 2) and in the specific local authority under question (see also Chapter 6, Phase 1) is now considered in more detail.

1.3 Emergency Duty Social Work Today.

As indicated in the Introduction, it is possible that throughout Britain, the work of EDT carries additional risks with increased elements of danger, compounded by limited support and, in many areas, lone working. Despite the large percentage of the week covered, EDT has only been the subject of one systematic piece of research (Etherington and Parker 1984), known as the 'BASW report', and one Inspection by the Social Services Inspectorate (DoH 1999a). The BASW 'research' was undertaken in response to the rapid development of EDT's in the late 1970's early 80's. BASW identify such issues as the referral patterns, the costs of different EDT models and training and management concerns, (for a more detailed analysis of this report see 2.2 in Chapter 2). Written in 1984, using data from 1978-81, it is interesting to note how little has changed with some of the EDT machinery, but disappointing that even this level of research has not been repeated since.

This apparent lack of research exists despite the 'significant occurrences out of hours', (O'Hagan, 1986, p.10), as well as the substantial increase in 'out of hours' psychiatric

admissions and 'tragedies' that have occurred over the past 20 years, (for more detailed discussion on the tragedies see 2.7ff). Put simply, social work research appears to have ignored a major part of social care provision despite events that one might have thought would draw attention to the out of hours services.

The social work publication Community Care, citing Department of Health research, suggests that the number of formal admissions to hospital under the Mental Health Act 1983 has increased over the past decade from 18,000 in 1990-1 to 26,700 in 2000-1, (Community Care, November 8-14, 2002 page 13). According to the 'Shaping the New Mental Health Act (DoH 2001), the most widely used section of the 1983 Mental Health Act for informal patients is a section 5(2)[2]. The use of section 5(2) has increased nearly two-fold from 5,000 per annum to 9,000. The majority of section 5(2)s were found to be implemented outside of normal office hours. In one local authority's internal Best Value Report (Lancs,2001) it was noted that EDT affects 30% of all hospital admissions under the Mental Health Act 1983, and 70% of all Section 136[3] assessments done in the County. It seems sensible to assume that the team that covers three quarters of the week will inevitably face more 'significant occurrences'. It is also possible that the night-time and weekends are 'different' from daytime socially, psychologically, culturally and organisationally which may contribute to the types of crises to which EDT's are expected to respond.

Whilst EDT may cover three times more of the week than the daytime staff, it is probable that this is undertaken with at least fifty times fewer members of staff. It is likely that even the notion of an Emergency Duty 'Team' is misleading, as in many of the local authorities being researched, the 'Team' constitutes ONE social worker only being on duty at any one

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[2] Section 5(2) of the 1983 Mental Health Act gives doctors a holding power of a person, who is already an informal patient, for up to 72 hours, for the purposes of arranging assessment for an application for admission to psychiatric hospital. Often applied, for example when an informal patient decides to leave the ward against psychiatric/medical advice.

[3] Section 136 of the 1983 Mental Health Act is the police power to remove someone from a public place who is thought to be mentally disordered and in need of care for up to 72 hours. The purpose is to secure an assessment by a Doctor and an Approved Social Worker.

time. This 'Team' will be expected to cover the whole geographical area of an Authority rather than smaller Area Team catchments, which exist during the day and which, are staffed by specialist social workers. EDT, unlike their daytime specialist counterparts, may be called upon to deal with and prioritise a far more generic set of referrals. For example, the EDT worker may be asked to attend a Mental Health Assessment (see *Mr A*), investigate child abuse, undertake at least one interview of a young person under the Police and Criminal Evidence Act, arrange housing for a homeless family and transport the family to the accommodation, and assess an older person who may be in need of urgent domiciliary services or residential care. This could all realistically occur on one shift staffed by one person, and be in different parts of a very large geographical area. Some of these requests for an EDT response would probably have been received, by the lone worker, whilst in the middle of dealing with *Mr A*.

A further result of specialisation, is that some service user groups are differentiated by 'problem' and address. This means that daytime social workers will cover one 'group' of service users only, and one part of the borough only, (e.g. North or South), unlike the night-time counterpart who will have borough wide responsibilities. All this means that the lone EDT worker needs to be able to prioritise what can/should be attended to and in what order. An extract from the autobiographical diary captures some of these issues.

Monday 22ⁿᵈ June 1998

'This was a hard shift: A 16 year old female heroin user refusing help; a 13 year old being threatened with being kicked out of his house, negotiation needed with dad; Spot check on drinking parent could not be found and this is worrying; 5 year old home alone, mum eventually found; suicidal 12 year old boy and mum at the end of her tether plus the request for the mental health application. This was an emotionally draining shift, all the calls seemed to be priority one, I missed the

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World Cup and yet I feel simultaneously as if I am chasing my tail and yet also in charge of what is going on.'

The SSI (DoH 1999) indicated that the core skills for EDT '..are probably unique in social services. Staff need the ability to assess and manage risk, often alone and with limited access to management support. They may have little background information about the service user.' (6.29).

1.4 Benefits of EDT Working.

Although it has been indicated above that in some respects, EDT is a crisis waiting to happen, it would be misleading to ignore the many benefits and advantages to working out of hours.

The BASW report (1984), and the SSI Inspection (DoH 1999) demonstrate that, unlike their daytime counterparts, EDT social workers have been in post many years since qualifying, and tend to remain there, not choosing to move around the department. Whilst it is possible that this is because EDT work is an employment 'cul de sac' that one has to come out of completely in order to move on within the hierarchical management structure of the social services department, it is argued here however, that the advantages to EDT work may far outweigh the disadvantages:

1.4a Lone working can mean an increased degree of autonomy that 'allows' the EDT worker to make decisions at night that would normally during the day, be made by a group of workers including at least one manager. Lone working and this increased level of 'power' means that some EDT workers have greater access to resources that are only

available to the daytime workers following, for example, a panel decision, a case conference or a budget meeting.

In some authorities, because there is only one worker on duty, or a significantly reduced number of workers, there may be a reduced sense of expectation of what service can be provided after hours. The majority of local authorities provide an emergency-type service only out of hours; this inevitably reduces the type of work that EDT's will respond to and means that there is usually a very 'tight' criteria for achieving an EDT service, (this is examined in some detail below). Lone working means that there is minimal, managerial monitoring of the social workers' performance or actions whilst they are on duty. For some EDT workers this allows them to make decisions quickly, gives them a sense of responsibility that is less actively supervised than during the day. Finally, there is often an increased sense of support and camaraderie from the other agencies operating at night, such as the Police, Doctors, Nurses who appreciate that the EDT worker is alone.

1.4b Conditions of Service for the EDT worker usually means that they are paid more than their daytime social worker counterparts either to reflect the increased responsibility, or, more likely, to compensate for the unsociable hours and days that are covered by EDT (New Years Eve, Xmas Day and all Bank Holidays for example). Whatever the rationale for the varying amounts and systems of payment, the difference between the pay for a full time daytime social worker and a night-time one can range between £1000 and £15,000 per annum. The very nature of the shifts of the EDT worker means that child care or dependant care costs can be reduced because the EDT worker is off during the day, this can further increase the income differentials between night and daytime social workers. Not working during the weekdays also allows other sources of employment to be sought by the EDT worker such as teaching, or allows hobbies or academic studies to be pursued when others are at work.

Whilst the long shifts undertaken by EDT's (in some cases 15 or 24 hour shifts) may appear to be draconian and contrary to the European Working Rights Directive EDT workers across the country may choose to sign a 'waiver' that allows them to continue to work such long shifts. The reasons for this preference are that the EDT worker that does a 24 hour shift and is on say a 35 hour working week, has in one shift nearly completed the weeks hours. In other words, the longer the shift, the fewer the EDT worker has to do. It is also the case for some EDT's that in a long weekend shift of 24 hours, there is an assumption that the worker will take rest periods and, even for some teams, go to bed, or at least take rest periods, if things go quiet. The Inspection Report (DoH 1999) controversially reported that '...few EDT's were under pressure, during the time of the inspection. At times demand was very low.' (ibid 6.20).

Finally, the additional bonus of working unsociable hours is that training days, supervision and other work related meetings only ever occur during the weekdays and so attendance by EDT workers can attract payment or, more likely, a 'time back'-agreement with the employer, thus further boosting the time off EDT workers are entitled to claim.

1.4c Generics in a Specialist World.

It is the case that EDT workers are generic in the sense that they are expected to deal with the full range of service user groups, 'from cradle to the grave' so to speak. But this genericism does not require each worker to know everything about each specialism. For example, EDT workers will need to have a detailed, working knowledge of child protection and legislation relating to emergency action. They will not though, need extensive training in care proceedings. Similarly, whilst it is imperative EDT workers understand the practice and legal aspects of compulsory admission to psychiatric hospitals, it is unlikely that they will need detailed training on such as Guardianship (Mental Health Act 1983) or writing reports for a mental health review tribunal.

In other words, EDT workers could, more accurately, be described as 'specialist generics' who need to know specific elements of each service user group particularly relating to emergency situations, (for further discussion on this issue see Chapters 7 and 8).

For some workers, this author included, this area of 'generic specific' emergency responses has its attractions because there is no caseload, no long term involvement and the 'luxury' of being able to 'patch things up' until the caseworker or the duty officer return on the next working day. The crises are dealt with but the follow up is passed on.

BASW (Etherington and Parker, 1984) and the SSI (DoH 1999) highlight the implications of the varying EDT models that appear to exist throughout the country. This author will suggest that for every different Local Authority, there is a different EDT model. Whilst these can grouped together into certain categories there are, possibly inevitably, significant differences between even those placed within the same category.

It can be argued then that the benefits of working at night and unsociable hours outweigh the negative implications of such as outlined above. One area of possible concern to EDT workers that is beginning to receive increasing attention is the impact of shift pattern working upon individual's health and family life. The Family Policy Studies Unit published research in 1996 (Labour Research Department) identifying the social consequences of excessive working time and found a direct correlation between extended male working hours and problems in family life. The Health and Safety Executive (HSE 1992) says that working patterns which disrupt normal sleeping patterns have also been shown to affect performance and productivity.

The Labour Research Department (1998) suggests that over the years, research has found that workers' health can be affected both by excessive and unnatural hours of work. It is suggested that particular problems arise when they try to go against the '24-hour body clock' ('circadian rhythm'), for example by working at night. The evidence suggests that

constantly changing shift patterns are especially damaging to health because the body clock never gets a chance to adjust.

The HSE review showed that:

- Shift workers are more likely to die younger than day workers;

- Shift workers are 40% more likely then day workers to suffer from heart and circulatory disease;

- After 15-20 years of shift work, 20% of shift workers had heart and circulatory disease, three times the rate in day workers in similar jobs;

- 30%-50% of shift workers suffer from indigestion, two to five times the rate for day workers

- shift workers suffer from peptic ulcers at an earlier age and if they leave shift work, their peptic ulcers improve; and

- more shift workers and former shift workers suffer from anxiety and depression that day workers.

A critical review of shift work and health published by Harrington (1994) argued that the link between shift work and heart disease had strengthened in the preceding years, that there was strong evidence for an association with gastrointestinal disease and evidence of poorer work performance and increased accidents, particularly on night shifts. A study by Folkard (1995) and colleagues found that accidents happen more often at night. The nuclear disasters at Three Mile Island and Chernobyl, and the Exxon Valdez oil spill, are all examples of this.

Whilst a crucial aspect of EDT working, the implications of such shift working for health and safety are cited here to emphasise the need to develop research into such potential crises. The imperative for more research into EDT is stressed throughout this study, but the potential harm to an individual's health does not form part of this research, other than as a counterbalance to some of the perceived benefits to working as an EDT social worker. It is

possible that some of the perceived benefits of EDT conditions of service may well, in actual fact, be harmful to the health of the worker or the service user. Already EDTs in some parts of the country have begun to address some of the difficulties identified above, whilst others continue almost regardless. The difficulty in identifying which EDT is more likely to 'suffer' is complicated by the wide-ranging types of out of hours provision to which we now turn.

1.5 Models of EDT.

There is a variety of differing models of EDT service provision being used in different parts of the country. The models could be placed on a continuum that ranges from a full-time, office based out of hours service staffed by out of hours workers at one end, to large rota systems staffed by daytime social workers with a period of shut down, at the other end, (see diagram 1 below). The models however, are complicated by the numerous variables that exist within each of them. Put simply, there does not appear to be one 'pure' model of EDT that, whilst it may have variations, derivatives and adaptations, is essentially the same in all EDT's. It is almost the case that for every out of hours service, there is a unique EDT model. There are common elements within some of the EDT models that can be highlighted. The diagram below attempts to draw together some of the commonalities of these models rather than present them as absolutes.

Diagram 1: Continuum of EDT Models

Full-time service Out of hours workers	*Dedicated team backed up by daytime workers*	*Full-time dedicated co-ordinator with dedicated staff*	*Co-ordinator with 'on call' social work staff*	*Rota system Daytime workers*

Office based	*Home Based*

All hours 'out of hours' covered	*Some hours not covered*

Team working/joint visits	*Lone working/solo visits*

Extension of daytime service ·	*Emergencies only*

Full-time service out of hours workers

In this model, there is a dedicated full-time team that has 2 or more workers on duty. There is no 'relief pool' of daytime workers to cover absences and the EDT Team is self-sufficient.

Dedicated team backed up by daytime workers

This model has an out of hours team dedicated to covering the nights and weekends, but is also reliant on daytime social workers covering absences of the team (sickness/leave).

Full-time dedicated co-ordinator with dedicated staff

This type of EDT provision has one full-time worker that takes all the calls and never leaves the office during each shift. The co-ordinator allocates the referrals to the out of hours social workers who visit as required.

Co-ordinator with 'on call' social work staff

The EDT co-ordinator who may also have daytime responsibilities, processes all calls and contacts daytime social workers on 'stand by rota' at home to undertake any necessary work.

Rota system daytime workers

This model has no dedicated out of hours team and depends entirely on a pool of daytime workers being rostered to cover certain shifts at night and at the weekends.

Office base - Home based

Each of the above models may vary according to the base from which the service is delivered.

Some of the out of hours services are always provided from an office to which the public and other agencies have direct access, (by phone or by calling in). Other models are entirely run from home with only indirect access to the social worker via a paging service, the police, a Call Centre or some other 'filter'.

All hours out of hours covered - Some hours not covered

Another variable in discussion regarding the different EDT models is the amount of hours that the service provides and whether or not there are periods, for example 4-8 a.m., when there is no EDT service at all.

Team working/Joint visits - Lone working/Solo visits

Another variable is whether the out of hours service is staffed by a team that can take all the calls, arrange joint home visits whilst all calls will be answered by another worker or, if there is only ever one worker on duty to take all the calls and undertake any necessary visits.

Extension of daytime service - Emergencies only

One final variable, that may have a fundamental bearing on the nature of the EDT response, is the way in which the organisation and the individual EDT workers view the role of the out of hours team's work. Is it to provide a seamless extension of the daytime services, or is it to respond only to emergencies that cannot wait until the next daytime working day?

Even with the above grouping of commonalities other variations in practice may impact upon the actual EDT response to such as *Mr A.* (see above): The use of private agencies, volunteer groups, availability of alternative resources such as respite centres, emergency foster carers or support workers that can move into a home situation, whether EDT has responsibility for homeless people out of hours, and locally agreed protocols with colleagues in health plus many other potential variables all contribute to a complex set of EDT models.

One hypothesis examined in this research therefore, is that EDTs are different in each local authority throughout the country. It will be shown later (see Chapter 7) that some EDTs have 2 workers on duty, but only one undertakes home visits whilst the other takes the phone calls. Another model would have at least 3 staff on to ensure that all visits were carried out by 2 social workers. A different model saw one social worker on duty who took

all the calls either directly by phone or, if called out to do a lone visit, then via a pager or other filter system. In this model all visits will only ever had one social worker present. The decision- making processes and the access to colleagues or managers for consultation also varied considerably between the models and is examined in some detail for both Phases of the research (Chapter 6 and 7)

It is possible that EDT's resemble other emergency services out of hours. In a review, carried out in the 1980's (Katschnig et al, 1983) of 32 psychiatric emergency and crisis intervention services in 19 European countries, some patterns were detectable but no two services closely resembled each other. As with the origins of EDT (see above), Katschnig found that most of the emergency psychiatric services had been created out of local initiatives because of dissatisfaction with existing emergency provision. As with social services, no systematic attempts had been made to provide good psychiatric emergency care on a nation-wide basis. Phelan et al (1995) suggest that, for emergency out of hours psychiatric services, 'There can never be a universal model to apply everywhere.' (p.340).

As suggested earlier, it is not surprising to discover that throughout the country there are different payment systems for those working out of hours. Some EDT workers are classed as Team Managers, others as Senior Practitioners and others as basic grade social workers, all of which is reflected in the salaries. There are differences in the payments for the unsociable hours worked by EDT ranging from an additional 30% on top of the salary through to 15% through to no 'bonus' payments at all. Fixed fees, allowances, enhanced rates, retainer fees and additional payments all feature in various EDT workers payments depending on who the employer is.

It certainly appears to be a truism that the only consistency about EDT is its inconsistency. Such inconsistencies may go some way to explain the variations in service provision and EDT workers' responses to certain types of referrals. The diverse nature of the models of

EDT though do not account for the differing, even contradictory responses that EDT workers make to the same referral. In other words, this research suggests that EDT workers from the same local authority, from the same EDT team, even on the same shift (where there is more than one worker at a time), when faced with a number of referrals simultaneously will assess, prioritise and respond differently irrespective of the EDT model. This hypothesis and others that form the basis of this study are now described. The findings of the research are presented as a response to each of these hypotheses in the Final Chapter

1.6 Outline of the Research Problem and Hypotheses.

There are a number of questions and accompanying hypotheses that underpin this research. These are illustrated below in brief and a more detailed discussion of these issues is in Chapter 4.

> i] *Are there any patterns in 'out of hours' social work in terms of the 'types' of referrals which are made?*

It is the belief of the author that there are 'peaks and troughs' in the duties of an EDT worker. This research seeks to establish what factors (such as the time of the year, day of the week, time of night) if any, impact upon social work out of hours.

> ii] *Is there any consistency in the way in which individual EDT workers assess, prioritise and respond to those referrals?*

There is an argument that suggests that the nature of the EDT response to any referral may well reflect the specific individual on duty, rather than any agreed departmental priorities or procedures. It is the contention of this author that autobiographical and practical issues have as much, if not more, influence on EDT work than statutory duties and responsibilities and, therefore there can seldom be any consistency in the way individual EDT workers assess, prioritise and respond to referrals.

> iii] *Is there any theoretical framework that might assist EDT workers in achieving consistency in relation to the referrals they receive?*

The author's hypothesis here is that EDT workers do not consciously operate within any theoretical framework that might serve to produce some degree of consistency (thus further compounding the situation in ii above), but that one might exist that can usefully be applied by the out of hours social workers.

> iv] *(How) can social work practice 'out of hours' generally and the researcher's own practice specifically, be more effective?*

There is much evidence to support the view that out of hours social work could be improved throughout the country. It is also suggested that the author's own social work practice might improve because of undertaking this research. Both aspects to this question are examined in some detail within this work.

The general aims of this research therefore, are to explore the nature of social work 'out of hours' and to examine what factors impact upon the provision of this social work service when the daytime offices are all closed.

CHAPTER 2.

OUT OF SIGHT OUT OF MIND

LITERATURE REVIEW.

Chapter One sought to explain the origins and development of social work generally and EDT specifically. It introduced some references to the autobiographical diary as well as set out the main objectives of this research and introduced the methods by which the various aspects of EDT were examined. Having established some of the positives and negatives associated with working for an out of hours 'team', and having outlined some of the various models from around the country, attention is now turned to literature already produced regarding EDT and related social work issues.

2.1 Introduction

An internet search for the term *'Emergency Duty Team'* provides scarce data. Using a range of search systems, such as the general search engines of Microsoft Explorer and AOL , the University's BIDS and LION systems, the Department of Health's website (www.doh.gov.uk), social work journal websites (www.communitycare.co.uk, www.careandhealth.com and www.bjsw.oupjournals.org), CD Roms such as Caredata as well as several 'standard' social work text books (for example Davies, 1997 and Coulshed, 1992) the results remained scarce. This was also true when the search was for such keywords as 'EDT', 'Out of Hours social work' or 'stand-by social work'. The references that do exist produce very brief, somewhat descriptive 'A Day In The Life'-type information rather than analytical journal articles. This contrasts with the thousands of

references that appear if the literature search is for *'social work'*. What was noticeable when seeking data on out of hours social work was that there was almost a complete absence of references from 1978-1999, but then an increase in the number of articles that appeared in the social work press around the time the SSI Report was undertaken and published, (see SSI below), but very little would appear to have been produced since early 2000. This chapter presents and analyses some of the literature that exists that may have specific or general relevance to EDT

There is potential conflict between the level (lack) of research and the nature of 'out of hours' social work practice. O'Hagan refers to how exposed EDT workers can be to *'criticisms of entirely inadequate social work responses to significant occurrences out of hours..'* He suggests that these occurred in *'numerous child abuse scandals, the most notorious of which was Maria Colwell'* (1986 p.10). This conflict is further illustrated in the Cleveland Report (DoH.1987) which reports that of the 125 children who were *diagnosed* as having been sexually abused, 49 Place of Safety Orders were taken by the EDT (p.66, Para.4.95). EDT in Cleveland at the time of this 'scandal' consisted of four full-time and two part-time workers being deployed so that there were two social workers on duty part of the time and one on duty overnight. At the weekends two social workers were on duty during the day, whilst during the remainder of the weekend, only one worker was available. During this period one social worker for Cleveland EDT was responsible for providing an out of hours social work service to a population of approximately 600,000 (P.66, Para.4.95.). The report also states that, *'The arrangements for their professional support to deal with complex cases appeared somewhat haphazard...'*(Para.4.96.). The report (DoH 1992) and publications relating to the events in Orkney in 1991 (Black, 1992) indicate further 'significant occurrences' out of hours by social work practitioners during, what became titled by the media as, the so-called 'Dawn raids' (which did in fact take place at 7 a.m.).

Despite the potential crucial role of EDT in such circumstances as indicated above, and in more detail below, (see 2.7ff) there is still a dearth of relevant and systematic literature relating to the nature and quantity of EDT social work outside normal office hours. The literature that exists is written with a 'daytime mentality' that believed social work services operate only between 9 am and 5 pm. In the main such literature is descriptive, has a narrow focus and is noted for its brevity in contrast to the vast amount of research and literature available for the daytime counterparts. There are however, two exceptions to this: Out of Hours Social Work (BASW 1984) and 'Open All Hours?' (Social Services Inspection, 1999) which I will now consider in turn:

2.2 BASW. (British Association of Social Workers)

The context to the BASW publication is of interest in that it explores EDT as a 'new development' that has had a *profound influence on the types of service offered to clients between the hours of 5.30 pm and 9.00am.*' (Etherington and Parker 1984, p.2). The report was very much written to consider issues around the growth in the numbers and types of out of hours teams. The project team also set themselves the following aims (pp2-3):

(i) *Examining referral patterns and whether they correlate to the 'type' of team provided,*

(ii) *Comparing the development of EDT's to that of daytime Intake teams,*

(iii) *Considering the way staff are deployed, the relative costs of teams and their make up, and*

(iv) *Analysing professional matters such as 'the reasons for staff becoming night duty officers, the training which they receive, their supervision and their management.*

The 50 page report relies substantially on two main research sources: Unpublished papers and individual Local Authorities' own in-house reports on the creation and development of their own out of hours social work service.

Unpublished papers referenced are, for example, by the Association of Directors of Social Services (Report of a survey conducted on stand-by duty teams, 1978), or BASW's own project team's work, 'Study Day on Out of Hours Provision.'(Unpublished paper 1979).

Local Authority examples relied upon by BASW include such as Hampshire County Council's 'An Evaluation of Stand-by Duty' (Bruner and Ward, 1976), the same Association produced a 'Report of the First Six Months Operation' that BASW refers to (BASW 1980). Strathclyde, Bradford, Tower Hamlets and South Glamorgan are the other 'in-house reports that the 1984 report relies upon for its own literature search. There are few other literary sources cited in the report's bibliography.

Notwithstanding the historical and contextual limitations of this report, it does give this author a clearly defined 'benchmark', against which, more contemporary EDT research can be compared. It should also be noted that much within the BASW report remains pertinent today generally, and to my own research specifically:

'The out of hours officers have very little access to training opportunities, a factor which increased their isolation... '(p. 16) 'Similarly, the level of supervision is low and not of the type which would facilitate discussion of casework techniques.' (p. 16).

'The idea of emergency is central both to our study and in the minds of out of hours officers.'(p. 16).

The report indicates two working definitions of an emergency – organisational and personal. The personal definition is explained as being 'difficult to qualify' and as being affected by the bombardment rate (of referrals) and the varying levels of anxiety felt by the out of hours worker. This aspect of the 1984 report is one that I have tried to develop in much greater depth in my own research but is summarised in the following:

'Social workers are able to redefine referrals to enable them to respond at a variable rate.' (p. 21, BASW 1984).

I was particularly interested to note that the BASW report found that in 1979 several out of hours workers were conducting post graduate studies to PhD and MA level, but of equal note was its comment that 'This motivation appears to have declined.' (p. 32).

The BASW report concludes with 13 recommendations but attention is drawn to the following 3:

'Consideration needs to be given to the distinctive supervision needs of out of hours workers...' (Recommendation 6, Section 1)

'There should be an advanced post-qualification course established for the development of crisis skills in night and weekend settings...' (Recommendation 1, Section 2)

'A consideration of the range of different models of out of hours service.' (Recommendation a, Section 3).

This author seeks to address some of the gaps and the recommendations identified in the 1984 report and develop aspects of out of hours work not mentioned in BASW's study. Before this however, it is appropriate to briefly examine the only other relatively detailed source of EDT information, namely The 1999 Social Services Inspectorate's (SSI) report.

2.3 SSI. (Social Services Inspectorate)

Tuesday 2nd November, 1999.

'I attend the North West EDT Annual Conference at which the author of the SSI Report 'Open All Hours' into the out of hours social work service, presents his findings. I am staggered by the shallowness of the methodology, the paucity of the sample group, the sweeping generalisations that underpin the 'Key Messages' and the 'cheek' that the findings of such a small scale piece of work can be extrapolated and presented as applying and having validity across the country. There is very much a feeling at the conference that we have enjoyed being 'in the shadows' for so long, and concern that this government report might be selectively quoted to bring EDTs into the daylight and thus, in line with our daytime counterparts.'

(Autobiographical Diary)

'Open All Hours?' Inspection of Local Authority Social Services emergency Out of Hours arrangements, was first published in 1999 and so some of the contextual limitations of the BASW study of 1984 (see 2.2 above) cannot easily be levelled at this report. I would contest though, that the context is equally as important in order to make sense of its content and the areas of EDT that I have chosen to develop. The Social Services Inspectorate (SSI) is part of the Social Care Group in the Department of Health. SSI assists Ministers in carrying out their responsibilities for personal social services and exercises statutory powers on behalf of the Secretary of State for Health.

The first point to make is that the question mark in the title 'Open All Hours?' indicates the perspective that the Inspectors took when looking at the service. The Inspection's remit was consistent with the government's apparent intention for public services to pay more attention to out of hours provision. To justify this perspective, the author, Rourke, cites 'Modernising Social Services' (DoH1998a), and 'Modernising Government' (DoH1999d)

and quotes from each respectively suggesting that the first reminded Social Services Departments of the need to 'provide reliable and sufficient emergency out of hours services', whilst the second 'urges flexibility in providing both information and services.' The question mark in the title therefore, illustrates that part of the remit of the inspection team was to establish whether 'out of hours' services were 'open all hours', and how accessible, efficient and effective they were. Whilst the inspection focussed on EDT as the principal service provider (1.6) it also looked at the strategic thinking and the extent to which departments had, or were developing, a comprehensive policy that took account of all services out of hours, not just EDT (1.7).

The team inspected in detail 8 Local Authorities (logging referrals in each one over an 8 day period), they also surveyed 24 Local Authorities about the organisation and scope of their services. Interviews were held with Directors of SSD's, key managers and EDT staff, postal surveys were sent out to service users, some of the 20 service users chosen for closer scrutiny were followed up with phone interviews. The inspectors also spent time with EDT staff on duty.

It was not the intention of the Inspection to make recommendations, but to produce *Key Messages for Practitioners and Managers*, with many examples of good practice.

The key themes of the inspection therefore would appear to be 'accessibility', 'efficiency' and 'effectiveness'. These would certainly fit with the functions of the governmental inspectorate as they appear in the inside cover of the report (DoH 1999a):

- To provide professional advice to Ministers and central government departments on all matters relating to the personal social services;

- To assist local government, voluntary organisations and private agencies in the planning and delivery of effective and efficient social care services;

- To run a national programme of inspection, evaluating the quality of services experienced by users and carers; and

- To monitor the implementation of Government policy for the personal social services.

On the matter of costs, the report identified that EDT budgets were relatively modest compared to the daytime mainstream and suggested that EDT's *'appeared to provide good value'* (6.18). It did go on to state that further analysis of activity and 'outputs' suggests that *'better value could be achieved'* (6.19). This was supported by the 'evidence' of the referral rates from the 8-day period covered by the inspection, from which the conclusion drawn was:

'...few EDT's were under pressure, during the time of the inspection. At times demand was very low.' (6.20).

In addition to this, the report then identifies that 'most EDT work was done over the phone, and most referrals were dealt with speedily' with only 14% of referrals involving a visit, (6.21).

Whilst it is not the intention of my research to duplicate the work carried out by the SSI, there are several aspects of the report that I would seek to explore further and question:

(a) The size and nature of the research - Eight local authority EDT's were inspected over an eight day (or night) period. Whilst this was the first time such a detailed examination of EDT had ever been carried out, it is my contention that such a short study period can only provide a snapshot of what EDT was like during that one week, in those few teams. It would be misleading, as with other uses of sampling, to extrapolate the findings from such a survey and apply them to the rest of the country without validating such data over a longer period and for more teams. This

is particularly applicable to models of EDT as, it is argued in this research, there are more differences than similarities between the models of EDT.

(b) The remit of the Inspection Team - accessibility, efficiency and effectiveness are the stated aims of this government department's inspection. Given that the central government drive is to make social services departments more accessible, more efficient and more effective, it is possible to see how this inspection's agenda focused attention towards value for money rather than quality of social work practice.

(c) The confusion between referrals received and work carried out after midnight - The report states that referrals to EDT dropped 'dramatically' after midnight (page 29), but the report ignored first, the fact that even by its own statistics, after 2 am the referral rate rose again, and secondly that by concentrating solely on the referrals, no account was made of the amount of work undertaken after midnight. In other words, referral numbers before and after midnight do not demonstrate the amount or type of work undertaken during those times. For example, some referrals often come in before midnight but are not responded to until much later, sometimes because the EDT worker knows the intervention will take hours. By merely recording the referral numbers, no recognition is given to the length of time some referrals may take. The 14% of referrals that required a visit (page 31) were not recorded for the amount of time to resolve, only that few referrals ended up with a visit.

(d) The fact that this report does not claim to be research - When presenting the findings of his report to two separate gatherings (ESSA Conference[1] and NWEDT[2] Conference in 2000 and 1999 respectively), Rourke very specifically pointed out that this report did not claim to be 'research', but an inspection. Rourke acknowledged that there were several methodological and procedural weaknesses in this survey if analysed as research. Although, in my view, many authorities have interpreted this report as a sound piece of systematic study, the authors did not intend this, and the preference should be to read it in its context of governmental policies and objectives.

In my research I have tried to develop some of the key messages of the SSI report but also have sought to examine aspects of EDT that the SSI do not explore at all. For example, the report states that the core skills for out of hours work are *probably unique in social services. Staff need the ability to assess and manage risk, often alone, with limited access to management support.*' (6.29). The report though does not provide any indication of what these core skills are other than, in the summary of key messages at the end of the chapter, encouraging Local authorities that:

'Better attention to training for EDT staff is needed. This should be based on the core skills needed for providing out of hours services.'(6.49).

Similarly, the report states that 'assessing need, and risk, and then responding with services to support service users are core EDT tasks', but does not provide any indication as to how best these core tasks can be met. The report criticises the quality of the assessments as being 'patchy', pointing out that, *'More often than not, it was difficult to evaluate the*

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[1] Emergency Social Services Association (ESSA) is a national body (established in 1998) that seeks to support and represent EDT's from throughout the country.

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quality of assessments, and how they informed the worker's response' (7.3). Predictably, given the report's function, a key message (7.26) within the report concerns the need to establish standards for the scope and range of out of hour's assessments.

It is interesting to note that the recommendations of the BASW research in 1984 are very similar to the 'points of good practice' that the SSI produced in 1999. Both BASW and SSI highlight the need for specialist supervision. Both reports describe the requisite skills base that needs to be met for EDT workers and both are concerned regarding the need for comprehensive health and safety procedures, *'that reflect the isolation and potential risk out of hours'* (DoH 1999a page 35). The 15-year gap between the publication of these two pieces of work and their common identification suggests, as does this research study, that little has changed for EDTs specifically, despite major changes in social work generally. (This current research developed some of the areas identified in both studies but from the perspective of a practitioner and an academic simultaneously).

2.4 Paucity of Research.

Other than BASW and the SSI referred to above, the only other research undertaken into EDT *recently* was initiated and carried out by EDT workers themselves. One example of this was a study undertaken in the North West of England by a group of EDT workers who had formed their own training group (see NWEDT above, page 24). This research in 1992 consisted of a questionnaire being sent out to the EDT workers in the then 18 North West Local Authorities (one questionnaire per 'team'). The 14 responses received were quantitative in nature seeking to establish such matters as numbers of staff on duty at any one time, access to information and services out of hours, and whether written policies

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[2] North West Emergency Duty Team Training Consortium is a regional body established to offer training opportunities to EDT's in the North West of England. This consortium is referenced in the SSI report as an example of good practice (DoH 1999a, page 33).

existed for certain circumstances. Indeed, the questionnaire acknowledged its own weaknesses:

'As stated in the preamble, the intention of the original study day was to pool information in the hope of sharing ideas of good practice and looking to see if these could be translated from authority to authority. The responses to the questionnaire are disappointing in this respect. However, this may be attributable to poor questionnaire design rather than the substance of the work being carried out.'
(North West EDT, p16, 1992).

Alan Skelt produced a two and a half page article for a social work journal in 1988 (Social Services Insight 6/12/88, pp.18-20) which indicated the need for specific training to be established for Emergency Duty Teams throughout the country as, he argued, the nature of the work out of hours is different, although he did not go into detail. Alan Skelt appears again in the literature search, with reference to a single page article he co-produced with Carol Clark for the journal Social Work Today (28/5/92) Again, it is argued, that specific training needs to be provided for EDT staff that are, 'the last bastion of genericism in social work'. As explained above, the generic nature of EDT work is in contrast to the specialisation that has taken place with daytime social workers. Whilst the article from Social Work Today briefly indicates the gaps in the training provision for EDT staff, it concentrates more on promoting the North West EDT Training Consortium as a positive model of EDT training. This had been established to meet the perceived EDT gaps in knowledge and indeed, the author of this research has attended many of the sessions provided by the consortium and is a member of the planning committee that arranges the training.

The same two authors produced a very similar article (in both length and content) for the Journal of Training and Development (Jan. 1993). An article followed this by Skelt alone

that was even briefer and described a 'typical' night in the life of an EDT officer in one particular Local Authority. Its intentions were not analytical, but were to give other practitioners a description of what type of work occurs during the night.

Similar in content is the article by Smith and England that attempts to describe a thirty-hour period over a busy weekend on EDT in the County of Buckinghamshire. Within this, there is limited analysis of some of the issues which typically face these EDT workers and some interesting comments conclude it:

'The work of those providing responses to Social Services crises arising out of normal office hours may receive relatively little attention in the Social Work literature but some kind of cover is needed 365 nights of the year. For those involved in attempting to provide an appropriate response to requests for services the work can be considerable, daunting, challenging, overwhelming, exhilarating and, at times all of these at once.'(Kay and Jeffrey, p.28, 1990).

Already therefore, it can be seen that of the 16 references discussed so far, the same author has written four entirely or in part. The nature of Skelt's contributions to EDT research is further contextualised when his employment as an independent social work consultant is highlighted, as it could be argued, that he has a clear vested interest in promoting the need for specific EDT training.

Further analysis of the literature available that examines EDT results in the same conclusion, namely that there is insufficient research concerning the work of Emergency Duty Teams. Excluding the BASW (Etherington and Parker, 1984), SSI (DoH 1999a), and the Cleveland (DoH 1987) reports referred to above, there are few references remaining. Of those that remain, the majority is in the form of articles written for social work magazines (see, for example, Social Work Today 17/5/90, Social Services Insight 28/2/89 and Community Care 1/11/90)

All that remains of the references are an explanation of the existence of Emergency Duty Teams as part of the wide- ranging services provided by Social Services (Broad & Fletcher, 1993); a description of the way in which a Scottish Local Authority provides its out of hours service (Lativy, 1980); and the briefest of mentions in a CCETSW Training Handbook which examines how researchers within social work should capitalise on their experience; within the groups of workers referred to are EDT officers. The only other pieces of 'research' with reference to EDT's, other than those indicated above, are very brief contributions to journals written by prominent members of the recently formed Emergency Social Services Association (ESSA) referred to above. Further literature searches were carried out using a variety of 'key' words such as 'out of hours', 'Stand By', Emergency Duty' and 'EDT' but no other references were forthcoming. It is against this backdrop of such a vacuum of relevant U.K. research and information that this research is undertaken in an attempt to up-date what little already exists regarding the practice of out of hours social work.

This study will examine the concepts of 'crises', and 'risk' and emergency duty team workers responses to them, as well as critically and systematically analysing the 'types' and rates of referrals and the associated feelings, which EDT encounter. In order to address such specific EDT matters appropriately it is necessary to review literature which, whilst not specifically intended for out of hours social work purposes, has an application to both day and night time social work practice and from which EDT workers may benefit. In other words, since there is such a dearth of material specific to the nature of EDT, it is necessary to explore what might be relevant from the more general texts and assess its applicability to out of hours work. It is <u>not</u> claimed here that EDT is the only social work that has to deal with crises or risks, only that the organisational, procedural, professional and personal circumstances of EDT work makes the responses different to those that occur during the day.

2.5 LESSONS FROM THE DAY FOR THE NIGHT.

2.5a Literature That May Have General Relevance to EDT.

Within social work generally there is a wealth of knowledge that is required irrespective of the specialism or service user group. Social workers are expected to have knowledge of legislation, policies and procedures as well as sociological and psychological theories. An understanding of social policy and the role of the department is also expected of the 'average' social worker who will need to operate within the budgetary constraints set by the employer, local and central government.

It could, therefore be argued that all the social work texts relating to these matters will have some relevance to the work of the EDT social worker. Part of the difficulty with the literature written for practising social workers is that the focus generally assumes that the worker will have more than one contact with the 'service user', and will have time to establish a working relationship and some degree of rapport; furthermore, the literature also assumes that the visiting social worker (to the service user's house) will only be dealing with one matter at a time, and will not be frequently being asked to urgently attend elsewhere, (as happens out of hours).Essentially then, the social work texts produced so far operate on a 'casework'-type relationship that has a social worker with a certain number and type of 'cases' on his/her caseload that is their 'responsibility', (for example see Coulshed, (1992) Davies, 1985: Dominelli,1988: Everitt, & Hardiker, (1996) and Payne, 1991). Even in one of the very few textbooks that specifically examines the nature of EDT work (O'Hagan, 1986) the material focuses on two aspects of EDT: The worker's motivation for doing out of hours work and the (lack of) training in effective crisis work. O'Hagan makes the same assumptions as the other social work texts that practice within the profession is based on sustained commitment: '...crisis intervention often necessitates a selfless and sustained commitment to clients...'(p11). Whilst this is a laudable aim within social work practice per se, it has very limited application to the work of EDT who need

only to retain such commitment for the length of that shift and who do not carry a caseload, rarely see the same 'client' twice, do not carry statutory responsibility for the 'case', and do not undertake any follow up work, even if they have, as O'Hagan puts it, succumbed to the 'Plea for removal'. The case examples that are presented by O'Hagan are also underpinned by a type of daytime mentality that anticipates regularity of contact, the ability to spend significantly long periods with the service users, and the absence of other priorities arising whilst in the middle of interviewing 'clients'. It is ironic that the specific example that O'Hagan (Chapter 7) chooses to illustrate effective responses to a 'crisis' is one which most EDT workers might not have visited at all, (for evidence of this see the 'scenario statistics' in Chapters 6 and 7).

Notwithstanding the 'daytime mentality' of some social work texts mentioned above, it can be argued that there is much for the EDT worker to gain from having a knowledge of aspects of social work practice such as crisis intervention, risk assessment, communication and decision-making skills, all of which are addressed within a variety of 'daytime' textbooks.

2.5b EDT's Skills Toolbox.

Sunday, 1940hrs. 13th December 1998.

'86 year old woman, Mrs R. keeps leaving the gas on her fire, she is described as wandering, hoarding food (9 month old 'meals on wheels' food in the oven), not eating at all. The 2 Community Psychiatric Nurses, the GP and the niece have all requested she be moved. I visit and turn off the gas, provide alternative electric heaters, plus some electricity cards to ensure sufficient funds exist, increase the care package but not to the 24 hour level demanded by the medics and the relative. I make the decision that the situation is now safe enough to be left to the following

working day and less traumatic to Mrs R. than moving her out of her own home, but am aware of the inherent dilemmas of this practice.' (Autobiographical Diary)

The nature of EDT work is very brief, usually consisting of only one contact and mainly when there is the threat of 'removal' of someone, whether that is a child or an adult. If the service user or care providers are not already in some form of 'crisis' then it is quite possible that the arrival of the EDT worker may well create one for them. All such scenarios, like that of *Mrs R.* above and *Mr. A* (see above) demand a range of skills of the EDT worker. Trevithick (2000) describes 50 skills she believes are commonly used in social work, but she highlights the central importance that communication and interviewing skills play within social work practice stating:

'I do not believe that it is possible to be an effective practitioner without being an effective communicator' (page 3, Trevithick 2000).

Trevithick's 50 skills are collated into 8 categories by Boswell (in Davies, 1997) that are as follows:

1. Communication
2. Assessment
3. Intervention
4. Understanding of agency function
5. Workload management
6. Professional relationships
7. Record/letter/report writing
8. Use of supervision.

Whilst it is not within the remit of this study to explore all of the data relating to each of the abovementioned categories, it is consistent with the objectives of this research to develop those that have particular relevance to the night-time social worker. This does not mean that those not discussed below have no application to the EDT worker, but, for the purpose of this study, I have concentrated on the skills that are more likely to be required and, to date have received less attention from an EDT perspective.

Sunday 2000 hrs 7ᵗʰ September, 1997.

'Major conflict with the police regarding an eight year old victim of sexual abuse. The police want an EPO, PPO, but I refuse the former and argue against the latter suggesting that if they did take a PPO, I would place the child back at home (the alleged perpetrator was known to but not living with the family and I felt we would simply be punishing the victim further by removing them from home. Have we learned nothing from the events in Cleveland?).

Autobiographically, I wonder how I managed to resist 4 senior police officers even when I was accused of various things including 'putting the child at risk' and 'creating a farce'. Part arrogance on my part, part believing what I was arguing for what right, part a detailed knowledge of the child protection procedures and also part because I detest being instructed to do anything, I stood firm. No PPO or EPO was taken. ' (Autobiographical Diary).

Much has been written about the necessary skills of a competent social worker including those eight categories identified above, but it is the skills of risk assessment, decision-making and 'keeping a cool head whilst all around is boiling' as well as knowing your own personal strengths and weaknesses, that I believe are the absolutes of an EDT worker and are not referred to in the comprehensive list to detailed above. It is to these specific EDT

skills we now turn our attention exploring some of the literature written for the majority (daytime social workers).

Coulshed,(1992) rightly differentiates between a 'crisis' and an 'emergency'. The differences between being 'in crisis' and being 'under stress' are also examined and it is acknowledged that there is a range of differing interpretations as to what constitutes 'crisis intervention'. The interesting point that Coulshed makes is that recognising and working with crises, does not necessarily entail a sort of 'blue lights flashing' emergency response. The point is well made that a crisis is part of a process that individuals or groups go through during most of their lives, and the skill on the part of the worker is recognising whether the event is a crisis for that person, or group, or merely a reflection of the panic on the part of the worker.

The accepted definition of a 'crisis' is 'an upset in a steady state' (the 'homeostasis' or 'equilibrium'), (Rapaport, 1971). The manner in which 'normal' coping strategies fail to address the crisis could apply to the service user and to the EDT worker simultaneously. It is important therefore, that the EDT worker is able to provide the 'immediate, calm support' in a clear-headed fashion that Coulshed (1992, p.40) suggests is required. No guidance though is to be found that explains how to maintain this calm and clear-headedness.

The EDT worker may be statutorily required to assess people who, it is suggested, are no longer able to employ their normal strategies for dealing with such as depression, or the hearing of voices. It is possible that the EDT worker can enable the service user to rediscover their coping mechanisms, and re-establish the homeostasis by exploring 'corrective' problem-solving strategies, and possibly avoid the need for compulsory detention under the Mental Health Act 1983.

Caplan suggests that whilst the signs of someone 'in crisis' might be difficult to detect, there are some 'typical paths' or 'phases' that should inform the crisis interventionist's

approach. Within these phases there are peaks and troughs of the person's ability to help themselves, as well as highs and lows in their willingness to be 'helped'.

Caplan's (1964) four phases of a crisis have applicability to EDT particularly relating to mental health assessments. Caplan outlines the nature of the tension that arises in a crisis:

1. The intial rise in tension caused by the problem stimulus.

2. An increase in tension because the problem has not been solved

3. A further increase compelling the individual to do everything in their power to solve the problem: novel methods of attack; redefining; perceiving hitherto neglected aspects of the problem; giving up trying to solve the whole problem.

4. If the problem continues and can neither be solved with need satisfaction or perceptual distortion, the tension mounts beyond a further threshold or its burden increases over time, to a breaking point; major disorganisation of the individual with drastic results then occurs.

In order for the lone EDT worker to avoid what O'Hagan (1986) calls the 'Plea for removal', s/he needs to recognise crises as a process rather than an incident and seek to redress that series of events that have led to a disruption in the usual functioning. In this way, Payne (1991) argues that crisis intervention is not necessarily concerned with reacting to events, but should be involved in preventing a breakdown in coping strategies should those events occur. Such preparatory, preventive work however, is not the remit of a standard EDT worker that will be involved in only being able to respond to the crises of people who have self referred or been referred for whom the breakdown of the usual coping strategies has broken down. In other words, by the time the details get to EDT, the usual coping strategies have already failed.

With reference to Lindermann's (1944) early paper dealing with the grief reactions in various groups of 'patients', Payne (1991) cites the emergency of the 'Boston Cocoanut

Grove' fire in which the ways people cope with bereavement were explored. The conclusion was that people manage better if they have experienced crises previously in their lives, less well if past problems had not been fully resolved. It is important therefore, for the EDT worker to resist the easier option of 'removal', and to have the confidence, and no little 'courage', to work with the crisis and allow the energy such events bring with them to be channelled positively towards rediscovering formerly held coping mechanisms. When faced with several family members, a G.P. and a psychiatrist who are all clamouring for the removal of the relative with the mental illness, it is imperative that the EDT worker does not compound the situation by denying the individual the opportunity to examine the nature of the crisis. Indeed, the 'upset in the equilibrium' may be on the part of all except that person labelled with the mental illness. It is a 'brave' EDT worker who resists the pressure to collude with the demands of the other professionals and family members.

It is possible then, that the research into crisis intervention has some applicability to the work undertaken 'out of hours'. There are, however limitations to its relevance: Golan (1978) offers an articulated account of crisis intervention theory believed by some (Payne, 1991) to be 'one of the best' (p.101), but her model of treatment assumes between 7 and 8 interviews with the person/s in crisis. According to Golan's model, EDT could, at best, achieve a focus on the crisis state, and would not therefore be able to see the crisis process through as the EDT worker rarely sees the same service user more than once.

Part of the crisis for the EDT worker will be attempting to balance, amongst other things, the rights of the individual to autonomy, self-determination, and the scope to take risks on the one hand, against the personal and professional desire to minimise risk and meet the needs of the carers directly affected by the 'crisis'. Particularly within the field of mental health, there is the added 'risk' of the individual worker being sued should a complaint be made about their practice.

A significant amount of the work undertaken by EDT relates to gathering the relevant information upon which to decide what, if any course of action is required. The nature of

the referrals that come the way of the EDT worker means that often there is an element of 'risk' involved. The nature of 'risk' and its assessment is now discussed in relation to out of office hour's social work.

2.6 Risk Assessment.

Friday 2ⁿᵈ May 1930 hours, 1997

'Cot death referral. I can feel my heart beat increasing. The baby aged 18 months was found by the parents. I am unsure of the procedures, I fear high profile coverage and am 'glad' on hearing the words 'no suspicious circumstances' then guilty for feeling the same in contrast to the poor parents. I remember ages ago reading the procedure and finally dig it out. My pulse increases again to find that the baby was 'known to the department' and an open case, but relieved to discover there were no child protection concerns. What an emotional roller coaster ride this job can be sometimes? Do we get de-sensitised to such tragedies, tending to put our own self-preservation before the tragedy of a child dying? Is this the inevitable culmination of a society that wants to 'risk manage' rather than allow 'risk-taking' and seeks to blame rather than understand?' (Autobiographical Diary)

For all social workers, the concept of risk is central to their practice. Difficulties exist because the term is used to refer to a range of different aspects of social work and because the term is not a static one that retains its meaning necessarily through time. The situation is further complicated because the context of 'risk' and 'risk assessment' in social welfare have been driven in conflicting directions and there remains a balance between a 'risk taking' culture and that of 'risk management'. The very nature of 'risk' entails elements of the unknown, improbabilities and uncertainty and, sadly in my view, has become

associated only with negative outcomes rather than the positive outcomes and opportunities that used to be associated with risk taking (with its origins in gambling). 'Risk assessment' therefore has become associated with the collation of information upon which decisions about 'dangerousness' can be made. In other words the focus is upon the potential for 'harm' existing, and there is an absence of examining what benefits and positives may also exist. In social work with people as they are located in their local and broader contexts, risk assessment is not an exact science because it deals with the uncertainties and imponderables that life entails. For the EDT worker, risk assessment involves a systematic collection of information that will enable the worker to establish what, if any risks are involved, how these risks may compare to others that have been referred that shift, and whether the risk is such that it cannot safely be left until the next working day. Put simply the notion of risk for the out of hours workers has to be contextualised by reference to such relativities as 'harm', 'safety' and 'danger' as well as such absolutes as the time of night, and how many other referrals have come through on that shift. It is not surprising that the risk assessment models and guidance that have been created to assist professionals in the decision-making process can only ever claim to be a supplement to sound professional judgement and thus, in some respects, fail to achieve what it might be believed they seek to represent, namely some form of 'objectifiable riskometer'. Calder (1997; 2000; 2001) suggests that 'the term' risk assessment' can refer to both a structured form of decision making and specific instruments or frameworks that are used in the process' (Calder.2002 p.8). One interesting example of the uncertainty of 'risk' accompanied by an attempt to quantify and calculate the degree of 'dangerousness' is found in Morgan's work, interestingly entitled 'Clinical Risk Management' (2000). It is noteworthy that this 'Clinical Tool and Practitioner Manual' begins with the following disclaimer:

> *The guidelines and documentation offered in this publication are intended to promote good practice in the assessment and the management of risks. They may be*

adopted in whole, or adapted in part to local needs. However, the prospect of eliminating all future risks is unrealistic, and we strongly support the aim of practitioners, teams and organisations in pursuit of risk minimisation. Even with the best quality clinical practice and procedures in place, some incidents will inevitably occur.

For this reason, neither the author, nor the Sainsbury Centre for Mental Health, can accept liability in respect of any claims for personal and/or property damage, or any financial losses, sustained following the occurrence of incidents in local mental health services. (Morgan, 2000 page iv).

Morgan explains that what little research has been undertaken into 'risk' 'generally focuses on the on the incidence of tragedies...'(2000 p.3) and sets his writing within the context of 'risk minimisation rather than risk taking. Parton details the chronology of risk and the changing contexts in which social work has operated risk assessments. He suggests that we have moved from a post war optimistic collective, to a new right, meritocratic and individualistic blame and litigating culture (1996p.99). In a previous work Parton identified a cultural change and a growing emphasis on management and containment of risk, as exemplified in Morgan (2000, see above), rather than a therapeutic, supportive and permissive one (Parton & Small 1989). Tension rose as workers became more publicly accountable for their individual actions on behalf of a public organisation. Douglas (1992) suggested that:

'The more culturally individualised a society becomes, the more significant becomes the forensic potential of the idea of risk. Its forensic uses are particularly important in the development of different types of blaming system, and the one we are now in is almost ready to treat every death as chargeable to someone's criminal negligence..' (1992 p.15-16).

Today's risk society has possibly lost its post war optimism, its belief in a welfare state, collective responsibility and positivist acceptance of absolute facts. In turn this has become replaced by scepticism of global realities and individualism. There is a growing recognition that advances in knowledge and technology carry new global threats and individual consequences. In 2002 there is a belief that we live in a modern world that can explain many, if not most things, but simultaneously, there are horrific events that occur that still defy explanation and lead many to seek refuge in pathologisation and a blaming of certain individuals. Whether it be the circumstances in America of September 11th 2001, or Victoria Climbie (see later) or Ainlee Walker whose two and a half year old body was left dying on the parents' kitchen table (Guardian September 20th 2002) in England, modern society needs a 'scapegoat' and preferably a single scapegoat rather than the complexity of seeking to understand the inter-relationship between tragedies and their causes. This new blaming culture has put social workers back on the front pages of media coverage of some human tragedies. Calder (2002) argues that this approach has become adopted by the social work protective mechanisms of practice that now pathologises individuals and locates risk factors intrinsic to them or their immediate environment. By adopting such an approach it avoids considering the risks arising from wider social, economic or political factors and he succinctly suggests that at a time when the profession should be moving towards a tolerance of risk and uncertainty, viewing risk taking as positive and creative, social work has become *'the last line of defence'* (2002.p.9). Isolated and autonomous, EDT operates within this context that expects risks to be taken, but punishes those taken deemed unacceptable after the event.

Whatever the particular model of EDT, and irrespective of the variations referred to above, the generic nature of the work, the isolation, the physical size of the area to be covered, the long shifts, the absence of any 'case records' and the sheer volume of referrals on some shifts, force the EDT worker to make speedy decisions, often without direct access to any

of the relevant, recorded information or the senior manager and without discussion with any 'caseworker' who would know the service user better, (as can occur during the day). All these factors enhance risk, risk of suffering violence, without anyone knowing the whereabouts of the EDT worker; risk of not being able to respond to a genuine emergency, and the related risk of a service user being harmed (with the related risk of being disciplined) as well as the risk of failing to assess situations appropriately because of the sheer number of competing claims for EDT to respond to a generic set of demands. Of interest is Morgan's suggestion that whilst the methods of assessment are many and varied, *'the most significant factors are: access to relevant information and time for gathering, discussing and analysing the information.'* (2000, page 9). These two significant factors are those that are more often than not, in short supply for many out of hours workers.

Given the nature of the work (with vulnerable, upset, angry and threatened people), risk for social services generally, and EDT specifically, is part of the trade. As Davis (1996) points out, there is an element of risk assessment in most aspects of the (social) work, from decisions that affect an individual's liberty and the amount of support they receive, to policy decisions about the provision of resources. Foster and Roberts (1998) take this further and argue that for social work generally and mental health work specifically, 'There is no formula or government policy that is going to eliminate either risk or mental disorder...' (p.79). For daytime social work teams however, it may be more feasible to reach mature and considered decisions, concentrating on one 'case' at a time and following detailed discussion with colleagues and other daytime professionals who may have specialist knowledge of the service users. This process allows risk to be considered and, to some extent, shared. The pressure of time and the absence of support for 'out of hours' social workers may increase the extent of risk.

The different nature of EDT work, places at risk a range of service users in a variety of contexts; these are more likely to go unnoticed, again, because of the nature of the EDT service. With limited time, limited support, limited access to information, but significantly

increased access to emergency resources and monies, there is always the risk that using the latter may be too easily justified by reference to the former.

I would argue therefore that because of its nature described above, if any part of social services provision is in need of some structured and practical guidance regarding risk assessment, then EDT is it. It would appear though, for both day and nighttime social workers, whilst an increasing amount of literature is being produced on risk assessment, the development of good practice herein remains relatively new.

One publication, 'Good Practice in Risk Assessment and Risk Management' (Kemshall & Pritchard 1996) is interesting because in between the first and the last chapters, the book adopts a 'specialist' perspective and is divided into chapters that deal with differing service user groups. The first chapter 'risking legal repercussions' raises important issues of negligence, duty of care and liability for all those practising with risk. Whilst there can be no dispute that the legislative framework of risk work is critical, it could be argued that its prominence at the very start of the book leads the reader towards the avoidance of litigation as the most decisive factor in practice. Of equal note is the fact that the final chapter deals with the risks to the workers. It might be the case that the dangers to workers is saved until the last so that it stays in the memory of the reader longer; alternatively, it might be viewed as an afterthought to a risk assessment process that is fraught with personal risks to the social worker. For the lone, night-time EDT worker, the concerns about the risks to self are paramount and do not sit easily in the final chapter. However, there is much within this book of relevance to the EDT worker: Having noted the increasing number of agencies that are producing policy documents intended to address the issue of risk, it is critical of the complete absence of any practical guidance or training on how to implement such policies. Of particular interest to EDT workers is the statement that:

'..,workers are left to make decisions in a climate of uncertainty, having to interpret and carry out policies as they see fit. This leaves a number of workers exposed to risk, especially in situations where their decision making has been unsupported.' (Carson, 1996, p.1)

The fine balance between risk taking and risk management is summarised by Carson (1996), The health and safety measures (Health & Safety at Work Act 1974 and the numerous policies that stem from it), that every local authority employer has for its staff which are designed to minimise the likelihood of injury to employees is contrasted with the absence of any policy or legislation that helps (social) workers take high quality risk decisions that will minimise the likelihood of injury to members of the public or the employee him/herself (Carson, 1996, p.11). Corby (Corby, 1987, p.16) distinguishes three main stages at which risk assessment is carried out:

1. The preventive stage

2. Initial investigation stage

3. The child protection, decision-making process.

Corby suggests that social workers are mainly excluded from the first stage, but involved in the final two stages. He emphasises that for stage two practitioners are reliant upon the child protection procedures laid out in the ACPC (Area Child Protection Committee) Handbooks and that:

'there are few guidelines in procedure handbooks about the content of assessment. Some handbooks include information about types of injury...suspicious child behaviours...and social/psychological factors that have been correlated with child

abuse. However, these provide only the bare bones on which to build assessments'
(Corby, 1987,p.19).

Corby goes on to identify the complicating factors that exist in assessing risk and says that
what little research is available suggests that 'social workers in Britain have not up to
recently explicitly used rational methods of assessing risks (p.20 ibid, see also Corby and
Mills 1986, Campbell 1991 and Higginson 1991). Even with the development of
sophisticated risk assessment instruments (Wald & Wolverton 1990, English & Pecora
1994, Milner 1995) Corby questions their applicability as predictors or evidence of risk.
The Department of Health produced what became commonly known as 'The Orange
Book' (DoH 1988) in response to criticism from the Social Services Inspectorate (see
chapter 1) that systematic assessment of families where children were at risk was not
taking place. The guidance comprised 167 questions regarding life history of the
child(ren), and the parent(s), quality of the parents' relationship, parent-child interaction,
support networks, material circumstances. Question 112, for example asks parents to
describe their sex life and if they use contraception. Question 78 inquires about the
parents' teenage years and their then drug and alcohol use. The relevance of such questions
to a risk assessment for the daytime caseworker undertaking this risk assessment over a
period of weeks is questionable; the relevance for the EDT worker is almost non-existent,
yet for over ten years, this remained the governmental tool for deciding on the nature and
level of risk for children and families, only to be replaced by a forty page questionnaire
booklet (core assessment) under the Looked After Children procedures (Framework for the
Assessment of Children in Need and their Families 2000). Corby concludes that risk
assessment in child protection matters is still at an early stage of development. He notes
that there is an understandable desire to achieve a 'firmer, more objective base' on which
to base child abuse risks, suggesting that such desires have not yet been achieved (p.27
ibid). Indeed in support of Corby's view is the way in which the term 'risk' is completely

avoided and reframed by the expression 'assessment of need' in the new assessment framework. Despite the fact that risk occupies such a pivotal position in present social work practice, major governmental documents and research have tended to either ignore it, or reduce it to a set of checklists that are applicable separately to referrals for mental health, child protection or adult protection. There is not as yet a framework that generic (EDT) workers might apply that also assesses the comparative risk between referrals as well as within them.

Some commentators in the field of risk assessment (Blom-Cooper, Hally & Murphy 1995; Ritchie, Dick & Lingham 1994) have pointed out that the quality of risk work is linked directly to the establishment of relationships of trust and empathy and have highlighted that the achievement of these requires time. It is pointed out that there are no short cuts to risk assessment or risk management. This will be of little comfort to most EDT workers however, given the nature of the referrals and the type of contact that they have with service users. Davis (in Kemshall 1996) acknowledges that not all risk work takes place between caseworker and 'known' service user. Davis points out that practitioners operating in crisis services, engaged in assessments as Approved Social Workers[3] are being called upon to make quick responses to and decisions about people who they do not know. In these scenarios Davis argues that the timescales mean that practitioners must take responsibility for clearly communicating their concern for the individual service user, their reasons for being in the encounter, what the outcomes may be and what steps will involve them and the service users in. Feedback from service users says:

'ASW's need to listen to people in distress and crisis. Even when the person appears unable to talk rationally and coherently, professionals must listen to them. Constant communication needs to be maintained and can only be achieved if the

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[3] Section 114 (1) of the 1983 Mental Health Act makes it a statutory obligation for the local social services authority to appoint a sufficient number of approved social workers for the purposes of discharging then functions conferred on them by the Act. Section 114 (2) requires the 'ASW' to have appropriate competence in dealing with persons who are suffering from mental disorder.

ASW is prepared to spend time listening to the person, trying to empathise with them and to enter their experience.' (Hastings and Crepaz-Keay 1995 p.14).

Once again, as an EDT worker there are aspects of the above that seem wholly appropriate and applicable to the type of risk assessment scenario likely to arise out of hours. There are though also limitations to the amount of time any service user can be afforded at times when other equally 'risky' referrals are being received by the same worker.

As indicated above, an increasing amount has been written recently about Risk Assessment within social work: D.o.H. 1988, Davis, 1996, Kemshall & Pritchard, 1996 and Clifford, 1998, all attempt to produce systems for working consistently with the inconsistent and complex nature of risk. Davis, (1996) differentiates between 'risk-minimisation' (the negative possibilities of dangers arising), and 'risk-taking' (allowing autonomy and self-determination). The risk minimisation framework is one which is promoted in the guidelines that result from some of the Inquiries (see 2.7) and one that builds in systematic assessment, agreed care/child protection plans, allocated 'keyworkers' and regular reviews. Within this risk minimisation framework, there is the tendency to locate risk in a deficient and potentially dangerous minority of individuals who need to be identified, registered and managed by medication and surveillance. Within the risk taking framework, the starting point is not a set of practice procedures, but a set of shared values that inform practice. This risk-taking framework has been developed by practitioners seeking to involve and empower users of the mental health and child protection services. Risk, within this framework, is firmly located in its social, cultural and political contexts and becomes part of working for change in the relationship between the individual and the social structure. Practitioners adopting this framework tend to make connections with service user literature

and campaigns for service and/or societal change, (for example, the literature and practice of MIND, Survivors Speak Out, National Schizophrenic Fellowship and SANE).

The notion of risk therefore, is not a static one that has remained unaltered irrespective of, for example, media coverage of social work and the public enquiries that have taken place over the past twenty years. Similarly, 'risk' operates at a variety of different levels: There is the risk of violence to the EDT worker from Mr. A. above, or from the other family members if the worker does not 'section' him (compulsorily detain him against his wishes under mental health legislation). There is the risk to the worker of being sued by Mr. A. if he is sectioned. There is the risk to Mr. A. should he 'succeed' in killing himself; this, in turn, would bring the accompanying risk to the long- term welfare of his children. The children may be at risk of 'harm' if Mr. A. is not removed, as too are his relatives who are in the house.

At a different level, risk has been created by competing political ideologies that are represented in pieces of legislation. On the one hand there is the Community Care legislation that promotes independence, the rights of individuals, freedom of choice, and the underpinning belief in the sanctity of the family; on the other hand though, there is official guidance issued to those working in the mental health field (DoH.1990) that tries to balance risk-taking and risk-minimisation. This is then confused by official guidance that the public has a right to be protected from dangerous people, (DoH.1994) who need supervision and monitoring, if they are to remain in the community.

There is risk conflict for social workers that try to support risk-taking, within the 'promotion of individuality' ethos of the Children Act 1989, and the N.H.S. and Community Care Act 1990, particularly when fatal assaults by service users or public scandals demand that the same social workers move to minimise the risk of harm. The whole notion of risk-taking has taken a dramatic twist, with the (16/2/99) announcement that the government intends to create a 'Renewable Detention Order.' This is intended to compulsorily detain people who have a diagnosis of 'personality disorder', and who are

thought to be dangerous, even if they have not actually committed any offence. This will come within the remit of the Mental Health legislation currently under review.

The whole notion of risk assessment is complicated by the changing understanding, and legal definition, of what constitutes 'harm', and more recently, how that 'harm' might be deemed 'significant' (as per the Children Act, 1989). This is further compounded if it is accepted that the process of assessment cannot, and indeed should not, be separated from the specific, idiosyncratic perspective of the assessor. In other words, it is possible that the outcome of any assessment may well reflect the values and attitudes of the assessor, rather than any 'objective' or 'neutral' evaluation of a certain set of visual, verbal and sensory stimulants. You cannot take the 'assessor' out of the 'assessment'. There has been an increase in the production of risk assessment checklists and tools and it is acknowledged that these have a key role in identifying potential key risk factors that may exist in circumstances like those faced by the worker knocking on *Mr. A*'s door. However, it will always be necessary, within certain frameworks, to recognise that interviewing is an interpersonal and interpretive process, and one that requires a dynamic to exist between assessed and the assessor.

In the case of Mr.A., the level of concern to the social worker might be reduced if they were 22 stone, over 6 feet tall and an expert in self-defence. The individual worker might decide that the children are at risk based on knowledge and personal experience of being raised by a parent with alcohol dependency, and a mental health difficulty. Alternatively, the worker may be in awe of the medical profession that is clamouring for removal and accede to that request. The nature of perceived danger, and the potential targets of that danger may well illustrate more of the assessor than that which is being assessed:

Quirk *et al* (2000) identify some of the 'biases' that influence Mental Health Act assessment decisions. The examples given of such 'biases' are those that tend to increase professionals' propensity to 'section' people include:

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1/ pressure to avoid risk taking due to the 'blame culture' within which practitioners work. Sectioning is often seen therefore, as a 'low risk' option, and

2/ a perceived lack of alternatives to in-patient care.

Biases, which decrease the propensity to section, include:

1/ team support in 'risky' decisions (for example to care for someone in the community rather than to section them), and

2/ high occupancy rates, and poor conditions, on acute psychiatric wards.

Whilst some of these biases prevail in the case of Mr. A and his family, I believe, and will examine in some detail later, a range of others also exist, such as the sense of personal confidence/fear, personal safety, individual values (in my case not wishing to be bullied by a medical model advocate, or an acutely anxious Mr. A and his family).

Hunt and Macleod (1998) suggest that the Children Act 1989 undoubtedly sharpens rather than resolves the dilemmas intrinsic to child protection work, increasing the level of risk that has to be managed. They argue that the importance of professional judgement cannot be over-emphasised, and that the children who run the risks (of being removed) have the right to expect that the social workers, charged with such awesome responsibility, have the skills, support, and opportunities for reflection and analysis, to enable well-founded decisions about the need for compulsion to be made. It is possible that the nature of EDT militates against reflection, analysis and support occurring, more so than the daytime counterparts, because of the isolation from colleagues, and the level of generic responsibility afforded to the worker.

There is little doubt that much of the material relating to risk and risk assessment could be compulsory reading for any EDT worker. It is quite possible that EDT is 'responsible' for a disproportionately high percentage of 'admissions' (children, adults and older people) into

'care'. This may be because it is often 'easier' to risk-minimise, and admit the person, than it is to promote risk taking and support a person in the community.

The number of people coming into 'care' via EDT has never been researched. Hunt & Macleod express surprise at the number of children entering the care system following police compulsory orders (1998,5.3,), and urge that research be commissioned into the circumstances in which police powers are invoked. They reflect with incredulity that this is 'an aspect of the child protection process which has been remarkably little studied.' (1998,5.6,). There may well be a correlation between those numbers entering the system via police powers, and the role of social services outside of office hours. According to Quirk *et al* (2000), the most widely used section for informal patients is section 5 (2) of the 1983 Act. The use of 5 (2) has increased nearly two-fold from 5,000 per annum, to 9,000. The majority of Section 5 (2) were found to be implemented outside of office hours and more than 24 hours after admission

'Crisis intervention' and 'risk assessment' have been highlighted here as potentially having specific relevance to the work of EDT, and in the social work textbooks, currently recommended on the Diploma in Social Work Course, (see Howe (1988), Payne (1991), Coulshed (1992), Burke & Dalrymple, (1995) and Dominelli (1997)), there is a wealth of data that is relevant to the out of hours team, and it is very much a matter of the EDT worker selecting parts of the recommended texts to suit their needs.

There is little doubt that some of the research undertaken into such aspects of 'daytime' social work as the 'signs and symptoms' of abuse (and not just those that apply to children) are pertinent to the night-time worker, as too is the plethora of material which explores the value and legislative base of social work practice and the principles upon which 'we' are intended to operate.

More recently there have been several significant pieces of research which have been viewed as essential reading for social workers, (For example 'Messages from Research' (DoH 1995), 'Working Together (DoH 1999e) and various Enquiry reports into abuse

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scandals or deaths of children and adults with mental health difficulties), and again there are aspects of all of these texts which have a general pertinence to the work of EDT. Similarly some of the 'risk assessment' checklists (particularly prevalent in the field of psychiatry) have their applications to out of hours social work despite their specialist service user focus (Morgan 2000; Worthing 1995).

However, the relevance of the underlying message (see particularly Working Together, DoH 1999e) that seeks to promote interagency working and inter-departmental communication, sharing of information and better planning (at a structural and individual level) have only limited application to the EDT worker. The night-time social worker can literally go for months without seeing another social work colleague and has minimal contact with schools, health visitors, Community Psychiatric Nurses, GP's (as opposed to the locum GP service) and all the other wide-ranging professionals who operate during the day. Without wishing to minimise the need for all agencies to work together, it is clear that the general principles that apply during the day do not and could not apply at night, for example the procedural imperative to undertake agency checks with such as the schools, Education Welfare Officers, Probation Officers etc. when undertaking a Section 47 (Children Act 1989) investigation would be impossible outside of 'normal' office hours.

In many respects therefore, the majority of the research carried out for social work practitioners has only general applicability to the actual work undertaken out of hours by EDT workers. Similarly the enormous amount that has been written about social work has almost entirely concentrated on occurrences during the day to the exclusion of events at the weekends and after 5.30 p.m. Whilst literature regarding the knowledge, skills and values required of all social work practitioners is of use to EDT workers, there are too many differences with their daytime counterparts for the general literature to be of any significant use to the night-time workers. In reality, what happens is that the EDT workers are either sent everything to read from all the other specialisms almost as if the night-time worker is expected to be a 'specialist expert' in all the different service user groups, or they

are sent nothing at all. What is actually required is a far more focused source of literature, which sees EDT social work as part of the main provision but with many significant differences.

The need for specific EDT literature is highlighted by some of the significant events that have occurred outside 'normal' office hours that have contributed, in a variety of ways, to some of the tragedies and 'scandals' detailed in public inquiry reports. It is ironic that even when tragedies have occurred outside of office hours, little attention is paid to a potential crucial issue, the actual time and the day the event took place. In the few inquiries that do indicate an awareness of the timing of such events, the full implications are not examined and few recommendations propose any changes. Adopting an EDT perspective when approaching these reports may highlight different lessons to be learned.

2.7 Lessons not Learned From Inquiries.

A detailed and systematic analysis of the wealth of material contained in the reports of Inquiries illustrates the role that is undertaken by EDT, and the significant events that occur, outside of office hours. The following represents an attempt by the author to highlight the 'daytime mentality' of the report writers and, at the same time provide an out of hours' perspective to the detail of some of the Inquiries. It was not the intention of this study to examine every single Inquiry Report, but to analyse some of the higher profile Inquiries that for a range of reasons received much media attention, as well as some of those that had direct relevance to the out of hours social work teams. In an attempt to measure any changes in approach that may have occurred since the publication of some of the earlier inquiry reports, the circumstances of Victoria Climbie, and associated recommendations, provided by Lord Laming (DoH 2003) are also included. Although, at the time of writing, this report awaits the governmental Green Paper response (DoH

'Children At Risk' – not yet published), the early indications are that EDT's and the work of the out of hours teams will remain completely misunderstood, or worse dismantled.

2.7a *Cleveland 1987.*

The Cleveland Inquiry (DoH 1987) is unique in that it gives consideration to the work of EDT. The report details the nature and size of the EDT provided in Cleveland in 1987 and specifies their role in the removal of suspected 'victims' of sexual abuse (pp. 66 -68). Within the main body of the report there are incidents that indicate possible ways in which the course of the Cleveland 'affair' might have been altered if EDT had intervened or, different action had been taken out of hours. Some of these significant events are as follows:

The first time Dr Higgs diagnosed sexual abuse on the basis of physical signs alone occurred late in March and, significantly, from an EDT perspective, in the evening, (DoH 1987, Para.11 p.15).

The police then interviewed the same children that had been diagnosed as having been sexually abused. These interviews took place on a Saturday and Sunday, and no social worker was present when the children were seen. 'The elder boy was believed at one time to be the possible perpetrator. According to his father he was 'grilled' by the police. The boy was upset. This was a matter of some concern to the social workers later involved in the case.' (Para.13.)

The first time that children who were in foster placements were interviewed took place at the weekend: 'The weekend after this group of children had been admitted to the ward happened to be the first Bank Holiday weekend in May and there was not the full complement of social workers available.' (Para. 22, p.16).

Throughout the report of the Inquiry reference is made to events that took place outside of normal office hours. Indeed, at one point there is the suggestion that critical incidents were more likely to occur during the EDT shift than during the day: 'Also during June, members

of the Emergency Duty Team of social workers were asked to obtain place of safety orders late at night mainly by Dr Wyatt.' (Para. 46) It then goes on to say (Para. 47): '..Dr Wyatt was making a late evening round, a usual occurrence with him.' It is clear that events outside of normal hours took place during Cleveland that had a significant impact upon the entire process. The report singularly fails to recognise the way in which the time of day may be a critical element in avoiding any repetition of the events reported within this Inquiry.

There are however, two pages within the report that specifically examine the out of hours events. Within these two pages (66-68), examples of the actions of specific, individual EDT workers are detailed, but, from an EDT perspective, critical issues remain ignored.

In the case of the three children for whom Dr Wyatt, the consultant paediatrician, requested Place of Safety Orders (4.99 page 67), the EDT worker had no access to the daytime hospital social worker's 'preliminary assessment' (4.100) and the degree of co-operation that had already been achieved, during the day, between the social services department and the Mother of the three children.

The critical issue here, from an EDT worker's perspective is that any voluntary agreement between families and the hospital established by the daytime social worker needed to be communicated to the out of hours worker. In itself, this may not have given sufficient confidence to the individual EDT worker to delay the implementation of the departmental instruction to take a place of safety order on children who had been diagnosed as sexually abused. Nor might it have been viewed as sufficient 'ammunition' to withstand the pressure exerted by the consultant paediatrician. It may though, have provided the necessary 'safety net' to allay the fears of the EDT worker (fear of repercussions of failing to carry out a departmental directive as well as fear of what might happen to the children), until the daytime team returned. A critical issue in this case may be that it was a Friday night and the fact that no daytime social work staff would be returning for a further two days. This meant that the individual EDT worker, with minimal information regarding the

family, would have to be confident that her decision not to apply for the order would not endanger the children longer (i.e. Friday - Monday) than was absolutely necessary. It is a matter of conjecture whether or not the decision might have been different had the request from Dr Wyatt been passed to EDT at 4 a.m. on a Tuesday for example.

The Inquiry report does however, describe the way in which numerous Place of Safety Orders were taken on the following Saturday, 13th June (4.102, p. 67), again, seemingly without any resistance from the EDT worker to either of the prominent consultant paediatricians. Only on 17th June does the report indicate that an individual EDT worker attempted to oppose the plans of Dr Wyatt:

'Dr Wyatt was firmly of the opinion that the children should be returned to the ward that night. The social worker thought to proceed at such a late hour was unreasonable particularly as, to admit the children, other children would need to be moved from one ward to another. She expressed her concern about what she was being asked to do to Dr Wyatt.' (4.105, p.68).

From an EDT point of view, it is not surprising that the day this 'resistance' occurred was a weekday, in this case a Wednesday. This means that, in literal terms, the amount of time the EDT worker's decision and its implications would 'run' for, were limited to a few hours as that would be when the daytime team returned. The Inquiry report, in the main, sees no need even to identify what the day was, merely providing the date; this could be a crucial omission.

No mention is made of the experience level of this particular EDT worker. The experience of this author is that confidence to withstand external pressure, in part, comes from experience of having worked alone, out of hours for several years. Whilst the nature of personal authority and confidence should not be overly simplified to mere 'job experience', (as this conceals complex factors such as personal autobiography, professional

status and individual values), I would suggest that the crux for much EDT intervention, or lack of it, might be the individualised nature of the service and its inherent idiosyncratic decision-making process (see Chapters 6 and 7). The report fails to acknowledge the lack of any consistent framework or reference point for the EDT workers. Instead it is recorded in the Inquiry report (4.105) that ' *the children were roused from their sleep and taken to the hospital and admitted in the early hours of the morning.* '

A significant issue, from an EDT viewpoint, in the outcome of the above-mentioned case is the position the lone EDT worker found herself in, perfectly exemplified in the following account of what happened when Dr Wyatt responded to the worker:

> '*He re-iterated his diagnosis and told the social worker that she would have to take full responsibility if she chose not to act.*' (4.105).

This scenario crystallises the professional, practical and ethical dilemmas faced by the lone EDT worker who needs to combine statutory imperatives with competing generic priorities and competing perceptions and sources of authority, including personal authority and autonomy. The only comment that the Inquiry report makes on this complex matter is that it was an 'impossible' situation, (see below).

A further significant issue that the report fails to include is the level and type of work that was also being passed to EDT on any night. The detail regarding other 'urgent' priorities that were being referred to the 'team' (which was one person after midnight) could have more accurately contextualised the dilemmas faced by the EDT worker. From an EDT perspective, the work undertaken needs to be seen against a background of only undertaking emergency type work and having to prioritise often equally demanding and urgent matters. The fact that no credence is given to this aspect of EDT is a weakness of the report and an example of the daytime mentality that appears to prevail within such Inquiries.

The section on EDT concludes by stating:

'The fact that they [EDT] did not contact senior staff for consultation and advice when faced with such an unusual request as to seek eleven place of safety orders suggested the need for improvements to be made to the training, management and support for the Emergency Duty Team.' (4.110, page 68 ibid).

As indicated above, the Report highlighted the 'impossible position' (4.108, page 68) that EDT workers were put in by the events of Cleveland. However, despite the 'impossibility' of this position, despite the 49 Place of Safety Orders taken outside of office hours, and despite the 'haphazard' nature of the support available to the EDT, (4.96, page 66), the entire report fails to make any recommendations that specifically seek to rectify any of the 'failings' indicated within the main body of the report that consider the significant part played by EDT. The two pages committed to EDT contrast with the 318 pages that deal with primarily daytime matters surrounding the Cleveland 'crisis.' Given that out of office hours accounts for approximately 80% of the working week, and given the amount of significant events that took place in the evenings or at the weekends, it could be argued that the Cleveland Report (1987) actually only gives scant regard to the role of EDT and the nature of social work after the daytime offices have closed.

There is no mention whatsoever of EDT in the report's *Conclusions And Recommendations*, Part Three, (p.241), neither are the social workers from EDT identified as such in the Appendix to the report (Appendix B) that lists the people who gave oral evidence to the inquiry.

It is beyond question (albeit, knowledge after the event) that if EDT in Cleveland had acted differently, then significant numbers of children might never have been removed on Place of Safety orders during 1987. Given that nearly 40% of all those removed on orders took place outside of normal office hours and the fact that out of hours constitutes the majority of the working week, only limited attention has been given to the nature of social work

'after hours' in the Inquiry's report. It is suggested here therefore, that whilst there is much within the report that relates generally to EDT, there are no specific recommendations that will meaningfully reduce the likelihood of EDTs throughout the country making similar decisions with similar consequences as are reported in the Inquiry Report. It is a matter of debate whether the Key Messages of the SSI report (1999) being applied in full would make any difference to the out of hours response should the events of Cleveland be repeated today. Essentially, therefore, it is difficult to know what lessons, if any, are being learned by EDT's from some of the Inquiries or tragedies, more of which are now explored.

2.7b Paul Steven Brown.

'At approximately 10 p.m. on the night of 11th August 1976, Paul Brown, aged 4 years and 3 months was admitted to Birkenhead Children's Hospital. He was deeply unconscious and in an appallingly neglected state. He had extensive bruising, was highly emaciated and was in a filthy condition....On 19th November, 1976, Paul died from his injuries.' (DHSS, 1980 p. ix).

The report of the committee of inquiry into the death of Paul Brown details the manner, in which a social work service used to be provided by the local authority. It is worthy of note, given the lack of information shared during the Cleveland events (see above), that in 1980, the inquiry illustrated the regularity with which 'emergencies' arise 'in the evenings or at weekends' (page 8) that require a social work response.

The report goes on to state that '...it is of the utmost importance that a clear practice is laid down for full communication of information between members of the 'stand-by' team concerned and the regular social worker allocated to the case.' (p.8).

The DHSS report (1980) notes that a request was made to the 'stand-by' social worker at 7 p.m. on a Saturday to visit Paul. The caller alleged that the child was not being fed. The social worker covering the out of hours promised to call that evening if possible, but half an hour later received another urgent call and was busy until 10 p.m. The report notes that the social worker did not visit because the caller 'had not stressed any urgency..' and because the social worker was 'aware that the case was actively known to the Social Services Department.'

Two days later Paul was seen and was recorded as 'smelling foul', and 'crying. 'At the same time the mother of Paul is said to have admitted beating her children and added that she had been taking drugs and had been 'tripping.' (p.30). Once again, it can only be a matter of conjecture what the outcome might have been if a social work visit out of hours had been completed on that Saturday night. It is certain though, that the actual timing of the referral to the social services department was crucial in determining the nature of the staff available and, therefore, the nature of the response. Of note also is the likely outcome of a similar referral being made tonight to any EDT in this country. Given that EDTs today seem to operate a referral filter system that is underpinned by such aspects as 'emergencies only' or 'something that cannot safely be left until the next working day' (see Chapters 6 and 7), it could be argued that Paul Steven Brown would not receive a visit out of hours either in 2003. It is not clear what the other 'urgent call' was that the worker received that kept them busy until 10 pm. What is a critical issue, that the report does not consider, is the nature of prioritisation, and the way competing referrals should be ordered, (this thesis examines this in detail in Chapters 6, 7 and 8).

2.7c Jasmine Beckford.

'Sometime during the last days of July 1981...Louise Beckford, then a baby two months old, was physically abused by her own father...Louise's left arm had been subjected to a 'yanking, twisting action of some severity, producing a spiral fracture of the left humerus...given no perceptible lessening in the swelling over three days, the mother finally took the baby to Dr Mallick's surgery on the morning of Saturday, 1st August 1981. The doctor instantly suspected a fracture and directed Beverley Lorrington (mother) to St Mary's hospital where she was re-directed to St. Charles' hospital arriving around 8 p.m. Louise was admitted.' (DHSS,1985, p.77).

The report highlights the facts that the senior social worker was not appraised of Louise's admission until Monday 3rd August 1981, and states:

'This serious omission that delayed the application for a place of safety order in respect of both children, might have prevented the physical abuse of Jasmine Beckford. Had such an order been obtained on that Saturday evening, and no later, Jasmine might have been spared the fracture of her left femur.' (p.77).

The critical nature of events that occur outside of 'normal' office hours is exemplified throughout the tragic circumstances surrounding the Beckford children's lives, and, ultimately Jasmine's death. It was on a Sunday when Jasmine was seen by relatives 'in evident pain with her left leg whenever she moved.' It was the evening surgery that Jasmine's mother promised to attend in order for the child's leg to be examined.' (p.77). It is poignant as the report records: *'Had someone seen Jasmine on that Monday they would have discovered a child with a broken thighbone.'* (p.78). Finally, from an EDT

perspective, it is interesting to note that the place of safety orders on both children were applied for in the evening.

Once again, little account is given of either the role of the EDT worker, or the actual time the tragic events occurred and the availability of the relevant personnel to deal with such matters. At a number of critical moments throughout the process EDT social workers might have been able to literally change the course of the Beckford children's history. It is a failing of the report into the inquiry that cognisance is not given to the out of hours nature of such tragedies, but rather appears to be approached from a similar daytime mentality to other inquiries as suggested above and below. As with the other inquiries there is no reference to EDT in any of the conclusions or recommendations, despite the crucial out of hours nature of some of the incidents, and the apparent lack of social work response.

2.7d <u>Tyra Henry.</u>

Tyra Henry died, aged 22 months in the early hours of 1st September 1984. This was a Saturday, (DHSS 1987). The report of the public inquiry into the death of Tyra Henry by the London Borough Of Lambeth (1987) provides several examples of incidents that occurred during the lives of Tyra and Tyrone Henry but not during the 'normal' office hours of the social services department.

Despite the longstanding and serious reservations regarding the presence of Tyra's father (Andrew Neil) in the house with the children's mother, Claudette Henry, no evening visits or 'spot checks' were either undertaken by the daytime team in the evening, or requested by the daytime social worker of EDT.

The report tells how Andrew Neil had already assaulted Tyrone, Tyra's younger sibling, causing brain damage and blindness, a fracture of the skull and fractures to both thighs. The way in which Tyrone was eventually removed by a place of safety order is also detailed.

From an EDT perspective this inquiry once again fails to address the relevance of the actual time these events took place, all too often ignoring the actual time and providing only the day or date when the events took place. Without this context it makes it very difficult to fully assess the social services response to the tragedy. Ironically, from the perspective of the EDT lone worker, the report recommends that 'Joint visiting should be recognised as an appropriate and useful form of supervision of social workers, and allowance should be made for it wherever possible in staffing and timetable.' (p.112). It is evident from this, that the role of the lone, generic EDT worker has not informed such recommendations, despite the crucial part that EDT played in these tragic circumstances.

2.7e Victoria Climbie

At the time of writing the final report (DoH 2003) with the accompanying recommendations have been completed and were presented in January 2003 to Parliament. The Government is expected to respond to the Inquiry findings via a Green Paper 'children at risk'. The hearing (Chaired by Herbert Laming) into the death of Victoria Climbie considered evidence from 232 witnesses (DoH website ref. www.victoria-climbieinquiry.org). The opening statement by counsel to the inquiry, Neil Garnham QC, served as a reminder that, far from being an 'isolated act of madness' or being 'hidden away, out of sight of the authorities', Climbie's suffering was both 'prolonged and detectable.'

The circumstances as they were presented to the Inquiry, surrounding Victoria Climbie were that in the 10 months this eight year old girl spent in England, she was known to 70 health, social, and child care professionals. Only when she arrived at St Mary's hospital in Paddington, west London, at 3.10am on 25th February 2000 did the gravity of her situation finally hit home. Climbie was pronounced dead at 3.30 am that same morning, having suffered repeated episodes of respiratory and cardiac arrest. A post-mortem carried out the

following day confirmed that the eight year old, brought from her home in the Ivory Coast, West Africa, by her great aunt Marie-Therese Kouao, had died of hypothermia as a result of neglect and ill-treatment. Victoria had 128 separate injuries to her body.

From a research and an EDT, out of hours perspective it has been interesting to follow the developments of this inquiry. Of particular note already are some of the alleged 'missed opportunities' that the (social work) press have already highlighted, one of which specifically involved the out of hours team in Haringey (DoH 2003,6.172-181). The relevant paragraphs of the report are reproduced here in full to contextualise the EDT involvements and the recommendation that ensues. The numbers represent the paragraphs of the Inquiry Report.

6.172 Haringey Social Services first learned of Victoria's admission to the North Middlesex Hospital on Saturday 24 July 1999 - the day she was admitted.

6.173 That evening, it was Luciana Frederick's turn to single-handedly cover the out- of- hours duty for the whole of Haringey Social Services. She started her 12-hour shift at 6.30pm and some time between 8pm and 9pm, according to her report form, she answered a telephone call from Dr Simone Forlee. In fact, the social services duty call log shows that a telephone message from Dr Forlee was taken at 8.42pm and was passed to Ms Frederick as the duty social worker an hour later.

6.174 Ms Frederick does not remember the telephone conversation, but she believes that the report form which she completed at the time - the only record of the telephone conversation that exists - is a concise summary of the information Dr Forlee gave her.

6.175 Ms Frederick noted:

child admitted to hospital - concerns about injury caused by hot water poured onto face causing facial burns; it appeared to be an accident, however, mother may need support; advice given - doctor agreed to discuss case with the hospital social worker the following day;

NFA [no further action].'

6.176 Dr Forlee disagreed with Ms Frederick's summary in one material respect. She did not recollect describing Victoria's injury as appearing to be an accident and believed she told Ms Frederick that she had admitted a child about whom she had concerns.

6.177 We cannot be certain what passed between the two because of the lack of recorded information - indeed in the case of the hospital there was none whatsoever - or whether Ms Frederick simply misunderstood what Dr Forlee was saying. That Dr Forlee had telephoned social services out of hours suggested a degree of concern about Victoria's injuries. This was understandable. Ms Frederick told the Inquiry that she made 'concise notes' but admitted it would have been helpful if she had made a full recording specifying Dr Forlee's concerns. Ms Frederick accepted that more detail could have been put in her recording of the conversation, but stated, 'The relevant detail is there.

6.178 Both Dr Forlee and Ms Frederick agreed that because Victoria was 'safe in hospital' and there appeared to be no immediate risk of her being removed, there was no need that evening for any further investigative action, including seeing Victoria. Dr Forlee was also told to contact the hospital social work team 'the following day'. Since the referral came in late on Saturday night and there was no

hospital social work team working on Sunday, that meant in reality a delay until Monday morning. Ms Frederick admitted that the following day was 'probably not appropriate'.

6.179 Working from home, Ms Frederick was in no position to do any checks to see if Victoria was known to social services or on the child protection register. She stated that she assumed - though she did not pursue this with Dr Forlee - that these checks would have been done by the hospital, which had access to the names of children on the child protection register and by the hospital social work team, as part of any follow-up.

6.180 Ms Frederick subsequently faxed the report form to the out-of-hours office for filing. She said that if there had been a clear indication of child protection concerns - especially if there had been no other professional involved - she would have made the referral herself direct to the duty team at the NTDO and undertaken whatever was necessary that evening to secure the child's safety. Ms Frederick stated that she had no doubts about what she should do if child protection concerns had been raised.

6.181 As a result of the decision to take no further action and because Victoria's injury 'appeared to be an accident', the out-of-hours referral report was consigned to a filing cabinet. No copy was forwarded to the hospital social work team to put them on alert, nor to the local district duty, investigation and assessment team who may have held information about the child and family. Also, there was no system in place to ensure that Dr Forlee made contact with the hospital social work team as advised or that, once in the out-of-hours office filing cabinet, this referral could be automatically linked to any future referral. Ms Frederick accepted that if Dr Forlee

had not been on duty on Monday or had forgotten to make the referral to the hospital social worker, the information from Saturday evening may never have got to the hospital social work team or Haringey Social Services. Therefore, I make the following recommendation:

Recommendation

The chief executive of each local authority with social services responsibilities must ensure that specialist services are available to respond to the needs of children and families 24 hours a day, seven days a week. The safeguarding of children should not be part of the responsibilities of general out-of-office-hours teams.

As with previous Inquiry Reports, the role of EDT has not been accurately understood. The report describes the out of hours service as being provided by a lone, home-based female EDT worker covering the whole of Haringey on a 12 hour shift, without access to consultation with a manager or any records (including the Child Protection Register) computerised or otherwise, but fails to analyse the implications of these factors. Interestingly and disappointingly from an EDT perspective Laming potentially condemns the most experienced Child Protection workers in any local authority, namely the EDT workers, to an uncertain future with his recommendation 47 (see above).

