Education, Children and Adult Services Committee

17 March 2016

Agenda Item	10.
Report No	ECAS 23/16

Highland Practice Model – Further Evaluation Outcomes

Report by the Director of Care and Learning

Summary

The report provides Members with a further update on core findings which have emerged from an ongoing evaluation of the Highland Practice Model along with key areas for improvement and the actions proposed to take these forward. The report also provides Members with a short update on the implement of the Children and Young People (Scotland) Act 2014.

1. Introduction

1.1 *Getting it right for every child* (GIRFEC) is a national programme[1] which aims to improve the outcomes for all children and young people in Scotland.

1.2 The core ethos of the programme is that all staff across services for children work collaboratively to ensure that the needs of each child are addressed. Central to this approach are ten Core Components including: improving outcomes for children and young people, a common assessment and planning framework, a shared approach to information sharing and a Named Person and Lead Professional to coordinate activity. In Highland, this approach is called the Highland Practice Model.

1.3 Following on from a report to this committee in May 2015, this report provides a further update on core findings which have emerged from an ongoing evaluation of the Highland Practice Model. It summarises findings across a range of sources and notes key areas for further improvement and the actions proposed to take these forward. The report also provides Members with a short update on the implement of the Children and Young People (Scotland) Act 2014.

2. Background and Context

2.1 *Getting it right for every child* is a national programme developed by the Scottish Government in consultation with partner agencies. The GIRFEC Implementation Plan was published in June 2006 and identified the need to test the approach within several areas in Scotland, in order to help inform the development of the national guidance. Partnership working within children's services in Highland was already well developed through *For Highland's Children* and the Highland partnership became the national pathfinder for the GIRFEC approach. The GIRFEC approach was developed here between 2006 and 2008, at which point it was rolled-out across the Highland area, and fully implemented by early 2010.

[1] www.scotland.gov.uk/Topics/People/Young-People/gettingitright/background

2.2 An Evaluation Team was embedded within the pathfinder project, initially to consider the development and implementation phases of GIRFEC, and then to assess the extent to which the new systems and process were being utilised and the impact they were making. The evaluation reported in 2009[2] and concluded that "green shoots of progress'' were being made through the introduction of GIRFEC. This included signs of progress towards improving outcomes for children and families and improvements in professional practice.

2.3 The approach has since been established as the way of working for children's services and the Highland Practice Model[3] (HPM) has emerged as the delivery framework to take forward the GIRFEC components, principles and ethos. The Practice Model sets out the roles and responsibilities of staff and a common assessment framework for identifying and addressing the needs of the child. Examples of the Practice Model in action are provided at **Appendix 1.**

2.4 A decision was taken in Highland to progress the integration of children's services even further with the adoption of the lead agency model in Highland. The resulting transfer of the majority of community health based staff and the development of the Family Team structure has advanced the integration of services for children even further. This has been an incremental process and has evolved over a period of over 10 years.

2.5 The pathfinder evaluation noted that it would be important to evaluate the approach going forward, especially once it had time to embed and be extended to all areas within Highland. The current evaluation began in 2013 and carried on through 2014 alongside the Joint Inspection of Children's Services by the Care Inspectorate and into 2015. It was timely given the development and enactment of the Children and Young People's Bill which will bring many elements of the Highland Practice Model into law, and in turn will have implications for the arrangements already in place within Highland.

2.6 **Appendix 2** sets out some of the key terms that are used in the Practice Model, that are referred to in this report.

3. Highland Practice Model Evaluation – Approach

3.1 The current evaluation was undertaken in house and aligned to the Practice Model Improvement group to ensure the findings were taken forward and actioned. The approach encompassed a number of elements. This included:

3.1.1 Research to explore the experience of children, young people and families of the HPM approach. This piece of work was undertaken by the Highland Children's Forum to ensure independence and utilising their considerable experience of working with children and families.

3.1.2 Interviews and focus groups with professionals across Highland and across disciplines. This included interviews with strategic managers as well as with

[2] www.scotland.gov.uk/Publications/2009/11/20094407/0
[3] www.forhighlandschildren.org/5-practiceguidance/

operational staff.

3.1.3 An appreciative evaluative approach from professionals working directly with families. This involved professionals undertaking an evaluation approach in the course of their day to day work in order to collate feedback from families and, where appropriate young people, about their experience of services. The approach was an appreciative one - it focused on what had gone well, and also what could be done better together.

