Guidance for Social Workers undertaking assessments of Parenting Capacity
Foreword
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### SECTION 5: REFERENCES AND RECOMMENDED READING  

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SECTION 1: INTRODUCTION
The Southwark Parenting Assessment Framework has been designed to assist practitioners when assessing a parent’s ability to meet the needs of a child; to consider the issues known to potentially impact on parenting capacity; and to consider relevant factors when assessing parental capacity to change within a timescale consistent with the child’s developmental needs. The aim is to enable practitioners to feel confident and competent when undertaking parenting assessments. The concepts and themes will be familiar. The Department of Health Framework for the Assessment of Children in Need and their Families (2000) provides the overarching conceptual map, ensuring the three inter-related domains of parenting capacity - children’s needs, family, and environmental factors - are addressed. Additionally, the Southwark Parenting Assessment Framework takes into account up-to-date research and recent developments in social work thinking and practice.

The framework aims to promote the use of a systematic, evidence-based and analytical approach to facilitate the identification of risks, strengths and protective factors to enable practitioners to come to a structured professional judgment about whether a parent has the capacity to meet the needs of a child. It has been designed to build on the Single Assessment and the Southwark Family Risk and Safety Assessment (FRaSA), so that some requisite information and analysis should already be available to the practitioner, and can be included within the parenting assessment, providing these assessments are recent. The Parenting Assessment Framework is consistent with a systemic model and the Signs of Safety approach to safeguarding.

The Parenting Assessment Framework is suitable for use during pre-proceedings or care proceedings, where the child is at home or placed away from home. A robust and rigorous parenting assessment will contribute to the local authority evidence where a decision is made that it is necessary to issue care proceedings to ensure that a child is safeguarded. Pre-birth assessments should continue to be undertaken using the Southwark Pre-Birth
Assessment Tool (refer to Section1.2.13 of Southwark online procedures). Where it is necessary to complete a parenting assessment following the birth of the child, much of the information within the pre-birth assessment would be relevant and could therefore be included in the parenting assessment.

The Parenting Assessment Framework identifies a number of tools, questionnaires and scales that can be used to explore and enhance particular aspects of the assessment. Both the framework and the tools are intended to be used flexibly, and tailored to individual family circumstances and the nature of the concerns. The assessment should be dynamic in the sense that information may emerge during the course of the assessment which suggests additional factors are particularly relevant and need to be explored further. Importantly, the assessment should be approached with an open mind, and the evidence gathered may mean that initial hypotheses need to be re-visited.

The handbook is intended to be a resource, as well as to provide guidance. The guidance in relation to some sections of the report includes examples of prompts aimed to support practitioners in thinking about how to elicit information where this is not spontaneously forthcoming in the narrative of the person being interviewed. It is important to emphasise, however, that where prompts are used, these should not be used in the form of a checklist; rather they should be used selectively, and with sensitivity to the particular circumstances of the family and the presenting concerns.

Whilst the elements of assessment that need to be addressed and analysed are set out under separate sections and headings, the overall analysis needs to consider the inter-relationship between the various elements.

The term “parent” has been used in the guidance to apply to a parent, or a caregiver who has responsibility for the upbringing of a child, or a person who has a significant role in looking after a child, including a parent’s partner.

The guidance in this handbook will be supplemented and reviewed through training workshops.
What is parenting capacity?

The term “parenting capacity” was used in the Department of Health Assessment Framework (2000) to refer to “the ability of parents or caregivers to ensure that the child’s developmental needs are being appropriately and adequately responded to, and to adapt to his or her changing needs over time.” This includes:

- **Basic Care**: providing for the child’s physical, medical and dental needs;
- **Ensuring Safety**: ensuring the child is adequately protected from harm or danger;
- **Emotional Warmth**: ensuring the child’s emotional needs are met and giving the child a sense of being specially valued and a positive sense of his/her own racial and cultural identity;
- **Stimulation**: promoting the child’s learning and intellectual development through encouragement and cognitive stimulation and promoting social opportunities
- **Guidance and Boundaries**: enabling the child to regulate their own emotions and behaviour. The key parental tasks are demonstrating and modeling appropriate behaviour and control of emotions and interactions with others, and guidance which involves setting boundaries, so that the child is able to develop an internal model of moral values and conscience, and social behaviour appropriate for the society within which they will grow up. The aim is to enable the child to grow into an autonomous adult, holding their own values, and able to demonstrate appropriate behaviour with others rather than having to be dependent on rules outside themselves. This includes not over protecting children from exploratory and learning experiences
- **Stability**: providing a sufficiently stable family environment to enable a child to develop and maintain a secure attachment to the primary caregiver(s) in order to ensure optimal development.
Reder et al. (2003) define parenting as “a constellation of behaviours, attitudes, emotions and responsibilities directed by an adult to a child.” They go on to provide a helpful analysis of the elements of parenting, which includes:

- the aim of parenting is to facilitate the child’s optimal development within a safe environment;
- parenting initially serves to ensure the child`s survival and gradually aims towards ensuring their autonomous functioning;
- different parental behaviours are necessary at different times in the child`s life;
- parenting involves a relationship between adult and child, to which both contribute;
- a child`s parenting, and the family relationships in which it occurs, is a fundamental contributor to their future psychological well-being;
- other close relationships affect the parent-child dyad;
- the potential to parent satisfactorily may be influenced by past and present experiences.

A child’s basic care needs for safety, food and shelter will remain to a relative degree throughout childhood. Other needs are more responsive to a child`s developmental stage, such as providing guidance and boundaries, and promoting autonomy, and a parent needs to respond appropriately to these changes (Birch, 2015).

A parent needs to understand their child`s emotional needs, and that emotional security and responsiveness are essential for psychological development, including intellectual and emotional functioning. A parent also needs to understand and be able to meet their own psychological and physical needs, and understand how their child`s needs are different (Birch, 2015).
Recent research has identified as significant the parent’s ability to perceive, understand and respond appropriately to the child’s needs, enabling a secure attachment relationship to develop in which the child experiences safety, with the confidence that his or her needs will be met (Dent, 2015). Also highlighted is the parent’s ability to respond to their child’s behaviours in an empathic way, which enables to the child to feel “held in mind”; and their ability to think about the child’s mental state and mirror the child’s affect, which helps the child to develop the ability to regulate their affect and understand others as having separate mental states from him or herself (Fonagy et al., 2004).