EDTs around the country are at the time of writing awaiting the government's response to the Inquiry Report generally and this recommendation specifically. It came as no surprise to this author though, that even when the work of the out of hours social workers was specifically referred to and accurately described, there remained little, if any understanding, of the actual nature of the work and its decision-making processes. In terms of 'lessons to be learned' from Laming, it remains unclear whether the actions of EDT workers around the country 'post Climbie' would be significantly different.

So far, concentration has been on a sample of child care related inquiries and the way in which a form of 'daytime mentality' appears to prevail in the compilation of the associated reports. A similar approach to inquiries appears to have prevailed in the reports regarding tragedies involving people with mental health problems to which attention briefly now turns.

2.8 Mental Health Inquiries.

'Learning The Lessons' (Sheppard, 1996) examines in some detail 58 of the Mental Health Inquiry Reports published in England and Wales 1969 - 1996. Specifically, the author looks at the circumstances surrounding the tragedies and the recommendations made therein for improving practice. It is interesting from an EDT perspective, that the author, David Sheppard is now a freelance consultant, but was a social worker for 19 years and managed for a time an out of hours social work team. My intention here is to draw on some examples from the inquiries that further highlight the 'significant out of hours incidents', but also to illustrate that, despite the title of the publication, some lessons have not been learned because such night-time and weekend incidents do not feature as part of the daytime approach to mental health social work services and tragedies.

This sample of some of the inquiry reports illustrates that serious incidents occur 'out of hours'. In all of the examples below, EDT could have been expected to become involved. It is interesting to note that the majority of the reports do not see the need to clarify the day or the time the tragedies took place in terms of the resources that were available. The following is intended to highlight the importance in inquiries to paying more regard to the actual time and day events take place (e.g. Saturday, Bank Holiday, midnight) and contextualise them more appropriately:

- Frank Hampshire <u>at midnight</u> on 31st May 1994, killed his wife in a frenzied attack, stabbing her over 300 times in the head and neck.

- On <u>the evening</u> of <u>1st January 1995</u>, Kenneth Gray killed his mother.

- Brian Doherty discharged himself form informal admission to hospital at <u>5 pm</u> on 18th January 1994<u>. Later that day</u> he abducted and killed Kieran Hegarty, aged 11 years.

- John Rous attacked Jonathon Newby aged 22 years in the evening of April 1993, Newby later died.

- On the <u>evening</u> of 5th March 1994, Alan Boland strangled his 71 year old mother and hit her repeatedly about the head with a hammer.

- On 2nd August 1993 David Usoro was assessed by a Senior Registrar in psychiatry and a Community Psychiatric Nurse who found him to be 'excitable, over familiar and with pressure of speech'. He would not agree to informal admission and assessed as not meeting the criteria for formal admission. The <u>following evening</u> he attacked two residents with a knife in the rest home where he was living, fatally wounding Samuel Vernon.

- During <u>the evening</u> of 31st May 1988, Alma Simpson was found unconscious in a corridor on her ward. She had been brutally assaulted by another psychiatric patient, and died as a result on 6th June 1988.

- Christopher Clunis, on 17th December 1992, attacked Jonathon Zito, a complete stranger and stabbed him to death in an unprovoked attack at Finsbury Park Tube Station. On the day of the murder, an Approved Social Worker visited Christopher Clunis' address <u>unaccompanied,</u> leaving a note asking him to call and see her. He was by then already in custody.

Of even more significance, than the apparent absence of any recognition that times and days may be important, is the fact that only one of the inquiry reports see fit to make a

specific recommendation regarding the availability of (Approved) social workers outside of the 'normal' working week:

'An Approved Social Worker [ASW] should be available in each social services department to respond to crises and to provide advice. An ASW should be contactable throughout the working day, as well as at night and during weekends and public holidays.' (Clunis, p.120).

In The Report of the Luke Warm Luke Mental Health Inquiry, (DoH,1998c), which is 572 pages long, there is no mention of the significance of the specific days or times when events took place, only the date and the year. Interestingly though, the report goes on to make a recommendation that, in a related way, makes reference to EDTs:

'Forensic psychiatry has...a need for a 24 hour emergency service...It is not satisfactory, when making provision for the acutely mentally ill, to structure provision so as to create a lacuna in out of hours provision. A 9 to 5 service will not suffice...General psychiatry has established cover through emergency clinics in the Health Service and through duty teams in the Local Authority Social services...' (p.546, 1998)

The report then goes on to make recommendations regarding the development of a formalised 24 hour service, dedicated to the management of patients who may be at the point of crisis.

Once again, it is possible that the overwhelming research into, and response to, such tragic events is approached with, what I have termed, a 'daytime mentality'. Whilst some of the possible explanations for this approach are examined below, it should be noted here that greater consideration may need to be given to the specific time and day of 'significant

events' such as those described above if those 'in control' of resources are to meet the challenge of preventing similar tragedies occurring in the future.

It is positive to note that, although not directly related to the majority of the work undertaken 'after hours', namely child care, at the time of writing the government are critically examining the Mental Health Act and seeking to modernise the whole of mental health services. It is interesting also to note that there is some prominence being given to the need to address the out of hours provision (or lack of provision) for services. Conscious of the high profile tragedies (outlined above), the Department of Health argues that:

'Modern mental health services will assess individual needs, deliver better services, treatment and care whether at home or in hospital, enable 24 hour access to services, ensure public safety and manage risk more effectively.' (DoH 2000 p.3)

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It is argued by the government departments that the new investment (£700 million over three years) will provide extra beds of all kinds, better outreach services, better access to new anti-psychotic drugs, 24 hour crisis teams, more and better trained staff. Accompanying these aims, the government have identified standards:

Standard 3 stipulates that any individual with a common mental health problem should:

'be able to make contact round the clock with the local services necessary to meet their needs, and receive adequate care' (DoH 2000 p.3).

It is interesting, from a local authority EDT perspective, that the report gives concrete examples of the type of services that should be available such as the helplines of SANE, The National Schizophrenic Fellowship and The Samaritans, as well as NHS Direct. Performance will be assessed and monitored through local milestones. One example of these milestones that is cited is the need to demonstrate evidence that services respond to

mental health needs quickly, effectively and 'consistently' (a matter I will return to later) 24 hours a day, 365 days per year.

Standard 4 (*ibid*) requires all mental health service users on the Care Programme Approach to be able to access services 24 hours a day, 365 days a year.

On the one hand, it should be seen as positive that the issue regarding the time of the 'crises' and the response of services to such incidents is beginning to feature in some government documents. On the other hand though, little attention has been paid to the role of the social worker in the tragedies discussed above and, in the main, the reports tend to ignore any social work input outside of office hours. The main drive, within mental health work particularly, is to produce a system that reduces the likelihood of some potentially 'dangerous' individuals being able to avoid assessment and receipt of services (even if they are not requested). From an EDT perspective, whilst the 'adult tragedies' demand meticulous review and raise fundamental practice issues, mental health work forms only a small fraction of the overall nature of EDT work (about 15% of EDT referrals are related to mental health, as opposed to approximately 65% that deals with children and families[4]).

The drive towards this 24 hour, 7 days a week, 365 days per year service, imagined by the governmental groups developing mental health provision is, at the time of writing, nowhere to be seen for the majority who seek, or are given, a social (or health) service: Children and families and older people.[5]

It is my contention that without contextualising the tragic events, as outlined in the Inquiry Reports, some of which are referred to above, by time and day, a distorted picture is likely to arise and the 'lessons learned' from such incidents may not be entirely appropriate, thus increasing the potential for tragedies and their accompanying 'errors' to be repeated. Chapter 4 examines the research hypotheses in detail and specifically asks whether there are lessons to be learned for EDT that might improve out of hours practice. If it is the case

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[4] See statistical data in Chapter 6

that such significant events take place 'after hours', why should such apparent scant regard be paid to the statutory services that operate during this time? One, or a combination, of the following factors might, in part I believe, address this problem. These factors have been collected over many years in my role as an EDT worker, at numerous Conferences and EDT meetings.

2.9 After Hours: 'Out of sight, out of mind.'

Given that the Emergency Duty Teams provide a personal social service for the overwhelming majority of the week, why is it then, that they have received such scant attention from researchers, policy makers or the media? There are a number of possible explanations for this dearth of data:

1. Catering for the Majority

Despite the amount of the week that is covered by EDT, the overwhelming number of social work staff is employed to work during the day. This is particularly true of 'fieldwork' staff. It might therefore, be assumed that any research, in order to be of benefit to the majority, should focus on what takes place during 'normal' office hours. In terms of 'saleability' of research, there would appear to be less profit in catering for the few, as for the many.

2. Out of Sight

'In many departments, the out of hours service has been out of sight and out of mind.'

(DoH 1999a, p.1)

It may also be the case that politicians and researchers are unaware of the nature and volume of the work carried out when they are likely to be asleep or socialising. This

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[5] See statistical evidence in Chapter 6

'ignorance' is combined with an 'if it isn't broken, then don't fix it' mentality that allows systems of service provision to go unchecked simply because they operate unnoticed, and seemingly without too much bother.

3. Financial Aspect

It is possible that there is a financial aspect in refusing to raise the profile of EDT. There can be little doubt that Local Authorities throughout this country, operate the out of hours social service at relatively little cost (DoH 1999a), particularly when this might be contrasted with some daytime social work teams that work shorter shifts, have greater access to supervision, and are significantly greater in number.

4. Out of step with the Rest

As indicated above there has been a movement away from genericism and towards specialism. This has happened in all but the Emergency Duty Teams that remain the 'last bastions of genericism'. In some respects though, this might also go some way to explain the apparent lack of interest in the work out of hours, since it could be viewed as an obsolete 'dinosaur.'

5. Vested Interest

EDT workers themselves may contribute to this seeming lack of interest, by the way their work remains largely unmonitored, and yet they do not make greater demands for the way in which the service that is provided out of hours, should, or could be altered. They are accused of being elitist and esoteric by their daytime counterparts, because they tend to operate from a different set of priorities than exist during the day, this often may necessitate refusing to agree to requests to visit from daytime social workers, but the EDT workers themselves do little to 'put the record straight.'

It is also feasible that EDT workers are the most 'content' group of social workers who, despite the loneliness, pressure and long hours, would not return to the lower paid, overly-managed system that exists during the day. In other words, EDT do not raise their own profile for fear of losing that which they presently 'enjoy.'

There is some validity in the view that all social work research can be of some use to EDT, and that such aspects as identified above, ('risk) assessment' and 'crisis intervention', can be applied by this group of social workers. The premise for this is that it should not matter what time of day or night it is, the knowledge, skills and value base of the worker should be applied with some degree of consistency. This premise however fails to acknowledge the fundamental differences in resource allocation, support networks and organisational systems that exist between the day and the night time social work provision. It may also assume similar human behaviour occurs during daylight hours as occurs during the dark of night time.

Finally, if it is true that the subject of research usually reflects something the researcher is already committed to, and interested in, then it makes sense that so little research has been carried out in the field of EDT. There will have been few researchers who have undertaken out of hours duty. This will be in direct contrast to the plethora of social work textbooks that have been written by authors that have had direct experience, through employment or otherwise, of daytime social work.

2.10 After hours: Out of Sight but not Out of Mind - GP service.

Some of the reasons provided above to explain the apparent lack of attention given to out of hours provision are set in a new context when the role of and research into the out of hours GP service is examined. There are clear comparisons to be made between the work

of the out of hours (locum) GP and the out of hours social worker. They work at night and at weekends, they both tend to work alone, both undertake home visits with limited information about the families, long shifts, generic and having to make their own decisions regarding what constitutes a priority. As there is much to compare between the two services, it might be anticipated that some of the possible explanations outlined above re. the lack of attention might equally apply to out of hours GP's. Unlike EDT though, the GP out of hours service has been the subject of regular scrutiny and review culminating in the recent report 'Raising Standards for Patients, New Partnerships in Out-of-Hours Care' (DoH 2001b). This report, and its summary are the result of an independent review of the GP out of hours services in England.

The Summary Report (2001) makes 22 recommendations in which the review team intend to ensure the needs of patients are at the very heart of its work by which an out of hours service could deliver safe, prompt and consistent responses to those urgent patient needs that could not be safely left until the patient's own GP practice is next open. The report spells out in some detail the general aims and the specific means by which these can be reached under such headings as 'The Single Call', 'Delivering an Integrated Service', 'Delivering High Quality Services', 'Funding the New Integrated Service' and 'Implementation'. In direct contrast to the SSI report (DoH 1999a) that highlights 'areas of good practice', this report is much more definite and sets out what will happen to create a much more integrated, seamless and consistent out of hours GP service. To address the inconsistencies the report notes that:

> *'One striking feature of current provision is the marked variation in the character and quality of the service in different parts of the country and, to resolve this problem, the Review proposes a set of Quality Standards which all providers will have to achieve. In order to be able to meet these standards, all providers of out of hours services will need to be able to record the numbers of telephone calls that*

are abandoned, the length of time taken to answer the call, all the communications that take place when the call is answered and accurate details of all clinical consultations, recorder in an appropriate IT clinical system' (DoH, 2001b p. 4).

Similar to the SSI report (DoH 1999a), this report acknowledges the different skills necessary for the lone out of hours worker stating that *'there is a particular need to ensure that those delivering these services pay appropriate attention to the special skills and competencies that are required to deliver effective out of hours services'* (p.6), but, unlike the SSI report, (DoH 1999a), then goes on to develop a systematic means of ensuring these skills are achieved and monitored. The report establishes clear standards to be achieved in such as clinical practice, telephone triage skills, record keeping and auditing, prescribing practices, referral patterns consistencies and inconsistencies in call disposition, calls that result in a home visit and calls that don't and a wide range of activities that the report has tried to make quantifiable. To support all of these developments there is to be investment in complex IT packages, regular appraisal, auditing, sampling, and a refocusing of the finances with a reconfiguration of responsibilities.

It is clear that from the above report and the accompanying recommendations for the GP's out of hours service that policy makers are aware of some of the activities after hours, have researched, reviewed and analysed on a national basis how to make the service more consistent and more accessible as well as efficient. This positive approach to the GP out of hours service however, only serves to further highlight the isolation of EDT's given that no such attention has ever been paid to their service.

2.11 Conclusion.

This chapter indicates that there is an absence of any systematic and/or detailed research into the social work practice that is of specific use for EDT workers. It is acknowledged that the two main sources of EDT 'research' to date are the BASW (Etherington & Parker

1984) and the SSI (DoH 1999a) publications, but there are historical and contextual limitations to both of these reports. This is in direct contrast to the attention given to General Practitioners who work out of hours, whose service has received much attention and recent development, (DoH 2001b). I will try and develop issues identified by these reports, but also examine those aspects not mentioned at all. It remains the case that the amount of literature dealing with 'daytime' practice appears to contrast starkly with that produced for EDT, and this is despite the 'significant occurrences' that arise outside of 'normal' working hours. Whilst much of general social work practice and research can be usefully employed 'after hours', serious restrictions exist when trying to apply a 'daytime square peg into a night time round hole.'

It is possible that the level of interest in EDT is increasing, as evidenced by the first ever national Social Services Inspection in 1999. Furthermore, there are presently attempts, albeit organised by the EDT workers themselves, to sustain a national website on the Internet (www.essa.hants.gov.uk) and a national network: Emergency Social Services Association (ESSA) but both are in their infancy. Specifically this research has sought to avoid duplication with the BASW and SSI reports choosing, instead, to explore a range of diverse questions by a variety of methods that are outlined in the next Chapter.

CHAPTER 3.

A QUESTION OF ETHICS, METHODS AND METHODOLOGIES.

3.1 Introduction

This chapter examines some of the ethical and methodological difficulties in researching social work generally and EDT specifically. It looks at the contributions of competing methodologies to the evaluation of and evidence for social work research and practice and briefly visits the qualitative v quantitative debate. Having discussed the complex ethical and methodological issues involved in undertaking social work and research, justification of the chosen methods of 'data collection' are then presented. Included within this justification are the Autobiographical Diary questionnaires and (semi-structured) interviews as vehicles for gathering 'data'. Chapter 4 then presents the study's chronology and the process by which this research attempted to address such matters.

3.2 Ethics in Social Work.

The first ever UK-wide codes of practice for social care workers and employers were launched by the General Social Care Council (GSCC) in September 2002. The codes were intended to provide a clear guide for all those who work in social care, setting out the standards of practice and conduct workers and their employers should meet. They were described by the GSCC, (formed in October 2001) as a critical part of regulating the social care workforce and helping to improve levels of professionalism and public protection. At the beginning and during the majority of my social work practice and this research these 'national' codes did not exist. Prior to these GSCC's UK wide codes, social workers have had to contend with a confusing array of ethical and value-based guidance (discussed

below). Whilst referencing more contemporary literature, I have tried to present the ethical framework that underpinned the research, writing and practice of this author between 1996 and 2003.

Ethical issues in social work involve tensions between individual rights and public welfare, between individual responsibilities and organisational policies and practices, people's inequality and structural oppression. An ethical response in social work may conflict with financial accountability and resource availability, it may inform or conflict with legal accountability. It is suggested that ethical issues *'lead to moral dilemmas and a balancing of rights, duties and responsibilities for which there may be no 'objective truth', no 'right answer'*, (Lishman, 1998, p90). Lishman appears to reflect an acknowledgement that 'ethical' and 'value' issues are an integral part of social work practice and research. Similarly, Banks says *'There is general agreement amongst social work practitioners and academics that questions of ethics, morals and values are an inevitable part of social work'* (Banks 2001 p.9) and CCETSW stated that *'practice must be founded on, informed by and capable of being judged against a clear value base.'* (CCETSW 1995, p.18).

The difficulty for social work though, is compounded in that its roles are not precisely defined and, at differing times, they are required to react to varying degrees of public scandal that create a moral panic that somehow makes the social services departments responsible for societal difficulties and some individuals' behaviours. Such tensions and difficulties are inevitably reflected in any research into social work. Butler suggests that social work research is about social workers, what they think, what they believe, what knowledge they claim and what they do with it and its primary (but not its only) audience will be social workers, service users and those who determine who falls into which category for the purposes of public policy, (Butler 2000). If this is so, then the ethics of social work research must, I would suggest, be at least compatible if not coterminous with the ethics of social work. The tensions between these different expectations and purposes of social work lead to its ambiguity and uncertainty, particularly in practice, and also

render simple definitions of the nature and ethical base of social work research, problematic.

The proposition remains that the ethical foundation for a code of ethics for social work research is to be derived from the ethics of social work itself. Such a code of ethics is to be applied when the nature of the research activity is designed to engage with the practice of, in this case EDT, social work and to be addressed primarily to a social work audience, which might include practitioners, service users, policy makers and other social work researchers.

At the time of writing there were difficulties in finding one general, consensual statement of social work ethics that could easily be applied to the service of social work researchers. There were several. *How* then can the ethics of social work be made the foundation for the ethics of social work research, assuming one accepts the argument that they should be? Hugman and Smith (1995) having traced a brief history of social work ethics from Biestek, (1961); and (Butrym), 1976; to the CCETSW Paper 30, (1991) echo MacIntyre, (1985), and bemoan the *'failure of the philosophers of the late eighteenth-century Enlightenment to provide a rational basis for morality which would command general public assent'* (1995 p.9). They clearly recognise social work as a moral activity and see in the complexity of social work practice (see also Trevillion, 2000) the impossibility of devising universal ethical principles. There are simply too many contradictory 'world views' at play and too many conflicting interests. The promotion of choice for one may restrict the choices of another; the protection of the vulnerable may entail the attachment of stigma to someone else and so on. Hugman and Smith (1995) also make it clear that whilst social workers make moral choices (*'What is the right thing for me to do here?'*), they do not necessarily make them in circumstances of their own choosing in that social work also serves other than individualised, welfare directed ends. Banks illustrates the diversity of ethical positions by presenting three of the main frameworks of moral thinking, 'Kantian',

'Utilitarian' and 'Radical' (Banks 2001 p. 60) and explains the challenges to traditional thinking about ethics posed by radical and anti-oppressive approaches.

This research sought to examine whether any implicit or explicit code(s) of ethics were applied by the group of EDT workers and if so, to what extent they informed practice and/or helped these workers make consistent decisions when faced with practical dilemmas.

As an EDT worker and researcher into out of hours social work, Husband's account (1995) of the 'morally active practitioner' is helpful. In articulating the struggle for an ethical pluralism that arises from his engagement with anti-racist practice, Husband argues for eternal moral vigilance in the form of the 'morally active practitioner' who would recognise the implementation of professional ethical guidelines as desirable and as being permanently irreducible to routine. Doing one's duty may not be the same thing as being morally responsible. Doing one's duty may be mere compliance; an habitual and ultimately habituated application of generalised responses to a particular instance. *'Morally engaged practitioners could not hide within this professional ethical anaesthesia, but would retain their responsibility for their professional practice and its implications'* (Husband,1995 p.87). One of the aspects of this research (see Chapter 1, 1.6 and Chapter 4, 4.2) was to examine some of the theoretical frameworks applied by EDT workers and how or whether consistent approaches were achieved, (or desirable). The 'morally active (EDT) practitioner' therefore, should acknowledge the need for an ethical framework but will not reduce the application of such a framework to mere routine.

This research was closely linked to the ethics and value base of my own social work practice (for further detailed discussion see 3.7 below) that was developing and informed by such codes as those provided by CCETSW (1989) (see Table 3.1 below) and BASW (1996) that promoted a commitment to 'social justice'.

Table **3.1** *The values of social work (1989)*

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1. Qualifying social workers should have a commitment to:

- the value and dignity of individuals;

- the right to respect, privacy and confidentiality;

- the right of individuals and families to choose;

- the strengths and skills embodied in local communities......

2. Qualifying social workers must be able to:

- develop an awareness of the inter-relationship of the processes of structural oppression, race, class and gender;

- understand and counteract the impact of stigma and discrimination on grounds of poverty, age, disability and sectarianism;

- demonstrate an awareness of both individual and institutional racism and ways to combat both through anti-racist practice;

- develop an understanding of gender issues and demonstrate anti-sexism in social work practice;

- recognise the need for and seek to promote policies and practices which are non-discriminatory and anti-oppressive,

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Source CCETSW (1989), pp.15-16

The term social justice was not always clear but BASW prescribed certain objectives:

> *'the worker has the right and duty to bring to the attention of those in power, and of the general public, ways in which the activities of government, society or agencies create or contribute to hardship and suffering or militate against their relief.'* (BASW, 1996, para.7)

Whilst it is not within the remit of this research to explore the developments of such 'codes of ethics for social work' since CCETSW and BASW published theirs, it is clear that the

recently formed GSCC has promoted the importance of social work having and adhering to such a code.

The ethics of this research study are complicated therefore, because the subject matter is complicated. The process of this research not only sought to be located within the 'code of ethics for social work practice' such as are referred to above but also, because 'human volunteers' were involved, had to be guided by another set of principles namely the ethical code laid down by the University's own Research Committee, '*Research projects involving human volunteers are subject to the Ethics Committee Regulations and Guidelines.*' (LJMU 1995, G 4.9). Although 'human volunteers' referred mainly to subjects of medical research in which more intrusive action than interviewing took place, taking blood samples for example, a separate process was completed to ensure this research remained within the proper framework of the University's own ethical code. Specific application was successfully made to the University's Ethics Committee before commencing this study and was expected to follow similar (social work) principles as are indicated above (respect, privacy, honesty and confidentiality).

Social work and ethics separately are complicated. Research into the ethics of social work therefore is potentially very complicated. Research into lone EDT working by a lone EDT worker of his own practice, his colleagues and counterparts was likely to need a clearly defined ethical code with boundaries that were all embracing but at the same time flexible and adaptable over time.

This combined approach in which research and social work codes of ethics were applied to underpin a 'morally active practitioner' model is now discussed.

3.3 Ethics and EDT Research

(a) Confidentiality – This refers to the preservation of personal information concerning the participant (service user or research participant) which is disclosed within the professional relationship. Whilst Biestek (1961) describes confidentiality as based upon a basic right of participants and as an ethical obligation for the social worker, Banks (2001) portrays an ethical position that EDT workers should recognise in which there are boundaries to confidentiality. Participants' rights are not absolute and may be limited by a higher duty to self, by rights of other individuals, the social worker, agency or community. EDT workers are expected to set the appropriate confidentiality boundaries at the outset of any contact with service users ensuring they understand that any request 'not to tell anybody else' can rarely be agreed. Similarly EDT workers are regularly faced with decisions regarding what 'kinds' of information should be passed to colleagues in the daytime teams or the police. Letters were sent to the Ethics Committee, the Association of Directors of Social Services, North West Emergency Duty Team Training Consortium (NWEDT) and the Emergency Social Services Association (ESSA) as well as to prospective participants in Phases 1 and 2 outlining the nature of the research and specifically highlighting the issue of confidentiality stating:

> *'I would like to stress that this research is completely confidential and is entirely separate from any internal review of EDT presently being produced. Your contribution to this study will remain anonymous and confidential.'* (Letter dated 24th June 1997 see Appendix 3).

The issue of ensuring that information given via questionnaires and interviews would only be used for the intended purposes of the research was particularly pertinent in phase 1 when all of the respondents were well known to the researcher as friends and/or EDT colleagues from the same local authority. Participants were given an explanation in writing

before the questionnaires and in writing and orally before the interviews of how, when and where the data collected would be used for the purposes of this research. Participants in the interviews that were tape recorded with their prior permission were offered the opportunity to stop the tape at any time, have their own copy at the end and their own transcript of the interview.

An underpinning value base of social work practice is to behave in an honest and open manner giving as much information as is relevant and allows the participant (service user) to be as fully informed in the assessment process as possible. Within this research I have tried to adopt a similar position by giving research participants full information regarding the background, aims and objectives and the eventual possible final uses of this research.

(b) Anonymity - This refers to the process by which information is collected from participants but any details that might enable the readers of the research to identify the contributors are withheld, concealed or appropriately altered. In this study it was impossible for the interviewer not to know the interviewees in Phase 1 as they were colleagues; however this meant that additional assurances had to be given to the respondents that anonymity would be preserved and no data reproduced in the thesis would identify them as individuals. Written and verbal assurances were given during both phases of this research regarding anonymity. I felt this was particularly important as both sets of questionnaires asked the respondent to identify their local authority, their status, age and gender. In the covering letter to respondents in phase 2 it states:

'The completion of this questionnaire is completely confidential and no attempt will be made to identify those that fill them in. The only reason for asking you to identify your gender and the 'type' of EDT team you work in, is to test a hypothesis concerning possible different responses between men and women, and to examine

the influences, if any such exist, between working alone and working with others.'
(Appendix 13).

Interestingly, many respondents signed their questionnaires even though they were not asked to identify themselves, nor provided with any specific space for signatures. As some of the respondents were the only ones from their local authority I was not able to make specific references to the actual local authorities other than their participation in the research as this might have identified the lone contributors. Instead I had to generalise certain findings to 'types' of EDTs (See Chapter 7). Similarly when certain contributors have made valid comments regarding their personal circumstances, I have not been able to include it as it would have identified that respondent to the others in phase 1 (many of whom also know each other). Maintaining this level of confidentiality and anonymity meant that the questionnaires were categorised on return by number and not name. The tapes of the interviews that followed were also numbered (even though I knew all the interviewees in phase 1 and most in phase 2) so that the data collated was anonymous and confidential. One practical difficulty that arose was in the phase 1 questionnaire returns that were hand-written. Having worked with most of the 21 respondents I could recognise their hand-writing even if they had not identified their gender and length of experience. In other words it was very difficult to provide complete anonymity at the questionnaire stage for phase 1 respondents, and impossible at the interview stage. One option perhaps might have been to use a research assistant, this was however quite impractical given the additional time and expense involved.

These latter issues of confidentiality and anonymity relate specifically to the fact that as the researcher I had a range of different relationships to the respondents. As an EDT worker who saw himself as part of the research as well as the collator of that research, there were a number of specific ethical and practical issues to address during the research process. Some of these issues are now presented. There are complex methodological issues relating

to the researcher being part of the research group and the interviewing of peers, but these are considered separately later in this chapter (see 3.6). It is the ethical and practical implications of interviewing peers and the author being a part of the research that are now considered.

(c) Relationship of Researcher to Research Respondents –

In this research, it is hoped to be able to show how the identities of 'researcher' and 'researched' are fluid, dynamic relations of power, by which 'knowledge' is achieved through processes of negotiation and access to sites of knowledge/power (Foucault 1980). From this perspective, knowledge is not an entity for which definitive claims of 'reliability', 'validity' and 'credibility' can be made. Nor are 'research ethics' simply the responsibility of the researcher but instead are complex and shifting exchanges of power/knowledge between 'researcher' and 'researched'.

Bell and Roberts (1984) highlight a related methodological issue that they call the 'Personable and the Powerful' by which they mean the inherent obstacles of interviewing one's peers and they specifically highlight the complexity of the term 'peer' which transpired to cover a diverse range of different barriers to interviewing. Platt (1981) analyses methodological issues that are particular to doing research on a community of which one is a member and asserts that a major methodological problem is that data collected from one's sociological peers is not 'raw' data, but is filtered through sociological understandings, ('raw data' in this context is intended to mean the type of so-called 'objective' data, scientifically collated which is value-free, unaffected by the inter-relationship between the interviewer and the interviewee which can be objectively validated and measured.)

I was acutely aware throughout the 6 years I undertook this research process, that, as an EDT worker and the researcher into EDT related matters, I was involved in a complex set of inter-personal dynamics. This research needed to acknowledge the differing 'identities'

of the researcher and the powerful inter-relationships that existed during the 'data collection'. To the group of respondents in Phase One, this researcher was a colleague, a friend, a supervisor and a supervisee as well as a relatively high ranking trade union officer (Chair of the Branch and Regional Delegate). In Phase Two for some of the sample group, I was 'merely' another EDT worker from the North West of England (and relatively inexperienced after 'only' ten years of EDT service), whilst for others I was a regional delegate for the National Association (ESSA) and a member of the Planning Group that co-ordinates the North West EDT Training Consortium, as well as being an experienced EDT worker.

The author's position within this research therefore, may have served to provoke a variety of reactions from the respondents, some of which could be viewed as potentially negative and others that could be termed potentially positive, but all of which are likely to have had some impact.

Potentially negative

(i) Some respondents may have viewed this research as too 'academic' and a luxury that 'real' social workers should not have the time or the inclination to undertake. This may have meant fewer responses to the questionnaires sent out in Phase 2 or that the responses were not treated seriously as the respondents felt no connection with any 'EDT reality'. Other EDT workers may have viewed the 'project' as a means to acquiring unnecessary status (in academic and EDT terms) which similarly would have reduced the likelihood of questionnaires being returned. In order to address these issues and prepare respondents for the questionnaire, introductory letters (see Appendix 3 and 13), were distributed that tried to provide a context in which their contribution was viewed as being extremely valuable in the absence of any such research ever having previously been undertaken. Secondly, I was honest about, and clearly presented, the purposes of the research and the potential for a PhD 'academic' qualification to follow. In other words, and consistent with the right for

EDT workers to choose to participate based on full information, I tried to give as detailed information as possible.

(ii) In Phase 1 (see Chapter 4 for the process of the research and Chapter 6 for the 'results') questionnaires and interviews were used on a research group that consisted entirely of my work managers and colleagues (past and present). I needed to be aware that this new research relationship may have provoked different responses to the research and to our previous 'professional' relationship. My EDT peers might not have been comfortable sharing practice issues with a colleague, firstly because this might have been viewed as the remit of a supervisor, and secondly because the culture within this local authority was that lone EDT workers rarely shared practice issues with their manager let alone with each other. Whilst wishing to respect their right not to participate, I also needed some respondents in order to undertake this study and had to balance their reluctance against the purposes of this research and my ability to allay some of their concerns via letters and talking to them about the process of the study, its confidentiality and anonymity (see above for discussion of confidentiality and anonymity). By being clear about the purpose and process of the research, I also intended to prevent colleagues being 'too honest' in their responses on the assumption that as a colleague and/or friend I would not have to take contentious matters, such as poor practice 'confessions', any further. I explained before all the interviews for example, that any breaches of the Employer's Code of Conduct would have to be recorded and gave examples of dishonest acts such as theft and fraud as well as anything that might be considered gross misconduct. In an attempt to equalise the interviewee-interviewer relationship and in an attempt to 'set the appropriate tone', I gave many examples of weaknesses from my own social work practice as well as information from my own personal background and explained that confidentiality was a two-way process in that I expected my information to be treated appropriately.

(iii) Another negative potential outcome in the research relationship was that I was (am) friends with some of the participants in Phase 1 as well as being their work colleague. The

concern I had was that respondents would agree to participate not because they wanted to, but because they did not want to disappoint me. I was aware of the possible difficulties in, for example, being critical of a colleague's practice in interview when that person was also a friend.

(iv) One other negative possibility was the response from my managers of EDT who were also part of the research group and might have felt threatened by a supervisee being an interviewer. Throughout the questionnaire and interview stages I tried to avoid questions that would indicate a 'right' and 'wrong' response in relation to EDT practice, preferring to elicit views and explanations.

Potentially Positive

(i) I did not wish to unfairly use my influence within NWEDT and ESSA to promote my research, but was able to 'advertise' it via various conferences and training days. This meant that when EDT workers from around the country were sent or given a copy of the questionnaire they would have prior knowledge of it and be more likely to complete and return it. On reflection, I believe this use of my 'influence' exerted more pressure on respondents to complete the questionnaires and agree to be interviewed, than if I had simply sent them all a questionnaire with an accompanying letter. The positive is that so many EDT workers contributed to the research process – the negative is that they may have done so only because I gave numerous presentations at conferences during which some of them decided to complete the questionnaires. In terms of giving fully informed consent free from adverse pressure I am not sure this was achieved in all cases.

(ii) As an EDT worker I was most interested in the subject of the research and was able to empathise with many of the scenarios and dilemmas that respondents presented. A positive aspect of the researcher-researched relationship therefore, was that many respondents

acknowledged that I had undertaken many years of EDT service and therefore understood their difficulties. This meant that they were interested in the research and more than willing to participate in a study in which they felt comfortable about 'disclosing' practice weaknesses.

It was important that the researcher was properly and honestly located within the research process, the subject matter, and the dynamics of gathering 'data'. This location was informed by an anti-oppressive and autobiographical perspective (see 3.6). Potential hurdles were identified during the research process that sought to equalise, for example, the interviewer-interviewee relationship, and honestly acknowledge the value of their views as well as the inherent difficulties of entering into a participatory dialogue with a peer, friend, colleague or supervisee.

One specific dilemma that existed throughout this study was the decision to exclude service user involvement. This apparent contradiction of the researcher's objectives and values sits uncomfortably alongside social work practice and research values of promoting the interests of service users and carers. I have tried to explain my decision in the introduction (see 'Delimitations of the scope of the research and key assumptions') but feel that in this study I have perpetuated the notion of the service user group as powerless and voiceless, and therefore, the end product is I fear somewhat devalued. As is explained in the introduction, the difficulty with including service users' views in this research is as a result of the one-off nature of the contact and the fact that no caseload responsibility is carried by the EDT worker. Whilst a third party may have been employed to undertake such a study it was believed to be beyond the means of this researcher.

I would suggest though, notwithstanding the absence of service user involvement, that at all stages of the research process, from inception, resourcing, design, investigation and dissemination, I have tried to maintain an active, personal and disciplinary ethical awareness and to take practical and moral responsibility for this work. I have tried to be a 'morally active practitioner' (Husband 1995). I have chosen methodologies that I believe

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best serve the aims and value base of this study (see 3.6 – 3.9 below) and have maintained as a focus the potential benefits for the out of hours service users. By setting out clear boundaries to the research and specifically to both the questionnaire and the interview stages of the study I sought to avoid compromising the respondents (or myself), and by setting an anti-oppressive and tolerant framework in which discriminatory language or behaviour would not go unchallenged, I sought to reflect the aims of my practice and this research. At the same time by adopting an autobiographical approach and a semi-participative structure to the interviews I tried to have my own bias and that of the respondents acknowledged. I remain unsure how successfully I made explicit my own views, particularly relating to such matters as *social justice*, the impact of *poverty*, *class* and membership of the *social divisions*.

Throughout the production of this thesis I have reported the findings accurately, completely and without distortion and have noted any significant variables and conditions that may have affected the outcomes or the interpretation of the data. This included results which reflected unfavourably on some agencies of central or local government, vested interests (including the researchers' own and those of his employer) as well as prevailing wisdom and orthodox opinion.

Finally, I have already had some of the research findings during the process of this study published (see Appendix 1) and have properly and in proportion to their contribution, acknowledged the part played by all participants to that research process. In the thesis itself too, I have noted the major contribution of my tutor and two 'arms length' supervisors.

I have tried to present the ethical framework of this research and that of my social work practice. The ethical issues in social work and its research are not static; they are complex and involve a range of tensions. The issue of 'knowledge' for social work is similarly difficult to define and complex and one that is now discussed.

3.4 Qualitative and Quantitative 'Knowledge'.

The above represents a detailed consideration of some of the complex ethical issues raised by and during this study. Social work ethics are difficult to define because social work is difficult to define. Banks suggests (2001) that

> *'Social work has always been a difficult occupation to define because it has embraced work in a number of different sectors (public, private, independent, voluntary), a multiplicity of different settings (residential homes, area offices, community development projects) with workers taking on a range of different tasks (caring, controlling, empowering, campaigning, assessing, managing) for a variety of different purposes (redistribution of resources to those in need, social control and rehabilitation of the deviant, prevention or reduction of social problems).'*
> (Banks 2001, p.1)

The *knowledge* required of social work practitioners therefore, is inevitably very difficult to define given the broad and fragmented versions of what constitutes social work.

The impact this difficulty has on social work research is that anything that claims to have the 'absolute truth' regarding human action and interaction, the core of social work, is met with scepticism. In other words social work research needs to be conscious of the nature of social work 'knowledge' being simultaneously both 'practice wisdom' oriented and 'research-evidence-based'. The two should not be mutually exclusive despite any tension between them.

To further complicate matters, the concept of fact as a universal objective truth, challenged in the natural sciences since the 1960's (Popper, 1969) and a major issue within various professions since (Schon, 1983, 1987; Henkel, 1995 and Lyons, 1999) is more

problematic in social work, where individuals' perceptions, judgements, interpretations and meanings contribute critically to developing understanding and knowledge of the field.

As Lyons (1999) argues, *'scientific knowledge (concerned with prediction the workings of the natural world and controlling it) has been valued in society at the expense of hermeneutic and emancipatory forms of knowledge (concerned with comprehending and communicating with each other and developing views of the world which lead to changed understanding)'*. In social work, 'scientific knowledge' based on the positivist paradigm deals not with 'truth' and certainties but rather with probabilities. For the individual practitioner and user or client there is no set causal link between a problem or situation, a response and an outcome because individuals, their problems and situations are unique. Further, Lyons (1999) following Henkel (1995) argues that in social work we are 'reflective participants in, rather than privileged observers of, particular phenomena and situations,' Schon (1983, 1987) also questions the concept of a knowledge base for professional practice that depends only on positivist research, using techniques which are describable, testable and replicable and which assures objectivity and neutrality. Echoing Husband's (1995) 'morally active practitioner', Schon emphasises the uniqueness, uncertainty and potential ethical conflicts of each new practice encounter and argues for the development of practice knowledge based on reflection, on and in action.

Parton (1999), in an attempt to clarify a continuum of social work practice, contrasts contesting views of social work practice as a 'rational-technical' or a 'practical-moral' activity. It is suggested within this study, that the implications for research of how we view social work knowledge and practice require careful consideration. I believe we need to attend to both perspectives of social work practice since social work is a practical and ethical activity that also needs to account for what it does or fails to do, within the legal, political, cultural and economic parameters in which it operates. I believe it is necessary to attend to both of these perspectives, not simply because of the internally contested nature of social work practice and knowledge, but also because of externally driven requirements

of accountability and regulation (Everitt and Hardiker, 1996, Shaw, 1996). These can be seen in the range of performance indicators and standards being produced by the government presently, for example see The National Assessment Framework (DoH, 2000) or any of the practice standards (DoH, 1999, 2000 & 2001). These 'statutory' requirements drive social work research and practice in different directions of accountability, risk-management, resource rationing and empowerment of the 'customer'. Examples of the 'new' nature of 'knowledge' that are required of social work practitioners, in child care practice, can be found in Parker's quote (Parker, 1999 pp54-55) cited in the introduction to the recent Practice Guidance 'Assessing Children in Need and their Families':

'The body of knowledge available to those who struggle with today's problems of child care is still rudimentary compared with the physical sciences; but it is by far away greater than what could be called upon in the past...' (DoH 2000 p xi)

A further example of the statutory drive to redefine the nature of social work knowledge is found in the conclusion of the first chapter of the same Department of Health publication:

'If social work is to develop further in the twenty-first century, practitioners must not rely on practice wisdom for decision making but use evidence based knowledge...Social work beyond the millennium needs to come of age. This will happen when social workers find an effective voice, develop new roles and establish a better knowledge for their practice'. (ibid.p.22).

Social work research takes places against this background of a national governmental agenda, conflicting criteria and uncalculated risks. In part this is because of 'trade-offs' for the same individual. Is it better for a child to be safe in the care system but risk losing contact with her or his family or to remain at home with the dangers that may involve? In

part it reflects the different interests that social workers have to consider, for example, those of the child, the parent(s), the extended family, the disabled or older person, the carers, the neighbours, other users of the service, and the general public, even assuming for the moment that interests within these groupings are the same.

Sinclair (2000) argues that the complexity of the criteria against which social work can be evaluated provides researchers with both challenges and opportunities. It is possible for social work research to challenge not just the values themselves, but also the priority that is given to particular values in particular situations.

A current discussion is the degree to which social work research is distinguishable from other forms of social research. The degree of distinctiveness and its nature has been and continues to be debated (see in particular Trevillion, 2000, Pinkerton, 1999 Parton, 2000.). The basis of whatever differentiation that might ultimately be made rests, I would suggest, on the rather obvious point that social work research has the practice of social work as its operational domain. The question then becomes one of how far social work is a distinctive profession that draws on a specific combination of other disciplines. Whether social work is a distinct and special profession or a distinct combination of other disciplines, the way that research translates into practice is usually measured in terms of its relevance to the practitioner. In reviewing the broad approaches for research in social work it is useful to consider what constitutes evidence for practice. Macdonald and Sheldon (1998) draw on a definition from Sackett et al (1996). 'Evidence-based social care is the conscientious, explicit and judicious use of current best evidence in making decisions regarding the welfare of individuals' (p71). Few would disagree that social work should draw on current best evidence, conscientiously (from an ethical base), explicitly (clearly and openly) and judiciously (critically, analytically, and carefully balancing and judging the evidence). We should not simply practise on the basis of habit or unchecked practice information or wisdom.

One of the stated aims of this research (see Chapter 1, 1.6) reflects the author's ambition to improve his own social work practice and where possible, that of some of his local and national colleagues. The hypothesis (see 1.6 and 4.2) is that EDT workers operate within a theoretical vacuum and rely almost entirely on 'practice wisdom'. Based on the collective 'practice wisdom' of the EDT respondents collated within this study, an assessment framework, the '4Ps', (see Chapter 8, 8.3) is developed. This Framework seeks to apply such wisdom but also combines it with a more systematic application of, for example, the legislation and contemporary research. In order that this research translates meaningfully into practice, I have tried to present a framework that is neither overly prescriptive nor so open ended as to be meaningless. In particular I have tried to make the '4Ps Assessment Framework' accessible, relevant and applicable to practitioners. The 'knowledge' that is acquired by and presented in this research therefore is less than 'traditional' in that it does not seek to reduce subjectivity, but actively promotes it. Whilst the reliability and validity of the findings are important to the study, they are, to some extent, secondary to their usefulness in practice to the readership and therefore to service users. In contrast to traditional research, I have not opted for either quantitative or qualitative but have eclectically chosen from both.

'Traditional research' is understood as 'positivism' (Bryman, 1988; Stanley & Wise, 1993) and sees knowledge as an outcome, an 'objective' truth that is achieved by minimising 'subjectivity' (Riessman, 1994), that is also known as 'researcher bias' (Olesen, 1994). The value of the research according to this positivist approach is expressed in terms of its 'reliability' and 'validity' (Bryman, 1988). Within this tradition of research, the processes of inquiry are 'depersonalised' and 'neutral', completely and deliberately separated from the personal positioning of the researcher. Within the positivist paradigm, power is unevenly distributed but consistently greater on the part of the researcher rather than the researched, (Chandler, 1990; Everitt et al, 1992.). The interpersonal dynamic between interviewer and interviewee in the positivist tradition is seen as an aspect to be neutralised,

an obstacle to objectivity rather than a critical and integral part of the ensuing 'knowledge' that stems from the research.

This research will adopt the view that the various research traditions are 'different ways to the same end' (Bryman 1988), the end being the understanding of social phenomena. It is not the view of this study that qualitative research is underpinned by a completely different set of epistemological foundations than is quantitative research, but that there are many versions of epistemology. What is required is a less traditional interpretation of what actually constitutes knowledge, and what research is and is not 'valid' should not be determined by the way in which the data was collected necessarily, but also in its meaning to the research. Cheetham suggests that social work and the people it seeks to serve are too important to justify evaluative research that can only focus on a part of its activities and argues that *'a range of studies is required with rigorous analysis of what can and cannot be concluded from them.'* (1992, p.302).

It is acknowledged that some authors (such as Thyer, 1989) might argue that the qualitative and the quantitative research methodologies are juxtaposed, whilst others (Fuller & Petch, 1995) insist that any dichotomy of qualitative versus quantitative research is false, preferring to argue that there need not be a choice between the two ends of what should be seen as a continuum. Dawson, Klass, Guy & Edgley (1991) argue that social scientists cannot disrobe themselves of their personhood and that value free quantitative research is fiction, not fact; so much so that value free research cannot be a goal whereas value aware research can.

Whilst accepting that 'Positivism' has, in the Western world, in the main, monopolised research activity, it is also contended that it may not be possible, within the field of social work, for the researcher to entirely transcend the constraints of value laden research and subjectivity. The choice of subject matter indeed reflects the personal and professional interest of the author. Throughout this research there were parallels between my research and my EDT practice. Some of these parallels are reflected within the autobiographical

diary (see 3.6, 4.11 and Appendix 11), whilst others are reflected in the 'value base' (see 3.6b) and the 'methodological approach'. In my social work practice I am 'eclectic' in that I seek to combine two or more approaches at a theoretical and practical level (for a detailed examination of the different forms of eclecticism see Payne, 1991, pp 47-50). In this research I have combined qualitative and quantitative approaches and, as with my social work, I have tried to use differing but the most appropriate methods according to the subject being studied (assessed). Underpinning my eclectic EDT practice and this research is the recognition that I am an active participant in the gathering and making sense of information whether it is details about a family or data about referral rates. This concept of reflexivity is returned to below (3.6a) and is an example of one of the parallels that underpins this research and my EDT practice.

Finally, the 'audiences' for whom it is undertaken further compound the nature of social work research. Managers and politicians with strategic responsibilities will seek differing data (qualitative and quantitative) than 'practitioners' working face-to-face with families 'in crisis'. Within the target group of EDT practitioners, the very notion of research is often viewed with suspicion and hostility. It is fair to suggest that the relationship between research and social work is problematic (Everitt, 1992). Diverse evidence can be cited as testimony to an historical and contemporary difficulty between those 'in the field' and those 'in the classroom', Younghusband, (1967); Holman, (1988); Shaw, (1996) and Thompson (2002), have all drawn attention to social workers failing to pursue research, failing to implement the findings of research in their practice, and failing even to read the research. Cohen (1985) describes the way in which social workers have criticised researchers for being detached, elitist and preaching about practice from a distance: 'At best practitioners experience research as irrelevant; at worst, as the process of being ripped off.' (1985, p.5). Whilst social work research is sometimes perceived to be quantitative, objective and concerned with social categories, social work practice is viewed as uncertain, complex, spontaneous and concerned with individual difference, and recognises society as

stratified by gender, race, class, ability, sexuality and age, as well as questioning the notion of value free observation.

It is intended that this research will 'bridge' the qualitative and the quantitative seeking to provide what is called 'evidence for practice' (Macdonald and Sheldon, 1998, Everitt and Hardiker, 1996; DoH, 1995; Little, 1997.). This does not sacrifice the positivist for post-positivism, or promote the 'art' above the 'science', 'fact' above 'fiction', but seeks to question their usefulness and applicability for social work research and EDT social work practice. As indicated above, I have used a methodologically eclectic approach in this research. What follows is an attempt, to discuss some of the strengths and weaknesses of the methodologies that are applied within this research.

3.5. Methodological Pluralism

Within social work research therefore, there has been a tendency to a polarisation between quantitative and qualitative methodological approaches, a 'paradigm war,' with quantitative methodologies associated with measurement, causality, experiment and fact, and qualitative methodologies with judgement, values, interpretation, meaning and experience. My purpose is not to rehearse this debate but to argue that such polarisation is unhelpful and detracts from the real contribution of different methodological approaches to developing evidence for research and for practice. Rather, an eclectic or pluralistic approach, utilising qualitative and quantitative methods, as appropriate, and drawing on the concept of triangulation (Denzin, 1989a, 1989b) and 'bridging' (Miller 1997) may, whilst recognising they do not mean the same thing, better encapsulate the complexity of social work practice, and so research into such practice, and address the range of stakeholders and competing interests that presently predominate.

It can be seen from the objectives of this research (see 1.6 and 4.2) that the intention was to combine a study of the qualitative and the quantitative aspects of EDT social work. The range of issues to be explored included the number and type of referrals received by the

team as well as the way in which individual EDT workers prioritise and feel about such referrals. As the author of this research is an EDT officer he was the researcher and the researched, part of the sample group as well as the collator of the data, the interviewer and the interviewee.

It has been acknowledged from the outset that the author will need to carefully consider which methodology or methodologies will most accurately and appropriately, systematically and sensitively gather the diverse information anticipated from this research. A methodologically pluralist approach combining qualitative and quantitative research strategies will be adopted using longitudinal studies, questionnaires, semi-structured interviews, participative enquiry, autobiographical account and 'triangulation' of method. It will be argued that the researcher will have an impact upon and be impacted upon by the research process.

It is the belief of this researcher that a 'multiple study approach' is more likely to encapsulate the complexity of social work practice, and address the range of competing interests within such work, as discussed above. Social work deals with situations and people every day that exist within their own context and relationship to various realities. This is further complicated by the context in which social work itself operates as detailed above.

Against this apparent background within social work and social work research, it is the intention of this study, to eclectically select research methods which complement the subject matter and its stated aims, rather than adopting any single all-embracing method which seeks to address such disparate issues as: The feelings of the workers involved; the numbers of referrals taken by EDT each week, and the author's experience of the research process itself. This research will adopt a range of research inquiries irrespective of their location on the qualitative-quantitative continuum.

This combination approach of multiple study is one that bridges the schism between the research traditions and has been used successfully in social work, elsewhere. The evident

separation between qualitative studies and health surveys, for example, using multi-variate analysis, reflect a legacy of a dichotomised epistemological tradition evident in other areas of sociological research and discussed above. The last two decades has witnessed attempts to overcome the methodological schisms operating between the two traditions. Evidence of the viability and benefits of combined research designs have been illustrated by commentators who have drawn attention to a range of studies which have successfully incorporated both methods (Bryman, 1988, Brannen, 1993). Social researchers from both qualitative and quantitative traditions have stressed the need to incorporate aspects of both approaches in measuring overlapping and different facets of social phenomena (Silverman, 1985; Laurie and Sullivan 1991) Arguments made for the complementarity of mixing qualitative and quantitative methods have pointed to the need to consider both epistemology and the technical aspects in carrying out and resolving tensions in combined work. That is attention needs to paid to both the technical aspects of carrying out such research (e.g. which method has priority over the other and how to achieve convergent or confirmatory findings) and the type of knowledge which is produced and the type of reality or object to which different methods are relevant.

Arguments for using combined methodology within mainstream sociology are particularly relevant to the investigation of key areas of social work and social policy. In relation to the continuity of care and use of mental health services medical sociologists in the US have pointed to the conceptual need to bring together the social process model (associated with a qualitative tradition) and social contingency model (associated with a quantitative model) in order to examine who accesses care in the context of when and how care is received and how choices and strategies relating to help seeking are socially organized (Pescosolido, 1991; Pescosolido and Kroefield,1995; Pescosolido and Boyer 1996) The relevance of this approach for exploring contemporary out of hours social work in Britain is that it holds out the possibility of developing an understanding of the patterns and processes that take place during the night and at weekends. I hope to have demonstrated the benefits of using both

quantitative and qualitative methods to better understand the dynamics of help-seeking and help provision outside of the 'normal' office hours. In keeping with this combination approach, I not only have combined the methodological approaches to research, but also the systems for combining these multiple studies: 'Triangulation' and 'Bridging'.

The concept of 'Triangulation' (Denzin, 1978) goes some way to explain the position adopted within parts of this study whereby a range of research techniques is drawn upon. Triangulation systematically combines different methods of data collection to study the same phenomenon (between-method triangulation). The approach used in this study will be what Denzin refers to as 'Triangulation of method' in which several different methods of data collection are employed in a single study in an attempt to validate information derived from different sources. This approach also permits the weaknesses and strengths of different data collection methods to be balanced. It is hoped, that the use of such different methods and data sets, may also enhance the theoretical relevance of the research, by enabling the researcher to address a wider range of issues and perspectives, and thus obtain insights that would not be possible through the use of one method of data collection or one source of data alone.

The use of triangulation is different to the concept that Miller, (1997) calls 'bridging'. Miller uses the term 'bridging' to explain the research process that employs, 'several methodological strategies to link aspects of different sociological perspectives, not to discover indisputable facts about a single social reality.' (p.25). In contrast, Miller sees triangulation as the attempt to integrate 'different kinds of research evidence into a more comprehensive understanding of a common research object.' (p.25). Miller sees 'bridging' as developing a link, or a dialogue, between the different perspectives to make them 'mutually informative, not to obscure or deny their distinctive features.

In this study I have tried to both triangulate and bridge the research evidence regarding EDT activities. The methods chosen triangulate three different types and sources of information (1) the personal/participatory experiences of the researcher, (2) 'hard data'

relating to quantitative referral details and (3) The thoughts and practice examples of EDT workers from throughout the country, (see Diagram 1). Alongside these triangulated elements I have attempted to bridge the different research objects and establish a dialogue between the facts and the feelings, the researcher and the researched. The aspects that are being 'bridged' within this study are, on the one hand, the meaning and experience of EDT for the author and his colleagues, and, on the other hand, the reality of the pathway of a referral to the out of hours service. The 'autobiographical will be 'bridged' to inform the statistical, the perceptions of the workers bridged with the 'reality' of the service provision. Put simply, this research combines methodological approaches in examining different elements of EDT work and develops links between the differing 'types' of research evidence often seen as contradictory.

Triangulation (Diagram 1)
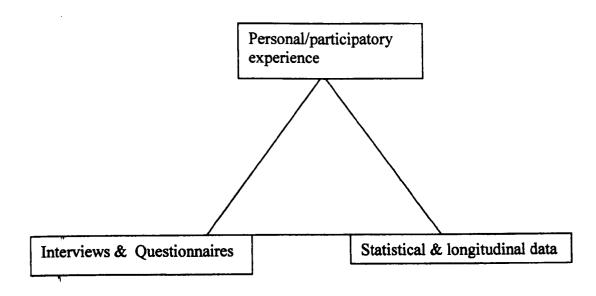
Diagram 1 (above) represents the methods that are employed in this study. A range of research techniques have been used to incorporate:

1. *The subjective, personal and autobiographical elements.* The researcher's views on the EDT matters being explored as well as the research process and how both impact upon

the author/practitioner. In order to gather this information an autobiographical diary has been kept and the nature of the subjective biases has been built into the research process. The author was seen as a participant in the process and experience of this research. For a detailed discussion of the autobiographical see below (3.6a)

2. *Practice wisdom*. The collective knowledge of EDT workers and the record of social work practitioners' views were gathered in this research via questionnaires and interviews. These methods are discussed below (3.6 i and 3.6 ii) and the results presented in Chapters 6 and 7.

3. *The theoretical*. The third aspect to this research was the 'theoretical' in which statistical data was collected regarding the number and types of EDT referrals. The longitudinal study over the six-year period of this research was also supplemented by a detailed examination of what could be learned from social work literature (Chapter 2) that already exists 'in theory' (legislation, literature, guidance and procedures). Chapter 5 examines in detail the longitudinal study whilst 3.6 iv presents an explanation for its inclusion in this research

The different methods of data collection referred to (see 3.6 i - iv below), namely diary, questionnaire, interview and longitudinal study, are combined to study the same phenomenon, EDT work. This triangulation of method seeks to validate information gathered from the varying approaches and seeks to establish the relevance of such data by reference to the range of method applied.

Bridging Diagram 2

| Qualitative | Quantitative |

| EDT Experience
EDT Processes | EDT Referrals
EDT Procedures |
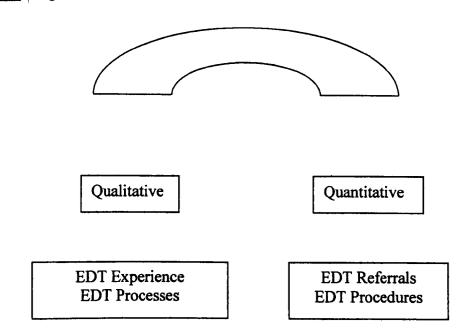
Diagram 2 above illustrates the 'bridging' that this research seeks to adopt. There are differing historical, hermeneutic, political and psychological perspectives that are employed whenever research is undertaken. This research accepts the differences between the techniques, but also uses aspects of the different research strategies to develop a connection between the 'bridged' perspectives. In the case of this research, I have explored the individual experiences and feelings of doing EDT work and 'bridged' this with the way in which various referrals are dealt with by the worker. I have attempted to apply statistical data collection methods (the longitudinal study), and link the process and findings of this data with the feelings of the EDT workers themselves, as well as the process of the referral. In other words, whilst the specific data of referral details are shared, these are bridged by an analysis of the various potential responses to them. Similarly, departmental and/or governmental procedures are 'bridged' with the reality of EDT processes, and, the collection of the 'facts' regarding, for example the number of referrals, is then compared with the workers' perceptions of busy and quiet times on duty. The quantitative is

'bridged' with the qualitative; the mathematical world is blended with the social world. The meaning of EDT for the practitioners and the author are bridged with the reality of what happens to an EDT referral. The 'practical' is contextualised by the 'procedural', the 'personal' be the 'political' (see Chapter 8). As such these aspects of the research are connected and interconnected by the subject albeit they are examined from different perspectives and could 'stand alone' as research subjects in isolation of each other. This strategy of employing and combining multiple studies enabled the research to incorporate the diverse nature of the subject matter.

Having provided a rationale for a methodologically pluralist position that spans the qualitative-quantitative continuum and a triangulation of methods that combines different research approaches, a justification of the specific methods used within this research is now presented.

3.6 The Range of Methods

The strengths and weaknesses of each of these approaches to research lie not simply in the methodology involved but also in the application to social work practice, the contested nature of social work knowledge and the complex nature of EDT social work, with its multiple purposes, agendas, constraints and stakeholders. How I chose to apply and use a methodological repertoire in research and evaluation needed to attend to the tensions and complexities involved in practising social work generally and outside of normal office hours specifically. I intended within this research, to try and identify a methodological repertoire that would both collect relevant information and withstand theoretical scrutiny, whilst also seeking to ensure that the outcomes were relevant to EDT social work practice.

In summary therefore, I am suggesting that social work is a complex activity that can neither be adequately encapsulated by a singular school of 'art' or 'science', nor any single method of 'data' collection. In order to accurately explore the 'individual' and the 'institutional', the 'rational-technical' and the 'practical-moral' components of social work,

it is argued here it is necessary to combine the qualitative and the quantitative research strategies and establish a methodological repertoire. It is my view that within the worlds of the social work practitioner and the social sciences researcher at least, there is a trend away from positivism and towards an increasing recognition that the researcher is a participant within, rather than a neutral observer of, the social world (Clifford 1998, Sheppard 1995, Lyons 1995, Schon 1987, and Parton 1999). The following methods were used within this study as the means to collecting the complex 'data' that could be viewed as EDT social work 'knowledge'.

(i) *The Autobiographical Diary*

Methodologically this research lay between the positivist and the naturalist traditions, and argues that along the qualitative-quantitative continuum, there should also be a place for what Opie terms 'Appropriation of the other' (Opie, 1989-90 p.53). In other words, the researcher needs to recognise that they are engaged in a fluid process of identifying and questioning ideology, the location of the writer within the literature and the personal and the political implications of methodology for the participants in the study. It has already been indicated above that the relationship of the researcher to the subject and the respondents is a complicated one (see 3.3 above *'Relationship of researcher to research respondents'*).

Some feminists have been critical of the methods of research, which predominantly promote the 'scientific' (positivist) tradition, arguing that in its pursuit of 'objectivity' and supposed neutrality, science has been conducted in such a way as to objectify 'the other'. Methods of feminist data collection and analysis, developed from an understanding of the personal as well as the political, have emphasised the exploration of subjective experience and understandings of the researcher, as well as the researched. (Roberts, 1981, Stanley, 1990).

Furthermore, Dutt (1990) suggests that a researcher's own value systems have an effect on the subject chosen for research and, indeed, the outcome of that research. Rather than denying this impact, this research will consciously locate the author within that research. It is the belief of this researcher that 'autobiography' and 'reflexivity' are component parts of the research process. As Clifford (1998) states: '...there is no justification for ignoring the issues of reflexivity in research, and every reason to take seriously the auto/biographical and ethical and political issues that arise in the study of lives in particular.' (p49).

Whilst some commentators regard all social research as 'asymmetrical' knowledge, (Chandler, 1990, p.129) characterised by one way flow of information (Hall & Hall, 1996 p.177), with knowledge and power all on the side of the researcher others, Humphries (1994), and Burgess, (1984) see it as a more fluid process, in which the positionings of the 'researcher' and the 'researched' are intertwined and at times interchangeable.

It is the expressed intention that as part of its repertoire, this study will positively promote an autobiographical (eclectic and generic methodological) approach, rather than attempting to stand outside of the subject matter looking in, the researcher will consciously explore the experience of the research process, at times deliberately advocating the need for subjective, person-centred research. As Reason demonstrates, the 'co-operative inquiry perspective is that research is always personal and political...' (Reason, 1993 p.108); similarly, knowledge is always from a perspective and for a purpose. By adopting a reflexive, autobiographical approach it should be possible for the author to recognise some of the impact of the subjectivity and the bias, which occurs as a result of class, culture, gender and power (perceived or actual).

The intention therefore throughout the duration of this study was to reflect upon the impact of the research process upon me and my impact upon it, as well as to consider my own EDT practice and any connections between it and the research. The method for recording this reflection was the 'autobiographical diary'.

Elliot (1997) suggests that diaries have been relatively neglected as a sociological research method. He argues that despite their relative invisibility, diaries have a contribution to make to sociological research which differs from life history accounts or in-depth interviews more commonly used in the literature on autobiography and on qualitative social research methods. Diaries track the 'contemporaneous flow of public and private events' (Plummer, 1983 p.170). They are not given 'all of a piece' - such as a life history might be - but rather are written discontinuously, either daily or over longer intervals of time (Allport, 1943) and as such provide a record of an ever-changing present. Rather than documenting the present, other autobiographical texts or life documents - such as letters, for example, tend towards making retrospective sense of a whole life or towards retelling significant moments. This proximity to the present, the closeness between the experience and the record of experience means that there is the perception at least that diaries are less subject to the vagaries of memory, to retrospective censorship or reframing than other autobiographical accounts.

Within the autobiographical tradition, diaries are one of the 'documents of life', that is a 'self-revealing record that intentionally or unintentionally yields information regarding the structure, dynamics and functioning of the author's mental life' (Allport, 1943 p. xii). The use of such documents is common within historical and anthropological research, but has been rather neglected within the social sciences (Plummer, 1983). There is however, a strong tradition of autobiographical and diary-based research within the feminist research (Personal Narratives Group, 1989, Swindells, 1995; Stanley, 1995). This kind of work has been influential in broadening the focus of autobiography from the 'elite few' (Stanley, 1995, p.13) and making visible experiences which are often hidden. Recently there has been a growth of interest in auto/biography within sociological research. This has drawn on a wealth of sources, including lonely hearts columns (Pearce, 1996) and Quaker meetings (Collins, 1996) and has highlighted the even greater variety of autobiographical texts in

everyday life, ranging from published memoirs to television and radio programmes such as *This is Your Life* and *Desert Island Discs* (Stanley, 1992).

From the outset of this research I decided to maintain an autobiographical diary for a number of purposes. One purpose was to record practice issues as they arose for me on EDT throughout the six years of this study. Given that one of the aims of the research was to improve my own practice and seek to improve that of my colleagues, this diary was an attempt to record practice issues with some reflective commentary so that I and possibly the readers of the thesis could directly compare and contrast experiences as well as considering other potential responses in similar circumstances. This diary method was intended to provide the 'audience' with some 'real' experiences encountered out of hours and clearly lays out the author's responses to those experiences. This diary approach was meant to identify some subjective aspects of the author, or what I have termed, my 'autobiographical template'.

Clandinin and Connelly (1994) assert that since the social sciences are concerned with humans and their relations with themselves and their environment, then they are founded on the study of experience. Experience, therefore is a starting point and key term for social science inquiry; this appears juxtaposed to the 'scientific' view that 'experience' needs to be constrained within rigid terms of reference that have the effect of minimising the appropriateness of subjective experience as a source of research data. Stanley (1992) supports a position which validates the use of such autobiographical material suggesting that the 'subjective' is an inherent part of the research which needs to be acknowledged. In reality then, this study was, in part, concerned with the study of experience and the autobiographical diary used to record actual experiences that then formed part of the research. Sarason's autobiography makes the point that his life as a psychologist, and his life at large are intertwined, 'He is a human being as a psychologist and he is a psychologist as a human being.' (Sarason, 1998 p8). The interconnections between the researcher and the subject matter are to be explicitly acknowledged as impacting upon

both. In many ways the methodological premise of this research is a reflection of the author's social work practice and value base, it is generic, eclectic and seeking to empower those usually excluded, whilst simultaneously challenging the so-called accepted 'norms' that impact upon social work practice and research. In order to explain and explore this relationship between the researcher and the subject matter (EDT) the diary was maintained and was intended to provide a context of the researcher's social work practice for the reader.

A secondary aspect to the diary was to record a reflection on the research process and how or if it related to my EDT practice. Entries in the diary present the reader with my subjective experiences of the research process itself and some explanation of the related difficulties. The purpose of this was to allow the reader to more fully participate in the entire research process as well as to provide me with the opportunity to review the connections between my research and my practice. Put simply, I wanted the 'audience' to be able to locate me (and possibly them) within this complex research process by having as detailed an understanding of the practice and research issues and my responses to them.

The autobiographical diary is consistent with a reflexive approach to research that is 'honest' about the autobiographical template of the author and seeks to locate the researcher as a participant in the social world. Stanley advocates the importance of intellectual autobiography for all researchers as a means of displaying the analytical issues involved and thus 'helping the reader to engage with the resultant knowledge-claims' (Stanley, 1996, p.48). The autobiographical details contained throughout this thesis and within the research process (particularly the semi-participative interviews see below) were intended to serve that function of locating the reader. Each diary entry is dated and in some cases the exact time is noted too to provide the reader with a sense of when each event occurred within the six years of this research. For example the following diary extract is from 2001:

Saturday January 27th 2001, Holocaust Memorial Day,

'I am heavily involved in a local Holocaust Memorial Project that seeks to promote understanding of and learn lessons from the events of the Holocaust. Organising events including trips to Auschwitz with survivors seems to put EDT work into a different perspective. Whilst there are commonalities such as the institutional inequalities, human cruelty to other humans and social divisions, the events of the 2nd World War are on a scale and intensity that I find much more difficult to comprehend. Once again the experiences of the Project tend to feed into my abhorrence of cruelty, injustice and 'bullying' and feed my determination to tackle such issues as they arise on EDT. This though is tempered by recognition of the limitations of such social work practice and an acknowledgement that as an EDT officer I am also part of the problem.' (Autobiographical Diary)

Consistent with the reflexive approach also, I have tried within the autobiographical diary and this thesis to locate myself within this research project and explain the personal/professional/political positions that I believe impact upon my social work practice and this research. There is no attempt here to disguise the subjective nature of some of these views, as the purpose is to enable the reader to share some of my 'biases' as a researcher/practitioner. The following is intended to help the reader understand the 'autobiographical template' of the author. It is also meant to contextualise the research approach and the EDT social work practice of the author. It is hoped that by including regular references to the Diary and the subjectivities of this researcher, the readers may be encouraged to examine their own autobiographical template in terms of how they might have managed the particular research or practice issue.

Difference:

On reflection, there are many examples I could cite that may go some way to explain my strong affiliation to supporting and celebrating 'difference'. I was brought up in a single parent family by a mother who was from a traditionally working class background who wanted what was best for her children and had educational (middle class) aspirations that would partly be met by getting one of her children into private school and University thereafter. Much to the delight of my Mother, and the amazement of my sisters, I was to fulfil those educational aspirations. A financially assisted place set me apart from my school colleagues, but no-where near as much as accent, address, personal wealth (or, more accurately, lack of), interests and values.

Influenced by my active involvement in the Anglican ('high') church, as well as my mother's work with children with disabilities for social services, I became interested in the religious/moral and philosophical debates around disability, poverty and social justice. Aged 12 years of age and much to the dismay of the priest at the time, I organised the first ever 'choir strike' in support of fairer wages for undertaking extra choral duties at the weekends (ironic given my present employment that covers weekend working). As a 'conscientious objector' to the Combined Cadet Force that saw sixth form pupils 'dressing up' in army uniforms 'on parade', as an alternative, it was arranged that I would visit 'the vulnerable' in the local community to offer them company.

Having spent 6 years listening to people saying they couldn't believe I went to a private school, I was to spend the next 4 years at University listening to people saying they could not believe I was training to be an Anglican Priest. As it turns out, they were right as, after the first year I decided to follow the Honours/Masters degree route rather than the Ordination route. My Final year dissertation was a study of Apostasy (loss of religious faith), which, I feel sure, set me apart from the other prospective ordinands. Whether it was actual or perceived, for the majority of my early 'academic' years, I felt different and the need to justify and even defend my life choices. As a vegan also, I had made choices that I

believed reflected, and were consistent with, my pacifist and anti-establishment values. Also at this time, 1983, I was expelled from the Labour Party for views and actions considered then to be 'outwith Labour party policy': (1) Cancellation of the Third World debt, (2) retension of a national coal and steel industry and (3) opposition to the privatisation of the public caring services.

My community social work training at another University further cemented my belief in the need to challenge established practices and ideas, celebrate difference and recognise the institutional impact of some policies and legislation upon some groups of, already disenfranchised, individuals.

Post qualification I worked as a Residential Social Worker in Scotland before returning 'home' to live and work as a generic 'intake' social worker in a multi-deprived area of Merseyside.

I have worked for the same local authority now since 1987 and was a full-time social work Lecturer at a local Further Education College for five years before that establishment became 'Incorporated' and therefore independent of the Local Authority. It was whilst teaching Diploma in Social Work students that I realised how poorly prepared for the job I had been by my 2 year post graduate qualifying course. Theoretically, I was saddened by how little I knew and how many families I had already worked with and probably failed. Difficulties arose as an active trade unionist and socialist working in what was effectively a private business and I soon left and returned to my original local authority employer. The specialisation of social work meant that only EDT work offered me the chance to continue with a generic form of face-to-face social work. I returned to social work practice and, at the time of writing, am still there.

Specific life events have had a significant effect on my personal outlook: Being present at two football tragedies, Heysel (1985) and Hillsborough (hospitalised at the latter in 1989); working with one particular child sex abuse 'survivor'; having to deal with a horrendous and extreme case of physical abuse to a 8 week old baby who was crammed into the freezer compartment of a fridge, suffering extensive 'burns'; several visits to the Holocaust extermination camps of Auschwitz and Birkenau, and becoming a father. These events have, I believe, permanently shaped some of my views on matters such as the value of life, the role of the social worker, the impact of institutions on individuals and the need for professionals such a social workers to be more open about the 'human' and 'personal' implications of our work. Whilst it is relatively painless to 'trot out' the list of values that are expected, respect, privacy, confidentiality etc, it is, in my view, extremely difficult sometimes to honour such standards. I would argue that social workers should never deny their humanity (warts and all), and robotically engage families in the complex (and usually statutory) process of change. It is, I believe, far more important to recognise how our own weaknesses, prejudices, and socialised reactions impact upon our interaction with service users, colleagues and managers, than it is to deny they exist and attempt to assess 'objectively'. Autobiographical self-analysis is, therefore critical to locating the social worker's knowledge and assessment of any situation, as too is a similar appreciation of the time specific nature and socialised context of the service user and their circumstances.

As a white, 'able-bodied', British male I am aware of the need as a social worker and researcher to try and assess the impact these may have on the both service users and the research sample group. To deny the potential for impact, or to proclaim that, for example, 'I don't see the skin colour, just a person', or, more typically, 'I treat everyone the same', may well be a denial of self as well as a refusal to accept the impact of a complex socialisation process we have all been through that shapes who we are. To adopt such a denial may be at least to perpetuate the social divisions that exist, if not worse, a dishonest

attempt to present a false reality. I cannot deny my 'maleness', but I can and should contextualise its impact on my work. I have to recognise that I am not always successful in repressing the competitive male spirit:

Wednesday 27th March, 2002.

> *'I attend an interview for a promotion to the post of EDT Manager/Practitioner. I have genuinely not prepared for the interview, other than all the research and reading undertaken for this thesis, however I enter the interview full of confidence that I am the best person for the post because I know more about EDT than any of the other candidates and more than the panel asking the questions. I fully expect to be offered the post, but have also prepared my 'defence' that it was not offered due to my 'political activities'. I am nervous and uncomfortable only because these feelings border on the complete arrogance.*
>
> *A week later I am offered the post and now I have to combine the role of researcher, EDT worker and EDT manager with responsibilities for ensuring the development of the out of hours service.*
>
> *All of a sudden it dawns on me that many of the inconsistencies highlighted in my research, and the out of hours dangers, have now become my responsibility (in part) to produce appropriate responses and safeguards.'*
>
> (Autobiographical Diary)

It can be seen therefore that references to the Autobiographical Diary throughout the research are intended to assist the reader in understanding the position of the researcher, but they also reflect the reflexive methodological approach adopted along with others within this study. I recognise that the use of an Autobiographical Diary in this way is unusual but hope the detailed justification above sufficiently contextualises its application

to the research. The other three methods of data collection, questionnaires, interviews and the longitudinal study are less contentious in social sciences than the diary and are explored below.

(ii) *Questionnaires*

(For detailed examination of the questionnaires used in this study see also 4.6 and 6.2 – 6.10 and 7.2 – 7.11).

In both Phases 1 and 2 of this research I used questionnaires as a means of collecting 'data' from the two sets of respondents (see Appendix 6 and 8). A rationale for the specific areas of questioning is presented in Chapter 4 (4.6) as too is the process by which the respondents were contacted. This section briefly outlines a justification for the use of this method.

Cheetham (1992) suggests that questionnaires generally sacrifice detail for breadth of coverage and may be appropriate where larger sample sizes are required; furthermore, it is said that if it is depth of coverage that is required then the interviewing of the respondents is preferable or a combination of both methods of data collection, as with this research, might be considered. This study intended to examine specific issues and general, broader aspects of EDT. On the one hand it did intend to examine one local authority and 21 EDT workers, but on the other it planned to gather data from numerous different local authorities and EDT workers from throughout the country (53 authorities and 112 EDT workers in total were eventually involved). The lack of relevant EDT research was outlined in Chapter 2 (2.4) and this study to some extent sought to rectify this apparent paucity by exploring the largest group of EDT workers ever undertaken in the history of the out of hours services. One way of trying to ensure that this research achieved this aim was to use a method of data collection that was practical, accessible, relatively inexpensive and likely to attract a good return. By choosing the questionnaire as one of the means to collect data,

distribution via post and fax as well as being handed out in person by the author at Conferences also increased the likelihood of more people returning them.

A major criticism of questionnaires, as well as the sacrifice of detail referred to above, is that the pre-determination of the questions constitutes the imposition by researchers of their interpretation of an issue; this may or may not correspond to the perceptions or experiences of the respondents. An example of this might be that the 'key' issues this research attempts to examine might not indeed be 'key' issues for any of the sample group and may reflect more the idiosyncratic thoughts of the researcher, albeit the researcher is also an EDT worker. The questionnaires (Appendix 6 and 8) combined 'open' and 'closed' questions to ensure that a blend of responses was gained. The intention was to provide the respondent sufficient opportunity to develop any views that they had rather than being entirely restricted by the agenda of the researcher. How well this was achieved is discussed in Chapters 6 and 7.

Another consideration was the time and cost factors associated with the questionnaires. As a lone researcher I was aware that I needed time to develop and pilot the questionnaire before then circulating it to EDTs throughout the country. Sending questionnaires by post or fax would need to be paid for and the processing and analysis of the data that was returned would be very time consuming for one person. As with all methods of data collection there are advantages and disadvantages. I did believe though that, on balance, the questionnaire was an appropriate form of gathering EDT information given the nature of the subject, the resources and time available and the size of the respondent group. The questionnaire though was not to be used in isolation and formed the basis for areas of discussion in the semi-participative interviews that followed.

Consistent with the parallels between my EDT practice and this research was the combination of the 'questionnaire' approach with the 'interview' approach. In other words, as an EDT worker I am called upon to complete a written assessment of a service user (Questionnaire) before deciding whether to undertake a home visit (Interview). The

majority of service users assessed by EDT do not receive a home visit and it was to be the same with this research in that I would send out questionnaires to significantly more respondents than I would interview (for explanation of this process see Chapter 4). As with my EDT practice the function of the face-to-face interview was to seek clarity on some of the issues raised via the assessment (questionnaire) that may be of a more sensitive nature and could not be clarified impersonally. It is accepted that such parallels between practice out of hours and this research are limited but I would argue that they do have some relevance to the choice of methods of 'data' collection.

The intention within this research therefore was, in the first instance, to use a questionnaire. The responses to this first stage (questionnaire) would then form the basis of more specific and detailed examination of both key themes and contradictions via a semi-participative interview. For details of the process of identifying these key themes and drawing together a group of interviewees see Chapter 4 (4.6).

(iii) _Interviews_

Reid and Smith (1981) assert that 'in-person interviews' are 'particularly useful for obtaining data on topics that are complex, highly sensitive, emotionally laden or relatively unexplored' (p.209). The work undertaken by EDT and the feelings this work generates appears to meet such criteria completely. One great strength of interviews is the validity of the data that is gathered there from. Individuals are interviewed in sufficient detail for the results to be taken as true, correct, complete and believable reports of their views and experiences. One major weakness though of the interview as a method of data collection is that small numbers of respondents cannot be taken as representative, even if great care is taken to choose a fair cross-section of the type of people who are the subjects of the research.

The skills necessary for interviewing, listening, directing, working in partnership, recording and empowering should be well known to any experienced (EDT) social worker.

All interviews are much more than just a 'cosy chat', they should be focussed, have a clear purpose and be part of a wider process geared towards achieving identified objectives (see Chapter 4, 4.7). This structure for interviews with service users was the basis of those carried out with the respondents of this research and is discussed in more detail in the next chapter.

The nature of the 'interview' is such that it was designed to facilitate a specific and focused dialogue and exchange of experiences between the 'interviewer' and the 'interviewee'. The perspective underlying this particular aspect of the research is one that recognises and believes in the politicised nature of knowledge and 'research'. It is one, which seeks to challenge the view that has knowledge as the monopolised possession of the elite, usually few in number and male. This view also seeks to oppose the more positivist position that sees the purpose of research solely in terms of its ability to provide what Everitt calls 'technological fixes' (1992) which serve to depoliticise social issues while enhancing professional status. Such an approach also only serves to perpetuate the more traditional type of interviewing that has the interviewer as the 'expert' seeking, and to a large degree dictating, the responses of the interviewee. The interviewer is perceived as some kind of 'authority' that has the task of 'teasing' out the data from the interviewee. This process is, to some extent, already pre-determined and the interviewee, as a passive recipient of the research process, would not be expected to have any part in the design of the interview or the research process, as the interviewer is usually seen as the expert within the field of questioning and data collection as well as to some extent also a specialist in whichever subject matter is being researched.

The participative intercommunication of the interview will attempt to reverse the positivist pattern of data collection, which uses experience as a means to an end rather than an end in itself that has value. The experience-sharing nature of this dialogue will be an attempt to achieve what Patti calls 'reciprocity' (1986) through interactive interviewing and a negotiation of meaning that may help the participants to understand and, if appropriate,

change their situation. The intention was to avoid the research interview that merely serves to maintain the 'academic' and social work patriarchal 'status quo' in which the 'master' interviewer is provided for by the 'servant' interviewee, with the former dictating the pace, content and reciprocity to the latter.

It is recognised that there are some weaknesses in using interviews generally and semi-structured interviews specifically, as a means of collecting information. Not only are there difficulties of recording accurately what the respondent says, but also risks involved in perpetuating the interviewer-interviewee relationship (and thus a power differential) by adopting a question and answer format to the interview. Semi-participative interviews can become so unstructured that they lose direction and stray from the objectives set beforehand. This can leave negative feelings on the part of both interviewer and the interviewee. One final weakness of interviewing discussed earlier (3.3c) is the potential impact of the relationship between the interviewer and the respondent.

The advantages of semi-structured interviewing though appear to outweigh the disadvantages in that issues can be dealt with in depth and with specificity. Sensitive matters can be discussed as part of a dialogue; non-verbal cues can be followed up by the interviewer, and the participant can be offered a genuine opportunity to add issues particularly pertinent to them, that can be discussed at length or not at all depending on the lead taken by that respondent.

3.7 Gender Sensitive.

Duelli Klein (1983) believes that whichever methodology/ies is/ are adopted, there is a need for a research approach, which includes women and is informed about the mechanisms that maintain the pervasiveness of gender inequality. The intention herein is to

be aware that often 'male' methodologies deny the need for self analysis, deny the exploration of feelings and their impact upon the research process, and value 'objectivity' and a scientific basis to decision-making. Maleness therefore associates subjectivity with weakness and objectivity with strength. Without wishing to further perpetuate gender stereotypes, a woman-centred methodological approach acknowledges the interpersonal dynamics of the research process, including the choice of research subject. The methodological approach I have used is one that seeks to combine 'absolutes' with 'relatives', and attempts to establish a type of knowledge that is set within an 'objective framework of subjectivity'.

The issue of gender is particularly relevant to the single Local Authority studied in Phase 1 and the 52 Local Authorities that responded in Phase 2 of this research, as the majority of both groups of EDT workers, that included the male researcher, were men (see Chapter 6, 6.3 for Phase 1 results and Chapter 7, 7.3 for Phase 2)). It is quite possible that a particular model of EDT that operates within many authorities militates against women applying for a full-time post. It is office-based; the worker is always on their own, and it is always the unsociable hours that are worked. There are a number of questionable premises here:

(a) Men are in some way 'safer' or more able to 'look after themselves' should violence occur when alone.

(b) Women are more likely to be assaulted when visiting alone, and in the middle of the night, than are men.

(c) Men have a greater propensity for working long hours, and being able to make autonomous decisions, without recourse to consultation. This is often accompanied by the view, that a need to consult is a sign of weakness.

(d) The role of EDT is presented as a quasi-management one, (this then goes on to be impacted upon by the same iniquitous discrimination and stereotypes that prevent women getting into any type of social work management.)

Another specific aspect of this research then, was to explore the gender issues of EDT work. For example the survey undertaken of 14 Local Authorities in 1992 (see Chapter 2) found that predominantly female teams did provide an EDT service in some local authorities. The major factor appeared to be whether or not the service was home based or office based, that is to say, where the EDT officer worked from home as opposed to having to operate from an office throughout the shift, more women were to be found undertaking EDT if it could be done from home. In other words, those teams that operated from an office were far more likely to be staffed by men; interestingly, the only exception to this appears to be in those (larger Authority) teams where there is a co-ordinator's role which does not entail leaving the office, but consists of taking all the referrals and deciding who should visit, if at all. On the surface, it would appear that some degree of security is experienced by being at home (even though there will be an expectation that home-based EDT workers will still have to undertake home visits within the community) in contrast to those teams in which one person only is on the shift and it is office based. Although the Local Authority studied in Phase 1 is office based, and does not have a co-ordinator's role, it is almost entirely staffed by men. However, as a balance to this, the larger sample group in Phase 2, examined the role played by women who appear to be in the majority when the service is home-based or the teams provide joint visiting, or a policy that precludes lone visiting.

There is a danger therefore, that this research will become what Eichler (1988) calls 'androcentric': The view of the world is only seen from the male perspective. This could occur at a number of levels within this research since it is a male that is undertaking the

research; my particular EDT is, and always has been an entirely male-dominated full-time team that has only ever been 'managed' by men. Men wrote the Job Description, and a male will devise the questionnaire, analyse the responses and then carry out the interviews. All of which will be shared with the researcher's male first supervisor. This entire process could, unless caution is taken, be carried out within the broader patriarchal framework of both social work and academic research. As part of the strategy to avoid such 'androcentricism', it was felt important to arrange that the second supervisor throughout the 6 years of this study be a woman. This was achieved and regular feedback was received from both tutors on social divisions matters and social work practice perspectives.

This study will also need to be aware of the possibility of 'overgeneralising' its findings (Eichler, 1988) to both men and women when, in fact, there have been few women participants within the sample group, (the findings in Chapters 6 and 7 show that less than 30% of the respondents were women).

Stanley and Wise (1979) reflect on their feelings as women undertaking research, of marginalisation, self-doubt, anger and the dissatisfaction at subtle and not so subtle sexism which they argue reflects the feelings about sociology and society as a whole. Similarly, many black women have written about the relationship between social divisions and (undertaking) research mirroring their life-experiences of minimisation and exploitation (Carby, 1982: Davis, 1982: Bhavnani, 1986).

3.8 Conclusion.

By combining qualitative and quantitative strategies, this study attempted to produce a synthesis of knowledge. Given that *feelings* and *figures, practice* and *procedures, cost* and *value, quantity* and *quality* were significant aspects of the research; such an approach was believed to be appropriate and consistent. This chapter sought to explain general problems of researching social work, and then looked specifically at EDT proposing a multiple study

of out of hours social work. Justification was then presented for each of the methods chosen within this study.

The aspects, detail and process of the research are now presented as 'The Research problem and The Hypothesis'. Having established the multi-dimensional, methodologically pluralist basis to this study, the next Chapter details the chronology and implementation of that research and having sought to justify them, provides discussion of the detail of each method of data collection.

CHAPTER 4

The Problem, Process and Practice.

4.1 Introduction

Chapter Three described the challenges that existed when researching social work and presented a detailed argument for a 'multiple studies approach' to this research. Having introduced them in Chapter One, Chapter Three suggested that the diverse aims and objectives of this research could only be addressed by a methodologically pluralist strategy. The following Chapter presents the research problem and hypotheses of this study and the manner in which the 'data' was collected, namely the research process.

4.2 Research Problem and Hypotheses.

The research undertaken intended to focus, by a variety of means, on the following questions:

A] Are there any patterns in 'out of hours' social work in terms of the 'types' of referrals which are made?

B] Is there any consistency in the way in which individual EDT workers assess, prioritise and respond to those referrals?

C] Is there any theoretical framework that might assist EDT workers in achieving consistency in relation to the referrals they receive?

D] (How) can social work practice 'out of hours' generally and the researcher's own practice specifically, be more effective?

The general aims of this research therefore, are to explore the nature of what may broadly be referred to as emergency duty social work (and how this might be defined) by Local Authority 'out of hours' social workers, and to highlight ways in which this service might be improved to the benefit of service users and providers, (although it is acknowledged as a limitation of this research that no direct feedback from service users was sought – see the Introduction p.2 for an explanation).

Based on the EDT experiences and knowledge base of the author there are within these areas of research and the questions noted above, some underlying hypotheses. For ease of reference the questions that reflect the hypothesis are re-stated at the beginning of each of the hypotheses. The hypotheses that underpin the questions therefore, are as follows:

A. **'Peaks and Troughs'.**

Are there any patterns in 'out of hours' social work in terms of the 'types' of referrals which are made?

The diversity of EDT models described earlier (Chapter 1, 1.5) indicates the varying number of actual workers that are on duty in a 'team' across the country. It is possible that the numbers in each team relates to the original creation of that team rather than any correlation

with the referral rates or patterns. This study sought to get a more accurate picture of the nature of EDT work, with its peaks and troughs and indications of any patterns of busy and less busy times of the week or year. Is it possible that certain times of the year produce more and less referral types, or that certain shifts are 'lighter' than others? If Fridays and Saturdays, for example, are significantly busier than the rest of the week, why would this be the case, and are teams structured to reflect busy and less busy times?

There are some peaks and troughs in the 'business' of an EDT worker depending on the day, the time of the day and the time of the year. It is possible that certain shifts are 'busier' than others and that the rate of referrals over the period of this research has varied. This may depend on how the term 'busy' is measured. For example, is it the number of referrals that are taken in any one shift, or week, that determines how busy EDT is, or is it the number of hours that the worker is occupied whilst undertaking EDT irrespective of the actual number of referrals?

Research undertaken by BASW (1984), internal reviews not published (Gamble, 1978, Ward, 1979 and Grundy, 1981) and the SSI (1999) have not taken a longitudinal perspective on the referral rates to EDT, tending to focus on which shifts might be busier than others and how many referrals are taken after midnight, (the implicit agenda here was to be able to 'justify' reducing the out of hours service or rationing the service after midnight. This was set within a Best Value context of ensuring 2% efficiency savings). This research seeks to take a longer term view of potential patterns in the rate and types of referrals to EDT and seeks to differentiate between 'pure' data of referral times and give examples of, for example, the differing amounts of time various referrals may take and how this might affect the time a call is responded to. In other words, it is felt to be misleading simply to present 'facts' that suggest x amount of referrals were received after midnight, without any contextualisation of what that

referral was, how long it actually took to deal with and whether it had been agreed to leave until then so that other matters could be dealt with first.

It is possible that certain 'categories' of service user will come to the attention of EDT in greater numbers at particular times of the year: For example, older persons during the winter, children and families during the long school holidays or alcohol-related difficulties around Christmas and New Year. The author's intention is to examine the possibility of any such patterns by a retrospective exploration of some of the statistics maintained (for research and other purposes) by his team since 1989. In addition to this, the author has established a longitudinal study that incorporates both the numbers of referrals taken per shift, as well as the hours worked on those referrals, (see Appendix 5).

B. 'Person not Procedure'.

Is there any consistency in the way in which individual EDT workers assess, prioritise and respond to those referrals?

Friday 7th December 2001.

> *'Training Day for our EDT workers on the role of the Appropriate Adult under PACE (Police and Criminal Evidence Act). I am amazed at the different practices that exist within this one small set of EDT workers. It turned out that we all take on slightly different roles and responsibilities when at the police station. For example whether we sit in with the solicitor when s/he is interviewing the young person or not; whether we feel we can give consent for fingerprints to be taken of a young person aged 12 years, and whether we*

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'allow' interviews to occur after midnight when the young person may require the period of rest. The conclusion was that there should be greater consistency without losing flexibility.' (Autobiographical Diary)

Given the small number of workers involved (usually only one) and the absence of consultation, live supervision, dialogue and debate, it would appear important to establish any variations/inconsistencies in the ways EDT respond to referrals. The 'busyness' of the shift and the individual on duty may have more of an impact upon the assessment and prioritistion than the urgency of the referral. In other words, subjective perceptions may prevail over objective risk analysis, (if such objectivity actually exists). This may mean that the same 'crisis' on one shift may not be a crisis on another even when the worker is the same individual. For EDT workers, the absence of any pro formas or assessment tools may compound the unpredictability of the referral response. Put simply, it is the 'person' on EDT and not any 'Procedure' or set of processes that may have the greatest influence during the assessment decision making process.

The BASW study (see Chapter 2) states *'a major factor in determining an emergency was the social worker's perception of pressure.'*(1984, p.21) This is supported by their statistics that they suggest indicate that 'the more referrals EDT receive, the less likely it was that a visit would result.' In other words, when the number of referrals was high, the number of visits was low. It is further argued that EDT workers are able to 'redefine referrals' (p.21) to enable them to respond at a variable rate. The study acknowledges that their conclusions regarding the process of decision making out of hours is tentative, 'but does suggest an avenue for future research.'