3.1.4 Analysis of primary sources. This has considered analysis of Highland documentation designed to support the Practice Model including the various iterations of the Child's Plan and Highland Practice Model guidance. Also utilised was evidence collected by the Care Inspectorate during their 2014 Inspection, which included the survey of professional groups and final report

3.2 Information across this range of sources has been collected and analysed. A summary of core findings is outlined below followed by key areas for improvement and the actions proposed to take these forward.

4. Core Findings

4.1 The following summaries the core findings of the evaluation across 4 areas of practice – Early Intervention, Vision and Ethos, Improving Outcomes and Planning for Improvement.

4.2 Early Intervention

4.2.1 There is a strong view amongst professionals that the Highland Practice Model (HPM) is assisting in earlier identification and intervention to support children and their families. This is supported through the survey of professionals undertaken by the Care Inspectorate which found that 70% of respondents agreed or strongly agreed that GIRFEC has made it easier to help children, young people and families at an earlier stage.

4.2.2 Professionals report that early intervention is being supported through key elements of the HPM including the Child Concern Form Process and the link through this to the Named Person. Staff have indicated that through the earlier identification of issues or concerns and the shared planning for that child as a result, families are better supported and this leads to preventing the escalation of issues. Inspectors agreed with this and reported that staff working well together and knowing their roles is helping to identify situations quickly. The Highland Children's Forum (HCF) report also highlighted that 80% of parents reported issues being recognised early and a plan being developed as a result.

4.2.3 The Care Inspectorate reported that the implementation of GIRFEC in Highland has resulted in effective, and improving, early intervention for vulnerable children. Of particular note, they highlighted that this was contributing to the fall in the number of children becoming Looked After. The effect of early intervention can also be viewed through a reduction in offending by young people and the decrease in number of referrals to the Reporter. The Reporter's Office notes that referrals are now more appropriate and although

fewer, more complex. It is suggested that this is a result of effective multi-agency decision making at an earlier stage on what is best for the child. It is only if these interventions are unsuccessful that referrals are then being made to the Reporter, and these decisions are now made on a multi-agency basis.

4.2.4 The Child Concern Form process was noted by staff across the professional groups as a key tool in the early identification of issues. It was noted that work was required to ensure all concern forms were received promptly to enable effective action and also for staff to be supported to risk-assess, given the differing levels of professional risk. A separate piece of work is ongoing to ensure consistency and effectiveness in approach to dealing with concern forms, and the Council is now one of three pilots regarding a new Wellbeing Concern process through Police Scotland.

4.3 Vision and Ethos

4.3.1 **Vision:** There is strong support for and understanding of the aims and vision of the Highland Practice Model. Staff across the professional groups welcome the strategic vision and attribute the success of the HPM to this clarity of approach. Staff support and understand the introduction of common language, assessment framework and one plan - it ensures a holistic approach and that the focus is on the child.

> "The *My World Triangle* it is embedded in professional culture."
> *Education Professional*

4.3.2 One clear benefit articulated was that there is no longer a dependence purely on the good practice of individuals - there are systems that ensure a consistent approach and clear processes are in place. 93% of professionals surveyed by the Care Inspectorate agreed or strongly agreed that they are clear about the vision for children, young people and families and 83% that this vision is shared across services. The Care Inspectorate attributed strong performance to the strength and clarity of vision for services for children.

4.3.3 Whilst overall there is strong support for the vision and approach, staff do acknowledge that this has also involved significant change and for some, perhaps unsurprisingly, this has been challenging. The move towards taking a more holistic view of the child, the integration of health and social care and the emphasis on earlier intervention, have all impacted upon professionals across the different staff groupings and this has challenged professional cultures. The level of change has been significant, and individuals have adjusted to this at different paces.

4.3.4 **Named Person:** Many professionals reported that being the Named Person has not in essence changed their role; they remain the key link person for the child and their family - whether that is the midwife, health visitor or head teacher. A number of Named Persons did report however that formalising this remit, had assisted them in clarifying their role and responsibilities, and empowering them to address issues on behalf of the family. It provides a focus for professionals.