There is no universally accepted definition of “good enough” parenting. There is however, some evidence to indicate that there is a general consensus amongst professionals working with families in the UK regarding what constitutes “good enough” parenting (Kellet and Apps, 2009):

- Meeting children’s health and developmental needs
- Putting children’s needs first
- Providing routine and consistent care
- Parental acknowledgement of any problems and engagement with support services

Ward et al. (2014, p.55) highlight that where a parent’s poor personality functioning is a concern, social workers would benefit from a conceptual framework of mature adult functioning that can offer secure and responsive parenting, in order to “assess parents` capacity to act as beneficial attachment figures”. Whilst there is no universally agreed conceptual framework for mature adult functioning, they suggest it would include:

- The parent’s ability to recognise emotions in others
- Their ability to control and manage their own emotions
- Their relationship to authority
- Their ability to trust
- Their capacity for intimacy and
- Their capacity to take responsibility for the impact of their actions
When undertaking a parenting assessment it is important to bear in mind the frequently cited judgment of Mr Justice Hedley in Re L (reported in 2007) in relation to standards of parenting:

“Society must be willing to tolerate very diverse standards of parenting, including the eccentric, the barely adequate and the inconsistent. It follows too that children will inevitably have both very different experiences of parenting and very unequal consequences flowing from it. It means that some children will experience disadvantage and harm, whilst others flourish in atmospheres of loving security and emotional stability. These are the consequences of our fallible humanity and it is not the provenance of the State to spare children all the consequences of defective parenting. In any event, it simply could not be done.”

Concept of Significant Harm

“Harm” is defined in Section 31(9) of the Children Act 1989 (as amended by the Adoption and Children Act 2002) as:

- *ill-treatment or the impairment of health or development, including, for example, impairment suffered by hearing or seeing the ill-treatment of another;*
- ‘development’ means physical, intellectual, emotional, social or behavioural development;
- ‘health’ means physical or mental health; and
- ‘ill-treatment’ includes sexual abuse and forms of ill-treatment which are not physical.

Under Section 31(10) of the Children Act 1989:

Where the question of whether harm suffered by a child is significant turns on the child's health and development, his health or development shall be compared with that which could reasonably be expected of a similar child.

However, there are no clearly defined criteria on which to rely when judging what constitutes “significant harm”. Sometimes, a single traumatic event may
constitute significant harm. In other circumstances, significant harm is caused by the cumulative effect of acute and long-standing events, or the damaging impact of neglect, which interrupt, change or damage the child's physical and psychological development. As highlighted in Working Together 2010: “Some children live in family and social circumstances where their health and development are neglected. For them, it is the corrosiveness of long-term emotional, physical or sexual abuse that causes impairment to the extent of constituting significant harm” (p.36).

Working Together 2010 lists the following as factors to consider in understanding and identifying significant harm:

- The nature of harm, in terms of maltreatment or failure to provide adequate care;
- The impact on the child’s health and development;
- The child’s development within the context of their family and wider environment;
- Any special needs, such as a medical condition, communication impairment or disability that may affect the child’s development and care within the family;
- The capacity of parents to meet adequately the child’s needs; and
- The wider and environmental family context.

The legislation refers not only to actual harm suffered, but the likelihood of harm - “likely” to suffer significant harm means a “real, substantial risk”.

**Definition of Abuse**

Working Together 2015 defines abuse as “a form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others (e.g. via
the internet). They may be abused by an adult or adults, or another child or children.” Working Together goes on to describe four categories of abuse:

**Physical abuse:** A form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

**Emotional abuse:** The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or ‘making fun’ of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child’s developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

**Sexual abuse:** Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via
the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

**Neglect:** The persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment)
- Protect a child from physical and emotional harm or danger
- Ensure adequate supervision (including the use of inadequate caregivers) or
- Ensure access to appropriate medical care or treatment

It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs.

**Potential impact of abuse and neglect**

There is extensive and growing evidence showing how the experience of abuse and neglect at any age or stage of development can have a negative impact on a child’s physical, cognitive, social, emotional and behavioural development that can last into adulthood (see Ward et al, 2014, p.44). Abuse and neglect during the first three years of life is now considered to be particularly harmful due to the impact on the child’s neurobiological development and on the attachment process (see Ward et al, 2014; Howe, 2005). As the child grows, maltreatment can have an adverse effect on self-esteem, emotional regulation, social skills and the ability to engage in learning. Abused and neglected young children may exhibit behavioural difficulties such as aggression, or cognitive issues including delayed language development.
During middle childhood, abuse and neglect may continue to affect the child`s emotional development, including the ability to regulate their feelings and responses and to recognise expressions of emotion in others, and their cognitive development and school performance (Pollack et al, 2001; Trickett and McBride-Chang, 1995). Older children and adolescents become increasingly aware of the stigma attached to parental difficulties, such as substance misuse or severe mental health difficulties, and they may try to hide problems from the outside world (Barnard and Barlow, 2003; Somers, 2007). This in itself can be a source of stress, and additionally may prevent young people accessing help. Adolescents who have been abused or neglected may have difficulty in peer relationships, and demonstrate antisocial or risky behaviour (Scaramella et al, 2002; Romer, 2010).

Abuse or neglect has been associated with a range of difficulties in adulthood including mental and physical health problems, poor educational attainment and difficulties with employment, antisocial or criminal behaviour (Ward et al., 2014, p 46). Attachment theory suggests that where parents have not resolved their own insecure attachment issues, this can potentially have a negative effect on the attachment relationship with their own children (Hesse and Main, 2000).

Although rare, the consequences of Factitious Illness by Proxy (also known as fabricated or induced illness, and previously known as Munchausen Syndrome by proxy) can be extremely serious: research in Britain indicates that 6% of children died as a consequence of the abuse; and many of the children who did not die suffered significant long-term consequences including long-term impairment of their physical, psychological and emotional development (McGuire and Feldman (1989); Neale et al. (1991), Bools et al. (1993); Sanders (1995); HM Government guidance (2008); London Child Protection Procedures (2015), Part B3, Section 2).

Research indicates that severity of any form of maltreatment has an impact on the severity of outcomes, and the more prolonged and persistent the abuse or neglect, the more difficult it is to overcome the impact.
### Table 1 Summary of the potential impact of abuse and neglect during key developmental timeframes for children (reproduced from Ward et al., 2014, pp. 47-48)