It is possible that the nature of the EDT response a caller receives may well reflect the individual on duty rather than any departmental procedure or priority system. Like many other

Local Authorities, the author's EDT operates with one person being on 'duty' at any one time, (see Chapter 1, 1.5 for an explanation of the various models of EDT). This person on duty in Phase 1's Local Authority is expected to provide a 'generic' service for the entire population of about 300,000 people, (for definition of 'generic see Introduction, p.1). The nature of out of hours work means that the worker may have the training and salary of a basic grade social worker, but delegated powers of the Director of Social Services. The individual EDT worker decides when and if a 'referral' needs to be followed up. It is the author's belief that due to a confused understanding of their role and competing generic demands within a specialist priority system, the EDT worker may create their own methods for determining which service user, if any, will get a service, and in what order during the shift that service will be provided. It is possible that the personal-professional preferences of the individual worker (for example a feeling of confidence on the part of the worker in the field of child protection may prioritise such a referral over that of, say, mental health. A belief that police stations are no place for young people may mean the worker deals with this before the older person whose Home Carer has not arrived).

The apparent absence of a generic priority system, coupled with the degree of autonomy afforded the EDT worker may result in members of the public and other agencies receiving a service out of hours that is dictated by the individual on duty rather than any 'agreed' procedures.

C. 'Seat-of-the-Pants' Theory.

Is there any theoretical framework that might assist EDT workers in achieving consistency in relation to the referrals they receive?

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It is shown in Chapters 6 and 7 that EDT workers are by far the longest serving, most qualified and experienced social workers in the profession today. It was therefore interesting to examine how such social workers approached the assessment and prioritisation of referrals process. I was seeking to establish what framework, if any, these experienced, mainly autonomous workers applied to assess and order the priorities of competing referrals. Given that the nature of EDT work tends to be emergencies that cannot safely wait until the next working day, it could be believed that those workers permanently operating within this arena might have developed a systematic system for addressing such referrals. Given the generic nature of EDT responsibilities, it might be expected that EDT workers would own a 'tried and tested' mechanism of assessment and prioritisation. If such a framework existed, it might prove useful for daytime social work activity, or for 'new' EDT workers seeking to clarify a model of operating.

The hypothesis though, was that EDT workers do not work within a conscious, systematically applied theoretical framework that informs their practice. It is suggested that out of hours workers operate an unconscious, 'seat-of-the-pants'-type theoretical model that views 'common sense', 'experience', and perception of relevant procedures as the basis for their intervention. This author suspects that the majority of the EDT workers will be confused by the term 'theory' and will not believe that it has any role in informing their practice. It is likely to be the case for the few who do see the relevance of 'theory' (however they may define it) that they are afforded little or no time to reflect upon its place within their EDT work.

Munroe (1998) highlights the deficiencies in social workers' grasp of theory. Whilst some, or all, of the above may be equally applicable to daytime social workers who operate within their specialisms, there are significantly more mechanisms in place during the day to oversee 'good' and 'bad' examples of practice.

Increasingly, within daytime social work also, is the imperative to produce evidence-based practice (see Chapter 4) both in child protection work and mental health practice. Social workers are expected to reference decisions to literature and research. This process of driving social work practice towards evidence based decisions would, however, appear to have fallen into the methodological vacuum that is EDT practice. The recent SSI Report (DoH 1999a) was right to highlight that the quality of EDT assessments was difficult to quantify stating that *'often recording was too poor to form a judgement of the quality of the assessment. In some cases we could only infer the worker's assessment from their response'* (DoH 1999a p. 4).

The argument for the relevance of methodology is well presented by Clifford who summarises the need for practitioners to have a methodology under two headings: Intellectual and Practical. The intellectual rational for practitioners is said to involve issues of logic and consistency:

'The use of various methods to assess people and situations cannot adequately be justified on a casual, common-sense basis' (Clifford 1998 p. 8).

The practical justification for applying a complex methodology to the work of assessment is to give the process of assessment some credibility, some consistency and some degree of comparability. Clifford points out, for example the connections between women as an oppressed group and women as the authors of assessments that are undermined or ignored not because of the content of the report but because of the gender of the author in contrast to that of the readers. It might also be argued that the status of social work assessments *per se* has never been given the deserved recognition, with courts, for example, opting for so-called 'expert witnesses'. By having a transparent methodology and consistent methods, social work

as a whole may benefit from more favourable comparisons with some of the other professions, e.g. medicine, psychiatry and education.

'The advantage of developing a methodology which is informed by a significant use of social science theory is not only that it gives the use of various methods some consistency, and an improved degree of comparability, but also that it gives social assessment the status it deserves, as an exacting and intellectually justifiable, as well as a skilful, ethical procedure' (Clifford,1998 p.9)

The need for a consistent approach to assessment applies both to day and night time social workers, but, out of hours, there may be a greater need for the isolated, lone working EDT officer to be able at all times to justify by reference to a theoretical framework the nature of the assessment and rationale for the prioritization of one referral over another. As indicated above, there are fundamental differences that may make it particularly necessary for the EDT worker to be methodologically informed, and consistent in the methods chosen. Specifically amongst these differences is the level of 'power' given to the EDT worker, and the minimal monitoring of, and opportunities to discuss, their social work practice. Neither of the two main studies into EDT (BASW, 1984 and SSI, 1999, see Chapter 2) explores the theoretical framework for EDT social work practice.

D. 'The Reflective Practitioner.' - 'Out of Hours' Social Work Could Be More Effective.

(How) can social work practice 'out of hours' generally and the researcher's own practice specifically, be more effective?

Everitt and Hardiker critically examine the place of evaluation within social welfare generally and the personal social services specifically. Their work highlights the differing perspectives that can be taken when considering what constitutes 'effective' social work practice:

> ' *We are concerned that, as part of new systems of public sector management, a form of 'managerial evaluation' is developing which, at worst, serves as a mechanism to ensure that practice conforms to New Right policy agendas....* ' (Everitt and Hardiker,1996 p.1).

In effect what is being suggested is that the way 'management' (at whatever level) define 'effective' is likely to be different to the definition offered by the EDT worker as their agendas and tasks are different. An example of this might be the managerial imperative to operate within the set budget; whilst the issue of committing the Department to additional, unplanned expenditure in the middle of the night may be viewed by the EDT worker as 'positive' and 'effective' social work practice.

In this research, the hypothesis is that from a number of different, and even conflicting, perspectives, the social work service provided 'after hours' could be more effective.

Undertaking this research may offer the opportunity to reflect upon and improve the author's own EDT social work practice. This reflection will be informed by the detailed feedback from the other workers who staff the EDT rota both in the author's own local authority and across the country.

Giddens (1984) applies the concept of the 'double hermeneutic' to the notion of reflexive research that would appear to apply to this research. Firstly I have chosen to study a social phenomenon that I believe to be meaningful (EDT), and have done so by entering into this

subject as a participant. Secondly it is hoped that the observations and conclusions to be drawn from this study may influence that phenomenon, but also recognise that any outcomes are part of that same social world. Clifford draws a parallel between the 'double hermereutic and reflexivity in qualitative research stating that:

'In qualitative research, reflexivity involves the consideration that any researcher in the social sciences is a participant in the interactions involved in research relationships, and the outcome of the research activity is a significant product of who the researcher is, and the whole interactive situation in which the person is doing the research.' (Clifford 1998 p.43).

For a variety of reasons I have chosen to research that which I am employed to do, EDT. There can be little doubt that the subject matter is meaningful to me, or that I am a participant in the research subject matter, and the research process, rather than an 'outside' or neutral observer. The second aspect of this 'double hermeneutic' is that it is likely that the outcomes of the research activity may reflect my own agenda (personal, professional and political), and the role I have played in the research process.

Is it the author's desire to be 'the best' EDT worker, and to be seen as such, that is the motivating factor behind this research, and if so, what are the life events that have led to this?

Is it the perceived lowering of professional social work standards with the accompanying dangers this may bring that has been the catalyst for this work?

As a social work lecturer as well as an EDT officer, I often encounter both sides of the academic/practitioner debate: On the one hand, there is the critique that academics may make of practitioners, namely that they pay too little credence to research and the academic contribution that has been made to social work practice. On the other hand, practitioners

(without wishing to stereotype either 'side') might argue that social work is a 'people-to-people' dynamic that cannot be encapsulated by any 'academic' study. Alternatively, there is the suggestion that social work is a matter of 'common sense' that cannot be learned through textbooks, but which is developed by the experience of 'doing'. Part of the motivation for undertaking this research may be to address these differences in the hope of being seen as part of both 'sides', and, therefore, somehow able to bridge the 'gap'.

The hypothesis here is that there may be aspects about myself, and certainly elements relating to research and the subject of EDT social work that I was to learn about which might improve the way in which I work out of office hours.

The hypotheses therefore that form the foundations of this research, seek to clarify the validity of certain perceptions held by the researcher, intend to examine EDT practice in detail and ask the author to consider possible ways of studying and improving the generic complexity that is out of hours social work. The manner in which I attempted to 'test' these hypotheses is now presented in terms of the process of the research. Attention now turns then to the specific methods within this methodological repertoire that sought to compliment the Research Problem and the Hypotheses, and were used to gather the differing types of 'data' required to address the questions posed by the hypotheses.

4.3 The Research Process

This chapter looks in more detail at the specific research methods that were used within this study: The longitudinal study, the questionnaire, the semi-structured, participative interview and the autobiographical diary.

It is helpful to recognise that this research was undertaken in two phases in which there are some overlaps as the diagram below indicates:

1996	1997	1998	1999	2000	2001	2002

Phase 1 1 EDT - 21 respondents (a) Questionnaire (b) Interviews (e) Longitudinal Study (f) Autobiographical Diary	$\longrightarrow$	**Phase 2** 54 EDT's - 112 respondents (c) Questionnaire (d) Interviews (e) Longitudinal Study

4.4 Phase One:

In many ways Phase 1 was the foundation for the entire piece of research. Although the focus

of this first phase was only on the one (Author's employing) EDT, the questionnaire used at

this stage was the basis of that which was applied to the much larger sample group in Phase 2.

The application of the questionnaire, the analysis of the findings and the interviews with the

first set of respondents was an independent piece of work in its own right. The findings of this

first phase, the responses via the questionnaires and the interviews then became the foundation

for the second stage of the research process that was to apply similar questions to a much

larger and more diverse group of EDT workers from throughout Britain. Similarly, the

longitudinal study and the maintaining of an Autobiographical Diary that continued through

Phases one and two also enabled the researcher to develop a more critical approach to the

second stage having analysed, in some detail, aspects of his own EDT practice and employer.

In this first phase then, the research focused entirely on one Local Authority's out of hours

social work team. The longitudinal study examined the referral patterns (outlined below in

Chapter 5), whilst the Autobiographical Diary (see 3.6i) reflected upon incidents stimulated

from within the researcher's own EDT practice. The Questionnaire was sent to all EDT workers who had worked or are working for that particular EDT (23 in total), and taped interviews were carried out with all the respondents (21 in total). The findings of this first phase were then used as the basis for the second stage. The diagram above illustrates the differing target groups of the differing stages and the similarities between the 2 stages.

4.5 Phase Two:

Whilst the Autobiographical Diary and the Longitudinal Study continued throughout the 6-year period of the research, for the one EDT, the second phase of the research examined EDT's from all over England, Wales and Scotland. The focus of the second phase was much more specific and the Questionnaires were followed up with semi-structured interviews with a representative sample of respondents. It is impossible to calculate the total number of questionnaires that were distributed to Local Authority EDT's, because some workers (kindly) photocopied them and distributed them to the rest of their team. However, 53 Local Authorities were sent or given copies of the questionnaire, and all 53 are represented in the individuals that responded. Including the workers and the authority from Phase 1, 112 EDT workers responded from 54 different EDTs. The questionnaire for the second phase was based on that used for the first phase with questions replicated to achieve some degree of consistency. However, the focus of the follow-up interview in this second phase was directed much more specifically towards one aspect of the research, namely assessment and prioritisation.

4.6 The Questionnaire, Phase 1:

EDT Population

(For a justification for the inclusion of questionnaires as a method of collecting 'data' see 3.6.ii)

For Phase One of the research process, the respondent group was to be all workers who had ever undertaken EDT in that one local authority. As an employee of the same local authority for over 10 years at the time of commencing this research, I was already aware that the majority of people within the target response group were still employed by the same local authority. I was confident therefore, that I would be able to contact the majority of those workers that had ever done EDT in this authority. The fact that most of them still undertook EDT duties in some capacity and/or were still within the same department meant also that locating them would not prove too difficult. I was aware that I knew most of the EDT workers (past and present) and that this might impact upon the success of the response rate. I tried to balance the need to avoid too much coercion with the desire to achieve sufficient numbers of questionnaires returned for the study to be valid.

The response group then were not a sample or a representative group, but the sum total of those that provided the out of hours social work service for that one local authority. The results (see Chapter 6, 6.2) show that 21 of the 23 questionnaires sent out were completed and returned, (of the two that did not respond one had left the employment of the local authority and could not be traced, the other simply did not return the questionnaire).

Distribution

A covering letter (Appendix 3) was sent out to the potential participants that sought to encourage these EDT workers to be involved in unique research:

'Within the U.K. there has never been any such research carried out before, so I hope you will accept this invitation to participate in what is a unique exercise (in contrast to the wealth of research undertaken into 'daytime social work'). Quite simply too little is known about 'out of hours social work'.......you are ideally placed to present your views on the service...' (Appendix 3 - Covering letter to Phase 1 respondents).

Participants were sent the questionnaire to their workplace firstly because I did not wish to access their home addresses and secondly because I wanted the respondents to view this as part of their work, relevant to the department's out of hours service and therefore something that ought to be completed 'in works time'. I wondered also if the response rate would be higher if the questionnaire was not taken home. The potential for the responses to be rushed because of the daily pressures of work needed to be balanced against the potential departmental gains by completing this study. Respondents also were encouraged to return the completed questionnaires in the (free of charge) internal post.

Practicalities

In devising the questionnaire I was aware of not wishing to make its completion too prolonged. The pilot study (see Chapter 6, 6.1 and Appendix 10) indicated that the completion per questionnaire was approximately 20 minutes. I decided that this was sufficiently long enough to gather the relevant information, but sufficiently short enough to ensure a high return rate. The combination of closed and open questions meant that specific details were being asked of the respondents as well as developments of some issues, but within a time-limited framework and a total of 16 questions (see Appendix 6 for completed Phase 1 questionnaire). The questions were spread over 6 pages in Phase 1 that created a spacious feeling to the layout of the questionnaire. For such relatively small numbers (23) I knew this would neither be too

costly nor difficult to send out in envelopes. This would contrast with the questionnaires in

Phase 2 (see below) that were two pages long and could be faxed, emailed or sent with relative

ease to the much larger group of respondents (91 in total, see Chapter 7, 7.1 and 7.2).

Choice of Questions

The questionnaire in the first phase of the research was used to gather basic information about

the respondent as well as more complex information concerning the way in which they operate

whilst on duty out of hours. The focus of the questions was the hypotheses discussed above

(4.2).The questionnaire consisted of 16 questions, some of which were in several parts. It was

identified in Chapter 1 (see 1.5 – models of EDT) that there are a range of different 'types' of

EDT provision throughout the country the first question sought to locate the respondent within

a certain category of worker (e.g. full-time generic or part-time specialist). Chapter 1 also

suggested that EDT workers were long serving and well qualified (see 1.4) and so questions

regarding length of service, qualifications, previous experience and nature of EDT experience

were specifically designed to establish the validity of the earlier claims. The final stages of the

process examine the respondents' priorities in a set of given circumstances as well as

identifying the types of feelings EDT provokes and any training undertaken specifically for

EDT. These latter questions were designed to examine the process of prioritisation between

competing referrals out of hours and whether any consistency was achieved. They were also

intended to illustrate whether workers applied any systematic framework to their practice.

Thus the final part of the questionnaire reflected the hypotheses indicated above (see 4.2, B

and C).

The 'data' that was being sought from these questionnaires therefore, was a combination of

the qualitative and the quantitative, 'facts' and 'feelings'. The use of open and closed

questions was intended to produce a blend of responses, different in both length and content.

In both phases of this research it was the preferred option to combine the use of a questionnaire with a semi-structured interview, but undertaken at different times. As far as the sample group were concerned they were told that the process would be in two separate parts, namely the questionnaire which they were sent with an accompanying explanatory letter (See Appendix 3) and a self stamped addressed envelope was part one of the process, and part two was the interview; the respondents who returned the questionnaire were written to again and then contacted by phone to agree an interview time and location as explained in the second letter. It was acknowledged that for this relatively small number of respondents, all of whom were known to the researcher and most of whom were still employed within the same local authority, whilst anonymity would be difficult but confidentiality was guaranteed. It was agreed that the responses would be anonymised and kept confidential within this thesis.

In order to avoid the imposition of the author's views on the respondents during the interview process, a variant was used to enable the respondent to the questionnaire to more fully participate in and even dictate the content of the research exercise. This variant was in the form of the follow up, semi-structured and participative interview which addressed issues raised within the questionnaire as well as exploring any aspects of EDT which the respondent thought should have been included but had not been covered in either the questionnaire or the interview,

In order to try and ensure a reasonable number of questionnaires were returned a variety of mechanisms were used to distribute them:

- The whole research process was raised at one of the Local Authority's Emergency Duty Team bi-monthly team meetings.

- Having already received the 'permission' of the ADSS, the Director of that specific local authority, and with the support of the manager of EDT, a covering letter (see Appendix 4) was handed to some of the sample group who attended the meeting.

- Those colleagues from EDT that were not in attendance, were sent the questionnaires with the covering letter and were contacted by phone to ensure the internal social services department's mailing system had worked and that people had received the questionnaire. This follow up contact was used in some cases to (re)-explain the research and encourage them to complete and send back the questionnaires through the internal post (i.e. free of charge).

- During the weekend handover periods, any who had not returned the questionnaires were reminded once again of the research and urged to return completed questionnaire. (On reflection however, for the two workers that required this prompt, it may have felt like undue pressure or coercion was being applied.)

Analysis of the data

Qualitative research certainly excels at generating information that is very detailed. Of course, there are quantitative studies that are detailed also in that they involve collecting lots of numeric data. But in detailed quantitative research, the data themselves tend to both shape and limit the analysis. For example, if you collect a simple interval-level quantitative measure, the analyses you are likely to do with it are fairly delimited (e.g., descriptive statistics, use in correlation, regression or multivariate models, etc.). And, generalising tends to be a fairly straightforward endeavour in most quantitative research. After all, when you collect the same variable from everyone in your sample, all you need to do to generalise to the sample as a whole is to compute some aggregate statistic like a mean or median.

Things are not so simple in most qualitative research. The data are more 'raw' and are seldom pre-categorised. Consequently, you need to be prepared to organise all of that raw detail. And there are almost an infinite number of ways this could be accomplished. Even generalising across a sample of interviews or written documents becomes a complex endeavour.

The detail in most qualitative research is both a blessing and a curse. On the positive side, it enables you to describe the phenomena of interest in detail, in the original language of the research participants. In fact, some of the best 'qualitative' research is often published in book form, often in a style that almost approaches a narrative story. One such writer is the American author Studs Terkel. He has written intriguing accounts of amongst other things, the Great Depression (Terkel, 2000), and socioeconomic and race divisions in America (Terkel 1992). In each book he follows a similar qualitative methodology, identifying informants who directly experienced the phenomenon in question, interviewing them at length, and then editing the interviews heavily so that they 'tell a story' that is different from what any individual interviewee might tell but addresses the question of interest. An autobiographical equivalent from Britain might be such as Tony Benn who has published several volumes of his diaries (based on tape recordings he made over a period of 40 years) that similarly 'tell a story' from his own subjective experience, but that have value in and of their own right, (Benn, 1970, 1975 and 1994).

On the negative side, when you have that kind of detail, it is hard to determine what the generalisable themes may be. In fact, many qualitative researchers do not even care about generalising; they are like Terkel and Benn, content to generate rich descriptions of their phenomena.

That is why there is so much value in mixing qualitative research with quantitative as I have sought to do within this research. Quantitative research as is presented in Chapter 5 excels at summarising large amounts of data and reaching generalisations based on statistical projections. Qualitative research as in Chapters 6 and 7, excels at 'telling the story' from the participant's viewpoint, providing the rich descriptive detail that sets quantitative results into their human context.

The analysis of the data gathered from both the questionnaire and the interviews held subsequently within this research therefore was informed by such measures as 'credibility', 'transferability', 'dependability' and 'confirmability' rather than the usual quantitative measures of 'internal and external validity', 'reliability' and 'objectivity'.

The credibility criteria involved establishing that the results of the qualitative research would be credible or believable from the perspective of the EDT participants in the research. Since from this perspective, one of the purposes of qualitative research is to describe or understand the phenomena of interest from the participant's eyes, the participants are the only ones who can legitimately judge the credibility of the results. The 'testing' of this credibility has already begun (see 8.11) and the findings have been presented to large groups of EDT workers and the participants.

'Transferability' refers to the degree to which the results of qualitative research can be generalised or transferred to other contexts or settings. From a qualitative perspective transferability is primarily the responsibility of the one doing the generalising. In this qualitative research, I have tried to enhance transferability by presenting in some detail the hypotheses that underpin the research context and the assumptions that were central to the research (see 1.6 and 4.2). The person who wishes to 'transfer' the results to a different context is then responsible for making the judgment of how sensible the transfer is.

The traditional quantitative view of reliability is based on the assumption of replicability or repeatability. Essentially it is concerned with whether we would obtain the same results if we could observe the same thing twice. But we can't actually measure the same thing twice, by definition if we are measuring twice, we are measuring two different things. In order to estimate reliability, quantitative researchers construct various hypothetical notions (e.g., true score theory) to try to get around this fact. The idea of 'dependability', on the other hand, emphasises the need to account for the ever-changing context within which this research

occurred. The research is responsible for describing the changes that occur in the setting and how these changes affected the way the research approached the study. One of the purposes of the Autobiographical Diary (see 3.6(1) for detailed discussion) is to describe the ever changing context and dynamics of the research from the researcher's perspective.

Qualitative research tends to assume that each researcher brings a unique perspective to the study. 'Confirmability' refers to the degree to which the results could be confirmed or corroborated by others. Within this research I have there are a number of strategies adopted to enhance confirmability. I have documented the procedures for checking and rechecking the data throughout the study (see Chapter 5). Another strategy is to adopt a 'devil's advocate' role with respect to the results, and this process was documented (see Chapters 6 and 7). In this study I have also searched for and described any *negative instances* that contradict prior observations (Chapters 6 and 7). Finally, after the study was completed, I conducted a *data audit* that examined the data collection and analysis procedures and made judgements about the potential for bias or distortion (see 8.2.).

The responses to the questionnaire from Phase 1 are presented in Chapter 6 and accompanied by an analytical commentary. The reader is provided with a representative sample of the responses as well as an analytical commentary thereon. For the purposes of completion and to allow the reader to achieve 'confirmability' a number of completed responses to the Phase 1 questionnaire are included (Appendix 6) as well as a complete set of responses to the Phase 2 questionnaires (see Appendix 14). The basis of the analysis of the questionnaires detailed in Chapters 6 and 7 was firstly to draw parallels with the responses and the hypotheses to establish any confirming or disconfirming data. Secondly, the intention was to group together under any developing themes data as it could be identified from within the research. The findings of the questionnaire from Phase one formed the focus of the areas of questioning for

the subsequent semi-participative interviews. Together the findings of both the Phase 1 questionnaire and interview findings formed the basis of Phase 2.

4.7 The Participative, Semi-Structured Interview, Phase 1:

(For examination of the findings of the interviews see also 3.6(iii), 6.11-6.18 and 7.12-7.15. For a justification for the inclusion of interviews as a method of gathering 'data' see 3.6 iii).

Introduction

At the same time as the questionnaire was distributed to the sample group of EDT workers, as described above, the (potential) respondents were informed that a 'follow-up' interview with each of them would be sought. The outline and purpose of this interview had already been introduced in the earlier contacts (see above). The nature of this interview was designed to address specific responses from within the questionnaire, but also different aspects of EDT that had not been raised within the first part of the process (i.e. the questionnaire).

It was hoped that by employing an interview schedule there would be the opportunity to discuss the responses to the questionnaire, but also to gain a richness of data 'face-to-face' that would also allow the potential to elicit personal meanings and interpretations that would not be available through sole reliance upon the single research strategy of the questionnaire. One other benefit of the interview was that it would enable the interviewer to clarify the respondent's understanding of the questions set out in the questionnaire; this would go some way to ensuring consistency or otherwise of the actual responses to that questionnaire, and should rectify any potential confusion which may have arisen during the first part of the research process.

A number of strategies were adopted to try and achieve a greater degree of 'equalisation' of the interviewing process and to avoid the traditional interviewer-interviewee relationship

referred to earlier (3.6 iii). The first of these strategies was to set the context of confidentiality to the research interview via a letter to all participants. Another strategy was to ensure the interviews included autobiographical material on the part of the interviewer. Other strategies were as follows:

- Questions relating to values or family history were preceded by examples from the author's own autobiography.

- Discussion points that related to practice were preceded by the author sharing some examples of good and less good practice and, whilst encouraging the other participant to share similar experiences, this was not 'forced'

- Participants were specifically asked how they felt the 'interview' had gone and whether or not it had felt like a 'question and answer' session

- 'Interviewees' were specifically asked whether there were any parts of the 'interview' or the research process that had been included which they thought should not be, and similarly whether there were any aspects that had not been discussed that should have been.

- All participants were offered copies of the taped 'interview' that they had given permission for at the outset.

It is the belief of the author that only by employing such a research strategy and interviewing style could the process move towards being egalitarian, fair and relatively evenly balanced in contrast to the more traditional power differential between the researcher and the researcher's sample group. It is the above that was intended to constitute the semi-participative interview.

Process

A pilot of the interview schedule involved the same two EDT students that had participated in the questionnaire pilot (see Appendix 10) and identified some confusing areas of the schedule that were amended accordingly. The pilot of the interviews also established that each interview would take approximately 1 hour.

The interviews 'proper' were organised by contacting all of the Phase 1 respondents who had returned the Phase 1 questionnaires. This contact was by phone, in works time and I took the opportunity to remind the respondents of the research as well as agree a mutually convenient time and location. These interviews took place at such locations as the homes of EDT workers, the EDT office and other social work offices as requested by each respondent. With the individual permission of each respondent before and during each interview, the discussion was tape recorded. Each interviewee was informed that the tape could be turned off at any time during the interview, copies of the tape would be available afterwards if they wished and they could have the tapes destroyed if, after the interview they decided to withdraw their consent.

These taped interviews were all then analysed by the researcher and detailed notes made on each recording (see Appendix 23). In order to accurately represent the 'data' that arose from these interviews a number of interviews were then transcribed in full (see Appendix 19) so that the reader was able to compare the detailed notes of an interview as well as an interview in its entirety. The interviews that were transcribed include one part-time female, relief specialist worker and one full-time male generic worker as well as a male relief generic worker. By including this cross section of EDT workers in the sample of transcripts, the intention was to provide a representative collection of EDT workers' views.

Interview Schedule (see Appendix 7)

The interviews were designed to be in 7 sections of differing lengths with separate headings and various introductions all of which were read out to the interviewee to set the context for that section. One example of this introductory statement is that taken from section 3, the subject of which was 'theory':

> *'As an EDT worker I sometimes wonder whether we work within a well established theoretical framework or simply 'fly by the seat of our pants'. The next set of questions is designed to explore this'.*

Each of the interviews followed the same pattern with the sections and all the questions being asked in the same order. The interview schedule meant that some degree of consistency was achieved in terms of the number and type of questions that were asked. The intention though was to jointly explore the issues raised by these questions with the interviewee and within the boundaries of the time allowed (as each interview was planned only to last approximately an hour) I sought to debate the EDT related issues rather than adhere to a strict question and answer format. As part of this intention I regularly gave examples from my own EDT practice and presented ways in which I might answer the questions as one way to equalise the interviewer-interviewee relationship and in an attempt to encourage the respondents to give full and frank responses. By acknowledging my own weaknesses in EDT practice to the respondents I sought to provide a framework in which they too felt able to resist any temptation to 'impress' the interviewer and one in which they could be open and honest.

The content and focus of the interviews were related to the hypotheses as well as the responses to the initial questionnaire. The intention was to focus more specifically on matters relating to the hypotheses in the interviews as well as follow up any inconsistencies that appeared from the questionnaires. There were 6 headings and a 'concluding' section to the interview schedule that sought to contextualise the information being explored. 'Professionalism' was the first

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section and this examined the role of EDT and its relation to daytime social work. 'Prioritisation' referred specifically to the questionnaire responses relating to the scenario exercise and gave respondents the opportunity to re-examine their responses and the scenarios and give more detailed explanation of the rational for their responses. This section was designed to gain a clearer view of how EDT workers choose between competing priorities. 'Theory' section explored the possible theoretical vacuum within which EDT workers were thought to operate. The 'Assessment' section had 4 questions to explore the respondent's views on the notion of 'assessment' and what the term means, if anything, to EDT workers. The next section was headed 'Anti-Oppressive/Anti-Racist values' and introduced a discussion about the role, if any, of our own socialisation process and the impact of membership of some of the social divisions. The penultimate section with 3 questions was headed 'Statistics' and was intended to discuss the EDT workers perceptions of the referral rates to EDT. The final section called simply 'Conclusion' also had 3 questions concerning the respondent's thoughts on improving and enjoying EDT as well as ways in which the questionnaire, interview or research could be improved. For detailed analysis of the discussions these interview discussions see Chapter 6, 6.11-6.18.

Non Verbal Communications

One very significant part of interviewing in social work is the recognition of the importance of non-verbal communication. Similarly in research interviews it was felt necessary to comment on any significant non- verbal clues such as long pauses, or laughter or interviewees shifting possibly uncomfortably in their seats. It is acknowledged that these signs alone will not explain the entire information being imparted but they do give signals to how the interviewee may be feeling during certain parts of the interview and during certain questions. The records

kept of the interviews (albeit subjectively) indicate some of the more significant examples of non-verbal communication relayed by the interviewee.

As indicated the research was undertaken in two phases parts of which ran concurrently (the autobiographical diary and the longitudinal study for the single local authority). The process for the second phase was similar to phase one in that a questionnaire (Appendix 8) and semi-structured interviews were used to gather the data.

Recording and Analysis of Interviews

The interviews were recorded in two simultaneous ways. Firstly all the interviews were tape recorded with the permission of the interviewee and secondly, contemporaneous notes were made by the interviewer as the interview progressed. Copies of both the tape and the notes were offered to the interviewee at the end of the interview. The notes made during the interview related to any significant non-verbal communication (such as smiles or facial grimaces) that would not be picked up by an audio tape recorder. Notes were also made for all answers so that a written contemporaneous record was available. I tried to summarise any key themes of the responses as the interview progressed rather than record the specific detail that would be recorded and studied later on.

When all then interviews were complete I then spent many hours listening to the tapes of the interviews and also made notes on blank interview schedule sheets so that the responses were matched to the areas of questioning. I listened for key messages or key themes and summarised the data collected from each question on the blank schedule sheets. In essence therefore, what I had done was record all the interviews, take notes during the interviews and then take notes whilst listening to the recording of the interviews. In other words I had three records of each interview. A fourth record was made when a representative sample of the interviews, as explained above, was transcribed in full (see Appendix 19).

There were difficulties in taking notes during the interview as I was aware of asking questions, discussing responses, wishing to note the non-verbal communication and at the same time taking notes. There were also difficulties in making notes when playing the tapes back not only because of the length of time involved, but also because of the subjective nature of my listening and my note-taking and therefore my conclusions on what the themes of the interviews were. It was hoped that by cross referencing the various sets of notes and the transcription of the entire interviews, aspects such as 'credibility', 'transferability', 'dependability' and 'confirmability' as explained above (4.6) could be measured and thus the relevance of the research evaluated. This concluded Phase 1 of the study and formed the foundation for Phase 2 to which attention is now turned.

4.8 The Questionnaire, Phase 2:

EDT Population

Once the questionnaires and the semi-participative interviews of Phase 1 had been completed Phase 2 began. Phase 2 was based on the findings of Phase 1 but was to a much more diverse and larger 'audience'. Whereas the first Phase concentrated entirely on the workforce of one local authority, Phase 2 was to explore nearly one hundred EDT workers from over 50 different local authorities (for specific details see 7.2 – 7.11). The questionnaire therefore, had to be designed to accommodate a larger group of respondents with a more specific focus as is now explained.

One fundamental difference with the Phase 2 questionnaire was that it went out to a much more diverse sample group that included a range of EDTs from England, Scotland and Wales (e.g. County and City Councils, Metropolitan Borough Councils and Unitary Councils).

Respondents from the first phase did not participate in the phase two questionnaire. Paradoxically therefore, the second phase questionnaire was more general in its target group, more specific in its focus and yet had some of the same questions as phase one. Unlike in Phase 1, that represented only the office based, lone working model, Phase 2 sought to include the full range of 'types' of EDTs as discussed in Chapter 1 (see 1.5). Unlike in Phase 1 also, the focus of the questions would be more specifically directed to some of the key themes identified from Phase 1 (see *choice of questions* below). The intention was to include all types of EDT models to ensure adequate representation. Inevitably with such a larger and more disparate group, the distribution of the questionnaires would be more difficult than with the 'local' population of Phase 1 respondents.

Distribution

The process for distributing these questionnaires employed a number of strategies and was different to that of Phase 1 in that two large gatherings of EDT workers from all over the country were used as a means to trying to ensure a high return. The strategies of distribution were as follows:

- At the first of these gatherings, which was the North West EDT Training Consortium's Annual 2 days Conference, questionnaires were distributed (placed on delegates' seats) before the event started. At this Conference there were EDT workers and managers from all of the North West (of England). At the beginning and at the end of each day I was allowed time to speak to the gathering and remind delegates about the request to complete them. Completed questionnaires were to be left in a box in the main lecture hall. Some workers told me they would take copies to complete at home or to give to colleagues who had not attended (this was, with hindsight, to cause

some difficulties in 'controlling' how many questionnaires were actually distributed so that the percentage returned became difficult to calculate exactly afterwards).

- The second event of this nature was the Annual 2 days Conference of ESSA. At this conference, delegates from all over the British Isles attended. As with the North West event, I made sure that all delegates had copies of the questionnaire on their arrival and encouraged all of them to complete before leaving at the end of the 2 days. Some delegates also took copies to complete at home or for their colleagues.

- At each of these events I was allowed some time to orally present the purpose of the research, the ways the audience might benefit from the study and to explain the process by which the questionnaires could be returned (i.e. by leaving them in a box at the conference centre, or sending them back to my workplace or faxing them to my workplace) and the way in which they would be followed up by a series of semi-participative interviews with a representative sample of the respondents.

Practicalities

Some of the same workers and managers attend both the NWEDT and the ESSA conference. In the presentations to each conference I stressed the need only to complete one questionnaire. It is possible though, as delegates come and go continuously that some workers may have completed two questionnaires. The busy nature of these conferences means that delegates do not have much 'spare' time to complete such questionnaires and I so I had to balance the focus and number of the questions against the length of time it would take them to be completed. I designed the questionnaire (see 'choice of questions' below) so that it could be completed in some detail in 20 minutes; however, I was aware that some delegates would view this as being too time consuming. I was also aware of the reduced likelihood of delegates returning completed questionnaires if they took them home with good intentions to complete and send,

fax back to me at a later date, but also wished to support those saying they would spend more time on the exercise if they could do it at home. Finally, in order to give the perception that the questionnaire was brief, I managed to present the 18 questions on 2 sides of A4 paper without having to cluster the document.

Choice of Questions

The analysis of Phase 1 findings suggested that the hypotheses of this study (see 4.2 above) were 'true' of that one local authority. The aim of Phase 2 was to confirm whether this was also the case for the larger EDT sample. Due to the larger amount of respondents and the limited time available to complete the questionnaires explained above, the questions focussed more specifically on the hypotheses than did Phase 1. In addition, as the longitudinal study (see 4.10 and Chapter 5 below) related only to the one local authority, the first hypothesis concerning patterns and types of referrals to EDT was omitted from Phase 2. Whilst this was a relevant area for all EDTs the decision was taken to focus on the other three hypotheses in Phase 2. This meant that the questionnaire for the second Phase and the larger respondent group would explore the following areas:

- Is there any consistency in the way EDT workers assess, prioritise and respond to referrals?

- Are there any theoretical frameworks that assist EDT workers in assessing and prioritising referrals?

- (How) can EDT be more effective?

The focus of Phase 2 was therefore, the decision-making processes of EDT workers. Six questions from the Phase 1 questionnaire were also used in the 18 questions of Phase 2 and 5

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questions from the Phase 1 interviews appear in the Phase 2 questionnaire. In other words 11 of the 18 questions in the second questionnaire were taken directly from Phase 1. The format of the questions in the second phase used charts and boxes that enabled questions of, for example, age and gender of the respondent to be combined (see question 1 appendix 8) as too did the question that combined length of service and years since qualifying. This was intended to simplify and accelerate the completion of the questionnaire. It was also designed to simplify the analysis of the 'data'. Once again a combination of 'open' and 'closed' questions was used with sufficient space for respondents to comment or develop points as they wished. At the same time as allowing participants to expand on any issues raised by the questionnaire, the space to do so was deliberately limited so that the volume of commentary was manageable by the lone researcher after the questionnaires had been returned.

Analysis of the data

(For a detailed analysis of the responses to the Phase 2 questionnaire see Chapter 7, 7.2-7.11). The analytical measures outlined in 4.6 above (*analysis of the data*) were also applied to Phase 2 and key themes were identified in relation to the three hypotheses referred to above. The process for undertaking this involved every response to each question from all the returned questionnaires being collated and then presented in a number of ways – see Appendix 14 and Chapter 7. Analysis at this stage meant transferring every written questionnaire response and typing them all up into one mass of data. The next stage was to apply read through all this data and identify confirming and disconfirming material in relation to the hypotheses. In the analysis also (See Chapter 7), it was intended to reflect upon any aspects that the respondents or the researcher found of particular interest or significance. As with Phase 1, the analysis of the responses also directed the areas to be explored in the follow up semi-participative interviews to which we now turn.

4.9 Participative, Semi-Structured Interview, Phase 2:

Introduction

As with the Phase 1 interviews, the purpose in this second phase was to offer an opportunity, to a sample of the respondents, to discuss some of the key issues that had been identified via the questionnaire. A face-to-face interview also enabled the researcher to explore whether changes had occurred one year after the questionnaires had been completed.

Process

The focus of these interviews was 'prioritisation', 'consistency' and 'autobiography'. I was interested to further explore the respondents' views 'face-to-face' around how they assessed and how they prioritised situations in which there were competing high priority referrals. Having established some inconsistencies and possible autobiographical influences, via the questionnaire, I wanted to discuss the relevance, or otherwise of such factors with this representative group of EDT workers.

The context to these interviews was that they were held at the NWEDT Annual Conference and ESSA's conference in 2000/2001 the year after the original questionnaires had been completed. EDT workers attending these events were asked to volunteer to be interviewed only if they had participated in Phase 2's first stage (the questionnaires). Analysis of the responses from Phase 1 and the returned questionnaires of Phase 2 suggested that the differing models of EDT (see 1.5) might have been one source of influence on the manner in which referrals were prioritised. It was decided therefore, in Phase 2, to establish a representative sample group that reflected the differing EDT models. Given also, that Phase 1 contained predominantly male responses, and in order to ensure that women's responses were not

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ignored, Phase 2 sought to ensure that women's responses were included both in the completion of the questionnaires and these follow-up interviews.

Practicalities

In some respects, these Annual, National EDT Conference 'gatherings' were ideal for the lone researcher who wished to gather data from a representative national sample of EDT workers without having to travel the full length of the British Isles. In being able to speak directly to EDT audiences at these conferences from the lecture platform, the opportunity to persuade potential interviewees to participate was ideal. There were however, practical disadvantages to this strategy as it meant all interviews had to be 'fitted in' around the total four days of the conferences and around busy conference agendas. The time available for interviewing therefore, was limited and so the length and type of the interviews had to be designed accordingly. Finding time and space for the interviews, with hindsight, could have been managed more effectively.

Recording and Analysis of Interviews

Having identified a representative group of EDT workers (based on the 'type' of out of hours service they represented and the gender of the respondent), each individual interviewee was reminded of the initial 'questions' particularly the prioritisation exercise (see question 15 Appendix 8) and advised that there were significant discrepancies between the total responses. As all the questionnaires had been anonymous, it was impossible to identify who had completed which ones (other than the few who signed them) and so a copy of the scenarios was available to refresh the respondents' memories and to stimulate discussion.

Unlike the interviews held in Phase 1, these interviews were not tape-recorded. One practical reason for this was not having the time to set up the tape recorder for each interview, nor the

guarantee of a sufficiently noise free environment. Secondly, the interviewees had been given insufficient notice of the interviews (a weakness of the research process) and so I decided that to tape record would be too intrusive. Unlike in Phase 1, where the sample group had been written to well in advance, these respondents' first real contact with the interview part of the research was as they arrived for their 2-day Annual Conferences. I did not wish to unnecessarily add to their workload or detract from the work of the event and so 'compromised' by not trying to tape record the interviews. To replace the recording I made contemporaneous notes of the interviews that the respondent was advised they could read at the end should they so wish. Notes were made under each of the four headings of the interview schedule (see 7.14) and I gave an oral summary to the interviewee at the end of each section to ensure accuracy of recording and agreement of the recorded content.

The next stage of the analysis (see 7.14 for details) was to compare and contrast the responses of these interviews with each other, in relation to the hypotheses and then with reference to the responses of Phase 1. This exercise highlighted key areas of consistency and EDT themes that are recorded in Chapter 7 and developed in Chapter 8.

As far as the research group of EDT workers was concerned their contribution was now complete and no further questionnaires or interviews would take place. The next stage in their participation would follow when the initial and final findings were written up and presented to the respective Conferences of NWEDT and ESSA over the following 2 years. As indicated above (see 1.6 and 4.3), there were data collection processes that occurred throughout the period of both Phases 1 and 2, namely the Longitudinal study and the Autobiographical Diary, details of which are now presented.

4.10 Longitudinal study:

Whilst the majority of the detail regarding the longitudinal study is reserved for its own Chapter (Chapter 5) where a detailed presentation of its purpose, process and problems is provided (5.2), it is appropriate here merely to introduce the key aspects of this final method of data collection that formed a part of this research. The next chapter develops each of these issues in greater detail.

The longitudinal study adopted the recording mechanisms already used by the EDT (see Appendix 5) and was carried out for the 6 year duration of the research. The purpose of the study was to collate detailed statistics relating to EDT activity that could then be analysed from a number of different perspectives. The process for gathering this information was not without complications and potential sources of bias and inaccuracy. One key factor to be explored was the manner in which EDT workers categorised 'referrals' or 'contacts' and thus where they were placed on the Session Record (Appendix 5).

It was hoped that by collecting such data, specific questions about the out of hours social work service for this one authority could be responded to with some clarity and that the perceptions of the team could be compared against the statistical 'reality'. It was also anticipated that the data collected would identify any patterns in referrals rates and types. From the information collected within this longitudinal study it would be possible to produce graphs and diagrammatical presentations to present the detail (see Appendix 9 and Chapter 5). As stated above though, the main examination of the longitudinal study is presented in its own chapter that follows this.

4.11 Autobiographical Diary.

Chapter Three (see 3.6 i) presented a detailed examination of the growth of qualitative social research into life experience, and particularly the increased recognition of the parallels between the research and practice (Archer, 1990; Clifford, 1998; Everitt et al., 1992; Sheppard, 1995). This research maintained a diary that logged autobiographical experiences of both EDT 'crises' and the experience of undertaking this research into EDT. This reflective log informed the author's academic research and his social work practice as well as the dialogue that occurred within the interviews, (see Appendix 11, pages 133-135 and 153). Hampl (1991) says that 'when autobiographical writing is shaped into an autobiography or memoir, it is a research text.' Whilst the diary would not become as such, an 'autobiography' it was hoped it would provide a rich data source for this research.

The mechanism for maintaining this diary was relatively simple in that the author made contemporaneous notes on events as they occurred. The intention was to record a variety of aspects relating to both the social work practice and the research process. Some of the entries refer to specific feelings experienced by the author during EDT shifts and, at other times the feelings of the author whilst undertaking various research subjects. It was anticipated that the autobiographical content would provide the opportunity for the researcher to monitor the development of the research, as well as maintaining a reflective log (similar to that expected of qualifying social work students whilst on placement) that would give the reader a first hand account of the feelings of the researcher at different points throughout the period of the study. It was also anticipated that reference to such autobiographical material would reflect the researcher's genuine commitment to breaking down the traditional interviewer-interviewee type of data collection in which little, if anything, of the researcher him/herself is shared with the sample group. Primarily the purpose of the diary was to provide a commentary upon and a source of reference for the research subject itself. In other words, the diary would be used as

'evidence' and 'data' in its own right to support or contradict the data that was collected from the other sources. As an experienced EDT worker and the researcher I used the autobiographical diary to contextualise the subject (research and EDT social work) for the reader. The data contained within the Autobiographical Diary was also intended to be of value in itself as a qualitative record of the researcher's own thoughts on the process and the practice. Extracts from the diary are used sparingly within the dissertation to support or contradict a variety of points that are being presented, or to provide the reader with 'real' examples of practice or research issues. The few extracts from the diary that are included provide a different context for the reader. The extract at the very outset of this study presents the reader with a real situation, experienced by the researcher and allows the reader to imagine their own responses as well as analyse those of the researcher. This extract includes reflection on the case (Mr A) who features as a focal point later on (Chapter 8) for a more theoretically sound assessment framework. Autobiographical extracts appear in Chapter 2,(2.5(b) and 2.6) as examples of the author's own views on such as social work skills and the notion of 'risk'. Chapter 3 details the use of the Diary and inevitably presents some extracts on the author's value base and in Chapter 6 one extract presents some of the dilemmas experienced by the researcher during the research process itself.

Other than those mentioned above, use of Diary extracts is rare but the complete 'works' are in the Appendix (11) as a comprehensive account of the author's experience of the research process and reflections on practice both as a means of improving my own EDT practice as well as developing research skills. The complete Diary is hoped also to offer the reader some insight into the practice and research process experienced by the researcher throughout the period of the study.

4.12 Conclusion

This research therefore, uses a combination of research methods as indicated above. It was not the intention of the author to give particular precedence to any specific method since different, but complementary types of information, were being sought by the differing methods adopted, although 'cross-fertilisation' between methods and material does occur: The same subjects are examined in different ways by the various methods. An incremental approach to the research was adopted in that aspects of one team were studied at first and then the findings of the one formed the basis of the research into the rest of the teams from around the U.K. Running parallel to this process were an autobiographical diary and a longitudinal study. The findings of the questionnaires and the interviews are presented in Chapters 6 and 7, whilst references to the Diary feature throughout the thesis. The next Chapter specifically presents the details of the six-year long 'data' collection process explained in this chapter, namely the longitudinal study.

CHAPTER 5

Statistical Survey, A Longitudinal Study

5.1 Introduction

It has already been noted in previous chapters (3.5 and 4.6) that two elements of this research continued throughout the six-year period. The first was the Autobiographical Diary (3.6i and 4.11) and the second, the Longitudinal Study (4.10) that concentrates on referrals from the author's own local authority. This chapter explains the process and presents the detailed findings that arose as a result of that longitudinal study.

5.2 The Longitudinal Study.

Process

The process for gathering the data for the purposes of this study used the recording strategies that already existed for that EDT of the Phase 1 local authority. These strategies were believed to be adequate for the purposes of the research as well as the department and this avoided unnecessarily adding to the work of the EDT. All the EDT workers were made aware that their records from 1996 – 2002 would also be used as part of this research and, possibly because the recording did not create any extra administration for the team, 99% all the sheets during the six year period were completed, in full, by those undertaking EDT (see Appendix 5). As an EDT worker in the team, I was already aware that 'we' already maintained detailed contemporaneous records of every contact in at least three different ways.

The first type of record completed by EDT workers were the 'referral' or 'contact' forms that were filled in for every appropriate contact taken by the worker on each shift. These forms would detail the time and nature of the referral and provide a detailed account of the action and/or decisions taken. These forms were faxed or hand delivered to the relevant daytime offices for information or follow up the next working day. Daytime workers also completed the same forms 'in normal office hours'.

The second record kept was a log sheet that records every single phone call received or made, the time and length of the call and a brief summary of the content. Initials of service users rather than names were used and these log sheets remained in the EDT office (indeed there are still log sheet records dating back to 1978 in the office that are referred to later on – see Chart 1, 5.3). This log sheet was also used to note when the EDT worker leaves and returns to the office on visits and is divided in terms of 'before midnight' and 'after midnight' activity. This log sheet is not kept by the daytime counterparts and provides EDT workers with the only source of continuity between out of hours shifts as it records what each worker did about every phone contact and visit.

The details of this log sheet were also noted on the 'session record', the third means of EDT recording (Appendix 5). The 'session record' logs the number and 'type' of referrals worked on by the EDT social worker, in any one shift. This log sheet also records how much time is spent, in and out of the office, as well as the time taken completing the numerous administrative tasks required of every shift. As can be seen from the example (Appendix 5), this session record details the individual identifying number of all known service users as well as an indication of whether any money was spent on the shift. To make the monitoring of the work and the compilation of the related statistics easier, the workers themselves had always been expected to provide the totals, as stipulated on the sheet, and so this practice continued for the duration of this study.

At some during every shift, the worker was expected to complete the session record and, at the end of that shift, attach to it his/her log sheet of phone calls (which includes details of

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the time, duration and synopsis of the content of every phone call). Both work logs were then sent to the administrative support secretary, who would compile monthly returns based on the sheets received. Copies of all the session records and log sheets, with the workers' consent, were kept by the researcher.

These session records had, therefore, a dual purpose in that they served as the monthly returns for the department, and they more than met the requirements of the author who wished to analyse the numbers and types of work coming to EDT. These completed sheets have been used as the basis for the statistics and charts that follow within the main body of the text.

It was worthy of note that no other social worker in that particular borough, was expected to record as much, or in as much detail, as the EDT worker of the same local authority. This level of recording is more detailed than that expected of the daytime social worker who needs to complete the various assessment forms, and referral sheets that give, in greater depth, the details of the intervention.

To establish some degree of confirmability, I made checks of the records once per month completely at random. These checks consisted of a cross-referencing of the details submitted for the computer based records with that of the EDT maintained records. Such aspects of the referrals as the date, time and nature of the call could be 'verified' by checking both records. Of the 50 random checks undertaken over the period of this research, 45 of them matched completely, 2 in part and 3 not at all. It is likely that the three without any cross reference were due to human error in recording the individual identifying code number allocated against each service user. Despite the potential for inconsistencies, 90% 'reliability' suggests the recording by the EDT workers in this team was suitable data to be examined for such aspects as referral patterns and rates of referral. There was however, no way of establishing how many referrals were never recorded, by accident or design, on the records by the EDT workers and this could have impacted upon the final data. This was then the process by which the data for the longitudinal study were

gathered over the six years of this research. In short, the method of data collection simply used the departmental strategies that already existed for monitoring the out of hours social work activity.

Purpose

By compiling these log sheets and session records it was anticipated that, over a period of years, any forms of patterns of referral would emerge. Similarly, by analysis of the data, details could be given regarding the more common types of referral to EDT. Based on the subsequent information, it should also be possible to determine which service user groups rarely come to the attention of EDT as well as those that are most often referred after hours. The purpose of gathering this statistical data therefore, was to provide an opportunity to examine whether patterns exist in the rates of referral or the types of referral, and to look at what might be considered as the 'usual' or 'regular' pieces of work an EDT officer can expect. Using this information it should then be possible to examine the following questions:

A/ What type of work does EDT do?

B/ which service user group does EDT have most/least contact with?

C/ are there variations in referral rates between the different times of the year or within each week?

D/ how much mental health work does EDT undertake in a year?

E/ how many PACE interviews does EDT undertake in a year?

F/ what percentage of EDT work is concerned with children and families, what percentage with adults (i.e. older people, adults with a disability etc)?

G/ how many referrals are taken by EDT per week, per month?

H/ what amount of EDT work is carried out before and after midnight?

I/ how much time does EDT spend in/out of the office?

J/ how do the numbers of referrals and total time worked compare to three and six years ago?

It should be understood that the above data is specific only to Phase 1 (the single local authority) and cannot appropriately be applied to the sample group of Phase 2 without further research questions that did not form part of this thesis. Phase 2 was interested though in cross- referencing some of the statistical findings of Phase 1 to establish whether there were any comparisons or contrasts in the rates and types of referrals to other local authority EDTs.

Problems

In order to complete the session record (Appendix 5), upon which the data for the longitudinal study are founded, the EDT workers had to decide firstly whether the contact constituted a referral (and therefore should be logged on the session record) and secondly, what type of referral it should be categorised as. For example, there is little difference it would appear between the categories 'Children' and 'Family Work'. Similarly, if a family had been referred because of concerns for the children because a parent who had mental health problems how would the workers record this on the session record – as one 'Mental

Health/Illness' referral, or as 'Family Work' or under the category of 'Children'? Given that the options to record this contact could also include having both the adult and the children recorded in separate categories, then there is scope for confusing data and misleading conclusions to be drawn. The notion of a referral is discussed in some detail later (see 5.3 (1)), it is sufficient to say here that the collation of these statistics was not as straight forward as was anticipated at the outset.

The second set of difficulties relating to the completion of the session record was that there appeared to be no consistency in terms of when the session record was completed. Some workers filled in the boxes as the shift progressed (this was my method), others brought the record up to date during quieter periods or did what others also did which was to complete it at the end of a shift. There are implications for each approach as the first 'contemporaneous' method, that might on first sight appear to be the best, means that the session record is completed as the information arrives. The difficulty of this in terms of continuous time recording is that the situation may change and the focus of the intervention may alter. This means that the definition of what category the referral will be recorded as on the session record is decided upon before all the information may have arrived. I am aware from personal experience that once on the session record, the categorisation of the referral never changes and thus the data may be misrepresentative. Another strategy for completing the session record is to leave it until the end of the shift. At the end of every shift there is a significant amount of administration to be completed a small part of which is the session record. It is evident from some of the session records that workers have 'rounded up' to their calculations to simple figures. In other words, workers have not calculated the sum of all the time spent on the telephone, all the time spent doing write-ups and administration and then added this to the time away from the office before and after midnight, but have provided 'guestimates' for some of these categories. One related feature of this method of recording work activity for some workers, and I include myself in this, is the culture of 'wanting to be seen to have had a busy shift'. What this means is that the

calculations for the time occupied doing admin and write-ups for example is inaccurate at best and exaggerated at worst. Either way it, to some degree, distorts the reliability of the data. The other issue for those workers who complete the session record at the end of the shift is that they rely more on their memory than those who record as the shift progresses. Given that the shifts undertaken that are the subject of this research were of 15.5, 18.75 or 24 hour duration, the difficulties of leaving the written record of a busy 24 hour shift until it is time to go home are self evident. Not only would the worker have to complete most administration at the end of the shift, that worker would also be at their most tired and, probably most eager to leave the office – this influenced the recording of the session records.

The issues with continuous time recording therefore revolve around the subjective nature of the record, the retrospective nature, their potential for guesswork or exaggeration not to mention the inevitable human errors in both recording and calculating. This meant that some totals did not add up accurately or in a small number of cases (less than 1%), the session record simply was not completed at all. The cross-referencing exercise undertaken monthly (see above in 'process' section) also established a 90% degree of consistency with the electronic records maintained by the department. This meant that although there were areas of potential discrepancies in recording of any one shift, a high degree of consistency was actually achieved.

Despite then, the potential weaknesses of this method of data collection, it still meant that a detailed and consistent record of over 99% of the 2,190 shifts covered throughout the period were available and formed the basis of the longitudinal study, the findings and analysis of which now follow.

5.3 FINDINGS OF THE LONGITUDINAL STUDY.

CHART 1
EDT December Referrals
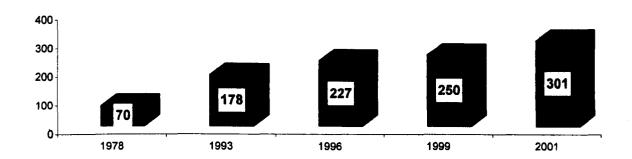
Chart 1 above illustrates the increase in referrals to EDT between 1978, when the team was first established, and 2001. Because detailed statistics were not maintained at the beginning, the only figures available from 1978 formed part of an internal audit of the 'take-up' of the, then, newly formed team. Figures for this audit were only collected for the months of November to January. This chart has taken figures for the month of December from a sample of the years as shown to indicate the change in the rate of referrals to the team. The source for these figures was the record and session sheets kept every shift by the EDT workers. The rise is, for example from 70 in 1978, to 250 in the December of 1999, then up to 301 in the year 2001, this represents a rise of over 400% in the number of referrals being received by the team. The number of workers taking these varying numbers of referrals has remained the same since 1978, namely one worker.

Mention needs to be made of the difficulties that exist when recording such matters as the numbers and types of referrals and the nature of EDT work as there is a range of potential areas of confusion, namely:

1. The definition of a 'referral'

During the 6 years that data has been collected for this research, it has become apparent that different EDT workers (possibly as with daytime social workers) have varying interpretations as to what actually constitutes a referral, what constitutes a message for the daytime worker that has case responsibility and what is neither. Given the headings that exist on the EDT Log sheet (see Appendix 5), further confusion arises when it is accepted that different scenarios/referrals are categorised differently by the various workers. Whilst the PACE category might appear on one level to be self explanatory, it does not stipulate whether this was a piece of work relating to a young person or a vulnerable adult. This means that potentially the totals of PACE referrals are misleading because they could include significant numbers of such duties that are actually not child care related at all. In order to decide which category a referral/message is placed the worker needs to decide which is the more prevalent, more prominent feature of the referral whether it is the mental health of the parent or the risk to the children will determine whether the referral is recorded as a children and families matter, a family work matter or a mental health matter. As with the assessment that takes place with the service user, this is a process that, it is argued here, is imbued with autobiography rather than any policy. To complicate matters further it should be noted that the majority of work undertaken by EDT (however a referral is defined) is work on 'open' cases. This means that presently for the local authority in Phase 1, a full child protection investigation carried out by EDT does not constitute a referral, but will be recorded as having the status of a 'message' or a 'contact' on the case file. However, a similar investigation on the same family once the case is 'closed' would merit the status of a referral, and so would figure in the EDT statistics held on the authority's computer. Put simply there are complications for the recording of EDT referrals on 'open' cases that some daytime teams might only give 'contact' status to.

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2. *The number of referrals against the time occupied*

The collation of the statistics regarding numbers of referrals to EDT as a means of illustrating how busy a shift or a certain time of year is, is further complicated by the way in which the number of referrals taken in any one shift, week or any period does not, in itself, necessarily accurately reflect how busy the EDT worker actually was. For example, the worker may have taken 3 referrals in one night but been occupied for 15 hours. On another shift, the same worker may have taken 20 referrals but only accrued 5 hours on the log sheet. This anomaly is explained by the way in which some referrals (Mental Health Act assessments for example) usually take several hours to undertake, whereas other referrals (failure of a Home Carer to arrive) can take only 10 minutes. The strange contradictory aspect to EDT is also reflected in the fact that, for these two examples, the opposite is also true, in that to arrange a replacement home carer can sometimes take hours and a Mental Health Act assessment could take less than an hour, (if, for example, the 'patient' is already in hospital, both medical recommendations have been completed, doctors are available for consultation, the Nearest Relative has consented and no other priority 1 referrals have come in). What is true is that the number of referrals alone does not fully account for how busy or otherwise any particular shift or week was. The charts featured below will seek to clarify a combination of the number of referrals taken on any one shift, but also the amount of actual time taken in dealing with those pieces of work.

One final possible weakness in the data being collected this way is that focusing on the numbers of referrals taken and the time spent thereon, does not account for the differences in time and approach taken between the differing workers. One worker may spend a considerable amount of time with a young person detained in a police station clarifying that they have been properly looked after and ensuring that they are aware of the process to follow, whereas another EDT worker, who perhaps knows the young person and that young person's knowledge of PACE, may spend less time with them and thus reduce the overall time spent on this referral. Another example would be the EDT worker who knows

the service user who regularly becomes 'homeless', but who also always finds alternatives if asked to do so. The worker who knows this service user may spend less than 10 minutes dealing with this matter, whereas the EDT officer that does not know the homeless person could easily spend hours dealing with this and ultimately even placing the person in accommodation. Whilst there are clear issues here regarding the communication to and between EDT workers, the point is that different workers may spend different amounts of time on the same referrals, and these statistics do not reflect this.
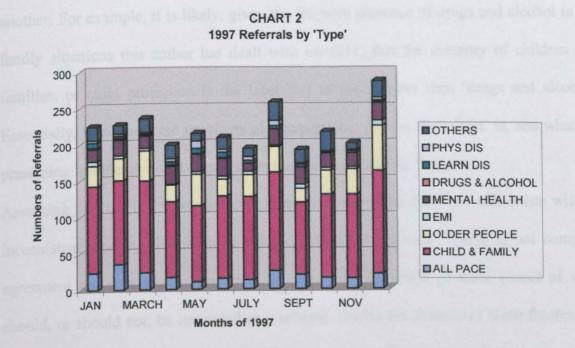
3. Relief staff rota

In the local authority from Phase 1, the full-time team is supplemented by the use of a relief pool of daytime social workers who cover the Leave and sickness of the team. It is possible that these workers spend different amounts of time on the same referrals because of their different perceptions of the role of the out of hours team. Some may see it as an emergency service only, whereas others may see it as an extension of what occurs during the day. Both of these perceptions are likely to impact upon the response given to referrals out of hours and the amount of time spent thereon. It is also likely that the relief staff members are less likely to know the 'regulars' to EDT who, as suggested above, can be dealt with very quickly. The 90 year old who phones in floods of tears saying she has no food, is freezing cold, has no carer and cannot cope is likely to be responded to differently by a relief staff member with no prior knowledge of the caller, as opposed to the regular full-time EDT worker who speaks to the caller every shift at the same time and is presented with exactly the same details that reflect the caller's confusion rather than any 'verifiable reality'.

To summarise then, there are multiple difficulties concerned with the definition of a referral, and the amounts of time spent on each one. EDT workers would not appear to agree how pieces of work should be categorised, and there are different responses to the referrals taking varying amounts of time. It is suggested that these variations need to be

acknowledged when analysing the data collected as the information, in part, is derived from the log sheets that form the basis of the following statistics.

There is a variety of ways by which the longitudinal study can be used. The data provided can be analysed to establish whether any 'patterns' exist in the rates and types of referrals that EDT deal with. The statistical material also provides the necessary data to examine whether particular times of the year are more demanding than others and whether certain shifts are 'busier' than others. The definition of 'busy' can be divided into two categories, the first deals with the number of referrals being dealt with, whilst the second looks at the amount of time (to the nearest minute) spent dealing with those referrals. So, for example, the chart below illustrates the numbers of referrals for 1997.

CHART 2
1997 Referrals by 'Type'

A glance at Chart 2 above suggests that, in terms of the numbers of referrals taken by EDT in 1997, December was clearly the busiest and August the next busiest. The chart shows that September saw the least number of referrals to EDT, with July and April providing only a few more.

Superficial analysis would also indicate that by far the greatest source of referrals to EDT, for every month, is the category 'Children and Families'. The category that provided EDT with the second largest number of referrals for 1997 was that of 'older people'. Based on this chart, it would appear that the least source of referrals is those situations, which are categorised by the EDT worker as 'drugs and alcohol'.

From the outset, it should be noted that there are a variety of potential difficulties inherent in the analysis of this data, not least of which, is that the categorisation process depends entirely upon the individual EDT worker deciding which scenario will go under which heading on the log sheet. It is evident from the interviews (see below) that there are some inconsistencies in the way referrals are categorised.

Another difficulty is the way in which some of the categories can be subsumed under another. For example, it is likely, given the frequent presence of drugs and alcohol in the family situations this author has dealt with on EDT, that the category of children and families, or child protection is the label that is used, rather than 'drugs and alcohol'. Essentially, then, there are problems of interpretation of who the 'client' is, and what the presenting 'problem' is that impact upon the accuracy of these figures.

Assuming that the log sheets are completed accurately, the difficulty still exists with an inconsistent working definition of what constitutes a 'referral'. There is not complete agreement amongst those doing EDT in this authority which of these pieces of work should, or should not, be construed as a referral. Whilst the absence of these figures will affect the overall numbers of 'referrals', it would not affect the overall percentages, i.e. 'children and families would still be by far the largest category.

The more obvious weakness with such reliance on this chart for reliability is that it only provides a 'snapshot' of what the case was for that particular year. Whilst this information has value 'in its' own right', it remains of less significance without other sets of similar data for other years to compare and contrast it with. This was collected and is presented below.
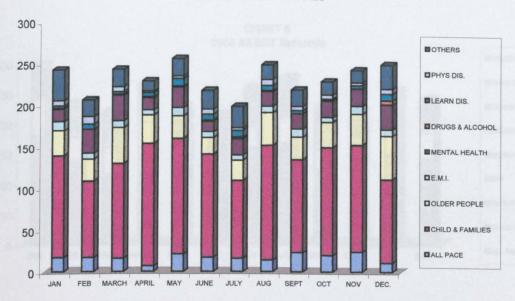
5.4 EDT referrals for 1996-2002.
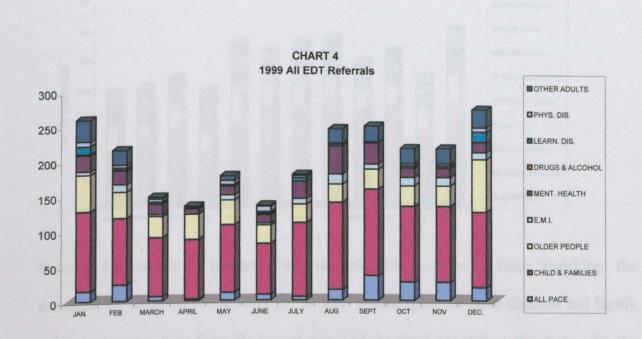
Children and Families produced by far the greatest number of referrals. As in 1997, the second largest source of referrals for 1998 and 1999 were Older People. People with Mental Health Problems also appear to feature prominently in the work undertaken out of hours.
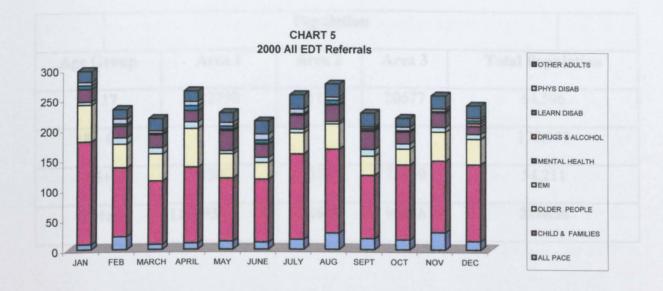
The months of December and July would appear to be the busiest and least busy respectively. It is possible though, that these graphs do not accurately reflect the true nature of the work undertaken by EDT. It would appear to make sense that the more hours EDT provide a service for, the more referrals they are likely to receive. In other words if EDT are on duty for a month that has two public holidays and 31 days in it, then it inevitably may receive more referrals than the month with thirty days and no Bank Holidays. It could be argued that December would always be the 'busiest' month because it falls into the former rather than the latter category. A more detailed look at the figures for other years, however shows that there would not appear to be any true correlation between amount of hours worked and the number of referrals taken by EDT.
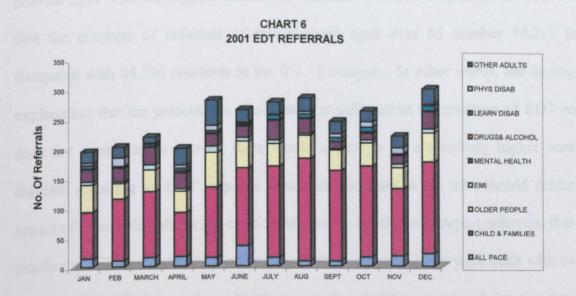
Another possible explanation of the data presented by these charts might be an extension of the hypothesis above: It is conceivable that if EDT receive more referrals Friday – Sunday then the months which have more weekends in them, are more likely to reflect higher referral rates than those months with a majority of weekdays in them.

CHART 3
1998 All EDT REFERRALS

CHART 4
1999 All EDT Referrals

because they form the ... Intervention or practical support to older people considering the ... Children and family referrals, because they form the largest group of the local population. Similarly with the referral rate for older people, it could be argued, particularly in the borough in question, that this reflects the prevalence of that service user group in the area. The following table shows how the population of the Local Authority from Phase 1 is broken down into different age groups and locations, and the fact that the population of the authority is approximately 282,000 (Office for National Statistics mid-1999 population estimates).

CHART 5
2000 All EDT Referrals

Legend: OTHER ADULTS, PHYS DISAB, LEARN DISAB, DRUGS & ALCOHOL, MENTAL HEALTH, EMI, OLDER PEOPLE, CHILD & FAMILIES, ALL PACE

Months: JAN, FEB, MARCH, APRIL, MAY, JUNE, JULY, AUG, SEPT, OCT, NOV, DEC

CHART 6
2001 EDT REFERRALS

Legend: OTHER ADULTS, PHYS DISAB, LEARN DISAB, DRUGS& ALCOHOL, MENTAL HEALTH, EMI, OLDER PEOPLE, CHILD & FAMILIES, ALL PACE

Months: JAN, FEB, MARCH, APRIL, MAY, JUNE, JULY, AUG, SEPT, OCT, NOV, DEC

It might be possible to interpret these referral rates in terms of them 'matching' the

demographic make-up of the borough. In other words, there are more children and family

referrals, because they form the largest group of the local population. Similarly with the

referral rate for older people, it could be argued, particularly in the borough in question,

that this reflects the prevalence of that service user group in the area. The following table

shows how the population of the Local Authority from Phase 1 is broken down into

different age groups and locations, and the fact that the population of the authority is

approximately 289,000 (Office for National Statistics mid-1999 population estimates).

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	Population			
Age Group	Area 1	Area 2	Area 3	Total Population
0 - 17	22790	21129	20677	64,596
18 - 64				170,049
65+	93003	55518	75739	54,211
Total	115793	76647	96416	288856

The above statistics do not, it would appear, entirely explain why Children and Families provide EDT with the highest number of referrals. It can be seen from the above figures that the numbers of residents of this borough aged over 65 number 54,211 in total compared with 64,596 residents in the 0 – 17 category. In other words, the demographic explanation that the percentages of residents is reflected in the numbers of EDT referrals does not appear to be true as, there would appear to be a relatively higher number of children requiring an EDT response than their numbers in the area should demand. An aspect of these calculations not considered was the incidence of repeat referrals, that is, the number of children and family referrals (or other categories) that were dealt with over one weekend by different workers. Neither were the statistics examined for the number of times the same family recurred in the data.

Part of the value this single chart does have, is in providing an effective illustration of the 'type' of referrals EDT dealt with in this particular year (1997), as well as the overall numbers being referred to EDT in that year.

Based on this and other charts, and the figures that led to their compilation, it is possible to conclude the following statistical breakdown for 1996 - 2002: It should be noted though

that the details for 1996 were only collated from March through to December, and so the statistics for that year are incomplete; they are presented as a percentage of the total for the majority of that year.

Referral Category	% of Total Referrals for 1996	% of Total Referrals for 1997	% of Total Referrals for 1998	% of Total Referrals for 1999	% of Total Referrals for 2000	% of Total Referrals for 2001
Children & Families	51.95%	53.12%	51.81%	50.10%	50.91%	51.79%
Older Persons	14.17	15.11	13.97	17.52	17.9	16.29
Mental Health	8.70	9.47	9.16	9.45	9.50	9.16
PACE	8.44	8.45	7.29	7.74	6.50	6.28
Others	8.70	8.00	9.27	7.41	8.17	28.4
EMI	2.50	1.87	3.48	3.75	3.30	2.26
Learning Disability	2.70	1.80	2.33	2.16	1.73	2.19
Physical Disability	2.13	1.76	2.19	1.83	2.38	2.33
Drugs & Alcohol	0.67	0.37	0.46	0.16	0.37	0.43

Table 1

CHART 7
Average Percentage of EDT Service Users 1996-2002
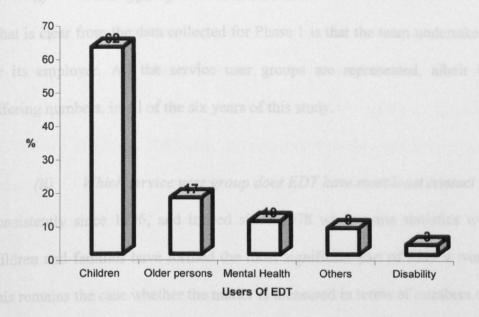
Chart 7 (above) represents the average total percentages of service users to EDT in the

Phase 1 local authority over the six-year period of the study. For the purposes of accuracy

it should be noted that some categories have been combined in this general overview chart:

'Children', for example, includes PACE work undertaken for young people, and 'Older

Persons' includes the service users categorised as Elderly Mentally Ill. What would still

appear to be the case from the data is that the largest proportion of the work undertaken by,

and referred to, EDT is that related to children and families. A relevant question, not really

considered within this study is in relation to the absence of referrals concerning Adults

with physical difficulties or learning disabilities. Why so few contact the out of hours team

is a mystery to this author but may be worthy of consideration of further research. In other

words we should be interested in why so many people appear to contact EDT from the

Phase 1 local authority, but simultaneously be asking why certain groups of service users

rarely use the service.

(i)   What 'type' of work does EDT do?

What is clear from the data collected for Phase 1 is that the team undertakes a generic role for its employer. All the service user groups are represented, albeit in significantly differing numbers, in all of the six years of this study.

(ii)   Which service user group does EDT have most/least contact with?

Consistently since 1996, and indeed since 1978 when some statistics were maintained, children and families have formed the most significant part of EDT's work out of hours. This remains the case whether the matter is measured in terms of numbers of referrals or in terms of amount of time spent on referrals, (see Chart 8 below). In other words, however it is measured, the majority of work that EDT undertakes in the authority in Phase 1 relates to children and families.

Chart 8
Number of EDT Referrals/Hours Worked 1997-99

Similarly by looking at the statistics provided above it can be seen that the service user group that EDT in this authority consistently has the least contact with, is the category of Physical Disability. Two things however, should be noted: First is the fact that the statistics for Learning Disability are particularly close in number and hours spent thereon to those for Physical Disability. Secondly, the category that has consistently scored by far the lowest is that termed 'drugs and alcohol'. It is difficult to quantify, based on the data provided, why some EDT workers would apply this category rather than another, but what is likely to be the case is that this drugs and alcohol column is ticked on the log sheet when there are elements of such substances to the referral and no other category properly explains the circumstances, i.e. there are no mental health or child protection or childcare aspects to the referral.

(iii) *Are there variations in referral rates between the different times of the year/week?*

This research tends to suggest that certain days and months are 'busier' than others:

The evidence (see charts 1,2,3,4 and 6 above)) suggests that December is regularly the busiest month for EDT whether this is measured in terms of the time occupied or the actual number of referrals taken by the team, but even this is not a constant feature of the research data gathered. June and July tend to be less busy using the same criteria. This would appear to accord with the subjective perceptions of the interview group referred to above who said that Xmas was the busiest and the summer months were quieter. The statistics also demonstrate a degree of correlation between the number of referrals received and how busy the shift is. Whilst it is possible for the worker to very busy on one referral in terms of administration, phone calls and being out of the office, it is also the case that, on some shifts, the worker dealt with many referrals but did little administration, few phone calls and never left the office. The general trend however, was that the higher the number of

referrals, the busier the shift and the fewer the referrals the lighter the shift. This is not to ignore though many single referrals that can take several hours, only to indicate that there was a correlation between the number of referrals and how busy the shift was.

Friday tended to be the busiest shift (hours worked and referrals taken), closely followed by Saturday, but this was not always the case and there were many exceptions to this. The rest of the week tended to have even less of any recognisable fixed pattern.
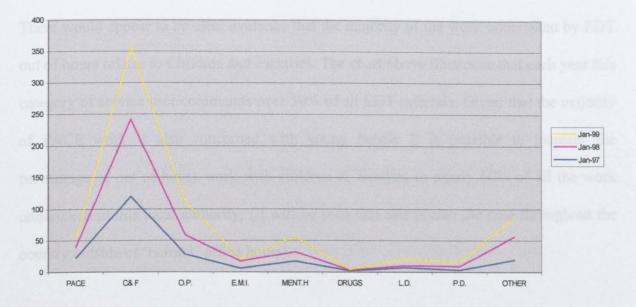
There would not appear to be any 'obvious' explanation to any of the (albeit inconsistent) patterns. For example, it was anecdotally suggested by colleagues that the cold weather increased referrals out of hours as the icy conditions caused 'slips trips and falls' of people who were often the main carer for other vulnerable people. By checking the monthly weather records of the Met Office (reference www.metoffice.com/climate/uk) against the most and least busy EDT months it was possible, to some degree, to explore any correlation between 'nature' and EDT referrals.

The findings are set out in the table below.

DATE	**EDT Statistics**	**Met office Record**
May 1998	Busiest month of year	Warmest May since 1992, driest since 1991
December 1998	2nd busiest month of year	This has been a statistically near average December
August 1998	3rd busiest month of year	Mildest January since 1994. Wettest since 1995, sunniest since 1954
July 1998	Least busy month of year	This has been the dullest July since 1992 and the coldest and wettest since 1993

December 1999	Busiest month of year	The sunniest December since 1962 and the wettest since 1993
January 1999	2nd busiest month of year	This has been the sunniest January since 1994
April 1999	Least busy month of year	This was the warmest April since 1993
June 1999	2nd least busy month of year	This was the coldest June since 1991
January 2000	Busiest month of year	Sunniest January since 1994; mostly cold and frost for 2 weeks
August 2000	2nd busiest month of year	Average temperature and sunshine for the month but some heavy hail and thunderstorms.
June 2000	Least busy month of year	Record lows produced record breaking gales (for June)
December 2001	Busiest month of year	A very sunny month with many stations breaking their sunshine records. Temperatures close to average
January 2001	Least busy month of year	Sunniest January since 1954
April 2001	2nd least busy month of year	Changeable and wet overall.

Whilst the above data does not support the suggestion that cold weather increases EDT referrals, there would appear to be a possible correlation between busy out of hours shifts and sunny winter months (especially January and December), although January 2001 contradicts this. The relationship between the weather and contacts with 'welfare' services could form the basis of more detailed analysis, but is beyond the scope of this research.

Another hypothesis from colleagues was that the business of the daytime teams reflects the business of the out of hours team. In other words, if the daytime teams are really busy then there is an 'overspill' to the EDT that similarly becomes busier. It was not within the remit of this research to examine the rate of referrals to the daytime social work teams; however, monthly management reports from the local authority that was the subject of the longitudinal study, (children and families division only), outlined staff ratios and 'team pressures'. Once again though, there did not appear to be any correlation between the referral rate to the daytime and night-time teams. It is accepted however, that much more systematic exploration of this relationship could be undertaken. Further attempts by colleagues to explain increases and decreases in EDT referral rates were such as the school holidays, hospital bed crises or a Flu epidemic! Notwithstanding the possible norm that Fridays and Saturdays are often busy, the only truly consistent aspect of EDT seems to be that there is no consistency. Thus various suggestions of the interviewees were tested for validity, but did not appear to correlate. Indeed, from experience, when EDT workers least expect it, it usually gets extremely busy, and vice versa!!!

(iv)   *How many Mental Health assessments does EDT undertake per year?*

As identified above (Table 1) the amount of mental health work undertaken by EDT in this local authority consistently forms around 9% of the total number of referrals to the out of hours team. In numerical terms this ranges from 252 referrals in 1998 to 271 referrals in 2001. Closer scrutiny of each of the mental health application forms would produce more exact data relating to the time spent on each of these referrals, but for the purpose of this study it is enough to note that behind children and older people, mental health is the third largest source of referrals out of hours.

(v)   *How many PACE interviews does EDT undertake each year?*

As with the referrals for mental health the figures are available for the relative amount of work created by EDT's role as the Appropriate Adult under P.A.C.E.(see Table 1). The range for PACE work is from 8.4% in 1996 to 6.2% in 2001; the numbers that accompany these percentages are in the range of 225 – 186 per year, or approximately 4 per week.

(vi)   What percentage of EDT work is concerned with which service user group?

There would appear to be clear evidence that the majority of the work undertaken by EDT out of hours relates to Children and Families. The chart above illustrates that each year this category of service user commands over 50% of all EDT referrals. Given that the majority of PACE work is also concerned with young people it is possible to increase the percentage of out of hours work with children & families to nearly 60% of all the work undertaken in this local authority, (It will be seen that this is also the case throughout the country outside of 'normal' office hours).

(vii)   How many referrals does EDT take per week, per month?
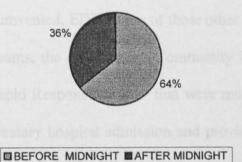
Data has been collected on a daily basis over the past 6 years and so it is possible to analyse this giving detailed responses to questions of referral types and patterns. As has already been noted though it would appear that the only consistent feature is EDT's inconsistent nature. Fundamental to this possible inconsistency, it is argued here, is the differing ways in which the individual workers not only respond to the referrals, but indeed and perhaps inevitably, the way such referrals are recorded, if they are recorded at all. This whole concept of the autobiographical element of the assessment process is returned to in the final Chapter.

(viii)   What amount of work is undertaken after midnight?
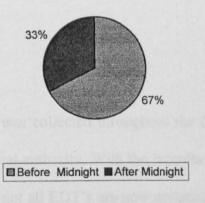
The SSI suggested (1999) that a small fraction of the overall total of EDT referrals were received after midnight (299 referrals 5pm-midnight, in contrast to 22 referrals midnight – 2am, SSI, 1999 p.29). However, my own research sought to set the figures in a different context and, rather than replicating the Inspectors survey, I chose to examine the amount of time an EDT worker is occupied before and after midnight (accepting, for the time being, that midnight is a cut-off time that is sensible) rather than merely the number of referrals

dealt with. The following charts illustrate that analysis of the numbers of referrals in itself does not provide a full explanation of EDT activity. These charts indicate that at least one third of the work carried out 'after hours' takes place after midnight.
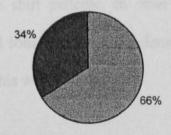
EDT Hours Occupied Before/After Midnight 1997

36%
64%

☐ BEFORE MIDNIGHT ■ AFTER MIDNIGHT

EDT Time Occupied Before/After Midnight 1998

33%
67%

☐ Before Midnight ■ After Midnight

EDT Time Occupied Before/After Midnight 1999

34%
66%

☐ BEFORE MIDNIGHT ■ AFTER MIDNIGHT

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(ix) How do the numbers of referrals compare to 3 and 6 years ago?

Chart 1 (see 5.3 above) clearly illustrates the significant increase in the rate of referrals to EDT in this particular authority, a rise of over 400% since 1978, and yearly increases in the number of referrals and time spent dealing with them from 3 and 6 years ago. It is interesting to note that this rise in the number of referrals to EDT was also at the same time as other agencies began providing their own out of hours services that supplemented and, in some circumstances, circumvented, EDT. Some of these other agencies were such as the out of hours Home Care Teams, the out of hours Community Psychiatric Nurses Teams and a range of different 'Rapid Response Teams' that were multi-disciplinary but whose aims were to prevent unnecessary hospital admission and provide home-based support. It was apparent that a new range of services were developing outside of the 'normal' working day, but also that, despite this increase in available resources, the referral rate to EDT in this authority continued to increase.

5.5 Conclusion.

A significant amount of data was collected throughout the 6-year period of this research relating to the one, specific local authority. With the introduction of Best Value during the process of this study, most, if not all EDT's are now collating some form of statistics. The picture that emerges from this EDT (which is replicated throughout the U.K.) is that referrals relating to Children and Families are consistently the largest proportion of the out of hours social worker's 'business'. The aspect of EDT that is difficult to prepare for is the lack of any consistency in the shift patterns. In other words, whilst some shifts are regularly busier than others, and some months more demanding than others, there was no clearly identifiable reason why this was the case.

(A more comprehensive set of data can be found in Appendix 9).

CHAPTER SIX

EDT in One Local Authority, Phase One

Phase 1

Questionnaire findings
Analysis of findings
Interview findings
Analysis of findings

Phase 2

Questionnaire findings
Analysis of findings
Interview findings
Analysis of findings
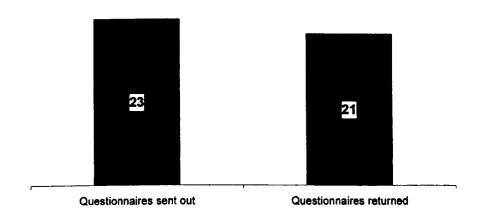
LONGITUDINAL STUDY
AUTOBIOGRAPHICAL STUDY

6.1 Introduction:

A pilot study was undertaken 'testing' out the usefulness of the questionnaires, details of which are contained at the end of the thesis (see Appendix 10). The following two Chapters present the findings of the research in two distinct stages: The findings of Phase 1 (Chapter 6) and then the findings of Phase 2 (Chapter 7). The reader is initially 'introduced' to the EDT workers from the first Phase, based on the feedback from their questionnaires. Elements of their practice that were gathered via the interviews are then presented and analysed, before turning attention to a similar structure that is then produced for the next part of the study, namely Phase 2, with details of the types of EDT workers and elements of their practice. Phase 2 develops some of the key themes identified in Phase 1 and focuses on those themes via questionnaires and interviews. The longitudinal study (see Chapter 5) and the autobiographical diary (see Appendix 11) spanned both phases and were developed throughout the six year period

Chart 1: The Questionnaire

A total of 23 questionnaires were sent/given out to social work staff who had all, at some stage, undertaken generic EDT. There were 21 questionnaires returned.

From the outset it needs to be understood that there were a variety of 'types' of EDT worker: Full-time, Part-time, Childcare only, Generic and Mental Health cover only. The sample group was decided upon by seeking responses only from those people who have undertaken generic EDT, i.e. only those who were expected to provide a social work response for all service user groups. It should, however be noted that, for some, this generic EDT role had not been undertaken for some time, albeit that they may well have continued to provide the mental health cover for those workers who undertake EDT on a part-time basis but are not Approved Social Workers, and therefore, are unable to partake in an integral part of EDT work, which is the assessments under the Mental Health Act 1983. Put simply, there were 4 'kinds' of EDT worker:

1/ Full-time generic,
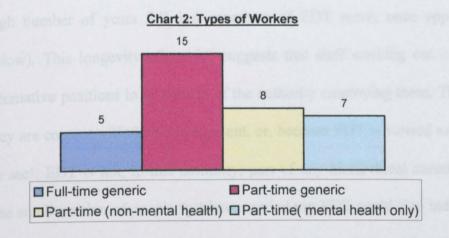
2/ Part-time generic,

3/ Part-time specialist (all referrals except mental health)

4/ Part-time specialist (only mental health cover provided for those in 3 above)

All respondents, irrespective of their 'kind' when participating in the research had, at some time, past or present undertaken sole, generic responsibility for EDT shifts.

Of the 23 questionnaires sent/given out, 21 were returned. Chart 2 (below) illustrates how the respondents could be categorised as follows in terms of their present EDT 'status'.

Chart 2: Types of Workers
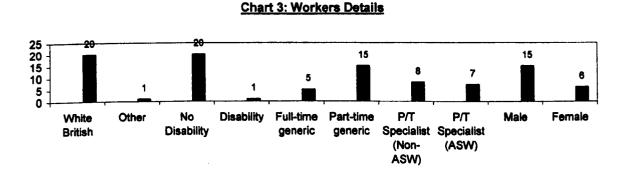
The figures do not add up to the response total of 21 because some of the workers have undertaken different 'types' of EDT and therefore figure more than once in the statistics. For example, the author has been a part-time EDT worker as well as a full-time one, and has also provided the mental health cover only, on some occasions. The sample group, to which questionnaires were sent, therefore, consists of 23 people.

It should though, be noted that since 1978, when the full-time team of three staff was established, only 8 people have undertaken EDT as a full-time, generic post. Interestingly, of these 8 people, 7 are still working in social services with the same local authority. It was

not possible to contact the one previous full-time EDT worker (from 1978) who is no longer employed by the authority.

Having identified all the members of staff past and present that had undertaken various EDT roles, (by working through minutes of meetings from 1978 onwards, and talking to some of the longer serving staff), they were sent a copy of the questionnaire with a covering letter that set out the process and purpose of the research (see Appendix 3). The final 23 members of staff contacted therefore represent all the staff that have undertaken some form of generic EDT work, part or full-time, within this authority.

The relatively small group is in itself of interest because it reflects the paucity of staff that has ever undertaken EDT. This could be for a variety of reasons including the unusually high number of years full-time members of EDT serve, once appointed (see Chart 5 below). This longevity of service suggests that staff working out of hours do not seek alternative positions in or outside of the authority employing them. This could be because they are content with their employment, or, because EDT is viewed as an employment 'cul de sac'. EDT is not, in this authority, part of any hierarchical career progression ladder. The small number of people that have carried out EDT could also indicate that few people are attracted to this type of work because of the long shifts, and unsociable hours and the nature of the job itself.

Chart 3: Workers Details

6.3 <u>GENDER (Phase 1).</u>

The responses could be broken down by gender as follows:

Male: 15

Female: 6

Since completing this research, my replacement as a full-time generic EDT worker in this authority, now that I am Manager/Practitioner, is a woman but has not contributed to this part of the research. There had never been a female full-time EDT worker in this local authority before this. At the time of writing there are three women who regularly do EDT on a generic (but not mental health) basis. One of the differences between the A.S.W. cover and the generic worker is that the latter is office based, whereas the former operates from home. There is, again at the time of writing, only one woman included in the A.S.W.rota who 'backs up' the EDT 'relief pool', (these are the workers who cover for the 3 full-time staff when off sick or on holiday). It is misleading to read the 'raw' data above and assume that 40% of the EDT staff is made up of women (6 out of 15). When these statistics are looked at in more detail it should be recognised that of those 6 women, 2 are no longer part of the night duty rota, and one works from home providing the mental health cover only.

The gender make-up of this Emergency Duty Team would appear to contradict the 'norm' that has the majority of basic grade social workers as female, whilst the majority of senior managers are men (Social Services Inspectorate, 1991).

It is likely that EDT reflects the gender power perspective that involves social work, like society, being run largely to male priorities, derived from male thought processes, and as Fawcett says (1994) 'within male operation systems.'

EDT workers, although they are categorised as social workers (there is, however, some confusion regarding this, which is discussed later), are given the delegated authority of the Director of Social Services whilst on duty. This means that the EDT worker is operating at a level of management, far in excess of the daytime counterparts, and one, which meets

with the traditional gender stereotypical expectations (defined by men) that have the effect of precluding women. Qualitative responses during the interviews (detailed later) also indicates the perception of a 'macho', male dominated 'in the dark' lone working culture that apparently precludes women.

The current EDT gender balance of the local authority in Phase 1, being office-based (as opposed to home-based which appears to incorporate more women into teams see above) is a product of and perpetuates the male-dominated system that is social work. To what degree individual workers view this as important is explored later in this research.

6.4 DISABILITY (Phase 1).

1 of the 26 respondents identified themselves as having a disability; no further details were available.

The present site for the EDT staff is not accessible for people with a leg disability, being located upstairs without a lift. Other than the telephone that is adapted for people with a hearing impairment, there are no adaptations to the EDT office, neither have alterations been made to the building in which it is situated.
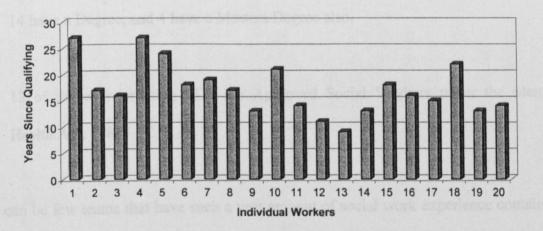
The post of EDT attracts the essential car user allowance that means that in order to undertake EDT duties you must own, and be able to drive a car. This is in contrast to the daytime social workers who are paid a casual users allowance, which means they do not have to drive a car.

6.5 ETHNICITY (Phase 1).

- 20 of the respondents identified themselves as 'White'.

- 1 respondent identified him/herself under the 'other' category, but did not add any further detail.

According to the most recent population census, the ethnic make-up of this authority is over 99.6% 'white', (1991 Population Census reported in 2000-2003 Community Care Plan). The Authority has a population of approximately 289,000 (Office for National Statistics mid-1999 population estimates).

CHART 4: EDT QUALIFICATION TIME

6.6 Qualifications and Experience of EDT Workers (Phase 1).

It can be seen from chart 4 above, that there is a vast amount of post-qualifying experience within the staff group that undertakes EDT: This experiences ranges from qualification in 1974, to one person who qualified in 1991.

The current three full-time EDT workers, at the time of writing, have between them, 48 years post qualifying experience (23+13+12=48).

- The average amount of post-qualifying experience is 15 years.

- The greatest amount of post-qualifying experience by any one worker is 27 years.

- The least amount of post-qualifying experience by any one worker is 7 years.

- The total amount of post qualifying experience of the 20 respondents is 344 years.