> "I think being a Named Person has helped clarify my role and means that I understand my responsibilities." *Health Visitor*

4.3.5 66% of all professionals surveyed by the Care Inspectorate agreed or strongly agreed that they understood their role and responsibilities as a Named Person. This included 33% who indicated that this question was not applicable, which would include Social Workers and Allied Health Professionals who are not Named Persons.

4.3.6 Some Named Persons did report that the importance of the role of the Named Person could be reinforced to ensure that the Named Person is always kept informed of any significant changes, given that not all staff are consistently sharing information, and this point was reinforced in the recent revision of the Practice Model guidance.

4.3.7 **Lead Professional:** 90% of staff surveyed by the Care Inspectorate indicated that they agreed or strongly agreed that they understood their role and responsibilities as a Lead Professional. Whilst there are guidelines in place to support staff to determine when a Lead Professional should be appointed and who is best placed to take on the role of Lead Professional, at times there do appear to be different interpretations of the Practice Model in relation to who should be the Lead Professional. It was reported to be a particular challenge when the main issues relate to the health of a child.

4.3.8 The Care Inspectorate found that staff in schools understand the Named Person responsibilities, but would benefit from more support when taking on the Lead Professional role. This view is supported by some individual staff across different professional groups. It is unclear whether this is related to individuals feeling that they are professionally not the best person to be the Lead Professional, or feel they lack confidence or capacity to take on the role. There was strong support, and staff reporting they feel supported, by the various enabling roles such as the Integrated Services Officer – now Practice Lead role.

4.3.9 The Named Person model has been in place for some years now, and has become embedded as normal practice. None of the children spoken to during the course of the HCF evaluation were aware of the terminology of Named Person or Lead Professional – however, all spoke of a key person that they could speak to. Trust in individuals rather than specific posts or roles appear to be of greatest importance to children and young people.

4.4 Improving Outcomes

4.4.1 Professionals are supportive of the move through the HPM to having a common assessment framework and one shared Plan for each individual child. This shared document ensures that all the information about the child is in one place, reduces duplication and provides a focus for the child's needs. It ensures buy in from professionals and accountability through the review process.

> "The Child's Plan itself encourages openness and transparency and it's made it easy." *Health Visitor*

4.4.2 Many staff report a reduction in paperwork given the multiple uses of the Plan, for example as a referral tool and for children subject to compulsory measures, and also a reduction in meetings given that professionals and families come

together to discuss and review plans rather than holding separate service specific meetings. Some feedback however, suggested that there was not always consistency in all staff feeding into the Plan, the challenges of drawing together meetings, the time taken to develop plans and a suggestion that shared electronic solutions would improve and reduce duplication.

4.4.3 83% of staff surveyed by the Care Inspectorate agreed or strongly agreed that GIRFEC has improved the assessment of children's needs, and 81% stated that it has improved the way they plan to meet children's needs. Staff welcomed the development of the assessment tools, particularly the My World Triangle and the Resilience Matrix as effective tools for assessing the child's needs, keeping them at the centre and removing subjective emotion from the assessment.

4.4.4 Both staff and the Care Inspectorate acknowledge that improvements in the quality of assessments and plans can be made. Internal processes and tools have been developed to assist managers to audit Plans and provide feedback, but it has been suggested that mentoring support could assist in building further confidence.

4.4.5 There is strong belief amongst staff that the planning process helps to support the involvement of parents and children and a commitment from staff to this. The Care Inspectorate supported this view in their report. Staff reported the approach makes it easier to include the views of parents. The change in language has made documentation more accessible, and also there is an expectation about family involvement. It was suggested that the strength of the Plan is the shared nature of the process, of which the family is a key element.

> "….think we were always good at asking families their views but they're written now and disagreements are also written so the plan is more honest." *Social Worker*

4.4.6 The HCF report found that the majority of parents (97%) and children (72%) were aware of their Plan, and a majority also felt that their views were included. 94% of parents had a copy of the Plan, but many young people had not seen it, although 91% did report that they were involved in developing it. The majority of children and young people reported being asked regularly by professionals how they felt about things and so felt listened to, but some concerns around the appropriate sharing of information were noted. Whilst HCF found the majority of parents and children consulted felt supported by the planning process, a small number did not, citing concerns including the large volume of information in a plan, their views not being represented and a perceived lack of communication.