<table>
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<th>Impact of abuse/neglect</th>
<th>Before birth</th>
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<td>Exposure to drugs/alcohol <em>in utero</em> can increase the risk of preterm birth, low birth weight and foetal alcohol syndrome (Autti-Rämö, 2002; Pinto <em>et al</em>., 2010). Pre-natal exposure to domestic abuse can be fatal; it can also damage a child’s future ability to cope with stress (Shonkoff <em>et al</em>., 2012). The process of attachment begins before birth (Benoit <em>et al</em>., 1997; Canella, 2005).</td>
<td>Maltreatment during early childhood can cause functional and structural changes to brain development which can predispose to psychiatric vulnerability in adulthood (McCrorry, De Brito and Viding, 2012). Child neglect can have severe, deleterious short- and long-term effects on children’s cognitive, socio-emotional, and behavioural development. Consistent with attachment and related theories, neglect occurring early in life is particularly detrimental to subsequent development (Hildyard and Wolfe, 2002). Infants and very young children are dependent on caregivers for survival. Feelings of hunger, cold or discomfort indicate a threat to survival and generate stress. Infants cannot regulate their own stress response systems and are therefore dependent upon caregivers to re-establish their equilibrium by meeting their needs and soothing away their stress (Hofer, 1995). The stress response system begins to self-regulate at around six months, but does not become fully established until a child is around four years old. It will develop atypically in response to aggressive, hostile or neglectful parenting. Children and young people with maladaptive stress responses will find it difficult to control their behaviour, or to regulate their emotions (Tarullo and Gunnar, 2006). The attachment formed with the primary caregiver(s) shapes the way in which the child develops, and may be influenced as much by negative as by positive parenting behaviour; up to 80% of children brought up in neglectful or abusive environments develop disorganised attachments, and these are strongly associated with later psychopathology (Van IJzendoorn, Schuengel and Bakermans-Kranenburg, 1999). Children are more likely to demonstrate early developmental delay if their mothers demonstrate avoidant attachment styles and depressive symptomatology including postpartum depression (Alhusen, Hayat and Gross, 2013). Physically neglected toddlers have been found to cope less well with problem-solving tasks, reacting with frustration or anger (Hildyard and Wolfe, 2002). A systematic review by Naughton and colleagues (2013) identified negativity in play, reduced social interactions and deficits in memory performance as potential developmental outcomes of neglect and abuse.</td>
<td>Between the ages of three and five there is a dramatic spurt in the development of executive function skills such as working memory, inhibitory control and cognitive flexibility. The sequential nature of childhood development requires earlier stages to be completed before more complex skills can be acquired (Blair, 2002; Knudsen, 2004). As maltreated children start pre-school and school they are likely to have fewer positive social interactions than their peers, occurring as a response to previous insensitive care giving (DiLalla and Crittenden, 1990). They show an increased risk of aggression and other conduct problems, find it difficult to recognise that others will</td>
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### Impact of abuse/neglect

Help them, and complex language skills may be developmentally delayed (Naughton et al., 2013).

Studies suggest that early negative emotional experiences can alter the way maltreated children recognise and process emotions such as anger (Pollak et al., 2001). Deficits have been identified in the moral development of neglected and abused school aged children, which have been associated with an increase in negative behaviours including cheating and stealing (Koenig et al., 2004).

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<th>5-10 years: Middle Childhood</th>
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<td>In middle childhood maltreated children may experience delayed cognitive and educational development. For example, their complex language skills may continue to be delayed (Naughton et al., 2013). They may exhibit emotional or behavioural problems including fear, anxiety, anger or aggression (Barnard and Barlow, 2003; Covell and Howe, 2009). They may have difficulty understanding emotional expression and not recognise others as a source of help (Naughton et al., 2013). Children at this age are starting to become aware of the stigma attached to their parents’ issues (Somers, 2007). They may also begin to take on caring responsibilities both for their parents and their siblings, and consequently miss out on school and social activities (Aldridge and Becker, 2003).</td>
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<td>Adolescence is the point where young people are becoming more socially independent and peer relationships become as important, or more important, than those with family. The formation of these relationships, however, may be compromised where young people have not developed secure attachment styles (Levendosky, Huth-Bocks and Semel, 2002). The ability of adolescents to form social networks can also be hampered where they have to assume a caring role for a parent or sibling because of their parent’s problems (Aldridge and Becker, 2003). Caring responsibilities or anxiety about their parent’s wellbeing during school hours may also detrimentally affect young people’s education (Aldridge and Becker, 2003; Barnard and Barlow, 2003). However children who experience domestic abuse may find that school can offer a ‘safe haven’ for several hours a day (Buckley et al., 2007). Adolescents who have not experienced nurturing and involved parenting are more likely to become involved in antisocial behaviour and delinquency (Scaramella et al., 2002). Early stressors such as abuse and neglect have been linked to adverse adolescent outcomes and risky behaviours including drug taking, addiction, teenage pregnancy and suicide (Herrenkohl et al., 1998; Romer, 2010).</td>
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<td>Adults with unresolved attachment issues may find it difficult to open up and trust others or develop supportive social networks (Anders and Tucker, 2000). Unless parenting skills are learnt and attachment issues resolved, there is a risk that parents’ unresolved or disorganised attachments will impact on the nature of the relationship with their own children (Hesse and Main, 2000). Childhood abuse and neglect has been linked to negative physical and mental health outcomes (Springer et al., 2007); lower educational attainment, employment outcomes and earnings (Currie and Widom, 2010; Perez and Widom, 1994); and an increased likelihood of re-victimisation in adulthood (Widom, Czaja and Dutton, 2008).</td>
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**Factors that can affect parental capacity**

There is substantial evidence concerning the range of problems that can impair parental capacity to meet the needs of children (Cleaver et al, 2011; Brown and Ward, 2012).

In their overview of research, Brown and Ward (2012) identified mental illness, problem drug and alcohol use, learning disability and intimate partner violence as difficulties which *may* impair parents’ capacity to meet the needs of their children, such that children growing up with parents affected by these issues are at greater risk of maltreatment. The co-existence of two or more of these factors substantially increases the likelihood that the child’s future life chances will be jeopardised (Woodstock and Sheppard, 2002; Brandon et al, 2010; Cleaver et al, 2011). Studies have also found there is often an overlap of difficulties: for example, up to 40% of people with learning disabilities are affected by poor mental health, and almost half of people attending mental health services report problems with alcohol or drugs (Cleaver et al, 2011).

There is some evidence that the parenting capacity of individuals, particularly mothers, with Borderline Personality Disorder may be compromised due to a lack of sensitivity to their children (Newman et al, 2007) and “frightened/frightening” behaviour that can lead to the development of disorganised attachment (Hobson et al, 2009).

Research indicates that where parents were themselves abused or neglected in childhood there is an increased risk of maltreating their own children (Reder et al, 2003; Dixon et al, 2005). It has been suggested that the more severe the abuse or neglect experienced by parents in childhood, the more difficult it is to resolve early losses and traumas, and the greater risk that parents will maltreat their own children (Howe, 2005).