- All EDT workers are qualified: 20 have the C.Q.S.W.1 has the C.S.S.

- 14 have a Degree, and 4 have a Masters Degree also.

- 13 of those undertaking EDT are Approved Social Workers under the Mental Health Act, 1983.

There can be few teams that have such a vast amount of social work experience contained within them, specialist and generic. There cannot be many other teams that have an average of 15 years post-qualifying experience, or a full-time team of three workers whose total years of experience since qualification is so high (48 years).

It would though, be misleading to confuse 'experience' with 'expertise': Simply because a person has worked for a specific period of time, does not, in itself demonstrate competence. It may well be that that social worker has practised ineffectively for that period of time without ever having been challenged to change. This non-correlation of experience and expertise may be particularly pertinent to the Local Authority workers that

are the subject of this study, since they operate alone, and do not have the advantages

inherent in discussing decisions or practice as they arise, unlike their daytime counterparts.

The lack of debate during practice, the high degree of autonomy and the minimal times that

the EDT workers actually meet as a group may well conceal some poor practice, rather

than promote the long serving, and 'experienced' image which such an average length of

post qualifying experience may initially suggest.

Chart 5: Length of EDT Service

6.7 Length of Service.

- 20 of the respondents indicated how long they have been doing EDT, and their

   responses range (question 10 on the questionnaire) from 21 years to 4 years.

- The average length of time these 20 workers had undertaken EDT is 13 years (13.2

   years).

- The total amount of time these workers had done EDT is 196 years.

In terms of qualifications and experience of those people undertaking EDT, it would appear that this group of workers are all qualified, very experienced in social work generally, and in EDT specifically. Fewer 'teams' have more experience or qualifications than the EDT workforce have.

The Job Description for the post of EDT stipulates having a CQSW/CSS/DIP.SW as essential. This is no different to the majority of daytime fieldwork posts. The post differs from the daytime social workers in its Person Specification, in that is requires, the applicant to have, as essential, 'significant fieldwork experience...' To some extent, therefore, this precludes relatively newly qualified social workers from applying for an EDT post. The inevitable result of this is that only longer-serving workers will appear in the statistics, because it is only those that the post allows to be employed in the role.

EDT, therefore, does not have any newly qualified social workers, indeed, the 'newest' person doing EDT in this Authority at the time of writing, still has over seven years post-qualifying social work experience. There are however, disadvantages as well as advantages to this amount of experience as indicated above. These figures do not indicate the frequency of undertaking EDT and so may not be an accurate representation of EDT experience since some will undertake duty four times per week, whilst others may only be on shift once every three months. This relates to the status of the worker: Whether they are full-time worker or a part-time member of the 'relief pool' that covers the holidays and sickness of the former group of workers.

6.8 EDT PRIORITIES (Phase 1).

The respondents were asked to prioritise a range of generic scenarios/referrals that came through to them whilst on duty (see question 13 of the questionnaire in the Appendix). The question stipulated that it was:

"6.30 p.m. on a Monday Evening and the following referrals have come to you on EDT. Which of the following (if any) would you <u>attend</u> and in which order (i.e. place (1) in the box against the first <u>visit</u>, (2) against the second <u>visit</u> and so on. Place (0) against any you would <u>not</u> visit."

The scenarios/referrals that the respondents were requested to 'score' were as follows:

<u>Scenario (1)</u> PACE Interview on a "well-known" 15 year old accomodated male in the North of the Borough.

<u>Scenario (2)</u> Regular spot check request on 'drinking parents' for evening visit.

<u>Scenario (3)</u> Mother and 3 children presented as homeless at south of the borough Police Station.

<u>Scenario (4)</u> Children's Hospital (south) phone regarding 4 year old child with "suspicious" fractured leg – "probable NAI", child is on the CPR and will be kept in overnight with parents' permission.

<u>Scenario (5)</u> Request by Area Team to complete Section 2 Assessment (Mental Health Act, 1983), on "potentially violent male". Psychiatrist and G.P. due to arrive at the house at 8.00 p.m.

<u>Scenario (6)</u> Mother phones – plea for removal of her thirteen year old son – not known to the department.

Priority 1 status therefore, would indicate that the worker felt the scenario needed visiting first and as an absolute priority; priority 6 indicates that whilst a priority, that scenario would be visited last of all. Respondents were asked to put a score of '0' against any scenarios they felt they would NOT visit.

Based on the details set out in the table below, the following charts illustrate the way in which the individual worker prioritised each scenario:

Scenario 1:PACE Interview
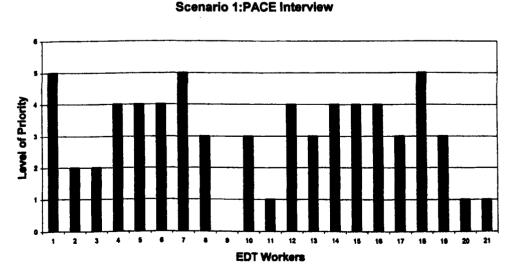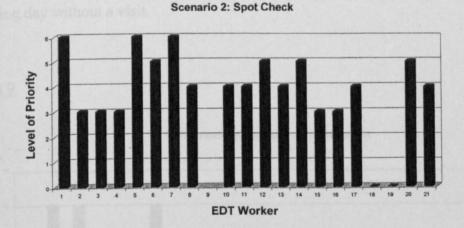
<u>Chart 6</u>

1. PACE Interview on a "well-known" 15 year old accommodated male in the north of the borough.

With the exception of EDT Worker 9 (who was an Approved Social Worker under the Mental Health Act, 1983) and who prioritised only the referral relating to Mental Health (Scenario 5), all the respondents felt that they would have visited this PACE Referral. Whilst there were clear differences relating to the priority given to this request, all agreed that it would require a response and could not be left until the next working day, a Tuesday, when the daytime staff returned. From chart 6 it can be seen that some workers would have dealt with the young person in custody first, others would have attended to him last, whilst the remainder would have dealt with the referral before some, but after other of the scenarios.

Chart 7

Scenario 2: Spot Check

2. Regular spot check request on "drinking parents" for evening visit.

Scenario 2 identified two workers who would <u>not</u> have visited this family at all to undertake the regular 'spot check' on the drinking parents, and the remaining 18 (excluding the ASW from the result) would all have visited, but none would have seen it as

a priority 1, or 2 visit and all would have attended to a range of the other referrals before dealing with this one.

Scenario 3:Homeless Family
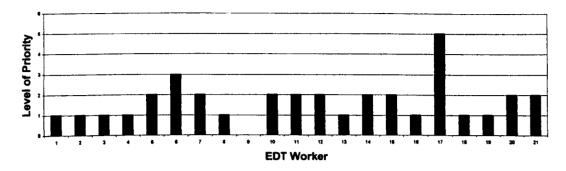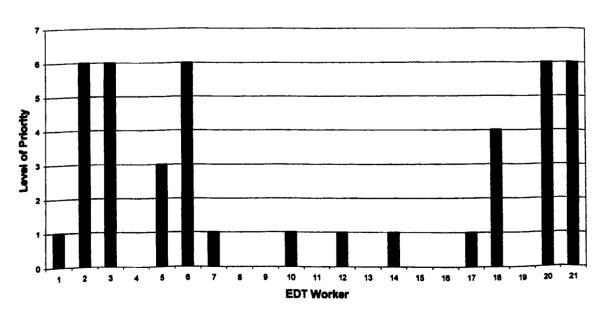
Chart 8.

3. Mother and 3 children presented as homeless at south of the borough Police Station.

This referral received the highest priority in terms of EDT visiting. Nine of the respondents gave this the position of being dealt with first, whilst another nine would have visited this homeless family second, leaving only two workers that would have left it third and fifth in their order of visits. No worker indicated that this referral could be left until the next working day without a visit.

Chart 9
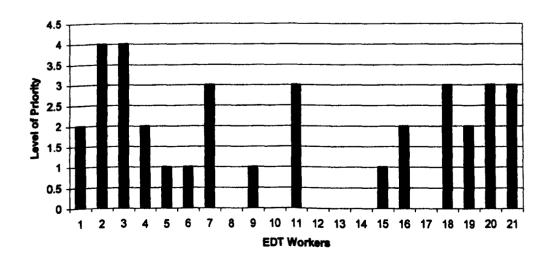
EDT Priorities.Scenario 4:Probable NAI

4.Children's Hospital (south) phone regarding 4 yea-old child with "suspicious" fractured leg – "probable NAI", child is on CPR and will be kept in overnight with parents' permission.

Seven of the respondents indicated that they would not visit the hospital to interview this family. Six suggested that it would be their first priority, whilst five of the remainder indicated that they would attend the hospital, but only after all the other referrals that required a visit had been dealt with. In this one scenario there is a diverse range of responses that appear completely inconsistent.

There are some interesting parallels to be drawn between this hypothetical scenario and the awful reality of Victoria Climbie (see Chapter 2, 2.7e) in which the lone EDT worker was faced with a child protection referral involving a possible non accidental injury to a young child from a hospital that required the lone EDT worker to make a decision. Based on the view that the child was safe and that the matter would be followed up 'the next day', the EDT worker saw no reason to visit the hospital. Despite the apparent split indicated above, the Climbie EDT worker was criticised for her decision and actions.

Scenario 5: Sec.2 Assessment

Chart 10

Scenario (5) Request by Area Team to complete Section 2 Assessment (Mental Health Act, 1983),on "potentially violent male". Psychiatrist and G.P. due to arrive at the house at 8.00 p.m.

Once again, there would appear to be a lack of any consistency between the respondents in terms of the priority assigned to visiting this referral. There are a number of EDT workers that did not include this scenario in their choices because they do not undertake statutory duties under the Mental Health Act 1983, and so have ignored this scenario. This strategy of ignoring this referral as part of the six inevitably makes it less likely that there will be any agreement between the manner in which all six are prioritised, but, it is argued later, does not account entirely for all the inconsistencies.

As the chart above shows, even when the mental health workers have identified this as a priority, there is little agreement regarding the order in which it would be attended to. It should be noted though (although this is not apparent from the graph itself), that none of the respondents, that included this scenario in this exercise, believed they could not visit this assessment. There was also some thought that this referral merited high priority as the chart shows the range of priority as being between 1 and 4.

The final scenario (6, below) was responded to in a similarly inconsistent way with some workers believing they would give it no priority at all and not visit the teenager, whilst others gave it some (although not first or last priority) precedence suggesting that a visit was required.
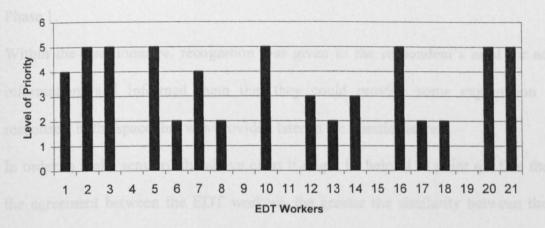
Chart 11

Scenario (6) Mother phones – plea for removal of her thirteen year old son – not known to

the department.

Seven of the respondents gave this a priority 5, none of the workers believed that this

referral was the top priority for an EDT visit that night, and indeed, some of the workers

indicated that they would not have visited this referral at all.

Chart 12

EDT Priorities

Scenario 6
Scenario 5
Scenario 4
Scenario 3
Scenario 2
Scenario 1

EDT Workers
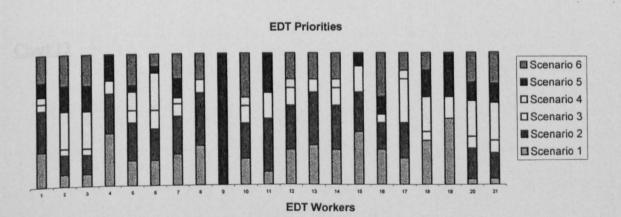
Chart 12 represents the total responses provided by the sample group of EDT workers in Phase 1.

Within the questionnaire, recognition was given to the respondent's need for additional information, and informed them that they could provide some explanation of their responses, in the space that was provided later in the questionnaire.

In order to make sense of the above chart it might be helpful to point out that the greater the agreement between the EDT workers, the greater the similarity between the size of each shaded area. The more the workers disagreed, the more the size of the shades differ. If the workers had all agreed in their prioritisation, then the chart would have looked more like the Hypothetical Chart 13 below.

Hypothetical Chart

Legend:
- Scenario 6
- Scenario 5
- Scenario 4
- Scenario 3
- Scenario 2
- Scenario 1
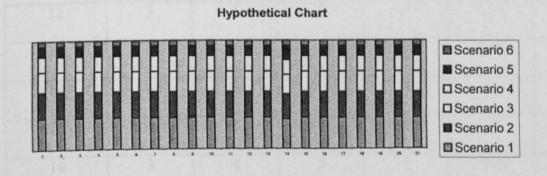
Chart 13

Table 1: The 'scores' for each Scenario.

EDT Worker	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5	Scenario 6
1	5	6	1	1	2	4
2	2	3	1	6	4	5
3	2	3	1	6	5	4
4	4	3	1		2	
5	4	5	3	6	1	2
6	5	6	2	1	3	4
7	3	4	1	0	N/A	2
8	N/A	N/A	N/A	N/A	1	N/A
9	3	4	2	1	N/A	5
10	1	4	2	0	3	0
11	4	5	2	1	N/A	3
12	3	4	1	0	N/A	2
13	4	5	2	1	N/A	3
14	4	3	2	0	1	0
15	4	3	1	0	2	5
16	3	4	5	1	N/A	2
17	5	0	1	4	3	2
18	3	0	1	0	2	0
19	1	5	2	6	3	5
20	1	4	2	6	3	5
21	2	3	1	4	5	6

(Please note that the lower the 'score', the higher the priority.

A score of '0' indicates the worker would not visit.)

Respondents have marked some of the scenarios as 'N/A' not applicable, on the basis of their current EDT status (see above for fuller explanation of the various 'types' of EDT officer). Some are no longer Approved under the Mental Health Act (1983), and, therefore, would have no involvement in scenario 5; others (now) only deal with the mental health and so have 'ignored' the other scenarios besides scenario 5 as requested in the questionnaire. It was acknowledged within the questionnaire that such a prioritisation exercise had its limitations and that there would have been a range of 'what if' type questions that each of the respondents would have needed clarifying. Space was provided for some of those queries to be noted by the respondent as well as the opportunity to expand on this aspect of EDT referral priority making in the semi-participative interview that was to follow at a later date (see below).

The various tables and charts above show there were several workers that would have visited, for example, the homeless family first. There are, though, no two workers that prioritised the remainder in the same order. In other words, faced with the same referrals, at the same time, on the same shift, no two EDT workers have agreed on the order in which these matters would have been dealt with. Indeed, it is possible to conclude that there is no agreement either on whether all of these referrals merit a visit by EDT, or not, irrespective of the other priorities.

More revealing, is the way in which an equal number of workers gave Scenario 4, (the 4 year- old child with the suspicious fractured leg), Priority 1 status, this means that it would have been the first visit undertaken, as scored it '0', which means they would not have visited at all.

Faced with the same scenario (singular), in which a child on the Child Protection Register is said to have suffered a serious non-accidental injury, the same number of EDT workers

believe there is an absolute priority to visit, as believe there is absolutely no need to visit at all.

A similar set of results can be found by looking at the responses to Scenario 6. Five workers have accorded this 'plea for removal' of the teenager a priority 2; whereas, ten workers faced with the same scenario have 'scored' this as 5 or 0. For one set of EDT workers, this referral would have been given a relatively high priority, whereas for another group of EDT workers, it is unlikely whether the teenager scenario would have been visited at all.

There is a range of possible explanations for the apparent inconsistent way in which these scenarios were 'scored':

First, it may be due to the lack of information available to the respondent. (For details of the written rationale for their system of prioritisation, see Appendix 16). It is clear that in many of the scenarios, the worker was put in an artificial situation that precluded gathering further relevant information that would have a bearing on the order in which they approached these referrals. For example, the status of scenario 4 (Non- accidental injury) would rise if the parents changed their mind about the child remaining in the hospital, or if there were other children in the house that had not been seen. Similarly, the status of referral 3 (homeless family) might alter if the children were very young, or they had been at the police station for a long time.

Essentially what was said in the written responses to this exercise was that additional information could increase or decrease the priority of that referral. What was not clear at this stage of the research was whether each EDT worker would be seeking the same sort of additional information, upon which to make further decisions. This area was addressed in the interviews and the outcomes are discussed below.

Secondly, the apparent lack of a consistent approach to the question of prioritising the scenarios, may be a result of the focus of that system: The EDT workers were specifically

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asked to indicate which, if any, of the scenarios they would visit first, second, etc. The question did not ask the respondents to indicate which they would 'respond' to first. For many of the EDT workers, the exercise was an artificial one because a lot more information, as suggested above, would have been gathered whilst taking the original referral over the telephone.

It is possible for example, that some discussion on the phone could calm and even resolve the situation with the teenager in scenario 6. This could then be supported by a referral to the daytime team the following day. In this case, based on the phone contact, there would no longer be any need to visit. Concerning this scenario, one respondent wrote:

' *It would depend on the degree of distress, the age of the child, possible telephone counselling, 'holding operation'...- cooling off period.* '

Similarly, phone contact with the hospital staff and the parents in scenario 4 (N.A.I.) might allay any concerns the EDT worker has about the security of the hospital, and the attitude of the parents towards the child remaining in the hospital, at least until the morning. Some EDT workers suggested that if all seemed 'safe' based on this type of contact, then there would be no need to visit; thus they have 'scored' this scenario as 0 or 6.

A further explanation of the inconsistencies that exist within the prioritising exercise of the questionnaire, is that the responses are in fact, no different to the way in which daytime social workers would have answered them, and that this is largely due to the way in which social work cannot be undertaken 'by numbers'. It is suggested that as human beings we all bring something different to social work that cannot be reduced to any impersonal priority system. Such a system cannot function effectively within such work with people, because it attempts to remove personal judgements that are the core of social work practice. The reason the EDT workers did not come to the same conclusion regarding the various scenarios, is because they have all internalised, and interpreted the information through a

form of 'autobiographical filtering.' This information then becomes more or less a priority (within a general priority framework) depending upon how the individual processes the information, clarifies the details and assesses the level of risk. (The potential responses to these referrals of daytime workers are potentially an area for further research.)

Another explanation for the uneven distribution of the scenario priorities could be a 'mathematical quirk'. It only needs two respondents to disagree over one scenario, and this means they fail to concur on all of them. This 'quirk' would exist in all exercises, which require the respondent to rate a variety of factors. If such an exercise is so fundamentally flawed, then it could be questioned why some common areas of response did emerge. It is shown below that there is some 'common ground' in which EDT workers demonstrate, despite all the above, some degree of consistency in the way they responded to this exercise.

Many of the respondents have indicated in their written comments that the geography and the logistics of the 6 scenarios are contributory factors in the way priority calculation:

' Response to scenario 4 depends on the location. i.e. north or south of the borough. If it's in the south then it's okay to do after the others. If it's in the north, then I would complete it following the PACE interview. '

This means that the PACE interview and the Homeless family become a higher priority, not because they are more, or less important than other priorities, but because they can be 'boxed off' quickly and dealt with by visits to the same part of the borough. Conversely, the PACE interview will become less of a stated priority, if the interviewing police officers will not be ready for an hour, and the duty solicitor has not been called, plus the custody sergeants will be in the middle of a change over of shift. This ability to 'box off' some referrals quicker than others introduces another factor that may have distorted the consistency levels of the above responses as some respondents have indicated the order

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they would deal with the referrals rather their order of importance. This was raised in the interviews detailed later (see 6.13). Part of the practicalities that inform any priority system might be the knowledge of the 'potential'. For example, with experience it is possible to gauge how long a piece of work might take, although these are 'guesstimates' rather than concrete absolutes. The EDT worker may realise that the Mental Health Assessment will take a minimum of 2 hours, whereas the regular spot check 'could' only take 15 minutes, and the PACE process 'could' only take one hour. Knowledge of the 'potential' is also concerned with the effect of not responding.

One respondent wrote in the space provided to explain their prioritisation of the scenarios:

'Logistics will determine the priority as much as anything else like, for example, the Section 2, not due until 8 p.m. but where? North or South of the Borough? If it is in the South then one has over one hour to spare. If it is in the North then there is less time. The homeless family can be dealt with quickly, e.g. if the section is in the north, take the family to the homeless unit in the north. The NAI may have precedence as the parents may change their minds. Immediate response to the 13 year old does not allow the situation to calm down; a couple of hours later the heat may have been taken out of the situation. PACE can wait, the child is not going anywhere. No point checking on parents who drink too early as 1/ They may not have gone out yet and 2/ they may not have had time to get drunk.'

Another respondent wrote:

' I put scenario 3 first (homeless family), on the presumption that this could be 'boxed off' before scenario 5 (mental health assessment) which looks to have the highest "real" priority. Scenario 6 (plea for removal of teenager) is the hardest to assess because of the limited information given. Scenario 4 (NAI) will require some phone calls to, for example, the police, at an early stage... I have already abandoned Scenario 2 for tonight. I would do

everything possible to get Scenario 6 to accept a referral to the day office in the morning, but if it will not wait, this will come before the PACE interview.'

These responses attempt to combine the practical, the procedural and the possible, and indicate the complex multi-factorial process that exists when trying to decide a priority system for the scenarios presented in the questionnaire.

It may be of concern that no two responses were the same, even when the current three full-time workers' prioritisation is examined. This may be for a variety of reasons, including, that the nature of the 'beast' defies consistency, particularly when such factors as geography, may take precedence over statutory procedure.

Further examination of the rationale for the respondents' chosen priorities was carried out in the questionnaire and interviews of Phase 2 that are reported later in this research (see Chapter 7).

6.9 Some Responses were the Same (Phase 1).

It would be misleading of this research to concentrate on the differences in the way the respondents prioritised the 6 scenarios without paying some attention to any commonalties that exist within that same process.

Given the possible explanations for differences outlined above, it is, in some respects, surprising that mutual ground does exist between all the responses to the scenario question. There are common features that can be highlighted:

All respondents (notwithstanding the N/A responses) indicated that they would visit the same three scenarios: The PACE interview, the homeless family and the mental health assessment (Scenarios 1, 3 and 5).

It would appear that there might have been the perception of an underpinning statutory imperative here that dictates these scenarios as requiring a visit. In other words, whilst not impossible, it is very difficult usually to 'avoid' having to undertake visits with these types of referrals. Whilst there is no unanimity concerning the order in which these matters will be dealt with, all respondents agreed that they would be visited at some stage during that Monday night shift.

All the respondents agreed that additional information would alter their stated order of priorities. In effect, therefore, they are all in agreement that there is not necessarily only one 'correct' answer to this question. It does, however, also still remain the case, that a number of respondents would have opted to visit some of the scenarios, whilst other workers with the same information, would not have felt the same need to visit.

Potentially, this is the most revealing of the data provided within the questionnaire. There could not have been a clearer contradiction, or at least juxtaposition within the priorities individual workers decided upon. As indicated above the same number gave the highest priority possible to scenario (4) as gave the lowest priority possible. In other words half of the workers would definitely visit this situation, whilst the other half may not have done.

It may also come as a surprise that no two workers gave the same order of priorities to the six scenarios.

Some respondents gave detailed feedback as to their choice of priorities, these tended to contain several 'what if' suggestions in which they explained the way in which their prioritisation of the six scenarios may have changed given other circumstances, (for example, they would have been more likely to visit scenario (4) if there were other children in the family and at home).

The reason why this particular question is so potentially revealing is because within the social services departments there are priority systems in place that appear to operate 'successfully' during the day, (see Corby, 1987 and DoH.1995). The responses provided in

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the questionnaires for this research, clearly indicate that a different system or no system whatsoever operates during the out of hours shifts. There are clear implications for a team that is bound by a set of priorities but would appear to accord these priorities little attention in practice.

This apparent minefield of priorities is re-examined in the interviews in which the interviewees were informed of the inconsistencies and some explanation sought (see below).

Whatever the explanation for the inconsistency in prioritising the scenarios between all those who undertake EDT, it is evident, that in any given situation, it is possible that one worker will act upon the information as a priority one, whilst another will not act upon it at all, because it is not assessed as a priority for that individual worker.

Further analysis of the questionnaire responses and the additional comments therein suggested that when deciding what course of action, if any is necessary, certain key aspects seem to be operating at any time for the EDT worker:

1. The notion of 'danger', 'risk' and threat to 'life and limb'

2. The working definition the individual worker has of the role of EDT, (for example, is it an emergency service only or more like an extension of the daytime provision?).

3. Can the situation be resolved over the telephone?

4. What are the statutory duties?

5. What is the worker's definition of 'significant' and 'harm' (particularly for the child care scenarios)?

6. How long will it take to 'box off' the more straightforward ones before attending to the others?

7. What part of the borough are they in? This will have an impact on the order in which things will be dealt with, if at all, because of the travelling time involved in going from one end of the Authority to the other.

8. Can this matter wait until tomorrow?

It is possible that there could never be a generic priority system, other than a broad framework, to cover all eventualities that arise out of hours, (for a detailed discussion of this 'framework' see Clifford & Williams, 2002, Appendix 1) Indeed, there is much sense in preventing overly prescriptive systems of response that result in reducing assessment and decision-making by the individual worker. It is concerning, however, that such a contradictory set of priorities emerged from this exercise. This area of concern was further developed in the interviews that took place with the questionnaire respondents, the findings of which are reported later. A tentative, generic EDT Assessment Framework is also described in Chapter 8, based on the findings of Phases 1 and 2.

One aspect that may have an impact upon the way in which individual workers prioritise multiple referrals, is the way that individual worker feels at the time a response is required or expected. For example, it is possible that one EDT worker, faced with the scenarios outlined above (Scenarios 1 – 6) might feel unable to cope with the sheer volume of responses required. This, in turn might force the worker to adopt a response that is

informed by a 'life and limb cover only'- mentality. What is indicated, is that, if the worker feels overwhelmed, then s/he is less likely to respond to the referrals in the same manner, or possibly in the same order, than is the worker who feels 'in control', or perhaps 'able to handle anything.' Indeed this would be consistent with Crisis Theory that pinpoints the person's response, rather than the event, as being the source of the 'upset in the homeostasis'. The impact of feeling overwhelmed therefore may drive some EDT workers to a minimalist response only, whereas, the same feelings may drive other workers to a determined resolution of all the referrals, and a sense of 'not being beaten'. This potentially 'macho' and 'competitive' response may in fact be more prevalent in male-dominated 'teams', as in the one being studied.

The potential correlation between the worker's feelings and the way in which the scenarios are approached is reflected upon later. It is at this stage appropriate to report the findings from the questionnaire that specifically addresses the type of feelings EDT workers have encountered.

6.10 Feelings of EDT Workers.
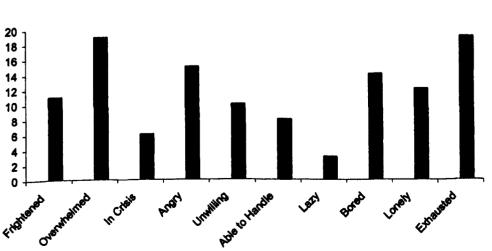
Chart 14: Feelings of EDT Workers

All 21 of the respondents completed this question that asked:

'Whilst on EDT have you, like me, ever felt any of the following:'(please tick all that apply)? The respondents were provided with a list of possible feelings as indicated in Chart 14 above.

An overwhelming majority of the sample group (19 out of 21), state that they have at some time, whilst on EDT, felt 'overwhelmed'. A similar majority, though not entirely the same 19 workers, suggested that at some time they have felt 'exhausted'. It is difficult, based on this information alone, to estimate how much an impact this might have had on the EDT workers, because there is no reference to how often these feelings are occurring, what the circumstances are, or how long these feelings last for.

It is possible that the feelings of being 'overwhelmed' stem from a variety of sources. One such source may be the intensity of the service users' stress that the worker often has to 'carry'. It is not necessarily the number of referrals that have come through that might create the feeling; it may actually be one or two particular scenarios that cause the worker to feel overwhelmed.

Similarly, it might not be the number of referrals that arrive on any one shift that causes the worker to feel exhausted. It might be due to the length of the shift; it might be due to a lack of sleep the day or night before; it could be due to a high number of particularly 'draining' visits or telephone calls, all of which need to be recorded in sufficient detail. The amount of driving from one end of the borough might cause some workers to become exhausted, as too might the absence of sufficient food that often occurs during a busy 24-hour shift.

Only 3 out of the 21 responses indicated that workers ever felt 'lazy' on the shift. This may have been due to the pejorative nature of the word 'lazy', which might be associated with workers sat, for long periods of time doing nothing. Alternatively, it could be related to being 'on duty' the whole shift, even if the worker is not occupied the whole time. In this respect, workers might have been resistant to this being labelled 'lazy'. The irony is that

the author was one of those that ticked the 'lazy' category. This was based on the belief that there are often long periods of inactivity when EDT is not called upon to do anything other than be being on duty, in an office waiting for the phone to ring. The worker may be sat watching television, listening to the radio; eating or having endless drinks of coffee, or even asleep, often for hours at a time. For the researcher, this constituted laziness, as there are usually other things that can be done whilst 'on duty.' Whilst there may be differing definitions of 'lazy', this author is interested that so few people ticked this box.

The few that ticked 'lazy' become even more of an 'oddity' when put against the 14 respondents who acknowledged that at some time, on EDT, they had been 'bored'. It could be assumed that the boredom stems from having nothing stimulating to do. Whilst it is entirely possible that the boredom came from too many 'straightforward' pieces of work to undertake, this is unlikely due to the nature of the referrals that are made to EDT (see longitudinal study), and the fact that they usually require much thought and energy. The assumption is that the boredom refers to periods of inactivity, but this would not appear to correlate to those who viewed these periods as ones in which the worker was being 'lazy'.

It is also interesting to note that, despite the high number who felt overwhelmed, frightened and bored, only 12 workers felt able to suggest that at times they felt lonely. Five of these responses came from women; only six women participated in the questionnaire.

Five out of the six women stated that they had felt 'angry' at some time on EDT; this compares to the ten out of fifteen men that ticked the 'angry' box.

It could be argued that within this questionnaire the categories listed are fairly negative. It is worthy of note that in the space marked 'other', 2 workers inserted feelings that could be construed as 'positives': 'Pleased, grateful' and 'satisfied'. The more positive feelings associated with working out of hours are explored in the interviews in Phase 2 detailed in Chapter 7.

It is likely that a variety of dynamics exist within the responses to the question concerning the feelings of the EDT workers. Part of those dynamics may well be the desire, on the part of the respondent, to avoid being seen by the researcher (a full-time EDT worker), as somehow unsuitable to undertake EDT – this may explain the fact that all 3 that ticked the 'lazy' category are still or have been members of the full-time team. It is possible that members of the 'relief pool', which backs up the full-time team, covering for their leave and periods of sickness, are less inclined to acknowledge periods of 'laziness'. This could be because they perceive themselves as being paid 'extra', that is, on top of their usual salary, and therefore there is a belief in having to 'justify' their work. As one who has also been a member of this relief pool, this author recognises the differing 'status' of the relief worker against the full-time worker, and a sense of having to justify the payment. This justification could manifest itself in two ways: First it might mean that the relief workers are more likely to go out on referrals because of a combination of having to 'prove' themselves, and a lack of confidence in any EDT protocol that dictates priorities, (ironic since the material above indicates no such protocol exists). Secondly, there could be an increased pressure on the relief workers not to advertise 'laziness' for the fear that this information might be used to withdraw them from the 'pool'. Within this research, it has been difficult to quantify whether either of these suggestions has any validity or not.

No respondent has ticked all of the boxes. This tends to suggest that each worker completing the questionnaire has not merely skipped through the options and ticked them all without thinking, but has in fact, given some thought to each of the possible feelings that could be ticked. Whilst this might provide some degree of 'validity' to the process, it does not necessarily accredit this part of the questionnaire as being 'true'.

The more qualitative aspects of the questionnaire were explored during the semi-structured, participative interviews that took place some time after the questionnaires had been returned.

6.11 Semi-Structured, Participative Interviews (Phase 1).

As indicated earlier, the next stage in the research process for Phase 1 was to follow up the questionnaires with an interview of the respondents. Based on the details of the questionnaires a more specific focus was made on specific aspects of EDT practice. Of the initial 21 respondents, 19 were interviewed as part of this Phase. One of the respondents had actually left the authority and the other respondent was the author of the research. All of the interviewees were written to in advance of the interview and their permission sought to use a tape recorder. In all cases this permission was granted. The duration of the interviews ranged from 50 minutes to 1 hour and 25 minutes. On completion of the all of the interviews, each of the tapes was listened to by the researcher, detailed notes, with verbatim quotes, were then compiled. These notes formed the basis for the written feedback submitted as part of this research. One interview was also transcribed in full (see Appendix 19)

The interview itself was divided into 7 different areas each with a different focus. The following details the way in which each of the different sections to the interview were explained (in italics) to each of the participants:

1. **Professionalism** - *It is possible that the 'professional status' of social work generally and EDT specifically has been reduced, in contrast to some other 'professions'. These questions examine some aspects of this hypothesis.*

2. **Prioritisation** – *This section refers specifically to the case scenarios which you were asked to prioritise in the questionnaire*

3. **Theory** – *As an EDT worker I wonder sometimes whether we work within a well established theoretical framework or simply 'fly by the seat of our pants.' The next set of questions is designed to explore this.*

4. **Assessment** – This section sought clarification on the respondents' understanding of the term assessment and any different types thereof.

5. **Anti-Oppressive/Anti-Racist Values** – *All too often we make decisions without consciously recognising the divisions that exist within society and our own socialisation process. The following questions will try to clarify the validity of this statement.*

6. **Statistics** – *In this section it is your views that are being sought irrespective of the actual 'facts'.*

7. **Conclusion** – *Your thoughts on improving and enjoying EDT are sought in this final section.*

A range of questions/statements designed to elicit the views of the interviewee then followed each of these headings. These separate questions/statements and some of the responses are reproduced below. There is no attempt here to include every response to each of the questions and the subjectivity of the selection process, to determine which contributions should be included or excluded, is acknowledged in the commentary that accompanies this section.

6.12 Section 1: Professionalism

Question 1. Generally speaking, how do you see the role of EDT (for example, is it a 'stop-gap' measure, an emergency only service or an extension of daytime social work)?

The assumption of this EDT worker/researcher was that this question would receive an almost unanimous response, namely that, for this specific authority, the role of EDT was an emergency only service. I could not have been more wrong as interviewee after interviewee spoke of the blurred roles of the service and how their roles altered depending how busy the shift was.

'It depends, is the answer. If the shift is busy we can only be an emergency service, but if it is quiet, I know I agree to do things that I wouldn't do on a busy shift.'

'I like to be helpful and, within reason will respond to referrals that aren't exactly emergencies but that I would follow up during the day.'

'There needs to be an extended daytime service as sometimes this is how I feel EDT is used by daytime colleagues. As long as the urgent referrals are dealt with, I usually try and 'box off' any others as well.

Whilst there was acknowledgement of there only being one worker on duty and the impact this had, there was also the clear belief that at times EDT could be all of the roles asked within the question. One aspect to this question that interviewees explained was that they would undertake some tasks on a quiet shift, that they would not do on a busy shift, but generally they would try to respond to all referrals.

The reason that these responses were interesting was because this first question sets the fundamental framework for all of the workers responses to EDT referrals. The worker who believes EDT can, at times be an extension of daytime social work practice, will do work

that the pure 'emergencies only' out of hours social worker would simply never do. This scenario though was further complicated by the responses that then suggested that if the shift was particularly busy, they would 'fall back' into the 'emergencies only' role of the EDT service. In other words the same worker would respond very differently to the same referral from the same agency or service user depending, not just on the assessment of need, but on what other referrals had come in already on that shift. Put crudely, the same worker would give a service user a service on a Monday, but not on a Friday, even if the details were exactly the same.

Even when the nature of appropriate referrals to this EDT are written down in terms of having to be 'unplanned, unexpected emergencies that cannot safely be left to the next working day' (publicity leaflets for professionals and members of the public), there appeared to be a wide range of differing applications of this criteria.

Question 2: What do you think are the main differences between EDT and daytime social work?

Respondents could identify a number of significant differences such as 'not working in a team', 'being able to get things done', 'not having a caseload' as well as the absence of 'continuity'. The interviewees all acknowledged that out of hours social work in this local authority was different to daytime social work. The total responses tended to fall into process, procedural, practice and personal categories.

Process:

1. *'We don't have to mess about with panels or other managers on EDT. We have such autonomy that we make a decision and act accordingly. The process for us and the client, I would think is much quicker.'*

2. *'There are no conferences, consultation and endless talk of what should be done. On EDT you get on and just do it!'*

3. *'We do not have caseload responsibility – the process is that we sort things out until the next day then hand things back to the daytime social worker. We rarely see or talk to the same client twice.'*

Procedure:

1. *'It's almost as if the daytime procedures are suspended at night. We cut to the quick, take short cuts and often cannot follow procedures that do not apply at night.*

2. *'There seems to be an acceptance that EDT will do as much as possible on any case, but also that this might not be very much. Procedures for filling in LAC forms, for example, seem relaxed for EDT.'*

Practice:

1. *'The whole decision-making framework is different for EDT workers who operate on their own'*

2. *'We are generic and tend to take a much more holistic, generic view of the referrals we get. It could actually be said that the families get a better assessment from us because we are not specialists.'*

3. *'We always do lone visits, we record much more, we work entirely on our own, consult with nobody, work longer shifts, and are as busy only as the shift is. In other words, when the shift ends so do we!'*

Personal:

1. *'Working long shifts means more time off during the week – this is great for hobbies, child care and other interests.*

2. *'You are beholden to nobody. I could not go back to working in a team where you have to clear anything you want to do first with a manager.'*

3. *'I do too many other non-social work things during the day to ever want to go back to 9 – 5. Oh God, what a thought, I'd leave or take early retirement before I went back to a day job.'*

Question 3: What qualities do you think an EDT worker needs?

'It's a special type of person who can do EDT. They must have lots of energy, be able to think on their feet, to ask the right questions, cut to the quick and make decisions'.

Most of the other responses echo all or part of this one interviewee's answer to this question. Other different responses highlighted the requirement for the EDT worker to be able to work autonomously and 'keep a cool head whilst all around is losing theirs.' Emphasis also arose in some of the interviews on the need to have assessment skills and specifically risk assessment skills.

Summary

What is interesting from the responses in this section is that few of the interviewees seemed to accept that social work as a profession is being eroded in contrast to other professions. The responses tended to view social work generally, and EDT specifically as still being pivotal to the entire welfare services, even though comments suggested this might not be reflected in salaries. Those interviewed saw EDT as particularly important in the 'grand scheme of things' as one person put it as *social work cannot be all things to all people, but EDT can!'*

6.13 Section 2 Prioritisation

The next set of questions related specifically to the interviewee's responses to the prioritisation 'exercise' contained in the original questionnaire. Having been given the opportunity to re-read their initial responses the interviewee was then asked a series of questions to establish why such variations existed between the total of initial answers in the questionnaire.

Question 1: An equal number of people said they would visit scenario (d) as a priority1 as said they would not visit it at all. Why do you think this might be?

The responses to this question fell into 3 categories:

   (a) The lack of information misled the respondent

   (b) Social work is not an exact science

   (c) Some of the respondents were simply 'wrong'.

   (a) Responses that fell into this category tended to stress the 'reality' of an EDT shift and thus the 'artificiality' of the exercise. Discussion centred around the massive amount of relevant information that was absent from the scenarios, but crucial to making a decision as to the priority of each referral.

     'If the Dad has just punched the son in the face and broken his nose before going on to smash up the house then it is a high priority. But if the teenage son has 'thrown a wobbly' and smashed up his own bedroom and his own stereo, then it is less of a priority.'

Much weight was also given to the interaction that 'must' have taken place on the telephone in order for the few details that were given to exist. The argument tended to

be that it would have been at this stage that the EDT worker would have been able to elicit other appropriate information to enable the decision regarding the priority to be more properly made. Some of this other information included whether or not there were other siblings to the child in hospital and how co-operative the parents were. Essentially the interviewees suggested that in order to establish risk some basic information was essential. It is significant though, I feel, that there was little agreement about what other information was required in order for an appropriate response to be given to each of these scenarios. In other words, at this stage of the interview, the interviewees were not able to provide a systematic set of questions, or areas of questioning that would suggest a consistent risk assessment framework. Such a framework, that would enable them to be confident that their responses would be based on the same premise irrespective of the circumstances, was not produced by any of the interviewees.

(b) 'The whole business of Social Services is not an exact science and there is more than one way of doing things. '

The responses that fell into this category tended to emphasis the 'art' aspect of social work rather than the 'science'. Interviewees spoke of a range of variants that might impact upon the prioritisation process that operated when deciding how to rank the scenarios. The explanations given for the apparent inconsistencies alluded to "boxing off" some of the more straightforward referrals before moving onto the more complex ones. In other words, whilst one referral might have been more of a priority than another, this did not, on EDT anyway, necessarily mean that they would be visited in that same order of priority. The subjective nature of assessing risk was acknowledged by those who responded within this category, but again, any systematic approach to assessing the scenarios did not appear to have informed their decision-making processes.

(c) The third 'type' of responses are characterised by a belief that there is a 'right' and a 'wrong' way of responding as EDT workers:

'The reason it (scenario d) is not high up the list is because the kid is safe. The urgency of the visit is more to do with departmental procedures than risk to the child. It would not be a priority visit. I would guess that the daytime relief staff that cover the EDT rota have looked at this and child protection alarm bells have rung, whereas the full-time EDT workers have looked at it differently. Our priorities are for safety of people rather than adherence to procedures.'

'Those who said they wouldn't visit scenario (d) are simply wrong.'

'I would only visit (d) if other things arose like there being other young people in the house. I can only think that those who said they'd visit are inexperienced relief staff.'

It may be of interest to note that 'relief staff' referred to above and full-time EDT workers featured in each of the categories and provided no discernible differences in their responses. A common feature also of this category was the feeling that daytime procedures 'do not really apply out of office hours' because 'we act with the delegated powers of the Director and so we make a decision and stick to it' seemingly whether or not the departmental procedures were breached or not.

The discussion around this section was interesting for a different reason in that it appeared that many of the sample group had not had the opportunity or inclination to think about their practice in these ways for a long time, if indeed ever before. On the one hand it felt refreshing to hear most of the interviewees say that it (the prioritisation of the scenarios)

had been a useful exercise because they do not usually get the chance to stop and think about what they do each shift, or how they prioritise one referral above another. On the other hand though it also confirmed part of my hypothesis that EDT workers theoretically 'fly by the seat of their pants'. It was also of some concern that what the respondents said was a valuable exercise has not been repeated in supervision or group discussions. More worrying still was this apparent belief of some that they made the 'right' decisions in the circumstances, and others who prioritised differently were 'wrong'. It was, furthermore frustrating to 'grapple' with these issues only to feel that little would change at this stage as a result of the discussion:

> *'How frustrating it is to hear experienced EDT workers casually disregard masses of knowledge based on the 'fact' that it is 'academia gone mad'. How dangerous is EDT practice when it remains unchecked, powerful, autonomous and common sense orientated rather than theoretically sound. Throughout these interviews I have never ceased to be surprised by people's boredom by what I find fascinating.'*
> (Author's Diary entry 28/8/98).

In summary, I found this section a source of much fascination as well as frustration as no 'clear' answers emerged regarding the way we have practised for many years, and yet neither did there appear to be any concern at the inconsistent manner of this practice.

6.14 Section 3: Theory.

The responses to this section gave the clearest and most consistent indication that the respondents view their practice as in some way 'atheoretical'. What was recorded on tape, but not in the written record of the replies, was the period of silence that followed both questions 1 and 2. Whilst it could be argued that the silence was thinking time, it was firstly, much longer than for any of the other questions, and secondly accompanied by a

squirming of the face as if having being asked a difficult or trick question. The responses themselves indicate an interesting viewpoint on the place of social work theory within EDT practice.

Question 1: 'Theory' means a range of things to a range of people – within EDT social work, what does it mean to you, can you give examples?

> *(After long pause) "I must confess, er, I suppose er, that's a good question that, I don't know."*
>
> *"One of the problems is that I have been out of this scene for ages as I qualified so long ago."*
>
> *"I don't operate by any theory at all, there are simply the procedures that I follow."*
>
> *"I can't even begin to answer that question about theory...I suppose it has all become part of my practice and practical experience even though I no longer recognize it."*
>
> *"There are Grand Theories such as politics, philosophy, Maslow and Weber."*

Question 2: Which theory/framework would you say you know most about?

This question produced equally interesting responses that may reflect a particular EDT perspective on application of 'theory' to practice:

> *"Maslow's theory of motivation and behaviour, that's a theory that I use."*
>
> *"I wouldn't know."*

" I guess very few social workers think about these theories out of a text book. I don't consciously think about behaviourism or cognitive theories in the middle of an assessment."

"I can't really remember any of them. I'd love to be doing Crisis Intervention or get some Crisis Intervention training and get our work put back into a theoretical framework."

The responses to these 2 questions together I found most illuminating for a number of reasons. The responses appeared to confirm the hypothesis referred to above, namely that EDT workers work' without theory' consciously applied. The association of applying theory in social work with being a student social worker on placement is there for all to read, as too is the belief that 'practice wisdom' ('common sense') and experience takes over at some stage replacing the theoretical frameworks and perspectives that did not appear to be best understood in the first place. In the discussion around these questions, I found myself again frustrated that the respondents appeared to suggest that their practice was systematic and rigorous, and yet no connections with or reference to any theoretical framework was forthcoming. At the same time there was a suspicion that such areas of debate were 'academic', that is, not for social work practitioners to worry about but 'academics' or people undertaking research! It was difficult not to be critical of the responses especially when the majority appeared to hanker after greater consistency and justifiable practice, and yet simultaneously resisted using terminology other than that which was perceived as being practice based such as, *procedures, the law, child protection matters and risk assessment,* rather than *social, psychological, macro and micro, behaviourist, humanist, socialist and systemic.*

The remainder of the responses to the questions in this section suggested an inconsistent set of views in relation to theory and any attempts to make our practice more consistent. Some interviewees believed very firmly that we could achieve unanimity whilst others

thought it was neither possible nor necessary. These views appeared to match those of section 2 (Prioritisation). One interviewee, very much the exception, spoke about theory meaning 'a combination of research, reading and doing' and something that had to be kept up to date by all practitioners. Interestingly, this respondent was completing a management theory course and applied lessons from this to some of these questions. Other than this respondent the overwhelming majority of the other answers tended to try and recall from their student social work training days such names as 'behaviour modification', 'task-centred practice', 'crisis intervention' and 'systems theory'. For workers who are isolated, operate almost entirely on their own and are by far the most experienced (see charts 4 and 5 above), I found it fascinating that the majority of those interviewed, genuinely saw little place for this concept called 'theory', and yet were able to demonstrate that their practice was, unconsciously at least, based within a theoretical framework. I concluded that the reluctance or inability to articulate the notion of 'theory', did not necessarily indicate atheoretical practice, but I still remained uneasy with some of my colleagues responses.

6.15 Section 4 Assessment.

Question 1: What do you understand by the term 'assessment'?

This part of the interview tended to see the respondent adopt one of two positions. In the first, they would relax slightly after the 'challenge' of the theory discussion that preceded it and provide much more information about assessment, a subject they felt they understood with greater clarity. Their body posture altered and they sat back in their seats, unfolded arms, smiled and gave much more detailed answers with little hesitation or need to take time to think before responding. In the second position adopted, respondents seemed to me to be much more defensive and cautious in their responses. Those who fell into this position tended to give quite terse, clipped answers and seemed reluctant to be engaged in any debate.

'Despite my attempts to equalise the interviewing relationship by openly acknowledging my own areas of weakness, gaps in knowledge and mistakes, I feel the theory set of questions provoked retreat into academic cynicism for some of the interviewees. This may well have been reflected in some of the responses to the following section on assessment during which I felt that the discussion became dismissive.' (Autobiographical entry for 23/11/98).

Some of the responses indicated that whilst the process of assessment was difficult to put into words, the actual mechanics of their practice were both sensitive and appropriate. Respondents spoke of assessment as being *'the means by which we gather relevant information to help make a decision regarding whether they get a service, whether they are a priority and whether there is a risk of harm.'* During the debate that ensued I wished to clarify how the interviewees decided which information was relevant and which was not. The responses indicate that some EDT workers have the skill to be direct and sensitive.

"On EDT you need to cut to the quick. You do not need to know the entire family history, but can focus on the here and now and direct the family members to discussing what has caused the upset right at this particular moment. EDT workers need to acknowledge that the family's history is important, but for the purposes of getting through to the next working day safely, the focus needs to be on establishing degrees of risk or eligibility for a service. This, for EDT is assessment."

"If the purpose of the visit is to assess the safety of a young child, then I will be gathering information from the family members about the allegation, observing their non-verbal communication as well as what they actually say. If there is a specific injury I will note its size, colour, shape and the explanation from the family as well as from the child (if they can speak). My assessment therefore, is collecting

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diverse information, including records checks (at the office) that focuses on the allegation."

The interviewees felt that they were thorough but focused in their assessment, but at the same time acknowledged that it would often be helpful to undertake joint visits because *"I am sure I miss things"* and *"different people may see different things."* None of the interviewees said they always used pro formas for their assessments. The majority of the respondents relied on their own internalised, assessment format, rather than any checklist or written framework. The exception to this absence of any assessment schedule being regularly used seemed to be the use of the mental health forms that some used to 'steer' their interview. Even with these exceptions though, the data tended to be collected without reference to any form, and then completed retrospectively. In other words, when assessing, there appeared to be a reluctance to rely on any forms, or a lack of awareness that some assessments could be led by various forms. Interestingly, only one respondent spoke of exploring such socio-economic factors as the family's income, their housing as well as the environment. Whilst others may well include these aspects in their EDT practice, they did not feature in their responses to this question. Question 2 that sought to explore understanding of differing types of assessment generally showed that these EDT workers had not been introduced to differing assessment 'mechanisms', or they had but chose to ignore them.

Question 2: What do you see as the difference(s) between: Screening, Initial Assessment, Complex Assessment, Risk Assessment and Social Assessment?

For some in the interview, they could not begin to explore differences between the types of assessment, because they had not heard of all of them. The following quote is fairly representative of the majority:

'I don't know what 'screening' is; initial assessments are brief assessments. Risk

assessing is what we do on EDT all the time, but we do not get involved in complex

assessments. Social assessments, I would guess because I am not too sure, would be

looking at family trees, support networks and trying to identify their social needs.'

All had experienced Risk Assessment, but few understood the notion of Screening, or

interestingly, Social Assessment. A small number of those interviewed were able to

articulate clearly the differences and the similarities as well as the various purposes of the

different assessment types. I should add though that the EDT workers that gave the more

detailed answers were entirely from the 'relief pool' of staff that work in daytime teams

and cover when the full time members are on leave or off sick (see 'models of EDT'

section in Chapter 1).

Question 3: (How) does our assessment differ from the G.P., the police officer, the

psychiatrist, and if so how?

A distinct sense of unanimity arose from the responses to this question. There appeared to

be a certainty that what 'we' did on EDT, and in social work generally was different to the

other professionals in the question. The discussion illustrated a belief that our role in

assessment was to 'advocate' and 'protect'. Many of the responses contained references to

the need to recognise the impact of poverty, poor housing, domestic violence and the way

other agencies oppress service users. The specificity of the other agencies' assessments

was contrasted with the generality of EDT's that sought to look much broader than

'simply' the medical problem, or whether a crime had been committed. Underpinning most

of the responses to this question there seemed to me to be a strong sense of what might be

termed 'social justice',

"Our job is to ensure that their rights are upheld and that they are treated properly. It is the role of the EDT social worker to understand that a lot of service users are discriminated against by the likes of the police and doctors."

Whilst there was some cognisance of the different models of assessment operated by the police and doctors I did sense some tension existed at night when EDT workers felt the other agencies had little understanding of, or patience with, the role and duties of the out of hours worker. I did also feel though, that such confusion was inevitable given the inconsistent manner in which our service was being provided and represented.

In light of this perceived sense of what I have termed 'justice' above, the discussion around the next section's set of questions was particularly enlightening.

6.16 Section 5 Anti-Oppressive/Anti-Racist Values.

Question 1: What do you understand by the term A.O./A.R. practice and does it have any place in EDT?

"Not a lot I have to say. We don't have any racial issues in this borough, you can count on one hand the number of black people. I hope I don't have any prejudices."

"It's inherent in our society that people are prejudicial. A.O. practice is about counteracting that. We all have prejudices and it's the way we counter it. You develop an arrogance on EDT because of the power you have."

These two quotes from different respondents encapsulate the breadth of discussion that took place in this section. Put simply, some saw no place for anti-oppressive practice in EDT, whilst others failed to see how EDT functioned without it. The depth of

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understanding of the terms varied from very well informed to an absence of any understanding that society was divided into certain social groups. As the discussion progressed it became evident that on an individual level, each of the workers applied a value base to their practice that reflected such as 'respect' 'dignity', 'confidentiality', 'honesty' and 'integrity', but this was presented in terms of 'treating all people with equal respect and equal dignity', rather than any recognition that we, as EDT workers might be part of the oppressive system in the eyes of the service user.

Some of the interviewees equated this question with the need to be 'politically correct' in the use of language and they poured scorn on some of the 'extreme examples' such as 'black coffee', 'manhole' and 'lady'. Whilst it was accepted that language is a powerful tool and means of communication, the feeling of the majority was that 'political correctness' had gone too far, to the detriment of that which it was intended to achieve. What was common amongst the responses was the message that, even if acknowledgement of social divisions existed, EDT was not really the place to be tackling such issues. This was seen as an 'add on' rather truly integral to EDT practice.

Question 2: Do you think your background and general autobiography impacts upon your practice?

Once again there was unanimous agreement that autobiography played a significant part in one's social work practice. Although I gave examples from my own background, the impact of being brought up by a single parent, and being a parent, some of those interviewed appeared reticent to share personal details preferring to use generalities to support their agreement for the question. Some of the women spoke of the impact of being a woman and a social worker, but none of the men, until prompted suggested that their gender impacted upon their practice. Many saw becoming a parent as having a significant effect upon the way they viewed for example, child protection, and spoke in terms that indicated they felt the need to protect more and take risks less with such referrals. Others

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spoke of how their own life experiences had been shared with service users to try and 'normalise' some of their current 'crisis. There was undoubtedly much assurance in the interviewees' responses to this question.

"Yes, definitely the case. My own childhood and being a parent and managing to manage."

"I find myself telling parents what my kids are like to help them see that their own kids aren't the monsters they think they are."

"Yes, undoubtedly, the way you are brought up does effect your practice, that's what social work is all about, it's an extension of what you are."

In the discussion it became evident that all the EDT workers agreed that our own socialisation process was important to the way that we practised. It was equally evident that little opportunity was afforded these workers to reflect, analyse and learn from what exactly the differing implications of biography for practice really were. Referring back to the scenarios and the prioritisation exercise, it was further agreed that our autobiography might, at least in part, explain some of the different priorities given to each case. Any framework that reduced inconsistencies and helped individual workers out of hours to make more consistent decisions in the absence of opportunities to discuss such matters, was expressed in positive, welcoming 'much needed' tones by the respondents.

The penultimate section attempted to gather the workers' subjective impressions of statistical data related to EDT.

Question 1: Which service user group do you think is the source of most referrals for EDT and which is the least?

All of the responses, except one, accurately reflected that children and families form the largest source of referrals to EDT, (for evidence of this see the longitudinal study in Chapter 5), but there was no agreement as to which service user group were least represented and answers ranged from Adults with Learning Disabilities, to Homeless families to adults with physical disabilities to "I haven't got a clue!" I was interested to learn that they all knew that children and families was the primary focus of EDT, but surprised to discover the variations in the manner in which we decide how to categorise the referral (see categories on EDT Record in Appendix 5). Whilst some, for example recorded a benefits Agency enquiry as a referral under 'Other Adults', others put it into the 'Children & Families' Category, whilst others again did not record it as a referral at all. This echoed the findings set out below (see 'definition of a referral' in the longitudinal study below) that suggests that there needs to be greater clarity on what constitutes a referral, a contact or a message.

The reason this question might be important is that EDT workers have already indicated that they base most of their decisions on a combination of factors including how busy a shift might be or become. The statistics show that certain service user groups frequently feature more than others. If EDT workers' perceptions were not in tune with the reality of EDT referral rates, this could lead them to respond to some referrals expecting things to be quiet, or not respond because of an expectation the shift might get busy. Either way, having some informed view on referral types and rates could be helpful for EDT workers to plan, as far as this can be done, their shifts. This is also the case for Question 2 below.

Question 2: Do you think there are any patterns of referrals, for example, the school holidays, Tuesday nights, Winter? ... Why might this be so?

Throughout the years of working out of office hours I have always wondered why some shifts are very busy and others are particularly quiet. It remains a mystery whether there are any patterns to the referral rates to EDT (see below) but I was interested in my colleagues' perceptions of this question and was not disappointed by the responses:

"I believe there are patterns, but nothing to do with anything like the lunar cycle. Busy shifts tend to come in waves, so if a Wednesday is very busy then the Thursday and the Friday will also be very busy. I do not know what makes it busy in the first place, but you rarely get one busy shift on its own."

"The pattern of referrals to us reflects the business, or otherwise, of the daytime teams. If they are busy during the day then work spills over; if there are staff vacancies or illnesses during the day, this spills over and makes our shift busier."

"I think there are patterns, there's a reduction of referrals in the school holidays. Monday nights are always busy, Friday and Saturday are also usually busy, but I'm not really sure why."

"Sundays are not usually busy and it gets quieter during the summer but otherwise the referral rate is consistent. Climactic conditions seem to affect the shift, people stay in if it is raining and come out if it's sunny. The sun lifts the mood, but when it rains we seem to go quiet. The period after Xmas is always busy, people have no money, the weather can mean slips and trips and the festive mood is thoroughly tested in families."

"The last 5 Sundays I have done have been very busy. I would think that the winter and the bad weather would be the busiest times for the elderly. PACE is also increasing."

What was apparent from the responses was that people believed there might be some patterns to the referrals but could not really give a satisfactory answer as to why this should be so. Analysis of the rates of referrals to EDT was presented above in the longitudinal study. It makes it particularly difficult to plan sufficient cover for any one shift when there is an absence of any obvious pattern or consistency to the work that arrives out of hours. Discussions with EDT workers from around the country suggested that this was a common difficulty in all the other local authorities also. For the EDT in Phase 1 that only ever has one worker on duty, this means that some workers are extremely busy on one shift, whilst others may be very quiet the next.

The final section headed 'conclusion' sought to gather respondents' thoughts on improving the EDT service. Their ideas will be included in the final chapter, but one comment that surprised me because of its content, as well as the amount of times it appeared, is reflected in one worker's concluding remark that was in response to the question *'have you any questions, comments about the interview, the questionnaire or this research?'* Their response was:

"This has been very thought provoking – I've quite enjoyed it really. It's been good to reflect on things like practice because we don't usually get the chance."

6.18 Conclusion.

Whilst the interviews had been, at times extremely exhausting and time consuming, it was only at the end when I fully appreciated how much information had been provided, and the extent to which my own colleagues had permitted me to view some of their practice 'warts and all'. It was fascinating to realise with each interview how differently we all do things out of office hours, and yet we appeared to have some of the same objectives for the service and the service users. What was very apparent was an absolute need for (lone working) EDT officers to be prepared to share knowledge, ideas, practice issues, strengths and weaknesses and for us all to accept that social work knowledge has not stood still since most of us qualified many years ago.

Given that Phase 2 of this research concentrated exclusively on the past and present workers of one specific local authority EDT, and it has already been established that there is a diversity of EDT models throughout the country (see Chapter 1), I felt that it would be appropriate to extend the reach of this study to examine specific aspects of other EDT's. It was always possible that the 'data' forthcoming from the one EDT might not necessarily be able to be applied to other out of hours teams, especially where there was more than one worker on duty at any time. It was possible that the findings of Phase 1 were idiosyncratic to the single EDT studied, and therefore, in order for a more complete and balanced perspective on out of hours social work, it was necessary to explore other local authority out of hours social work provision. It is to these other EDT's (Phase 2), that attention is now turned.

CHAPTER SEVEN

EDT Throughout Britain, Phase Two

7.1 Part One - Introduction.

As suggested earlier, Phase two of the research sought to develop some of the key issues arising from Phase 1 and examine their relationship to many other EDT's throughout Britain. As an active member of the North West EDT Training Consortium and the Emergency Social Services Association (ESSA) that, together, attract over two hundred EDT workers to its meetings, I chose to maximise the questionnaire returns by distributing them at both of these organisations' Annual Conferences along with a covering note explaining the purpose of the research, (see Appendix 13 for a copy of this letter) At both meetings I was allowed some time to speak to the whole group to 'encourage' members to return the questionnaires. Some workers completed the questionnaires during the 2-day conferences, whilst others took them away and sent or faxed them to me later on. An unforeseen difficulty was seeking to calculate how many people received the questionnaire because, for example, one EDT representative who attended the conferences took a copy of the questionnaire and copied it for colleagues to complete. As several of the respondents did not indicate which Local Authority they worked for it was impossible to establish exactly how many were distributed. Notwithstanding this, a total of 91 questionnaires were completed and returned by hand, post, and fax.

The questionnaire distributed to the much larger group of EDT workers in Phase 2 was similar to that used in Phase1, but shorter. The intention with the larger group of phase 2 respondents was to focus much more specifically on certain aspects of the findings that

arose from Phase 1, particularly the process of assessment and prioritisation. (For the complete version of the questionnaire see Appendix 8).

7.2 Findings of the Questionnaire in Phase 2.

A total of 53 different local authority EDTs were identified by the returned questionnaires, 6 questionnaires did not identify where the respondent worked and there were 91 questionnaires returned in total. The range of Local Authorities represented (see list below), included EDTs from Scotland, England and Wales and a combination of Metropolitan Borough Councils, City Councils, County Councils and Unitary Councils. The full (identified) list of local authorities represented in the research in Phase 2 was as detailed below in Table 1, and was identified in response to the first question. I have included the name of the Phase 1 Local Authority within this list but have not included their (21) questionnaires as part of the total sum of Phase 2 responses. The numbers of responses from each of the responding authorities is available but not included as this would identify the Phase 1 authority (as being the only one with 21 respondents).

Question 1 of Phase 2 questionnaire therefore, identified the following Local Authorities as the sample group:
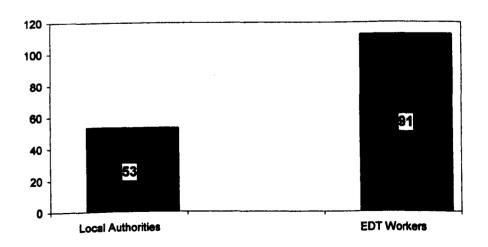
Chart 1: Phase 2 Total Responses

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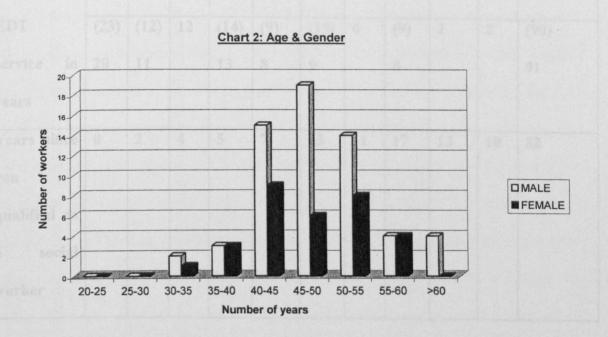
Question 1/. Name of Local Authority you work for:

Table 1

Barnsley	Hillingdon	Sheffield
Blackburn with Darwen	Kensington & Chelsea	Somerset
Blackpool	Kent	South Gloucester & Somerset
Bolton	Kirklees	Staffordshire
Bradford	Knowsley	Stockport
Bury	Lancashire	Suffolk
Cambridgeshire	Lincolnshire	Surrey
Camden	Liverpool	Swindon
Cardiff	Manchester	Tameside
Cheshire	Norfolk	Torbay
Derby	Nottingham	Trafford
Dorset	Oldham	Walsall
Dundee	Oxfordshire	Warrington
East Riding	Rhondda Cynon Taff	Wiltshire
Edinburgh	Rochdale	Wirral
Gloucester	Salford	Wolverhampton
Harrow	Sandwell	Worcestershire & Herefordshire
Hertfordshire	Sefton	Unknown 6

AGE	20-25	25-30	30-35	35-40	40-45	45-50	50-55	55-60	>60	TOTALS
MALE	0	0	2	3	14	19	14	4	4	60
FEMALE	0	0	1	3	9	6	8	4	0	31

Table 2

Chart 2: Age & Gender

7.3 'Types' of EDT Workers.
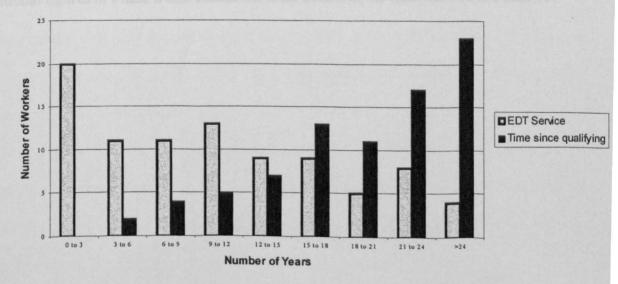
Table 2 and chart 2 above illustrate that all (91) respondents identified their gender and age. The findings also suggest that nearly twice as many men are employed in EDTs as are women with the majority of all workers irrespective of gender being aged 40 and 55 years. (This was consistent with the data received from Phase 1). It is also noticeable that there is an absence of 'young' workers out of hours. In part, this may be because many local authorities require staff to be at least 3 years post qualified before they can undertake EDT duties. It may also reflect the move of SSDs generally to recruit older people to their

vacancies. In all the employee groups surveyed by UNISON (2001), the under 25's made up around 5% or less of employees. In general, depending upon the employee group, around a half to two thirds of employees were aged over 40, (2001 p.7). These figures would not, however entirely explain the 'missing youth' that is a feature of the EDT workforce.

Table 3: Question 2.

	0-3	3-6	6-9	9-12	12-15	15-18	18-21	21-24	24-27	>27	TOTALS
Length of EDT service in years	(23) 20	(12) 11	12	(14) 13	(9) 8	(10) 9	6	(9) 8	2	2	(99) 91
Years since you qualified as a social worker	0	2	4	5	7	13	11	17	13	10	82

Chart 3: EDT Experience

The figures in brackets in Table 3 above indicate the actual responses recorded against this question. It was clear however that 8 respondents had misplaced their 'tick' for the length of service question rather than the 'years since qualifying' question. And thus made the total responses as 99. These misplaced responses are noted in brackets but ignored for the purposes of the charts and analysis. The correct totals for each category form the basis of the statistical calculations. As it was impossible to guess which category the respondents would, have completed for the 'years since qualifying' category these have been omitted from the final analysis – hence the reduced total (82) of respondents.

It was noticeable that 78% (71 respondents) of the respondents had at the time of the research accrued more than 3 years EDT service, and over 52% (48) had more than 9 years EDT experience. It was interesting also that 74% (64) of the respondents had over 15 years post qualification experience. These figures suggest that EDTs have some of the most qualified and experienced practitioners and that the retention of staff is relatively high when compared with daytime counterparts. A survey of 149 local authorities in England found that the average grossed vacancy rate was just fewer than 10%. For some regions (London and the West Midlands for example) on the 30th September 2001, 20% of the field social worker posts working with children and families were shown to be vacant. The survey also indicated (p.9) that the average turnover of staff was nearly 13% and 50% of all authorities reported difficulties in recruiting field social workers (UNISON, 2001). The national figures of Phase 2 also reflect the local details of the team studied in Phase 1.

7.4 Ethnicity

Question 3. How would you describe your own ethnicity?   (e.g. Black British, Irish,
Asian, White British)
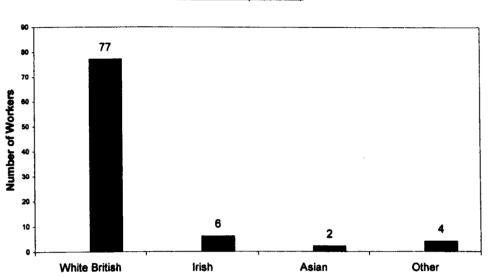
Chart 4: EDT Ethnicity

It is evident from the data in the chart above (EDT Ethnicity) that over 85% (77 out of 90)
of the respondents identify themselves as White British. This issue becomes particularly
pertinent when the respondents were asked whether they thought that their own ethnicity
and autobiography had any impact upon the service provision out of hours; this had already
been demonstrated in Phase 1 (see 6.16, Question 2). Given that it has already been shown
that twice as many men as women carry out the role of EDT, and given the level of
responsibility that EDT workers have plus the power that accompanies this, there is some
strength to the view that EDTs in this country are staffed predominantly by white, middle-
aged men, 75% of whom qualified more than 15 years ago.

Although the material of another research project, it might have been interesting to
establish the perceptions of service users who have contact out of hours. It would appear
that they are not offered any choice in terms of the gender or ethnicity of the worker who
assesses them; this may not always be the case during the day.

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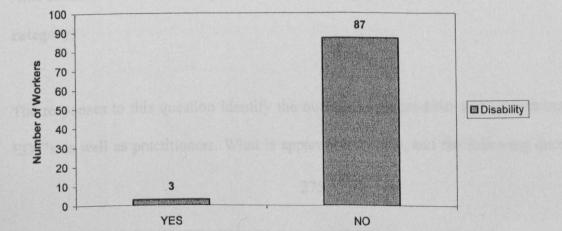
One of the myths surrounding EDT that I have encountered from both EDT workers themselves as well as from many daytime social workers, who say they do not envy the role of the out of hours workers, is a 'macho' perception that you have to be 'brave' out there on your own knocking on doors of unknown, potentially violent service users that use the cover of darkness to confront social workers. The adherents of this 'macho' element suggest that EDT workers have to single-handedly tackle such aspects as 'part and parcel of the job'. As indicated in Chapter 3, there are a number of assumptions underpinning this myth, not least of which is that men are somehow more able to ensure their own personal safety when confronted with threats and/or violence. There is, in my view, some worrying issues associated with such a misperception of 'maleness' that was further examined in the interviews with the respondents. This notion of 'maleness' though, cannot explain the entire situation, since a significant number of women also undertake EDT duties throughout the country on their own as well as in teams. The notion of gender and autobiographical influences, indicated earlier (3.7), is returned to in the final chapter (see 8.4). Whether the workers acknowledged their own ethnicity as an influence in their practice or not, EDT, based on this research, is delivered by predominantly white social workers, the majority of whom are male and middle aged. The issue of the respondents' disability was also explored, the details of which are below.

7.5 Disability.

Question 4. Would you describe yourself as having a disability?

(please tick appropriate box)

Chart 5: EDT & Disability

The overwhelming majority of EDT workers have identified themselves as not having a disability. It is possible that this apparent absence of workers with a disability reflects social work as a profession. In other words, the same small proportion of workers with a disability is represented during the day as can be found in EDT's. As with Phase 1 (see 6.4 in Chapter 6) though, questions remain concerning the environmental support that exists for workers with a disability, and the manner in which out of hours work is presented or at least perceived by potential applicants. One example of this would be the requirement for EDT workers to be able to drive and possess access to a car as part of their contract. As with daytime offices, physical access to EDT buildings, or indeed service users' homes, are not user friendly for those with mobility difficulties).

Question 5. Please tick the following boxes that apply to you presently.

Table 4

EDT Manager	EDT social worker	A.S.W.	Full Time	Part/Half Time	Job Share	Other (please specify)
38	55	56	47	13	1	1(cover spare shifts)

N.B. Numbers do not add up to totals because respondents can meet more than one category)

The responses to this question identify the number of respondents that were managers of EDT's as well as practitioners. What is apparent from this, and the following question, is

that some of the EDT managers also undertake home visits as part of their role, (see question 6). The general picture that emerges is that EDT workers tend to be full-time, generic, experienced and qualified workers, qualified, that is, in both child care and mental health. This supports the BASW study and its findings referenced in Chapter 2 (BASW 1984). These findings though, are in contrast to the most recent Department of Health staffing return figures (cited in UNISON, 2001) that show that, as of September 2001, 283,500 persons were working for SSD's in England. Of these, 125,500 (44%) were working full-time and 158,000 (56%) were working part-time.

Question 6. Does your role usually include home visits?   YES 66   NO 20

One important aspect of this question was that 19 of the 20 respondents that do not undertake home visits, are managers. The overwhelming majority of the sample group did need to' knock on doors' as part of their duties and responsibilities. The reason that this question is important is because this research is trying to identify the decision makers and the way in which they assess and prioritise high priority referrals. It has already been identified in Chapter 1 that there are a many different models of out of hours social work provision in Britain today. For example there is the model that has one worker, who never leaves the workplace to do visits but who takes all the calls and then contacts social workers on a roster at home whenever s/he decides such visits are required. The workers at home are paid in different ways across the country (some, for example, get paid a 'retainer' irrespective of being called out or not, others get paid by the hour whilst they are out, whilst others again, get paid per callout). In other words, in this model, the person who makes the decision to visit, is not the same person as the one carries out the visit. Another

model of service provision involves one EDT worker taking the details over the phone, deciding what priority that referral is and then, that same person making the decision whether or not to carry out a visit to assess further what if anything needs to be done. One other model that has been developed in the past couple of years is one in which all calls to the authority are taken by some type of 'call centre', then re-directed to the relevant person who might be at home and ready to visit, or in an office and ready to give advice or call upon another worker at home to undertake the visit.

The amount of 'filters' is different in each model as is the number of decision-makers. This means that the process of prioritisation and the factors that inform that process, may well be different depending on the type of EDT model that exists. Whilst, to some extent some of these factors exist during the day too, there are, no models of daytime social work that have employees waiting at home to be called to undertake visits, or only one person providing all 'filters' and controlling all decision-making processes. This may further be complicated if the person in charge of the 'budget' for EDT, is also the person who decided whether or not a visit by a paid worker from home is required.

The dynamics, intricacies and idiosyncrasies of the priority and decision-making processes out of hours therefore, are significantly more complicated than might be expected and, to some extent, this may explain the differing ways in which the individual workers questioned responded to the priority exercise of question 15 (see below). To further explore any connection between the decision-making processes and the individual respondents, the 'make up' of the teams in which they worked was also examined.

The next section (7.6) looks at the 'types' of teams the respondents operated within.

Question 7. How is EDT mainly delivered by your Local Authority? (please tick box)

Chart 6: EDT Delivery
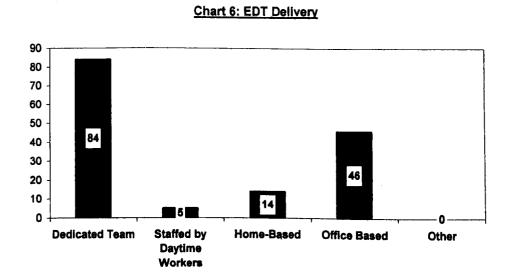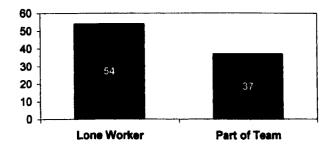
Chart 7: Lone/Team Work

This question sought to establish the nature of the EDTs that exist across the country. The clear message from this data is that very few (5 only), of those local authorities that participated in this research, do **not** have a dedicated emergency duty team. The overwhelming majority (93%) of the respondents work as part of a dedicated (i.e. specifically designated) out of hours team. This would seem to support the BASW findings (BASW 1984) that suggested that, whilst there was a dramatic growth of EDTs between

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the mid to late 1970's and 1980, 'by 1980, the situation appears to have stabilised' (BASW 1984, p.8). It is possible that this development of dedicated out of hours teams has been part of the reason little changed for years in EDTs. Whereas previously daytime workers were expected to be available to cover the out of hours requirements for the reasons identified earlier, (for the origins of EDTs see Chapter 1), teams began to be established that were separate to the daytime staff. In some respects it is possible that these changes heralded years of being 'out of sight and out of mind' for EDTs as the daytime staff were left to concentrate on their daytime responsibilities and the newly formed EDTs expected to deal with the rest of the time. Since their creation though in the 1970's, EDTs have continued to change. Less of the service is provided by staff working from home, and far more from an office base as part of a dedicated team.

There still remains a relatively high proportion of EDT workers that work entirely alone, (54 out of the 91 responses equates to almost 60% of the total responses). This may also under-represent the total number of workers that do lone home visits because, it transpired from the interviews that even though the EDT may have more than one person on duty, solo visits remain 'part of the norm'. Whilst it is the case that dedicated teams emerged and expanded in the period mentioned above, this has not been accompanied by any significant lessening of the amount of EDT service that is provided by a lone worker.

Question 8. How do you view the role of EDT? (Respondents were asked to choose one category).
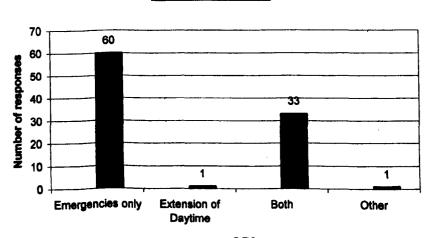
Chart 8: Role of EDT.

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Nearly two thirds (60%) of the responses indicated that the role of the EDT officer was to provide an emergency service only as opposed to broader type of provision that reflects the daytime activities. Almost one third thought that the role of EDT could embrace both emergencies and be an extension to daytime activities. Put simply, less than 1% of the responses saw the work of EDT as an extension of the daytime service only. The reason this would be of importance is because it informs the types of priorities that each EDT worker feels their service should respond to and this is likely to be reflected in their process of prioritising and assessment of referrals in the exercise below (Question 15).

This part of the questionnaire attracted many additional comments that suggested, for different reasons, that the 'out of hours' service had always been, or was now slowly becoming both an emergency service as well as an extension of the daytime service (but that significantly more resources would be required). Those who saw the EDT as an extension of the daytime service tended to be critical of the need to be this as it was viewed as 'covering up for their inadequacies of the daytime staff who could not cope and so they pass referrals over to us'. Although one respondent wrote that 'I would like to see a full social work service available out of hours' others tended to reflect the lack of clarity between what constitutes an emergency and what does not. For the remainder of this Chapter multiple references are made to direct quotations obtained from the questionnaires. I have tried to present a balanced of views but recognise that any selection may involve subjectivity, (for the complete set of responses see Appendix 14).

'Emergencies; Helpline, advice and information and the inevitable extension of daytime services (in the form of 'mopping up' operations!!)'

'Emergencies plus always trying to be helpful in resolving problems presented.'

'Serious expectations by other agencies and the public to be an extension of daytime=serious overload.'

'Sometimes there are some tasks which are borderline daytime & emergency which I undertake.'

'But inevitably some handover from daytime services.'

'It should be (emergencies only) but increasingly we are becoming an extension of daytime services'.
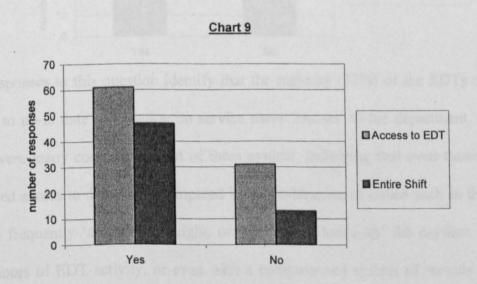
'Although essentially emergencies, EDT provides a lot of support to users out of hours.'

'We offer a flexible service and often 'gap-fill' holes in daytime team service provision.'

'We attempt to maintain emergency role but find ourselves increasingly pressured to take on preventative and extended daytime duties.'

Some respondents had ticked the 'both' box but had written underneath: 'But mainly emergencies'

Question 9. Does the public have access to an EDT social worker? If yes, is this access throughout the entire shift?

Chart 9
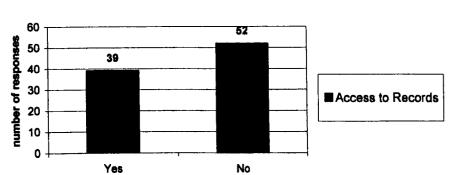
There were quite detailed notes that accompanied this question to more fully explain the responses. For the lone workers they clarified that when they were out on visits then

contact would be made via a pager or call centre or mobile phone. Other comments indicated that access to the EDT worker might not necessarily be immediate but would be 'filtered' via such as receptionists, hospitals, call centres and hospitals, but the member of the public would ultimately gain access to the EDT worker. As the intention of this question was to establish the direct contactability of the EDT worker and how many people 'processed' the referral before it came to the social worker, I feel the results of this part of the questionnaire may have limited application as it is not that clear from the additional comments that this was the respondents' understanding of it. When this matter was raised with the sample group in interview, it was clear that a diverse range of differing 'filters' exists and continue to be developed throughout Britain thus making direct and immediate access to the social worker more difficult and more distant.

Question 10. Do you have access to records that are kept up-to date (at least weekly)?

Chart 10: Access to Records.

The responses to this question identify that the majority (57%) of the EDTs do not have access to up-to date information on service users 'known' to the department. Once again there were many comments, most of them cynical, indicating that even those teams that indicated access to data, were hampered by a combination of issues such as the computer system frequently 'crashing' at night, or the system 'loads up' the daytime data during peak hours of EDT activity, or even with a computerised system of records and regular access to it, the actual detail contained thereon was "less than useful" to EDT staff.
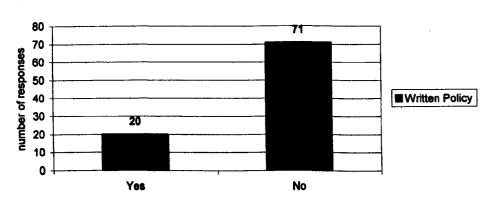
This absence of relevant information may mean that EDT workers throughout the country are indeed, having to make some of the critical decisions highlighted in Chapter 2, based on minimal amounts of information and very little prior knowledge of the service users or their history. Even in those 'teams' where the information is kept up-to-date, as was the case in Phase 1's 'team', this does not necessarily mean that the information required to make an informed decision is to be found on the computer as it tends to record only basic details and possible contacts rather than day to day contacts or details of previous referrals that are still recorded and placed in a file locked away in a daytime office. As the SSI report noted: '..none of the EDT's could access mainstream case files, even those teams based in mainstream offices.' (1999 p.37).

Another difference to the daytime workers therefore, is that there is only very limited access to relevant information on the majority, if not all, of the referrals that are dealt with by EDT. This might inevitably lead to relatively less well developed assessments compounded by pressures of time and the generic shift responsibility. In fairness, though, as the SSI suggested, it could also be hampered by the absence of any systematic and recorded process of EDT assessment (1999 p.36).

7.7 Decision-making Processes.

Question 11. Does your EDT have a written policy to assist in prioritisation of referrals?

Chart 11: Written Policies

Given the absence of access to relevant files or information to assist the EDT worker in their assessment of a referral identified above, and their generic and often 'emergency

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only' responsibilities, it might have been assumed that some type of framework or prioritisation policy would have been developed to support the decision-making process, ensure some degree of consistency and establish some boundaries of accountability. The responses in Phase 2 indicate that the overwhelming majority (78%) do <u>not</u> have any such policy or document.

One of the hypotheses of this research was concerned with the individualistic manner in which referrals were dealt with out of hours, and the thinking, in part behind this, was the absence of any generic and appropriate framework to assist EDT workers make decisions of priority. Question 11 responses illustrated this point and the apparent lack of any written policy to enable EDT workers some degree of consistency. Having established the context of the particular model of EDT the respondent worked in, and some of their autobiographical details, the questionnaire moved into the finer detail intended to explore how difficult decisions are actually made, and by whom on EDT.

<u>Question 12</u>. How is a decision to visit a service user made, please explain who is involved and what factors are considered?

90 out of the 91 respondents made some contribution to this question.

A number of themes emerge from the total responses to this question and they can be gathered under the headings of:

- Lone working

- Consultation

- Emergency only

- Vague assessment.

'Lone Working' would appear to have a direct impact upon the decision making process in that where this out of hours model is adopted, the single worker, sometimes with access to consultation via a manager at home, will usually make the decision themselves. Being the only person on duty tended to focus the workers' priorities on absolute emergencies

that could not safely be left until the next working day as the following examples demonstrate:

- 'Statutory responsibility in child protection and Mental Health often dictate a visit, but also other circumstances where concern is high and an immediate assessment of the situation is required: often a manager of another service may be involved.' (10)

- 'Nature of the problem, degree of urgency, availability of worker. EDT worker decides with occasional back-up from on-call manager.' (17).

- 'EDT worker decides (could consult manager if really necessary but rarely). Legislation is the first criteria. Ie. Sec 136, sec 2 or 3, sec 47. Assessment of elderly admission needed, granting sec 17 money or travel warrant.' (18).

- 'Lone worker decision made sometimes in conjunction with other agencies. Rarely in consultation with social services manager.' (26).

- 'EDT worker's decision. Consideration of risk to service user, need to visit to assess risk, procedures in case of child protection only. Health & Safety factors ie lone-working EDT social worker; policy regarding rationing of residential home places (child care only).' (43).

- 'Single worker – basis of need – depends whether I am in or already out – is it safe?' (52).

- 'Only social worker on duty involved in decision to visit (sometimes, not very often, in consultation with management). Factors considered: level of risk, what service is required, who makes referral and why?' (53).

- 'Lone worker, no management back-up. If visiting potentially risky situation request police back up. Only visit if situation cannot safely be left to the next working day.' (74).

- 'Decision is made by me as a lone worker. Usually factors involved are priority of need eg matter cannot be dealt with any other way – alongside this would be consider health & safety of worker.' (81).

'Consultation'.

The theme that emerged here, is that sometimes consultation does take place, within some teams, although not necessarily with another social services employee. The different types of consultation seemed to range from a procedural imperative through to discussion with a manager or team member, discussion with other agencies (police often being named), through to absolutely no consultation with anyone at all.

- 'EDT worker on shift makes the decision, - self-managing team. May consult with appropriate daytime team manager. Different arrangements for different decisions' (7).

- Manager and social worker make decision. Situation cannot wait until the next working day. Resource available to meet need. Input will have an effect on situation. Statutory requirement. (13).

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- 'Depends on the nature of the referral – child protection, joint decision with the police CPT; adults – mental health could be at request of doctor – need to assess under the MHA. Person with disability may be unable to communicate over the phone – decision may be made with police if risk to safety involved.' (24).

- 'Decision is made by the social worker who takes the referral. There is no requirement to consult the other social worker on shift but most team members do to gain agreement.' (31).

- 'Decision usually made by one member of staff taking telephone calls, sometimes decision made in consultation with visiting colleague and occasionally after consulting daytime staff/manager.' (48)

- 'The person on telephone duty makes the decision and then consults with the visiting person. Sometimes there is discussion whether or not to make the visit between these two officers or with consultation with police via strategy meeting in child protection cases. Safety factors are taken into consideration also urgency.' (50)

- 'I decide whether a visit will elicit additional info not available on the phone and there is a large element of back covering, i.e. will I get into trouble if I haven't visited this one.' 65)

- 'Depending on 1. health & safety of service user/others; 2. vulnerability of service user/others; 3. Possible consequences of not visiting now. EDT worker

makes the decision, but may be dependent on other agencies (e.g. police) to negotiate joint visit or joint action.' (79)

- 'Risk assessment made by worker on duty – if in doubt, consultation is made via manager who is always available.' (88).

Emergency Only

A common theme that emerged also from the responses was that the teams saw themselves as only being expected to address emergencies that could not wait until the next working day. The criteria often reflected a working definition of only really being able to respond to those referrals that were statutory, urgent and could not be passed elsewhere or wait for the daytime teams to return to work. This would seem to be consistent with the responses found to Question 8 above in which over two thirds saw EDT's role as emergencies only. It was however difficult from these responses to gauge whether there was any agreement as to what actually constituted an 'emergency' (this was examined in the actual scenarios of question 15 below), and what if any 'type' of referral could never be left until the next working day. The following examples seem to indicate some degree of certainty that the referral had to be an emergency to merit a visit but do not really develop or explain this in any detail:

- 'The urgency of the situation. Whether assessment is required. Usually no visits to ongoing clients.' (5)

- 'Degree of emergency and nature of emergency.' (8)

- 'Safety of user or carer; high priority cases; service user's distress or difficulty; all where emergency assessment is needed.' (11)

- 'EDT respond to situations that cannot safely be left until the next working day. Child Care (Child Protection) and then ASW take priority.' (40)

- 'Decision made by 2 or 1 Social worker on duty. Criteria – statutory duty, risk, can't wait until end of shift'. (59)

- 'EDT Manager, degree of urgency.' (63)

- 'Worker only decides. Dependent upon service requested, degree of urgency, element of risk and need for assessment.' (64)

- 'High need risk, can't wait until the next day. Decided by the worker on duty.' (70)

- 'Urgency, protection issues, safety and need to involve others. Information about user.' (87)

'Vague Assessment'

Nearly 80% (see question 11) indicated that they did not have access to a policy that would help them to make difficult decisions when faced with competing priorities. The responses to this question further indicated that there was a clear understanding that an assessment ('Risk Assessment') was required to be made by the worker(s), so that they could respond appropriately to the referrals and avoid missing dangerous and urgent matters. Whilst the need for such an assessment is stated consistently within these responses, the actual nature and focus of such an assessment are completely vague and seem to assume that the reader

will have a clear understanding of what such terms mean. Put simply, (risk) assessment is used to explain the process that enables the worker to prioritise referrals, but no explanation is given of what (risk) assessment entails. No mention, for example is made of such things as the type or severity of injury that might have been suggested, the closeness to death a person may be, the history of violence from a service user to another, presence of excessive alcohol or illicit drugs etc. The term 'assessment' is anticipated as being commonly understood, when, as question 15 illustrates, it is not:

- 'Telephone assessment made – Home visit depends on result of assessment and current workload of team' (1)

- 'Risk Assessment. Team philosophy.' (6)

- Decisions made by EDT worker – risk assessment undertaken, some situations specified, e.g. accommodation of children. (9)

- Senior on duty assesses risk and marshals resources. E.g. uses other agencies 'in situ' to safeguard family resolve. Visit made when need to respond clarified and role clear. (12)

- 'Individual taking the call makes a risk assessment/benefits of an intervention strategy based on a home visit.' (16)

- 'Decision taken by involved social worker. Statutory responsibilities. Nature of degree of risk.' (25)

- 'Via a process of risk assessment and prioritisation.' (35)

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- 'On the basis of eligibility criteria (is it an emergency?) and prioritisation of work coming in. The worker normally decided for themselves; occasionally consults with myself or another manager.'(45)

- 'Made at the time via risk assessment' (51)

- 'Individual's decision. As EDT worker, I would do assessment of risk. Also need to prioritise as lone worker. Look at referrals and prioritise what level of risk is involved – will the situation hold until the next working day. At times will consult with manager when needed.' (54)

- 'Only if absolutely necessary.' (67)

- 'High need risk, can't wait until the next day. Decided by the worker on duty.' (70)

- 'Control worker manages decision to visit and prioritisation. Legal responsibilities paramount and risk. Weather conditions and distance to travel will inform decision, i.e. recent floods availability of other personnel, i.e. police, neighbours etc. (90).

Question 13. How many people per shift usually determine whether a referral is a priority or not, 1, 2, 3 or more?

This and the previous question have been connected as they complement each other and the responses to them indicate part of the decision-making process out of hours. As

indicated above, many of the respondents gave detailed additional comments to question 12, but the theme that emerged from all of them was that essentially, there was usually one person who tended to make the decisions regarding the priority and requirement for EDT to visit. Whilst the positions held by these people within the EDTs were diverse, the key issues were that not only did one person take these decisions, but also that the prioritisation and assessment process by which this one person gathered information and accorded importance to each referral, was particularly vague.

The Chart for question 13 indicates that the overwhelming majority of decisions out of hours are made by one person. It might be anticipated therefore that there would be a clear, systematic, transparent and well grounded framework or policy within which these lone decision makers might operate. There was not.
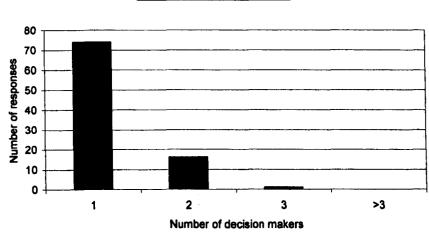
Chart 12: Decision-Makers

71 of the responses (82%) to question 13 indicated that one person made the decisions regarding EDT referral priority and whether a visit is required or not. 16 people believed that 2 people usually determine the degree of priority. Overwhelmingly, therefore it can be seen that the major decisions rest with one person in many local authorities in Britain. This might be inevitable in those areas only employing lone workers, but more surprising is the evidence of solo decision makers even when access to consultation and debate is present.

Question 14. EDT workers appear to have differing priorities between competing referrals, why do you think this might be?

Chapter One introduced the hypothesis that there is little consistency in the EDT process of assessment and prioritisation because of the role 'autobiography' plays:

There is an argument that suggests that the nature of the EDT response to any referral may well reflect the specific individual on duty, rather than any agreed departmental priorities or procedures. It is the contention of this author that autobiographical and practical issues have more influence on EDT work, than statutory duties and responsibilities and, therefore there can seldom be any consistency in the way individual EDT workers assess, prioritise and respond to referrals. (Chapter 1 page 13).