4.4.7 The Child's Plan is seen as a living document. It has already changed significantly since its inception, responding to staff comments and suggestions. Staff report that the changes have improved the Plan and made it more effective. The HCF report suggested further changes to the plan should be considered in order to improve the experience of children, young people and their families. These included a section in the plan detailing who should read it and who it will be shared with, and providing child friendly information about the plan.

4.5 **Planning for Improvement**

4.5.1 There is a strong commitment to improving services for children across professional groups in Highland. The way in which services for children and families in Highland have developed has clearly been an evolutionary process, and the approach to service delivery has been redefined as the learning experience has evolved.

4.5.2 The Care Inspectorate reported positive outcomes to the approach adopted in Highland, noting that the GIRFEC pathfinder had provided an opportunity to establish more effective joint working at an early stage and praised the foresight of subsequent integration which has integrated working methods and organisational structures.

4.5.3 Perhaps unsurprisingly, for some staff, these developments have been unsettling, given the changes in roles, in organisational structure, management and, in the case of Health Visitors and Allied Health Professionals, organisation. 68% of staff responding to the Care Inspectorate survey, agreed or strongly agreed that their views are fully taken into account when services are planned and provided, although there were some concerns expressed about the way change was managed. Staff remain supportive of the approach, ethos and vision across children's services.

4.5.4 The effectiveness of the model is overseen by the Highland Practice Model Improvement Group, which is one of 13 Improvement Groups in Highland. The Improvement Group structure supports the culture of improvement. The Care Inspectorate found that there was a commitment to joint self-evaluation, which it sees as contributing to service improvement and achieving better outcomes. On an individual staff basis, 87% reported that they agree or strongly agree that they know what they need to do, to improve the services that they provide.

5. Key Areas for Improvement

5.1 Since the original evaluation of the GIRFEC pathfinder, the Highland Practice Model has evolved and the approach has become embedded within professional cultures. Professionals are supportive of the approach, parents and carers report positive outcomes, and the Care Inspectorate highlighted the positive impact upon services for children, young people and families.

5.2 There are several key areas which are identified as requiring further work or consideration:

5.2.1 Whilst the model is well understood and the basis of it is welcomed by all staff groups, there is some evidence (as might be expected) of variation in individual practice. The HCF report highlighted concerns that parents and children were not always being involved in the development of the Child's Plan in a fully inclusive way. The Practice Model Improvement group agreed that the best way to address this was through ongoing training.

5.2.2 The routine sharing of information with the Named Person has been reinforced

in the Practice Guidance, and will be strengthened in the forthcoming national Statutory Guidance which places the role of the Named Person on a statutory footing.

5.2.3 Staff highlighted the importance of the Child Concern Form process in supporting early intervention and the HPM approach. Under the Children and Young People (Scotland) Act, there is a move towards standardising the process of sharing Wellbeing Concerns across Scotland, led by Police Scotland. Highland has been identified as one of the pilot areas for this approach.

5.2.4 The experience from staff would suggest that at times there are differing interpretations of the Practice Model guidance in relation to when a Lead Professional should be appointed, and who is best placed to take on that role. The Care Inspectorate also noted this as an area where staff are requiring support. The Scottish Government is considering how best to cover this point in the Statutory Guidance. The Highland Practice Model Improvement Group is looking at the distribution of the Lead Professional role across the various professional roles.

5.2.5 Other issues raised in the HCF evaluation are also covered by the Act or the Statutory Guidance, for example the training required for someone to be able to act as Named Person and the continuity required during school holiday periods.

5.2.6 There was some reluctance by the Highland Practice Model Improvement Group to introduce a different (family-friendly) version of the Child's Plan, as it was felt that this may undermine the benefits of having one plan, and lead to a bigger burden on the Lead Professional. This issue is now being addressed nationally as part of the roll-out of the Act.

5.2.7 The role of the School Years function of the Family Teams in supporting the model will be an area of scrutiny for the Highland Improvement Group. Specifically, the focus will be on the interface with school staff and considering the extent to which the School Years function is contributing to effective earlier intervention.

5.3 Through the pathfinder approach and now through the Improvement Group structures, there remains a focus on improvement and the evidence collated through the evaluation approach will assist in taking forward and improving the Highland Practice Model and in turn, services and outcomes for Children and Families.