Mental illness, problem alcohol or drug use, the consequences of domestic violence or parental history of abuse and neglect may affect parenting capacity across all domains of caregiving (Cleaver et al, 2011). In summary, such difficulties can lead some parents to:
- Behave in inconsistent and unexpected ways
- Have difficulty in organising their lives
- Have difficulty controlling emotions
- Experience feelings of depression and despair
- Become isolated from sources of family and community support
- Become insensitive to, or unable to prioritise, their children’s needs
- Fail to ensure the safety of their children

Some parents with learning disabilities or significant learning difficulties may:
- have difficulty learning and retaining practical parenting skills
- struggle to understand their children’s more complex needs, such as the need for structure, guidance, boundaries and stimulation
- experience low self-esteem and a poor sense of self-worth
- be vulnerable to financial and sexual exploitation, domestic violence, harassment and bullying

A parent’s capacity to meet their children’s needs may also be undermined by social and environmental stressors, such as poverty, poor housing, unemployment, discrimination, isolation and geographical dislocation – particularly where parents have been dislocated from their country of origin (Reder et al, 2003; Selwyn et al, 2010; Ward et al., 2014). Moreover, parental difficulties and socio-economic circumstances are often inter-linked, for example, parents with mental health difficulties may experience problems obtaining or holding down a job, which then limits household income. Parents’ own attributes, and their perceptions of self-efficacy and confidence will also affect the ways in which they respond to difficult circumstances (Ward et al 2014, p 36).

Crucially, the research also highlights that not all parents who experience the problems identified above are unable to parent effectively. There is substantial evidence that certain protective factors can mitigate the impact of parental problems (Cleaver et al 2011). It is essential that parenting assessments include an assessment of resilience and protective factors in
relation to the child, parents, wider family and community, as well as adversity and vulnerability factors (refer to Appendix 8).

Higgins and McCabe (2000) identified the following characteristics of family functioning as being associated with multi-type maltreatment i.e. experience of more than one form of child maltreatment (sexual abuse, physical abuse, psychological maltreatment, neglect and witnessing family violence):

- Poor family cohesion (family members feeling disconnected from one another)
- Low family adaptability (rigid roles and inflexibility in relationships and communication)
- Poor quality of the adults` relationships

Table 2 below is reproduced from Ward et al. (2014, p.42-43) which was compiled from two systematic research reviews into risk factors associated with child maltreatment and the reoccurrence of child maltreatment (HIndley et al, 2006 and White et al., 2014). It shows those factors which were found to be associated with an increased risk of harm or the reoccurrence of harm, contrasted with those where the likelihood is decreased following identification of significant harm to a child. Items in italics were most strongly associated with recurrent maltreatment; the other factors were identified in the studies, but were less strongly associated with recurrence.
<table>
<thead>
<tr>
<th>Factors</th>
<th>Future significant harm more likely</th>
<th>Future significant harm less likely</th>
</tr>
</thead>
</table>
| Abuse   | Severe physical abuse including burns/scalds<br>
\textit{Neglect}
Severe growth failure
Multiple types of maltreatment
More than one affected child in the household<br>
\textit{Previous maltreatment}
Sexual abuse with penetration or repeated over a long duration
Fabricated/induced illness
Sadistic abuse | Less severe forms of abuse (defined in terms of harm, duration and frequency) |
| Child   | \textit{Developmental delay with special needs}
Child’s mental health problems
\textit{Very young – requiring rapid parental change} | Healthy child<br>
Child does not blame themselves for sexual abuse and recognises that it caused harm<br>
Later age of onset<br>
One good corrective relationship |
| Parent  | \textit{Personality disorder (anti-social, sadistic, aggressive)}
Lack of compliance
Denial of problems
Learning disabilities \textit{plus mental illness}
Substance abuse<br>
\textit{Paranoid psychosis}
\textit{Significant parental mental health problems}
Abuse in childhood – not recognised as a problem
History of violence or sexual assault | Non-abusive partner<br>
Willingness to engage with services<br>
Recognition of problem<br>
Responsibility taken
Mental disorder responsive to treatment<br>
Adaptation to childhood abuse |
<table>
<thead>
<tr>
<th>Factors</th>
<th>Future significant harm more likely</th>
<th>Future significant harm less likely</th>
</tr>
</thead>
</table>
| Parenting and parent/child interaction | Disorganised; severe insecure patterns of attachment  
Lack of empathy for child  
Own needs before child’s Parent-child relationship difficulties | Secure attachment; less insecure attachment patterns  
Empathy for child  
Competence in some areas |
| Family                          | Inter-parental conflict and violence  
High stress (associated with family stress; parental stress; large family size; poor home conditions and housing instability)  
Power problems: poor negotiation and expression of emotions; poor sense of autonomy  
Children not visible to the outside world and continuing perpetrator access | Absence of domestic abuse  
Non-abusive partner  
Capacity for change  
Supportive extended family |
| Professional                    | Lack of resources  
Poorly skilled professionals | Therapeutic relationship with child  
Outreach to family  
Partnership with parents |
| Social setting                  | Social isolation  
Lack of social and family support networks and lone parenthood  
Violent, unsupportive neighbourhood | Social support  
More local child care facilities  
Volunteer network  
Involvement of legal or medical services |

**NB Items in italics most strongly associated with recurrent maltreatment**
Capacity to Change
Research indicates that with appropriate support some parents whose parenting has given rise to safeguarding concerns, are capable of effecting and sustaining positive change in order to adequately meet the needs of their children (Davies and Ward, 2011; Ward, Brown and Maskell-Graham, 2012; Ward, Brown and Westlake, 2012). However, research has also indicated that there are families where children have been exposed to ongoing maltreatment despite professional intervention (Jones, 2009). A critical element therefore of a parenting assessment is an analysis of a parent's capacity to change.

Capacity to change incorporates two elements: the motivation to change and the ability to change. These elements are addressed in detail in the guidance to Part Ten of the report below, and in Appendix 9.

Planning the Assessment
The assessment should be planned as part of group supervision. Consideration should be given to the following:

Reason for the assessment
Clearly identify the nature of the concerns, the reason for the assessment and why now. It is envisaged that the majority of parenting assessments will be undertaken:

- Prior to a legal planning meeting
- During formal pre-proceedings
- Directed by the Family Court within proceedings

However, it may be appropriate to undertake a parenting assessment at a different stage.

Who needs to be assessed?
Consideration needs to be given to who needs to be subject to the parenting assessment. Evidence from serious case reviews and research shows that fathers and male partners are often overlooked in child safeguarding, both in terms of risk and protective factors (Scourfield, 2003, 2006; Brandon et al.,
All adults who are part of the household and/or have a significant role in caring for the child should be assessed. Other adults who have a significant role in the child’s life should be interviewed as part of the assessment wherever possible.

**Timeframe**

Assessments should not generally exceed ten weeks, eight weeks to undertake the assessment and a further two weeks to complete the report. In exceptional circumstances, the assessment may need to be extended by a maximum of two weeks, for example, where parents have a learning disability or a child in the family has a disability or complex needs, requiring additional factors to be addressed. Agreement for an extension should be sought from the Practice Group Lead in these circumstances. An assessment may need to be completed within a reduced timeframe, where time constraints are imposed externally, for example, by the Court, or where an assessment is required prior to an urgent Legal Planning Meeting. The timetable for the assessment should be included in the agreement drawn up with the parent(s).