The intention of this question at this stage in the questionnaire was to enable the respondents to consider the variant factors in any prioritisation of EDT referrals before they were asked to undertake the final exercise that appeared on the next page. I wanted to 'test out' the above-mentioned hypothesis and try to discover what the thoughts of other EDT workers were concerning the apparent inconsistencies in decision-making that Phase 1 (see above) had highlighted. The responses, some of which are detailed here, were both detailed and fascinating in that the vast majority of respondents acknowledge the critical role of the individual EDT worker's 'experience', 'values', 'personal preferences' and 'background' (i.e. 'Autobiography'); the other consistent factor was references to an absence of any clear 'protocols' or 'procedures' that would enable individual workers to make consistent decisions (i.e. Framework):

- Different interpretations of criteria maybe depend on the historical perspective of the EDT worker, ie former child care worker v former mental health worker. Also knowledge of current local resources may affect the decision. (1)

- Different professional background, no clear policies, subjectivity. (8)

- Individualised interpretation of risk, resolution and application of theory, legal framework to practise. Bottom line following assessment of risk is to take appropriate steps in partnership with other agencies, family etc to safeguard, using legal power to secure safety if needed. (11)

- A variety of reasons: 1/ Different workers expertise and skill with a particular client group may mean they are either likely to leave things – ie feel confident everything will be ok & await daytime services – or have a commitment to provide an out of hours type service. 2/ Very little research available regarding what works in EDT or where priorities should be, but, maybe this isn't that different than what happens in the daytime – ie daytime services would also show differing priorities. 3/ We are probably inconsistent ourselves re. Priorities – depending on variety of factors, immediate (ie tired/stressed) or wider (ie responses to child protection type enquiry may be responded to in a different manner if there has recently been a death of a child. 4/ As a new member of the team (joined *date given as 3 years ago, detail withheld to retain*

anonymity by author) I think that I tried to respond very quickly to stabilise – I still continue to operate like that to some degree, but experience has taught me that a number of situations 'cool down' naturally – so maybe sometimes it is better to wait a little. (13)

- Difference in personalities/experience/social work background. (16)

- EDT workers are individuals and the level/quality of their service reflects this individuality. In a situation where people work entirely alone this is unavoidable. (18)

- Some people do not like to leave the office, they would prefer to commission other people to do the direct work. (22)

- Some social workers might make decisions dependent on their own strengths and weaknesses. This is especially true of EDT workers who have been in EDT a long time and where they have not been helped to keep up to date in all aspects of generic work. (25)

- More a case of some workers will go out on some referrals when others wouldn't, but may offer a service, and others would just refuse a service. Depends on how client centred worker is and maybe also perceptions of level of service we are offering. (28)

- Subjectivity, knowledge base/experience, value base. (31)

- Background – work experience – areas of interest/expertise. (51)

- Individual perception of risk; individual preferences of type of work due to confidence, experience etc. (52)

- How confident they are in making judgements and saying 'no'. How lazy they are, how busy they are, what they enjoy doing most, what their sw background is, or just different opinions. Also have to weigh up the level of risk. (56)

- May depend on worker's own experience/values/confidence; available resources with which to respond; Level of stress of demand for services at the time of referral. (68)

- Bias of training and previous experience. Personal preference for type of work. (71)

- Some EDT staff have particular interests in some client groups. (72)

- Gender of the worker; statutory imperatives. (76)

The above sample of responses to the 'autobiographical' indicate significant scope for EDT workers to operate alone, not only in terms of their autonomy meaning that they are literally 'lone' workers, but also in that their personal and professional history, their value base and experience sets them in a different context to other similar workers as individuals. In other words, the very nature of out of hours service provision is individualised to the person(s) on duty. As there are so few people on duty (usually one person, or in larger teams maybe two-three), and one decision-maker as indicated earlier, there is a clear requirement to have transparent decision making processes and

policies assisting prioritisation when competing generic referrals appear. The following responses however, suggest that no such policy exists and may also, in part, be the reason for out of hours inconsistencies:

'Framework'

- **Individuals working independently without written procedures. Although these are developing – practice takes longer to change. (6)**

- **Lack of clear policy. (20)**

- **Different staffing levels, different authorities have different resources available. Protocols will vary within authorities. I don't think you can easily categorise referrals eg mental health assessments can vary, location/severity of illness/ asserting behaviour/ other support available etc, etc – which is why I found the next question difficult, and can only prioritise crudely. (34)**

- **Individual s.w's on teams have differing views on 8 above and 11; pressures re possible complaints; in general a hierarchy exists of child care risk first, then statutory mental health work, with Adult PACE and elderly jointly for softer priorities. This hierarchy is not explicitly expressed by the LA and so leads to differing interpretations. (39)**

- The authority does not have enough procedures and guidelines set out. Workers come from different backgrounds eg child care M.Health – therefore they have different priorities. Also individuals have their own value systems. (47)

- Level of experience and background; lack of departmental procedures; lack of training on development of insight. (48)

- Depends how they view the role of EDT ie responsive or proactive. Emergency or OOH SW Team. (57)

- No clear protocol. I suspect people put child care first/ mental health second and elderly last. I also think people respond to other agencies shouting the loudest. (62)

- Different experiences; different perspectives; lack of protocols/procedures. (64)

- Lack of clearly defined and communicated method of prioritising and in some areas influence of other agencies and lack of workers resulting in crippling pressures. (65)

- Because we do not have clear written guidelines/policies. Also think individuals tend to prefer to take on the type of work they are comfortable with. (69)

A few of the respondents to Question 14 did not believe that inconsistencies existed within their teams or within their own practice. Their comments, under the heading, '*Consistent*', are included here in order to ensure a balanced reporting of their views and the total responses (that can all be found in Appendix 14):

'*Consistent*'

- **Our team is close knit and work fairly consistently. (5)**

- **This is not my experience – and EDT priorities are usually based on assessment of risk and departmental policy. (9)**

- **Disagree with the question!! (15)**

- **There is nearly always agreement. (43)**

Other than the above, the theme of the responses to this question was that differences and inconsistencies do exist. The types of differences vary but some consideration should be given to the impact of the personal as well as the absence of the procedural (protocol). The responses combined the issues of subjectivity and specialisms with lack of procedures and protocols. All but four of the responses acknowledged that we may have differing priorities when faced with competing referrals on the same shift, and even in at least one of those responses, there would appear to have been a 'management' agenda at work (see responses '9' and '10' in Appendix 14 as response '9' is from the manager of the team '10' works for.)

Chapter 8 looks in more detail at a possible protocol or framework for out of hours workers to ensure the 'autobiographical' elements highlighted in these responses are considered

when assessing and making decisions regarding competing priorities. Attention now is turned towards the referral prioritisation exercise respondents completed in question 15.

This next exercise was designed, as in Phase 1, (see Chapter 6) to explore some of the decision-making processes referred to above. The respondents were given 5 of the 6 scenarios used in Phase 1 and asked to number them in the order a priority visit would be undertaken for each one, the lower the number, the higher the priority any that would not be visited were scored with a zero (see Phase 1 above for details of the scenarios). The decision was taken to omit the scenario used in Phase 1 of the 'Spot Check' request, as the experience of the author suggested that very few, if any, other EDT's undertook such a role. Given that I also thought only a minority of out of hours teams provided a Homeless service, it was decided to include the Housing referral but to omit the 'Spot Check' in order to focus on shared EDT tasks, rather than on tasks that, for the majority, were never dealt with.

7.8 Scenarios Exercise.

Question 15.

It is 6.30 pm on a Monday and the following 'referrals' have come to you on EDT. Which of then following (if any) would you prioritise as requiring a visit by EDT, and in what order would you advise they are visited?

Place (1) in the box you would visit first, (2) for the second and so on; Place (0) for any of the scenarios you do not think require a visit on that night.

(N.B. It is recognised that more details would be required for such decisions to be made, but for the purpose of this exercise please prioritise the scenarios as you might in 'real life', and explain the difficulties and the reason for this choice after each one).

The 5 scenarios were as follows:

(a) 'PACE' interview on a 'well known' 15 year old

(b) Mother and three children presented as homeless at a local Police Station

(c) Local Hospital phone re. 4 year old child with a 'suspicious' fractured leg: "Probable NAI", child is on the Child Protection Register and will be kept in overnight with parents' permission

(d) Request by G.P. to 'complete Section 2' (Mental Health Act 1983) assessment on "potentially violent" male at home. G.P. and Psychiatrist due to arrive at the house at 8 pm.
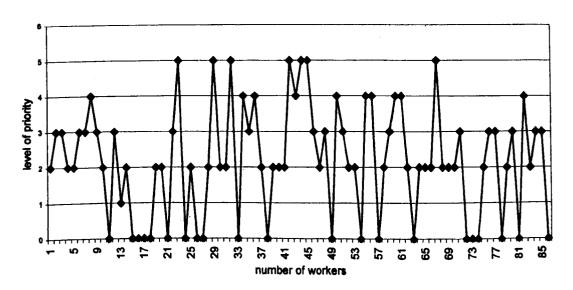
(e) Mother of 13 year old daughter phones, 'plea for removal', not known to the department.

In total 88 people completed the exercise, 3 papers were completed by placing the same number in all of the scenarios. This may have represented a view that each scenario was viewed as having equal priority, or that the respondents could not decide, or that they were completed incorrectly. As there were no accompanying written comments on the questionnaire to explain a position, these three sets of responses have been disregarded from the charts. As can be seen below, not all respondents gave written reasons for each of the scenarios they prioritised.

7.8(a)PACE INTERVIEW

Chart 13: PACE Interview

number of workers

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If all respondents had accorded this scenario the same priority then the line would have been horizontal and smooth. As the Chart above illustrates, there was little consistency as to the importance given to this referral; 21 respondents indicated that they would not visit at all, whilst the remaining 67 suggested that they would, with 29 of those according it a priority of 2.

Many of the written comments explained that they would request that the foster carer, parent or residential worker undertake the PACE duties, or that their team had access to Appropriate Adult Schemes that meant they would not have to visit. The respondents also seemed to be split between those that felt the young person was 'safe' in custody whilst other matters could be dealt with, and others who believed that this referral should be a priority as custody was not the place for young people to be kept. The sample of the written responses to this question set out below seem to encapsulate a divide within the workers' practices and values between 'safe' and 'unsafe', whilst accepting that resource availability also impacts upon the prioritisation process:

'Safe'.

16. In situation he is familiar with – safe and sound.

32. Y.P. used to police set up – but we will need to have the case disposed of.

33. Would deal with this last. Juvenile in safe place.

35. Either AA from Vol. Scheme or if EDT required. BUT y/p is safe at present.

36. Not at risk – would have to wait in custody until other tasks completed.

38. Statutory responsibility, police will be pushing for priority of EDT attention. But client is ok, not going anywhere.

44. Child is in safe place, need to contact solicitor etc.

45. Not appropriate place for a young person – but relatively 'safe' while I deal with other more pressing urgent matters, and then deal with when more urgent matters are finished.

58. Would visit depending on (e), but as he is 'safe' would not come above (d), but as a legal requirement would come above (e), unless that situation deteriorates.

59. Low priority – 15 year old could be bailed for interview at another time. Sometimes another Appropriate Adult 'appears'. Would attend later if before midnight or if quick (1) immediately.

70. Child is safe, (d) and (e) have priority.

'Unsafe'

3. Providing 15 year old is awake I would prefer to get him out of the Police Station, but I would check the accommodation and ask them to attend, or a relative or could commission AA to attend.

13. Let's get this kid out of the police station as soon as possible, this should not be his home for the night!

22. Would attempt to seek volunteer – social worker to attend with reasonable priority if volunteer not available.

24. Such young people sometimes get left for hours at police station – this is not appropriate and needs to be prioritized and could be '2' if we decide not to start CP Investigation (c) tonight. I would not use vol. Scheme because he is accommodated.

25. As the 15 year old is accommodated the LA has a duty which puts this in higher priority.

46. We have a statutory duty to provide an appropriate adult, we also have a protocol with the police guiding how/ when we respond.

47. Has some priority as we receive funding for this – done by sessional staff.
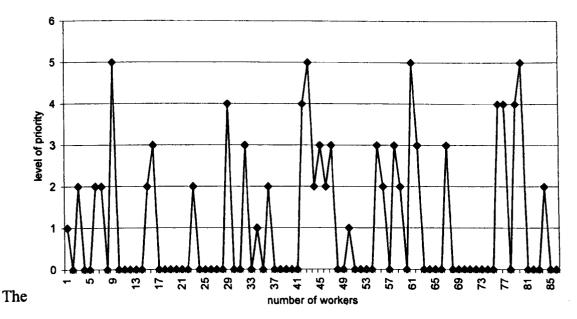
50. Aim to minimize time in custody. Priority declines if police intend to detain in custody after interview.

62. Appropriate Adult (PACE trained) visits in two hours standard.

66. Would prioritise this in order to secure his release from detention or to ensure he could appear at next available court.

67. Need to limit time in custody.

7.8(b)HOMELESS FAMILY.

Scenario (b), the homeless family, similarly produced juxtaposed, if not contradictory responses. As with the PACE referral responses above, a combination of the perceived statutuory requirement to attend, availabilty of resources, perception of the role of the out of hours service (i.e. out of hours or emergency – see earlier question 8) and the autobiographical/professional aspects of the respondent seemed to impact upon the priority given to this scenario.

As with the PACE interview responses there would not appear to be much unanimity regarding the need to visit this homeless family and those who thought there would be a need to call out varied in the priority given to this scenario. Three scored this as a number '1' priority and eleven as their second priority, but 55 people indicated that they would not visit this scenario at all, making it less of a priority than any of the others. The majority of those who scored the scenario '0' explained that another agency, a homeless officer for example would be contacted and they would deal with the matter. As can be seen below, another common explanation for no visit being made to this homeless family at the police station, was that the matter could be resolved over the phone. (The scenario with the next highest amount of '0' scores against it was scenario (e), the 'Plea for removal' that scored 46 'no visit' scores).

Chart 14: Homeless Family

The responses to the Homeless Referral fell into three categories. The first seemed to indicate that, for the majority of the respondents' EDT's this was not viewed as part of their remit and was appropriately passed to a Housing Representative available out of hours. For this category it was not a priority because it was simply not their job. The second category of EDT's however, saw the duty of Homelessness remaining within their responsibilities, albeit that it could be resolved over the telephone, and thus without a visit. The third category saw EDT workers having to take this referral and resolve with a visit and tended to give this a high priority. Despite the above demarcations, some of the responses still reflected scope for significant different approaches for varying (autobiographical) reasons. The sample of responses to this scenario given below are divided up into the three categories: (a) 'Not Our Job'; (b) 'Over the Phone'; and (c) 'Visit'. (Again the priority accorded to the scenario by the respondent appears in brackets)

Category (a) 'Not Our Job'

2. **refer to housing (0)**

4. **Housing provide out of hours service. (0)**

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7. Refer to housing department. (0)

11. Refer to housing. (0)

17. Refer to Housing Officer on call. (0)

37. Would pass to homelesss officer. (0)

44. Done by Housing – simply pass on info. (0)

50. Referral to Housing Officer. (0)

63. Homeless officer on duty 24 hours. (0)

67. Refer to Housing Dept. (0)

Category (b) 'Over the Phone'.

12. I would try to liaise with the police and Housing and arrange accommodation over the phone. If need be I would arrange a taxi, but would hope the police might help in transport. If the woman was a victim of domestic violence I might offer a social worker to escort (or if any other reason, i.e. child with a disability) (0)

13. Resolve over the phone by reference to women's refuge/homeless persons' officer. (0)

15. Can be dealt with by phone – police or taxi to transport if she does not have transport herself or a friend etc who can assist.(0)

33. No visit, would arrange accommodation and use taxi, unless suggestion of risk factors requiring investigation. (0)

36. Can be dealt with over the phone and arranging accommodation and transport. (0)

39. Telephone assessment, discuss with Police/Housing Dept., possible Women's Aid, might arrange taxi, probably wouldn't visit unless child care

issues clearer but would arrange follow up. Hope to sort this in half an hour. (0)

40. I can arrange access over the phone and send them transport. (0)

47. Deal by phone. If appropriate place in B&B. (0)

54. After consultation with housing, most of the work would be done over the phone. No visit would be normal. (0)

Category (c) *'Visit'*.

1. Clients in place of safety – assure arrangements made with homeless unit following completion of case (d) (2)

9. Whilst safe at the police station, age of children and basic needs if very young may increase higher priority. (3)

28. Family in a place of safety and can wait in a safe environment. However, if very young children, prioritise to 3. (4)

30. Police Station unsuitable for family, particularly children. (2)

41. Need to find alternative accommodation and resolve why they have become homeless at this point in time. (3)

42. Mother and children at Police Station – not suitable place for them. I would interview re. Situation and look for placing appropriately. Would not want to leave mother and children at Station for long period of time – may have been subject to domestic violence, may take some time to find alternative placement. (2)

65. Needs early response - may take a long time. (2)

69. Would want to give this early attention and explore potential solutions. Distance to travel would determine timing of visit. (2)

The majority of workers that scored this '0' had the option of an out of hours Housing/Homeless officer that would deal with it for them and so the requirement to visit did not arise. It might be argued that, notwithstanding the possible autobiographical elements, the differences in the response priority to this referral are organisationally driven and, therefore understandable and relatively clear; this cannot be said of the next scenario that produced, as in Phase 1, some very interesting responses.

7.8(c) N.A.I. ON 4 YEAR OLD IN HOSPITAL.
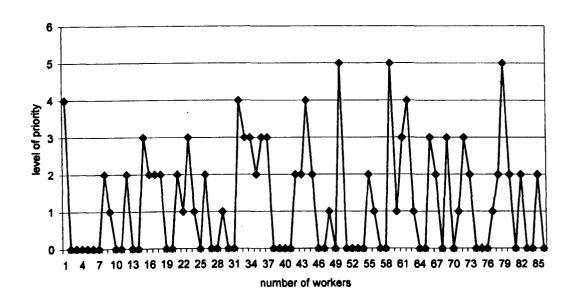
Chart 15: NAI on 4 year old

As with the responses in Phase 1 (see 6.8), the scoring of this scenario was full of inconsistencies: 41 of the EDT workers indicated that they would not visit the hospital, whilst 47 said they would and of these, 28 gave the scenario a priority '1' or '2'. As with the Phase 1 responses, (see 6.8) EDT workers illustrated the dilemmas of real practice that were faced in cases such as that recently reported by Lord Laming (DoH 2003) and reproduced earlier (see Chapter 2, 2.7e). Unlike the previous referrals, there were no other agencies that could take responsibility for this referral and so it reflects the more complex aspect of EDT decision-making. Once again, as in Phase 1, we have the situation in which

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more or less the same high number of EDT workers were arguing that they absolutely must visit this child, as were arguing there would not have been any need to visit at all. Two critical factors seemed to have been operating in the respondents' thinking and the reaction to one of these has dictated the priority of the scenario for each worker.

- If there were other children in this family this scenario MUST be visited

- There is a procedural imperative to visit in this scenario

The complication within these two factors is that some of the respondents clearly believe that if siblings exist they would have to visit, but if there were no brothers or sisters there would be no need to visit, whereas other respondents believe that whether siblings exist or not, EDT has a (statutory) obligation to visit. Both of these factors are now examined with some reference to the remarks of the respondents. Again the priority accorded the scenario can be found in brackets.

Other Children – MUST visit.

For many of the respondents the existence of siblings seemed to be a critical issue that would determine whether a visit would be made or not. Essentially what is being said by these workers is that if there were no siblings and the situation remained stable (i.e. no attempt to remove the child) they would not visit. Notwithstanding the paucity of information (deliberately) given about the referral, there would appear to be a number of assumptions in these responses, namely that a member of the immediate family may be responsible; that the other children may be at risk because of the harm sustained by the four-year old and that the existence of others would automatically increase the priority of this referral. It is not suggested that any of these underlying premises are misplaced, only that they are presented almost as incontrovertible. What is not in dispute is that the absence

of siblings and any attempt to remove the child, would ease the perceived requirement to visit for some and that the hospital is a safe place to be for the child as the following references illustrate:

7. Child is safe. Specialist resources can be mobilised in the day. (0)

13. Child safe, parents co-operative. No SW role. (0)

18. No need to visit – liaise with the police CPU and refer to Area Team. (0)

21. Write up in detail and pass to relevant team for CP follow-up the next day. Child safe, no need to visit, but need to find out if other children at home at risk. (0)

26. No urgent need to visit as child is safe for tonight, but may require visit to hospital to gather info. Also would definitely require a visit if there were any other children at home – becomes priority '2' (0 or 2)

33. Would not visit if no other children in family, but if there were other children, would visit to assess risk issues and make this a priority. (1)

41. Child already in secure environment, no need to intervene. (0

51. Can hold over unless parents try to remove the child, then would require first priority – probably PPO. (0)

62. Child protection is already secured. Would refer this on to the daytime team. (0)

(Procedural) Imperative – MUST visit.

On the other hand however, there were also many respondents that felt that even without the presence of siblings or the threat of removal, they would still have to visit and give this referral a high priority. The reasons for this seemed to be a combination of the perception that 'guidelines' or 'procedures' made such a visit mandatory and that it was a matter of good practice that parents were informed about the child protection procedures. Specific reference is not provided to which protocols or procedures are being referred to so it is difficult to establish the degree of accuracy therein. Nevertheless, what is indisputable is

that where some of those above felt there was absolutely no need to visit, the respondents cited here below believed there was absolutely no choice but to visit:

2. **Child safe but good practice to see medical staff and parents and explain CP Procedures. (2)**

15. **Need to liaise with police/do strategy meeting. Good practice to deal with the situation a.s.a.p. but child is safe and parents are co-operating and family social worker may be available next morning. Visit for initial fact-finding etc. Need to check if other children are in the home and that they are safe and well. (1)**

16. **Although this could be left, good practice for info gathering dictates visit to hospital; gather immediate info. And make contingency plans with the medics. (1)**

20. **Likely to be dealt with quickly, but legally a high priority. (1)**

43. **This needs a 'hands on assessment' either by yourself or by an appropriate worker called in from home. (1)**

46. **Although the child is safe, there is a need to gather info and ensure parents know procedures and will leave the child in hospital. (1)**

58. **Childcare worker would visit hospital within 2 hours. (1)**

59. **Statutory duty. Current further risk to children. Would in any event discuss with duty Police Inspector as per guidelines. Joint decision would be made depending on information available. (2)**

In the responses to this one scenario are encapsulated the complexities of social work, the role diversity of EDT's and the varying ways in which the same referral might be approached by different people with a similar job description. It is debatable how the media would react, or possibly some managers of Social Services Departments if they knew that such a referral would be visited by some EDT workers, but not by others, especially because of the high profile that is usually ascribed to child injury cases. It is

apparent that there is inconsistency within the responses to this referral, indeed it could be

argued that large numbers of EDT workers' approaches to this case are juxtaposed and

might not be able to agree any 'middle ground' of agreement at all. As with the Mental

Health Act assesment in the follwing scenario, the respondents are silent on which

statutory duties they believe they are having to meet by visiting. However, unlike scenario

(c), the responses to scenario (d) indicate a clear consistent approach to the prioritisation

of such a referral.

7.8(d) MENTAL HEALTH ACT ASSESSMENT.
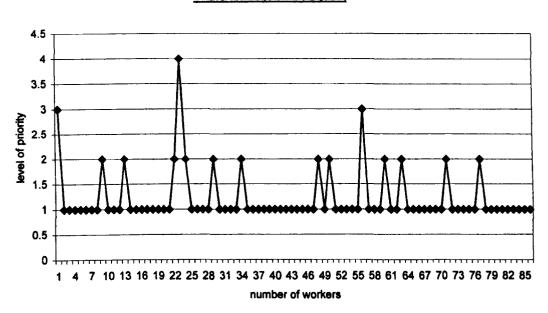
Chart 16: Section 2 Request

There was almost complete unanimity in regards to this referral in that all 88 respondents

believed that a visit would have to be made to this house. Indeed the consistency is greater

than first might appear because, as the chart above shows, 73 of the EDT workers

identified this referral as a priority 1, and the majority of the remainder scored the visit as

'2'. Whilst the written comments of some of the respondents querie what constitues

'violent' and wonder whether the police should be available, others view the existence of

potential violence and mental ill-health as the factors that make this referral an absolute

priority for EDT. This is further underlined by the large amount of responses that indicate a

statutory requirement to respond. Not one, single EDT worker suggests that there is no requirement or need for the Approved Social Worker to attend, quite the opposite as the majority viewed this case as the clear priority irrespective of values, geography, background and all the other variables that are discussed above. This type of referral is one that EDT workers definitely saw as being within their domain, and in some sense, one that they could not 'avoid'. Under the themed headings of 'Statutory Duty' and 'High Risk', there was consistency in the 'priority 'score' given to this scenario (as the graph above demonstarates) and also in the written responses to the question too as the sample below indicates:

'Statutory Duty'

2. Priority – Statutory. (1)

4. Legal responsibility to be involved. Police to be on stand by. (1)

5. Statutory responsibility. (1)

15. Statutory responsibility to attend. Would ask for police back-up. (1)

17. No contest! (1)

33. Statutory duty to attend. Person at risk. (1)

35. Statutory priority. Should not be postponed until daytime (potential risks and Code of Practice). (2)

40. Legal obligation under Mental Health Act. Level of risk in situation. (1)

45. Stat. Duty under the M.H.Act. (2)

59. Statutory responsibility to respond. (1)

There is also some degeree of consistency, other than the perceived statutory imperative, in the reasons given as to why a visit would have to be undertaken as these responses suggest.

As indicated above these responses tended to be categorised by the level of percieved danger and high risk.

'High Risk'.

>7. Serious risk. (1)

>9. Potentially unsafe, i.e. at home, unpredictable, violent behaviour. (1)

>23. Risk factors in this scenario, ie apparent potential for violence, would make this very high priority. (1)

>24. High priority due to risks and insecurity, I might need to have the police on stand-by. Need more info from family/carers etc and recent hospital admissions. 2 Social workers would visit. (1)

>28. Person in urgent need of assessment – possible risk to self and others in community. Possible risk to own safety request police to be in attendance. (1)

>31. Due to the fact that male is in the community and potentially violent I would visit with the medics. (1)

>43. Clearly top priority as family members may be at risk. (1)

>49. Would definitely do this first as most pressing and most dangerous situation. (1)

>61. Most 'unsafe' situation. (1)

What is interesting from a 'legal' perspective is that it might not be as 'clear cut' or without choice as the respondents believed, (see also 'Procedural' in Chapter 8). Whilst there is no specific reference to the part of the Mental Health Act (1983) or the Code of Practice that is supposed to make this the ASW's statutory responsibility, it is assumed that the following sections are those being used to explain the 'duty' to visit:

- Section 13 (1) (Mental Health Act 1983)[1]

- Section 13 (4) (Mental Health Act 1983)[2]

As can be seen from this legislation, there would, theoretically, be the option for the EDT ASW to delay assessing the 'potentially violent' male, or even leaving the matter for the caseworker or daytime team the following day, because all the Act stipulates is that the requires timescale should be 'as soon as is practicable'. As with all other legislation there is no specific timescales by which certain responses to such emergencies have to be attained. Whilst it is theoretically possible for the EDT worker to argue that, given the other referrals that have come into this shift, it would not be practicable to begin the assessment process tonight and would be better left until the next working day, it is evident from these responses that this is the only referral that could not be left. The Code of Practice (1999)[3] does not really offer any significant clarity regarding the need for EDT workers to visit and expects the individual ASW who has '*overall responsibility for co-ordinating the process of assessment..*' *(Code of Practice, 2.11)* to establish the priority of the referral by reference to reliable evidence, the willingness of family or friends to cope with the risk posed by the service user and the degree of risk and its nature. Interestingly, the Code of Practice says quite clearly:

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[1] It shall be the duty of an approved social worker to make an application for admission to hospital or a guardianship application in respect of a patient within the area of the local social services authority by which that officer is appointed in any case where he is satisfied that such an application ought to be made and is of the opinion, having regard to any wishes expressed by relatives of the patient or any other relevant circumstances, that it is necessary or proper for the application to be made by him'. Section 13(1) Mental Health Act 1983.

[2] 'It shall be the duty of a local social services authority, if so required by the nearest relative of a patient residing in their area, to direct an approved social worker as soon as is practicable to take the patient's case into consideration under subsection (1) above with a view too making an application for his admission to hospital; and in any such case that approved social worker decides to make an application he shall inform the nearest relative of his reasons in writing'. Section 13(4) Mental Health Act 1983.

[3] 'Arrangements should be made to ensure that information about applications is passed to professional colleagues who are next on duty. For example, where an application for admission is not immediately necessary but might be in the future, the necessary arrangements could be made for an ASW to attend the next day. 2.39 Mental Health Act Code of Practice, 1999.

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'A risk of physical harm, or serious persistent psychological harm, to others is an indicator of the need for compulsory admission.' (2.9, 1999):

It is quite possible that the 'biases' referred to in Chapter 2 operate within the minds of the EDT respondents within this research and in practice. The Department of Health provided examples of 'biases' that impact upon the decision making processes of professional when undertaking mental health assessments, one that tends to increase professional propensity to section people:

'pressure to avoid risk taking due to the 'blame culture' within which practitioners work, sectioning is therefore often viewed as a 'low risk' option'(DoH, 2001 page 2).
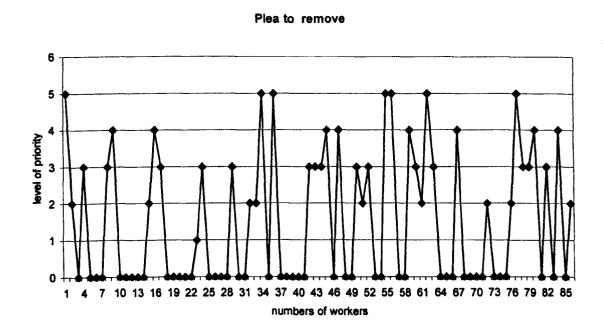
and one that tends to decrease the propensity to section people:

'team support in 'risky' decisions (eg to care for someone in the community rather than to section them.'(DoH,2001 page 3).

In essence therefore what I am suggesting is that the EDT workers have prioritised this referral because of the perceived imminent risks to the service user, the community and also the risk of what might happen to them as local authority employees if it is not dealt with tonight and left, as I believe it could be, until the next working day. Whilst it is my belief that this referral could be left, I too would have visited this male at home with the other medics for the same reasons identified above, and would not have had the 'confidence' to delay the response by asking the daytime team to deal with this assessment. This is possibly because I am a lone worker without the support of a colleague or any team opportunities for discussion and a joint weighing up of the possible risks. There is also a

range of different factors within this decision including wanting to resolve the situation quickly for the potential patient; knowing there would be other professionals present with whom I could discuss the situation as well as a concern for my safety if I visited alone and a worry of what might happen (to me and to the service user) if I did not visit.

7.8(e) PLEA TO REMOVE 13 YEAR OLD.

Plea to remove

The contrast in the shapes of the two charts above (Section 2 request and Plea to remove) is evident. 46 respondents indicated that they would not visit this family by scoring it '0' whilst the remainder of the group did not view the scenario too seriously at this stage, although written comments tended to draw attention to details that might increase its priority: Allegation of an injury having been caused; inability to resolve over the phone or the parent evicting the teenager from the home and refusing to have her back. What this scenario does highlight is the importance of the contact over the telephone and the ability of the EDT worker to focus on the most immediate perceived problem. As the examples of

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some of the responses below indicates the views are split between those who believe it is necessary to visit to prevent the accommodation of the child on the one hand, and those who argued that they would try everything possible over the phone to avoid having to visit at all. Numerically there were significantly more respondents seeking to resolve via the phone than there were intending to visit.

Visit.

29. Visit and offer support. (4)

34. Visit to attempt prevention of accommodating/facilitate alternative family placement/accommodate as last resort. (2)

42. I have workers available to do this type of 'support' visit so would receive priority. (2)

44. Could be visited by family support team. Policy is NOT to accommodate. (3)

No Visit.

4. Telephone counselling – advice, refer to daytime staff (0)

11. I would do a really good counselling type job and try to encourage her to manage the situation or arrange for daughter to go to a friend or family member for the night. (0)

14. Give ownership of problem back to the mother unless young person is injured in any way, this would not be dealt with other than by the phone. (0)

22. Assess on telephone first. EDS do not accommodate children except where no carer available. Listen and help plea. (0)

36. Every attempt would be made to calm and hold this situation o/night and referral would be made to the daytime colleagues. (0)

38. Listen – try to reassure and tell her there are no beds! (0)

39. Resolve via telephone. (0)

50. Telephone work on handling and coping mechanisms. (0)

51. Always try to resolve over the phone. (0)

56. Try to deal with by phone and referral to daytime staff for planned response. (0)

57. Would try to deal with over the phone. (3)

63. Would try to resolve via the phone. If need to visit it would take lowest priority. (0)

There did appear to be some degree of agreement that this referral would not, for the majority, have been a priority unless other factors arose from the phone conversation regarding the safety of the child. Furthermore, many of the responses illustrated the way in which EDT's rely on telephone skills for assessing and communicating. This 'plea for removal' would not have been a high priority for most EDT's and similarly would not have received a visit.

7.9 Summary.

This exercise produced 19 EDT workers that prioritised the 5 scenarios in exactly the same order (priority '2' to the PACE interview and Priority '1' to the Section 2 request with all the others scoring '0'). 19 workers out of 88 completely agreed. It may be interesting to know that of this group of 19, 10 of them could be subdivided into 5 sub-groups of people that work together in the same local authority EDT. Notwithstanding the uniform approach to the mental health referral, there remain, in my view, serious enough inconsistencies in

all of the other responses to warrant interest, if not concern. The order in which the respondents have given priority to these scenarios may be less significant than their explanations for deciding why some would be visited and why others would not. To some extent the availability of other 'teams' to assist in some of these scenarios (for example the Homeless Family and the PACE interview) meant that the order of priority would not necessarily be the same between different EDT's as they do not all have the same access to resources or team members. What is significant is that the only agreement seemed to be the need to attend to the Mental Health assessment although there were some differences in terms of the priority it should be accorded. None of the other four scenarios were responded to with any degree of consistency. As with Phase 1, scenario (c) responses proved to be the most divided and juxtaposed.

It could be argued that the nature of social work cannot, and maybe should not, become a quantitative process that is depersonalised and almost robotic, denying the fundamental dynamic of the human interaction that is social work assessment. However, what these responses suggest is that there is greater variability of assessments amongst this group of out of hours workers than might be intuitively expected. I am suggesting that the priorities and judgements of the EDT workers recorded above are integrally related to their particular social circumstances and values and that the impact autobiography and subjectivity have upon our assessments need to be given greater prominence rather than denied.

7.10 Other Factors in the Decision-Making Process.

Questions 16-18.

The final part of the questionnaire in Phase 2 sought to clarify any other factors that the EDT workers believed impacted upon their decision-making processes. The absence of any direct reference to autobiographical elements in their responses, despite all the

inconsistencies detailed above, suggests to me at least, that little recognition of the influence of the subjective exists amongst this group of workers.

The following examples of the responses illustrate the emphasis that seemed to be placed on three factors, 'Statutory Duty', 'Notions of risk', and 'Practicalities' (especially staff availability):

1. **Statutory obligation, level of risk, departmental responsibilities**

2. **Statutory need; child in custody; vulnerable, frail person in need; The immediacy of risk to self/others or children.**

3. **Legal/statutory responsibility. Who is most at risk?**

4. **Risk to self and others, statutory duty.**

1. **Risk to child or vulnerable adult; protection of individual; statutory requirement; availability of resources to resolve; safety of the worker.**

21. **Physical safety; risk factors. Priority of needs/risks; availability of SW.**

23. **Risk to people, statutory duty.**

24. **Statutory responsibility/ risk to client and others.**

25. **Safety of service users; well being of service users; staff availability; alternative support to service user.**

38. **Risk factors to client/others; availability of staff.**

46. **Level of risk to client/family members; level of need; availability of staff – nothing can't wait an hour.**

65. **Risk, danger, safety, alternatives, statutory work, guidelines etc.**

73. **Statutory responsibilities and risk of immediate harm.**

What is evident from these responses is that there is consistency in the EDT workers' views that there are certain referrals that must be responded to because of a combination of factors that include some or all of the following:

(a) a statutory requirement on the part of EDT to respond,

(b) high risk of immediate harm to client/family/community/worker

(c) no other agency to whom referral can be passed and

(d) matter cannot safely be left until the next working day.

The difficulty is that along with most daytime social workers, other than (c), there would appear to be no uniformity or consistent application of these factors in the majority of the scenarios examined in the questionnaire. Whilst it has been demonstrated above that the mental health assessment (scenario c) would be responded to by all of the EDT workers because of the perceived statutory requirement so to do and the perception of the risks therein being high, there remain significant elements of subjectivity within such factors as notions of 'risk', 'statutory requirements' and matters being able to be left 'safely', and it is these types of elements that remain the 'core' business of EDT workers throughout the country. One significant difference though for the EDT worker is that their work context, access to information and decision making processes are different to that of their daytime counterparts involving, as they do much fewer people and very little, if any, consultation.

7.11 Conclusion.

EDT workers throughout the country deal with extremely complex and often dangerous referrals. These out of hours workers have limited access to information or consultation that enables them to make a detailed and informed assessment of service users. Whilst the workers agree that they are guided by certain factors – statutory duties and prevention of harm – there would appear to be inconsistencies in the way in which such factors are being applied. Such inconsistencies may be due to differing access to staff and other alternative

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agencies, differing local policies or the confidence or professional interests (or lack of) of the particular EDT worker on duty. It is however, I would suggest possible that the absence of any helpful (risk) assessment/prioritisation framework (see question 11) plus the complex autobiographical filtering that occurs when we all process information which combine to create the lack of cohesion that this chapter has highlighted.

Following the completion of the questionnaires in Phase 2, a sample of the respondents was interviewed to further explore this hypothesis.

7.12 Part 2:

PARTICIPATIVE INTERVIEWS.

7.13 Introduction.

Twenty-one of the original fifty-three local authorities that took part in the Phase 2 questionnaire, detailed above, were included within the next stage, an interview. One individual from each of the 21 EDT's was identified and this ensured fair representation from the differing EDT models that exist (see Chapter 1, 1.5). Details and analysis of these interviews now follow.

7.14 Phase 2 Interviews.

(For detailed discussion of the process and content of these interviews, see 4.9)

The semi-participative interviews were based on the findings of Phase 1 and analysis of Phase 2 questionnaires. An interview schedule (see Table 4 below,) was designed that sought to focus much more specifically on the process of prioritisation and EDT consistency as both had been identified by this research as key themes. The interview schedule reflects the hypotheses of the study (see 4.2) and sought to concentrate on specific EDT issues as identified in the schedule. In total 21 EDT workers were interviewed as part of this process from 15 different Local Authorities. All the varying models identified in Chapter 1 (1.5) were represented in the sample group of interviewees.

Table 4

Question 1	New schemes that would affect EDT response to scenarios?
Question 2	How do you prioritise between competing priority 1 referrals?
Question 3	(How) Could EDT responses be more consistent?
Question 4	Does autobiography impact upon your assessment? (This question was not asked as the responses to 1-3 addressed similar issues).

Question 1: New schemes that would affect EDT response to scenarios?

In the first instance, the respondents were reminded of the original questionnaire and asked whether in the last year (since they completed the questionnaire) any new schemes or procedures had arisen that might alter their ordering of the scenarios. Five of the respondents in interview advised that new 'projects' had arisen during the previous year in their authority that would reduce the need for EDT to actually visit, albeit that they would still have to 'respond' to the same scenarios in the questionnaire. Some of these projects mentioned were the 'Appropriate Adult Schemes' that would attend to the young person in custody (scenario (a)). Other interviewees spoke of the development of Mental Health Teams that were now beginning to operate outside of office hours (at least up until midnight) that would attend to a range of mental health related crises up to and, in some cases, including a request for a Section 2 application (as with scenario (d)). To varying degrees therefore, it appeared that 'out of hours social work' was becoming an issue for some local authorities, but the feeling was that EDT's, that had 'survived' for so long, were now being forced to accept the inevitability of change or face being 'sidelined' as one worker put it.

"The game has gone on around us for years without drawing us in, but now we have to be on the pitch with all the others or we will become sidelined."

An opposing view by some is represented by one respondent who felt that EDT's remained a crucial and 'cheap' way of providing an 'insurance policy' for the community's welfare after hours. The worker suggested that:

'You will not find a more experienced, generic set of workers that can provide such a quality crisis service to so many members of the community at so little cost.'

Another, borrowing from history said:

'Never has so much been owed by so many to so few for so little!'

There appeared to be a division amongst those interviewed between those, on the one hand who believed EDT's would have to adapt to survive, and those, on the other, who felt EDT's had, since the early 1970's, endured many organisational, legal, political and institutional changes and that those presently perceived as posing a threat to EDT would similarly leave the out of hours teams unscathed and unchanged. For this latter group of workers, the introduction of 'extra' services out of hours, such as the mental health and Appropriate Adult schemes, merely reflected how busy social work is out of hours and that it was important to 'supplement', rather than 'substitute' the current EDT provision. For the former group of *'nervous about the future'* EDT workers, given the perceived increase in services available after hours, it was not surprising to note an element of scepticism and concern regarding their future as they felt they had been 'out of sight and out of mind' for so long, but whose service felt like it was being *'carved up without anybody asking us what might be the best options.'*

In summary therefore, it was apparent that there was an acceptance that change regularly occurs within Social Services Departments, but a split between how much EDT's were a part of these departmental rearrangements and how much they 'stood alone.' Alongside this, and irrespective of whether the interviewees felt EDT would survive or not, was a sense of the worth and quality of the service they as member of the out of hours teams provided. In essence what was implied was, as one person put it, that the *'wheels of EDT are not broken, have worked very well since 1978, so why try and fix them now?'*

Question 2: How do you prioritise between competing priority 1 referrals?

The discussions regarding the processes through which EDT pass in order to make a decision regarding the status of a referral were interesting because there was little new information that arose that had not already been included within the written responses to the questionnaire the previous year. In interview the EDT workers reiterated their belief in the combination of factors that exist when trying to resolve competing priority referrals. These were:

> - *Referrals should be resolved over the phone as much as is safely possible,*
> - *EDT have definite statutory duties that cannot not be ignored.*
> - *Identifying certain risk factors and hazards is critical*
> - *Being practical in terms of what one (or two) out of hours workers can achieve.*

- *Referrals should be resolved over the phone as much as is safely possible,*

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This representative group of workers stressed that the decision to visit a service user was usually a '*last resort*' or as a result of there being simply '*no other way round it*'. The skills involved in telephone work on EDT, whether as the co-ordinator or the worker who both took calls and visited, were highlighted as an important filter. These skills necessitate a calm, methodical and sensitive gathering of focused, contemporary information. As one worker put it:

> '*The skill is to get to the present crisis details sensitively but quickly. Questions like, what is the child doing now? Are there any signs of injury? Who else is in the house and what did you hope would happen when you phoned us? All help to get the caller focused on the present crisis and thus help to get the EDT worker systematically to establish the immediacy of the dangers.*'

One of the other more obvious advantages of dealing with people in distress over the telephone is the complete elimination of the threat of physical violence to the EDT worker. Whilst some of the Phase 1 respondents said they preferred to talk to people face-to-face, they acknowledged the increased risk of harm to themselves when in someone else's home as opposed to being on the other end of the phone. Many of the respondents in Phases 1 and 2 spoke of having to hang up the phone, following repeated warnings to the abusive service user, and wondered whether the phone had been an aide or a barrier to clearer communication as, from the service user's perspective, it is likely to increase the sense of frustration if their crisis does not even 'merit' a home visit. The reality for all the EDT workers involved in this research was very much that only a (small) minority of those who phone to request a social work visit actually receive one. I would suggest that on at least every other shift, I have somebody, whether that be a service user, relative or another agency, on the phone requesting or insisting that I must go and visit X. Very often there is not even any need for EDT to be involved, let alone make a home visit, and in the

overwhelming majority of cases where I do choose to make contact with X, the matter can be resolved, from an EDT perspective, over the phone as many of the respondents in Phase 2 have already indicated (see Question 15). The telephone is a critical tool for EDT workers and, despite its limitations for both the service user and the worker, remains the major filter via which information is processed upon which priorities are decided. This becomes even more the case given that only two of the local authority EDT's surveyed offered interview facilities at their workplace for service users to 'drop into'. Unlike daytime counterparts that can be accessed via letter, office visit, drop-in, fax, email and phone, the access to EDT's is much more restricted. This restriction becomes more pronounced if the 'direct access' (i.e. via the phone) is handled by an operator or a pager service or a call centre

- **EDT have definite statutory duties that cannot not be ignored.**

Having suggested that the telephone is the means by which the vast majority of work comes to EDT and by which crucial decisions are made to visit, or more realistically, not visit, those interviewed suggested that in 2 of the scenarios (c and d) there were clear statutory imperatives that needed to be responded to. As indicated above, there is some doubt regarding the statutory obligation to visit both of these scenarios (especially c), but many of those interviewed could not envisage <u>not</u> visiting the man with mental health problems. They expressed fear for his safety and that of any family members or people in the community but also indicated that it was their independence of the local authority as an ASW (a status not ascribed to child care workers or any other social workers other than Approved Social Workers) that added to the pressure to visit. As one worker put it:

'There's a clear statutory duty to visit this man under the Act. I would not like to think what would happen to me if both doctors signed the forms and I decided not to visit. As an ASW you are out there on your own.'

Another interviewee said he could *'almost see the headlines now: Mad axe man murders whilst EDT sleeps in bed!'*

As was the case in the questionnaire responses to the NAI referral, the interviews produced a difference of opinion regarding the statutory requirement to visit this child in hospital. Some interviewees argued that their procedures 'demanded' they visited, others suggested it would be 'made' safe' over the phone. What became clear was that EDT workers seemed to focus very much on the present crisis rather than historical reasons why it may be occurring now.

The skill of concentrating on the present perception of difficulties and of EDT having a time-specific assessment role in order to be able to prioritise and decide whether a referral can wait until the next working day is also echoed in the following comment:

'Whether the parent attended ante-natal classes, the child was breast fed as a baby or whether there are four children sleeping in one bed in an overcrowded, damp house, may well be relevant to the daytime caseworker. The EDT worker needs to know where the children are <u>now</u> and whether there are any recent physical signs of injury. Whilst the impact of neglect is potentially, if not more, damaging, I have never come across any EDT worker removing a child on such grounds.'

In other words, if it was felt by the worker that a risk could be 'clearly (visibly) identified' then there was a requirement to act if that risk endangered people during that EDT shift. One common reference was made to the existence of, for example, an injury in child protection cases that could be 'investigated' and 'seen'. Statutory duties to *'make, or cause to be made, such inquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare'* (Children Act 1989 sec.47 (1)(b) allows EDT workers to define what constitutes 'significant harm' and

what does not; and, in reality, what happens particularly for such as emotional abuse and neglect is that they are not viewed as constituting significant harm over a short period of time.

The complexities of assessing emotional abuse and the neglected child for daytime workers appear to be wrought with definitional and practice difficulties even when several periods of assessment are 'built in' (for detailed research into this see Iwaniec, 1996). For EDT workers, that have one off and usually short contacts with service users and their children, 'assessing' let alone 'addressing' issues of neglect and emotional abuse are seen as being beyond their out of hours and emergency only role. Considering some of the many lessons that were not learned from the tragedies (reported in detail in Chapter 2), and the statutory imperative of the DoH Guidance that states: *'Neglect, as well as abuse, can pose such a risk of significant harm to a child that urgent proactive action is needed.'* (1999, 5.23), it could be argued that identifying neglectful and abusive (emotionally) home environments should be within the means of all EDT social workers, but it would appear that only the extreme, life threatening cases, would be acted upon by the out of hours workers, who would tend to leave matters of chronic neglect another night and until the following (working) day. This would be consistent with the view that the role of EDT is to respond to matters that have arisen suddenly, unexpectedly, are urgent and cannot safely be left until the next working day, inconsistent with the view that we only respond to urgent statutory duties (as the reference above indicates that neglect can fall within this category), and would not appear to accord with the expressed views of more than 33% of the questionnaire respondents that indicated a blurring of the out of hours role between 'emergencies' and being an 'extension of the daytime service.' One worker summarised the dilemma thus:

'A chronically neglected child living in squalid conditions has not become so overnight. The effect of staying there another night needs to be balanced against

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the harm that may be caused to the child by removing them from this situation and putting them into some of our homes!?'

One other related concern that I have regarding our out of hours social work practice is that we are too narrow in our focus of assessment and tend to concentrate, in the investigation, on whether abuse has occurred or not, rather than on the wider issues of the needs and strengths of the family and child. In other words EDT's are precisely the workers targeted for criticism by the Department of Health' research (DoH 1995)that states:

> Over half of the children and families who were the subject of section 47 enquiries as the result of professionals' interest in their lives. Too often, enquiries were too narrowly conducted as investigations into whether abuse or neglect had occurred, without considering the wider needs and circumstances of the child and family.(2.25).

- <u>Identifying certain risk factors and hazards is critical</u>

The interview discussions indicated that 'living with (other people's) risk' was a basic requirement of EDT, as was being able to be decisive and determine when the 'risk threshold' had been breached. As one interviewee put it:

'It is highly likely that we deal with greater risks and make riskier decisions on EDT because we do not have full access to information, nor the full array of staff to deal with such risks. However, where we feel the risk is too great for a vulnerable person, we will act swiftly, without conferences, without consultation, but with confidence that we will make that situation safe until tomorrow. I prioritise things in terms of their inability to be safely left until tomorrow.'

The discussions with the interviewees indicated that there was a high standard of practice of risk assessment and issues were very carefully considered before a visit was made. Whilst this assessment may not have always been recorded in any great detail (one of the criticisms of the SSI, 1999 p.36, 7.2), there was very much a sense gained from the interviewees that this was their area of expertise:

'Risk assessment and taking calculated risks based on years of experience of taking difficult decisions is what we do, it's our bread and butter'.

Or as another EDT worker put it:

'Other agencies contact us as a' back-covering' exercise and we have to be able to get to the root of a potential problem quickly and decide whether their backs are covered or not. This is risky and a risk assessment, and something we do all the time.'

Whether we are experts or not, the clear message from the questionnaires and the interviews was that the assessment and prioritisation is undertaken in the main without any reference to any written framework or pro-formas tending to rely almost entirely upon 'experience', 'practice built up over years' and a detailed generic knowledge. As with the feedback from Phase 1 it appeared that the actual process of risk assessment may have been theoretically sound, but the process was not consciously theoretically informed and so it was possible that some elements of a thorough (or as thorough as an EDT worker is allowed to be by competing pressures) risk assessment were never or seldom considered. In other words without necessarily articulating the specific order and type of hazards and

dangers present in any referral, what appeared to happen was that the workers focussed on the most critical factors, that are considered in more detail in the final chapter, such as:

- ❖ History, targets and types, of violence

- ❖ Presence of any life threatening injury

- ❖ Safety of present whereabouts to self, service user, family and others

- ❖ Statutory duties

- ▪ <u>Being practical in terms of what one (or two) out of hours workers can achieve.</u>

The EDT workers stressed the need to be practical and creative when trying to deal with competing priorities. As with the questionnaire responses (see above) the interviewees said that there had been times when competing priority 1 referrals had come in around the same time and they had managed by identifying which referral was safe for the time being and could be resolved after the other had been dealt with. Some of the factors they mentioned were such as the absence of an injury, the absence of any statutory requirement to visit, how far away the visit was from the office/base, how many staff were on duty, the time of night and whether other agencies needed to be in attendance too.

'I can't be in two places at once, but I can deal with several referrals at once without necessarily visiting any of them as I can commission others to visit, counsel over the phone, suggest alternative strategies for coping or redirect to another more appropriate resource. All this would preclude the need to visit.'

In my own experience on EDT there have been many times when I have been unable to respond to several referrals that have come via the pager whilst I have been en route to a priority referral. Simply saying to service users sometimes that I cannot visit now, but will call back in an hour (on the phone), or advising the father at the end of his tether with his

15 year old truculent daughter and worried he might hit out at her that it would be better for his sanity and her safety tonight, if he did let her go out to the party and stay over with friends. I would also suggest he remind her that he will contact the adults at the house where she says she is staying, that she would have to be reported missing to the police if she did not stay there and that the matter will not go away and will be discussed when tempers have calmed and she returns home the following day at the specified time. My strategy would always be to try to avoid immediate clashes and to take one or more people out of the equation (especially the alleged source of tension) for some breathing space (time out). Other interviewees concurred with this adding that sometimes they would stress the length of time over which the difficulties had developed and that a single visit from EDT not would be able to achieve significant change, but a referral to the daytime team would enable a social worker a longer period of time to ensure that a proper assessment was undertaken. It was also acknowledged however that some parents would not be persuaded and would even say they had assaulted their child when they had not, to get the social worker out, usually to be used as a threat against the child or young person. In other words what was suggested by the interviewees was that some parents have realised that the criteria for getting a social worker to visit after hours is so 'tight' they have to present extreme circumstances that may well reflect their frustration rather than any serious injury or incident that had taken place.

'It is much better for the allocated worker who knows the family to be resolving disputes. I would try everything possible to avoid getting drawn into such an argument unless specific risks were identified.'

'Some families phone demanding we come and take their child. I will explain that this should be the very last step, not the first, but suddenly threats to harm or

'confessions' of having injured the child surface and make it very difficult to ignore.'

None of those interviewed had ever seen any prioritisation or assessment framework that they felt would assist them with their ordering of competing referrals. All indicated that it would be a welcome addition to their EDT toolbox but tended to specify the need for any such framework to be easily accessible and 'practical' reflecting the practical and generic nature of the work. Some were keen to stress that the length of any such 'document' would have to be concise and of a particular format:

'EDT workers do not need tick box assessments. A brief guide to ensure all factors had been considered would be very helpful for new workers and a helpful reminder to the rest of us.'

Question 3 (How) Could EDT responses be more consistent?

Interviewees all had suggestions regarding ways in which EDT work might become more efficient as well as expressing some caution concerning any 'robotic' assessment of the interaction between people and their environment. The following four areas summarise the nature of the suggestions made by the EDT workers:

❖ Share ideas:

Opportunities that enabled EDT workers to share ideas and views on practice either within the team or within teams from other authorities were promoted as ways in which greater consistency might be achieved. Conferences and training provided by such as

ESSA and NWEDT were mentioned specifically as being extremely helpful vehicles for sharing ideas and EDT issues. Within teams it was felt that having more than one worker on duty would create some greater degree of consistency, but also being able to meet as a team more often to discuss matters of practice and complex decisions, rather than only in supervision with the manager, were also included as ways to greater consistency. As one worker said:

'Any forum dedicated to EDT matters and problems would be helpful. NWEDT is great for sharing ideas and getting specific EDT training.'

Another said:

'I would love to be able to discuss difficult decisions with a colleague and see how they would do it. I would also love to be given the chance to reflect and debrief on difficulties I had experienced on a shift. This might make me more consistent as well as those I work with.'

❖ <u>Stick to role:</u>

Another factor that featured in the interviews was this notion of having to be much clearer about the role of EDT. Workers needed to know whether it was expected to provide an emergency only service or an extension of daytime services (see question 8 above). There was a feeling that we do not do achieve consistency sometimes because we perform different functions depending on how busy the shift is. In other words on a busy shift some referrals of a non-statutory nature would not be attended to, whereas on a less busy shift they might be. The discussions during the interviews centred around being able to say 'no' to requests that were inappropriate, irrespective of who

they came from and giving consistent messages to the public, daytime colleagues and other agencies about what the specific role of the out of hours team actually is, or as one person put it:

'A quiet shift can become very busy with just one phone call. We sometimes give out inconsistent messages because we do not like to say 'no' to the likes of the police or doctors but also because we do visits we know we shouldn't do and wouldn't do if things were busier.'

Another worker said that she saw it as part of her social work role to help and support vulnerable people, and if that meant spending long periods on the phone (and thus tying up the telephone line) preventing the need for an emergency response then that is what she would do. This worker though acknowledged that some of her colleagues on the shift with her had commented that it was not really part of EDT's role to get involved in what they perceived as longer term casework.

'My first thought is usually 'how can I help' and not 'do I have to help here?' I try to resolve whatever comes through even if it is not an emergency as per our procedures, it usually is for the caller. I am sure this gives inconsistent messages to the callers.'

❖ Consistency in inconsistent work is difficult:

The example above illustrates the individualistic nature of some of the EDT responses to referrals and the impact of differing value bases or understanding of the roles of EDT and social work. When discussing ways in which interviewees felt there might be more consistency, some wondered whether it would ever be possible to be completely unanimous in referral responses because *'as different people we deal with different people'*

as one worker put it. The point that was being made combined the different perspectives that EDT workers have of their role with some of the many 'ifs' and 'buts' that can occur in any one scenario that might increase or decrease the worker's response. The particular model of EDT adopted by the area was believed to impact upon the consistent, or lack of consistent approach and the belief was that teams that had more than one person on duty, and were thus able to discuss matters, were more likely to be more consistent. However, EDT workers interviewed from the same (small) team suggested that when you start discussing such terms as 'risk' and 'significant' and 'emergency' inevitably there would be subjective differences of opinion.

'People in crisis are responded to by people. We are not robots or automatons, we have feelings and fears and often have to be guided by our intuition. This intuition is grounded in long years of experience of dealing with people on crisis. Nevertheless we remain people. Consistency might never be achievable.'

'I know there are some referrals that my colleagues hate going out on, PACE and difficult teenagers. Whilst I would not say I love them, I do relish such referrals. What's the expression about one man's meat is another man's poison? I wonder if we can achieve consistency.

One interviewee believed that essentially EDT workers were consistent and had more similarities in their practice than dissimilarities. Essentially what he argued was that in terms of the more 'dangerous' referrals, whilst they might be attended to in a different order, they would be attended to and so he did not believe there were fundamental differences of practice across the country or within individual teams, only in terms of their relative priority. He was critical of the scenario questions suggesting that too little information was available upon which to make a thorough assessment and that too many

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other factors might create what seemed like an imbalance and inconsistent set of priorities. In relation to scenario (c) he believed that those who said they would visit (assuming there were no other 'risk factors' were wrong and had '*no understanding of child protection procedures*'. I would add that this person was an EDT manager that did not undertake home visits or undertake emergency duty team work.

❖ Framework:

The suggestion of some type of EDT generic, assessment framework seemed to be received positively by the interviewees as another means of establishing greater consistency. Several workers criticised the L.A.C.[4] documents (DoH, 2000) as being 'completely impractical' for the EDT worker and most had never fully completed the required documentation out of hours. Many commented that there seemed to have been very little consideration, let alone consultation, with EDT workers regarding the type of documentation that they would be expected to complete:

> *'Daytime forms seem to be imposed on them and we do as little or as much as we can, but a much simpler form would be much more appropriate for EDT.'*

> *'I would welcome any framework that helps us systematically record the excellent work we do but rarely commit to paper.'*

> *'Our authority uses P.C.'s and inputs referrals. The recording is a bit hit and miss and maybe we should record more in the spaces left for professional decisions and why they were made.'*

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[4] Looked After Children – A set of department of health guidance procedures (DoH, 2000) that many local authorities have adopted as the means of assessing children and children in need.

L.A.C. has clearly been devised for daytime caseworkers and not generic EDT workers who do not need to know the inside leg measurements of the family dog! Any process that formulates a more systematic response, focused on the very short-term role of EDT would get my backing!'

The explanations for the differing priorities, namely 'professional background', 'autobiography', 'values', 'experience' and 'knowledge' (or lack of) tended to dominate the interview.

"Service users are all different, social workers are all different and EDT workers are all different again because of the autonomy and experience they have. It is no wonder so many people saw different ways to respond to the scenarios."

"It might not be a priority for the department, but, as a parent and a woman, I would feel drawn to sorting out the mother and children who are homeless. This might not be the 'right' answer, but it's an honest one."

"In my view, those who said they would not visit the child at hospital are wrong. There is a clear procedure to be followed here under child protection."

"Unless there were other siblings, or the parents were not co-operating with the hospital, I see absolutely no need to visit the NAI."

The group seemed to fall into 2 categories. On the one hand there were those that felt that there were so many 'ifs' and 'buts' that it was difficult to answer consistently and anyway *'you cannot do social work by numbers' as one person put it.'* On the other hand, there

were those who felt that there was a greater degree of procedural clarity and certainty regarding the order in which to respond to the scenarios. Put simply, the first group did not see the process in terms of responses being 'right' or 'wrong', whereas the second group tended to see it almost exactly in those terms.

Initially my concern was that the EDT workers felt pressured to give speedy responses to limit the time of the interview, but on reflection, even those where time was less of an issue produced no significantly new information. Rightly or wrongly I concluded that the original questionnaire had gathered sufficient and relevant information. It was interesting to note that, despite some of the 'new' projects' referred to above all but three of the 21 interviewees said that, as far as they could remember completing the scenario exercise the first time, they would prioritise the scenarios in the same way as the year before.

One form of new information that was provided was the non-verbal clues of a face-to-face interview. An example of this, that I read as suggesting that even if there was a manager available for consultation and the person who is supposed to be the 'decision-maker,' in real terms they are *"You know, sort of by-passed"* accompanied by a wry smile and a rapid look up to the ceiling which I understood to mean that the 'managers' were ignored and 'on the job experience' counted for far more than an official title:

> *"We have done this for years without having to check things out with anyone and so I can't see that this will change. This way it suits us as that's partly why we do this job, to be able to get things done without any of the red tape, but also because, as long as the shit doesn't hit the fan, managers are quite happy to leave us to get on with it. Everyone's happy."*

> *'Consult with a manager about a difficult referral? I know they can be contacted at home but tend not to bother them.'* (Again eyebrows raised accompanied by a shaking of the head).

' I know they are in the office and there if we need them but, in over twenty years of

doing EDT I have never felt the need to approach them! (Again a wry smile

suggested to me that the interviewee had very little confidence in the managers, but

they would not commit such thoughts to paper).

7.15 Conclusion.

The data gathered via the interviews, reinforced the findings of both sets of questionnaires

(Phase 1 and 2) and the previous set of interviews in Phase one with the EDT workers from

the one local authority. The intention of these interviews had been to allow the respondents

to expand or clarify their reasons for ordering the scenarios in the manner they did. What

became apparent very quickly was that the types of responses were consistent with those

discussed in all of the interviews of Phase 1 described above. It is interesting to reproduce

here, the summary of the findings of those interviewed in Phase 1 (see Chapter 6):

When deciding what course of action, if any is necessary, certain key aspects seem to be

operating at any time for the EDT worker:

1. The notion of 'danger', 'risk' and threat to 'life and limb'

2. The working definition the individual worker has of the role of EDT, (for example,

   is it an emergency service only or more like an extension of the daytime

   provision?).

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3. Can the situation be resolved over the telephone?

4. What are the statutory duties?

5. What is the worker's definition of 'significant' and 'harm' (particularly for the child care scenarios)?

6. How long will it take to 'box off' the more straightforward ones before attending to the others?

7. What part of the borough are they in? This will have an impact on the order in which things will be dealt with, if at all, because of the travelling time involved in going from one end of the Authority to the other.

8. Can this matter wait until tomorrow?

It is evident from this summary of Phase 1 EDT workers that there are common elements of practice and process to both sets of workers, Phase 1 and Phase 2. The combination of the 'procedural', 'personal', 'policy' and 'practical' ('the 4P's) underwrite all of the decisions taken by the respondents in both phases. These 4P's will be returned to in the final chapter.

An interesting common theme that also emerged, but I had not expected, was the feeling of all the respondents, via the questionnaires and the interviews, that EDT provides an excellent out of hours service that fundamentally should remain the same despite the significant changes that were taking place elsewhere in the Department. It may be that I had accidentally stumbled on one of the few areas of consistency and agreement amongst

EDT workers and teams generally, which was that we believe we have managed very well for about 25 years without 'interference' from 'outsiders'; we have survived the dramatic changes experienced by our daytime colleagues relatively unscathed, but now, with great reluctance, accept that the 'good old days' of genericism, lone visits and freedom from bureaucracy are possibly coming to an end. None of the views gathered believed that the changes would necessarily make EDT a better service for the EDT workers or the service users. One respondent from Phase 2 said in interview:

'We have worked out of the limelight since the 1970's and have always complained about being ignored – out of sight and out of mind – now we have been brought out of the shadows, there's not many of us like the light and desperately seek the autonomy of the darkness once again!'

This Chapter presented the findings of Phase 2 of the research, and built upon the findings of the smaller group of EDT workers of Phase 1. There was much common ground between the two sets of findings and much evidence regarding the complexity of the assessments and prioritisation that EDT workers have to grapple with almost every shift. Whilst there were some very positive comments regarding the work undertaken out of hours by those who do it, there was less optimism regarding the future of the service in the form in which it presently exists. It is possible that in more ways than one, the EDT final chapter now follows.

CHAPTER 8.

CONCLUSIONS AND IMPLICATIONS.

8.1 Introduction

Did I make the right decision? Was there only one 'right' outcome for Mr.A and what would my colleagues have done? Would the doctor carry out his threat to 'make a complaint' or was he wishing simply to be seen to side with the family? I was confident the situation could, with the family's support, be managed until the next working day, tomorrow, the focus now needed to be to reduce the anxieties of the family members in order for them to prevent this man ending up on a psychiatric ward. God, it would be so much easier just to 'section' him! (Diary 20/2/97)

By a range of different means, this research set out, six years ago, to explore aspects of social work that, to date, had received little attention. EDT and the out of hours social work service was the primary focus of this study and Mr A one point of reference to explore the differing personal, procedural, practical and political 'realities' [4P's] that exist specifically, but not exclusively, for EDT workers faced with such a scenario.

As a piece of research, this study sought to fill a perceived gap in attention to social work 'after hours' and address also why this service had managed to avoid the degree of scrutiny that all other sections of social care/work had experienced. A series of hypotheses in the form of questions underpinned the research and I attempted to examine the different perspectives individually as well as the relationship between them.

It is possibly inevitable in a piece of research such as this that a significant amount of the information gathered needed to be omitted. This process of prioritising certain sections of

'data' over others was not easy and formed an interesting parallel to the complex issues raised via the research in which EDT workers' tried to explain their rationale for prioritising some referrals over others. I would not claim to have included all the relevant information gleaned as a result of the research, nor that there were elements omitted that could and maybe should have formed part of the main body. What I would indicate though, is that this piece of research, in some ways, feels as if it will never be a 'finished' article because the pace of change for the service and for the people within the teams is continuous and, at the time of writing, relentless.

8.2 Conclusion about each research question and hypothesis

A] *Are there any patterns in 'out of hours' social work in terms of the 'types' of referrals which are made?*

The longitudinal study (see Chapter 5) provides a detailed breakdown of the referral rates and 'types' to the Phase 1 local authority, whilst the questionnaires and the interview records provide detail of the EDT workers perceptions of referral rates and 'types' to the out of hours service. The charts (Chapter 5) and statistical breakdown indicate that December tends to be regularly the busiest month, Friday the busiest shift, children and families the largest source of referrals out of hours but for all of these there would not appear to be any satisfactory or consistent explanation.

An interesting range of possibilities has been examined in this research in an attempt to establish any patterns of referral. Children being off school during the holidays (particularly in summer) does not appear to lead to an increase in referral rates for the children and families' category. Interestingly, I was informed by a worker at a domestic violence agency recently that their referral rate almost always drops during school holidays because, they believed, Mothers usually 'try to keep a lid on things for the sake of the

children' with the consequence that such agencies become busy after the holidays are over when women feel that their children are at less risk. Families being 'fed up' after the Xmas festivities and inter-familial stress being higher as a result would not seem to explain the increase in December referrals to EDT. The weather would appear to play some part in the referral rates, especially relating to snow and ice causing people, who may be carers or vulnerable themselves (or both) to fall. It was also suggested by more than one EDT worker that their shifts are not as busy when it rains and the explanation seemed to be that people stay indoors and 'shut out the rest of the world'; it was suggested that young offenders tend to find somewhere dry rather than being 'out and about committing offences'. What is inconsistent about the weather hypothesis though is that January, for example, when it might be expected to be busier for older people referrals and less so for 'juveniles,' was not reflected in the statistics of this research. The suggestion that EDT gets busy when the daytime teams are busy is difficult to correlate as EDT's become stricter about accepting referrals commenced during the day. It is also difficult to establish a link with the daytime activities since different notions of what constitutes a 'referral' appear to operate 'after hours'.

Even if a liberal interpretation of the statistical data was adopted and it was accepted that December and Fridays are busier, no single explanation seems to exist to account for such patterns. It may be that Fridays are 'busier' because of a combination of factors namely, that for the majority of working families it is the end of the week and the beginning of the weekend, a time for social gatherings, increased use of alcohol and other drugs, a time when expectations are raised within the family as well as them actually spending more time with each other. Once again though, the statistics suggest that if this multi-factorial explanation was accurate then by Sunday one would expect the referrals to reach a peak they don't.

There is some consistency when examining which 'types' of referrals form the majority of the work for EDT. Children and families work consistently featured as forming at least

50% of the referrals taken by EDT every year throughout the six-year period of the study, and indeed beyond. If PACE work undertaken with young offenders (i.e. children) are added to the children and families figures, then the overall total is more accurately 60% of the total EDT referrals.

The difficulty for managers of EDT (one which this author has become acutely aware of since becoming a half-time manager/half-time practitioner in the final year of this study) is that whilst there are very busy and unpredictably busy periods, there are also significant periods of (referral) inactivity in which the EDT worker(s) are not called upon to do anything at all. These periods of inactivity also fall in December and also fall on Fridays making it difficult to plan increases or decreases in the requisite staffing levels, except, of course, if the 'team' constitutes one lone worker, as it does for the majority (60% see Chapter 7) of the local authorities studied in this research.

The conclusion to this hypothesis is that, for the local authority of Phase 1, there are general patterns of referral rates on certain shifts but the data alone could not sensibly justify changing or building the out of hours service because of it. The data does however indicate that the children and families aspect to EDT is consistently the highest source of referrals and, whilst some shifts continue to contradict this, the experience and knowledge base of the out of hours workforce, it could be argued, must be matched by the skills required to deal with such children and families matters at least.

B] *Is there any consistency in the way in which individual EDT workers assess, prioritise and respond to those referrals?*

The responses to the scenario exercise highlight significant practice variation within and between EDT teams. Whilst the mental health referral achieved a relatively consistent response (although the reasons why are not clear), none of the other scenarios did.

Chapter 3 introduced the 'art-science' continuum debate in which opposing views seek to establish social work practice more towards one or other end of this range. This research

adopted the view that social work research and practice lies between the qualitative and the quantitative. I have argued that social work practice is 'artistic' when seeking, as it does, to understand the meaning of social behaviour, as it has to accept that the inevitable uncertainties and contradictions that exist in social life. Social work is 'art', in that we work with people and the full range of values and differing perspectives that both the assessor and the assessed bring to the dynamic process of that 'evaluation'. To a large extent, I have argued (see 7.10) that, for the EDT worker to deny (consciously or otherwise) the autobiographical aspect of the assessment process is to deny the importance of the service user's biography. In order to achieve a greater degree of consistency, if indeed this is possible or desirable, EDT work needs guiding principles and a prioritisation framework that allows for the creative skills of the assessor and is quantifiable, but does not undermine the necessity for personal judgement. Once again it might be appropriate for EDT workers to learn from our daytime counterparts who are guided by the National Assessment Framework (DoH 2000) that states:

'Knowledge is defined as theory, research findings and practice experience in which confidence can be placed to assist in the gathering of information, its analysis and the choice of intervention in formulating the child's plan' (DoH 2000,p.1).

Quoting Schofield (1998, p.57) the chapter clarifies this definition of knowledge that underpins the entire Assessment Framework:

'Social workers need a framework for understanding and helping children and families which takes account of the self and the outer world of the environment, both in terms of relationships and in terms of practicalities such as housing. It is the capacity of social workers to be aware of and integrate in their practice these

different areas of concern which defines the distinctive nature of their professional identity.' (ibid p.1)

One area of concern that stems from this research is the apparent over reliance of EDT workers on 'practice wisdom' and experience and a lack of reference to other theory or research findings when making crucial high-risk decisions. I have tried to underline the importance of 'science' in that our practice cannot only be an extension of ourselves and 'common sense'. What is required is reference to and connection with a basis in research evidence. Thus the aim for EDT workers would be to establish a blend of evaluative judgement and theoretically informed social work practice.

The simple response to the question posed above is that there is little consistency in the way EDT workers respond, but some consistency in the explanations why this should be so. The scenario exercises in both Phase 1 and Phase 2 demonstrated that there was little consistency in the way that EDT workers would prioritise those referrals (albeit with limited information). The responses during the two sets of interviews, as well as the written responses to both sets of questionnaires (see Chapter 5), suggest that there might never be agreement amongst members of the same EDT, let alone members from different local authorities. The different explanations from the EDT workers suggest that a diversity of factors operate for each EDT worker when seeking to establish an order to the referral response. On the one hand it can be seen from some of the responses that there are almost as many possible explanations as there are workers, but on the other hand, there does appear to be two 'themes' that emerge from the feedback. There will always be variation in EDT responses because social work is more 'art' than 'science'. This contrasts with the other theme that suggests that some referrals 'must' be visited and there is a quantifiable 'right' and 'wrong' response to the scenarios. In discussion though it became apparent that even faced with the same details of a referral on two different shifts, the response would

have to be dictated to by such 'practical' factors as geography, what else had come in on that shift, the experience (autobiographical as well as professional) of the worker and the actual time of the shift (and, therefore distance away from the next working day) that the referral came in. In short the status and priority of any referral was at times 'absolute' as well as 'relative'. The mental health referral of the scenarios was an 'absolute' one in that there was unanimity that it had to be visited, but 'relative' in as much that it could be visited practically, when some of the other referrals had also been dealt with. Out of the total referrals though, no other one could be said to be an 'absolute'. In this way then the assessment and prioritisation process that occurs outside of 'normal' office hours is difficult to formulate because, as the nature of the work allows it, it appears that referral responses are impacted upon by the person as much as the procedure and whilst the persons are all different but the procedures the same, different persons will have different knowledge and understanding of the application of such procedures, if indeed they exist. Above all, what this aspect of the research has confirmed is that, other than in the case of a mental health assessment of a potentially dangerous man, (and even then), there will be variations in terms of how quickly it might be dealt with. There is little consistency in social work practice after hours and the services users' success or failure at receiving, or being given a service is somewhat of a lottery. BASW suggested that 'a major factor in determining an emergency was the social worker's perception of pressure', (1984, p.21). Given the complexities involved in establishing individual's definitions of 'emergencies' as well as 'pressure' and their responses to it, as well as the large number of issues that might make the worker more or less prone to feeling such pressure, it seems self-evident that there is not much likelihood of consistent approaches arising especially out of hours when often, the worker is alone on duty, or even when working as part of a team may still undertake solo visits as can be seen from the findings (see Chapter 7).

C] *Is there any theoretical framework that might assist EDT workers in achieving consistency in relation to the referrals they receive?*

The hypothesis that EDT workers do not work within a conscious, systematically applied theoretical framework that informs their practice appears to be well substantiated by this research. The interviewees' interesting responses to the question regarding their practice and its relationship to any theoretical framework has been noted above. Given the amount of autonomy that EDT workers also appear to have and the minimal amount of consultation, it is interesting that these most experienced workers do not demand such a framework that would make their practice more consistent, systematic and accountable. The theoretical frameworks of the individual EDT workers who took part in this research appear to rely on 'practice wisdom' and what several called 'obvious' or 'common sense' and 'practical' approaches to problems. This idiosyncratic means of formulating an out of hours social work response means that comparisons are difficult, the practice of social work assessment may lack the status it merits and consistency is almost impossible.

In response to the question posed by this hypothesis, the answer presently is 'no' there isn't any theoretical framework that helps EDT workers to prioritise, assess and respond to referrals. One benefit of undertaking this research though, is that for many EDT workers this was the first time in 'ages' that they had been able even to consider the theory and application of EDT work. All respondents acknowledged that their own autobiography had an impact upon their social work practice, what had been missing was the opportunity to explore what the impact actually had been. The respondents certainly welcomed a framework that would make their decision-making processes more definable, less 'hit and miss' but no less subjective and certainly the respondents did not wish to make the interpersonal process of assessment and priority making a robotic, depersonalised one. It would appear certain that the conventional expectations of social work assessment that

operate during the day struggle to exist during the night. Clifford and Williams suggest that:

> *'Emergency work represents one extreme end of social work where there is no time to consult assessment schedules or detailed proformas. It could be said to exemplify the special nature of expert practice in social work in certain key respects relating to professional judgement...However, in our view this does not preclude the use of schedules specifically designed for EDT work covering the various specialist areas but geared to the needs of EDT workers.'* (Clifford & Williams, 2001 p.214)

Whilst existing frameworks for assessment exist (see Appendix 15) they have only limited applicability to the out of hours worker and could not be used as a practice guide. A relevant framework for the generic worker that might increase the individual consistency of that EDT worker's practice as well as the general practice out of hours and thus make it also more systematic and possibly more effective is returned to later, but the theme of effectiveness is now examined.

D] *(How) can social work practice 'out of hours' generally, and the researcher's own practice specifically, be more effective?*

One key issue within this question is the perspective taken on what constitutes 'effective'. The research considers the term from the viewpoint of the EDT worker, but could equally have adopted and attempted to examine that of the service user, a daytime social worker, any manager of a social work service or another agency that operates during the night. Each of these viewpoints could be the basis of further research, and is presently the subject

of some EDT's throughout the country being taken through the Best Value process, a process that most, if not all, EDT's will experience at least once within the next five years. It is hoped that social work outside of office hours might become more effective because attention is drawn herein to the lack of any framework, the prevalence of the 'daytime mentality' when writing public inquiries, the absence of any consistency in EDT assessments and the prevalence of autobiographical content dictating EDT referral priorities. EDT can become more effective when we are clearer about the actual boundaries of the roles of the service and the differentiation between it remaining an emergency only service, or moving towards an extension of the daytime model. The responses to both sets of questionnaires clearly show the confused understanding of the function of EDT amongst workers from the same and other teams. This absence of a clearly defined specification that has uniform application by the different EDT workers means that some referrals are always responded to by some, and never attended to by others. This does not make for an effective EDT worker or service as it serves only to confuse those who seek, or who are referred to the service. Whilst some of the inconsistencies will never completely be resolved, indeed it would not be appropriate as this might automate an assessment process that can only start with the dynamic of the interaction between EDT worker, service user and their environment. EDT workers would welcome greater consistency, but not entirely at the expense of the subjective, autonomous (presently framework-less) process that presently exists.

There is a great deal that EDT workers undertake with confidence and skill and from a generic knowledge base that is rarely equalled by daytime (specialist) counterparts, but there is much also to be learned from the weekday workers who acknowledge the regulatory impact of assessment schedules and frameworks and, as one daytime colleague put it, seek to 'make them their own', but who also have developed with a different attitude towards consulting with colleagues and managers, and decision-making. Daytime social workers are increasingly expected to justify, with reference to research, the decisions that

have been taken regarding major decisions, and yet, in the main, EDT's have managed to escape the same degree of 'academic' justification.

Since undertaking this research I have become much more aware of the different routes taken by EDT workers, sometimes towards the same end, but other times to a completely different outcome. This study has made me question my own practice by comparing it to that of my colleagues as well as to that of many other EDT workers from across Britain. Is my assessment framework any more consciously 'theoretical' or, in reality do I apply it retrospectively? I decided that I do try and apply a similar framework to my practice, one that is informed by crisis interventionist recognition of the 'healing' potential of all crises, one that when face-to-face employs strategies from behaviourism and family therapy as well as being underpinned by a sense of social justice, hatred of 'bullies' (professional or service user) and recognition of the major social divisions. This research has forced me to re-think my 'eclectic' approach to social work, and, if anything, be much more theoretically proactive rather than retrospectively reactive. In other words I try to create some degree of consistency in my own practice, even when some of all the other factors that militate consistency mentioned above, are also present. In my new position as Manager/Practitioner of EDT, it is the plan to continue the process of reflective practice that some of my colleagues 'enjoyed' in the interview and to introduce mechanisms of shared analysis of interesting decisions that EDT workers encountered, (such as 'live' supervision of lone workers) as well as a consultation process before such decisions become finalised. I believe that there needs to be a different type of 'culture' to EDT which, whilst retaining its autonomy, returns to a value base and practice that questions the appropriateness of major decisions, assessments and priorities being made that impact upon service users' lives, without the opportunity to reflect on the justification behind such crucial decisions, or the chance to talk it through with someone first. Currently for some EDT workers this would be viewed as a weakness, with cynicism and seen as encroaching upon that which they have done for years and, indeed is part of their job. A different view,

already adopted by some EDT workers, is that this perspective of wanting to consult on points of practice, and acknowledgement that we sometimes get things wrong (and horribly wrong if some of the Inquiries are indicative, see Chapter 2) can lead to greater consistency for the service user and for the EDT worker. It is likely, therefore that there are several ways that this author's practice and that of other EDT workers might become more effective if part of the findings of this research are integrated into the out of hours social work service provision.

8.3 Implications for policy and practice.

The '4P's' Framework for EDT Practice.
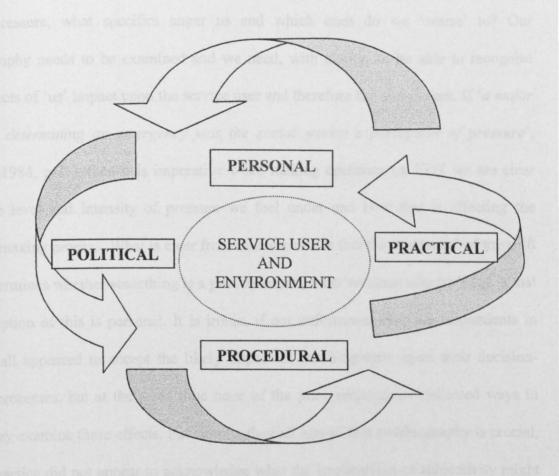
What, if anything, therefore can be learned from this research and are there any implications for social work policy and practice 'after hours'? A combination of the 'procedural', 'personal', 'political' and 'practical' (what I have termed the '4P's) appear to underwrite all of the decisions taken by the respondents in both phases and reflect the diverse dilemmas that exist for EDT workers. By examining these 4P's in some detail, a framework for EDT practice is developed. This framework remains underdeveloped but represents a starting point, where presently one does not exist, for EDT workers that have both many years of experience as well as those with little. This 'framework is based on the feedback from the research and has tried to 'pull together' diverse aspects of practice, in an attempt to address many of the shortfalls identified by the respondents. The framework is an attempt to provide some degree of systematic thinking and assessing out of hours.

The EDT '4P's' Framework is divided into 4 sections: Personal, Procedural, Political and Practical. In some respects the demarcation between these elements is artificial as there is overlap and common ground between them, there is an interconnection between the

sections as well as each one standing in its own right. The '4P's' represent the aspects of EDT social work that, in this EDT worker's view and based on the evidence of this research, would go some way to ensuring that our practice out of hours was systematic, research-based and theoretically informed without losing sight of the person that is the service user as well as the EDT worker.

The framework seeks to establish certain questions about practice that, if considered before acting, may alter outcomes. The framework also seeks to stimulate a reflective/autobiographical perspective to EDT decision-making processes and interventions. It is not suggested that EDT workers do not adopt some of these perspectives in their practice already; it is suggested that these perspectives are not all systematically incorporated in one generic framework for the EDT worker out of hours.

Each 'element' is considered in turn and then the concluding remarks seek to bring together and simplify further the process that is assessment and prioritisation by EDT workers. A chart has been developed (see below) that is intended to act as an 'aide memoir' rather than a checklist and is meant to contribute to areas of inconsistency that might be avoided.

The first element of the '4P's EDT Assessment Framework' asks the worker to systematically consider the impact that their own person may have on the entire assessment process. Under different headings (a-d) the assessor out of hours is taken through a range of issues that impact upon all assessments and, therefore need to be part of any assessment framework for the EDT worker.

8.4 PERSONAL

(a) Autobiography

EDT workers work in isolation and with greater powers than their daytime counterparts. There are fewer 'checks and measures' out of hours and yet serious decisions and actions

are taken by these workers. EDT social workers, more so than the daytime ones, need to be comfortable and clear about their values, preferences, hopes and fears. There has to be a recognition of their weaknesses as well as their strengths – how do we respond when under intense pressure, what specifics anger us and which ones do we 'warm' to? Our autobiography needs to be examined and we need, with clarity, to be able to recognise what aspects of 'us' impact upon the service user and therefore the assessment. If '*a major factor in determining an emergency was the social worker's perception of pressure*', (BASW, 1984, p.21), then it is imperative when making decisions on EDT we are clear about the level and intensity of pressure we feel under and how that is affecting the decision-making process. What is clear from this research is that the 'busyness' of the shift often determines whether something is a priority or not, what we must acknowledge is that the perception of this is personal. It is ironic, if not unfortunate, that the respondents in Phase 1 all appeared to accept the likely impact of autobiography upon their decision-making processes, but at the same time none of the same respondents indicated ways in which they examine these effects. Put simply, they all agreed that autobiography is crucial, but, in practice did not appear to acknowledge what the implications of subjectivity might actually be.

(b) Values

The way in which we assess a referral and 'define the problem' reflects our own values and informs the action that follows. Particularly on EDT we are faced with crises, high tension and high risks that, if they cannot wait until the next day (and within that there are complex factors at play), need to be resolved urgently and involve potential harm to vulnerable members of the community (including the worker). On EDT it is invariably a person who becomes the 'target for change'. The inadequate state systems that create poverty and class divisions, material and social deprivation rarely feature in the assessment of the EDT worker, indeed no recognition is given to the potential oppression by the assessor of the

already oppressed 'service user' (usually, in EDT terms this expression is inappropriate anyway and, maybe more properly, should be entitled 'service victim'

The absence of any reference to social factors such as these is all the more ironic when it is considered that many of the respondents in Phases 1 and 2 indicated in interview their strong concern for social justice, but failed to examine issues of poverty, poor housing or income when making assessments of service users. It was also interesting to note that gender was identified by the respondents as 'clearly' and 'obviously' an issue for the assessor and the assessed, but in practice it rarely appeared as an issue (see 3.7 and 7.4).

EDT more than its daytime counterparts takes individuals with individual problems and seeks to resolve by means of individual-focussed action. This reflects a personal value system that pathologises the 'victim' further and sees them or the EDT worker as the resolution of the problem. There should more to EDT social work than simply conforming to, and fitting in with, the organisation and the wider environment. The ability to show a certain independence of thinking is what makes the EDT worker 'professional'. Social work generally and EDT specifically, has a rich store of knowledge, activity and debate accumulated over the past thirty years. EDT social work should draw on this rich heritage and challenge the increasingly conservative environment within which it operates. It is however acknowledged, paradoxically, that this position of arguing the importance of social context (of both assessor and assessed) is itself a value-based perspective that is not free of major influences. This position, it is argued herein, is linked to social justice and anti-oppressive values that are essential to adequate EDT assessments.

It is possible on EDT to incorporate a social perspective into social work. It asserts that the assessment of the client's 'needs' should not only be driven by the availability of resources but should also be concerned with the reduction of inequality and social injustice. As with 'autobiography' above (see 8.5a), the responses from the EDT workers suggested a deep concern for such themes as social justice, fairness and social inclusion, but, in practice terms did not indicate ways in which such themes could be addressed out of hours.

Unfortunately, in my view, EDT and the social work profession now seem divorced from its roots in social justice and have become more inward-looking and narrowly concerned with its own image and status. All too often the interventions out of hours replicate the inequity that is part of the cause of the 'problems' we seek to remedy. This would require a radical personal and personal-political change to that which presently operates out of office hours. One starting point might be simply to consider, if it is not already considered, when assessing and prioritising, the possible effects of the poverty in which virtually all of those referred to us have to survive. Our own values impinge upon our assessments and the way in which we prioritise. This framework encourages out of hours workers (and any other social welfare workers involved in assessments) to consider a more 'social' perspective when assessing and also suggests that EDT workers need to consciously scrutinise the impact their values may have on referral outcomes.

(c) 'Attitude'

Another aspect to the 'personal' element is the need to consider the value we ascribe to service users views. The Working Together document offers several helpful 'tips' when working in child protection by referencing research findings. These also illustrate further the impact of autobiography on our assessments:

> *Not enough weight is given to information from family, friends and neighbours.*
>
> *Not enough attention is paid to what children say, how they look and how they behave*
>
> *Attention is focused on the most visible or pressing problems and other warning signs are not appreciated*

Pressures from high status referrers or the press, with fears that a child may die, lead to over-precipitate action

Professionals think that when they have explained something as clearly as they can, the other person will have understood it

Assumptions and pre-judgements about families lead to observations being ignored or misinterpreted.

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

When the initial inquiry shows that the child is not at risk of significant harm, families are seldom referred to other services which they need to prevent longer term problems

When faced with an aggressive or frightening family, professionals are reluctant to discuss fears for their own safety and ask for help

Information taken at the initial inquiry is not adequately recorded, facts are not checked and reasons for decisions are not noted. (DoH 1999, p.45).

These statements could stimulate questions of EDT pieces of work that might never really have been considered before such as how do we view information given by families, does it have the same 'status' as that of another agency for example. What were my assumptions about this family and how did I try to gather hard evidence to support this view? Did I try to gather any evidence that refuted this view? If the family was co-operative or unco-operative why might this have been, what other explanations might there be, including the way I presented or things I had said? If I felt at risk what created this and what was being discussed at that time, would I have felt differently with a colleague or the police there, what was actually said and done to create this feeling of fear?

(d) Social Divisions.

This research has demonstrated (see Appendix 19 and 22) that the EDT workers believed that their autobiography and the socialisation process through which they had travelled, in conjunction with their own personal location within the social divisions, combined to have an effect on their social work practice. What were missing were opportunities to reflect upon these issues and the framework within an assessment to evaluate the impact such factors might have.

Recent work in feminist moral theory suggests that: *'the feminine has been defined in terms of its locatedness and connection as opposed to the masculine qualities of abstraction and autonomy'* (Hekman, 1995, p.133). It is evident that such qualities are to be found unevenly distributed amongst EDT workers. It would be crucial for all workers to consider which of these 'qualities' are part of their 'persona' and thus may impinge on their social work practice.

One assessment framework, the 'Critical Auto/Biographical', sets out key sensitising concepts such as 'reflexivity' and 'power', 'interactive social systems', 'social difference' and 'historical location' (Clifford, 1998). Writing in the joint paper (appended to this thesis), Clifford suggests that two are particularly relevant to the EDT experience of autonomous personal judgement:

> *'reflexivity' combined with thorough exploration of 'social difference' are key sensitizing concepts which require the worker to assess themselves (and the reactions of others towards them) in relation to social differences and positions in the process of assessment. The autobiographical template of the worker and their specific circumstances are central elements. The concept of Critical Auto/Biography is based on the significance of both the autobiographical positioning of the worker and their understanding of the biography of the user in relation to the social divisions.* (Clifford and Williams 2002, p211).

Guiding questions that assist the white, male worker towards incorporating such principles into a framework are, for example, how might a woman view this scenario, or would the assessment be different if the assessor were a black, working class single mother on state benefits? However, it would be important, before reflecting on other social division perspectives, to be clear about our own position on such a 'scale'. I have tried in this research to indicate my personal position via the autobiographical diary and 'Value Base' (see Chapter 3). Clifford provides detailed 'practical questions for assessors' throughout Part One (Clifford 1998), and it is not the intention to repeat them here. What is intended is that the '4P's assessment' takes cognisance of such detailed questions but that greater focus is given to the nature of EDT assessments.

In summary therefore, the *'Personal'* aspect of the '4P's' EDT Framework encourages each worker in response to each referral to analyse their own autobiography, values and attitude, acknowledge the impact of their own membership of social divisions, but also that the biography and social location of the service user and the effect of such as poverty should be taken fully into account within any social (EDT) assessment.

8.5 PROCEDURAL

Having established the autobiographical template of the EDT worker (above), the next element of the assessment framework is to consider the *'procedural'* aspects of all assessments. As with the *'Personal'* these are divided into sub-headings (a- c)

Statute

This research has shown, (Chapters 6 and 7) that there were many different views relating to the statutory imperatives that EDT workers believed must be responded to. Some were

very clear that certain referrals required a response because of statute or local procedures (although no specific legislation or procedures were referenced), whereas others indicated that for most referrals there was discretion regarding the type of response, if any that was to be made. The very nature of legislation, Procedures, Guidance and Codes of Practice militate against consistent practice because they are underpinned by an explicit understanding that they require interpretation. The language of law demands that interpretation is used when considering terms such as 'reasonable', 'significant', 'risk', 'harm' and 'assessment'. For most, if not all social workers and EDT workers this will already be known. The knowledge and application of the law however, is different out of hours because we tend only to deal with emergencies that cannot safely be left until the next working day and, therefore need to be very clear when we have a 'duty' to respond, the 'power' to respond, a 'responsibility' to respond or that a response would be 'good practice'. The crucial difference for the EDT worker, (other than all those related to the fewer numbers, genericism and absence of consultation opportunities, especially with colleagues from the legal department), is that knowledge and application of the law will tend to involve service users being left in or removed from 'high risk' situations based on minimal information. Whilst I am not suggesting that this is never the case for daytime workers, there is usually a higher risk for the EDT worker because their high risk decision often has to be made alone and on low levels of information and therefore the risk of getting the decision 'wrong', is greater out of hours than it is for the daytime worker.