6. Implementation of the Children and Young People (Scotland) Act 2014

6.1 The final implementation of the Act will take place from August 2016 and will formalise a national version of the Practice model. It will bring some challenges in Highland as processes are formalised and, to some extent, altered by the legislation. There will be a formal Named Person service, a national minimum data-set for a Child's Plan and a process for making complaints about Parts 4 and 5 of the Act. The Highland Practice Model will require to be revised to take account of the changes.

7. Implications

7.1 **Resource implications** – There are no resource implications arising from this report.

7.2 **Legal implications** – The Council is working to ensure it complies with the new duties as set out under the Children and Young People (Scotland) Act 2014.

7.3 **Risk implications** – The Council must ensure that the Highland Practice Model approach complies with the terms of the Children and Young People (Scotland) Act 2014 however there are processes in place to mitigate this risk.

7.4 There are no **Equalities, Gaelic, Rural** or **Climate Change/Carbon Clever** implications identified.

8. Recommendation

8.1 Members are asked to:

- Consider and scrutinise the evaluation findings summarised in section 4 of the report;
- Note the areas for improvement and actions detailed in section 5 of the report.

Designation Director of Care and Learning

Author: Sandra Campbell, Head of Children's Services
Alison Clark, Principal Policy Officer

Date: 4 March 2016

Appendix 1

The Practice Model in Action

Practice Examples

The Highland Practice Model seeks to support circumstances in which families and professionals work together to achieve the best for children. While most children and parents rarely, if ever, need extra support, timely and proportionate help when needed can make an important difference to a child's wellbeing.

The need might be met through a relatively simple or time limited means such as putting a parent in touch with a source of advice or developing a child's confidence through access to an additional activity in school or in the community. Less commonly, families and professionals in a variety of services work together in more complicated or risky circumstances that are tiring and demand a lot of effort in order to cope.

Every situation is unique, especially for the child, and every effort to support should make the best of the resources available. These examples are not based on specific, real children or families but are informed by many typical experiences that help to illustrate the types of support needs and collaborative work that the Highland Practice Model can encourage.

Charlotte and George

Charlotte is 8 and her brother George was born 4 months ago. The Named Person for Charlotte is her primary school Head Teacher. The Health Visitor acts as the Named Person for George. Like all parents of young children, their mum and dad had lots information over the years from the health visitor and school, including an explanation that the Named Person is available and able to be approached for assistance.

The Head Teacher noticed that Charlotte was sometimes arriving late for class and that she had days off school with increasing frequency. The Head teacher also noticed that Charlotte's mum was less likely than usual to call the school to advise of an absence or be around the school gate to say hello to staff. Charlotte seemed happy to be in school but was a little less organised than normal and, unusually for her, seemed less confident and robust in her relationships with her school friends.

The Head Teacher telephoned Charlotte's home to say that she was popping an invite in the post to suggest that the parents call in to school at a convenient time. The Head Teacher realised that Charlotte's mother was tearful on the telephone and again extended the invitation to talk with her soon. In preparation for this discussion, the Head Teacher reflected that she should remember to ask Charlotte's mum about contact with George's Named Person in case some assistance might be useful.

Charlotte's mother visited school and talked with the Head Teacher, sharing that she was caring for the children alone for periods of 2 to 3 weeks at a time. Due to a redundancy and the inevitable financial consequences, Charlotte's dad had no option but to seek work away from home and for the foreseeable future would only get home for a long weekend every couple of weeks at best. Charlotte was missing her dad and George was proving to be a less settled and more demanding infant than Charlotte at that age. The children's father was worried about work as well as being away from home and his family. Mother was feeling tired and a bit overwhelmed at present. She had recently realised that she was using a couple of glasses of wine in the evenings to relax – something that she would not normally do when caring for the children on her own. Her own family did not live in the area and a couple of her local friends who had children of Charlotte's age had recently returned to full time work and different routines and commitments.

Charlotte's mum and head teacher agreed that it might be useful to contact the health visitor about George in advance of the next scheduled contact. Charlotte's mum was appreciative of the head teacher's offer to let the health visitor confidentially know about their conversation.