**Who will undertake the assessment?**

Identify who is responsible for leading the assessment and authoring the report. It is anticipated that this would usually be the lead social worker for the child, but there may be reasons why another social worker in the group, or from another group, should lead the assessment. Identify any tasks more appropriate and/or helpful for other practitioners in the group to undertake, for example, psychometric testing, observations of parent-child interaction. Where the parenting assessment forms part of the Local Authority evidence in any proceedings in the Family Court, the lead assessor is most likely to be required to give oral evidence, but other practitioners contributing to the assessment may also be required.

**Who needs to be included as part of the assessment?**

- Identify who needs to be interviewed – parent(s), partners (present/past), other members of the household who play a significant role in the life of the child(ren), members of the wider family
• Where both parents, or a parent and their current partner, are presenting as a parenting couple, they should be interviewed separately and together unless there are identified risks
• Identify the potential benefits and any risks in meeting with all members of the family together, for example, to develop a genogram, to observe family functioning and/or to talk about significant family issues
• Identify the nature and purpose of observations - who, when, where, how often, duration

Where should the assessment take place?
There are evident benefits to interviews, meetings and observations taking place in the family home. However, where a child is placed away from the family, it may not be appropriate for observations to take place at home and these may need to take place in a contact centre. It is also important to consider any known or potential risks presented by the parent to practitioners, which may necessitate office-based interviews and consideration to security.

Other sources of information
Multiple sources of information are essential to enhance the reliability and accuracy of the assessment. Identify potential sources of information including:
• Records of Southwark Children’s Services – current and archived
• Records of other Local Authority Children’s Services
• Other services within Southwark Social Services, such as the Community Learning Disabilities Team, the Community Mental Health Team
• Services providing input to the family, such as SFFT
• School or nursery
• Family GP, Health Visitor, Hospital, CAMHS
• Police
• Probation Service
• MARAC
• Housing
• Other agencies with current or recent involvement, including voluntary agencies
• Foster carer/residential staff where a child is placed away from home
• Contact notes where a child is placed away from home

Consultation with other professionals/agencies
Consent should be sought from each parent/carer with Parental Responsibility who is subject to the assessment, to request information from other agencies/professionals for the purposes of the assessment where this is not already available, or is out of date (refer to Appendix 2). There may also be a need to make enquiries of other agencies about other adults who are members of the household, or have significant contact with the child, and separate consent forms should be used for this. Where a parent or other person refuses to consent, attempts should be made to ascertain the reason for refusal and this should be recorded. The reason for any decision to request information against the wishes of a parent, or other relevant adult, should be recorded following consultation with a relevant manager.

The statutory guidance in this respect states:
“Effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision ….. Fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children.”
Working Together to Safeguard Children 2015 (pp.16-17)

“Where there are concerns about the safety of a child, the sharing of information in a timely and effective manner between organisations can reduce the risk of harm. Whilst the Data Protection Act 1998 places duties on organisations and individuals to process personal information fairly and lawfully, it is not a barrier to sharing information where the failure to do so would result in a child or vulnerable adult being placed at risk of harm. Similarly, human rights concerns, such as respecting the right to a private and family life would not prevent sharing where there are real safeguarding
“Information Sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers (2015)

Reference should also be made to the Local Authority’s *Information sharing governance framework for agencies working with children, young people and families in Southwark* (2012).

*Ensuring accessibility to a fair assessment*

This handbook includes particular guidance when assessing parents with specific needs and these sections should be read where relevant. In respect of all parenting assessments, efforts should be made to ensure that the parent understands the reason(s) for the assessment:

- Communication needs to be clear and consistent
- Where English is a parent’s second language consideration should be given to the need for any letters/documents to be translated, and for meetings/interviews to be conducted with an interpreter
- A parent who is deaf, or hearing impaired, and uses sign language should have a sign language interpreter
- Where a parent has learning difficulties, including difficulties in reading or writing, these needs should be taken into account when planning the assessment and how to communicate with the parent
- Where a parent has a suspected or known learning disability, the Good Practice Guide on Working with Parents with a Learning Disability (Department of Health, 2007) should be followed, and letters, records of meetings, and the Assessment Agreement, should be in an appropriate format, which may need to include picture prompts. If a cognitive assessment is not available, consideration should be given to whether a cognitive assessment is necessary to ensure that the parenting assessment is appropriately tailored – for example, whether an assessment using the PAM framework is necessary
- A parent who experiences mental ill-health, or a parent with a learning disability, may need an advocate to attend meetings with them
- Other parents can be signposted to independent advocacy if necessary, for example from the Family Rights Group
- If there are concerns about the capacity of a parent to agree to, or engage in a parenting assessment, for example, due to the severity of a learning disability or mental health problems, advice should be sought from the legal department.
- Parents who are in care themselves, or are care-leavers should be offered the opportunity to speak to the Children’s Rights Officer.

**The Assessment Agreement**

An Assessment Agreement meeting should be organised to consider and record:

- The reason for the assessment
- Summary of the areas to be assessed
- The timescale for the assessment, dates and venues for interviews and observations
- Roles and responsibilities
- Any special requirements to enable the parent to participate in the assessment, for example, an interpreter, travel arrangements to meetings/contact

The Assessment Agreement (see Appendix 2) includes a template for signed consent for the Local Authority to request information from:

- Identified agencies/professionals for the purposes of the assessment.
- Identified members of the extended family, or other persons connected to the family, where appropriate

**Process of assessment**

*Principles and parameters of a good assessment*

Recent government guidelines in relation to single assessments (Working Together, 2015) can helpfully be applied to parenting capacity assessments. These state that a good assessment should:

- be child centred;
- be rooted in child development and informed by evidence;
- be focused on action and outcomes for children;
• be holistic in approach, addressing the child’s needs within their family and wider community;
• ensure equality of opportunity;
• involve children and families;
• build on strengths as well as identifying difficulties;
• integrated in approach;
• be a dynamic process not an event;
• be timely, transparent and open to challenge.

The Children Act 1989 incorporates the principle that all children and their parents should be considered as individuals and that family structures, culture, religion, ethnicity and other characteristics should be respected. Every assessment should reflect the unique characteristics of the child and parent within their family, community and cultural context.

**Integrating systemic practice**

Laszlo (1972) described “systems” as “meaningful wholes that are maintained by the interaction of their parts”. Taking this into consideration a system can be defined in multiple ways, but from a social work perspective, it is usually referred to in the context of the families who access support and the professionals who work with them. Thinking systemically helps practitioners to understand that individuals exist in relationship to others and that these relationships are circular and recursive; that the feelings and behaviour of one affects the feelings and behaviour of the other and the resulting feedback helps to either adjust or sustain these actions.