One essential item of the out of hours worker's toolbox therefore, is a detailed knowledge of the emergency legislative framework that informs decisions concerning urgent crises. It is imperative that we know when we have duties to respond and when we have the discretion to leave 'safe' matters to the next working day. It is also crucial to acknowledge when a piece of practice is carried out because of a local procedure. Most local authorities, in my experience though, rarely acknowledge the different circumstances of the EDT and will still require for example, that agency checks undertaken during the day are also

applied out of hours. These checks would be with such as the Probation Service, the School Nurse, Education Welfare Officer or the Headteacher, all of which are impossible outside of office hours, but good practice and procedural imperatives during the day.

Knowledge of 'EDT Law' will certainly involve the sections cited below and they will be well known to out of hours workers. The purpose of presenting them here is firstly to bring together in one place some of the more commonly used legal imperatives out of hours, and also to draw attention to the *'personal'* discretion that still exists within such primary legislation.

(i)Child Care/Protection Legislation

Many of the respondents to the scenario involving the 4-year old child with a suspicious fractured leg indicated a belief in a statutory responsibility to follow this referral up with a visit. The following represents some of the legislation that the EDT worker would consider when assessing the necessary out of hours response.

English law contains no duty to report cases of suspected child abuse or neglect. Local authorities are under a legal duty however to conduct inquiries when receiving such concerns:

Children Act 1989 s47(1):

> *'Where a local authority –*
>
> *are informed that a child who lives, or is found in their area –*
>
> *is the subject of an emergency protection order; or*
>
> *(ii) is in police protection; or*
>
> *have reasonable cause to suspect that a child who lives, or is found in their area is*
>
> *suffering, or is likely to suffer, significant harm,*

the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard the child's welfare.'

The discretion that is afforded all social workers, particularly EDT workers, is exemplified in the latter section of section 47(1)(b) '...*the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard the child's welfare.*' In the case of EDT, '*the authority*' is the (often lone) EDT worker and it is '*they*' who decide what is '*necessary*' and what action may '*safeguard*' that child. Whilst the local child protection procedures may specifically define who can take such decisions (e.g. Team Managers) and may be more prescriptive, the primary legislation clearly expects a 'professional' assessment to be made and action that is relevant to the outcome of that process. In part, this explains why there were such discrepancies between the respondents' reactions to the child protection scenario. The law is unclear, as it cannot decide for the practitioner, it can only set out a legal framework. Notwithstanding the detail of the local procedures, this primary legislation could lead a worker to visit the hospital, or not, depending on how the detail of this legislation and the procedures are interpreted by the individual worker. As has been shown in Chapter 7, the responses were split between believing there was a statutory responsibility to visit, and those who believed there was no need to visit at all after having made the necessary inquiries and established that the welfare of the child was safeguarded.

The latter part of section 47 of the Children Act 1989 is specifically relevant to EDT workers who will rely on those fewer agencies outside of office hours who may have crucial information regarding a child protection referral. This part of the Act attempts to promote the interagency co-operation which was a central feature both of the Jasmine Beckford (DHSS, 1985a) and Butler-Sloss (DoH, 1987) reports and, more recently was

prominent in the recommendations of the Victoria Climbie Inquiry, (DoH 2003). The former reports argued that there were powerful reasons why the duty on local authorities to co-operate under section 22 of the National Health Service Act 1977 should be more specific in the context of child abuse. This was accepted and is reflected in the following: Where there is reasonable cause to suspect that a child may be suffering, or is at risk of suffering significant harm, section 47(9)(10)(11) places a duty on:

any local authority

any local education authority

any housing authority

any health authority, special health authority, National Health Service Trust or Primary Care Trust; and

any person authorised by the Secretary of Sate,

to help a local authority with its enquiries.

In addition the police have a duty and a responsibility to investigate criminal offences committed against children.

In other words what this means is that the EDT workers' access to relevant information cannot be limited by other agencies' refusal to share. Given the limited availability of relevant information that we often have to base our prioritisation and assessments on, this statutory imperative becomes all the more important out of hours.

Police Protection Powers (PPO)

In my experience of out of hours child protection referrals, EDT will almost always seek a PPO rather than an EPO (see below) when the safeguarding or the removal of a child is required. The reasons for this centre around the expediency and urgency of such an order being necessary that precludes any approach to a court or a magistrate out of hours. Put simply, if there is sufficient time to put the matter before a court, then it is questionable how much of an emergency it is and whether it could not wait until the next working day.

For example, in the scenario (c) of the child in hospital, many responses outlined the discussions with the police that would take place and the possibility of a PPO should the parents attempt to remove the child. No mention was made of the possibility of applying for an EPO. It could though be argued that elements of the *'Personal'* (see above) meant that some EDT workers were opposed to such *'ex parte'* processes that completely exclude the parents (and for that matter, the child) preferring to adopt the lesser of the two evils and opting for an EPO that allows, albeit at a later date, participation in an otherwise exclusive legal process. The practical aspects of the immediate safety of the child could be addressed by the hospital security or the police being asked to attend. The point being made is that PPO's have almost become the 'norm' out of hours, and I would argue that there must be times when application to a magistrate or a court is possible and, as happens during the day, more appropriate. The legislation though for such emergency action exists as follows:

Under Section 46 of the Children Act 1989,

> *where a police officer has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, s/he may:*
>
> *remove the child to suitable accommodation and keep him or her there; or*
>
> *take reasonable steps to ensure that the child's removal from any hospital, or other place in which the child is then being accommodated is prevented.*

No child may be kept in police protection for more than 72 hours.

Emergency Protection Orders (EPO)

The court may make an emergency protection order under sec. 44 of the Children Act *1989*

> *if it is satisfied that there are reasonable cause to believe that a child is likely to suffer significant harm if:*
>
> *he is not removed to accommodation; or*

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he does not remain in the place in which he is then being accommodated.

An emergency protection order may also be made if sec. 47 enquiries are being frustrated by access to the child being unreasonably refused access to a person authorised to seek access, and the applicant has reasonable cause to believe that access is needed as a matter of urgency.

An emergency protection order gives authority to remove a child, and places the child under the protection of the applicant for a maximum of eight days (with a possible extension of up to seven days).

Local Child Protection Procedures may lead workers to different paths after hours as opposed to during the day. Different local authorities will interpret 'strategy discussion' (see below) with the police differently; very few of the EDT responses indicated that they would set up such a formal discussion, believing this would take place, and be the remit of the daytime worker. However, the Guidance is fairly clear, although, once again, there is much scope for interpretation:

'Planned emergency action will normally take place following an immediate strategy discussion between police, social services and other agencies as appropriate. Where a single agency has to act immediately to protect a child, a strategy discussion should take place as soon as possible after such action to plan next steps. Legal advice should normally be obtained before initiating legal action, in particular when an Emergency Protection Order is to be sought.' (DoH Working Together, 5.24, 1999).

It is interesting to note that the guidance expects a 'strategy discussion' to occur and also assumes access to legal advice before initiating such emergency powers. Whilst this part of the guidance will not create out of hours access to local authority lawyers (as there is the

caveat of *Legal advice should normally be obtained..)* it should make EDT workers more aware of their need to liaise with other agencies when they are the 'single agency' that has to act to safeguard a child, and make agencies such as the police similarly liaise with EDT when they are the single agency that acts to protect the child.

In terms of child protection work (the majority of EDT work – see Chapter 5) therefore, I am only proposing that we take a 'fresh' look at our practice, questioning the almost automatic PPO assumption for example and develop our working practice around areas such as neglect and emotional abuse (see discussion Chapter 7) as well as the type of interagency discussions that take place after hours.

Whilst some of the referrals from the scenario exercise were diverted to other agencies, the child protection matter was seen by all as the responsibility of EDT. The same was not the case for the role of the Appropriate Adult in scenario (a) the PACE interview. The relevant legislation is included for those EDT workers that do undertake such duties:

(ii) PACE (Police and Criminal Evidence Act 1984)

For EDT workers that carry out, or advise upon, PACE interviews, the Code of Practice (HMSO 2000) has many of the significant sections that should assist the worker when deciding whether to respond to a request to attend a police station for such an interview.

> *All persons in custody must be dealt with expeditiously, and released as soon as the need for detention has ceased to apply.*
>
> *1.1A A custody officer is required to perform the functions specified in this code as soon as is practicable. A custody officer shall not be in breach of this code in the event of delay provided that the delay is justifiable and that every reasonable step is taken to prevent unnecessary delay. The custody record shall indicate where a delay has occurred and the reason why. [See Note 1H]*

(1H Paragraph 1.1A is intended to cover the kinds of delays which may occur in the processing of detained persons because of, for example, a large number of suspects are brought into the police station simultaneously to be placed in custody, or interview rooms are all being used, or where there are difficulties in contacting an appropriate adult, solicitor or interpreter.

In terms of EDT undertaking the 'statutory' role of the Appropriate Adult, the realities of the out of hours pressures and priorities are reflected. In essence this Code of Practice expects detained 'juveniles' to be dealt with as quickly as possible, but accepts that, for a variety of reasons, this may not always be possible. The Code defines 'Appropriate Adult' (Section 1.7 of Code C) for a juvenile in three categories: Parent or guardian, social worker or, failing either of these, another *'responsible adult'* (1.7(a)(i-iii). For the busy EDT worker there is legislative acceptance that they might not always be immediately available. In some cases, EDT may be specifically excluded from acting as the Appropriate Adult:

'If a juvenile admits an offence to or in the presence of a social worker other than during the time that the social worker is acting as the appropriate adult for that juvenile, another social worker should be the appropriate adult in the interest of fairness' (1D p.33).

It should also be noted that, unless there are very specific and urgent circumstances (C 11.1(a-b) a juvenile *'must not be interviewed or asked to provide or sign a written statement in the absence of the appropriate adult'* (C 11.14).

The role of the Appropriate Adult is to 'advise the person being questioned and to observe whether or not the interview is being conducted properly and fairly, and secondly, to facilitate communication with the person being interviewed.'(11.16).

Specific mention is made in the Code of Practice to night-time provisions:

'In any period of 24 hours a detained person must be allowed a continuous period

of at least 8 hours for rest, free from questioning, travel or any other interruption

by police officers in connection with the investigation concerned. This period

should normally be at night. The period of rest may not be interrupted or delayed,

except at the request of the person, his appropriate adult or his legal

representative...'(12.2).

Finally the issue of consent for EDT workers (who often act with the devolved authority of

the Director of Social Services) is sometimes misunderstood (more so in my experience by

custody sergeants than EDT workers). The Code of Practice for the Identification of

Persons by Police Officers (Code D), I believe is fairly clear:

In the case of any procedure requiring a person's consent, the consent of a person

who is mentally disordered or mentally handicapped is only valid if given in the

presence of the appropriate adult; and in the case of a juvenile the consent of his

parent or guardian is required as well as his own (unless he is under 14, in which

case the consent of his parent or guardian is sufficient in its own right). [See Note

1E]

(1E For the purposes of paragraph 1.11 above, the consent required to be given by

a parent or guardian may be given, in the case of a juvenile in the care of a local

authority or voluntary organization, by that authority or organisation.)

The way that I read this section of the Code of Practice is that, despite some custody

officers' protestations, EDT workers cannot consent to such as fingerprinting for detained

young people unless they are 'Looked After' by the employing authority of the out of

hours worker. If the young person has no connection to the social services department the EDT worker cannot give consent, that responsibility falls to the parent or guardian, not the EDT worker acting as appropriate adult.

The responses to scenario (a) demonstrated that many out of hours teams have alternative Appropriate Adult schemes that deal with all or most of police requests under PACE. The legislative base upon which the response is made, or not, once again is not overly prescriptive and acknowledges some practical realities of competing priorities. The task of the EDT worker may well be to work within such frameworks, but, at times, it will also be to refuse to operate within such constraints. In both cases, a working knowledge of the legislative base is crucial as this combines with some of the 'personal' aspects described above.

(iii) Mental Health Act and Related Codes and Guidance.

In both Phases of the research, the mental health scenario received almost consistent 'statutory status' from the respondents. This has already been discussed in some detail in Chapter 7 and specific references to the relevant legislation made. It would be incomplete however if no mention was made of Section 4 of the Mental health Act 1983 which seeks to specifically provide for 'emergency' psychiatric incidents:

In any case of urgent necessity, an application for admission for assessment may be made in respect of a patient in accordance with following provisions of this section, and any application so made is in this Act referred to as "an emergency application". (4.1).

The Act then goes on to explain the process and the duration (up to 72 hours) of the section. It is however, the Code of Practice that seeks to clarify what constitutes an emergency and what conditions need to exist before such an application can lawfully be made. Given that section 4 only requires one medical recommendation and an applicant (ASW or Nearest Relative) in contrast to the other more common sections (2 and 3) that

require two medical recommendations and an applicant, the code of practice advises that the referral must be of such urgent necessity that there is insufficient time to get a second medical recommendation (6.1b). Specifically though, the Code says:

> *An emergency arises where those involved cannot cope with the mental state or*
>
> *behaviour of the patient. To be satisfied that an emergency has arisen, there must*
>
> *be evidence of:*
>
> *An immediate and significant risk of mental or physical harm to the patient or to*
>
> *others: and/or*
>
> *The danger of serious harm to property; and/or*
>
> *The need for physical restraint of the patient (6.3)*

Once again, it can be seen that the use of terms such as 'significant' and 'harm' are not unequivocal absolutes, but relative terms that require interpretation. Of particular interest to EDT workers is 6.4 of the Code that prevents, or more reasonably seeks to prevent, patients being admitted under section 4 merely to suit the convenience of the doctor already at the hospital who prefers not to assess in the community. EDT workers will recognise the irony of the Code's assertion that *'Those assessing an individual's need must be able to secure the attendance within a reasonable time of a second doctor and in particular an approved doctor.'*(6.4).

The scenario within the research questionnaire has two medics attending the home at the same time, but more often than not there are significant difficulties in obtaining a second medial recommendation, let alone one provided by an 'approved' 'Section 12 Doctor'. In some respects, it is arguable that most of the applications under the Mental Health Act (1983) that EDT deal with, probably fit the criteria for a section 4, probably involve major difficulties in managing the risk and almost always involve delays getting a second medical recommendation, and yet the numbers of Section 4 applications remains negligible

(in 12 years I have completed one and some of my colleagues have never completed one). Several professional bodies have expressed concerns regarding the use of Section 4 applications (MIND, BASW and Rethink), and the Code of Practice itself makes it the duty of the hospital managers to monitor the use of section 4 making them responsible for the provision of doctors being available '*to visit a patient within a reasonable time after being so requested*'. The minimal usage of this section may indicate that there is no problem with the availability of second doctors and thus no requirement to use section 4; it may also indicate that psychiatric 'emergencies' are being managed during the day and out of hours. It could also indicate that the urgency and severity of the risk of such emergencies is being 'diluted' or interpreted by practitioners prepared to take and manage 'risks'. There does though appear to be an irony in that EDT deal with urgent emergencies and yet do not use the legislation that is specifically designed to cope with such emergencies.

The pieces of legislation and guidance referred to above do not represent the entire body of legal knowledge required of out of hours practitioners. There are several other aspects of the law that EDT workers use such as The NHS, Community Care Act 1990 and such as the Adult Protection Procedures (often called 'elder abuse'), and The National Assistance Act 1948, but this section intended to highlight the major legislative basis of social work practice 'after hours'.

In summary therefore, in terms of the 'procedural' aspect of an EDT workers' assessment and prioritisation of a referral, it can be seen that EDT workers need specific knowledge about generic pieces of legislation and not generic knowledge of generic legislation. The worker's interpretation (through the 'personal' filter) of this legislative framework will contribute to the decisions taken regarding that referral.

(b) Emergency Service or Extension of Daytime Team

Another contributory factor that this research has highlighted as impacting upon this decision-making process, is the worker's perception of the role that EDT is expected to undertake. Responses to the interviews in Phase 1 and the questionnaires in Phase 2 indicated that the workers had differing understandings of the type of service their 'team' was expected to provide outside of 'normal' office hours. It was suggested that whilst they were an emergency only service, some would undertake referrals if the shift was quiet that ordinarily would never be responded to as a priority. The converse was also true in that on very busy shifts referrals that might usually receive a priority may 'fall off the list' if other higher priorities came in. It is likely that such a 'flexible' interpretation of the role of the 'team', whilst helpful to the service user on a quiet shift is confusing to the same service user on a busy shift. The differing types of responses may lead to inconsistencies that could be reduced with a clearer team and individual application of an EDT job description. It is not suggested here that that description necessarily should mean a tightening of the access to a service out of hours, only that whichever 'type' of provision the departments intend to provide, it needs to be as clear as possible about what it can and cannot respond to whether the shift is busy or not. As the worker tries to decide what, if anything should be done in response to a referral, the purpose and scope of EDT should be very clear in their mind.

Put simply, presently inconsistent responses are, in part due to inconsistent understandings of what EDT is meant to do. As an extension of daytime services it will mean workers having to say 'yes' to far more referrals and thus having to make more decisions involving priorities; as an emergency only service the EDT workers will have to say 'no' to more referrers (daytime staff, other agencies and the public). Whichever service is adopted the worker must be clear about their roles and responsibilities in terms of the procedures they are expected to apply and those they are not.

Whilst many EDT's have a 'Statement of Purpose', I believe further discussion needs to take place amongst teams to establish a more consistent application of such 'Statements', this should lead to a more consistent out of hours response.

(c) Obligations and Protocols

Other aspects of the EDT process that were researched concern the 'unwritten rules' about the responses by workers to agencies rather than service users. Some of the feedback suggested that part of the prioritisation process included recognition of wanting either to keep 'good' professional relationships with such as the police and the out of hours G.P. as there would be mutual benefits from positive interactions, or it was noted that referrals from these agencies usually meant a greater delay and possibly treatment as less of a priority for fear of those agencies 'abusing' EDT and viewing them as there to merely service their needs. Whichever response was adopted, this made for some degree of inconsistency when individual workers were left to prioritise referrals.

Some authorities are beginning to establish 'Protocols' with some of the agencies who have regular contact with EDT so that both 'sides' can be clear about what, if any type of referral EDT will see as a priority and which it will not. Similarly EDT's within regions are drawing up or have long established 'cross boundary protocols' for pieces of work involving, for example cases where a service user from one local authority appears and needs an urgent service from another local authority. Obligations and Protocols, if given greater clarity, should establish some greater consistency in the way EDT's respond or refuse to respond and an individual EDT worker needs to know what such protocols contain, in order to assess and prioritise fairly and consistently between competing referrals.

The 'Procedural' therefore expects the EDT worker to consider the legislative (statutory) basis of their assessment and be clear which, if any Guidance, Acts or procedures need to

be noted as underpinning the framework to the priority ascribed to that referral. This part of the 4P's framework expects EDT workers to be very clear regarding which type of service they are able to provide and how this might be informed by jointly written and agreed protocols. Reference to these aspects should enable the worker to both justify their assessment and prioritisation process and achieve greater consistency within their own individual referral responses and with their colleagues' responses. The combination of these 'procedural' factors should lead to a more consistent and theoretically informed response out of hours by EDT workers.

8.6 POLITICAL

The third part of the 4P's Assessment Framework for EDT workers to consider is the *'Political'*. The term for EDT workers to consider within this assessment framework seeks to embrace this range of definitions of 'political' combining that which is 'prudent' with that which is 'advisable' and seeking to make more consistent the 'affairs' of EDT, with the 'principles' that underpin its work and decision-making processes. The definition of *'political'* of this framework therefore, seeks to re-locate EDT assessments within a context they respondents believed was crucial. This definition tries to contextualise the 'micro' within the 'macro', the 'individual' within the 'institutional' and the 'personal' within the 'political' without losing sight of the actual work that EDT are expected to carry out. The *'Personal'* aspects of this assessment framework have already identified a need to adopt a more social assessment perspective on EDT and highlighted the impact of social injustice and poverty on service users as well as the personal value base from which EDT workers operate. This element of the 4P's Framework identifies other aspects that warrant consideration when decisions are being made by EDT workers outside of office hours, but may also have relevance to daytime social workers.

(a) Risk Taking v Risk Management

The Literature Review (Chapter 2) presents in some detail the EDT context of the dilemmas between risk taking and risk management. Inevitably individual decisions taken outside of office hours regarding 'risk' are the result of a number of complex factors that are detailed throughout this research. This part of the 4P framework seeks to ensure that the EDT worker reflects upon the contemporary pressure that may drive that worker towards risk taking or towards risk management. Such pressure may be from within the specific team, department, local authority or more public, media pressure that tends to evolve in tandem with high profile tragedies (see Chapter 2). Such pressure may be actual or perceived, written or unwritten, spoken or unspoken, internal or external, but time taken to clarify the reality, type and intensity of such pressure may impact upon the EDT worker's decision-making process, and should assist the rationale for their subsequent actions. This, it is argued here, should also lead to a greater degree of consistency in the process for decision-making and prioritisation by (especially lone) EDT workers.

The *'Political'* aspects of this part of the framework are underpinned, in part, by the *'Personal'* in that the worker's own status, perceived or actual, (manager, senior practitioner, very experienced, confident), values, attitude, knowledge of relevant research, the legislation and risk assessment models 'allows' her/him to make a decision regarding a complex referral knowing and being able to tolerate the potential ramifications of the decision should things go wrong. This 'personal' confidence should also be informed by that worker feeling that her/his definition of 'risk taking and risk management are shared and supported by colleagues within that team. This is not to dissolve all aspects of individuality from EDT social work practice, but to try to promote a more uniform, consistent and justifiable response to competing priorities that is contextualised by broader boundaries of the concept of 'risk'. Part of this process involves taking a different view of

the very nature of EDT work and its functions and seeking to locate its practice within a 'political' context as explained below.

EDT Politics.

It has already been argued above that social workers and EDT workers should adopt a more social assessment framework that seeks to locate the difficulties experienced by families as being, in part at least, the responsibility of policies rather than personalities. The 'New Right' drive towards pathologising the 'victims', that continues under the current political administration, needs to be resisted and reinterpreted. One way for EDT workers to review the way in which they see their role and the process of assessment and prioritisation may be to re-establish the language of social justice and, with colleagues explore ways in which they can adopt a different definition of what constitutes (emergency) social work. One such definition might be that put forward by the International Federation of Social Work:

'The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.' (IFSW, 1997 4.4).

As with the legislation and procedures referred to above, such a definition requires interpretation and application. For EDT workers who tend to view their work as being the minimal intervention necessary to make safe until the next working day, this definition makes us more responsible for at least attempting to contextualise referrals and their priorities from a 'political' perspective. It is certainly not suggested here that EDT workers

begin to ignore the personal symptoms of structural causes and leave individual service users and families at greater risk of harm to themselves and others. I am arguing though, that more consideration be given to assessments out of hours on the impact of more political/structural aspects of society that impact upon those families that come to EDT's attention.

Poverty for example, is not just about income but also relates to the quality of life and the home and the community environment. When Alvin Schorr, an American sociologist was asked to provide an outsider's view of personal social services in Britain he wrote, *'The most striking characteristic that clients of the personal services have in common are poverty and deprivation'* (Schorr, 1992, p.8). The research evidence is compelling. In the mid-1980's Becker and MacPherson (1988) discovered that 9 out of 10 service users were dependent on state benefits. The government's own research on children coming into care noted that one in ten of children aged between 5 and 9 years in families were dependent on state benefits were admitted to care, compared with 1 in 7,000 for children in the same age group living in families not on income support, (DoH, 1991). Whatever the category of service user, poverty remains a central issue. The causes of poverty though, are not seen as something that social services can, or should do anything about, and yet the links between poverty and health problems are well known. Poverty and illness together make people much more vulnerable and needy at all stages of their lives. These are all facets that are likely to be encountered on EDT, but presently feature little in our assessments. The government, local authorities and emergency duty teams assume that social workers can deal with the impact of poverty without tackling the underlying causes. In reality, social workers during the day and at night can do nothing about raising household incomes, improving housing or transforming the community environment. Social workers must therefore resist the notion that poverty can be tackled by apolitical social work solutions. Part of this resistance is to introduce into our process of assessments the recognition and recording of such structural inequities.

Social workers have an enormously difficult task. Social services departments have now abandoned any pretence of open-door, community-based services to individuals and families (Holman, 1988 and Stones and Singleton, 1994). The resources of local government are so very tightly controlled, that only those with the greatest needs, or those assessed as being at greatest risk by such as EDT workers, receive services.

Dealing with the impact of poverty and structural inequality is central to the social work role. Social workers must recognise the effects of widening inequality over the past twenty years and challenge this trend. Unless social workers use their powers creatively to bring about practical improvements in the lives of service users they cannot claim to be any more than gatekeepers of resources, or social police officers. In some deprived communities, the trend emerging is one in which social work is already seen as a form of oppression against the poor.

In many respects, EDT workers are better placed than daytime colleagues to begin to challenge this trend because of their increased autonomy, greater access to resources including, for many EDT workers, access to monies and supportive rather than restrictive services, as well as their focus that is to 'make safe' until the next working day. EDT workers act as the decision-makers for the Social Services Departments across the country for the majority of the day/week/year. They are therefore in a better position to redefine the social work provision than daytime social workers. EDT workers with 'EDT Politics', could re-introduce a focus into assessments and priority decision-making that has been missing for many years and contribute to a different, fairer and more consistent response to service users in crisis.

8.7 PRACTICAL.

The 4P's Assessment Framework so far has sought to add elements to EDT workers' sources and types of information when trying to make decisions regarding priorities. I have not meant necessarily to replace the current out of hours practice with a completely new

framework, only to introduce a more systematic and generic one where none existed before. The fourth 'P' acknowledges what this research highlights, namely that much of what is done 'after hours' is often based on the realities of what is *'Practical'*. In other words, a vital component to the EDT workers referral assessment and decision concerning what is or is not a priority is based on 'practicalities, practical experience and a range of other complex factors some of which have been identified in this research (see Chapters 6 and 7).

The *'Practical'* elements of the 4P's Assessment Framework contain the range of factors that inform the EDT's decision-making processes that have been developed over the many years that the majority of workers have been undertaking out of hours social work. Some have referred to this as EDT 'common-sense', or EDT 'experience' and view it as a crucial part of any prioritisation process.

(a) 'EDT Common Sense'

The *'practical'* could be described as the unconscious theoretical reference point for many EDT workers that dictates responses. In other words, the EDT worker reacts to referrals almost without thinking about references to legislation, values, autobiography or politics and bases practice decisions on 'theories' and 'research' that are internalised, 'tried and tested' means of dealing with crises. What this 4P framework is trying to achieve is that the unconscious is made conscious, externalised and reflected upon as well as recorded as informing EDT decisions. EDT experience is a vital source of 'theory', but too often remains the only reference point and one that is 'hidden'. More importantly, in relation to consistency, this research has demonstrated that 'EDT common sense' may actually be neither 'common' nor 'sense' when it comes to making decisions about priorities.

This part of the 4P framework encourages practitioners to clarify their 'hunches', 'gut reactions' and 'common sense' responses and to provide a rationale for them. This rationale can include a justification that a decision was made because such a response has

worked 'successfully' many times before and achieved 'positive' results (however these are defined). In other words it is important to reference our own experience as part of a theoretical framework, but this cannot stand alone and needs to be supplemented by other connections with the 'personal', the 'procedural' and the 'political'. By cross-referencing EDT decisions to the 4P's it is hoped that a clearer and more consistent account of our decisions can be achieved. The 'practical' does not seek to deny the validity of 'intuition', 'common-sense' or EDT 'practice wisdom', quite the opposite, this framework seeks to promote and bring out of the darkness such knowledge into a forum in which it can be shared, analysed and valued.

(b) 'Practice Wisdom'

'EDT Common Sense' tends to be located within the individual EDT worker or team and develops idiosyncratically. *'EDT Practice Wisdom'* however, whilst having similarities to the above, is a term that explains a collective approach to EDT matters and tens to develop within teams and local authorities rather than solely within the individual EDT worker.

The *'Practical'* includes a large amount of *'practice wisdom'*. Such *wisdom* recognises that EDT workers' prioritisation process includes such imponderables as the time of night, the distance from the office/base of the worker to the service user's location, 'guesstimates' of the period a referral is likely to take, analysis of what the likely outcome of a visit might be, decisions on what is and what is not safe to be left until the next working day (and the difference therefore in referral response between a Tuesday night and a Friday night when the 'next working day' is a longer period). *Practice wisdom* knows about access to other resources that may preclude a need for EDT to visit or prioritise, and is able to focus on the present 'crisis' rather than the historical causes of the problem. In short, one of the skills of being an EDT worker is to be able to resolve difficulties quickly and safely; this entails 'practice wisdom' and a clarity of role and purpose crucial to the out of hours teams. For the majority of EDT workers and teams throughout Britain, this

practice wisdom is not written down anywhere, does not form part of any procedures or protocols, usually goes unchallenged (consistent with much EDT practice) but is a fundamental guide to much that directs referrals and decisions regarding priorities outside of office hours. As with *'EDT common sense'*, *'Practice wisdom'* needs to be promoted rather than denied or disguised. Such 'wisdom' is the result of many years of undertaking complex assessments in difficult circumstances and, often alone. Such a rich source of knowledge needs to be shared initially with other EDT workers and then with daytime workers responsible for 'crisis' and risk assessments. This source of 'wisdom' is likely to be a most appropriate reference point for EDT workers to justify their practice. The 4P's framework does not seek to erode the influence of such as 'common sense' and 'practice wisdom' but to promote its validity, as a source of practice justification, and to contextualise the nature of such 'knowledge'.

Such knowledge needs to be set against other types of 'data' that inform the out of hours social worker. Such data tends to have the attraction to some of being academically verifiable, usually carried out by either government departments or reputable researchers from various universities, and always intended to influence the practice of face-to-face workers. Some examples of this type of data are included in the following section, 'practical research'.

(c) 'Practical Research'.

There are a growing number of 'risk assessment' tools now available to social workers (for a detailed discussion see Chapter 2). Such tools are a supplement to, not a substitute for, good practice. They represent different approaches that seek to apply degrees of consistency to activities such as assessment and prioritisation of information. As has been shown throughout this research, assessment and priorities are the 'bread and butter' of EDT work. *'Practical research'* examines the nature of such models and such research and seeks to make it EDT relevant. Part of this process means that EDT workers adopting this

'4P' framework will begin more explicitly to adopt some of the assessment models that have been developed. It also means that EDT workers will need to be informed by up-to-date 'practical research' rather than relying on out of date 'anecdotes' and 'common-sense'. In other words, what informs social work practice out of hours should be current theory and recent research.

For example, in terms of seeking to identify risks and hazards 'Practical Research' based on studies undertaken into violence at work show that it is possible to establish that some risk to the EDT worker may exist by considering the nature of the visit. If the worker is visiting to remove a person against their wishes, or the wishes of others who may be present, or refuse (or reduce) a service, including the service of removing the person that most of those in the house wish to be moved, then the presence of risk of harm to the worker will be high. Without wishing to over-simplify matters, there are less risk factors involved for me when, for example, taking electricity cards or money to a receptive family with no lighting or food, than if I would be assessing under the Mental Health Act somebody like *MrA*. Previous history of violence and the severity of its type as well as the target should all form part of the EDT worker's assessment before visiting if possible (if such information is available, and the absence of such information suggests caution).
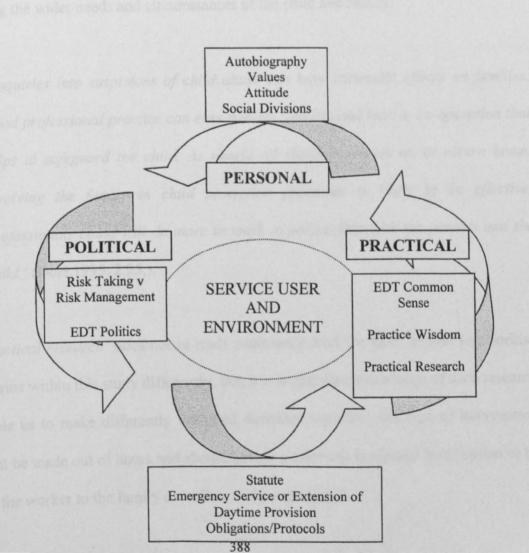
Certain risk factors and hazards may be identified before an EDT worker visits any service user's home. In the case of Mr A, I was able to establish before visiting, via our computerised records that there was no previous record of mental ill-health within the family or any violence to himself, other family members or professional staff. I had also been able to establish, via the referrer, that the wrist injuries he had caused were not life-threatening and had been done with a relatively high chance of being seen by people (i.e. in the house in front of his children and the other relatives). I had also been able to determine, before visiting, that the large amount of alcohol consumed (one and a half bottles of brandy) firstly, had been taken before the self harm and secondly had had the effect of lowering Mr A's mood considerably. Thus, as part of the prioritisation process and before I

even left the office, I had begun identifying risk factors and possible hazards regarding the request to attend this house, as well as identifying relevant information regarding Mr.A's 'pre-morbid personality'.

These steps will be well-known to most EDT workers and the 4P framework does not pretend to produce novel practice approaches out of hours, only to try to make the processes more transparent and consistent. Similarly, the 4P framework does not intend that by adopting such a system all EDT workers will necessarily come to the same conclusion regarding appropriate responses for Mr.A. The chart of the 4P's EDT Assessment Framework with the complete details included is presented below. A framework of questions is provided in Appendix 16 and one way in which the 4P Model might be applied to MrA is detailed below.

Diagram 1: 4P's EDT ASSESSMENT FRAMEWORK

The responses to the different scenarios examined in this study demonstrate the various responses and differing priorities that would be ascribed to those referrals. Each EDT respondent gives their own rationale for their ordering of the referrals and, in a sense, is providing a 'practical research' justification for the order in which matters would or would not be dealt with. However, what this study has also shown is that the 'practical research-' base of the EDT respondents does not appear to be informed by recent research: Where, for example, there is an injury to a child, the respondents seem to agree that there is a focus for their assessment and action. Governmental studies have been critical of an over concentration by social workers on an injury without assessing other facets of the family situation:

Messages from Research (DoH 1995), which summarises the key findings from 20 research studies into child protection, suggests that too often, enquiries were too narrowly conducted as investigations into whether abuse or neglect had occurred, without considering the wider needs and circumstances of the child and family.

'Enquiries into suspicions of child abuse can have traumatic effects on families. Good professional practice can ease parents' anxiety and lead to co-operation that helps to safeguard the child. As nearly all children remain at, or return home, involving the family in child protection processes is likely to be effective. Professionals could still do more to work in partnership with the parents and the child.' (DoH 1995. 2.25,).

Such *'practical research'* does not in itself necessarily lead the EDT worker to prioritise the scenarios within this study differently, but, it is hoped that, knowledge of such research will enable us to make differently informed decisions regarding the type of intervention that might be made out of hours and should enable a clear and consistent justification to be made by the worker to the family as well as to the department.

The 'Practical research' referenced above dates from 1995 and is therefore already several years 'out-of-date'. This PhD study commenced six years ago and, it is hoped, provides a more contemporary reference point for EDT workers. Put simply, this study is intended to provide contemporary 'Practical Research' for EDT workers as it is based on the first hand experiences of those people who are also the subject of this research.

8.8 The 4P's Assessment Framework and MrA.

The following is an extract from the detailed 4P Assessment Framework as applied to MrA. Several questions were posed in each of the four sections (for full version see Appendix 18), but only two are presented below in order to provide an example of how the framework operates.

One premise of this framework is that EDT workers might not all reach the same conclusions but that the questions we ask need to be more consistent. As with the framework, the issues to be raised are divided into the four areas: Personal, Procedural, Political and Practical. It should be noted that these areas do not necessarily have to be taken in the order set out below, as any combination should ensure a similar outcome.

PERSONAL

1. *What feelings exist for me and other people that will be at the house?*

I detest being told what to do and react frostily to the doctor's assumption that I will 'form fill and section' based on his recommendation. (I am also fully aware that unless a Section 4 is being suggested, a second medical recommendation will be required – this increases my frustration because I know what a nightmare it can be contacting Section 12 Doctors, let alone getting them to come out! At the same time though I am reminded that my working knowledge of Mental Health Law outstrips many of the visiting doctors that I

meet on duty). I accept the power that my role gives me but also see this in terms of knowledge and social insight.

How will the family be feeling and what will they be expecting to happen? I am aware how frightened the family is because for them they have not witnessed mental disorder before, least of all amongst their own family. The concerns they have are likely to be based on ill-informed stereotypes of such as 'One flew over the cuckoo's nest' and too much reactionary, right wing press coverage of, for example personality disorder and schizophrenia. At the same time though I recognise their distress at the father's presentation and their firm belief, supported by the high status-carrying doctor, that the best place for MrA is in hospital. I suspect they will simply expect me to arrive and take MrA to hospital because that is what the doctor will have led them to believe. How will I manage the situation, how will I sensitively alter their agenda if this is necessary.

2. *How do I assess the impact of social divisions?* This family live in poverty, they do not have a main wage earner and state benefits, council housing and child benefit provide the welfare safety net. To compound a difficult situation the family have evidently experienced much trauma recently and, by the very fact that 'sectioning' has been suggested stand to experience further trauma of loss and separation if MrA is removed. Throughout the interview I can hear myself thinking 'short term pain, long term gain' and thinking that the immediate pain would be to the majority of the people left in that house if MrA remains, whereas the long term gain would be for Mr A and the family too if they could be supported through this crisis, plus it might dispel some of the myths about mental illness as well as the roles of doctors and social workers.

PROCEDURAL.

1. *What policies, procedures, pieces of legislation, protocols or (unwritten) obligations could I reference so that I am clear about the way I am going to respond?* I feel generally confident about my working knowledge of the relevant legislation and recognise that I could have delayed my visit until a second medical recommendation had been completed before I even visited MrA. However, based on the details gathered over the phone (and a suspicion that the level of tension in the house was itself counterproductive, especially if MrA was to remain there) I decided to visit.

2. There is almost an 'unwritten rule' in this EDT that we try to avoid completing Section 3 and section 4 applications whenever possible, even though this might mean actually visiting and completing an assessment, the assessment may be more focused on whether the situation will hold until the next working day when the question of whether to make an application can be made by those who know the person and the situation better than the EDT worker. Many EDT workers will have been in the position of having to attend to assess somebody like MrA when neither of the two doctors know the 'patient' and the EDT worker has no prior knowledge of him either; in these circumstances there is (again unwritten) a protocol of 'making safe' and passing to the daytime worker who does know the family. Where the family are not known to social services or the psychiatric services, I would be more prepared to make an application for hospital admission (for a section 2) as, to pass the matter to the daytime would simply be delaying the referral to be dealt with by a daytime colleague who similarly had no prior knowledge of the family and their circumstances.

POLITICAL.

1. *I am aware of the different ways in which men and women are treated by the psychiatric systems, and also recognise grief reactions to life's crises.* MrA was not a man who would ordinarily talk about his feelings openly to anyone, let alone a complete stranger who had some control over his psychiatric destiny. I suspected that the combination of traumas, confused perceptions of being a 'good' father, son, husband and brother, an intense love for his wife that he never explained to her when she was alive, and a large amount of alcohol contextualised his present behaviour. The reaction to him by the family and doctor reflected the view of men that they should not cry, should not need to express such bare emotions, should remain in control and should be able to 'hold it together for the sake of his kids' as one relative put it. In one small scenario I saw the politics of family life, mental health, child protection and expectations on the state that they would intervene to protect all concerned.

2. *What did I see as the cause of the problem?* A combination of patriarchal expectations of men and women, the effects of having to live in poverty and poor housing on state benefits, the impact of the medicalisation of too many social difficulties and the absence of real support networks for some families to turn to without being stigmatised and removed by people in authority with the resultant longer term implications this brings.

PRACTICAL.

1. This for me was a priority because, on the basis of the details given over the phone there were several related hazards including:

   • MrA's health (physical and mental)

- A failure to provide basic needs (for himself and his children)

- Threats of violence (to himself)

- Actual violence (to himself)

- Out of control of self and actions

- Contravening social norms or expectations and

- Large amounts of alcohol involved.

It could also be seen that each of these categories would score fairly high on a scale of mild – very severe. Part of my reason for prioritising this referral for a visit was that ASW's do have responsibilities to assess people in such circumstances, but also it would only be possible to establish any mitigating circumstances by interviewing MrA and family face to face rather than through the filter of the doctor or over the phone. I was also determined to assess the viability of other options by establishing the availability and strength of any support systems that might be able to prevent MrA going to hospital. The immediate risk to MrA's life, (the cuts to his wrists), had already been assessed by the doctor as not life threatening, although, later on the same doctor was also to argue that such cuts were 'severe' and 'significant'.

2. *Emotions are running high, including my own.*

My worst fear is that he will stab me as soon as I enter the house, and I will die a slow and painful death never seeing my family again and being publicly blamed by my employer for breaching the 'violence to Staff policy! I make a cup of coffee and take five minutes with the phone on transfer. I am going through my normal, almost ritualistic, panic feelings that I know will reduce but never disappear making me a better, more cautious and aware social worker for acknowledging my fears than those who deny they exist. I try to work through the expectations and feelings of all the people in the house with MrA before I arrive, I make sure I have all the relevant

paperwork (including section 2 and section 4 papers just in case). My coffee has finished, I check I have everything, then double check (another ritual), take a deep breath and calmly leave the office to drive, slower than usual, to the house. I am now in the practice mode of 'I have handled hundreds of similar difficult situations before, there are other people in the house, I will be safe and I will be thorough and fair'. I make sure I know everybody's name before entering and double check I understand the version of events reported via the referral as this starting point will need to be verified by the various parties.

(For the complete '4P' Assessment Framework of MrA see Appendix 18. For information, MrA never was sectioned and, following two 'successful' psychiatric outpatient appointments, as far as I am aware, has 'survived' without social or psychiatric services ever since).

8.9 Conclusion.

As is demonstrated in the 4P Pro Forma (see Appendix 16) and its application to a 'real' scenario above (Appendix 18), the 4P Assessment Framework is not a tick box tool for decision-making out of hours and neither is it meant to be a step-by-step guide to carrying out an assessment. The 4P Assessment Framework is, what it says it is, a framework. This means that practitioners may apply the boundaries of the 4P's to their current practice to ensure their work is systematic and well referenced. EDT workers, it is hoped, will consider some aspects of the 4P's that maybe rarely feature within their own decision-making processes at present.

This framework is circular and not linear (see diagram 1, p.203 above) in that the assessor can commence at any point of the framework and progress through the 4P's. The sections

are interconnected rather than separate entities and thus can be returned to at various levels of complexity also.

This researcher argues that any EDT worker can take these four categories and apply them in any order to any assessments they have been involved in. If all four categories are examined, reflected upon and recorded as part of the related decision-making processes, I believe this would make our assessments fairer and more consistent. Consistent, that is, with other decisions those individuals have made as well as consistent with decisions other EDT workers from the same and other teams have made, 'consistent', in this context does not necessarily mean 'the same'. The application of this framework does not necessarily mean that EDT workers come to the same outcomes or action plan, but should mean that the same elements of a referral are considered. Whilst the framework seeks to provide a (more) systematic assessment approach to EDT assessments, this does not mean that all the ensuing decisions or outcomes will be the same. To intend this is to deny one fundamental principle of the framework, namely that the autobiographical template of the assessor means that some aspects of all assessments are individual and idiosyncratic. The principle is that to deny this subjective influence is futile and misleading, the skill is to acknowledge the autobiographical impact, reflect, reference and record the process that stems from it.

In the absence of other relevant, generic EDT assessment frameworks, it is hoped that this will be viewed as an attempt to combine the respondents' experiences with those of the researcher to produce a fair and accountable means of making decisions out of hours that incorporates the personal, political, procedural and the practical.

The 4P's Assessment Framework is this researcher's attempt to provide what the respondents say is needed for their practice and it is also developed from their responses throughout this research process. The principle of promoting the 'autobiographical' features at different levels, as I am aware I have built into this framework 'political' elements that some EDT workers may not necessarily agree with or see the relevance of for their work. However the framework is not meant to be prescriptive nor does it seek to

set questions that must be answered for every scenario faced on EDT. Rather this framework proposes areas of questioning for the EDT worker relating to both the general principles of social work assessment, as well as the specifics of child protection and adult risk assessment actions by (EDT) social workers.

The 4P's Assessment Framework, it is argued here, can be adopted by all workers, (daytime or EDT) and could be systematically applied and recorded with references to whatever 'theories' or 'knowledge' sources are used. This framework does not make claims of originality, only that it is the first time such an approach has been brought together for the purposes of EDT workers specifically. The use of such a framework would hopefully 'demythologise' some of the work carried out by EDT and extend as well as share some of the tremendous sources of 'know how' that EDT workers across the country possess. In a different way, it is also hoped that the use of this research and the 4P's Assessment Framework might, to some small extent, contribute to the future of EDT, if indeed it has one.

8.10 The future of EDT

This research has attempted to highlight the 'daytime mentality' of social services' senior managers and policy makers who have adopted an 'out of sight and out of mind' attitude towards the out of hours service. Whether there is a central government thrust towards 24 hour access to services or not, it seems apparent from this study that there are many lessons to be learned from EDT.

At a time when there are frequent reports in the (social work) press of a national shortage of qualified social workers and difficulties retaining the more experienced staff, EDT once again is at loggerheads with the daytime norms. This research has shown that the average length of service for EDT workers is 10 years, and nearly 75% of the sample group in Phases 1 and 2 had over 15 years post qualifying experience. Unlike daytime teams of

social workers, for EDT there were twice as many men as women, but similar to the daytime counterparts was the relative absence of representation from any of the other social division groups, particular when exploring ethnicity and disability. There are lessons, therefore to be learned from EDT regarding the reasons why staff stay as long in service as they do. There may also be policy alterations that could be developed using the generic EDT model of assessment in which the one person takes a disciplined, multi-disciplinary approach to a family from a social model perspective.

This research has highlighted (Chapter 1) the changing nature of EDT work in the social work world, but notes the consistent genericism of its workforce that enables families to be assessed against a broad and, it could be argued a more holistic background, than the single specialist practitioner's approach. On the matter of finances, there are few that could argue against EDT's throughout the country covering the most hours at the least cost. Whilst EDT with its current staff complement can only ever remain an emergency only service, (whilst retaining non-emergency aspirations as this study has shown) it may well be that daytime teams should take a closer look at the EDT model that is very focused, decisive, responsible and yet relatively inexpensive to run (with the majority of EDT's accounting for less than 1% of the department's annual budget, and in many cases even less than this).

It could also be argued that instead of EDT's needing to be altered to fit in with the plans for daytime delivery of social work services, the reverse might actually be better whereby the daytime teams adopt the model of EDT services. This model applied during the day would focus its resources, streamline its decision-making processes and enable service users to get a speedier response to requests. Whilst the need for 'caseworkers' and preventative work will never disappear, this EDT model would be the first point of contact for members of the public, who would receive generic advice and a focused, tailored assessments. It is certainly challenging to suggest that the EDT 'emergency only' approach could become the mantra of the daytime also. The advantage of such an 'emergency' model would be the separation out of the social policing and the social work role that is

inherent within the 'protection' element of EDT presently. Child Protection Teams/Vulnerable Adult Protection teams would be separate from the local authority social work teams.

The future of EDT's in Britain and the out of hours services generally would appear to be at a critical point in their development. What came out of this research were the findings that two main options and two lesser options essentially exist for EDT's.

Option 1: The first option is that they become integrated with the other out of hours services and streamline what they provide with greater emphasis on partnerships, sharing of staff, premises, phone lines and help lines. In this option EDT could well be part of a greatly enhanced (but probably not 24 hour) out of hours service in which the service seeker is assured a seamless service, one point of contact, one telephone call and relevant advice from a qualified person and all irrespective of the day or time of day. The concern of current EDT workers is that there will be a blurring of professional differences, a deterioration of the independent nature of social workers, as well as an erosion of their currently enjoyed conditions of service.

Option 2: This option is, in some ways, equally unattractive for EDT workers as the first one. In this option, the work of EDT continues to be 'carved up' as one worker put it, and 'hived off' to such as Appropriate Adult schemes, out of hours, mental health teams, out of hours home support schemes or family support schemes and a range of out of hours 'outreach' teams. Each of these schemes may well have its own co-ordinator contactable throughout the duration of the shift and accountable to their own line management hierarchy. Option two may see EDT workers realising their worst nightmare and being returned to some form of daytime employment as each separate specialism extends its

service beyond the 9am – 5pm current provision, thus making EDT's role potentially redundant.

Option 3: Two other (lesser) options exist but, for different reasons are unlikely to succeed: The first of these is the fully self-sufficient, 24 hour, 7 days a week out of hours social service that sees present staffing level double, if not treble, to accommodate a new enhanced social work role in which all aspects of the work are undertaken, irrespective of the time, by this team. Flexible working arrangements and a three shift work pattern that divides every day into three eight hour periods Sunday to Saturday and guarantees to provide emergency and non-emergency response all day every day. Linked to Primary Care Trusts but independent of it and employed by the Social Services rather than the Health Trust, this model of out of hours social services would be the culmination of what the SSI envisaged (SSI 1999).

Option 4: The final option that would probably receive less support than the previous one, is that EDT remains a 'stand alone' team, not harnessed to any specialist department. In this option EDT continue to act as the ultimate safety net and 'last resort' for the local authority. This option would see EDT workers retaining their generic status and knowledge, remaining within the Social Services Department but servicing all of the different service user groups. The team would continue to operate with the delegated powers of the Director, but also be accessed by all the 'outreach' teams referenced above. EDT workers may still be called upon to make visits, or, more likely co-ordinate some of the newly formed out of hours teams to undertake the visit and then report back to the EDT worker for a decision. There are many potential difficulties with this model, not least is the fact that it means for some teams nothing will really change, but for many current EDT's it may mean the workers become completely office bound. Retaining generic 'qualifications' in the current specialist Post Qualifying Award confusion may also be problematic as, at

the time of writing a generic award does not exist and the concern is that we might have to attend several Qualifying Award courses. The most serious threat to the continuation of EDT in this option is that it means out of hours one department has 'control' over other agencies resources; this would be a contradiction of the processes during the day and further undermine this move towards the 24/7/365 welfare provision that is to be created. It is probably typical of this author, that this final, unlikely option is the preferred one as it retains EDT independence, maintains our combined advocate, investigator, gatekeeper, service provider roles without relinquishing too much autonomy.

This research began at a time of relative disinterest in, and lack of awareness of, the after hours services, this now sharply contrasts with the current debate as to whether EDT's have any future at all. The initial resentment and dismay at EDT's being ignored has, during this research process, been replaced by a frustration at the potential pace of changes the out of hours service may be forced to endure. There is a sense amongst EDT workers throughout Britain that 'our time is up' and we will need to change with the other sections of the department. A recent article summarised the position of EDT's saying:

> *'Around 50% of social services departments are said to have a deliberate policy of not giving out the Emergency Duty Team number to the public in case it 'raised their expectations'. Not surprisingly then, the Government's document 'Modernising Social Services' changed the emphasis, re-advocating improved and more comprehensive 24 hour services. '*   (Care and Health, 13/11/02 p.14)

At the back of some workers' minds though, is the feeling that 'we have seen it all before and survived' and we will see out this more recent 'fad' of proposals. The new reality remains to be seen.

Whatever the future of EDT's this research has hopefully demonstrated the wealth of knowledge and experience, skills and 'expertise' that is available to all local authorities in the form of their EDT workers. To date, most authorities have managed, without major incident, for over 25 years with a hidden, forgotten reliance on the EDT workers.

8.11 Further Research.

Assessment framework for EDT workers – to test the 4P framework – The 4P Assessment Framework outlined in this study to date remains, other than this author, untested by EDT workers. It would be extremely helpful to progress such a framework if further attention could be given to this specific part of this research to establish what, if any aspects of the framework helped and which didn't. There are already plans for this research to be presented to large groups of EDT workers (NWEDT and ESSA have both requested input on the basis of this research). From these groups it is possible that some 'pilot' scheme may be set up to try out the 4P Framework. Clearly though this part of the research is not completed. This process has already begun in that I was given the opportunity to present some interim findings to the NWEDT Annual Conference of 2002, and more final findings at ESSA's national Conference in 2003. I have also been asked to return to NWEDT in November 2003 to present this 'finished' research and hope that any 'pilot scheme' may develop from this forum. The responses to the presentation were both extremely challenging and helpful and have certainly informed my writing of Chapter 8.

Service user feedback – re. framework specifically and EDT generally – The views of service users need to be examined relating to the application of any assessment framework as well as their experiences of any dealings with the out of hours services. In many ways such an examination might resemble some of the many reviews carried out under the remit of Best Value, but it would also be interesting to reflect with service users what they

believed to be the requirements of a 'good' EDT worker. Research into how best to deal with their crises out of hours should inform the types of services that are developed rather than assume that daytime difficulties are the same as those that arise 'after hours'.

Why do 'significant incidents' occur outside of office hours? – Throughout this study there has been evidence of the significant occurrences that take place 'after hours'. It might be of use to social services, the police and the health services to examine the incidence and types of work that they have to deal with outside of office hours. There may well be some common factors that increase or decrease the level and impact upon the types of 'referral' that arise at night or at the weekends. For example is the use of alcohol at night and at weekends is likely to create more difficulties for some agencies than during the weekdays? Are more crimes committed under cover of darkness or is it that certain crimes are more often committed during the night and if so what are they? The intention here is to include the time of the day and the actual day into a research agenda, rather than perpetuate the norm that ignores these factors and seems to assume that the time of day/night or the actual day itself do not matter. Further research into possible reasons why significant occurrences do occur outside of 'normal' office hours needs to be undertaken acknowledging that resources and levels of service availability may well need to be readjusted to reflect the community's real needs rather than merely creating a 24/7/365 type of service which may not actually address the issues.

Put very crudely, night-time is not the same as daytime, the weekends are not the same as the weekdays, Xmas day is not the same as three weeks later and school holidays for families are not the same as the rest of the year. This study though is suggesting that the differences between these have been ignored for too long and much more detailed examination may need to take place of what it is that explains these differences before the public services' responses are truly community oriented, effective, efficient, fair and transparent.

8.12 Concluding Summary.

This research commenced over six years ago with a number of different objectives. It sought to examine a critical aspect of social work that had previously been ignored by policy makers, academics, practitioners and social services departments throughout the country. Local Authority Emergency Duty Team social work has, within this thesis, been explored qualitatively and quantitatively, autobiographically, biographically and theoretically.

There have certainly been lessons learned by this author regarding both the research process and EDT practice. In terms of the process of this study I still feel a strange 'guilt' for omitting services users directly from the detail and am frustrated that this perpetuates, in some way, the lip service that is all-too-often paid to such feedback. Whilst the reasons for such action are explained at the outset, if setting out again on this research journey in 2003, the focus would be different. Similarly I have realised that I could have been more rigorous in my approach to this research over the past six years. It is possibly an inevitable bi-product of undertaking such a long period of study that there are peaks and troughs in the author's interest in and commitment to the process, however, with hindsight I would possibly be stricter with, and make better us of my research time. This relates also to the focus throughout the study that I now feel could have concentrated even more specifically in Phase Two on the findings of Phase 1. It is possible that by omitting some material, a more detailed study of assessment and decision-making processes (prioritisation) out of hours may have had broader and more specific relevance to day and night-time social (care) workers. Finally, in terms of the research process, it has been an interesting, if not uncomfortable journey of realisation that I have carried out statutory duties for too long without having an academic, theoretical foundation to my social work practice.

This research has also impacted upon the way in which I do EDT social work. Taking time to examine some of the relevant theoretical frameworks and the legislation as well as discussing EDT practice with experienced colleagues from around the country has enabled me to develop a better knowledge of numerous aspects of the out of hours service. I have been impressed by the compassion and commitment of many of the respondents who have participated in this study, but ashamed at times of my own internal responses to some referrals usually whilst on a busy shift. This research has made me realise I can remain calm in a crisis, but has forced me to acknowledge also the need to be patient. For too many years as an EDT practitioner, I have not been sufficiently systematic or rigorous in my approach and in my decision-making. This research process has forced me to be more reflective and analytical in my dealings with families in crisis as well as giving clarity to the focus of my intervention. In summary, I realise that both this thesis and my EDT practice could be improved and that one has informed the other over the past six years. This, often uncomfortable learning process, will most certainly continue but, at the same time I would also suggest that this thesis presents some important lessons for more than just its author.

It is clear from this research that EDT workers are by far the longest serving and the most experienced practitioners within the present social services/social care organisations. With its focus on local and national out of hours social work practice, this research involved 53 out of hours teams and 112 workers from the United Kingdom. This is by far the largest piece of research ever undertaken into the after hours social work services.

The longitudinal study of one local authority EDT confirmed what many practitioners already knew, namely that children and families produce the majority of the referrals and take up most of EDT workers' time, but that mental health crises and difficulties involving older people also contribute in significant numbers. This study confirmed that certain days

and months are busier than others, but also that there would not appear to be any consistent explanation for any of these patterns.

As an autobiographical commentary on both the research process and the experiences of the author as an EDT worker, this research brings a unique perspective to both out of hours work and to the process of researching that subject. The author was simultaneously the researcher as well as part of the research, shaping and being shaped by the research subject and process.

By analysing and applying the feedback from the respondents I have been able to develop a Framework of Assessment that is drawn from the experiences and practice of out of hours workers from across the United Kingdom. In other words, the Framework is an extension of what the respondents thought should be best practice and is presented here as the culmination of their views. In this generic and novel assessment framework, the EDT worker is offered a systematic and structured means of gathering relevant information, undertaking assessments, prioritising and making decisions. This framework seeks to combine the EDT worker's wealth of experience with relevant legislation, practice wisdom, organisational imperatives and a value base consistent with both social work and social justice. It is hoped that this generic assessment framework might be employed specifically by EDT workers throughout the country, but also be of some use to daytime social workers irrespective of their specialism, who are involved in assessment of risk and potential significant harm. The findings of this research and this assessment framework were presented to the NWEDT Conference in 2002 and the national EDT conference of ESSA (Emergency Social Services Association) in 2003. In total over 200 EDT workers were present and amendments to the framework have been made in light of their responses. Overwhelmingly, the feedback has been extremely positive and I have been invited to many EDT's around the country to present the framework as one means of improving out

of hours practice. Over 100 different local authorities were represented and provided with the details of this research. It has also been arranged for me to send out a summary of the assessment to all of those EDT's represented such was the level of interest. In many respects, providing the details of this research to those audiences, other EDT workers and my colleagues, was a 'stern' examination of both the relevance of the 'data', their ownership of the framework and it's applicability to out of hours social work practice. The feedback to date suggests this research and the framework is meeting that examination. Finally, one aim of this research was to try and improve my own out of hours social work practice. Undertaking this research has certainly forced me to ask some fundamental and often uncomfortable questions about the way I work, how systematic I am, what skills I have and which ones remain under-developed, what knowledge I have and which gaps need addressing. It is possible that I have become more of a 'reflective-reactive' practitioner, than the 'reactive-reflective' worker that existed before I began this thesis. As a direct result of completing this research, I am already experiencing more of a need to justify my social work practice to colleagues and other EDT workers as I present these findings around the country. This, in itself continues to be an invaluable exercise and part of an ongoing learning process for me that I can only hope other (EDT) social workers may benefit from in the future.

I believe I have fulfilled the objectives I set out to achieve for this research. However, I also know I have experienced the frustration of realising how little I actually know about a subject I thought I knew much about.

Feb 2003

The research is at an end and there is for me a strange mixture of immense relief that it is over, but also some feelings that this will never really be finished and

already there are aspects of the thesis that I would wish to revisit. Without doubt the process has been extremely challenging, I remain disappointed with the Assessment Framework, but accept it still needs to be developed. I look forward for a while to only using my home computer to play games on with the little people in my life and thank Liz for all her support, patience and sustained interest. I have no idea how this will be received but feel confident that I have to draw it to a conclusion at some stage. I also feel that my practice will now be much more theory aware, more social focused and seek to contextualise far more in socio-economic-political terms, rather than addressing individualistic aspects of referrals to EDT.

If you have got this far reading this research, you too deserve thanks, credit and a rest!!

Signing off for the last time

Glen Williams. (Autobiographical Diary).

Important Yet Ignored: Problems of "Expertise" in Emergency Duty Social Work

School Of Law And Social Work,
Josephine Butler House,
Liverpool John Moores University,
1 Myrtle Street,
Liverpool, L7 4DN.

June 15, 2000

ADSS Research Group,
C/o Hampshire County Council,
SSD,
The Castle,
Winchester,
SO23 8UQ.

Dear David Ward,

I am writing to request that the ADSS Research Group approve a project that is currently being undertaken by a research student at this University.

Glen Williams is a part-time research graduate and successfully transferred from an M.Phil. to a Ph.D. in October last year. Glen is a full time Local Authority Emergency Duty Team Social Worker and a qualified lecturer in social work. The research to date has focussed, almost exclusively, upon the student's employing authority, but now, as can be seen from the enclosed proposal, it is the intention to broaden the terms of reference to incorporate a variety of other Local Authority Out of Hours Teams into the study.

The plan for the extended research is to examine, in some detail, the process of assessment and intervention out of office hours. The study acknowledges the recent Department of Health publications 'Open All Hours' (1999) and 'The Framework For Assessment Of Children in Need and Their Families' and seeks to supplement their detail by combining the two areas of practice and exploring the nature of assessment out of hours.

As the proposal indicates, Glen wishes to use his contact with the North West Training Consortium and ESSA (Emergency Social Services Association) to progress his research, as well as visiting other out of hours teams to observe the nature of their service provision. Clearly the usual boundaries of anonymity and confidentiality will apply.

Liverpool John Moores University has actively supported this research project and fully endorses the proposal for further study. I hope that the ADSS Research group can similarly approve this Ph.D proposal to enable Glen to continue his course of study.

Please do not hesitate to contact me should you require any further clarification on this mater. I look forward to your response.

Yours Sincerely, Michael Preston-Shoot,
Professor of Law and Social Work.

APPENDIX 3

Covering Letter to Phase 1 Respondents.

Metropolitan Borough of

Social Services Department
Director of Social Services

Dear

You may be aware that I am currently undertaking research into Emergency Duty Team (E.D.T.) social work practice as part of an M.Phil/Ph.D. It is my intention, within this study, to explore how we work 'out of hours' and specifically I will examine such aspects as referral patterns, E.D.T. definitions of and reactions to 'crisis work' as well as whether the service we provide as E.D.T. workers could be made more effective.

Within the U.K. there has never been any such research carried out before, so I hope you accept this invitation to participate in what is a unique exercise (in sharp contrast to the wealth of research undertaken into 'daytime social work'). Quite simply, too little is known about 'out of hours' social work.

As one of only a few E.D.T. workers in this Authority, you are ideally placed to present your views on the service. I would like to stress that this research is completely confidential and is entirely separate from any internal review of E.D.T. presently being produced. Your contribution to this study will remain anonymous and confidential.

In order to complete the first part of this research I am sending all E.D.T. workers a brief questionnaire designed to gather factual quantitative data.

The second stage will be to interview all respondents (at a mutually convenient time and location) to gather more qualitative information relating to the questionnaire. As an E.D.T. worker myself I have certain views on the service and would hope to achieve an honest exchange of ideas as part of this second stage.

In order to help me with stage one and become part of this research it would be greatly appreciated if you would complete the enclosed, brief questionnaire and return it to me via Sefton's internal post within three weeks of receipt (addressed envelope enclosed).

I hope you are able to take part in this novel research and look forward to contacting you to arrange an interview once you have returned the questionnaire.

If you have any questions regarding the process of this study or any comments (positive or negative) on aspects of E.D.T. you think should be included, please do not hesitate to contact me 'out of hours' (   ) or leave a message during the day at Centre's Reception (telephone no.   ).

Professor Michael Preston-Shoot (Head of Social Work Department at Liverpool John Moore's University - 0151 231 2121) and Dr. Derek Clifford (Lecturer in Social Work at Liverpool John Moore's University - 0151 231 3927) are part of the team supervising this research. Steve O'Dea (extension 3927) is my Operational Manager. If you have any concerns or complaints regarding this study, you are invited to contact any of these individuals by 'phone or letter.

I look forward to working with you on this project.

Yours sincerely,

Glen Williams
E.D.T. Social Worker

APPENDIX 4.

Mr G Williams

Date	02 October 2000	
Enquiries to	David Ward	*My ref*
DW/MB		
Direct Line	(01962) 847259	*Your Ref*

Dear Mr Williams

'Out of Hours' Social Work: A Study of Local Authority Emergency Duty

I am writing on behalf of the Research Group of the Association of Directors of Social Services and am pleased to tell you that the Group has decided to recommend your project to social services departments. A circular advising directors of this decision will shortly be in their hands.

It would be helpful if, when approaching social services departments, you make it clear that you have the Group's support.

In the interests of ensuring that social services departments receive the maximum benefit from co-operating in research projects such as your own, the Group places great importance on disseminating findings and conclusions. It encourages researchers to find ways, including (but not exclusively) formal publication of a report, of feeding back the results of their research to participating departments. It would welcome a short summary of the findings of this project, once you have completed it, in a form suitable for distribution to social services departments.

Yours sincerely

David Ward
Assistant Director (Resources)
Social Services Department, Hampshire County Council

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RESEARCH GROUP

Chairman David Johnstone
Director of Social Services

Devon Social Services

County Hall, Topsham Road

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tel 01392 383299 fax 01392 382684

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Secretary David Ward
Assistant Director (Resources)

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Trafalgar House, Winchester

Hampshire SO23 8UQ

tel 01962 847259 fax 01962 864681

email david.ward@hants.gov.uk

TEXT
CUT OFF IN THE
ORIGINAL

...me of Officer								Day			Hours from:	
RISSP Ref. No.			ALLOCATION STATUS 999					Date:			to:	

CLIENT GROUP	All Pace	Children	Family Work	Older People	Elderly Mentally Infirm	Mental Health/ Illness	Drug Misuse	Alcohol/ substance Misuse	Learning Disabilities	Physical Disability	Other Adults	Sub Total A
NUMBER OF REFERRALS												
WORK												
ON OPEN												
CASES												
Write a												
CRISSP												
Ref No												
or each												
client?												Sub Total B
TOTALS												

TOTAL REFERRALS A & B

HOMLESSNESS (Record clients above and outcome here)

	Placed	Not Placed	TOTAL
amilies			
ingle Male			
ingle Female			

	Before Midnight	After Midnight
TPC/WRITING UP		
OTHER ADMIN.		
OUT OF CENTRE		
SUB TOTAL		
TOTAL HOURS		

OTAL PETTY CASH	£
XPENDITURE	

OFFICE USE	By	Date
CRISSP Input		

Signed

APPENDIX 6

Phase 1 Questionnaire.

A Completed Example.

E.D.T. Questionnaire - Part 1

(1)Interviewees confidential reference number ....**3**..........

(2)EDT status -   Full-time   (✓)
   (please tick all that   Part-time (volunteer)   ( )
   have applied to you)   Generic   ( )
                          ASW cover only   ( )

(3)Gender -   Male (✓)   Female ( )

(4)Age -   Under 25 ( );   25-35 ( );   36-45 (✓);
                         46-55 ( );   Over 55 ( )

(5)Disability -   Yes ( )   No (✓)

(6)Ethnic origin (please tick)

Bangladeshi	( )	Pakistani	( )	
Black African	( )	White	(✓)	
Black Carribean	( )	Other-Asian	( )	
Black Other	( )	Other	( )	
Chinese	( )	Not known	( )	
Indian	( )			

(7)In what year did you gain your main social work qualification?   *1985*

(8)What qualifications do you have? (Please tick)

C.S.S.	( )	D.M.S.	( )
C.Q.S.W.	(✓)	Degree	( )
Dip.S.W.	( )	Masters	( )
A.S.W.	(✓)	Other(s)	(✓) Please
			specify below

Certificate in Municipal Administration

(9)What social work/social care experience did you have prior to undertaking E.D.T?
(Please specify length and type of experience e.g. four years as R.S.W. in child care).

Six years, Intake Social Worker, Bootle Office

(10)How long have you done E.D.T. work?   *Six years*

(11)On average how often have you undertaken E.D.T. work in the past three years
(volunteers only - please tick).

Once per fortnight	( )
Once per month	( )
Once every two months	( )
Once very three months	( )
Once every four months	( )
Other (please specify)	( )
Don't know	( )

(12) Have you attended any of the following <u>on E.D.T?</u> (Please tick)

		<u>Yes</u>	<u>No</u>
PACE Interview (juvenile)		(✓)	( )
PACE Interview (adult)		(✓)	( )
'Spot Checks' (child care)		(✓)	( )
'Spot Checks' (other)		( )	(✓)
NAI Investigation -	Physical abuse	(✓)	( )
	Sexual abuse	(✓)	( )
	Emotional abuse	(✓)	( )
	Neglect	(✓)	( )
Accommodating (a young person). (Sec.20, The Children Act 1989)		(✓)	( )
Place of Safety Order (Child)		(✓)	( )
Emergency Protection Order		( )	(✓)
Police Protection Order		(✓)	( )

Sec.2 Assessment (Mental Health Act 1983)   (✓)   ( )
Sec.3   (✓)   ( )
Sec.4   (✓)   ( )
Sec.135 (Warrant)   (✓)   ( )
Sec.136 (Police powers)   (✓)   ( )
Sec.5(2)   (✓)   ( )
Sec.5(4)   (✓)   ( )
Sec.7 (Guardianship)   ( )   (✓)

National Assistance Act 1948/52. Sec.47 Removal   ( )   (✓)

Arranging Domiciliary Services for an older person   (✓)   ( )
Arranging emergency respite residential care for
                 older person   (✓)   ( )
Placement at Homeless Persons Unit   (✓)   ( )

Magistrates Court   (✓)   ( )
Magistrates Home   (✓)   ( )
Juvenile (Family) Court   (.)   (✓)

(12) E.D.T. work involves for example refusing services, providing alternatives, preventing admissions, referrals to daytime teams. By whatever means, which of the ___ list have you prevented, refused or provided alternatives for? (Please tick column for each category e.g. if you've refused P.A.C.E. (until parent is found for example); if you've never refused or found alternative or spot check leave box blank).

If you've refused placement at homeless unit and on another occasion resolved homelessness by other means tick both boxes). In other words, if you've refused or resolved please tick.

		Refused	Resolved
PACE Interview		(✓)	(✓)
PACE Interview		( )	(✓)
Spot Checks		(✓)	( )
Spot Checks	( )	(✓)	
NAI Investigation -	Physical abuse	(✓)	( )
	Sexual abuse	( )	( )
	Emotional abuse	( )	( )
	Neglect	(✓)	( )
Accommodating a young person		(✓)	( )
Place of Safety Order		( )	( )
Emergency Protection Order		( )	(✓)
Police Protection Order		(✓)	( )

Sec.2 Assessment (Mental Health Act 1983)	(✓)	(✓)
Sec.3	(✓)	( )
Sec.4	(✓)	( )
Sec.135 (Warrant)	( )	(✓)
Sec.136 (Police powers)	( )	( )
Sec.5(2)	(✓)	( )
Sec.5(4)	(✓)	( )
Sec.7 (Guardianship	( )	( )
National Assistance Act 1948 - Sec.47 Removal	(✓)	( )
Arranging Domiciliary Services for an older person	(✓)	(✓)
Arranging emergency respite residential care for an older person	(✓)	(✓)
Placements at Homeless Persons Unit	(✓)	(✓)
Magistrates Court	( )	( )
Magistrates Home	( )	( )
Juvenile (Family) Court	( )	( )

Comments

3) It is 6.30p.m. on a Monday and the following referrals have come to you on E.D.T. Which of the following (if any) would you attend and in which order (i.e. place (1) in the box against the first <u>visit</u>, (2) against the second <u>visit</u> and so on. Place (0) against any you would <u>not</u> visit).

(N.B. The factors which led to your decisions will be discussed in more detail in the interview (stage two). It is recognised that you would need more information on each scenario. For the purposes of this exercise the important thing is to answer the question and explain your response later. (Non-ASWs please ignore mental health referrals).

(a) PACE interview on a "well known" fifteen year old accommodated male in the North of the Borough.   (2)

(b) Regular spot check request on 'drinking parents' for evening visit.   (3)

(c) Mother and three children presented as homeless at South of Borough Police Station.   (1)

(d) Children's hospital (South) 'phone regarding four year old child with "suspicious" fractured leg - "probable NAI", child is on CPR and will be kept in overnight with parents' permission.   (6)

(e) Request by Area Team to complete Sec.2 (Mental Health Act 1983) assessment on "potentially violent male". Psychiatrist and G.P. due to arrive at house at 8.00p.m. *(Probably would rate higher if no pre-arranged appointment time)*   (4)

(f) Mother 'phones - plea for removal of thirteen year old son - not known to the Department.   (5)

(14) Please list what factors would help you decide your priorities (in real life) for your course of action with the above scenarios (e.g. how long has fifteen year old been in custody? How old are the three homeless children?)

1) Who is most vulnerable and at risk?

2) Which referrals will 'hold', allowing "pragmatic, quick solutions", and therefore not creating a backlog?

3) In respect of (d). Although I have given this low priority, is the child is safe in hospital, are there other children in the family, therefore increasing priority?

4) I think any 'priority' decisions would be after contact with all referrals (a) To assess by obtaining more details, and then (b) To explaining any delays etc.

(15) Have you been on any training specifically aimed at E.D.T?   Yes (✓)   No ( )
   (If 'yes' what and when?

North West District Training Association — bi monthly

(16) Whilst on E.D.T. have you, like me, ever felt any of the following (please tick only
those that apply to you).

Frightened   ( )
Overwhelmed   (?) — *nearly, but not quite*
'In crisis' yourself   ( )
Angry   (?) — *only with 'other' EDT members*
Unwilling to help   ( )
Able to 'handle' anything   (✓) — *bit arrogant really!*
Lazy   ( )
Bored   (✓) — *though not very often*
Lonely   ( )
Exhausted   ( )
Excited   (✓) — *especially when visiting G. House!*
Other (please specify)   ( )

Thank you for taking the time to complete this questionnaire. Please return your answers in
the envelope provided to me, Glen Williams at Sterrix Lane. I will contact you soon
regarding stage two (see covering letter). Once again, thank you.

....

Glen Williams
EDT Social Worker

7

APPENDIX 7

Phase 1

Semi-Participative Interview Schedule

INTERVIEW QUESTIONS.

PROFESSIONALISM:

It is possible that the 'professional status' of social work generally and EDT specifically has been reduced, in contrast to some other 'professions'. These questions examine some aspects of this hypothesis.

1/ Generally speaking, how do you see the role of EDT (for example, is it a 'stop-gap' measure, an emergency only service or an extension of daytime social work)?

2/ (How) Has your EDT practice changed with more experience of undertaking out of hours duty?

3/ What do you think are the main differences between EDT and daytime social work?

4/ Do you think there are some 'types' of social work which EDT may get asked to do but should not undertake?

5/ What qualities do you think an EDT worker needs?

6/ What, if anything, do you think we bring to multi-disciplinary interviews (i.e. PACE, M.H. Act assessments) which is different to the other agencies?

PRIORITISATION.

This section refers specifically to the case scenarios which you were asked to prioritise in the questionnaire.

1/ My impression from reading your questionnaire responses is that you tended to prioritise according to: (a) practicalities, (b) procedural priority, (c) your generic/specialist status or (d) personal preference/expertise - What is your view?

2/ An equal number of people said they would visit scenario (d) as a priority 1 as said they would not visit it at all, why do you think this might be?

3/ What values or assumptions do you think underpins your choice of priority, (for example, statutory obligation, age of the child, type of abuse, personal experience)?

4/ Which scenario did you view as the least serious (your own definition), and which did you view as the most serious, and why?

5/ Have you ever been unable to respond to a paged message, or decided not to? Can you give any details?

6/ Until February 1997 I was not aware of this risk assessment priority document, have you seen this before, and, if so what do you think of it in terms of its application to EDT?

THEORY.

As an EDT worker I wonder sometimes whether we work within a well established theoretical framework or simply 'fly by the seat of our pants'. The next set of questions is designed to explore this.

1/ 'Theory' means a range of things to a range of people - within EDT social work, what does it mean to you, can you give examples?

2/ Which theory/framework would you say you know most about?

3/ Would you say that EDT is a political activity, if yes, please explain how?

4/ Do you think there is any way by which EDT workers can ensure consistency in terms of the way we make decisions about people's lives?

5/ How do you decide who the 'client - service-user' is in any referral? Who would you say are the 'clients' in the case scenarios within the questionnaire?

ASSESSMENT.

1/ What do you understand by the term 'assessment'?

2/ What do you see as the difference(s) between: Screening
                                                 Initial assessment
                                                 Complex assessment
                                                 Risk assessment
                                                 Social Assessment?

3/ Do we use different methods to assess children at risk, people with mental health problems, older people - How do we assess these groups ?

4/ (How) Does our assessment differ from the G.P., the police officer, the psychiatrist, and if so, how?

ANTI-OPPRESSIVE/ ANTI-RACIST VALUES.

All too often we make decisions without consciously recognising the divisions which exist within society and our own socialisation process. The following questions will try to clarify the validity of this statement.

1/ What do you understand by the term A.O./ A.R. practice and does it have any place in EDT?

2/ Do you think that your background and general autobiography impacts upon your EDT practice?

3/ Have you ever seen these Principles of Practice before?
(Show the BASW Principles and Dip.S.W. Competencies). In terms of EDT how applicable do you think they are?

4/ With minimum information, limited support, less time than daytime counterparts and operating without discussion with other social workers, EDT still remove children, adults and older people against their wishes and refuse services to others and so act more 'oppressively' than any other section of the social work profession. How would you respond to this accusation?

STATISTICS.

In this section it is **your views** which are being sought irrespective of the actual 'facts'

1/ Which service user group do you think is the source of most referrals for EDT and which is the least.

2/ Do you think there are any patterns of referrals, for example, the school holidays, Tuesday nights, Winter?.....Why might this be so?

3/ How many referrals do you think EDT takes per year (A referral, for the purpose of this exercise, is a piece of recorded work which is passed on in writing to a daytime team)?

CONCLUSION.

Your thoughts on improving and enjoying EDT are sought in this final section.

1/ (How) Do you think EDT could become more effective?

2/ What do you enjoy most about doing EDT work?

3/ Have you any questions, comments about this interview, the questionnaire or this research?

THE END.

APPENDIX 8

Phase 2 Questionnaire

AGE	20-25	25-30	30-35	35-40	40-45	45-50	50-55	55-60	>60
MALE									
FEMALE									

2.

	0-3	3-6	6-9	9-12	12-15	15-18	18-21	21-24	24-27	>27
Length of EDT service in years										
Years since you qualified as a social worker										

3. How would you describe your own ethnicity? ....
(e.g. Black British, Irish, Asian, White British)

4. Would you describe yourself as having a disability?   YES ☐ NO ☐
(please tick appropriate box)

5. Please tick the following boxes that apply to you presently.

EDT Manager	EDT social worker	A.S.W.	Full Time	Part/Half Time)	Job Share	Other (please specify)

6. Does your role usually include home visits?   YES ☐   NO ☐

7. How is EDT mainly delivered by you Local Authority? (please tick box)

DEDICATED TEAM ☐   STAFFED BY DAYTIME WORKERS ☐

HOME BASED   ☐   OFFICE BASED   ☐

OTHER   ☐   (please describe)..
....

Are You a   LONE WORKER ☐   or PART OF A TEAM ☐ (please tick)
Comments...
....

8. How do you view the role of EDT? (please tick ONE only).

EMERGENCIES ONLY ☐   EXTENSION OF DAYTIME SOCIAL WORK ☐

BOTH OF THE ABOVE ☐   OTHER ☐ (please explain)............................
....
....

9. Does the public have direct access to an EDT social worker? YES ☐   NO ☐

If yes, is this access throughout the entire shift?   YES ☐   NO ☐

If no, please explain...
....

10. Do you have access to records that are kept up-to date (at least weekly)?
                                                        YES ☐   NO ☐

11, Does you EDT have a written policy to assist in prioritization of referrals?
                                                        YES ☐   NO ☐

12. How is a decision to visit a service user made (please explain who is involved and what factors are considered)?..
....
....
....
....
....
....

13. How many people per EDT shift usually determine whether a referral is a priority or not? 1 ☐   2 ☐   3 ☐ more than 3 ☐.

14. EDT workers appear to have differing priorities between competing referrals, why do you think this might be?...
....
....
....
....
....
....
....
....

5. It is 6.30 p.m. on a Monday and the following 'referrals' have come to you on EDT. Which of the following (if any) would you prioritise as requiring a visit by EDT, and in what order would you advise they are visited?

Place (1) in the box you would visit first, (2) for the second visit and so on; Place (0) for any of the scenarios you do not think require a visit on that night.
N.B. It is recognized that more details would be required for such decisions to be made, but for the purpose of this exercise please prioritise the scenarios as you might in 'real' life, and explain the difficulties and the reason for this choice after each one).

(a) 'PACE' interview on a 'well known' 15 year old accommodated male ☐
(please explain your priority, and any other details that might alter your decision)
....
....
....

(b) Mother and three children presented as homeless at a local Police Station ☐
....
....
....

(c) Local hospital phone re. 4 year old child with a "suspicious" fractured leg: "Probable NAI", child is on the Child protection Register and will be kept in overnight with parents' permission. ☐
....
....
....

(d) Request by G.P. to complete Section 2 (Mental Health Act 1983) assessment on "potentially violent" male at home. G.P. and Psychiatrist due to arrive at the house at 8 p.m. ☐
....
....
....

(e) Mother of 13 year old daughter phones, 'plea for removal', not known to the department ☐
....
....
....

16. What factors exist for you when trying to decide between competing priorities?
....
....
....
....
.... --

17. ".....assessment focused on whether the eligibility criteria had been met. Information gathered was intended to help the worker establish if the situation would hold until the mainstream services were available. This did not lead to a rounded assessment of the service user's needs." (Open All Hours, 1999, SSI).

Is this observation by the SSI accurate of your EDT?   YES ☐   NO ☐
Any comments...
....
....
....

18. Please use the rest of the space to make any comments regarding the way in which EDT workers prioritise/assess referrals, the decision making framework or any other related remarks.
....
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Thank You for taking time to complete this questionnaire.

All details will remain anonymous.

Glen Williams,   EDT.   April 2001.

Phase 1,Length of EDT Experience
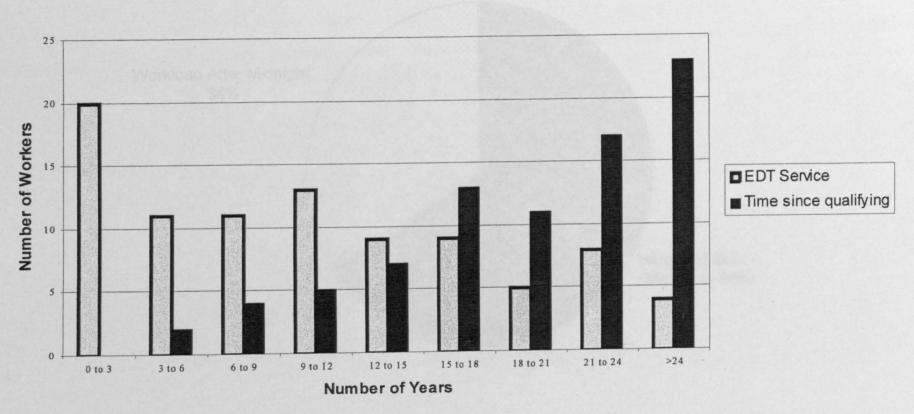
Phase 1.Post Qualifying Experience
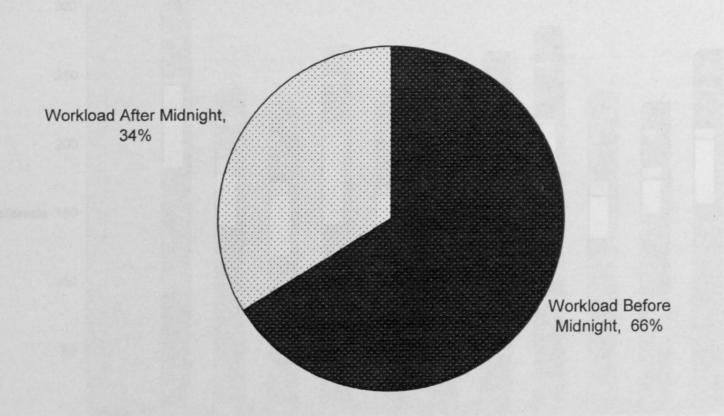
Chart 3: EDT Experience

Number of Workers (y-axis), Number of Years (x-axis)

Legend:
- ☐ EDT Service
- ■ Time since qualifying
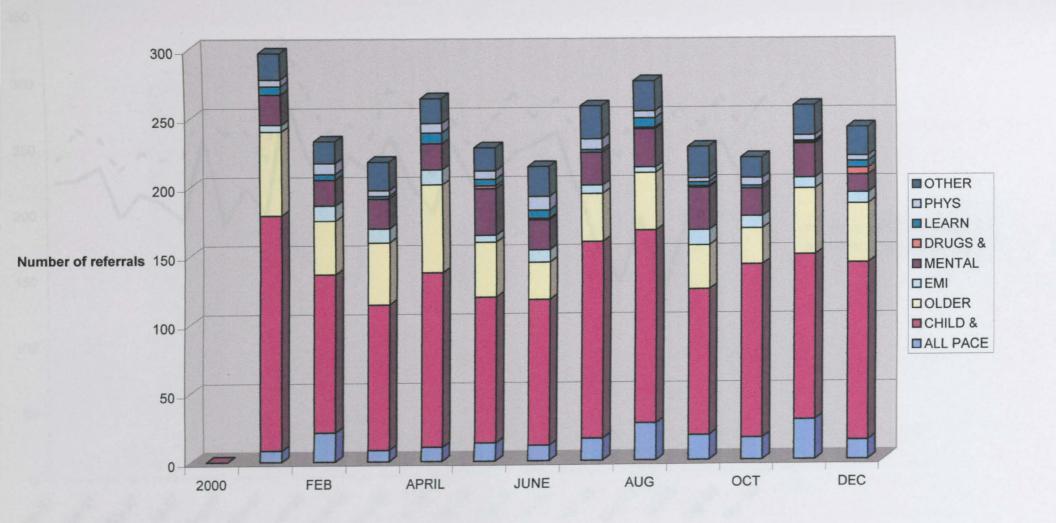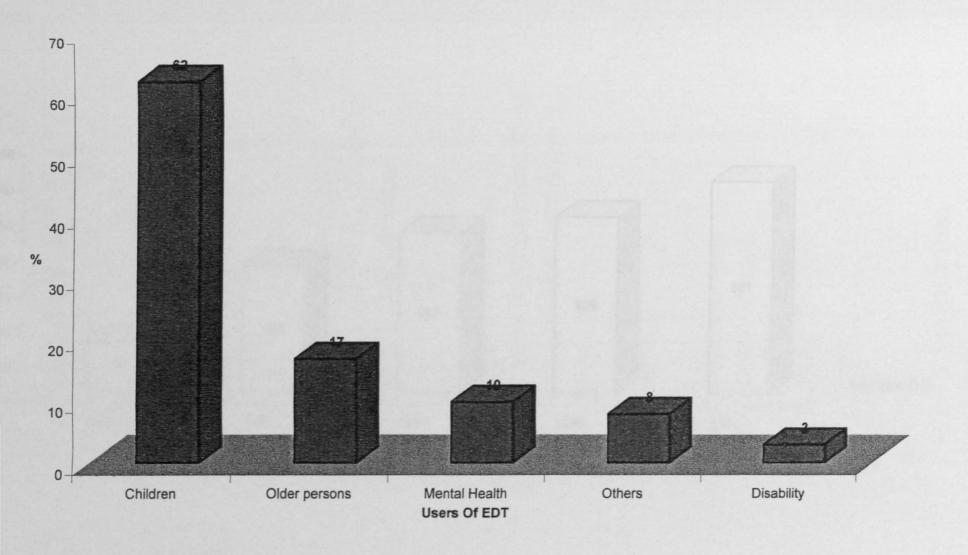
Average EDT Workload before & After Midnight 1996-2003

Workload After Midnight, 34%

Workload Before Midnight, 66%
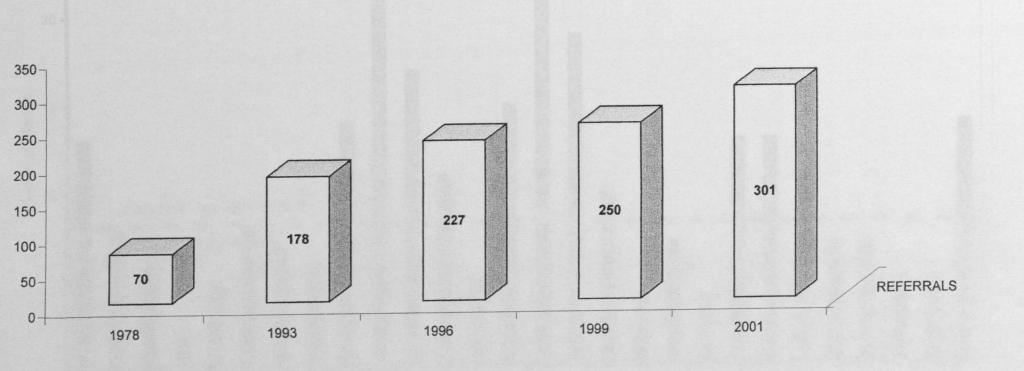
Year 2000 Referrals
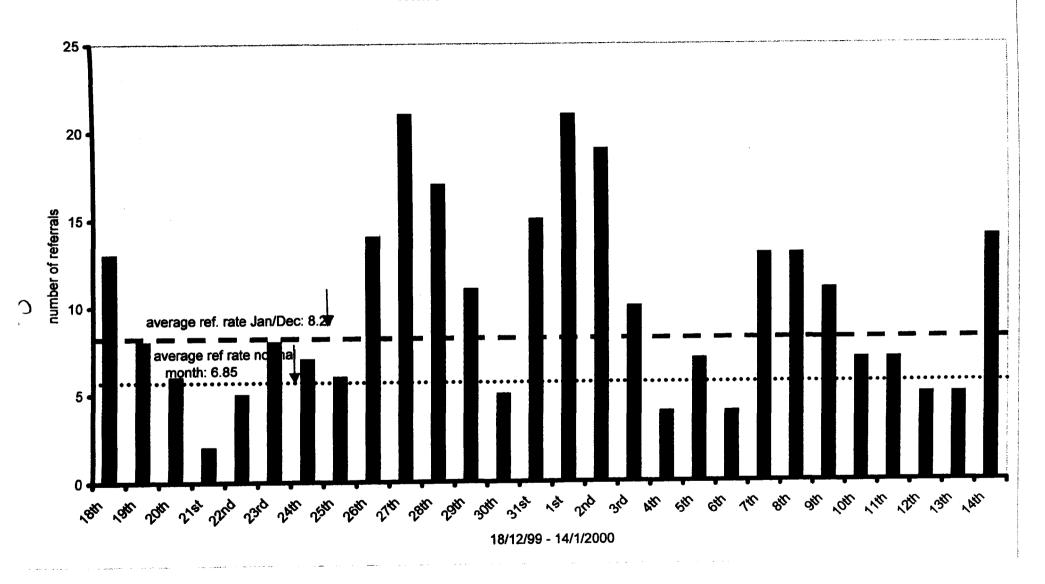
Hours Worked and Number of EDT Referrals 1997-99

HOURS WORKED
Number of Referrals

EDT Percentage of Service Users

EDT December Referrals
1978-2001

Millennium EDT Referrals

Bar chart titled "Millennium EDT Referrals" showing number of referrals on the y-axis (0 to 25) against dates on the x-axis from 18th to 14th (18/12/99 - 14/1/2000).

average ref. rate Jan/Dec: 8.27

average ref rate normal month: 6.85

18/12/99 - 14/1/2000

Pilot Study:

By sending a copy of the questionnaire to two students whom had each undertaken a 4 months placement with EDT in the authority being studied, a pilot study was carried out.

The purpose of this exercise was to test a variety of aspects of this part of the research process. It was necessary to establish whether the questions 'made sense' and could be answered, as well as checking whether the actual responses given, provided the type of information that was being sought.