The outcomes of the contacts between the family and both Named Persons were that:

- School were informed by parents when dad was likely to be at home or away so that any discreet emotional support that Charlotte might need was available and these ordinary but challenging family experiences did not undermine her social and educational progress
- Charlotte's mother became more able to discuss her mild depression with the health visitor and had assistance for a short time from the GP
- As a consequence of the improvements in her emotional health, mother felt more able to take part in parent and baby activities with others and feelings of isolation were contained and reduced. The health visiting practitioners also supported Charlotte's mother to regain her confidence as an experienced parent.
- The children's father's wellbeing was supported indirectly in the knowledge that he also could alert the services if he had any concerns. Charlotte's parents and head teacher made a special effort every term to let her see that they talked and enjoyed hearing about her successes in school.

Robert

Robert is 11.

School life for Robert has been difficult. Through work with Robert, his family and others who know him well, the Child and Adolescent Mental Health team have concluded that his difficulties should be understood as Autistic Spectrum Disorder. This means that he feels, thinks and behaves differently from many of his peers therefore needs different support and routines compared to most other children.

Robert has had a Child's Plan for a long time. At some stages the work to progress the assessment of his needs and the learning that adults had to do has been complicated. For a period of time, the plan has been co-ordinated by a social worker lead professional.

At other stages, it has been possible to reduce the number of professionals involved and the Named Person has co-ordinated the plan, with the support of the other colleagues such as the Family Team School Years practice Lead or the Educational Psychologist. At all times, Robert's parents and other family members have been the critically important partners to the plan. Robert's own involvement has been increasingly encouraged as he has matured. The family give informed consent to proportionate sharing of information with relevant professionals who have a role in assisting Robert.

Robert is moving into another important stage of his development and will transfer from Primary to Secondary education. This means that his needs are changing at the same time as his familiar school environment and relationships will change.

- In order to support Robert to build on the best of his educational experiences so far, the Named Persons will work closely with one another, Robert and his family to get to know and understand each other.
- Introductions to new people and places will be gradual and it is likely that everyone involved will benefit for the availability of a Lead Professional who can link purposefully between home and school during this time of important change.
- Adolescence will bring both predictable and unpredictable challenges and therefore the partners to the plan will require to work hard together to reach helpful assessments of Robert and his family's changing needs and solve problems
- Robert might need substantial support to be independent as a young adult and the experience of successful collaborative work during his adolescence will be in important foundation for future relationships that might need to be made.

Appendix 2

Key terms that are used in the Practice Model

Getting it Right for Every Child (GIRFEC)

GIRFEC is the national approach to improving outcomes through public services that support the wellbeing of children and young people. The Getting It Right For Every Child approach ensures that anyone providing support works collaboratively and puts the child or young person – and their family – at the centre. Based on children's and young people's rights, it supports children, young people and their parents to work in partnership with the services that can help them.

Highland Practice Model

The Practice Model provides a framework for practitioners in all services in Highland to gather, organise and make sense of information. The framework helps to identify and understand the strengths and pressures for the child and their carers, the child or young person's needs and any risks. The Highland Practice Model helps people to understand what support is required to improve outcomes for children and young people. It promotes the participation of children, young people and families as central to assessing, planning and taking action.

Assessment information about children and young people is recorded in a consistent way by all professionals. This should help to provide a shared understanding of a child or young person's needs and address concerns. The model and the tools which support it can be used by workers in adult and children's services and in single or multi service/agency contexts.

The Named Person

The Getting it right for every child approach includes the entitlement for all children and young people to have access to a Named Person from birth until their 18th birthday (or beyond, if they are still in school). Children and families have no obligation to take up this offer.

A named person offers one point of contact that children and families can go to for advice or support if they need it. In most instances the named person is someone in universal services who is already involved with children and their families. The named person will be able to listen, advise and help, providing direct support for families and other services and may help address concerns at an early stage, preventing them from becoming more serious. The Named Person does not change or replace the role of a parent or carer.

The Lead Professional

When two or more professionals need to work together to meet a child's needs, the practitioner who has most knowledge or responsibility in relation to the main assessed need will become the Lead Professional

The Lead Professional is the person who co-ordinates the assessment, actions and review of the Child's Plan. The Lead Professional will make sure everyone is clear about different roles and contributions to the Child's Plan and ensure that all of the support provided is working well and is achieving the desired outcomes.

Early Intervention

Action to assess and provide support to promote wellbeing, to prevent an increase in difficulties or to protect from harm. This can occur in universal, targeted or compulsory services:

- Early in the life of a child, including an unborn baby
- Early in the scale of complexity
- Early in a crisis

The Assessment Process