Several key principles influence systemic thinking and practice and should be incorporated into the assessment process whenever possible:

• **Think circular not linear**

  Historically, there has been a focus on linear causality – the connection between cause and effect; an antecedent event (cause) is thought to be responsible for the consequent event (effect). This view supports the belief that difficulties are solely located within the individual.
Systemic thinking is relational and promotes the idea that the behaviours and beliefs of one are influential on the other in a circular way. Within a system, patterns of behaviour, both positive and negative, are present. It is therefore important to think of the connection between behaviours and beliefs, with the intention of understanding how this influences family functioning and parenting capacity.

• **Understand difficulties within a contextual framework.**
  This view promotes the idea that what a person experiences is in relation to the different contexts in which they exist i.e. a person can be a daughter, sister, granddaughter, niece in a family situation; a partner in a couple relationship; or belong to a particular ethnic, cultural or religious group. This concept also relates to the professionals working with a family. Professionals too are located within multiple contexts which will influence how they perceive a situation, as it will largely be based on their own knowledge and experiences, as well as their organisational culture and professional expectations. Context can give meaning to behaviour, so understanding the multiple contexts that a person is located in, needs to be incorporated into the assessment process.

• **Strengths-based**
  The strengths-based approach recognises and attempts to build on the skills that a family already possess. The family is supported to think about and reframe existing views to find potential positives. Working from this premise limits the use of labelling or disparaging language/terms which the family, or the professional system working with the family, may already use to describe them. It is thought that the continuous use of negative or unhelpful language/terms as descriptors will eventually assist in creating identification, internalisation and a subsequent belief that the family is helpless in relation to making and sustaining changes. This idea also connects to the Social
Constructionist view which proposes that due to the influential (some would say powerful) position that professionals hold in this culture, the way in which a professional interacts with a family can impact on the reality that gets co-constructed.

When adopting a strengths-based approach, focus is placed on what may have historically worked well for the family and how this can be capitalised on or revisited again to support change. The family is very much positioned as the expert of their life, and this can assist in supporting a change in the power imbalance that is often seen in the client/professional relationship. Taking this stance can often lead to interventions being viewed as collaborative by the family; and the professional working with the family feeling they can take a more appreciative position. In many helping relationships, those who feel they are an important part of the process tend to positively engage and are more invested in the outcome.

- **Self-Reflexivity and Self-Other-Reflexivity**
  
  This is an invitation for practitioners to continuously pay attention to how their preferred ways of viewing the world can influence how they interact with the families they work with. Recognition of how families may also impact on the professional is just as important. Asking for feedback from those involved in the assessment process may help to promote more trust and facilitate open communication. The group supervision process can be used to assist practitioners with reflecting on the assessment process.

- **Technique and Approach**
  
  Some of the techniques and approaches that are used in systemic practice can be effectively integrated into the parenting assessment process:
  
  - *Hypothesising*: an opportunity to generate ideas about the situation, i.e. why the situation occurred, what supports the
situation continuing, the impact of the situation on family functioning. Hypotheses are based on the information the family or other professionals have given, or observations of behavioural presentations. Practitioners should not be wedded to any one hypothesis; rather they should hold their ideas lightly and be ready to generate different hypotheses once previous ones no longer fit.

- **Curiosity**: not coming from a position of curiosity can lead to fixed ideas that are not always helpful to the family or the assessor. Be open to asking more questions to gain a fuller understanding and a wider picture of family functioning.

- **Neutrality**: practitioners connect to the view that everyone in the family system is doing their best in their current circumstances. When in direct contact with the family, the practitioner attempts to convey that they are not taking sides and are not aligned to any particular family member. In a child protection context this is not necessarily an easy position to adopt, however doing so may facilitate better engagement.

- **Genogram**: an effective tool used to explore family relationships and patterns.

- **Reframing**: the professional or other family members helpfully provide alternative interpretations of the situation. This is especially effective if a family’s view is particularly negative or unhelpful. Holding negative views can limit the family generating their own ideas around finding solutions or maintaining changes. Reframing permits the generation of new ways of thinking about, and responding to, perceived difficulties.

- **Social GGRRAAACCEESS**: paying attention to, and being mindful of, difference.

- **Questions**: questions play a very important role in systemic interventions, with circular questioning being a key feature. Circular questions are questions that pay attention to relationships. There are four sequential parts to circular questioning:
**Problem definition** – questions are asked to understand the family’s perception of the difficulties, with an invitation for them to generate their own hypotheses about what may be contributing to the situation

**Sequence of Interaction** – these are questions that let the practitioner know who does what, when and where in relation to the hypotheses generated

**Comparison classification** – questions that are asked about other family members, i.e. their beliefs, feelings, thoughts, habits, values, traditions in order to compare and contrast similarities and differences

**Intervention** – these tend to be questions that challenge, inform or directly instruct

During the assessment process, think about how to use systemic concepts to influence how you engage the family and think holistically about the family’s strengths and difficulties, which will assist in developing your analysis and drawing conclusions.

**Information gathering**

The assessment should make use of information from multiple sources. Any discrepancies in significant information from different sources should be noted, and considered in discussion with the parent, and with the child if of sufficient maturity. Particular note should be made if a child’s account differs significantly from that of a parent.

**Review of records/information from other agencies/professionals**

Current and past records held by the local authority, including reports from other services and agencies should be systematically reviewed. The significance of this has been underlined by research (Brandon et al, 2008, 2009; Farmer and Lutman, 2009). This is particularly important in long-term chronic cases such as those involving child neglect, to help avoid the “start again syndrome”. Where a family has been known to other Local Authorities information should be sought from them, and it may be necessary to review
their records too, particularly where the family has only recently moved to Southwark.

The review of records should enable the practitioner to identify:

- Significant events in the life of the child, parent and other family members
- Patterns of events and behaviour, including intergenerational patterns
- Interventions that have been offered, the level of engagement and the outcome
- Discrepancies, or apparent inaccuracies, in information that require clarification

It is essential to consult with other services, agencies or professionals with current or recent involvement with the child, parent and/or other family member to ensure that information and views are up to date (refer to Appendix 2 for a consent template).

A Chronology should be drafted with a view to this being reviewed and added to as information emerges during the course of the assessment. Existing guidance for chronologies should be followed as set out in the Practice Guidance: Legal Planning and Care Proceedings in Southwark Practice Guidance W:\Programmes and Projects\Social Work Matters\Principal Social Worker\Chronologies practice guidance final 08.04.15.doc. The finalised Chronology should be appended to the Parenting Assessment Report.

A three-generational Genogram should be drawn up and embedded, or appended to, the Parenting Assessment report. Developing or reviewing a Genogram with a family can be a useful tool in engaging family members and talking about family history and culture, as well as checking the accuracy of information from other sources (refer to Appendix 3).