The pilot study was also able to establish how long it might take respondents to complete the questions. The researcher recognised the varying pressures on the sample group, and did not wish to sacrifice the percentage of responses by producing an overly long exercise for the respondents to undertake that might prevent them from returning the questionnaire.

The Pilot Study Process. (Phase 1)

The sample group for the pilot study consisted of two students, both in their second, and final year of the Diploma in Social Work Course. Three months prior to taking part in this study, one student had completed a 4-month placement with EDT, in the authority being researched. The other student had one month left of the four months placement, with the same EDT, still to complete.

Both students were sent a copy of the 'final draft' of the questionnaire, with a covering letter explaining the research and their role, as well as requesting that they time how long it took them to undertake the exercise. Each student was asked to make written comments on aspects of the questionnaire relating to, for example, whether they could understand the question; the layout of the questions; any aspects they thought should be covered, and how the exercise made them feel.

Once both students had returned the questionnaires, I arranged to meet with them to go through their written responses to the questionnaire, and their written comments regarding the process.

Findings of the Pilot Study. (Phase 1).

The completion of the questionnaire (without the 'extra' written comments) took one student 15 minutes, and the other, 18 minutes.

Both respondents indicated some confusion over the same question and so, based on their feedback, a clearer form of questioning was inserted.

Both respondents thought that, other than the misleading question, the process was 'easy to understand, non-threatening, clearly laid out' and covered the relevant areas of EDT given the objectives that the research had established.

The responses were then analysed to ensure that the information the research was seeking was provided, and in the form required. The pilot study seemed to be successful in gathering the type of 'data' and feedback that the researcher was looking for.

It should be noted that this pilot study was potentially 'biased' in a number of ways. For example, both of the respondents were women, unlike the overwhelming majority

of the sample group that would be sent the questionnaire. Any possible gender differences would not have been likely to arise for analysis via this pilot study. It could though, also be argued that this gender imbalance was a strength of the research, as it could identify potential differences in the male/female response to EDT matters.

A further 'weakness' of the pilot study reflects the power differential between the researcher and the researched: In both cases the researcher also acted as the Practice Teacher, responsible for the passing or failing of their placement. In the case of the first student, she had passed her placement, and may have felt 'indebted' to the researcher and possibly reticent to overly criticise the questionnaire because that same researcher may be providing references for employment. The second student was still on placement at the time the pilot study was undertaken, and may have felt some pressure to stress the positives of the questionnaire, rather than enter an 'honest' (not that either was being 'dishonest' in its literal meaning) critical dialogue regarding the quality of the questionnaire.

It is possible, as with all students on placement, that they may have felt 'in awe' of their supervisor, and this might have impacted upon the nature of their responses. Conversely, students may feel bitterly disappointed at the quality of their placement 'mentor', and refuse to accept the usefulness of any research that person may carry out. Thus a positive or a negative relationship between a student and their supervisor may have an effect upon the nature of any research responses.

Finally, the responses within the questionnaire reflect the level of experience of the EDT worker. The sample group within the pilot study would not be 'typical' of the other respondents because of their very limited length of service on EDT. It is 'untypical' also, because neither of the students was ever expected to undertake EDT on their own, as is the case with the other respondents.

Conclusion.

Notwithstanding the reservations identified above regarding the applicability of the questionnaire, it was possible to conclude that the final questionnaire would gather the type and range of information that the research project was seeking. It was anticipated that the exercise would not be too time consuming as to significantly reduce the returns, and that the layout would facilitate additional information being gathered. Additionally it would be possible to analyse any gender differences as the pilot study, completed by women, was in contrast to the Phase 1 research 'proper' that was entirely be male dominated. Whilst more women would be included in Phase 2, for the first part of this study this potential gender bias would need to be monitored specifically.

APPENDIX 11.

AUTOBIOGRAPHICAL DIARY.

1997

Mon 3rd Feb 1997 0030hrs.

Telephone call (t/c) from the police re. 14 year old female arrested badly and deliberately burned, both parents arrested Drunk & Disorderly, Breach of the Peace and suspected assault. Three other sons said, by the referrer, to be 'home alone', (although there was an Auntie present).

Feelings: Practical- need to get the auntie to move into the house with the three sons at least for the rest of the night.
Confident- procedurally, evidentially and legally.
Appropriate Adult (under PACE) needed for Mum as she may have Learning Disability; camera and FME (Police Surgeon) for child; transport and accommodation for 4 children (3 arrived whilst I was at the police station), explained the process to the auntie and child having sought permission from Mum for children to remain with her sister.
Although there was, initially much 'chaos' around who would be doing what, and some conflict between the priorities of the police and mine, outcome was that the 'injuries' were seen by Police Surgeon and noted, no 'interview' of the 3 child took place (it was by the 0145 hours), all four children returned home with the auntie 'safe' in the knowledge that neither parent would be released until both had sobered up, and calmed down sufficiently, thus giving the daytime teams time to liaise with each other (police, social services, schools etc) and plan interviews of parents and child(ren).

Thursday 6th Feb, 2245hrs.
T/c call re noisy and pest neighbours (again) – angry, demanding, complaining and abusive to me. Unresolvable situation other than through Environmental Health. Nervous about phoning back as unable to help and Mrs C hammering on the floor to stop the noise from the tv. Uneasy about my inability to help and ability to say 'no'.

Thursday 20th Feb Mr A
I receive a phone call at 8 pm on a Thursday evening from the family G.P. requesting a mental health assessment on a father of four children, all under 10 years of age. Father said by the doctor, to be 'very drunk', 'volatile', 'actively suicidal', and 'in need of psychiatric admission.'
Mr. A., the father answered the door, half-naked, weighing about 20 stones, and over 6' tall. The doctor was still in the house, but in another room with other relatives of the family, and the children.
Mr. A. was definitely drunk and spoke of the death of his wife who he "lived for and adored". He went on to tell me that his best man at their wedding had hung himself recently and last week his mother had been killed in a road traffic accident.
Throughout the interview, Mr. A's wrists were visibly bleeding as he had cut them earlier that evening. Mr. A. continued to express active suicidal thoughts as he sat

hugging a photograph of his wife on their wedding day, and sobbed throughout our discussion.

Why do I feel that I have been 'dumped on' by the daytime social workers (no lone visits for them!) that beat a hasty retreat as soon as I arrived at Mr. A.'s (they had been waiting outside the house!)?

I am frightened that Mr.A. will assault me, but at the same time feel dreadfully sorry for him.

Is my assessment being guided by the feeling that I would possibly be in a similar state if I had experienced such loss over such a short period of time? Is there something stubborn within me that refuses to be frightened by Mr.A? Is the focus of my risk assessment on the children, the relatives or Mr.A? I feel certain that this man is drunk, but at the same time I believe I have a relatively libertarian view towards 'drinking parents'. A final complication is that I am a person that seeks to challenge authority, in this case, the perceived authority of the visiting doctor who thinks I should merely turn up and complete the 'section' papers. I know that to commit this man to the particular psychiatric hospital available would intensify his distress and force his 'suicidal hand', but neither are the alternatives queuing up to be selected! Thoughts of the dangers and the risks, my role, statutory duties and powers, the children's welfare and an undirected anger that this practical dilemma has happened on my shift, all invade my mind, whilst simultaneously trying to listen what Mr.A. is saying to me.

Did I make the right decision? Was there only one 'right' outcome for Mr.A and what would my colleagues have done? Would the doctor carry out his threat to 'make a complaint' or was he wishing simply to be seen to side with the family? I was confident the situation could, with the family's support, be managed until the next working day, tomorrow, the focus now needed to be to reduce the anxieties of the family members in order for them to prevent this man ending up on a psychiatric ward.

God, it would be so much easier just to 'section' him!

Thursday 1st May 2200-0200.

Prevented a 14 year old male that trashed his house from being accommodated – no relatives prepared to help. Eventually took him home and made referral to Area Office. Feeling of a good piece of preventative work, calmed feelings that were running high in family, took control without entirely disempowering but had certainly decided that I would not be accommodating this child.

0400-0750 name of wandering woman finally ascertained, declined to attend – passed to area office, but felt guilty for doing so even though the consultant Psych could not attend until 0830 hrs.

Friday 2nd May 1930 hrs.

Cot death referral. I can feel my heart beat increasing. The baby aged 18 months was found by the parents. I am unsure of the procedures, fear high profile coverage and am 'glad' on hearing the words 'no suspicious circumstances' then guilty for feeling the same in contrast to the poor parents. I remember ages ago reading the procedure and finally dig it out. My pulse increase again to find that the baby was 'known to the department' and an open case, but relieved to discover there were no child protection concerns. What an emotional roller coaster ride this job can be sometimes? Do we

get de-sensitised to such tragedies, tending to put our own self-preservation before the tragedy of a child dying? Is this the inevitable culmination of a society that wants to 'risk manage' rather than allow 'risk-taking' and seeks to blame rather than understand?

Saturday 21st June 12 – 3 pm.
Spot check visit to 'violent male'. Domestic violence and brutal assault on a police officer. I fear that the male might return and what might happen to me. I phone first but there is no answer. Am I the only worker that does spot checks?? I am so unlucky...what's the worst that can happen..serious assault, death? I insist that the police attend, but despair when they send a solitary 'bobby' who has no idea about this husband's background, yet pushes me into the house first. Once in the house I realise that the P.C. has remained outside and has been told by the radio control to await back-up. The husband phones from outside somewhere to let his wife know he knows the police are inside. Mrs X mentions that Mr X has guns and access to guns and is 'on his way over with a gang from Manchester'. I am amazed by her calmness and presence of mind that plans her getaway, this seems to impact upon me as I calmly arrange alternative accommodation a long distance away and the transport arrangements too. The police riot squad arrive and Mr X is no-where to be seen although he rings another three times to give a running commentary on what is happening in the house where I am!
My thoughts flit between an amazement at the circumstances of some people's lives and the effect this must have upon the children, the 'evilness' of this man and fear for my own safety and a disgust towards the police who allowed me to end up in this scenario alone with Mrs X and the children. My emotions scurry between flight and fight a determination to 'stand up' to this bully, but a simultaneous recognition that I am petrified of what he will do should he choose to return.

Thursday 26th June 12 noon.
Shit!!! All work erased on disc. I deny reality at first, pacing the floor not wanting to believe or be told it has happened. I get more and more angry but have no target for these feelings. (This affected me for several days a disbelief and incredulity almost tearful, seeking sympathy but knowing there is no solution. Even phone calls to the computer company are futile).

2100 hrs
Spot check on children thought to be left home alone, no answer and in my view there was nobody in. I debate whether to call the police or not to break into what I believe to be an empty house (as this is what the daytime social worker had requested me to do). I leave a note and re-visit several times only to find the same lack of any signs of habitation. I decide not to call the police and, to add insult to injury cut my wrist when posting a note through the door of the house. (30/6/97- disbelief, Mum says she was actually in all night on the night that I called, absolutely no chance! Is it spite that suggests to me that she could now be repairing a door broken down by the police and applying to have her children back?)

Thursday 3rd July 1730hrs
This is the student's first time on duty and I notice how very nervous she is losing basic skills for example being able to open the door, follow simple instructions, she is hot and unusually flustered and unable to take in information or use the computer that

she has used without problems lots of times before. Useful to remember the level of responsibility EDT workers have and not to take this for granted; it was also useful to see the impact of nerves on a usually very competent worker.

Sunday 6th July 2300hrs
I feel omnipotent and as if I can handle anything that is thrown at me on EDT today as I have managed a very busy shift, I am learning to say 'no' to requests and feel more certain of my role and responsibilities. Even on a 'dodgy' mental health visit, possible suicide, I walked illegally, but confidently into the man's flat without his permission or knowledge and also in total darkness. Is this feeling of supreme ability the result of adrenalin, is it false and is it dangerous?

Saturday 12th July 2230 hrs.
Domestic violence to mother of seven children. I attend knowing that dad may arrive at any moment and once again fear for my personal safety, but simultaneously feel guilty that my fear should take precedence over that of this woman and her young children. The scenario fills me with anger and, again, a false idea that I will cope with whatever is to be thrown at me but these children and their mother will be moved by me tonight, whether some hairy-arsed father turns up shouting the odds or not. My usual flight response is strangely replaced by a fight reaction and one of being prepared should the dad arrive. I take control but try to keep mum informed about everything I am planning to do, namely move them all to alternative accommodation. What drives me here? Is it the pity for their plight that I feel, or is it the anger I feel towards the abusive father, or is it the role of child protector that this job demands of us?

Sunday 2000 hrs 7th September
Major conflict with the police regarding an eight year old victim of sexual abuse. The police want an EPO, PPO, but I refuse the former and argue against the latter suggesting that if they did take a PPO, I would place the child back at home (the alleged perpetrator was known to but not living with the family and I felt we would simply be punishing the victim further by removing them from home).
Autobiographically, I wonder how I managed to resist 4 senior police officers even when I was accused of various things including 'putting the child at risk' and 'creating a farce'. Part arrogance on my part, part believing what I was arguing for what right, part a detailed knowledge of the child protection procedures and also part because I detest being instructed to do anything, I stood firm. No PPO or EPO was taken.

Thursday 4th December 2300 hrs
Isn't it funny the way there is a knock on effect of feeling positive (or the opposite) in life and the way this seems to have the same impact on the way I feel at work. Today I have had a lovely day with family and friends and tonight I feel in complete control – mental health section. PACE interview, care package breakdown, child left home alone, no problem all taken in my stride; all this and it's my birthday as well!

Thursday 11th December 2215 hrs
Sister of a woman phones very concerned regarding the sister and her 4 children: Lad expelled, mum very low even depressed, tearful but nothing specific. Later another

sister phones demanding that I visit. I feel guilty at not visiting after the first contact, and fearful of what might happen if I don't visit, but still feel this is not an emergency. I ask myself what happens if nothing else comes in for the rest of the night and I am sat here twiddling my thumbs. On balance I think it is often easier to go out and do the visit than to say no and pass it to the daytime team. But this is an open case with ongoing social work involvement and nothing new has been indicated as having happened tonight. I do not visit and pass details to the area social worker.

Saturday 13th December 1330hrs
Absolute panic! I have been arrested at a football match in London for selling on two tickets for a friend. I feel my heartbeat racing, I feel helpless and hopeless, ashamed but angry for the 'crime' status this act has when compared to the 'touts' that are known to every supporter I know and who make a living out of their activities. I genuinely did not believe I had committed a crime and took exception to being treated as someone who had planned the entire process. Being processed by the custody sergeant made me feel powerless and worthless, angry at the inflexibility of a legal system that arrests me whilst others make a fortune from their trade; I was doing a favour for a mate! What a waste of resources, what a sad officer who arrested me for believing he was ridding the streets of criminals by arresting me.
Whilst in the cell it dawned on me that they were going to charge me. I am petrified that I may lose my job and I desperately want someone to tell me I will not lose my job and all will be okay, but nobody is there to help. All my awful pre-conceived stereotypes and dislikes about the police and the judicial system come flooding to my mind in a rage. This is bloody unfair and there is nothing I can do about it because this police force has a policy of prosecuting football related offences. I am interviewed and charged, fingerprints and photograph total degrading process and one I have treated too lightly as the appropriate adult many times before.
After much wrangling and many weeks later I 'win' and am awarded a 'caution' rather than having a criminal record. My line manger is informed and I keep my job!

New Years Eve 2310 hours
Once again a feeling of being able to manage anything that comes in as well as a false humility at having to work the New Year shift. Problems with an older person who is confused: Four carers already attend but the daughter is on the phone demanding more and insisting that I visit to assess. I chose not to visit as there is no apparent emergency but do feel awful the next morning to learn that the older person had become doubly incontinent through the night and had not gone to bed.

1998

Thursday 22nd January 1800 hours
Crisis of confidence for me as I have major relationship difficulties with my partner leading to separation (albeit, temporary as it turned out) and feel very low, no confidence, low self-esteem, indecisive. I attend a mental health assessment but decide not to 'section' but allow informal admission only to have to return three hours later to complete the application as the 'patient' was now refusing to stay on the ward. Again I am reminded that personal life can have professional implications for the way I practise.

Wednesday 13th May 1000 hours
Tutorial with supervisor – Feeling of beginning to regain the basic focus of the research which has been lost in the personal difficulties I have been experiencing. It was very useful to revisit the fundamentals of the research, especially the questionnaire and the objectives. Feelings of being completely lost begin now to disappear.

Thursday 14th May 1730 hours onwards
Despite the long day and the busy shift I feel in control and, once again, able to handle anything. There have been a number of complex referrals, massive pressure from 2 doctors to complete a 'section' and a feeling of vindication when the 'patient' agrees to attend hospital informally. I have a feeling of having much knowledge, clarity of role and a determination to be 'fair'.

Monday 22nd June
This was a hard shift: A 16 year old female heroin user refusing help; a 13 year old being threatened with being kicked out of his house, negotiation needed with dad; Spot check on drinking parent could not be found and this is worrying; 5 year old home alone, mum eventually found; suicidal 12 year old boy and mum at the end of her tether plus the request for the mental health application. This was an emotionally draining shift, all the calls seemed to be priority one, I missed the World Cup and yet I feel simultaneously as if I am chasing my tale and yet also in charge of what is going on.

Friday 28th August.
How frustrating it is to hear experienced EDT workers casually disregard masses of knowledge based on the 'fact' that it is 'academia gone mad'. How dangerous is EDT practice when it remains unchecked, powerful, autonomous and common sense orientated rather than theoretically sound. Throughout these interviews I have never ceased to be surprised by people's boredom by what I find fascinating.

Monday 23rd November.
Despite my attempts to equalise the interviewing relationship by openly acknowledging my own areas of weakness, gaps in knowledge and mistakes, I feel the theory set of questions provoked retreat into academic cynicism for some of the interviewees. This may well have been reflected in some of the responses to the following section on assessment during which I felt that the discussion became dismissive.

Thursday December 10th 1830 hours.
Dilemma – a 3 day old baby going off the ward home to mum who is a heroin user and partner who gets a methadone 'script'. They have both waited 72 hours (36 hours to ensure the baby is not withdrawing). Mum is not breastfeeding but has possibly taken some heroin since being on the ward. Regular 3 hourly feeds are given to baby by mum who is absolutely adamant that they are going home and that the agreement was for them to wait 36 hours before being discharged.
I decided that there was insufficient evidence to make a case for potential significant harm, and the midwife was due to visit first thing in the morning and then again in the afternoon, plus the social worker was also due to meet the family at home tomorrow.

*1945 hours phoned hospital and mum described as 'not being under the influence,'
and 'very gentle with the baby'. Agreed they should be discharged.
I contacted the social worker the next day who indicated a complete over-reaction by
the hospital staff last night and I felt relieved that my decision was consistent with
what the daytime worker would have done. It would, however, have been helpful to
have been put in the picture about this scenario beforehand.*

Sunday 13th December

*86 year old woman, Mrs R. keeps leaving the gas on her fire, she is described as
wandering, hoarding food (9 month old meals on wheels food in the oven), not eating
at all. The 2 Community Psychiatric Nurses, the GP and the niece have all requested
she be moved. I visit and turn off the gas, provide alternative electric heaters, plus
some electricity cards to ensure sufficient funds exist, increase the care package but
not to the 24 hour level demanded by the medics and the relative. I make the decision
that the situation is now safe enough to be left to the following working day but am
aware of the inherent dilemmas of this practice.*

Tuesday 15th December 0930 hrs

*Supervision – Feeling of clarity of direction for the research but also of the enormity
of the task ahead. I am suspicious of all the positives my supervisors pour on me but
at the same time intrigued by my frequent reluctance to accept my own level of
academic ability. I do feel inferior to my supervisors who appear as intellectual
athletes compared to my pedestrian attempt at research. Why do I find taking, and
giving for that matter, compliments so difficult?*

1999

*During this year I have started reading about the Inquiry reports into tragedies of
social work as part of the Literature Review. I am amazed at the lack of EDT
mentality but also the effect such reading is having on my practice:*

Thursday 1st July 1915 hrs:

*Having been asked to visit a 'well-known drinking mum' who had been seen drinking
during the day, I ring the bell for 15 minutes as well as the flat mate's bell. When I
eventually tracked mum down I 'pushed' her on tonight's events for information and
established that she was 'lying' to me to protect her partner. I was acutely aware of
the Inquiry reports that showed social workers 'backing down' when faced with
conflict and became even more determined that I would not be 'conned' by this mum,
and made sure that mum knew I did not believe her whilst also making sure she and
the child were safe from partner who was drunk but elsewhere. I arranged to return
later with the police to check he had not returned and all was well with mum and
child.
I recognised the impact my reading was having on my practice and would not be
'bullied' into simply leaving matters as mum wanted me to.*

Tuesday 2nd November

*I attend the North West EDT Annual Conference at which the author of the SSI Report
'Open All Hours' into the out of hours social work service, presents his findings. I am*

staggered by the shallowness of the methodology, the paucity of the sample group, the sweeping generalisations that underpin the 'Key Messages' and the 'cheek' that the findings of such a small scale piece of work can be extrapolated and presented as applying and having validity across the country. There is very much a feeling at the conference that we have enjoyed being 'in the shadows' for so long, and concern that this government report might be selectively quoted to bring EDT's into the daylight and thus, in line with our daytime counterparts.

31st December Millennium Eve.
Why am I at work when the entire world, it feels, is partying? Why am I such a sanctimonious git at times. I offer to do EDT, so why am I now moaning about it. Whilst the entire globe may be making new resolutions, I am negotiating with the police what to do with a drunken 15 year old arrested for criminal damage! This job has its ups and downs! What an interesting shift also because for the first time in my experience I was in the office with another EDT worker, (on the basis of the Millennium 'bug' sending all into chaos) and we shared the shift. It was interesting to discuss ways in which referrals could be handled or would not be dealt with. Interesting from another perspective was the fact that it was a very quiet shift and yet we had at least three times the normal amount of staff on duty with massive range of other support workers available to be called upon as required.

2000.

1pm, Monday 7th Feb,
Following supervision I feel again somewhat clearer re, the direction of the research, but also the large amount of work that I am going to have to fit in. I need to keep reflecting on the relationship between the research and my own practice and concentrate on one aspect of the work at a time to ensure the parts are finished off properly. Whilst supervision was positive, I feel weighted down by the amount that has to be done and unable to compartmentalise the different sections. It is interesting that, for the time being I decide simply to do nothing about it, not ignore it as such, but just have a break from the onslaught from work, research, home and union business. I realise that all that will happen is that I will begin to get restless because things are not being done, but, for the time being, this will be my strategy! I compensate for my work ethic by clearing certain days in my diary next month and beyond that will be committed solely to research and nothing else.

1730hours Thursday March 9th.
Telephone call from a Family Centre to report that a Mum is there, drunk and expecting to collect her children. The child is 7 years old. Decision is taken by me to take a PPO (Police Protection Order). Question of standards and degrees of drunkenness also assumption by the centre staff that this woman was 'unfit'. Question of objectivity of EDT with no historical knowledge of this woman, no relationship with her or the child and no likelihood of ever seeing her again irrespective of what I do tonight with the child. I am not prepared to collude with any lowering of parental standards, but this is a major decision to remove the child. I realise that socially the use of drink and its affect are far more likely to come to the attention of EDT than the daytime workers because of the times people tend to use and abuse alcohol. Fortunately there is one placement available, but what would I have done if there had not been any vacancies, would this have affected my decision to seek an order? I think

the reality is that it might have done given some of the other factors such as the age of the child (young, but not a baby), and Mum's alleged chronic use of alcohol that the dept. is aware of. No friends or relatives available though to help out; the child though is being punished because there are insufficient resources to support parents in such circumstances. The child had to be literally dragged away from the mother who could neither stand up straight or speak coherently. A member of staff from the centre came with me to the foster placement and the child seemed to settle worryingly quickly into this, albeit temporary, new 'home'. I felt that the child had been held back by the mum, not that he was trying to stay with her. Again though, all very sad for mother and child.

1000hours, Monday, 27th March
Supervision with my tutor and discussion re the joint paper is exciting for me, and all new territory. Blocking out certain times for research seems to be working and I am in a positive frame of mind towards the tasks ahead. It is worthy of note that the way I am feeling towards the research and the way I feel generally towards EDT and other life matters are in tune. In other words there is an interconnection between feeling bad about work that impacts upon my research and other life aspects. I am reminded of the inside cog mechanisms of a clock whereby the smallest (least obvious) cog can impact massively upon the largest one as they are all interrelated.
There is no doubt in my mind also that the news of the pregnancy of my partner is putting all else in a different context of importance. I am seeing things differently for the time being in terms of the practical things that will have to be done, and, therefore the things that will get left undone, but also there is a rethinking of the things that really matter in my life – this birth of a baby v EDT v Research v Union is almost continually fleeting through my mind as too is the mixture of anxiety and anticipation. I cannot get worried about some things when others seem so much more important. Already I am seeing child care and 'abuse' as more of a personal priority.

2150hours Friday June 9th
Home Visit – observed drug dealing going on outside the house I was due to visit and was then refused entry to the house by the same dealers. Reluctantly, but eventually they let me passed for me only to be refused access to the house by the mother. I could see the child inside the house from the doorstep of the interview, but could not investigate the anonymous allegation that there were needles lying around the house. Question – Do I phone the police to seek access? I feel annoyed because I was threatened by the dealers outside, did not gain access to the house and I knew I was being lied to by the Mum (because of her craving for heroin). I believed there was no immediate risk to the child, but irritated by having to 'back down' and not progress the matter. I know I am feeling prickly about child care matters because of the pending (October) arrival of my own child, and struggle with the conditions some families live in. I also though struggle with these feelings as I do not wish to pathologise the victims, but neither do I wish to 'allow' children to be put at unacceptable levels of risk when there might be something I can do.
I discussed the referral with the incoming EDT worker the following morning who said they would have done the same as me. The process of being able to share the concern was a refreshing and helpful one, even if we both got the 'answer' wrong!

Sunday October 1st 0127 hours: Birth of my baby girl.

I feel absolutely fantastic and cannot begin to imagine how it must feel for any parent to have their child removed at birth against their wishes, as I have had to do as part of EDT work. All the clichés are true, and easily the best moment of my life. The knock on effect for my research and social work is a re-evaluation of what is important, but also what standards of human behaviour are unacceptable.

October 3-4th NWEDT Conference

Positive response to the questionnaires handed out and the follow up interviews. EDT workers seemed genuinely interested in the content and process of the work, and happy to participate. A massive amount of information has been gathered and now starts the process of trying to make some sense of it all. I am sure that I am working on pure adrenalin since the baby's birth and at the same time am struggling to take anything else with any seriousness.

2001

Saturday, January 27th Holocaust Memorial Day,

I am heavily involved in a local Holocaust Memorial Project that seeks to promote understanding of and learn lessons from the events of the Holocaust. Organising events including trips to Auschwitz with survivors seems to put EDT work into a different perspective: Whilst there are commonalities such as the institutional inequalities, human cruelty to other humans and social divisions, the events of the 2nd World War are on a scale and intensity that I find much more difficult to comprehend. Once again the experiences of the Project tend to feed into my abhorrence of cruelty, injustice and 'bullying' and feed my determination to tackle such issues as they arise on EDT. This though is tempered by a recognition of the limitations of such social work practice and an acknowledgement that as an EDT officer I am also part of the problem.

Tues February 13th

Student Supervision – once again, what a refreshing experience having a student on placement with the team. It provides a sounding board for practice and a challenge to what I thought were aspects of good practice. Whilst embarrassing, it is most helpful to realise that I, as an EDT worker do not always practise as fairly (to the service user) as I would like to believe.

Thursday, May 24th 2315 hours

Homeless male 25 years old referred for accommodation. Once again I get annoyed that I am having to tell the referrer that there is little to be offered this man, other than contact numbers of hostels and 'sympathetic' B&B's. I begin trying to think of ways in which the present government may make real differences to the people that come EDT's way, but also recognise that part of this is my unwillingness to say 'no' and to acknowledge the limitations to the out of hours service. I try to think of ways to 'bend the rules' to offer more practical help to this man, but then the phone goes and it's an anonymous allegation that a child is being neglected...I wonder what happened to that homeless man?

Monday June 18th
Industrial Action commences in our authority in support of retaining 'in-house'
residential care for older people in contrast to Best Value recommendations that some
should close and be 'externalised'. Our Trade Union Branch grants no exemptions to
this action including children's homes, older person's residential homes and EDT. As
an EDT worker and Chair of the Trade Union I feel positive about the action, but
nervous of the ramifications. At the same time I am aware that sometimes we all have
to say 'enough is enough' and that 'some things are just simply wrong'. I am
interested by the employer's response and my perception of their effort being put into
trying to get EDT exempted, especially considering there is only one person on duty
at any one time!

Monday July 2nd
The industrial action ramifications (see June 18th) have started and I have been at the
High Court today as part of a team defending the industrial action. I feel that all
social workers should be here, indeed all council workers and service users should
also be in attendance in support of public services and in opposition to privatisation. I
feel that my role as an EDT worker and as a trade union official are actually at one
with each other and the aims, for once feel the same, albeit that the route to the goal
taken might be different. I think back to all the EDT workers I have met, sent
questionnaires to and have interviewed as part of my research and question whether
they would make the same connections politically between EDT work and strike
action. I suspect that most would not (there are some notable exceptions) and wonder,
given that the majority of present EDT workers in the country have been around for
so many years, and the fact that the very existence of EDT's stems from Trade Union
intervention, why has our profession become so de-politicised.

Wednesday 11th July
4 way supervision with tutorial mentors. I feel quite humbled and de-skilled by my
tutors' ability to internalise the content of my, by now lengthy, thesis and, without
recourse to looking at notes then provide a detailed and accurate verbal critique of
my work so far. I am thoroughly impressed by such intellectual athleticism but
somewhat concerned that I might have to attain anything like this standard. I take
ridiculous solace in my comforting belief that I am not an 'academic' but a
'practitioner', whilst in the back of my mind also accepting my desire to be both.
What a complex set of values I have, is it any wonder my EDT practice may fluctuate!

Sunday 26th August 0945 hours
Referral regarding a young woman with a learning disability found wandering in the
street in her night clothes, no shoes at 0930 hours. Person knows her name but cannot
say where she lives as she has not been there long. I establish her placement via our
computerised records, contact the residential establishment and am astounded by
their lack of concern that this woman was missing. I become quite irate on the phone
with the manager who argues that 'normalisation' means permitting people to make
their own decisions! I know I am angry because of the manager and the distressed
state the service user is in, but I also suspect I am annoyed because this is an
independent home charging significant sums of money, but one, I feel that is not
providing a safe level of care for this particular resident. I complete the relevant

'default notices' and write formally to the Inspection Unit, but feel the whole public sector system is unfair and the 'victims' are those such as this woman.

Monday 3rd September
I am invited to become a tutor for Social Work Students at the University I am carrying out my PhD. On the one hand I am quite proud to be asked, but on the other I am very nervous at the prospect of being aligned to the very staff I felt de-skilled by (see 11th July). Ever over confident in my own abilities, I agree to take the job.

Monday 3rd November
Competing referrals of Priority status 1 arrive whilst I am on duty. I begin meticulously planning the manner in which they will be prioritised as if this is a test of my research application. I find myself getting tied up in knots and reverting to practical questions such as which service user is least safe at the moment, which one is in a safe place (police station, hospital) and which is the furthest one away! I choose to visit the anonymous allegation that some children under 11 years of age are 'home alone' because I know least about this situation and, potentially, it is the most risky (or not as the case turned out to be malicious or misguided).

Friday 7th December.
Training Day for our EDT workers on the role of the Appropriate Adult under PACE (Police and Criminal Evidence Act). I am amazed at the different practices that exist within this one small set of EDT workers. It turned out that we all take on slightly different roles and responsibilities when at the police station. For example whether we sit in with the solicitor when s/he is interviewing the young person or not; whether we feel we can give consent for fingerprints to be taken of a young person aged 12 years, and whether we 'allow' interviews to occur after midnight when the young person may require the period of rest. The conclusion was that there should be greater consistency without losing flexibility.

Monday 31st December (New Years Eve).
Oh the joys of being an EDT worker when it seems that the rest of then world are out partying, I am stuck in this office waiting for the phone to ring, and it has been ringing, too often for my liking!

<u>**2002**</u>

Sunday 14th March 1320 hours
A particularly difficult mental health act assessment is referred to me on EDT. It is a request by a locum G.P. (not section 12 approved under the Mental Health Act 1983 as having had specific training in psychiatry) for me to attend to assess a woman in her 80's who has 'given up on life', is experiencing auditory hallucinations and responding to 'the voices' but is also, 'compos mentis', according to the doctor. The difficulty I have is not with the assessment as such, but with the practicalities of getting the other 2 doctors to attend at the same time as I do to ensure the necessary dialogue takes place. I am continually frustrated by the limited access to other professional after hours, and for a moment feel how it must be for a member of the public attempting to access certain 'welfare' services outside of 'normal' office hours. Completely at a loss as to how I can get a medic to visit, I visit alone to find a woman

who, in my view, is 'safe' to be left at home with a night-sitter that I have already established is available. I am not sure what the outcome may have been if my access to the medics had been easier, nor do I know what happened the following day (Monday) when I passed the details to the daytime team requesting an urgent follow up assessment. Whether this was a 'needs led assessment' or a 'service availability tailoring exercise' is debatable. What is not beyond doubt is the out of hours frustration that must be felt throughout the country when sometimes even statutory duties cannot properly be carried out.

Wednesday 27th March

I attend an interview for a promotion to the post of EDT Manager/Practitioner. I have genuinely not prepared for the interview, other than all the research and reading undertaken for this thesis, however I enter the interview full of confidence that I am the best person for the post because I know more about EDT than any of the other candidates and more than the panel asking the questions. I fully expect to be offered the post, but have also prepared my 'defence' that it was not offered due to my 'political activities'. I am nervous and uncomfortable only because these feelings border on the complete arrogance.

A week later I am offered the post and now I have to combine the role of researcher, EDT worker and EDT manager with responsibilities for ensuring the development of the out of hours service.

All of a sudden it dawns on me that many of the inconsistencies highlighted in my research, and the out of hours dangers, have now become my responsibility (in part) to produce appropriate responses and safeguards.

April

I am sent copies of the article co-written with my tutor that has appeared in the British Journal of Social Work and feel very proud of the finished article partly because I have never had anything published before, but also because it is one small way of putting EDT 'on the map' and raising the profile of a service that is generally 'out of sight and out of mind.'

Tuesday 11th June

I attend the AGM for ESSA (Emergency Social Services Association) and feel very positive again (see April above) that reference is actually being made to my jointly written article by some of the presenters at the AGM. It also highlights the fact that so little has ever been published about EDT's and that colleagues are grateful to see such material in print.

Tuesday 23rd July

'Viva' at Liverpool John Moores University. I suddenly realise that this 6 year project is coming to an end and fear that I have much still to do. The Viva seemed to go okay but, quite rightly I am advised that certain areas must be improved upon before final submission. I come away feeling that maybe the panel were 'gentle' with me or that I did not really take in all their advice. I do now believe that the end is in sight, and yet I also feel that the work is really only just beginning. I am once again grateful for the sound advice given by 'the panel' and, again, envious of their intellect and knowledge.

Tuesday 24th September
North West EDT Annual Conference.
The prospect of sitting listening to presenters on EDT matters for 2 whole days is
shattered by a request on the day of the conference, for me to cover a couple of hours
explaining my research. I spend much of the day worried about what I should say.
The session itself was challenging to me certainly and, according to the feedback, the
audience also.

Sunday 29th September 1930 hours
The classic 'come and get him' EDT referral from the parent who has simply been
pushed over the edge. I desperately try to be clear about the structure of the
discussion, aware that I want to understand the caller's plight but, at the same time
beginning to make the decision that the child should not be removed from the home
until the department (i.e. the daytime teams) have had the opportunity to work with
the situation. I use a strategy learned from the second day of the conference 'if in
doubt summarise' that enabled me to make sure I had got the details correct, but also
the caller to feel that they had been listened to. I end the discussion with some agreed
strategies for coping with the child until tomorrow and an assurance that the details
will be passed to the daytime team for their follow up without making false promises
as to when this might be. I do wonder though if sometimes all EDT can offer is a
listening ear, not that this is without its uses.

2003

The research is at an end and there is for me a strange mixture of immense relief that
it is over, but also some feelings that this will never really be finished and already
there are aspects of the thesis that I would wish to revisit. Without doubt the process
has been extremely challenging, I remain disappointed with the Assessment
Framework, but accept it still needs to be developed. I look forward for a while to
only using my home computer to play games on with the little people in my life and
thank Liz for all her support, patience and sustained interest. I have no idea how this
will be received but feel confident that I have to draw it to a conclusion at some stage.
I also feel that my practice will now be much more theory aware, more socialist and
seek to contextualise far more in socio-economic-political terms, rather than
addressing individualistic aspects of referrals to EDT.

If you have got this far reading this research, you too deserve thanks, credit and a
rest!!

Signing off for then last time, Glen Williams.

14
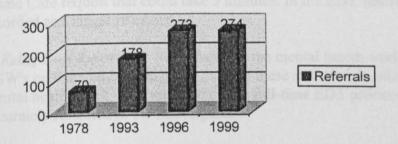
Presentation to Phase 1 Management Team

EDT Referral Rates.

Chart 1, below illustrates that the referral rates to EDT since its creation in 1978 have risen by over 300%.

CHART 1.

December Referrals 1978-99
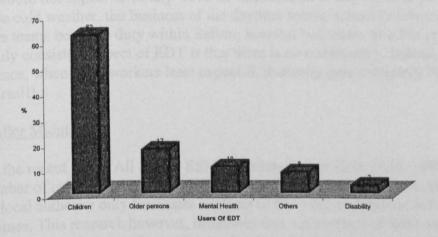
Over the past 5 years the average 'referral' (notwithstanding the variable definition thereof) rate for the out of hours team, is 2,500.

As can be seen from CHART 2, the majority of the work annually undertaken by EDT (62%) is related to child care (including duties under PACE). Work related to older persons is the second largest source of referral for EDT (17% of all referrals) with Mental Health work with adults forming the third largest referral rate (10%).

CHART 2.

EDT Percentage of Service Users

Referral rate versus time occupied.

'Cold' statistics in themselves can be misleading without clarification, and, in order to make accurate sense of the EDT figures a number of factors need to be acknowledged:

1/ *There is a differing notion of what constitutes a referral*: A tentative definition would be that it is **any recorded piece of work that is passed over to the daytime offices whether that be an open or closed 'case'.** The difficulty is that this is not, as yet, a uniformly applied working definition and so some workers record a piece of work as a referral, whilst others, with the same scenario, might not.

2/ *The number of referrals does not necessarily indicate the workload:* One 'referral' for a mental health assessment, for example, may take 5 hours, as opposed to the one Home Care request that could take 5 minutes. In the EDT statistics they are each recorded as a single referral.

3/ *Relief Pool Recording:* It is a fact that the mental health work undertaken by the ASW's on rostered backup is not fed into these statistics. In other words, all the mental health work undertaken when the full-time EDT officers are off is not accurately reflected in the final figures.

Patterns in Referral Rates to EDT.

Research into this Authority's referral patterns tend to suggest that certain days and months are 'busier' than others:
The evidence shows that December is regularly the busiest month for EDT whether this is measured in terms of the time occupied or the actual number of referrals taken by the team. June and July tend to be less busy using the same criteria.
The statistics demonstrate a degree of correlation between hours occupied and the referrals received.
Friday is the busiest shift (hours worked and referrals taken), closely followed by Saturday. The rest of the week tends to have no real fixed pattern.
There would not appear to be any 'obvious' explanation to any of these patterns. For example cold weather, the business of the daytime teams, school holidays, other out of hours teams being on duty within Sefton, hospital bed crises or a Flu epidemic! The only truly consistent aspect of EDT is that there is no consistency. Indeed, from experience, when EDT workers least expect it, it usually gets extremely busy, and vice versa!!!

EDT After Midnight.

Whilst the recent 'Open All Hours' SSI Inspection Report (SSI, DoH, 1999) looked at the number of referrals received by EDT before and after midnight, the data available to this local authority only facilitates analysis of the work undertaken before and after these times. This research however, illustrates that, on average, at least one third of EDT's work is carried out after midnight. Logistically the percentages are problematic because EDT works more hours after midnight than it does before, and so only a more detailed and complex analysis of the data would provide an exact pro-rata figure. The past 6 years have consistently demonstrated that over 34% of the EDT workload takes place after midnight.

APPENDIX 13

Covering Letters to NWEDT and ESSA

TO ALL EDT WORKERS IN THE NORTH WEST
EDT RESEARCH.

The questionnaire that has been faxed to you is an attempt to examine the way in which we prioritise/assess referrals as they come into us whilst on EDT duty. The same questionnaire was presented at the recent North West EDT Conference (thanks to all who returned it). This is a further attempt to ensure as many EDT workers as possible participate in this research. If you have already completed a 'survey' please DO NOT complete another one, but pass it to a colleague who was not present at the Conference.

Despite the 'inspection' of EDT ('Open All Hours'), it is felt that there were both large gaps of EDT that were not discussed, as well as some that possibly misrepresented the reality of doing EDT as we know it.
Part of the purpose of this exercise is an attempt to provide much more detail regarding the real dilemmas that face EDT workers when required to assess referrals of competing priority and when under a range of differing pressures.

The SSI and the ADSS have already approved this research, and it is the intention to feedback (anonymously) the results of this exercise.

This whole exercise is part of a 6 year PhD study of EDT that will be/should be completed in 2002.
I sincerely hope that you will agree to be part of this unique research that should provide a detailed analysis of the way in which we operate outside of office hours.

The completion of this questionnaire is completely confidential and no attempt will be made to try and identify those that fill them in. The only reason for requiring you to identify your gender and the 'type' of EDT team you work in, is to test a hypothesis concerning possible different EDT responses between men and women, and to examine the influences, if any such exist, between working alone and working with others.

The questionnaire should take approximately 20 minutes to complete, and I would like to thank you in advance for taking the time to be part of this study.

Thanks again for supporting this research.

Glen Williams, EDT Worker,   M.B.C.

PLEASE FAX YOUR COMPLETED QUESTIONNAIRES TO THE EDT
OFFICE: 3846 (or if you wish send them to the above EDT address)

ESSA ANNUAL CONFERENCE

EDT RESEARCH.

The questionnaire attached is an attempt to examine the way in which we prioiritise/assess referrals as they come into us whilst on EDT duty.

Despite the 'inspection' of EDT ('Open All Hours'), it is felt that there were both large gaps of EDT that were not discussed, as well as some that possibly misrepresented the reality of doing EDT as we know it.
Part of the purpose of this exercise is an attempt to provide much more detail regarding the real dilemmas that face EDT workers when required to assess referrals of competing priority and when under a range of differing pressures.

The SSI and the ADSS have already been informed, and have approved of this research, and it is the intention to feedback (anonymously) the results of this exercise.

The data collected from this questionnaire will also be followed up in some of the Local Authorities, by some direct observation of your EDT system 'at work'.

This whole exercise is part of a 6 year PhD study of EDT that will be should be completed in 2002.
I sincerely hope that you will agree to be part of this unique research that should provide a detailed analysis of the way in which we operate outside of office hours.

The completion of this questionnaire is completely confidential and no attempt will be made to try and identify those that fill them in. The only reason for requiring you to identify your gender and the 'type' of EDT team you work in, is to test a hypothesis concerning possible different EDT responses between men and women, and to examine the influences, if any such exist, between working alone and working with others.

The questionnaire should take approximately 20 minutes to complete, and I would like to thank you in advance for taking the time to be part of this study.

It is my intention to present the findings to this group at a later date and to make available a written synopsis of the final thesis.

Thanks again for supporting this research.

Glen Williams, EDT Worker,   M.B.C.

APPENDIX 14.

Phase 2 Responses in Full

Question 12: How is a decision made to visit a service user (please explain who is involved and what factors are considered)?
(90 of the 91 respondents provided a written comment to this question)

1. *'Telephone assessment made – Home visit depends on result of assessment and current workload of team'*

2. *'Risk CP – MH or Breakdown of placement at home or in placement.'*

3. *EDT worker on duty makes this decision; based firstly on statutory responsibilities and priorities. In smaller Unitary Boroughs, I believe there is greater scope for visiting to help resolve situation where there is less clarity of clear statutory responsibility.'*

4. *A statutory request could automatically need a home visit. If there appears to be an unclear need and the degree of response is not clear then a visit would be appropriate. 'B' is a geographically very small area, so visits do not take long.'*

5. *'The urgency of the situation. Whether assessment is required. Usually no visits to ongoing clients.' (4 & 5 are from the same authority.)*

6. *'Risk Assessment. Team philosophy.'*

7. *EDT worker on shift makes the decision, - self-managing team. May consult with appropriate daytime team manager. Different arrangements for different decisions.*

8. *'Degree of emergency and nature of emergency.'*

9. *Decisions made by EDT worker – risk assessment undertaken, some situations specified, e.g. accommodation of children.*

10. *Statutory responsibility in child protection and Mental Health often dictate a visit, but also other circumstances where concern is high and an immediate assessment of the situation is required often a manager of another service may be involved.*

11. *Safety of user or carer; high priority cases; service user's distress or difficulty; all where emergency assessment is needed.*

12. *Senior on duty assesses risk and marshals resources. E.g. uses other agencies 'in situ' to safeguard family resolve. Visit made when need to respond clarified and role clear.*

13. Manager and social worker make decision. Situation cannot wait until the next working day. Resource available to meet need. Input will have an effect on situation. Statutory requirement. (12 & 13 from same authority).

14. The operator (social worker) will assess the situation over the telephone based on information given by the referrer and information from the computer system or child protection notes. Factors considered are related to the likelihood of a person coming to harm, statutory requirements, i.e. mental health assessment and PACE; prevention of foster/family breakdown.

15. 'Initial info from phone call.' (14 & 15 from same authority)

16. 'Individual taking the call makes a risk assessment/benefits of an intervention strategy based on a home visit.'

17. 'Nature of the problem, degree of urgency, availability of worker. EDT worker decides with occasional back-up from on-call manager.' (16 & 17 same authority)

18. 'EDT worker decides (could consult manager if really necessary but rarely). Legislation is the first criteria. I.e. Sec 136, sec 2 or 3, sec 47. Assessment of elderly admission needed, granting sec 17 money or travel warrant.'

19. 'Discussion between social worker receiving the call and doing initial assessment and shift co-ordinator. Factors considered: Statutory responsibility; degree of perceived risk; availability of staff; anticipated effectiveness of visit (roughly in that order).'

20. 'Social Worker in discussion with the duty manager.'

21. 'Worker's own judgement – only if assessment/care provision cannot be co-ordinated/decided/arranged by phone.'

22. 'Worker's judgement – safety, statutory responsibility, co-working with other agencies.'

23. 'Number of referrals being dealt with at any point of time, number of staff on duty, level of concern about the situation.'

24. 'Depends on the nature of the referral – child protection, joint decision with the police CPT; adults – mental health could be at request of doctor – need to assess under the MHA. Person with disability may be unable to communicate over the phone – decision may be made with police if risk to safety involved.'

25. 'Decision taken by involved social worker. Statutory responsibilities. Nature of degree of risk.'

26. 'Lone worker decision made sometimes in conjunction with other agencies. Rarely in consultation with social services manager.'

27. *By social worker in discussion with shift leader, the latter being a manager who is present during daytime and evening shifts and on call from midnight to 9am.xxxxx (could not read writing) factors would trigger a visit, e.g. child protection issues, MHA assessments. We would also call out care manager to assess elderly clients for care package where a new/urgent situation arose. Preventive considerations may also trigger a visit, e.g. a family crisis to prevent accommodation of a child.'*

28. *'Shift leader decides with social worker – supervises the SW on duty – office based service.' (27 & 28 from same Authority).*

29. *'2 social workers would discuss the referral and decide on basis of risk and need of service user, family carers, referrers etc.'*

30. *'All calls routed via a Team Manager as duty coordinator who prioritises and sends 'runners' out as appropriate.'*

31. *'Decision is made by the social worker who takes the referral. There is no requirement to consult the other social worker on shift but most team members do to gain agreement.'*

32. *'In consultation with other members on duty and/or manager, if available to consult with. Some requests don't require consultation e.g. Sections. Factors considered – risk levels between now and when daytime shift starts, whether a visit will assist with assessment (e.g. in order to put home care in).'*

33. *'Certain jobs must involve visit i.e. accommodation of child, accommodation of elderly person, mental health assessment. Otherwise it is the social worker's decision whether a visit is required to gather information/make an assessment.' (31, 32 & 33 from same Authority).*

34. *'Information received/assessed by office based coordinator who then allocates the task to social worker; might be some consultation. N.B. Team members take both roles on rota.'*

35. *'Via a process of risk assessment and prioritisation.' (34 & 35 from same Authority)*

36. *Team manager, social worker and F.S.U. would be involved in child protection and hospital.'*

37. *'By coordinator/Resource Manager.'*

38. *'Is it an emergency? Is anyone in need of immediate protection? Is there need for urgent assessment? Can it be held together until other services can be accessed? Legal obligations? Policy? Good practice?'*

39. *'Main decision made by the manager who has responsibility for allocation. Occasionally there will be Team discussion on the matter.' (36-39 from same Authority).*

40. *'EDT respond to situations that cannot safely be left until the next working day. Child Care (Child Protection) and then ASW take priority.'*

41. *'If it's a stat. responsib. then we have to go. We have on call manager to consult about visiting.'*

42. *'In accordance with priorities policy.'*

43. *'EDT worker's decision. Consideration of risk to service user, need to visit to assess risk, procedures in case of child protection only. Health & Safety factors i.e. lone-working EDT social worker; policy regarding rationing of residential home places (child care only).'*

44. *'In most cases I decide for myself. Occasionally I discuss possible action with a manager, child care referrals especially.'*

45. *'On the basis of eligibility criteria (is it an emergency?) and prioritisation of work coming in. The worker normally decided for themselves; occasionally consults with myself or another manager.'*

46. *'If considered necessary to protect the welfare of a child or vulnerable adult. This would be my decision based on the information available.' (43-46 from same Authority).*

47. *'In discussion between referrer & EDT telephone coordinator, followed by discussion between coordinator and call out social worker.'*

48. *'Decision usually made by one member of staff taking telephone calls, sometimes decision made in consultation with visiting colleague and occasionally after consulting daytime staff/manager.'*

49. *'Entirely the decision of the worker on telephone duty – can be discussed with colleague, colleague can challenge but decision lies with the person who took the referral.*

50. *'The person on telephone duty makes the decision and then consults with the visiting person. Sometimes there is discussion whether or not to make the visit between these two officers or with consultation with police via strategy meeting in child protection cases. Safety factors are taken into consideration also urgency.' (48-50 from same Authority).*

51. *'Made at the time via risk assessment'*

52. *'Single worker – basis of need – depends whether I am in or already out – is it safe?'*

53. *'Only social worker on duty involved in decision to visit (sometimes, not very often, in consultation with management). Factors considered: level of risk, what service is required, who makes referral and why?'*

54. 'Individual's decision. As EDT worker, I would do assessment of risk. Also need to prioritise (sic) as lone worker. Look at referrals and prioritise what level of risk is involved – will the situation hold until the next working day. At times will consult with manager when needed.' (52-54 from same Authority).

55. 'There is a duty manager on each shift – my role – and we have to prioritise the incoming work bearing in mind departmental procedures, legal obligations and levels of crisis. The duty manager decides who will visit (if anyone).'

56. 'Level of need is priority. Availability of appropriate staff. Violence at work issue. Increasingly visits done by sessional staff attached to various projects – "managed" by full-time EDT staff.'

57. 'Duty managers prioritise referrals and allocate to relevant staff who are either office based or 'on call' from home.'

58. 'By the duty S.W.' (55-58 from same Authority).

59. 'Decision made by 2 or 1 Social worker on duty. Criteria – statutory duty, risk, can't wait until end of shift'.

60. 'By the SW who takes the call. May consult with the other worker if available and if worker doubtful.'

61. 'Mental health assessments and Child Protection identified as priorities in Service Level Agreement, but access all client groups in immediate danger is the over-riding consideration. If the matter cannot be contained over the phone and the matter cannot wait until the next working day.'

62. 'Duty Manager decision – based on urgency/availability of staff.'

63. 'EDT Manager, degree of urgency.' (62 & 63 from same Authority).

64. 'Worker only decides. Dependent upon service requested, degree of urgency, element of risk and need for assessment.'

65. 'I decide whether a visit will elicit additional info not available on the phone and there is a large element of back covering, i.e. will I get into trouble if I haven't visited this one.'

66. 'Response to statutory requirements in the main or major change of circumstances. Risk/legislation driven. Usually single worker call out.'

67. 'Only if absolutely necessary.' (62-66 from same Authority).

68. 'This is at social worker's discretion. If can't sort issue over the phone you visit. If you have reservations telephone duty OPS Manager and discuss.'

69. 'Decisions are made by the worker, but discussion takes place with others on the team at the time.'

70. 'High need risk, can't wait until the next day. Decided by the worker on duty.' (69 & 70 from same Authority).

71. 'The 'control' worker prioritises and decides whether a visit is necessary. Dependant on risks, e.g. child protection would be more important than PACE. Also legal necessity and plus worker availability.'

72. 'Worker usually makes the decision as to whether or not a visit is required. Factors include risk, need for assessment based on first hand observations and contact.'

73. 'Main priority is whether client is at risk currently.'

74. 'Lone worker, no management back up. If visiting potentially risky situation request police back up. Only visit if situation cannot safely be left to the next working day.'

75. 'Assessment of risk to client or others. Families/individuals going through 'crisis' and need an immediate response. Prevention to avoid complete breakdown.

76. 'Front-line worker and either ASW or child care, older people's worker, appropriate adult worker, then discuss the appropriateness of further action.'

77. 'Risk, stat. Responsibility, will it keep?' (76 & 77 from the same Authority)

78. 'Following written procedures and guidelines. Risk to service user/others, history, statutory duties/child protection/mental health/adult/new – existing service users. Reports from area teams as to response suggested, availability of EDT worker to visit.'

79. 'Depending on 1. health & safety of service user/others; 2. vulnerability of service user/others; 3. Possible consequences of not visiting now. EDT worker makes the decision, but may be dependent on other agencies (e.g. police) to negotiate joint visit or joint action.'

80. 'I make the decision as to whether or not to visit. Is it safe to go alone? I have option of asking for police accompaniment or I can ask our own security firm to accompany me.'

81. 'Decision is made by me as a lone worker. Usually factors involved are priority of need e.g. matter cannot be dealt with any other way – alongside this would be consider health & safety of worker.'

82. 'Entirely based on the prevailing circumstances and level of demand at the time.' (79-82 from the same Authority).

83. 'As deemed appropriate by the duty SW. The duty SDW alone.'

84. 'Decision made by the duty Social Workers.'

85. 'EDT coordinator decision.'

86. 'The duty resource manager decides.'

87. 'Urgency, protection issues, safety and need to involve others. Information about user.'

88. 'Risk assessment made by worker on duty – if in doubt, consultation is made via manager who is always available.'

89. 'Worker and colleague – usually safety of user is the priority.'

90. 'Control worker manages decision to visit and prioritisation. Legal responsibilities paramount and risk. Weather conditions and distance to travel will inform decision, i.e. recent floods availability of other personnel, i.e. police, neighbours etc.

Question 14: EDT workers appear to have differing priorities between competing referrals, why do you think this might be?

1. *Different interpretations of criteria maybe depend on the historical perspective of the EDT worker, i.e. former childcare worker v former mental health worker. Also knowledge of current local resources may affect the decision.*
2. *Because of their career background, their understanding of the law, departmental instructions, pressure from other professionals.*
3. *Cultural differences and geography: If EDT covers a large geographical area visits are more time consuming and one is aware of other higher priority case becoming active. Our team is newly formed and only one member has worker as EDT. Our history is of home visits being the norm and we have tended to bring that with us.*
4. *The background from which they came (MW,CC etc). Which person requires the earliest attention*
5. *Our team is close knit and work fairly consistently*
6. *Individuals working independently without written procedures. Although these are developing – practice takes longer to change.*

7. *Because assessing and screening referrals is based on experience. Some EDT are from elderly backgrounds, some from L.D. or mental health, others from childcare. There may be differing levels of knowledge regarding resources or legal/guidelines/protocol/policy requirements.*

8. *Different professional background, no clear policies, subjectivity*

9. *This is not my experience – and EDT priorities are usually based on assessment of risk and departmental policy.*

10. *Age, sex, race, attitudes, view of service function (9 (identifies himself as the manager) & 10 from same authority, also interesting because '9' saw the service as emergencies only and the other saw it as both emergencies and an extension of daytime social work in question 8)*

11. *Individualised interpretation of risk, resolution and application of theory, legal framework to practise. Bottom line following assessment of risk is to take appropriate steps in partnership with other agencies, family etc to safeguard, using legal power to secure safety if needed.*

12. *Background, training, risk level, stat. Requirement, availability of resources and experience.*

13. *A variety of reasons: 1/ Different workers expertise and skill with a particular client group may mean they are either likely to leave things – i.e. feel confident everything will be ok & await daytime services – or have a commitment to provide an out of hours type service. 2/ Very little research available regarding what works in EDT or where priorities should be, but maybe this isn't that different than what happens in the daytime – i.e. daytime services would also show differing priorities. 3/ We are probably inconsistent ourselves re. Priorities – depending on variety of factors, immediate (i.e. tired/stressed) or wider (i.e. responses to child protection type enquiry may be responded to in a different manner if there has recently been a death of a child. 4/ As a new member of the team (joined date given as 3 years ago, detail withheld to retain anonymity by author) I think that I tried to respond very quickly to stabilise – I still continue to operate like that to some degree, but experience has taught me that a number of situations 'cool down' naturally – so maybe sometimes it is better to wait a little.*

14. *Shortage of resources, different perspectives. I would presume that there is a consensus re. 'emergencies'.*

15. *Disagree with the question!!*

16. *Difference in personalities/experience/social work background*

17. *I think differing priorities happen at the margins, rather than in obvious cases. Factors might be skills of the worker and sense of effectiveness; prior knowledge of case.*

18. *EDT workers are individuals and the level/quality of their service reflects this individuality. In a situation where people work entirely alone this is unavoidable.*

19. *Different work experience/perceptions of need.*

20. *Lack of clear policy.*

21. *Lone working, independence, lack of supervision. Authority's emphasis on 'coping' out of hours.*

22. *Some people do not like to leave the office, they would prefer to commission other people to do the direct work.*

23. *My priorities are related to safety factors first – pressure from other agencies e.g. police) may influence their ability to maintain professional SW approach.*

24. *This would be to do with perceived level of risk to clients. However, I think prioritisation of referrals is more of an issue in the larger authorities with several people on duty at the same time.*

25. *Some social workers might make decisions dependent on their own strengths and weaknesses. This is especially true of EDT workers who have been in EDT a long time and where they have not been helped to keep up to date in all aspects of generic work*

26. *Not up to runners, ask coordinators*

27. *Sorry to say this but EDT workers go out to get away from the office and from the telephone!!*

28. *More a case of some workers will go out on some referrals when others wouldn't, but may offer a service, and others would just refuse a service. Depends on how client centred worker is and maybe also perceptions of level of service we are offering.*

29. *Personal preference/travel involved.*

30. *Worker's own professional background; knowledge of the worker; resources available both immediate and future; issues of time and distance; presented risk to service user; support available in family/community.*

31. *Subjectivity, knowledge base/experience, value base*

32. *Level of risk to individuals and community pitched against those requiring practical assistance.*

33. *Numbers of s/w's available. Resources and other agencies.*

34. *Different staffing levels, different authorities have different resources available. Protocols will vary within authorities. I don't think you can easily categorise referrals e.g. mental health assessments can vary, location/severity of illness/ asserting behaviour/ other support available etc, etc – which is why I found the next question difficult, and can only prioritise crudely.*

35. *Local policy/practice; individual's perception of the nature of the work.*

36. *I think because we are not generic in our training, but have specialised into either mental health or childcare.*

37. *Some workers are very happy to go out, others are not. Different views about why should be visited.*

38. *Different backgrounds and specialisms. There is always a manager on call so manager can act as final arbiter.*

39. *Individual s.w's on teams have differing views on 8 above and 11 (questions); pressures re possible complaints; in general a hierarchy exists of child care risk first, then statutory mental health work, with Adult PACE and elderly jointly for softer priorities. This hierarchy is not explicitly expressed by the LA and so leads to differing interpretations.*

40. *Legal and procedural obligations, safety of subject of referral, professional background, worker safety issues, willingness or lack of it to say 'no', generosity or lack of it with petty cash.*

41. *In this authority only one worker is ever on duty at any time; since they cannot split themselves priority between competing referrals is likely. Referrers tend to stress urgency because it's out of hours.*

42. *Individual workers have to prioritise the referrals, including decisions to make a home visit, at any one time. The most vulnerable person would be the absolute priority. Decisions on priority include factors such as whether the person is alone and whether other agencies are already involved e.g. the police, health service.*

43. *There is nearly always agreement.*

44. *Historic influences on team; influence of significant managers; local resources.*

45. *Perhaps background/ specialisms; different knowledge base – information available.*

46. *Different local authorities may have different priorities, different emphases, different resources etc. Social worker may have different skills.*

47. *The authority does not have enough procedures and guidelines set out. Workers come from different backgrounds e.g. child care M.Health – therefore they have different priorities. Also individuals have their own value systems.*

48. *Level of experience and background; lack of departmental procedures; lack of training on development of insight.*

49. *Lack of uniform development amongst different local authorities. Gov't funding is always 'ad hoc' based on deprivation indices, special grants etc. This may determine how EDT prioritise work as they have to satisfy dept's criteria/priorities.*

50. *Expectations of management; departmental priorities; custom and practice.*

51. *Background – work experience – areas of interest/expertise.*

52. *Individual perception of risk; individual preferences of type of work due to confidence, experience etc.*

53. *Resource availability*

54. *Degree of risk.*

55. *How much demand is put on EDT; availability of resources; perceived need.*

56. *How confident they are in making judgements and saying 'no'. How lazy they are, how busy they are, what they enjoy doing most, what their sw background is, or just different opinions. Also have to weigh up the level of risk.*

57. *Depends how they view the role of EDT i.e. responsive or proactive. Emergency or OOH SW Team.*

58. *Degree of risk.*

59. *This is rarely a problem in xxxxxxxx (name of authority) because bombardment rate is not impossible, and we can work through them in approx. time order. Difference would occur if staff were unclear about department's policy i.e. Risk of harm, then liberty and then children first*

60. *Previous experience of work.*

61. *Policies of the dept.; individual worker's perceptions of what constitutes a priority.*

62. *No clear protocol. I suspect people put childcare first/ mental health second and elderly last. I also think people respond to other agencies shouting the loudest.*

63. *Possibly specific interest/expertise, although L.A. advise that assessments under the mental health act should take priority.*

64. *Different experiences; different perspectives; lack of protocols/procedures.*

65. *Lack of clearly defined and communicated method of prioritising and in some areas influence of other agencies and lack of workers resulting in crippling pressures.*

66. *Pressure of work; time of day; mood.*

67. *Prior experience/specialism in area teams. Sometimes there is no definite answer.*

68. *May depend on worker's own experience/values/confidence; available resources with which to respond; Level of stress of demand for services at the time of referral*

69. *Because we do not have clear written guidelines/policies. Also think individuals tend to prefer to take on the type of work they are comfortable with.*

70. *Two factors:1. The prevailing demand and prevailing resources, 2. How the worker is feeling.*

71. *Bias of training and previous experience. Personal preference for type of work.*

72. *Some EDT staff have particular interests in some client groups.*

73. *Lack of basic information*

74. *Don't know*

75. *Pressure of work, lack of information.*

76. *Gender of the worker; statutory imperatives*

77. *Within our team it is unusual to have disagreements about priority. Core background may well influence.*

Question 15.

Scenario (a) PACE Interview – (Number in brackets is priority accorded by respondent)

1. *Young person is secure until such time as AA available – Resource centre staff should be encouraged to respond (3)*

2. *Accommodated child – residential staff should attend – if conflict of interest EDT attend but with no PR, low priority. (4)*

3. *Providing 15 year old is awake I would prefer to get him out of the Police Station, but I would check the accommodation and ask them to attend, or a relative or could commission AA to attend. (2)*

4. *Residential staff responsibility for children they look after, or use AA group. (0)*

5. *Put on hold – say not a priority, ask residential staff – await feedback. (3)*

6. *I would request solicitor and look to attend at the same time. I would balance need to rescue this asap v risk to self or others in MHA assessment referral. (1)*

7. *Urgent but safe. (2)*

8. *Could the carers do AA, or indeed AA service if we have one, or possibly a relative. (0)*

9. *EDT do not respond to PACE interviews but would refer to YOT Team for immediate attention. (0)*

10. *Refer to carer, residential staff, or YOT. (0)*

11. *I would establish when police were ready for interview – depending on this would depend on whether this would be a '1' or a '2' – If they are ready now, I'd send someone out – a lot of time wasted in Police Stations. (1 or 2)*

12. *Duty of parents but male is safe, therefore (d) takes priority (2)*

13. *Let's get this kid out of the police station as soon as possible, this should not be his home for the night! (3)*

14. *X Authority do not do PACE interviews. (0)*

15. *Sorry, don't know what PACE refers to but if it is a request to sit in on police interview, priority would depend on ability to get carer to attend instead of OOHS. (?)*

16. *In situation he is familiar with – safe and sound (2)*

17. *Not applicable in Scotland*

18. *Request vol. Agency to provide AA. (0)*

19. *No-one else available, reasonable hour. (2)*

20. *Seriousness of charge, the fact that he is accommodated. (5)*

21. *Would only do AA if volunteer unavailable or no parent. (2)*

22. *Would attempt to seek volunteer – social worker to attend with reasonable priority if volunteer not available. (2)*

23. *We have a dedicated AA Volunteer scheme and I would call them out. Visit from an EDT worker would not be needed. (0)*

24. *Such young people sometimes get left for hours at police station – this is not appropriate and needs to be prioritised and could be '2' if we decide not to start CP Investigation (c) tonight. I would not use vol. Scheme because he is accommodated. (3)*

25. *As the 15 year old is accommodated the LA has a duty which puts this in higher priority. (2)*

26. *Have AA list that we would use. If no-one on this list available I would try to assist and would want to get there before 10 pm so that it is not too late to interview. May become number '2' priority depending on further info on (e) and (c).(0)*

27. *Visit would be done by casual AA worker not EDT s/w. (2)*

28. *How long in custody; where accommodated; nature of offence, likelihood of overnight detention. (2)*

29. *X (name of voluntary agency) do the majority of PACE, but EDT would respond because the child is looked after. (2)*

30. *PACE would be a low priority because the child in custody is safe and protected. (5)*

31. *Seriousness of offence, bail warrants, under the influence? Anywhere to place? – or is he distressed and needs to be out of the police station soon? (4)*

32. *Y.P. used to police set up – but we will need to have the case disposed of. (5)*

33. *Would deal with this last. Juvenile in safe place. (5)*

34. *Again, statutory work that requires a visit. (3)*

35. *Either AA from Vol. Scheme or if EDT required. BUT y/p is safe at present. (2)*

36. *Not at risk – would have to wait in custody until other tasks completed. (3)*

37. *X (name of authority) has PACE Team for Juveniles.*

38. *Statutory responsibility, police will be pushing for priority of EDT attention. But client is ok, not going anywhere. (4)*

39. *Our authority has dedicated 24 hour PACE team who would deal*

40. *I would try to get people who 15 year old lives with to attend, if not EDT would respond. (2)*

41. *MH Act assessment would take priority as PACE procedures not likely to be completed by 8 pm. (2)*

42. *Can anyone else, eg parent, f/p, res. Worker do it? If not I will visit and can probably use second call out, otherwise it will have to wait until (d) is sorted. (2)*

43. *Pass to support worker to action. (0)*

44. *Child is in safe place, need to contact solicitor etc. (2)*
45. *Not appropriate place for a young person – but relatively 'safe' while I deal with other more pressing urgent matters, and then deal with when more urgent matters are finished. (3)*
46. *We have a statutory duty to provide an appropriate adult, we also have a protocol with the police guiding how/ when we respond. (4)*
47. *Has some priority as we receive funding for this – done by sessional staff. (4)*
48. *This would require a visit but not my first priority. (2)*
49. *Work Performed by App Adult scheme or community remand team. (0)*
50. *Aim to minimize time in custody. Priority declines if police intend to detain in custody after interview. (2)*
51. *Would wait until visit could be made, if carer or res. Worker could not attend. (2)*
52. *SSD agreement to respond in these circumstances. (2)*
53. *Will only do if ready to start and nothing else important pending. (2)*
54. *Normally expect to visit if parents can't/ won't but can be delayed until later. (2)*
55. *Not done by EDT we have service agreement with X (name) Care Trust. (0)*
56. *The department have arrangements for PACE which do not involve EDT. (0)*
57. *We don't do PACE. Done by volunteers. (0)*
58. *Would visit depending on (e), but as he is 'safe' would not come above (d), but as a legal requirement would come above (e), unless that situation deteriorates. (2)*
59. *Low priority – 15 year old could be bailed for interview at another time. Sometimes another Appropriate Adult 'appears'. Would attend later if before midnight or if quick (1) immediately. (3)*
60. *Residential staff will assist with PACE interviews (if possible) before 10 pm. One phone call will resolve this. (0)*
61. *Appropriate Adult would be sent. (2)*
62. *Appropriate Adult (PACE trained) visits in two hours standard. (1)*
63. *Time of conducting PACE would depend on how far away police station was, and availability of solicitor, interviewing officers (large county). (3)*
64. *'0- if can find someone else to come out (eg carer);'2' – if (c) does not require visit; '3' if (c) does require visit. (0,2,or 3)*
65. *If he is unlikely to get bail, or it is to be recommended, and it is in the middle of the night, may leave to the next morning*
66. *Would prioritise this in order to secure his release from detention or to ensure he could appear at next available court. (2)*
67. *Need to limit time in custody. (3)*
68. *No urgency, but attend during the shift. (3)*
69. *Will be undertaken by Vol. App. Adult Scheme. (0)*
70. *Child is safe, (d) and (e) have priority. (3)*
71. *Would want to visit asap, but will have to wait if parents unwilling, unable to attend. Not 'best practice', but best we can do. (3)*

Scenario (b) Mother and three children homeless.
   1. *Clients in place of safety – assure arrangements made with homeless unit following completion of case (d) (2)*
   2. *refer to housing (0)*

3. Would refer to homeless officer. If they were really homeless it could be sorted over the phone. (0)
4. Housing provide out of hours service. (0)
5. Ring homeless families unit – get police, taxi to transport. (0)
6. Refer to emergency duty housing worker. I would not usually attend or assess above. (0)
7. Refer to housing department. (0)
8. This may not be something EDT need be involved in. (0)
9. Whilst safe at the police station, age of children and basic needs if very young may increase higher priority. (3)
10. Negotiate with police referral to on-call homeless officer. If no risk factors, no child protection issues, no visit made but taxi may be used to transport once placement identified. (0)
11. Refer to housing. (0)
12. I would try to liaise with the police and Housing and arrange accommodation over the phone. If need be I would arrange a taxi, but would hope the police might help in transport. If the woman was a victim of domestic violence I might offer a social worker to escort (or if any other reason, ie child with a disability) (0)
13. Resolve over the phone by reference to women's refuge/homeless persons' officer. (0)
14. Arrange housing accommodation (B7B) or refuge accommodation; taxi to transport. (0)
15. Can be dealt with by phone – police or taxi to transport if she does not have transport herself or a friend etc who can assist.(0)
16. Telephone referral to Homeless Persons' Officer – visit only if there are other factors. (0)
17. Refer to Housing Officer on call. (0)
18. Refer to Housing – check files. (0)
19. Present options by telephone. (0)
20. Telephone discussion to establish no alternative. (0)
21. This would be passed to Housing – if they couldn't assist, may be have to locate B&B and arrange transport. (0)
22. Refer to Housing for initial assessment. (0)
23. They would be referred to Housing unless there were issues relating to the children. (0)
24. If homelessness straight forward and due to demands of other referrals I might accommodate in B&B and use taxi to transport. I would expect a social worker to speak directly to the Mother and not use the Police as a conduit. (0)
25. This would be referred to the Housing Dept. (0)
26. Give police numbers for Homeless Hostels and leave them to arrange it unless assistance requested. May assist if no other referrals. (0)
27. Do not deal with homelessness, would pass to District Council. (0)
28. Family in a place of safety and can wait in a safe environment. However, if very young children, prioritise to 3. (4)
29. We can refer directly to our Family Centres hostels. A phone call will do. (5)
30. Police Station unsuitable for family, particularly children. (2)

31. Can deal with this over the phone by providing Homeless Family telephone number. (3)
32. Police station very inappropriate – children may be 'active' to social services. (2)
33. Police may re-house at local hostel if required, but assessment may be required of children. (3)
34. No visit, would arrange accommodation and use taxi, unless suggestion of risk factors requiring investigation. (0)
35. Needs to be dealt with first but not necessarily visited. Telephone assessment could be sufficient to decide whether to refer to B&B, hostel etc. (1)
36. Can be dealt with over the phone and arranging accommodation and transport. (0)
37. Would pass to homeless officer. (0)
38. Housing have out of hours service and would organise B&B and transport. (0)
39. Telephone assessment, discuss with Police/Housing Dept., possible Women's Aid, might arrange taxi, probably wouldn't visit unless child care issues clearer but would arrange follow up. Hope to sort this in half an hour. (0)
40. I can arrange access over the phone and send them transport. (0)
41. Need to find alternative accommodation and resolve why they have become homeless at this point in time. (3)
42. Mother and children at Police Station – not suitable place for them. I would interview re. Situation and look for placing appropriately. Would not want to leave mother and children at Station for long period of time – may have been subject to domestic violence, may take some time to find alternative placement. (2)
43. Would not visit unless child care concerns exist. We would refer to out of hours housing officer. (0)
44. Done by Housing – simply pass on info. (0)
45. This would be passed to out of hours housing officer and referred to team the next day should there be any DV. (3)
46. Dealt with by emergency housing. (0)
47. Deal by phone. If appropriate place in B&B. (0)
48. Would attempt to resolve over the phone entirely, including transport and placement. (0)
49. Refer to District Council. (0)
50. Referral to Housing Officer. (0)
51. I would just ring the housing dept. (0)
52. Would be referred to Housing, and accommodation and transport arranged by them. (0)
53. Homelessness – District Council problem, remind police of DC out of hours number. (0)
54. After consultation with housing, most of the work would be done over the phone. No visit would be normal. (0)
55. Almost certainly could be sorted over the phone. (0)
56. Would request homelessness officer to speak to the police. (0)

57. *If no other issues (why are they homeless, any domestic violence and were children at risk if so?) I'd arrange B&B and ask police to take. This may be first if resolved quickly. (4)*

58. *Refer to Housing for urgent attention. One phone call. (0)*

59. *Find accommodation, establish if there are any risks or any needs. (4)*

60. *Initial intervention by Housing (Social Services next working day) food etc would be made available. (2)*

61. *My particular EDT has responsibility from the local housing society and can determine if it's a priority need by telephone if necessary. If in doubt, accommodate temporarily. (5)*

62. *In our EDT this is referred to Housing. I'd deal with this one first by telephone, set up a response from Housing and possibly arrange a taxi. (0)*

63. *Homeless officer on duty 24 hours. (0)*

64. *Would refer this on to Housing Dept. (0)*

65. *Needs early response - may take a long time. (2)*

66. *Arrange placement over the phone. (0)*

67. *Refer to Housing Dept. (0)*

68. *Will be dealt with over the phone. (0)*

69. *Would want to give this early attention and explore potential solutions. Distance to travel would determine timing of visit. (2)*

Scenario (c) NAI on 4 year old

1. *Confirmation by phone that child will be examined by Paediatrician – alert staff on ward of need to contact should circumstances change. (0)*

2. *Child safe but good practice to see medical staff and parents and explain CP Procedures. (2)*

3. *Would refer to daytime team following consultation with the paediatrician. (0)*

4. *Child safe. PPO could be used. (0)*

5. *Ensure safety for tonight, must visit. (2)*

6. *I will not attend but refer to child protection tomorrow. (0)*

7. *Child is safe. Specialist resources can be mobilised in the day. (0)*

8. *Unlikely I would do anything after telephone discussion. (0)*

9. *Whilst child should be safe with nursing staff and access to police, this is a serious injury and may need further assessment re. Safety of siblings. (2)*

10. *Research information, negotiate with professionals re parental agreement. Refer today. Visit to explain process. (2)*

11. *Child safe. Advise PPO if attempts to remove. Visit to get parents account if practicable. (2)*

12. *I would request that Hospital contact EDT should parents try to remove and they contact police – possible need for a PPO if they try to remove. If there were any other children in the family I would arrange for Social Worker to visit and assess further. (0)*

13. *Child safe, parents co-operative. No SW role. (0)*

14. *Arrange joint visit with the police. Check if any other children in the family at home. Brief medical staff, interview child (if appropriate). This visit may rate a '0' if other factors are known to SSD though! (1)*

15. *Need to liaise with police/do strategy meeting. Good practice to deal with the situation a.s.a.p. but child is safe and parents are co-operating and family social worker may be available next morning. Visit for initial fact-finding etc. Need to check if other children are in the home and that they are safe and well. (1)*

16. *Although this could be left, good practice for info gathering dictates visit to hospital; gather immediate info. And make contingency plans with the medics. (1)*

17. *Advice only, ie phone the police. (0)*

18. *No need to visit – liaise with the police CPU and refer to Area Team. (0)*

19. *Availability of parents following morning. (0)*

20. *Likely to be dealt with quickly, but legally a high priority. (1)*

21. *Write up in detail and pass to relevant team for CP follow-up the next day. Child safe, no need to visit, but need to find out if other children at home at risk. (0)*

22. *Basic assessment. Initial enquiries – consult Police CP Team – child safe. (0)*

23. *Ideally would visit tonight given the serious nature of the suspicion, but as the child is safe in hospital, the investigation could wait until the morning. In any case it may not be appropriate trying to talk to such a young child so close to bedtime. (0 or 3)*

24. *Need more info before deciding whether to visit or not. Would discuss with Police CP Team re. present need to start CPI tonight or leave to daytime staff. If medics think non-accidental injury CPI should start now. (2)*

25. *If definite NAI diagnosed we give this one more priority, but child is safe. (3)*

26. *No urgent need to visit as child is safe for tonight, but may require visit to hospital to gather info. Also would definitely require a visit if there were any other children at home – becomes priority '2' (0 or 2)*

27. *Would become involved if need for immediate investigation or if other children in the family. (0)*

28. *Child in hospital in place of safety, serious concerns in respect of injury and how it was caused need to be investigated, also parent may refuse child remaining in hospital. (2)*

29. *Discuss with FSU/Inspector as per protocol. Follow up with joint visit if agreed. Need to check records, anything known? (2)*

30. *Child is safe, main aim is to explain the procedure and initiate assessment – of a lesser priority. (4)*

31. *The child is in the hospital and is safe. If they are threatening to discharge I would advise they contact the police (2)*

32. *Telephone discussion may suffice for tonight as child is safe – parents need to be aware of CP procedures so visit may be necessary. (0)*

33. *Would not visit if no other children in family, but if there were other children, would visit to assess risk issues and make this a priority. (1)*

34. *No visit as long as parents don't try to remove. (0)*

35. *No need to visit. Talk to medics, ensure they are briefed to contact police if parents attempt to discharge child. (5)*

36. *Could be a visit to talk to the parents or could be information gathering by phone for assessment by day social worker. Child is safe and protected and has been seen by doctor. (0)*

37. *Hospital would initiate a PPO if parents tried to remove child. Not appropriate to start CP Investigation at night. (0)*

38. *This can be dealt with by daytime colleagues but advice would be given to hospital re action if parents attempt to remove child and visit might be needed if this occurred. (0)*

39. *Close telephone liaison with hospital, probably ring daytime senior for any history. Would be ready to visit if any changes, but safe to leave as it stands. (0)*

40. *Advise staff re procedure should parents attempt to remove. (0)*

41. *Child already in secure environment, no need to intervene. (0)*

42. *Would want to know if any more children at home. Depending on circumstances may not feel need to visit – child safe in hospital; advise hospital if parents try to remove child overnight – contact me and will re-assess. (5)*

43. *This needs a 'hands on assessment' either by yourself or by an appropriate worker called in from home. (1)*

44. *May need visit to clarify issue of procedure etc with parents. (5)*

45. *Child is in a safe place overnight and would not require a visit unless parents attempt to remove the child. (4)*

46. *Although the child is safe, there is a need to gather info and ensure parents know procedures and will leave the child in hospital. (1)*

47. *Pass to daytime services. Ensure child remains in hospital. (0)*

48. *May not require immediate visit. (3)*

49. *Investigation better dealt with by daytime social worker. (0)*

50. *Would probably leave until the morning, but would discuss with the police and tell hospital to ring if threat of removal. (3)*

51. *Can hold over unless parents try to remove the child, then would require first priority – probably PPO. (0)*

52. *This may not involve a visit if the child is safe in hospital. Discussion with the police would decide if visit necessary or wait until next working day. (2)*

53. *Telephone work but not a visit given the parent' co-operation. (0)*

54. *Not visit as child is safe, Daytime colleagues have info and so are better placed. (0)*

55. *Any other kids at home potentially at risk? If so this scores first priority. If not liaise with police and nurses re ensuring child remains in hospital. Would visit first if Mental Health Assessment folded. (1 or 2)*

56. *Establish details via the phone. If visit required arrange for later. (2)*

57. *Establish if other children in family. Normal procedures for hospital to notify family of CP process. (5)*

58. *Childcare worker would visit hospital within 2 hours. (1)*

59. *Statutory duty. Current further risk to children. Would in any event discuss with duty Police Inspector as per guidelines. Joint decision would be made depending on information available. (2)*

60. *Check with hospital. If no other children at home maybe no visit tonight, but if other children present, becomes highest priority for visit. (0 or 1)*

61. Concern for siblings? Child in place of safety already. Would not necessarily visit unless other children involved. Discuss with police and decide strategy. (2)

62. Child protection is already secured. Would refer this on to the daytime team. (0)

63. Situation safe. (0)

64. Liaise by telephone, only visit if really required. (0)

65. Check records, child likely to be known to daytime. Refer to them for action. (0)

66. Would discuss with police as per procedures. Discuss risk and scenario if parents change their mind about admission. Joint decision with police about visit. (?)

Scenario (d) Mental Health Act Assessment.

1. Good practice dictates joint assessment – time up to departure form office used to co-ordinate assessment process. (1)

2. Priority – Statutory. (1)

3. It is important for the ASW to be present with the G.P and the psychiatrist. (1)

4. Legal responsibility to be involved. Police to be on stand by. (1)

5. Statutory responsibility. (1)

6. Depending on the risk, I would see whether this could be postponed until tomorrow when services are operational. (1)

7. Serious risk. (1)

8. High risk – but would also ensure attendance of police and know where bed had been nominated. (1)

9. Potentially unsafe, i.e. at home, unpredictable, violent behaviour. (1)

10. Research information, negotiate and visit. (1)

11. Visit is the only method of resolution. (1)

12. Would send out an ASW (and hope that I could get one – we do not have an on call but depend on a core body of people who go out for a fee). (1)

13. Statutory duty at short notice, high risk situation. (1)

14. Tripartite assessment desirable, but ASW assessment be delayed if (c) takes priority. (2)

15. Statutory responsibility to attend. Would ask for police back-up. (1)

16. Statutory duty, but time to do (a) above. (2)

17. No contest! (1)

18. Visit at time agreed. (1)

19. Depends on urgency. (1)

20. Statutory piece of work that needs co-ordination. (2)

21. Would do this first AA might delay attending so wouldn't prioritise it. (1)

22. Having ascertained information, secured appropriate safeguards – re violence – respond within statutory framework. (1)

23. Risk factors in this scenario, ie apparent potential for violence, would make this very high priority. (1)

24. High priority due to risks and insecurity, I might need to have the police on stand-by. Need more info from family/carers etc and recent hospital admissions. 2 Social workers would visit. (1)

25. Needs a visit. (1)

26. Definite priority for visit, but no need to arrive until 8 pm. (1)

27. Known history, Police support, family dynamic and bed availability. (1)

28. Person in urgent need of assessment – possible risk to self and others in community. Possible risk to own safety request police to be in attendance. *(1)*

29. Who else is at home? Anything known on record? Does G.P. know him? History? *(1)*

30. Issue of illness and safety. Vulnerability in the community. Opportunity for joint assessment. *(1)*

31. Due to the fact that male is in the community and potentially violent I would visit with the medics. *(1)*

32. Statutory work which has to be undertaken. *(1)*

33. Statutory duty to attend. Person at risk. *(1)*

34. Might well have to wait my response until (c) completed. Would then speak to those concerned and decide re when assessment should be made. *(2)*

35. Statutory priority. Should not be postponed until daytime (potential risks and Code of Practice. *(2)*

36. Statutory visit gives priority. *(1)*

37. Would pass straight to ASW on duty. *(1)*

38. ASW work is a priority – need to be available when other professionals are. Risk of harm if assessment not done promptly. *(1)*

39. Would prioritise this and meet others at 8pm. *(1)*

40. Legal obligation under Mental Health Act. Level of risk in situation. *(1)*

41. Potentially dangerous/violent situation. May visit before 8pm. *(1)*

42. I would probably go to (c) then on to (d). *(2)*

43. Clearly top priority as family members may be at risk. *(1)*

44. This would take time to co-ordinate and would involve the police. *(1)*

45. Stat. Duty under the M.H.Act. *(2)*

46. High priority to visit at same time as doctors – arrange for police attendance due to potential violence. *(1)*

47. Need to attend on time to minimise threat to all with police attendance. *(1)*

48. Need to do joint visit with psychiatrist. *(1)*

49. Would definitely do this first as most pressing and most dangerous situation. *(1)*

50. The police would be requested to attend for the safety of the ASW and the medics. *(1)*

51. Would have to visit. *(1)*

52. Yes – would visit – would be the priority – would also arrange for the police to attend/be in locality. *(1)*

53. What is the basis of the 'potential violence', concern may need to involve police and if needs delay assessment. If client/public at risk, then this would take priority. *(2)*

54. Priority for call out. *(1)*

55. Mental health team separate so they would deal with this. *(1)*

56. ASW would visit with doctors and determine appropriate action together. *(1)*

57. Potential risk to third party looks high. Statutory duty. EDT covers a large county, likely to take an hour to get to the 'venue'. *(1)*

58. Depending on (c) above, otherwise would visit this one first. *(1 or 2)*

59. Statutory responsibility to respond. *(1)*

60. Would want to visit at the same time as doctors. Would also want police to be present. *(1)*

61. Most 'unsafe' situation. *(1)*

62. Great urgency because of risk of harm to patient/family/neighbours. *(1)*

63. *Arrange for stand-by ASW to attend. (1)*
64. *Would try to meet this deadline fitting other work around it.*

Scenario (e) Plea to Remove 13 year old.
1. *Telephone response urging parent to continue caring – advice given. (0)*
2. *Assess extent of difficulties. (3)*
3. *Would sympathise but advise about the wonderful daytime service and also point out parental responsibilities. (0)*
4. *Telephone counselling – advice, refer to daytime staff (0)*
5. *Phone – listen – advise- refer. (0)*
6. *I would gather info perhaps counsel. This scenario is low priority. (0)*
7. *More info needed. (0)*
8. *Possibly high risk at home, but needing more detail – exploration by phone. (2 or 4)*
9. *Assess the factors over the phone. Visit possible. (3)*
10. *Counsel on the phone and try to defer until the next working day. (0)*
11. *I would do a really good counselling type job and try to encourage her to manage the situation or arrange for daughter to go to a friend or family member for the night. (0)*
12. *No stat. Duty. Needs to remain at home. (0)*
13. *May do visit if circumstances dictate, but on the basis of this referral details to daytime team for follow-up. (0)*
14. *Give ownership of problem back to the mother unless young person is injured in any way, this would not be dealt with other than by the phone. (0)*
15. *Reassess by phone after visit 2. Make decision on basis of whether situation was settled – visit to help to manage rather than to remove. (3)*
16. *Telephone advice only (0)*
17. *Discuss on the phone – offer advice from Adolescent Crisis Intervention Unit if appropriate. (0)*
18. *Risk of violence. (0)*
19. *Would hold until the next day. Extremely unlikely to visit or accommodate without prior daytime assessment. (0)*
20. *Initial telephone assessment re nature of request and detail for referral. (0)*
21. *They would have to take second place to (d) because on evidence given, risk to child not acute. If the matter cannot be resolved by the phone at least for tonight, a visit would be required (because we have more than one worker on duty this might be possible later on). (2)*
22. *Assess on telephone first. EDS do not accommodate children except where no carer available. Listen and help plea. (0)*
23. *This should be left until the next working day. There would have to be a very good reason to visit. (0)*
24. *Unlikely to visit unless identify level of risk to the child e.g. physical abuse, 13 year old thrown out of the house – then would become priority 2 or 3. (0)*
25. *Depends on information gained. (?)*
26. *Possible breakdown in relationship need to ascertain the reason for requesting removal. Work towards keeping the family together. (3)*
27. *Try to advise over the phone and offer follow-up. (3)*
28. *Does depend on what mother is looking for – expressing the view that the child is at risk/ or mother just 'fed up', (3)*
29. *Visit and offer support. (4)*

30. *Telephone advice may prevent need to visit. (2)*

31. *Generally would not visit – would assess by phone and hopefully arrange response/ liaison with day staff. (0)*

32. *Unless compelling evidence of risk of physical abuse to child. (0)*

33. *Again, initially would be dealt with over the phone. Fact that enquirer is not known enhances need to assess and may need visiting. (3)*

34. *Visit to attempt prevention of accommodating/facilitate alternative family placement/accommodate as last resort. (2)*

35. *Co-ordinator would try to get situation to hold until Tuesday, but if not EDT worker will visit. (3)*

36. *Every attempt would be made to calm and hold this situation o/night and referral would be made to the daytime colleagues. (0)*

37. *Sympathise, advise, get background and send detailed referral. (0)*

38. *Listen – try to reassure and tell her there are no beds! (0)*

39. *Resolve via telephone. (0)*

40. *Depending on circumstances may not visit. Assess risk on phone, try to hold situation until office opens. If it looks like breakdown may need to visit. (4)*

41. *Would evaluate referral over the phone and decide whether appropriate to respond at all tonight and/or who to send if necessary. (3)*

42. *I have workers available to do this type of 'support' visit so would receive priority. (2)*

43. *We would offer support to contain the situation or diffuse. (5)*

44. *Could be visited by family support team. Policy is NOT to accommodate. (3)*

45. *Would resist – attempt to diffuse, defer to daytime – relocate child within family, only visit if immediate breakdown. (0)*

46. *Discuss this situation, explore alternatives, but could require a visit, (0)*

47. *These referrals are passed to area S.W. (0)*

48. *Would advise her to contact area in the morning. (0)*

49. *Visit would only be made if phone support to mother had failed. (0)*

50. *Telephone work on handling and coping mechanisms. (0)*

51. *Always try to resolve over the phone. (0)*

52. *Unlikely we would accommodate – if unable to resolve by telephone – low priority for visiting. (5)*

53. *Visit to assess carer's difficulties but assess over the phone first. (3)*

54. *Discuss over the phone, record and observe trend over time via computer records. (3)*

55. *Priority would depend on information gathered and assessment as to whether crisis/risk level determined immediate action or not. (4)*

56. *Try to deal with by phone and referral to daytime staff for planned response. (0)*

57. *Would try to deal with over the phone. (3)*

58. *Would deal with this one by the phone. Would only visit if risk factors meant child had to be accommodated that night. (0)*

59. *Depends on info gathered on phone, may go up priorities. (4)*

60. *Advise by phone. (0)*

61. *Telephone contact – visit by stand-by child care worker if required. (2)*

62. *Would first try over the phone to put off, but if this failed possible visit. (2)*

63. *Would try to resolve via the phone. If need to visit it would take lowest priority. (0)*

Question 16 What factors exist for you when trying to decide between competing priorities?