It may also be helpful to draw up an Eco-map to clearly show the involvement of agencies and professionals with the family (refer to Appendix 3).
**Interviews**

The template has been designed with embedded guidance to support practitioners in structuring their interviews and meetings with parents, the child(ren), the family as a group, and significant others. It is important to be alert while interviewing, not only to the information that is provided, but also to the behaviour, body language, emotional presentation and interactions of those being interviewed.

**Interviewing parents/carers**

Practitioners should use their best efforts to establish, or maintain, rapport with each parent/carer being assessed. Interviews should be undertaken using a collaborative approach wherever possible alongside sustained professional challenge (Brandon et al., 2009). Motivational interviewing techniques may assist collaborative working (Forrester et al., 2012). Practitioners need to be clear and honest with parents without creating hostility; and show empathy, without colluding with unacceptable behaviour (Forrester et al., 2008).

Where both parents, or a parent and their partner, are presenting as a parenting couple i.e. the partner is resident or having contact with the child, they should be interviewed separately and together unless it is not safe to do so. This provides the opportunity to observe the quality of the interaction between them.

The report template provides a structure for the areas that need to be covered during interviews, but can be used flexibly. The guidance to some sections of the report template includes examples of prompts that may further assist practitioners in thinking about how to elicit information relevant to the assessment that is not spontaneously forthcoming. Some of these are adapted from an assessment tool developed by Jeff Fowler (2003). However, caution is necessary – the prompts are not meant to be used as a checklist; rather inquiry should be tailored to the particular family’s circumstances, number and ages of children, and the presenting concerns. Questions should
be open-ended wherever possible, and should not interrupt the flow of a parent’s account; rather they should be used to facilitate and support the interview to ensure that all relevant aspects are addressed. The language used should be sensitive to the circumstances of the child and family. The acronym TED may assist practitioners in developing their inquiry:

Tell me about...........
Explain for me how ..... 
Describe that for me ....

If a parent does not appear to understand what is being asked of them, it should be re-phrased. Follow up questions may be needed to encourage the parent to expand on their response, or to query or challenge a statement made that does not fit with the evidence available from other sources i.e. interviewing should be an interactive process. It is sometimes the reason a parent gives for their response, or how they respond, that is as significant as the answer given.

Interviewing children
Children should be seen on their own whenever possible, and consideration given to the most appropriate venue. Time needs to be taken to build a relationship with the child or young person. Sensitivity and empathy is important to avoid compounding any distress the child may be experiencing. The boundaries of confidentiality should be explained to children in an age-appropriate way. Open-ended questions should be used. It should be borne in mind that children and young people do not always feel they can be open due to concerns about potential consequences for themselves and/or their parents of disclosure. Communication with the child should be in a way that is appropriate to their age, understanding and preference. This is especially important for children with disabilities, learning and/or communication difficulties, and for children whose preferred language is not English. Where children have severe disabilities, advice will need to be sought in relation to the best method of communication, and the assistance of an adult with
experience in communicating with the child, such as a teacher, should be sought (refer to Appendix 7).

A range of developmentally appropriate resources should be used to ascertain:

- The wishes and feelings of each child, including through play and drawings, and
- Their views, where they are of sufficient understanding and maturity to express these

The concept of sufficient understanding refers to the capacity of a child or young person to comprehend and make informed judgments about issues that affect them. This will be dependent on their chronological age, cognitive development, the complexity of the issues and the influence of associated personal and interpersonal conflicts (Reder et al., 2003, p.20).

Practitioners need to try to understand what the world looks like, and feels like, for the child. Getting a narrative of the child’s day to day experience is a good place to start, and avoid leading questions. Depending on the age of the child, their wishes, feelings and views might include:

- The child’s day to day experience at home
- The child’s feelings about their parent(s), siblings, significant extended family members, peers, significant others
- Their experience of relationships between family members
- Their experience of school and social relationships
- The child’s current concerns
- Their views in relation to the future

The child’s wishes, feelings and views should be reported using their own words, as far as possible. Older children and teenagers may want to write something down. Copies of any of the child’s work should be scanned and attached to the assessment report.
Meetings with family members together

Meeting with the whole family together can provide the opportunity to observe the family dynamics - how family members get on with each other, who is aligned with whom, how they manage differences and resolve conflict, whether they have a shared sense of family history and identity. A family meeting should be considered unless there are indications that this would be potentially damaging or distressing for individual family members (for example where there is suspected sexual abuse within the family or where a child is placed away from the family).

It is recommended that two practitioners should be involved in family meetings so that the meeting can be appropriately facilitated and family members supported as necessary, as well as observations made of the family dynamics. Consider the most appropriate venue and seating arrangement for the meeting. Think about activities you could ask the family to undertake together, which will need to be appropriate for the age and stage of development of the children, and the nature of the concerns. Appropriate materials will need to be provided. Where the activity involves talking together, ensure each family member has the opportunity to talk. Examples of activities might include:

- Doing an activity together such as constructing a genogram, playing a game, doing a craft activity, or having a family meal
- Talking together as a family about family life and significant events, for example:
  - Describe how you celebrate when it is someone’s birthday.
  - Describe the kinds of activities you do together.
  - Are there other things you would like to do together?
- Talking together about how they see the family and each other and how the family functions, for example:
  - Could you tell me who is like whom in your family? Describe how they are alike.
  - How would you describe your family to someone outside the family?
Could you tell me what the rules are in your family? Describe what happens if someone doesn’t keep to the rules.
Describe the good things about your family.
Is there anything you would want to change?

*Interviews with members of the wider family/significant others*
Parents should be invited to identify any members of their wider family or other significant people they would wish to be seen as part of the assessment. Where the parent does not identify anyone, practitioners may still consider it would be valuable to meet with particular people connected to the family. This should be explained to the parent and their consent sought to contact them. Where the parent does not want members of the wider family to be contacted, there should be exploration of the reasons for this, for example, it may indicate difficulties in the relationship, the parent may be estranged from their family, there may be concerns about risks posed by family members, or it may indicate issues about transparency on the part of the parent. Meetings with members of the wider family should only be pursued against parental wishes where there is evidence that the child would be at risk of significant harm if such contact was not made.

Practitioners need to ensure appropriate boundaries of confidentiality if meeting with wider family members/significant others, and the people interviewed also need to be made aware that the significant elements of what they say will be included in the assessment report, which will be seen by the parent(s).

*Observations*
Direct observations are valuable as these constitute primary evidence. It is essential that the assessment includes observation of parent-child interaction, sibling interaction and interaction between the adults in the household, for example, parent-parent or parent-partner. Observations are likely to be most informative when these take place in a variety of settings and at different times of day (Jones, 2010). It is important to remember that where a child is not living with a parent, observations of parent-child interaction during periods
of contact, may provide limited information as to how the parent would care for, and relate to, a child on a full-time basis. Refer to the guidance to Part Eight of the report template below and to Appendix 6.