1. *Statutory obligation, level of risk, departmental responsibilities*
2. *Statutory need; child in custody; vulnerable, frail person in need; The immediacy of risk to self/others or children.*
3. *Legal/statutory responsibility. Who is most at risk?*
4. *Risk to self and others, statutory duty.*
5. *Safety; what needs to be done now and cannot be done later to same effect; provide appropriate care consistent with role and service.*
6. *Level of risk to child/ child protection issues; level of vulnerability – risk to mental health.*
7. *Risk to child or vulnerable adult; protection of individual; statutory requirement; availability of resources to resolve; safety of the worker.*
8. *Risk v safety.*
9. *Nature of problem; degree of urgency; availability of worker; what can be dealt with most rapidly/easily; availability of resources*
10. *Risks in situation – staff skills/availability; pressure from partner 'agencies'.*
11. *First come first served unless law dictates otherwise.*
12. *Acuteness of risk*
13. *Are vulnerable people safe now?*
14. *Client safety; statutory duty; essential information to assess safety.*
15. *Number of staff on duty at any one time.*
16. *Safety of staff and client; time needed to complete the piece of work.*
17. *Statutory responsibilities; ability to deliver resources; time factors.*
18. *Is person in safe environment? Is there a statutory responsibility? What is the department's policy? Is there another agency that can deal with the referral?*
19. *Risk factors and urgency of need for action.*
20. *Risk, legislation and policy.*
21. *Physical safety; risk factors. Priority of needs/risks; availability of SW.*
22. *Risk, statutory duties, availability of staff.*
23. *Risk to people, statutory duty.*
24. *Statutory responsibility/ risk to client and others.*
25. *Safety of service users; well being of service users; staff availability; alternative support to service user.*
26. *Issues of risk; issues of statutory obligation; urgency and resources.*
27. *The need to protect and promote the welfare of those in the community who may be at risk of significant harm or causing harm to others.*
28. *Need for urgent protection/safety? Legal obligation? What if we were to leave it? Good practice – can we help?*
29. *Safety/health of individual; age vulnerability of person involved*
30. *Safety/level of risk; potential for violence; departmental procedures and statutory legislation.*
31. *Statutory duties exist in at least 2 or 3 scenarios.*
32. *Staff cover; ability of workers; risk to life; stat duty.*
33. *Risk of significant harm to any client group; child protection procedures; single working (need to remain available); statutory requirements.*
34. *Statutory requirement to assess; need for rapid response; whether I can achieve anything; whether some other service can do it.*

35. *Known risk – is situation better left to next working day – is client known to services?*

36. *Statutory work – mental health and child protection. Must take appropriate steps to protect a child in need. Vulnerable elderly need urgent attention – other referrals completed as time allows.*

37. *Risk to client or others; availability and appropriateness of other resources; whether good practice to respond tonight.*

38. *Risk factors to client/others; availability of staff.*

39. *Staff availability – the fear of the 'next call' if I send someone out on this. What happens if we get a child protection/urgent section call next?*

40. *Immediate safety issues in all cases.*

41. *It is unlikely that all of the above would land on the desk at the same time, priority may be on first come first served basis.*

42. *Necessity, risk, legislation.*

43. *Nature of referral, legal status of situation, level of risk.*

44. *What are the factors, where is the service user, are they in a relatively safe place? What are the risk factors, are they already known, risk assessment?*

45. *Evaluated level of crisis and risk to service users; availability of appropriate staff from within EDT and also from colleague agencies. Is it better to leave involvement to keyworkers from daytime teams?*

46. *Level of risk to client/family members; level of need; availability of staff – nothing can't wait an hour.*

47. *Statutory duties; ensuring safety and well being of vulnerable children and adults.*

48. *How great is the risk? What is our statutory duty? What will wait?*

49. *Level of risk/urgency to client/public; whether or not the authority has a duty to act/provide a service.*

50. *Immediate danger to service user and others; legal and agreed obligations; will a visit contain situation that might break down tonight?*

51. *What are the implications/risks of delay; level of distress of client*

52. *Degree of immediate risk.*

53. *Risk to client*

54. *Backcovering; level of risk; if acceptable solution by phone.*

55. *Risk and vulnerability*

56. *Child is safe – will need to be joint interviewed tomorrow – statutory requirement` and user at risk of loss of liberty.*

57. *Can this hold until the next working day? Are there risks to the client?*

58. *Whether it can be dealt with over the phone – degree of risk – can it wait?*

59. *Risk and legal obligations.*

60. *Is there an immediate risk to client/others – statutory duties?*

61. *Is the person safe? All calls are responded to by telephone usually within 30 mins max even if out on a visit.*

62. *Safety of client and other siblings/individuals, are they safe where they are? Can others respond to need of the client?*

63. *Level of risk*

64. *Risk – Stat. Resp. – reliability of referrer.*

65. *Risk, danger, safety, alternatives, statutory work, guidelines etc.*

66. *Risk, statutory responsibility to respond.*

67. *Statutory duties/urgency of situation/ linking up with other agencies. How quickly can I resolve something?*

68. *First priority is safety, second is what is known about each particular situation.*
69. *Effect of time delay on service user – risk of harm caused by delay.*
70. *What other resources/services are available and should provide that service?*
71. *Risk.*
72. *What will safely wait for even a short time?*
73. *Statutory responsibilities and risk of immediate harm.*
74. *Risk, legal responsibility. Making it manageable for the operational worker.*

Figure 1 The Assessment Framework

2

	PERSONAL
1	*How am I feeling before the shift commences –* tired, energetic, positive, negative, 'hung over', 'fresh', confident, nervous?
2	*How am I feeling as the shift progresses –* harassed, busy, under-worked, helpful, obstructive, raring to go, omniscient or overwhelmed?
3	*Do I operate with certain 'EDT rules of thumb'* such as 'minimum intervention necessary to get through safely until the next working day'; 'avoid removal from home wherever possible'; 'admissions to care generally are far better planned than as a result of EDT emergency action' and finally, 'if EDT <u>has</u> to respond within half an hour is the referral appropriate for us or should it be better dealt with by the other 'emergency services (ambulance, Fire Brigade or Police).
4	*Are there certain 'types' of referral that tend to stimulate certain responses in me* – sympathy, irritation, frustration, excitement or sorrow. For example the 92 year old woman who is 'very sorry to bother you', whose husband died last week, not known to the service, who reluctantly asks for 'a little bit of help' to get her back on her feet; in possible contrast to the mother of the 15 year old son, well known to the department who demands you come and 'take him away' otherwise 'he'll end up dead and it will be your bloody fault because social services are a waste of time anyway!' Do these responses effect the priority we give to some rather than other referrals?
5	*Are there certain types of callers to EDT that we seem to relate better to than others and does this effect the prioritisation process?* For example I can feel the hairs standing up on the back of my neck each time a caller commands or demands that I do something. I become irritated when, having 'allowed' the caller or interviewee to give me large amounts of information, I am not even then 'allowed' to summarise what I have been told so far without being constantly interrupted. I do not respond well to people who threaten me either and try always to remain calm or, following warnings to the caller/interviewee will put the phone down/withdraw. To the caller who promises that 'You had better bring an Army with you if you come to this house' why do I make sure not only that the police attend with me, but also decide that I will definitely visit if not only to show the caller that I am not afraid (paradoxically, even though I am petrified!)? How do we respond to the caller that refers to 'the fuckin' Paki family that lives down the street', or the man who tries to minimise the 'slap' he gave to his wife, or justify it on the basis of her 'having asked for it'?
6	*How do I feel I cope generally under pressure on EDT –* what helps or hinders these coping mechanisms and do other people use other strategies to keep calm?
7	*Do I have 'set' reactions to, and views of referrals from other agencies?* For example, do I feel the Police expect us to 'jump' to a PACE request as soon as they are ready to 'process' the prisoner; do medics have little understanding or interest in our mental health role other than responding quickly to their secretary's instructions that will enable them to get home; and do all A&E Staff Nurses see patients as 'social problems' when there are pressures on beds?
8	*How good am I at saying 'No' to some requests for EDT intervention –* what influences this ability to refuse a service, and is there any consistency?

9	*What is my immediate 'gut reaction' to the referral –* what is this reaction based on, can it's 'validity' be tested?
10	*What range of feelings I am experiencing about the referral –* will/have these impact(ed) upon the response given to the referrer?
11	*What is my definition of 'the problem' in this referral?* What will be the focus of any intervention? How do I decide who the service user(s) is in any one referral? Do I ever see the 'problem' in terms of a broader system?
12	*How will I ensure that my assessment is fair and systematic?*
13	*What skills and knowledge will I need throughout dealing with a referral?* Are their gaps in either my knowledge base or my skills? What kind of scenarios do I not deal particularly well with, why is this and how can I rectify this?
14	*Has my intervention been understood by the family –* how do I know and how has this been recorded?
15	*What factors have made this referral a priority or not?* Have these factors been recorded and have any decisions taken been explained and understood by those involved as well as recorded?
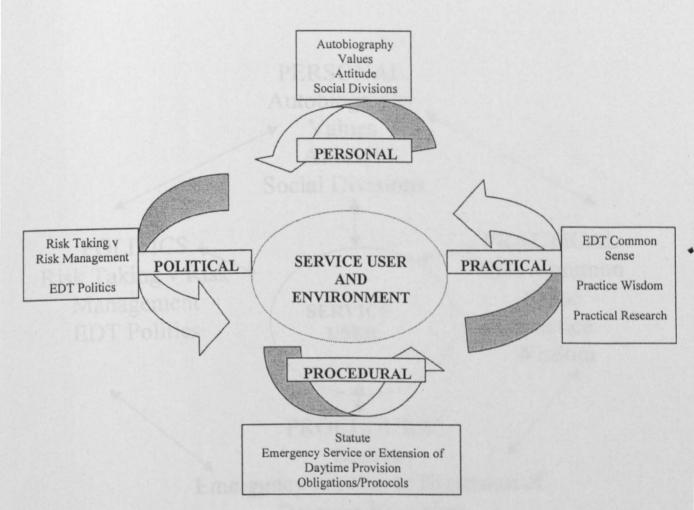
	PROCEDURAL
1	*What do I see as the role of EDT –* Is it an emergency only service or an extension of the daytime teams? How do my EDT colleagues, manager and department view the role of the out of hours service? Is this role of EDT written down and agreed?
2	*With the referral am I clear which legislation is being applied?* Which procedures, Codes of Practice are relevant, do I have access to them and do I understand them?
3	*Does the Violence to Staff policy apply?* Are there any aspects of a lone working policy or protocol that I need to be aware of?
4	*Do I need to record any of the above in relation to any priority given to this referral or not?*
5	*Do I have clear assessment models to follow* - to ensure relevant information is systematically gathered to ensure appropriate priority is accorded the referral?
6	*Do I use risk assessment models/checklists to decide the priority of a referral and establish levels of risk –* if so what are these models and are the referenced? For example (CASH, Compulsory Admissions Assessment Schedule (Sheppard 1993) is very helpful in mental health assessments as it requires the ASW to differentiate between 'Hazards', 'Dangers' and 'Risks' as well as categorising each by type and degree which leads the assessor to a recordable and quantifiable outcome that does not dispense with discretion on the part of the worker).
7	*Do the forms that I need to complete with this referral help to make the assessment decision or complicate the process?*
8	*Do I have specific EDT forms that can be used and are acceptable to the daytime teams that will be sent the referral details?*
9	*Are there any 'unwritten rules' –* such as 'no PACE interviews on young people after midnight', or 'EDT should try to avoid Sections 3 and 4 of the 1983 Mental Health Act whenever possible', or finally, 'removal of a person, or any major change to a person's circumstances have to be the result of fairly extreme circumstances that cannot safely be left until the next working day. This may include accepting that further abuse or harm could occur that night.'
10	*Am I given the opportunity to later reflect on this referral in supervision?* What aspects of the referral would I wish to discuss and when would I record these?
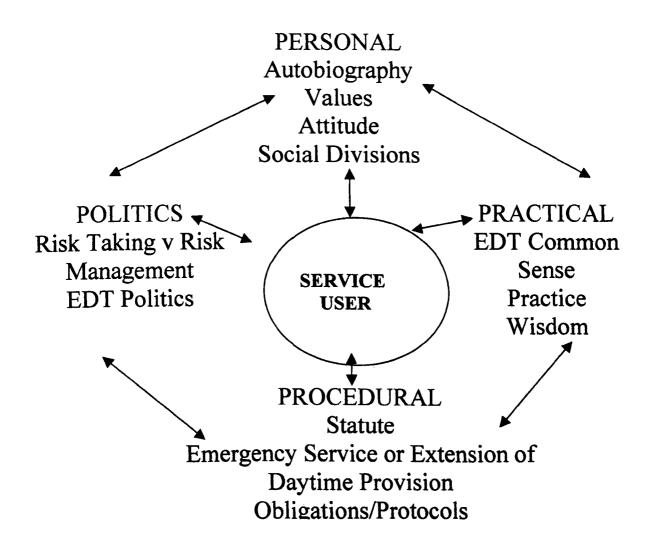
	POLITICAL
1	*What is my position on the 'risk taking v risk management' scale?*
2	*What 'power' or 'authority' is given to EDT workers – is this written down?*
3	*What is my own view on the level and application of this 'power' and 'authority'?*
4	*What is the position of my colleagues to risk taking v risk management?*
5	*What is the current position of the department towards EDT workers managing or taking risks?*
6	*Have I considered the impact of social divisions in this referral?*
7	*What impact, if any, has poverty had in this referral?*
8	*Do I see EDT work as 'political'? –* Is this reflected in my prioritisation of referrals?
9	*What do I see as the cause of the 'problem' in the referral?*
10	*Have I adopted a 'traditional' view of EDT -* that sees social work as providing services effectively to help individuals' personal problems and adjust to the society around them? In other words individuals 'treated' with individual resolutions. Another form of this would be to see social work as helping service users achieve personal growth and power over their environment by means of raising their self-esteem and teaching crisis management skills.
11	*Have I considered any scope for a more 'social(ist)/structural' view of what EDT does?* Put simply, this view proposes that rather than helping people to adjust to society to deal with their problems, we should change fundamental structures in society that are the origins of most people's problems.
12	*Has my office got details relating to other organisations that have concerns for injustice and inequality across the social divisions, and those that seek to establish cooperative alliances between people with shared problems, or is this seen by EDT workers as the remit only of daytime workers?*

	PRACTICAL
1	*Do I see this referral as an EDT priority – if 'yes' or 'no', why?*

2	*What other factors am I having to consider with this referral –*
	      (a) time the matter is likely to take
	      (b) distance needing to be travelled
	      (c) number and type of other referrals that have already arrived
	      (d) what might happen if I do not visit, or delay the visit
	      (e) what may happen if I do visit
	      (f) what is the time and what difference does this make
	      (g) can any other person/agency deal with this
	      (h) implications of dealing with the matter on my own

3	*I am clear there is a statutory obligation for me to respond to this matter as a referral and as a priority?*
4	*What order will I do things in –* what factors have helped me decide this order?
5	*What aspects of this referral or my response do I think are 'obvious' or 'common EDT sense'?* How many similar referrals have I dealt with and how were they managed?
6	*What information can I gather from the office, computer or other agencies that will help me decide whether I need to visit or not?*
7	*Am I responding to this referral almost 'without thinking'* or am I trying to consider the rationale for each decision taken, and apply some form of structure to my decision-making processes that can then be recorded with transparency?
8	*Could I reference any research, or statistics or literature to justify any of the factors considered and the decisions taken regarding the prioritisation process with this referral?*
9	*How might some of my colleagues have managed this referral, would there be any differences in priority, approach or outcome?*
10	*How will I justify what I did, when I did it and the order in which it was done or not done as the case may be?*
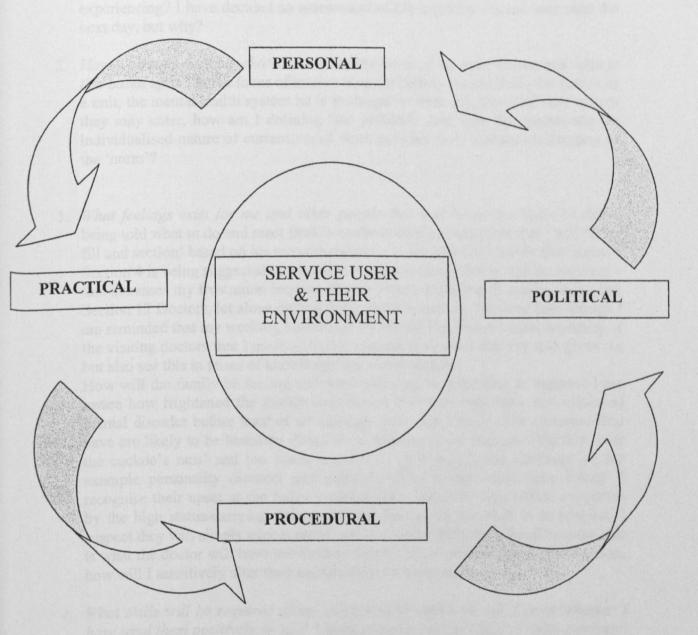
APPENDIX 17

4P's EDT ASSESSMENT FRAMEWORK

Autobiography
Values
Attitude
Social Divisions

PERSONAL

Risk Taking v
Risk Management

EDT Politics

POLITICAL

**SERVICE USER
AND
ENVIRONMENT**

PRACTICAL

EDT Common
Sense

Practice Wisdom

Practical Research

PROCEDURAL

Statute
Emergency Service or Extension of
Daytime Provision
Obligations/Protocols

PERSONAL
Autobiography
Values
Attitude
Social Divisions

POLITICS
Risk Taking v Risk
Management
EDT Politics

PRACTICAL
EDT Common
Sense
Practice
Wisdom

SERVICE
USER

PROCEDURAL
Statute
Emergency Service or Extension of
Daytime Provision
Obligations/Protocols

PERSONAL

PRACTICAL

SERVICE USER & THEIR ENVIRONMENT

POLITICAL

PROCEDURAL

Application of the 4P's Assessment Framework to MrA

PERSONAL

1. *What is my immediate reaction to this referral?* – fear, anger, irritation, confusion, certainty, confidence. What are the sources of whatever gut reaction/ feelings I am experiencing? I have decided an assessment of the situation cannot wait until the next day, but why?

2. *Have I already decided who/what will be the focus of my intervention and what is this based upon?* Is the focus of intervention the father, the children, the family as a unit, the mental health system he is in danger of entering, the child care system they may enter, how am I defining 'the problem' and does this perpetuate the individualised nature of current social work policies or is it more challenging of the 'norm'?

3. *What feelings exist for me and other people that will be at the house?* I detest being told what to do and react frostily to the doctor's assumption that I will 'form fill and section' based on his recommendation. (I am also fully aware that unless a Section 4 is being suggested, a second medical recommendation will be required – this increases my frustration because I know what a nightmare it can be contacting Section 12 Doctors, let alone getting them to come out! At the same time though I am reminded that my working knowledge of Mental Health Law outstrips many of the visiting doctors that I meet on duty). I accept the power that my role gives me but also see this in terms of knowledge and social insight.
How will the family be feeling and what will they be expecting to happen? I am aware how frightened the family are because for them they have not witnessed mental disorder before least of all amongst their own family. The concerns they have are likely to be based on ill-informed stereotypes of such as 'One flew over the cuckoo's nest' and too much reactionary right wing press coverage of, for example personality disorder and schizophrenia. At the same time though I recognise their upset at the father's presentation and their firm belief, supported by the high status-carrying doctor, that the best place for MrA is in hospital. I suspect they will simply expect me to arrive and take MrA to hospital because that is what the doctor will have led them to believe. How will I manage the situation, how will I sensitively alter their agenda if this is necessary.

4. *What skills will be required of me when visiting and how will I know whether I have used them positively or not?* I need to communicate clearly, listen carefully, assess systematically, intervene sensitively, have a clear view of the function, roles and responsibilities of EDT, manage the 'crisis' without being overwhelmed, make decisions and record accurately and concisely what took place and the resulting (preferably agreed) action plan.

5. *How do I feel about the possible risks?* Whilst I want to acknowledge the fears of the family for the children, MrA and themselves, I am determined to make sure

that he is simply not 'processed' as another mental health casualty. On the one hand I know what 'assessment and treatment' means in the local hospitals and am aware of the implications of being sectioned. On the other hand, there are risks in leaving MrA at home. What is my attitude towards taking risks, how confident am I in my decision-making and will this be supported by colleagues and managers alike?

6. *How do I assess the impact of social divisions?* This family live in poverty, they do not have a main wage earner and state benefits, council housing and child benefit provide the welfare safety net. To compound a difficult situation the family have evidently experienced much trauma recently and, by the very fact that 'sectioning' has been suggested stand to experience further trauma of loss and separation if MrA is removed. Throughout the interview I can hear myself thinking 'short term pain, long term gain' and thinking that the immediate pain would be to the majority of the people left in that house if MrA remains, whereas the long term gain would be for Mr A and the family too if they could be supported through this crisis, plus it might dispel some of the myths about mental illness as well as the roles of doctors and social workers.

7. Why, on reflection, am I reluctant to complete an application (notwithstanding the absence of a second medical recommendation that I know organisationally can be very difficult to organise), what are my reasons for believing this family need to remain together, what do I base my belief that the children will cope with their father's distressed state, and how do I know he will not further harm himself or others.

8. I want to be systematic and fair in my assessment as well as transparent as possible regarding the decisions that may be arrived at – but the general 'hubbub' of the family home and the 'comings and goings do make this difficult.

9. I am acutely aware of my own value base that usually will do everything possible to avoid detaining people under the Mental Health Act and am trying to balance that against an assessment of the hazards, dangers and the risks.

10. If I could reflect on this piece of work which aspects would I be pleased with and why, which less so and why? Later I commend myself for withstanding the different levels of pressure from various people present in the home of MrA to remove him, but wonder what the family remaining in the home now think of social services generally and me specifically.

PROCEDURAL.

1. What policies, procedures, pieces of legislation, protocols or (unwritten) obligations could I reference so that I am clear about the way I am going to respond? I feel generally confident about my working knowledge of the

relevant legislation and recognise that I could have delayed my visit until a second medical recommendation had been completed before I even visited MrA. However, based on the details gathered over the phone (and a suspicion that the level of tension in the house was itself counterproductive, especially if MrA was to remain there) I decided to visit.

2. I have already decided though that details gathered over the phone from the Doctor and some of the family members, precludes the need for a Section 4 of the Act even though the situation, it could be argued, meets all three of the requirements laid out in the Code of Practice (DoH,1999) for such an emergency section:

   • *An immediate and significant risk of mental or physical harm to the patient or to others: and/or*
   • *The danger of serious harm to property; and/or*
   • *The need for physical restraint of the patient* (6.3)

   My gut reactions have told me that the 'temperature' of this referral is getting higher and what is required is some controlled 'time out' for the family members and MrA to, more calmly, articulate what they fear and feel is going on and how it may be managed. I am convinced that procedurally I have the discretion to seek to avoid the compulsory detention of this man and know that this is consistent both with Human Rights legislation and Mental Health Law. In other words, even before I have visited the family, I seem to have adopted a specific position of not admitting unless there are good reasons.

3. I believe that the role of our EDT is to act as an emergency only social work service on referrals that have arisen unexpectedly, are unplanned and cannot safely be left until the next working day. This is the underpinning procedure that our EDT should follow. As such, I have already decided that this referral meets the criteria for an EDT response, but am also conscious that sometimes matters are dealt with that could be left until the next day when the caseworker who knows the service user is available. MrA is not known to our mental health services so this informs my decision to visit also. If this had been a request for an assessment under the Mental Health Act on a 'well known' service user with several psychiatric admissions in his history, and Section 3 medical recommendations had already been completed, my response may have been to try and 'make safe' the situation until the next working day to allow those who know MrA better (and thus have an idea of his pre-morbid personality for example) to make the assessment and consider the application. I am aware that procedurally this is possible.

4. There is almost an 'unwritten rule' in this EDT that we try to avoid completing Section 3 and section 4 applications whenever possible, even though this might mean actually visiting and completing an assessment, the assessment may be more focused on whether the situation will hold until the next working day when the question of whether to make an application can be made by those who know the person and the situation better than the EDT worker. Many EDT workers will have been in the position of having to attend to assess somebody like MrA when neither of the two doctors know the 'patient' and the EDT worker has no prior knowledge of him either; in these circumstances there is (again unwritten) a protocol of 'making safe' and passing to the

daytime worker who does know the family. Where the family are not known to social services or the psychiatric services, I would be more prepared to make an application for hospital admission (for a section 2) as, to pass the matter to the daytime would simply be delaying the referral to be dealt with by a daytime colleague who similarly had no prior knowledge of the family and their circumstances.

5. I am aware of the violence to staff policy that this department operates that does not support lone workers making home visits to potentially violent service users, but also realise that, like many EDT workers in this country, I am a lone worker. I do though ensure that possibly family members and definitely the doctor will still be at the house when I arrive. Whilst recognising my fears of being attacked by MrA (before I had even seen how large a man he was) and being quite comfortable with my own personal position of not needing, or even wanting to be a 'macho' interventionist, I am also aware that I do not like being frightened and often try to confront that which might be the source of this fear. Procedurally however, I feel that I am 'covered' because I have ensured that I will not be alone, at least initially, with MrA. This is, in my view, consistent with our department's policy and the Code of Practice that seeks to ordinarily offer the service user the '*opportunity of speaking to the ASW alone but if the ASW has reason to fear physical harm, he or she should insist that another professional be present.*' (2.13).

POLITICAL.

1. *What is my position on the 'risk taking v risk management' scale and how do I systematically establish degrees of 'risk', identify 'hazards' and respond to 'dangers'?* I do believe that I tend to take risks rather then manage them, but believe that this is measured by a willingness to spell out in the record of my work why I did what I did. I know that I have some political standing and professional status with some senior personnel in the department because of my trade union activities. I am also aware that they know I am undertaking a PhD specifically looking at EDT assessments and, I suppose, in some ways are defying them to challenge a well documented and referenced decision made by me out of hours. I feel comfortable that MrA can be managed at home with various caveats (see below – Practical) and do not believe I am merely using his circumstances as a pawn in my political 'game'.

2. I operate outside of office hours with the delegated authority of the Director of Social Services, and as an ASW, possibly with more power and authority than that. This gives me the authority and confidence to ensure that I am not usually pressurised by such as medics or the police into making decisions simply because they say so. As a daytime social worker other professionals tended to view me as either their equal at best or, more usually, subservient to them. On EDT, this is not the case and often I am the most qualified and experienced person with the most relevant knowledge in an assessment. I felt this was the case with MrA and carried out my role with this status and assurance and yet, hopefully, sensitively enabled the family to see that the medical model is not always the only appropriate one to adopt in a crisis.

3. I do believe that social workers generally, but EDT workers specifically have to be comfortable with the legitimate use of their powers. This applies to all EDT interventions including decisions to remove a person as well as, as with MrA decisions to leave people at home with elements of risk.

4. I am aware of the different ways in which men and women are treated by the psychiatric systems, and also recognize grief reactions to life's crises. MrA was not a man who would ordinarily talk about his feelings openly to anyone, let alone a complete stranger who had some control over his psychiatric destiny. I suspected that the combination of traumas, confused perceptions of being a 'good' father, son, husband and brother an intense love for his wife that he never explained to her when she was alive, and a large amount of alcohol explained his present behaviour. The reaction to him by the family and doctor reflected the view of men that they should not cry, should not need to express such bare emotions, should remain in control and should be able to 'hold it together for the sake of his kids' as one relative put it. In one small scenario I saw the politics of family life, mental health, child protection and expectations on the state that they would intervene to protect all concerned.

5. I did not wish to respond simply to the individual difficulties that MrA was perceived as having, after all there was absolutely nothing I could do to alleviate his feelings of loss at this time because, in my view they were totally understandable. I did want to establish what was stopping MrA killing himself and whether he had intentions still to kill himself and, if so how he planned to do this, and would anybody else be included in his plans (ie was he intending to 'save' his children by taking them with him?). At the same time I wanted to let MrA know that he was not 'going mad' as his family thought, but also to 'normalise' his need to grieve and ignore the stereotypical taboos that exist around men and emotions ('big boys don't cry' syndrome). MrA would need to be put in touch with others who had experienced similar trauma, were single parents on benefits in council owned property and organisations such as CALM, welfare benefits workers, Gingerbread, MIND as well as the local tenants association and even the local unemployed workers co-operative. MrA's feelings of isolation, desperation and powerlessness would not be addressed by removing him from the family home, this would serve only to increase those feelings.

6. *What did I see as the cause of the problem?* A combination of patriarchal expectations of men and women, the effects of having to live in poverty and poor housing on state benefits, the impact of the medicalisation of too many social difficulties and the absence of real support networks for some families to turn to without being stigmatised and removed by people in authority with the resultant longer term implications this brings.

7. The politics of social work are complicated as too are those of EDT whose role often is seen as being to 'patch things up' until the next working day. I do believe though that, on EDT more so than daytime social workers, we have a unique opportunity to combine the high level of experience we possess with the autonomy ascribed us by the organisation to fundamentally re-challenge the way in which 'problems' are defined, prioritised and responded to.

PRACTICAL.

1. Whilst I know I could delay dealing with MrA until the second medical recommendation has been completed, or even insist that the family get MrA to the local A&E Dept where I will attend later on, I do not feel this is good practice and apply my discretion in deciding to visit the home. I am also aware of the potential negative effects of trying to move MrA out of his home, as well as the pressure this would put the family members under, it also potentially increases the likelihood of violence.

2. There are other referrals to deal with and I know that dealing with MrA is likely to take at least two hours. I reassure the doctor and the family that I will be there in one hour. This gives me time to sort some other referrals out on the phone, advise of possible delays and also to make some calls to seek out a second medical recommendation, (needless to say, there were no Section 12 Doctors available before I set off to MrA's home, which, conveniently, was not too far from my base). Having decided this was a priority that required a visit I could also advise any other priority requests to visit would simply have to wait or be dealt with by such as the police or ambulance services.

3. This for me was a priority because, on the basis of the details given over the phone there were several related hazards including:
   • MrA's health (physical and mental)
   • A failure to provide basic needs (for himself and his children)
   • Threats of violence (to himself)
   • Actual violence (to himself)
   • Out of control of self and actions
   • Contravening social norms or expectations and
   • Large amounts of alcohol involved.
   It could also be seen that each of these categories would score fairly high on a scale of mild – very severe. Part of my reason for prioritising this referral for a visit was that ASW's do have responsibilities to assess people in such circumstances, but also it would only be possible to establish any mitigating circumstances by interviewing MrA and family face to face rather than through the filter of the doctor or over the phone. I was also determined to assess the viability of other options by establishing the availability and strength of any support systems that might be able to prevent MrA going to hospital. The immediate risk to MrA's life, (the cuts to his wrists), had already been assessed by the doctor as not life threatening, although, later on the same doctor was also to argue that such cuts were 'severe' and 'significant'.

4. *Emotions are running high, including my own.*
   My worst fear is that he will stab me as soon as I enter the house, and I will die a slow and painful death never seeing my family again and being publicly blamed by my employer for breaching the 'violence to Staff policy! I make a cup of coffee and take five minutes with the phone on transfer. I am going through my normal, almost ritualistic, panic feelings that I know will reduce but never disappear making me a better, more cautious and aware social

worker for acknowledging my fears than those who deny they exist. I try to work through the expectations and feelings of all the people in the house with MrA before I arrive, I make sure I have all the relevant paperwork (including section 2 and section 4 papers just in case). My coffee has finished, I check I have everything, then double check (another ritual), take a deep breath and calmly leave the office to drive, slower than usual, to the house. I am now in the practice mode of 'I have handled hundreds of similar difficult situations before, there are other people in the house, I will be safe and I will be thorough and fair'. I make sure I know everybody's name before entering and double check I understand the version of events reported via the referral as this starting point will need to be verified by the various parties.

5. I make massive mental notes of the bombardment of non-verbal communication that exists as I enter the house and soon realise that all the family, including MrA assume I am there to take him to hospital. My task now is to be in control without necessarily having to take control. I feel assured that I know my role, angry at being 'set up' but fairly quickly able to reduce some of MrA's misplaced distrust and anger by using all the interpersonal, interviewing skills developed over 20 years of working in social services. The effect is to help MrA listen and hear what is being said as well as 'give permission' for his grief to be expressed without embarrassing him. MrA continues to cry, but is much calmer and less angry – this is seen by the family who feel somewhat guilty for their removal demands, but begin to see mental health in different terms and feel less threatened by MrA. Whilst I need only to 'get things through' until tomorrow, I also try to offer contact numbers for organisations and specific names of people who can begin to work cooperatively with MrA, his children (who have also experienced much loss) and his extended family without passing responsibility entirely to the extended family to manage. I try to choose agencies that do not have statutory powers, ones that are staffed by equals, single parent groups, mental health agencies that deal specifically with issues relating to men and mental health, as well as making sure that the family are put in touch with the local council housing tenants' association (a particularly vocal one as it happens), unemployment workers' co-operatives and provide the names of MrA's local councillors as well as details of their 'surgeries' that are held near to where MrA lives. I accept that these contact points will have to run alongside referrals to the outpatient clinic, the Community Psychiatric Nurse service and the medication that the visiting doctor had prescribed. I send the details to the local mental health social work team detailing my refusal to make an application under the mental health act, asking them to offer any further supportive contact or contacts and send MrA, by first class post, details of the medication the doctor had prescribed. There are many helpful pamphlets, but I have always found those produced by MIND to be particularly 'challenging'.

6. I am aware that it would have been much easier to 'process' MrA and section him. I wonder afterwards how my colleagues might have managed this referral, and how less experienced ASW's handle those sorts of pressure. I reflect on the way that I probably came across as arrogant and over-confident and wonder if I have made the right decision, but resist the temptation to phone the house as I know the family who agreed to stay over for a few days

will contact me if things deteriorate. I am aware of the research by the DoH (2001) into bias in mental health assessments and acknowledge that I tend to under-react to crises rather than over-react (I am not suggesting one is necessarily better than the other). This period of reflection is brief as I am back in the office and being screamed at by the father of a difficult, teenaged son who has assaulted him and 'cannot stay in this house'.

MrA never was sectioned and, following two 'successful' psychiatric outpatient appointments, as far as I am aware, has 'survived' without social or psychiatric services ever since.

On EDT though, we would rarely get to discover the short or long term outcomes for most of the referrals that we deal with on every shift. MrA was an exception because he was the subject of this research, otherwise it might have been possible that he had been sectioned the very next day, or week and, unless I specifically checked or by coincidence came across him again on EDT, I would never find out.

7. I feel confident though that I made the right decision at the time based on the information I had available to me. What I still find of interest is that another worker could justifiably have sectioned (even using section 4 of the 1983 mental health act) MrA and few questions would have been asked of that ASW. What I hope is achieved by this 4P's EDT Assessment Framework is that we record our rationale for our decisions better, that we try to reference other than our wealth of experience and that we address the same areas of assessment even if they lead us all to differing outcomes.

APPENDIX 19

TRANSCRIPT OF PHASE 1 INTERVIEW

Date:17/12/98

Pen Picture of Interviewee: White, female Relief Pool EDT worker.

Introduction: This is Interviewee number 14 and it is the 17th December 1998, the time is nearly 12 noon. Just so that we try to keep the interview as anonymous and confidential as possible, I would ask you to try and refrain from using the name of the local authority we work for. Don't worry if it slips out. Also I would not want the names of service users or colleagues using for similar reasons is that okay?

Yes that's fine.

The interview is being tape recorded as you have already agreed to this. However, if at any stage you wish to stop the tape please let me know. You may have a copy of the tape if you so wish, just let me know.

Okay.

Just so that you understand the context of the interview, the questions are split into a number of sections and I will introduce each section as we go along. If you want to stop the tape or the interview at any time please say so, otherwise I will carry on with both, is that okay? You have been given a copy of the original questionnaire with the scenarios in that we will turn to later, okay?

Yep!

Just so that you understand the context of the next set of questions what I want you to do is try and explain to me how you view the role of the EDT worker. And what I mean by that is how do you see the work of EDT? Is it very much life an limb and emergency service only, do you see it as an extension of the daytime service or do you see it as a bit of both, neither or, whatever, how do you see the role of EDT?

Right, I would like to see it as an extension of the daytime teams but obviously when there is only one worker on that is impossible. I suppose I see it as emergency service, but with the flexibility, depending on how busy the shift is adding onto that. To start of with the basics that you are going to provide this emergency service, but if you are not very busy and someone comes on and they want a bit of social work, we could give it.

OK so, in terms of practical priorities, you see it as an emergency service first but needing the flexibility to allow it to respond to the less urgent cases.

Yes, yes.

Bearing that in mind then are there pieces of work that you have been asked to do on EDT that you fee this is not my job at all?

Yes.

Can you tell me what they might be?

Erm, Just on the recent shift to be honest with you something came through that was a follow up from one of the offices which in my opinion could have waited or could have been done earlier.. It actually came on the shift before mine and good enough they boxed it off, but even they expressed the opinion that it should not have been passed to EDT.

And that had come from the daytime worker?

That had come from the daytime worker

What about spot checks?

Right,

Spot checks erm, I think they need to be used carefully as sometimes I think they come o EDT because the daytime worker, and I include myself in that, because I am a daytime

worker, can go home and sleep more peacefully in their bed. I can think of situations were it might be appropriate to do a spot check but I think they should be rare rather than common practice.

What about regular spot checks where it is part of a child protection plan?

No I do not think it is appropriate. If you are doing time limited spot checks and then plan is to go onto long term checks then that is not part of EDT. If the long term plan is for spot checks then I think you have to question the child protection plan.

So, given your definition of EDT, how would you explain some of the fundamental differences between EDT and daytime social work?

I suppose the main difference is that you are on your own. So your decision making on EDT has to be sort of (clicks fingers) there and then, because even when you are doing duty on a day basis you might get a referral that gives you that sort of lift that makes you think ugh ugh, but when you discuss it with someone else and they throw in a few more options, it will bring you down coz we all get up that's human nature isn't it, but then you've got the option of whether you are going to deal with it one way or another. ON EDT you go with your initial information really and sometimes it's right and sometimes you find out later this could have probably waited, but you only know that once you have been out and done your assessment. That's what I find is the main difference.

Any other fundamental differences you think?

Well I suppose it depends on what type of shift you get, because on a busy shift, the only ones you are responding to are the emergencies and are the high profile which, in a personal way, at the end of that shift you completely burnt out. Whereas you don't tend to get that on a daytime duty basis.

Could that be in part due to the fact that some of the areas of work are new to that person, for example it could be an older person referral and a child care worker during the day?

Yep, very much so.

Right.

You are right I have overlooked that fundamental difference. During the day I work for children and families, on EDT I am working with everyone except for the mentally ill because I am not ASW.

I think what I am saying is that genericism brings with it an element of doubt.

Yes uncertainty about procedures, resources and all that goes with it. If you do EDT on a regular basis you will get to keep abreast of the sort of current trends and dangers, but if you are doing it rarely you are like a rookie and coming in thinking 'God, please don't let someone ask me to accommodate an older person, because I don't know what to do. And that undermines your confidence, but then I find that once you start doing it, you manage to do it.

So if you had to draw up a list of the qualities a good EDT worker has or should have what would be on that list?

Right, firstly you need somebody who doesn't panic, erm because you will be hit with panic situations. You need somebody who has the ability to problem solve, because you can head off an awful lot of work simply by giving the correct responses to families. You need to be really self disciplined because, the more confident you become doing EDT the more you realize there is quite a scope for avoiding working on EDT if you are that way inclined,

Do you mean avoiding going out?

Avoiding working. You can 'bob' people off to various agencies, which I don't think is good practice. So a good EDT worker is one who is committed enough to go that extra bit with them, rather than just say go here or there Yu haven't got anyone overseeing you like you have during the day.

Right, one of the things you mentioned before was the ability to make decisions and prioritise, are you saying this is more required on EDT than during the day

Yes I would say that is what I am saying and that on EDT you are alone, whereas during the day you have others and two heads really are better than one.. And I know that on EDT there is the option to contact 'other people' but you do not want to do that . You don't want to get in touch with people every time something comes in because you do not want to pester people. So yeh, I just think that the situation comes to you and you have to be the sort of person who can deal with it.

Just moving on, if we can focus on the way in which prioritise and if possible look at the scenarios that were prioritized. The hypothesis here that I am trying to test is to see whether it is possible to have some degree of consistency between EDT shifts. So for example if you are doing a shift, and a full-time colleague is doing a shift, and I am doing a shift and these scenarios came up, would they be given a similar priority and I can tell you now that they would not be given the same priority, they would be given quite contrasting priorities, The hypothesis looks at ways in which respondents have prioritized the way they did, if we can do that first, is that Okay? Can you talk me through how you gave priority to the scenarios then?

Yes that's fine. Okay, I suppose that working with children and families team you build up a confidence to face a situation and decide quickly that it involves a child and an injury, therefore the expectation is to drop everything and deal with that. Which in an ordinary office that is fine, whereas on EDT you have to establish okay there has been an injury, and yes it's awful but what is the safety of that child now and what is the risk to that child now and can this wait for the area to follow up. So that's the experience I bring to EDT. So when someone phones and says there's a child in hospital with a fractured leg, yes my first thought would be right who has done it, who is the suspicion about, does that person have access to other children. Now in the scenario I do not think he had access to other children, so having established that there are no other children at risk and having established that the child is going to stay in the hospital for medial reasons, then I would be thinking if there are other things going on then that can wait because the child will be receiving appropriate care for the injury, so I put letter 'c' as being my highest priority because it's something that needs sorting out there and then, there's a woman and a kid and they're homeless.

Sorry, just for the purposes of the tape, what did you score scenario 'd' the child in hospital?

I gave that a '0' to say I would not visit. For scenario 'c' I gave that a '1', for me that is an emergency and that is what EDT work is really about.

I am going to jump about here. For the PACE interview I gave that a 3 because although you would have to visit, there are other things you would have to look at. It says here that it's a 'well-known' so how well-known are there other people involved for example foster carers, or how well-known are they to the police and could they be released on Police bail and allow the PACE interview to take place at another time so that is what I did for that one. For the spot check on a drinking parent. I put that on a number 4 because I was

thinking who is there what's happened what extended family are there what is happening around them, previous checks might show us some things – I am also aware that this is a chronic situation, this is not an acute situation, you can't manage to do the spot check that night and, whilst we all know horrible things can happen, but when you are trying to make decisions like this you have to accept this family have lived with this situation for some time, so that is where my thinking is coming from there. The section on the mental health I left because I do not do mental health,

OK that's fine.

Then you have the mother ringing to request the removal of her son. I put that as a number two. Now number two does not mean I would necessarily visit as she is on the phone because I would try and resolve it over the phone, but this woman is at the end of her rope and I would, wherever possible try and get out to resolve this to try an shore up the situation and say I will pass it on to the daytime team. More often than not, because I cannot ever remember accommodating a kid on EDT, that's usually enough for the family.

So what's interesting is that all these 'what ifs' could absolutely change the priority of your response?

Oh absolutely.

One of the ones you seem fairly clear on, like a lot of other people, is scenario 'd', which you've given your explanation before why you gave it '0'. What I want you to do now is to respond to what is a fact based on this research which is that the same number of people who responded to it with a '0', i.e. lowest priority, also accorded it a '1', the highest priority.

I would suggest that the ones that gave it the 1 do not come from a children's background, that's just guesswork.

If I told you that is not the case and that it is a mixture of full-time and relief workers.

Right, right. It's a surprise isn't it?

The justification from them is that it is a very serious injury and the department has a responsibility to interview the parents. I am not saying this is right because I gave it '0' when I did the exercise.

Right, I wonder if the people giving it 1 were, you see, if you were giving me these scenarios on my daytime duty basis I would be going out on those, but because I am thinking of it in terms of an emergency duty situation, I would expect the area office to do all that. It's about continuity and for the police too. For such a serious injury it might be that the police would take the lead in interviewing the family and until they had sorted that bit out.

To be honest I am grappling with the explanations myself and I think part of it does come back to the very first question I asked about how you view the role of EDT. Is the role 'life and limb' or can there be more flexibility?

So in may respects, your answers reflect what you view to be the role of the EDT worker. To make matters worse, no two responses are the same. No two workers have given the same order of response to the scenarios. The same is true of other questions in which you would give it low priority and others have given it extremely high priority. So if you were the manager of this service what questions would you be asking?

I would be asking why is there such a diversity and what can we do to clarify through training and education what the policies are of the department.

Sorry to interrupt, but have you ever seen a policy that tries to explain how the type of priorities we are discussing on EDT should be managed?

No! I haven't seen any whatsoever (laughs).

Have you ever seen any that help you prioritise the sort of work you do during the day?

Erm, we have lots of policies to help us assess. I think I probably have but I am not sure I work to it now as we adapt don't we to the culture of an office.

Again, that might explain why there is no such culture on EDT, because there is not that same degree of sharing.

Have you done this with the full-time EDT workers as well?

Oh yes

And is there the same sort of diversity?

Oh yes

That's very worrying really isn't it. We expect it and vive la difference, in terms of our personalities and that but there should be a consistent 'backbone' so to speak.

Part of what we look at in the next set of questions is why that might be. Again to set the tone, about 4 times you have alluded to personality and the next questions is to tease out some of what that means.

The next set of questions is designed to explore the term 'theory' and the hypothesis I am trying to test is that as an EDT worker I wonder sometimes whether we work within a theoretical framework that we consciously apply before we act, or, and this is what I believe, we fly by the seat of our pants and if we are lucky we will get the chance to, retrospectively put the theory in?

I would agree with that.

If that is the case, in order to set the context for the next set of questions, how would you explain to me what the word 'theory' means to you?

Right...$64,000 dollar question. Erm, erm it's sort of like a set of tested hypotheses erm that can be used to facilitate good practice. It's not something that would be used in place of good practice and I know there is to theory, but is a useful set of knowledge and instructions, well not instructions but..(hesitates)

Guidance maybe?

Yes guidance.

Now I do not want to put words into your mouth but I am trying to understand what you mean by 'theory', so for example in practice there are crisis intervention, behaviour modification, task centred practice, counselling, transactional analysis Is that the sort of thing you mean by these sets of knowledge and 'theory'

Yes, they are the ones I mean as social work theory and the ones we all studied and loved on social work courses at college. What we do is to develop our own theory from those and use parts of them that we find useful.

I think the term 'eclectic' suggests that we choose from different aspects of theory is that what you mean.

Yes that's it.

What about those theories that are sometimes referred to as the 'Grand Theories' – sociology, psychology, feminism, do they play any part in your social work practice?

They do in my practice more than my EDT work certainly because in my practice I have got much more of an involvement with specific cases. My job on EDT is to help sort out temporarily or otherwise a situation that is given to me there and then and you know, for

instance, if I was working with a woman on EDT who was the victim of say domestic violence, and I am in there and getting sorted with all the practicalities I don't think she would be too happy about sitting down and having a discussion about the feminist perspective on domestic violence. I am not saying a client from my daytime job would, but in terms of helping them to change their situation you would bring that to it to try and help them raise their self esteem maybe.

So what I think you are saying is that it is the nature of the relationship that you have as a daytime or EDT worker that makes the difference in this case.

Yes definitely. I may provide a bit of counselling but it would not be on a long term basis and it would not be involving theory in that sense.

Have you had the opportunity to sit down and reflect theoretically on a piece of work you have done on EDT or elsewhere?

Yes I guess so cos I have good supervision with my team leader.

Was that during the day?

Yes.

What about for the work you have done in EDT, have you had the same opportunity?

No, never, never.

How would you view yourself in terms of how well informed you are about theory. Would you say you are relatively well informed?

I would say that I have not practice taught for a while and if you were asking me to sit down and write about some of the theories I would be struggling. But if I was a Practice Teacher I would re-acclimatise myself. However, if you are talking about my work, I would say that my work is very underpinned by theory.

So, is it possibly the case that whilst you might not be able to give the 'official' titles (Crisis Intervention, T.A. and so on) to explain the work that you do, you could at any moment explain why you are doing whatever it is you are doing with a particular client?

Yes.

And is it also the case that this is parts of resources you have internalised, parts of research you have internalised and parts of policies you have internalised?

Yes.

Are there parts of you that you bring to your practice?

All of me. All of me with the knowledge that I bring with me because we all have different values and we have to constantly ask am I minimizing that because of the way I was brought up, or am I overstating it because of the same background?

Moving onto the notion of values and the often heard expression of anti-racist/anti-oppressive value base, the hypothesis is that all too often particularly on EDT we make decisions without consciously applying an AO/AR value base. I am wondering whether EDT is potentially more oppressive than daytime social work.

I think the potential is there because when you have gone into a situation that might involve child protection and you are the only person on and all the support networks and daytime offices are closed I will have to go in and say OK how about your Mum has the child over the weekend, which is protecting the child. However if it was 9-5 and we all other structures in place it might not be the same decision and we would involve others.

So what you are saying, if I can make a distinction between the different levels at which oppression operates – there's an individual level and a structural level

Yes

I think what I am saying, very clumsily, is that at the individual level we think we may have some control over how oppressive we are in our practice..

You mean in the language we use

Yes and in the way we treat people individually.

Yes I agree with that.

On the second level, the structural one, it has such a massive impact on what we do and yet we have less influence over it despite our personal politics.

Yes and that is the conflict of social work. That is why we go home and rant and rave cos you are going along with something you know you don't agree with, but you also know you have no choice, cos of the limitations. That's what gives is all our ulcers I think (laughs)

What about as a woman, is it different as an EDT worker?

From a male worker?

Yes,

Yes it's scarier being out in the dark maybe. I know there are plenty of scenarios in which a woman will handle a situation better than a man simply because she is a woman. But there will always be that threat. It may be unfair saying that because men have just as much right to be scared as women do. A punch on the nose hurts both of us but I think it's only those physical things, but that is just me talking.

What about the things you bring to your practice. Is it possible that as a woman you have been socialized differently to me and I would suggest that some of the things you have said reflect that, but what is it about you as a woman that you think you bring to social work?

I bring this ability that is inherent in me to negotiate. I have never learned in the playground to punch first, and I am not saying that all men have, but it more likely that a man will have, so the negotiation skills are skills that have been there since I could talk. I suppose that's part of it. I would not say it makes me any more sympathetic or sensitive because there are a lot of very good male practitioners who are both of those.

Okay, moving on slightly, do you think your EDT practice has changed over the years?

Oh yes I have got the confidence to say no and that it is okay not to have all the answers. On EDT I thought I would have to have all the answers and I have learned that I do not.

Okay, I want you to give an answer, but I don't expect it to be fact because what the next section is about is your perception, it's your views I want and it does not matter about being right or wrong

OK

Which service user group do you think is the source of most referrals to EDT?

I would have to say it's young teenagers

So the logsheets would record children and families

Yes

Within that are you including pace?

Yes

Taking pace out would it still be children and families?

No, Older people would be the most.

Which would be the least?

Mental Health, funnily enough.

Just so that I am clear then, of all the categories mental health is the least
Yes
Including such as Learning Disabilities..
Oh it's probably AWLD.
Do you think there are any patterns to referrals? For example are there particular nights that are busier or times of year.
I do not really know, but I would say between Xmas and NY would be busy. The winter months may include more older people but I would honestly have to say I do not know.
That's fine.
How many referrals do you think EDT takes in any one year – and for the sake of the question, a referral is any piece of work that has had to be recorded?
I would say on average we do about 8-10 referrals multiplied..
So what is you perception for a year?
Maybe 2,000?
What is the answer?
Yes it's about that 2,600-3000.
How do you think EDT might become effective?
Firstly we need to clarify the rules on PACE and are we getting too led by the police. Another way would be to have 2 workers on duty at once during peak periods.
Have you used what I call radical non-intervention or therapeutic waiting time in response to a referral and what I mean by that is a deliberate delay in response to allow time for difficulties to be resolved without our immediate intervention?
Yes I have used those.
How and when?
Mainly when it is families that I know and have had dealings with before and I know that responding might actually escalate a situation.
How do you know when to use this?
Usually by instinct, you just know with experience that some things can and should be left to cool down.
Are there any aspects of EDT you enjoy?
I enjoy it all, erm, I enjoy the work it is just frustrating having to work within the limitations. I actually enjoy bouncing around with lots of referrals as long as it is manageable. It's when it all comes one after another and there is no time to do anything properly and you think ugh and it wears you down.
Have you experienced it yet where, you have been busy and you managed and you actually feel I have done a great job tonight and you are actually 'buzzing' off it?
Yes. I remember many shifts like that?
Have you ever had shifts where you are busy and one little relatively straightforward referral comes in but it almost 'tips you over the balance'?
Oh yes I remember one shift that had been busy and it was a weekday unusually for me and loads of referrals had been coming in, and then one silly little one came in and I put the phone down and remember having a right little paddy and then hearing somebody coughing (discreetly) in the next office and I remembered there were still other people in the building.
So you starting swearing at the phone or the bleep?
Oh yes and the wall and the floor?

The final question of this section, and I know it is a long time since you did the questionnaire, throughout the process of the questionnaire and the interview today, are there any aspects of EDT that you thought we would discuss or should have covered?
Erm You and I now?
Yes,
I thought we would have talked about the building and the isolation and that aspect of it, but I suppose that has been done today hasn't it?
Would that be something that you would have commented upon in terms of making the service more effective – would you maybe change the building, is that what you mean?
Yes, I think you are very lonely and isolated in that building. There's the adolescent building attached and when things are going very nicely they go very nicely, but if there's a problem you could end up in a situation that is dangerous. I also am aware that I do look at the darker side, but I mean, if you had a heart attack who is going to find you lying there, I always think along those lines (laughs)
Well to be fair, that's a serious issue. For example if you are going on a relatively dodgy visit but have decided not to take the police, do you tell anybody where you are going?
No I don't,
So if you did have a heart attack or were assaulted, who would know where you are?
Me and the assaulter!
I mean don't get me wrong I don't tell anybody either, but it worries me that there is no system in place to make this a safer place to work.
The other thing is that I did EDT one time and I did a PACE interview in (name of local place) and I funnily enough my car kept breaking down with this young lad in my car. I thought, he was an awful nice lad dead chatty, I brought him home in the car on my own and he'd said look if your car won't go I will give you a push and I found out, on the Monday, that this lad had a very, very violent past, to the extent that he did not like social workers. Now it might just be residential workers but this lad had gone into one of the units with a machete and a hammer to attack one of the staff there. Another time he had attacked someone with a screwdriver and the police knew but did not tell me!! So there is that kind of potential for violence that effects men and women
Anything else that you think that should be part of any sort of research into EDT?
I certainly think that us volunteers need some sort of training. I mean I have been doing it now for a couple of years and I have never had any training. My only training was to go and observe someone the day before I did my first shift and find out all the bits and bobs, but no specific training.
Nothing else you think should be looked into that we haven't.
No I can't think of any.
I suppose it's about somebody getting the referrals that we have had dealings with and doing something with them
You mean a sort of quality assurance thing?
Yes, you know follow up not just on the referrals, but on the log when we have spent ages on the phone preventing a referral, that should be looked at. I have never received any training specific to EDT
Do you think the full-time staff have such training?
I would hope so, I don't know, do they?

There is a training forum called North West EDT that puts on specific training to those authorities that subscribe but there is nothing internally provided by this authority. I think it might change as we are being inspected next year and that is highly likely to identify training as a significant gap.

Well that doesn't surprise me then that I have never had any training and that things are so inconsistent.

Well thank you for taking part in this, I hope it has not felt like a straight forward question and answer session

No it certainly hasn't, it's been interesting to talk about EDT because I never get the chance usually.

I will make available copies of the tape if you want, just let me know and if yours is transcribed I will also offer you a copy of the manuscript. This will be used as part of the research but will be anonymised so that people from this authority will not know it is you and people from outside this authority will not know which authority it is.

That's fine.

Once again (name) Thank you.

TRANSCRIPT OF ANOTHER PHASE ONE INTERVIEW

Pen Picture of Interviewee: White, male full-time EDT worker.

Introduction: This is Interviewee number 2 and it is the 10th December 1998, the time is nearly 11 o'clock in the morning. Just so that we try to keep the interview as anonymous and confidential as possible, I would ask you to try and refrain from using the name of the local authority we work for. Don't worry if it slips out. Also I would not want the names of service users or colleagues using for similar reasons is that okay?

Yes I understand.

Just so that you understand the context of the interview, the questions are split into a number of sections and I will introduce each section as we go along. If you want to stop the tape or the interview at any time please say so, otherwise I will carry on with both, is that okay? You have been given a copy of the original questionnaire with the scenarios in that we will turn to later, okay?

Sure, that's no problem

The interview is being tape recorded as you have already agreed to this. However, if at any stage you wish to stop the tape please let me know. You may have a copy of the tape if you so wish, just let me know.

OK that's fine.

Just so that you understand the context of the next set of questions what I want you to do is try and explain to me how you view the role of the EDT worker. And what I mean by that is how do you see the work of EDT? Is it very much life an limb and an emergency service only, do you see it as an extension of the daytime service or do you see it as a bit of both, neither or, whatever, how do you see the role of EDT?

I see it very much as being an emergency service only. It can only be this as there is only one person on duty at any one time. I know there are sometimes things, referrals I mean, that would not really fit the definition of an emergency but that I would do if the shift was not too busy, just because I would prefer to be out doing things.

Essentially though you see it as an emergency service?

Yes absolutely!

You have done EDT for many years now full-time; has your EDT practice changed with more experience of working out of hours?

Oh yes I think so. I think I have got better at saying no to other agencies when they make ridiculous demands of EDT. I also think I have got more confidence when standing up to medics and consultant psychiatrists or custody sergeants for example. I think that on EDT you quickly learn to cut to the quick and go to the core of the problem rather than spending too long examining the possible explanations. I also think that I have learned to use the extra authority we have on EDT more effectively.

What do you mean by that?

I mean that as we act with the designated authority of the Director, sometimes we have to instruct homes to take young people, or we can access resources on EDT that cannot be accessed without some panel meeting.

That takes us nicely into the next question that is 'What do you think are the main differences between EDT and daytime social work?'

Well I have already mentioned the level of authority we have, that would be one. Another would be that we do not carry any caseload responsibility but simply pass it back to the daytime worker after the shift is over. We make decisions on EDT that daytime workers cannot make. Is it too obvious to say that we are different because we work after hours and on our own?

No I think that is very relevant.

Well there is that fact and the fact that we are generic and cover the whole of the borough. I can't think of any others but I am sure there are some.

No I think that's a comprehensive response, thank you.

Do you think there are some types of social work which EDT gets asked to do that you think we should not do?

Oh yes, spot checks and picking up and taking over work that daytime workers have started but, for whatever reason, do not want to finish.

Why do you think we should not do spot checks?

Because they put us in a very difficult position if we 'catch' the parent out and, as is usually the case, there are no plans or placements for the children. It makes us like private detectives which we are not. Spot checks are planned pieces of work and we do not do planned work, we should concentrate on emergencies.

Okay, you have mentioned the 'cutting to the quick' nature of EDT, what qualities do you think an EDT worker needs?

Okay, they need to be able to make decisions, they need to be able to manage more than one crisis at a time and they must have good, generic knowledge as well as good recording skills. They must also be able to work long hours and work on their own without the back-up of any manager on site.

What do you think we on EDT bring to multi-disciplinary interviews (i.e. PACE or Mental Health assessment)?

I think we look at the whole picture; we take a holistic view of the person. Whereas the police may be interested in the crime and the psychiatrist interested in the medical psychiatric diagnosis, we take a broader look at the whole person and where they fit into the larger picture. It does not always work that well but I think that is what we bring that is different.

Okay that is fine thank you, moving on, if we can focus on the way in which you prioritise and if possible look at the scenarios that were prioritised. The hypothesis here that I am trying to test is to see whether it is possible to have some degree of consistency between EDT shifts. So for example if you are doing a shift, and a relief worker colleague is doing a shift, and I am doing a shift and these scenarios came up, would they be given a similar priority and I can tell you now that they would not be given the same priority, they would be given quite contrasting priorities, The hypothesis looks at ways in which respondents have prioritised the way they did, if we can do that first, is that Okay?

You mean according to those scenarios we did?

Yes that's right

Yes that's fine.

Can you talk me through how you came to give priority to which scenario then?

Okay. I did find this exercise difficult because some of the responses were what ifs and we only had limited information, but based on what we had I gave number 1 to scenario c as I would deal with that first and hopefully house the family before doing the PACE interview. I put the spot check third, even though I object to doing them, and the section fourth. I would deal with the plea for removal 5th but would probably not visit and the same for the child in the hospital that I would not visit but deal with over the phone, unless there were siblings or any attempt to remove the baby.

How did you come to that order of responses, what sort of things helped you decide?

I suppose I am thinking about the degree of vulnerability, who is the most vulnerable; I am also thinking about which ones will hold or which ones can I deal with quickly to avoid a backlog. The degree of risk is what I am assessing and in the case of the child

in hospital, he (I think it is a he) is safe and well. I would make sure the staff know who to phone should any attempt to remove occur, and I would probably liaise with the police to put them on alert, but I do not really see any need to visit. This would change if there were siblings in the house.

One of the ones you seem fairly clear on, like a lot of other people, is scenario 'd', the child in hospital, which you've given your explanation before why you gave it low priority. What I want you to do now is to respond to what is a fact based on this research which is that the same number of people who responded to it with a '0', i.e. lowest priority, also accorded it a '1', the highest priority.

Really!

Yes, why do you think that is?

Is it because the ones who gave it a high priority are form the relief pool and maybe have their daytime heads on?

No, there does not appear to be that correlation

Well, I am surprised. I wonder what they thought they would achieve by visiting, unless they thought they needed to check that all safety measures were in place in person...erm, no I do not know why this scenario would be a priority, that is interesting.

To be honest I am grappling with the explanations myself and I think part of it does come back to the very first question I asked about how you view the role of EDT. Is the role 'life and limb' or can there be more flexibility?

So in may respects, your answers reflect what you view to be the role of the EDT worker. To make matters worse, no two responses are the same. No two workers have given the same order of response to the scenarios. The same is true of other questions in which you would give it low priority and others have given it extremely high priority. So if you were the manager of this service what questions would you be asking?

I would want them to explain what they achieve by visiting the child in hospital and I would want to know how they have decided who is in the most vulnerable position. I would also want them to be very clear about our statutory obligations as we have them for PACE, homelessness and mental health, but they are less clear with the child protection cases in terms of how quickly we have to respond. I wonder if some people see the severity of the injury and the mention of the CPR and simply assume there is a need to visit possibly to cover their backs, I don't know really, you have got me thinking now and I am surprised by their responses, maybe I have got it wrong?

I am not sure at this stage whether it is a matter if right and wrong, but what is clear is that we have a clear difference of opinion and both sides justify their responses.

How do they justify the need to visit the hospital?

The justification from them is that it is a very serious injury and the department has a responsibility to interview the parents. I am not saying this is necessarily right and I gave it '0' when I did the exercise, but it does make you think.

It certainly does!

Have you ever seen a policy that tries to explain how the type of priorities we are discussing on EDT should be managed?

No, do they exist?

Not that I am aware of.

Do you think some sort of framework would be helpful?

Oh Yes definitely if it means that we become a bit more consistent as a group of workers, yes definitely.

Okay, that was helpful thanks.

The next set of questions is designed to explore the term 'theory' and the hypothesis I am trying to test is that as an EDT worker I wonder sometimes whether we work within a theoretical framework that we consciously apply before we act, or, and this is what I believe, we fly by the seat of our pants and if we are lucky we will get the chance to, retrospectively put the theory in?

'Theory' means a range of things to a range of people – within EDT social work, what does it mean to you, can you give examples?

What does theory mean?

Yes

Erm...erm...oh...it's not something you think about really is it? Theory, theory...I suppose it is the way that you do things, it's the difference between theory and practice and a theory tells you how something might be done..erm...I don't know to be honest.

Alright, well if we accept that a theory is a body of knowledge that informs how we do social work it could relate to some of the so-called social work theories for example, task centred, behaviour modification

Oh right I know what you mean now and crisis intervention and all those, blimey it's years since I read any of them but now I know what you mean. I suppose I have practised EDT for so long I don't think about them as theories, I just get on with it.

Okay, now that you have a clearer view of what I mean is there a particular theory that you would say you know most about?

Oh God, erm I suppose it would be crisis intervention, but don't ask me to tell you anything about it, is there something about 'homeo' something or other?

I think you might mean 'homeostasis' that refers to a sort of equilibrium, is that what you are thinking of?

Yes I think so, I cannot remember to be honest.

Okay that's fine, can we move on?

Yes

Would you say that EDT is a political activity?

Oh yes I think so. I don't think it is about party politics but I do think our personal politics play a massive part in how we view the world and how we do social work.

Can you give me an example of what you mean?

Yes, I mean, I believe that as people we are all born equal but because of societal failures we have different chances. People should not be blamed for this societal weakness – this is my personal politics and I hope it reflects in my practice being non-judgemental and not blaming the victim. I know there are times when clients drive me up the wall (laughs) but most of the time, even on really bad shift, I try not to judge people because of the lot they have been dealt. I don't think EDT is about party politics though.

Okay, is it fair to summarise that you are not too sure about the names of theories but are comfortable that you operate within a framework (political or otherwise) that helps your practice to be consistent?

Yes I think that is fair, I don't know the names but I suspect I have internalised them into my EDT. Theory is an awkward term isn't it?

I suspect it will cause people to think during these interviews

It has certainly made me do that (laughs)!

The next section looks at the notion of assessment and I would like to start with your understanding of what the term 'assessment' means?

Well it means how you work out what is going on in any given situation. It is how you establish what the risks are in a family.

Okay, just to be clear then can you tell me what your understanding of the following terms is:

Screening – *That is when you decide whether or not a client is entitled to a service, it's when you have to decide whether they should go on to the next stage that would be actually getting the service they were requesting*

Okay what about 'Initial assessment' – *Oh yes that is what we do all the time on EDT. This is when you get a referral and you have to go out and assess what is going on and then pass the details on to the daytime team if the matter can be left until the next working day. Is in not a complex or a comprehensive assessment but just enough to make things safe or it might be to take action, such as removing a child or an adult.*

Okay, the difficulty I have is that I am trying to explore what we mean by assessment and you are telling me you go out and do an assessment, but I m trying to find out what this entails.

Oh yes I see, I think I mean that I assess, oops I've done it again, erm another word for assessment...erm I know, I am collecting information from a family and deciding the level of risk. It's hard to put into words even though it is what we do every night.

What about the next three then, 'complex, risk and social assessment'?

Well the complex assessment is the more detailed one that the daytime workers do, it goes into much more detail than an initial assessment that could lead to a complex assessment. Risk assessment is what I have already said EDT is all about when you are deciding what the degree of risk is and acting accordingly and, what was then other one?

Social assessment

Social assessment, I don't think I have heard of that one is it to do with identifying what social networks a client has?

Yes sort of as it would indicate that a person's social world is important to them as much say as their medical world. The social assessment would be the way that social workers might explore social rather than medical explanations for difficulties. The impact of poverty on families would be one aspect of a social assessment.

Oh right I know what you mean. In essence it is what we do as EDT workers, rather than blaming the victim we are looking for a broader view and taking a holistic view of that family and their situation.

Yes that is it. The final question of this section seeks to clarify this and it asks How does our assessment differ from the G.P., the police officer, the psychiatrist?

How does it differ?

Yes

Well the G.P. does what we have just been talking about and focuses on the medical problem. The police officer looks at it from a crime perspective and gathers information relating to that whereas the psychiatrist has to decide whether a diagnosable mental illness is present and if so how it should be treated. I suppose it is a question of focus.

So how does our assessment differ from theirs?

Well, as before we look at the whole picture. We look at a holistic view of a person and try to see them in broad terms. We also have to look after their rights and act as an advocate for them against the likes of the doctors, police and psychiatrists. So yes our assessment is different as we have a wider focus and a role of advocate. I would also hope we treat people with a lot more respect than some of the other agencies. It is almost as if we have a different moral code that informs our practice because certainly in my experience, we are a lot fairer to and a lot more honest with service users than are those others.

That's handy actually because the next section explores our values and the way we treat people and I have put it under the heading of Anti-Oppressive/Anti-Racist Values. The statement at the top of the page reads: 'All too often we make decisions without consciously recognising the divisions which exist and our own socialisation process. The following questions will try to clarify the validity of this statement.' Is that okay?

Yes I think so on you go and we will see!

Alright the first question is 'What do you understand by the term A.O/A.R. practice and does it have any place in EDT?

I believe it means treating everybody equally and not discriminating against one person because they are black or a member of an ethnic minority. So it is about equal opps and making sure people are treated fairly.

Does it have a place in EDT?

Oh yes I think so, although in this borough there are hardly any black people. I think it should inform the way we treat all people whether they are black, white or whatever. It is more to do with your value base and whether you genuinely treat people with respect irrespective of their skin colour.

Okay, do you think that your background and general autobiography impacts upon your EDT practice?

Oh yes definitely, I was brought up in ....(name of local place) in a council house and my parents were both working class. My dad also worked for the council as a labourer and my Mum was a dinner lady at ....(name of local school) so we rarely had much money.

How do you think that impacts upon your EDT practice?

Well it informs it doesn't it by helping you to remember your roots and also that people get into all sorts of difficulties simply because of where they were born. I also think that I bring a lot of me to the job, you know, the way I do want to help people, because that's the way I was brought up, but also with a strong sense of fairness and justice and making a stand when things are not fair. Firm but fair is what my parents were and I think I bring a sense of that to EDT.

What about as man?

What do you mean?

Does being a man make any difference to your practice?

I don't think so, I don't know. It might do I suppose if the service user was a woman. I wonder if sometimes women are less likely to get threatened by clients but I have not got any evidence for this. No I don't think my sex would make that much difference.

Okay, I would like to read you a statement now and see what your response is.

Okay

Okay this is the statement: 'With minimum information, limited support, less time than daytime counterparts and operating without discussion with other social workers, EDT still remove children, adults and older people against their wishes and refuse services to others and so act more 'oppressively' than any other section of the social work profession. How would you respond to that accusation?

In part I think that is probably true, but it needs to recognise that we will try everything possible before we accommodate anybody. I think I have accommodated one young person in about 4 years, because I know what happens, and the damage that is done to kids once they get into the system. It is the same for the adults, even if it is a section, I will try to look at the community alternatives first. So yes I would say that the statement is true but, because of the nature of the job we do outside of office hours, we try to avoid removing people against their wishes and only do so when

absolutely necessary and even then we will still try to get alternatives if they are available. Is that what you wanted?

Yes that's very interesting, thank you. So in a nutshell what you are saying is that EDT workers only act like this when everything else has failed and if this is 'oppressive' then it is an accurate description of EDT?

Yes I think that is fair.

Okay thank you and now to the penultimate section. Are you okay so far?

Yes fine, cheers.

This next section is all about statistics. It is your views that are being sought irrespective of the actual 'facts'. In other words it is your perspective I am seeking so there are no right or wrong answers as such.

Okay

The first question is 'Which service user group do you think is the source of most referrals for EDT and which is the least?

In a year you mean?

Yes

Okay I would say the most is children and families and the least is...the least is Adults with Physical Disabilities.

Does your children and families include PACE?

No

Okay thanks. Next question is 'Do you think there are any patterns of referrals, for example the school holidays, Tuesday nights, winter?

Every shift I do feels like the busiest sometimes (laughs). Erm, let me think. I sometimes wonder if the referrals go through the roof during the summer holidays, or I mean towards the end of the holidays as families are beginning to get fed up of each other. It could be a combination of the weather getting hotter during the long summer school holidays as well. Friday and Saturday nights are always busy on EDT, but now that I am thinking about it I don't really know why this should be so, the use of alcohol maybe I am not sure, what's the answer?

Well so far there would not appear to be any obvious explanation although you are right certain shifts, namely Fridays and certain months namely December are routinely busier than the others but I am not sure why this is the case.

I suppose December might be busier with older people and with them falling or their main carers going into hospital and flu epidemics and the like taking place during the cold months.

Yes I think all those things might be factors, but I am not sure it is any one, single factor that explains any patters. It is likely to be a combination of a number of factors. The final question in this section is 'How many referrals do you think EDT takes per year (A referral, for the sake of this question is a piece of recorded work which is passed on in writing to a daytime team)?

Oh right, let me see, I would say about 2,500 referrals

Yes that is in the right region. 2,500 – 3000 referrals per year and rising each year too

Really?

Oh yes a 400% increase since the team started in 1978

Wow, we should get some recognition for that, or does it compare any differently to the daytime teams?

I a do not know but it is a fair question.

There are three questions in the final section and the first is how you think EDT could become more effective?

Well I think we should have more joint training and supervision so that we can share how we do things. I also wonder if we should have more staff on when the shift is busy, those Fridays, I mean you know Glen what they are like when you are running from one crisis to another and your feet don't touch, or when you are needing to be in three places at once and having to juggle all sorts of things all at once. Another member of staff on those shifts might make us more effective, but, having said that I do get a 'buzz' of shifts like that knowing that I have managed a really busy shift, do you know what I mean?

Yes it's a real sense of achievement and feeling of immense satisfaction

Yes that's it exactly. It feels like you know you have done a really good job. I often wonder how some of the daytime workers would cope with some of the shifts we do and they have no idea what it is like on EDT. Some of our critics should come and have a go, don't you think?

You sound frustrated that many colleagues don't understand what doing EDT is really like and I know some are critical of us as being 'paid to sleep'

That drives me mad, they have no idea but yes that is what I mean.

The next question is interestingly timed in light of what we have just been talking about as it is 'What do you enjoy about doing EDT?'

The autonomy, the time off, no caseload, being my own boss and knowing that we can make a difference. Oh yes and the unsociable allowance means we get paid more too. Best job in the world!

You certainly sound happy in your work?

Oh yes, I know I moan a lot, but I do recognise that this is good job.

The very final question is whether you have any questions for me, or comments about the interview or my research or whether there is stuff you thought we would talk about but didn't?

Is that it, oh God look at the time I didn't realise. That went really quick. Erm, no that was interesting. I hope it was what you wanted. No that did not feel like an interview at all, although I do not envy you having to listen to me going on. We should all do more of this so that we are clearer what each other is doing you know. We just don't share practice on EDT at all.

Well thank you very much and let me know if you want a tape so you can listen to yourself 'going on' (laughs).

Seriously though, I know you are in tonight so I hope it is quiet and thank you very much for agreeing to the interview.

No problem Glen, Good Luck with it all.

APPENDIX 20

Phase Questionnaire

Completed Examples

1. Name of Local Authority you work for: Wolverhampton

AGE	20-25	25-30	30-35	35-40	40-45	45-50	50-55	55-60	>60
MALE							✓		
FEMALE									

2.

Length of EDT service in years	0-3	3-6	6-9	9-12	12-15	15-18	18-21	21-24	24-27	>27
							✓			
Years since you qualified as a social worker									✓	

3. How would you describe your own ethnicity? White British
(e.g. Black British, Irish, Asian, White British)

4. Would you describe yourself as having a disability? YES ☐ NO ☑
(please tick appropriate box)

5. Please tick the following boxes that apply to you presently.

EDT Manager	EDT social worker	A.S.W.	Full Time	Part/Half Time	Job Share	Other (please specify)
	✓	✓		\	✓	

6. Does your role usually include home visits? YES ☑ NO ☐

7. How is EDT mainly delivered by you Local Authority? (please tick box)

DEDICATED TEAM ☑   STAFFED BY DAYTIME WORKERS ☐

HOME BASED ☐   OFFICE BASED ☑

OTHER ☐ (please describe)...
....
Are You a   LONE WORKER ☑ or PART OF A TEAM ☐ (please tick)
Comments...

8. How do you view the role of EDT? (please tick ONE only).

EMERGENCIES ONLY ☑ EXTENSION OF DAYTIME SOCIAL WORK ☐

BOTH OF THE ABOVE ☐ OTHER ☐ (please explain).......................
....
....

9. Does the public have direct access to an EDT social worker? YES ☐ NO ☑

If yes, is this access throughout the entire shift?   YES ☐ NO ☐

If no, please explain....Calls are taken by council
....telephone operator.

10. Do you have access to records that are kept up-to date (at least weekly)?
YES ☐ NO ☑

11. Does you EDT have a written policy to assist in prioritization of referrals?
YES ☐ NO ☑

12. How is a decision to visit a service user made (please explain who is involved and what factors are considered)?.................................
...As deemed appropriate by the duty
...worker.
...The duty worker alone.......................
....
....

13. How many people per EDT shift usually determine whether a referral is a priority or not? 1 ☑ 2 ☐ 3 ☐ more than 3 ☐.

14. EDT workers appear to have differing priorities between competing referrals, why do you think this might be?......................................
...Bias of training and previous experience
...personal preference for type of work.
....
....
....

15. It is 6.30 p.m. on a Monday and the following 'referrals' have come to you on EDT. Which of the following (if any) would you prioritise as requiring a visit by EDT, and in what order would you advise they are visited?
Place (1) in the box you would visit first, (2) for the second visit and so on; Place (0) for any of the scenarios you do not think require a visit on that night.
(N.B. It is recognized that more details would be required for such decisions to be made, but for the purpose of this exercise please prioritise the scenarios as you might in 'real' life, and explain the difficulties and the reason for this choice after each one).

(a) 'PACE' interview on a 'well known' 15 year old accommodated male   [3]
(please explain your priority, and any other details that might alter your decision)
...... No urgency but attend during shift ......
....

(b) Mother and three children presented as homeless at a local Police Station [0]
..... Arrange placement by phone .....
....

(c) Local hospital phone re. 4 year old child with a "suspicious" fractured leg: "Probable NAI", child is on the Child protection Register and will be kept in overnight with parents' permission.   [2]
....
....
....

(d) Request by G.P. to complete Section 2 (Mental Health Act 1983) assessment on "potentially violent" male at home. G.P. and Psychiatrist due to arrive at the house at 8 p.m.   [1]
...... Great urgency because of risk of harm .....
...... to patient / family / neighbours .....
....

(e) Mother of 13 year old daughter phones, 'plea for removal', not known to the department   [0]
...... Advise by phone ......
....
....

16. What factors exist for you when trying to decide between competing priorities?
...... Effect of time delay on service user .....
...... Risk of harm caused by delay .....
....

17. "......assessment focused on whether the eligibility criteria had been met. Information gathered was intended to help the worker establish if the situation would hold until the mainstream services were available. This did not lead to a rounded assessment of the service user's needs." (Open All Hours, 1999, SSI).

Is this observation by the SSI accurate of your EDT?   YES ☐   NO ☑
Any comments...... Assessment is intended to fulfil ......
...... need, if possible and appropriate. ......
....
....

18. Please use the rest of the space to make any comments regarding the way in which EDT workers prioritise/assess referrals, the decision making framework or any other related remarks.

...... It is desirable to complete a piece of work ......
...... wherever possible ......

...... that, preparing for the efficient completion ......
...... of a piece of work by daytime worker to ......
...... de-skilled. ......
....
....
....
....
....
....
....
....
....

Thank You for taking time to complete this questionnaire.

All details will remain anonymous.

Glen Williams,

Name of Local Authority you work for: LANCASHIRE

1.

	20-25	25-30	30-35	35-40	40-45	45-50	50-55	55-60	>60
AGE									
MALE									
FEMALE								✓		

2.

	0-3	3-6	6-9	9-12	12-15	15-18	18-21	21-24	24-27	>27
Length of EDT service in years							✓			
Years since you qualified as a social worker										✓

3. How would you describe your own ethnicity? WHITE BRITISH
(e.g. Black British, Irish, Asian, White British)

4. Would you describe yourself as having a disability? YES ☐ NO ☑
(please tick appropriate box)

5. Please tick the following boxes that apply to you presently.

EDT Manager	EDT social worker	A.S.W.	Full Time	Part/Half Time	Job Share	Other (please specify)
✓						

6. Does your role usually include home visits? YES ☐ NO ☑

7. How is EDT mainly delivered by you Local Authority? (please tick box)

DEDICATED TEAM ☑   STAFFED BY DAYTIME WORKERS ☐

HOME BASED ☐   OFFICE BASED ☑

OTHER ☐ (please describe)...
....

Are You a   LONE WORKER ☐   or PART OF A TEAM ☑ (please tick)
Comments...
....

8. How do you view the role of EDT? (please tick ONE only).

EMERGENCIES ONLY ☑   EXTENSION OF DAYTIME SOCIAL WORK ☐

BOTH OF THE ABOVE ☐   OTHER ☐ (please explain).......................
....
....

9. Does the public have direct access to an EDT social worker? YES ☑ NO ☐

If yes, is this access throughout the entire shift?   YES ☑ NO ☐

If no, please explain..
....

10. Do you have access to records that are kept up-to date (at least weekly)?
YES ☑ NO ☐

11, Does you EDT have a written policy to assist in prioritization of referrals?
YES ☑ NO ☐

12. How is a decision to visit a service user made (please explain who is involved and what factors are considered)?.........................
Certain jobs must involve visit i.e. accomodation of child: accomodation of elderly person; mental health assessment. Otherwise it is S/WS decision whether visit is required to gather information / make an assessment.

13. How many people per EDT shift usually determine whether a referral is a priority or not? 1 ☑ 2 ☐ 3 ☐ more than 3 ☐.

14. EDT workers appear to have differing priorities between competing referrals, why do you think this might be?.............................
Personal preference / travel involved
....
....
....
....
....
....
....

15. It is 6.30 p.m. on a Monday and the following 'referrals' have come to <u>you</u> on EDT. Which of the following (if any) would you prioritise as requiring a <u>visit</u> by EDT, and in what order would you advise they are visited?

Place (1) in the box you would visit first, (2) for the second visit and so on; Place (0) for any of the scenarios you do not think require a visit on that night.

(N.B. It is recognized that more details would be required for such decisions to be made, but for the purpose of this exercise please prioritise the scenarios as you might in 'real' life, and explain the difficulties and the reason for this choice after each one).

(a) 'PACE' interview on a 'well known' 15 year old accommodated male [2]
(please explain your priority, and any other details that might alter your decision)
.... Visit would be done by casual A.A.
worker if EDT shorted not EDT S.W.
....

(b) Mother and three children presented as homeless at a local Police Station [0]
.... Do not deal with homelessness - would
refer to District Council.
....

(c)Local hospital phone re. 4 year old child with a "suspicious" fractured leg: "Probable NAI", child is on the Child protection Register and will be kept in overnight with parents' permission. [0]
.... would become involved if need for
immediate investigation or if other
children in family.

(d) Request by G.P. to complete Section 2 (Mental Health Act 1983) assessment on "potentially violent" male at home. G.P. and Psychiatrist due to arrive at the house at 8 p.m. [1]
....
....
....

(e) Mother of 13 year old daughter phones, 'plea for removal', not known to the department [?]
.... Depends on information gained ....
....

16. What factors exist <u>for you</u> when trying to decide between competing priorities?
.... Statutory responsibility / risk to client -
others.
....

17. ".....assessment focused on whether the eligibility criteria had been met. Information gathered was intended to help the worker establish if the situation would hold until the mainstream services were available. This did not lead to a rounded assessment of the service user's needs." (Open All Hours, 1999, SSI).

Is this observation by the SSI accurate of your EDT?   YES ☑   NO ☐
Any comments..
...... We cannot do "rounded" assessments -
our function is to conduct emergency
assessments.:

18. Please use the rest of the space to make any comments regarding the way in which EDT workers prioritise/assess referrals, the decision making framework or any other related remarks.

...Decision making depends on:
.....1) Whether the right to statutory
.....2) the risk to client
.....3) knowledge of client & client's
.............situation.

Thank You for taking time to complete this questionnaire.

All details will remain anonymous.

Glen Williams

Glen Williams,

Name of Local Authority you work for:.......OLDHAM......

1.

AGE	20-25	25-30	30-35	35-40	40-45	45-50	50-55	55-60	>60
MALE							✓		
FEMALE									

2.

Length of EDT service in years	0-3	3-6	6-9	9-12	12-15	15-18	18-21	21-24	24-27	>27
							✓			
Years since you qualified as a social worker									✓	

3. How would you describe your own ethnicity? ....White British........
(e.g. Black British, Irish, Asian, White British)

4. Would you describe yourself as having a disability? YES ☐ NO ☑
(please tick appropriate box)

5. Please tick the following boxes that apply to you presently.

EDT Manager	EDT social worker	A.S.W.	Full Time	Part/Half Time	Job Share	Other (please specify)
✓	✓			✓		

6. Does your role usually include home visits? YES ☑ NO ☐

7. How is EDT mainly delivered by you Local Authority? (please tick box)

DEDICATED TEAM ☑   STAFFED BY DAYTIME WORKERS ☐

HOME BASED ☐   OFFICE BASED ☑

OTHER ☐ (please describe).......................
....
....

Are You a   LONE WORKER ☑   or PART OF A TEAM ☐ (please tick)
Comments.......................................
....

8. How do you view the role of EDT? (please tick ONE only).

EMERGENCIES ONLY ☑   EXTENSION OF DAYTIME SOCIAL WORK ☐

BOTH OF THE ABOVE ☐   OTHER ☐ (please explain)...................
....
....

9. Does the public have direct access to an EDT social worker? YES ☑ NO ☐

If yes, is this access throughout the entire shift?   YES ☐ NO ☑

If no, please explain...Answerphone when S.W. out visiting....
....

10. Do you have access to records that are kept up-to date (at least weekly)?
YES ☐ NO ☑

11, Does you EDT have a <u>written</u> policy to assist in prioritization of referrals?
YES ☐ NO ☑

12. How is a decision to visit a service user made (please explain who is involved and what factors are considered)?...........................
...EDT workers decision. Consideration of risk to service user, need to visit & assess risk. procedures in case'g child Protection only, health & safety factors re lone-working EDT s.worker. policy regarding rationing of Residential Home places (child care only)...

13. How many people per EDT shift usually determine whether a referral is a priority or not? 1 ☑ 2 ☐ 3 ☐ more than 3 ☐.

14. EDT workers appear to have differing priorities between competing referrals, why do you think this might be?...........................
- Individual s.ws on teams have differing views re (1) role & the leeway because of (2) to do this.
- Pressures re possible complaints
- In general a hierarchy exists of child care with first than statutory mental health work, with Adult PACE and elderly work jostling for bottom position. This hierarchy is not explicitly expressed by the LA & so leads to differing interpretations.

15. It is 6.30 p.m. on a <u>Monday</u> and the following 'referrals' have come to <u>you</u> on EDT. Which of the following (if any) would you prioritise as requiring a <u>visit</u> by EDT, and in what order would you advise they are visited?

Place (1) in the box you would visit first, (2) for the second visit and so on; Place (0) for any of the scenarios you do not think require a visit on that night.

(N.B. It is recognized that more details would be required for such decisions to be made, but for the purpose of this exercise please prioritise the scenarios as you might in 'real' life, and explain the difficulties and the reason for this choice after each one).

(a) 'PACE' interview on a 'well known' 15 year old accommodated male [3]
(please explain your priority, and any other details that might alter your decision)

Not at risk - would have to wait in custody until the tasks completed.

(b) Mother and three children presented as homeless at a local Police Station [✓]

No visit - would arrange accommodation & use taxi, unless suggestion of risk factor requiring investigation

(c) Local hospital phone re. 4 year old child with a "suspicious" fractured leg: "Probable NAI", child is on the Child protection Register and will be kept in overnight with parents' permission. [1]

Would not visit if no other children in family (on a weekday at) but if other children, would visit & assess risk issues & make tual point

(d) Request by G.P. to complete Section 2 (Mental Health Act 1983) assessment on "potentially violent" male at home. G.P. and Psychiatrist due to arrive at the house at 8 p.m. [2] (c)

might well have to wait my departure until completed. Would then speak to docs concerned & relatives & decide if when assessment should be made

(e) Mother of 13 year old daughter phones, 'plea for removal', not known to the department [✓]

Generally would not visit - would consult by phone & hopefully arrange response / liaison with day staff

16. What factors exist <u>for you</u> when trying to decide between competing priorities?

- Risk of significant harm to any client group
- Child Protection procedures
- Single working (need to remain available)
- Statutory requirements   - Health & Safety issues

17. "*.....assessment focused on whether the eligibility criteria had been met. Information gathered was intended to help the worker establish if the situation would hold until the mainstream services were available. This did not lead to a rounded assessment of the service user's needs.*" (Open All Hours, 1999, SSI).

Is this observation by the SSI accurate of your EDT?   YES [✓]   NO [ ]
Any comments..... In general true, however under assessment does go on, but lack of feedback as to whether followed up by day staff

18. *Please use the rest of the space to make any comments regarding the way in which EDT workers prioritise/assess referrals, the decision making framework or any other related remarks.*

- Lone working can lead to inadequate decision making because of lack of consultation opportunities during working periods.

- Resource availability may have strong impact on decision making regarding possible preventative work.

- Power struggles between Social Services specialist teams (mental health, child care, or Adult Care) impacts demands on the last remaining generic service

- Lone working has major impact on decision making re impact of ie health & safety with lone working & lack of availability of police to assist these days or the inappropriateness of using police. Departments seem to have different attitudes to workers' safety out of hours versus daytime workers

Thank You for taking time to complete this questionnaire.

All details will remain anonymous.

Glen Williams

Glen Williams,

Name of Local Authority you work for: Liverpool

1.

AGE	20-25	25-30	30-35	35-40	40-45	45-50	50-55	55-60	>60
MALE					✓				
FEMALE									

2.

	0-3	3-6	6-9	9-12	12-15	15-18	18-21	21-24	24-27	>27
Length of EDT service in years	✓									
Years since you qualified as a social worker					✓					

3. How would you describe your own ethnicity? .... Asian ....
(e.g. Black British, Irish, Asian, White British)

4. Would you describe yourself as having a disability? YES ☐ NO ☑
(please tick appropriate box)

5. Please tick the following boxes that apply to you presently.

EDT Manager	EDT social worker	A.S.W.	Full Time	Part/Half Time	Job Share	Other (please specify)
	✓	✓		✓		

6. Does your role usually include home visits? YES ☑ NO ☐

7. How is EDT mainly delivered by you Local Authority? (please tick box)

DEDICATED TEAM ☑   STAFFED BY DAYTIME WORKERS ☐

HOME BASED ☐   OFFICE BASED ☑

OTHER ☐ (please describe)..
....

Are You a   LONE WORKER ☐   or PART OF A TEAM ☑ (please tick)
Comments..
....

8. How do you view the role of EDT? (please tick ONE only).

EMERGENCIES ONLY ☐   EXTENSION OF DAYTIME SOCIAL WORK ☐

BOTH OF THE ABOVE ☑   OTHER ☐ (please explain).........................
....
....

9. Does the public have direct access to an EDT social worker? YES ☑   NO ☐

If yes, is this access throughout the entire shift?   YES ☑   NO ☐

If no, please explain...
....

10. Do you have access to records that are kept up-to date (at least weekly)?
YES ☐   NO ☑

11, Does you EDT have a <u>written</u> policy to assist in prioritization of referrals?
YES ☐   NO ☑

12. How is a decision to visit a service user made (please explain who is involved and what factors are considered)? Team manager, s.w. and FSU would be involved if Child protection + hospital.
....
....
....
....

13. How many people per EDT shift usually determine whether a referral is a priority or not? 1 ☑   2 ☐   3 ☐   more than 3 ☐.

14. EDT workers appear to have differing priorities between competing referrals, why do you think this might be? Level of risk to individuals and community pitched against those requiring practical assistance.
....
....
....
....

15. It is 6.30 p.m. on a Monday and the following 'referrals' have come to <u>you</u> on EDT. Which of the following (if any) would you prioritise as requiring a <u>visit</u> by EDT, and in what order would you advise they are visited?

Place (1) in the box you would visit first, (2) for the second visit and so on; Place (0) for any of the scenarios you do not think require a visit on that night.

(N.B. It is recognized that more details would be required for such decisions to be made, but for the purpose of this exercise please prioritise the scenarios as you might in 'real' life, and explain the difficulties and the reason for this choice after each one).

(a) 'PACE' interview on a 'well known' 15 year old accommodated male   [5]
(please explain your priority, and any other details that might alter your decision)
Pace would be a low priority, accom. child in custody is safe and protected.

(b) Mother and three children presented as homeless at a local Police Station [4]
the family in a place of safety and can went in a safe environment. However if very young children prioritise to 3

(c) Local hospital phone re. 4 year old child with a "suspicious" fractured leg: "Probable NAI", child is on the Child protection Register and will be kept in overnight with parents' permission. [2]
Child in hospital in a place of safety, serious concerns in respect of injury and how it was caused, need to investigate & protect if need be also parent may refuse child remaining in hospital

(d) Request by G.P. to complete Section 2 (Mental Health Act 1983) assessment on "potentially violent" male at home. G.P. and Psychiatrist due to arrive at the house at 8 p.m. [1]
Person in urgent need of assessment possibly risk to self and others in community. possible risk to own safety request police to be in attendance

(e) Mother of 13 year old daughter phones, 'plea for removal', not known to the department [3]
Possible breakdown in relationship need to assess, ascertain the reason for requesting removal. Work towards keep family together

16. What factors exist <u>for you</u> when trying to decide between competing priorities?
The need to protect and promote the welfare of those in the community who may be at risk of suffering further harm or causing harm to others

17. "......assessment focused on whether the eligibility criteria had been met. Information gathered was intended to help the worker establish if the situation would hold until the mainstream services were available. This did not lead to a rounded assessment of the service user's needs." (Open All Hours, 1999, SSI).

Is this observation by the SSI accurate of your EDT?   YES ☐   NO ☑
Any comments...
....
....
....

18. Please use the rest of the space to make any comments regarding the way in which EDT workers prioritise/assess referrals, the decision making framework or any other related remarks.
....
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Thank You for taking time to complete this questionnaire.

All details will remain anonymous.

Glen Williams, - .

Phase 2

Interview Schedule

Question 1	New schemes that would affect EDT response to scenarios?
Question 2	How do you prioritise between competing priority 1 referrals?
Question 3	(How) Could EDT responses be more consistent?
Question 4	Does autobiography impact upon your assessment?

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