Parent-infant observations should include attention to those aspects of parent-infant interaction that have been identified as laying the foundations for a secure attachment, such as reciprocity and mirroring (refer to Appendix 6).

Animal abuse

Practitioners need to be alert to the care and treatment of family pets whilst carrying out the assessment. There is increasing evidence of links between abuse of children, domestic violence and abuse of animals. Animal abuse is defined as intentional harm of animals including the wilful neglect, inflicting injury, pain or distress, or malicious killing of animals. The research suggests a correlation between animal cruelty, household violence and child abuse within the family (see for example, Bell, 2001; Hackett & Uprichard, 2007). A child displaying intentional cruelty to animals could indicate that the child has been a victim of neglect and/or abuse themselves, and in some circumstances, acts of animal cruelty may be used to control and intimidate partners and children (see also London Child Protection Procedures 2015: Part B, section 32). Use of the Aggression Questionnaire, Interpersonal Reactivity (Empathy) Index and the Child Abuse Potential Inventory may be helpful where there are concerns about animal abuse by a parent (refer to Appendix 12).

Use of validated tools/consultation with other practitioners trained to use specific tools, techniques, questionnaires or scales

Judicious use of standardised, evidence-based techniques and tools can be used to support and evidence the assessment process: to inform, but not replace professional judgment. Psychometric questionnaires and scales can be used to further explore specific issues, for example in relation to the strengths and difficulties experienced by a child, or the psychosocial functioning of a parent. Refer to Appendix 12 for details of some
questionnaires, scales and tools that may be used. Some require particular expertise or specific training to administer and interpret the results. Others may be used in consultation with practitioners who have had specific training in using them. Individual practitioners may also be qualified to use other techniques, such as the Adult Attachment Interview, the CARE-Index or Video Interaction Guidance, which may support the assessment.

Practitioner bias
The parenting assessment should be reviewed in group supervision, as a minimum at the mid-way and concluding stages, in order to:

- Critically reflect on the progress of the assessment
- Identify issues that may need additional exploration
- Analyse any difficulties encountered and support practitioners in addressing these
- Support practitioners in reflecting on how the process of the assessment may be impacting on family members and the family system
- Support practitioners to remain focussed on the needs of the child (risk of practitioners becoming “enmeshed” with chaotic families, responding to needy parents and losing sight of the child)
- Assist practitioners in being mindful of any personal values and beliefs, and biases that may be impacting on the assessment process

The following types of bias have been identified in child protection work (Dingwall et al., 1983; Brandon et al., 2008):

- The “rule of optimism” – finding the most positive explanation
- Cultural relativism – perceptions of elastic norms linked to cultural difference regarding the social norms and practices surrounding the care of children and family life
- “Natural love” – a belief that parents invariably and naturally love their children
Strategies to mitigate against bias include:

- Avoid searching for information that supports the practitioner’s preferred view
- Be open-minded - reassess risk and safety factors, and revise initial hypotheses in the light of new information
- Use multiple and reliable sources of information
- Play “devil’s advocate” by taking the opposing view and arguing for that view. This “dialectic mindset” promotes alternative hypotheses and the exploration of alternative explanations (Reder & Duncan, 1999)
- Explore cultural perceptions
- “Think the unthinkable” (Brandon et al, 2009)
- Maintain a “healthy scepticism” and “respectful uncertainty” (Laming, 2003)
- Adopt a position of “curiosity” (Cecchin, 1987)
- Reflect on areas where assumptions, values or lack of knowledge may be influencing the practitioner’s responses to the family

Presentation of the Assessment Report

A good report will include the following elements:

- Professional presentation - grammar, punctuation, spelling
- Evidence-based - clarity about what is first hand evidence and the source of other information
- Balanced, fair and honest - all relevant information included
- Avoids speculation
- Clear what is fact and what is opinion
- Analytical not just narrative
- Succinct and concise – focuses on the key issues arising from the assessment and does not include extraneous information
- Clear and coherent - the content of the report leads to defensible conclusions and recommendations - reasoned professional judgment
• Clearly and accurately sets out the child’s wishes and feelings, and where old enough their views
• Clearly sets out the purpose of any plan for further intervention and the timescale
• Includes relevant theory and research where appropriate

Approval of the Parenting Assessment Report
Once the report has been drafted, it should be read and approved by the Advanced Practitioner and/or Practice Group Lead.
SECTION 2: GUIDANCE ON THE PARENTING ASSESSMENT REPORT

Part One: Framework of Assessment

Family composition

The table should provide succinct information about the family structure that gives the reader an at-a-glance picture of significant family members. This should include parents and partners, adults other than parents who hold Parental Responsibility, all siblings (full, half-siblings and step-siblings), and any other members of the wider family who are important in the lives of the child and/or parent, both currently and historically, who are significant to the assessment. Determination of the significance of family members may only emerge as the assessment progresses.

The table should include in respect of each family member:
- His/her name
- Date of birth (or if not known, age or approximate age) and death where appropriate
- Gender
- Address (or if not known, the area or country)
- Relationship to the child(ren) concerned and whether the person has Parental Responsibility

Ethnicity, cultural and religious identity, and linguistic background

The racial and ethnic heritage, religious and cultural identity of significant family members should be succinctly set out here. The first language of the parents should be recorded.

It is helpful to establish whether the parent holds a passport, and if it is up to date. If they have a passport but do not hold it, try to establish who holds the passport. If a family member or partner holds it, explore whether this may be a form of control. Establish immigration status as appropriate, noting specifically if the parent has leave to remain, or if status is unresolved, and if so, whether the person has No Recourse to Public Funds, or is at risk of deportation. Has the parent accessed appropriate legal advice/support from relevant agencies?
Consideration should be given at relevant points throughout the assessment
to any implications arising from racial background, immigration status,
etnicity, religious and cultural identity and linguistic background. Where
English is not the parent’s first language, consideration should be given as to
the need for an interpreter and translation of documents.

Genogram
Wherever possible, a genogram should be drawn up, or reviewed, with the
family. It is likely that information ascertained in the process of drawing up a
genogram in relation to family culture and relationships will be particularly
relevant to include in Part Seven of the report.

The genogram is an effective social work and therapeutic tool used within the
assessment process to help uncover family history, map family relationships
(especially during significant times like transitions and lifecycle changes),
establish and make sense of recurring patterns and understand the family’s
current situation - all of which can be valuable when working with complexity
and risk. A genogram can give a wide view of the family’s circumstances,
provide chronological data and highlight the quality of relationships in a
succinct visual snapshot.

Completing a genogram with a family can assist the practitioner during the
assessment process by supporting the creation of working hypotheses and
identifying areas for further exploration. It has the additional bonus of
providing a conducive space to test out ideas around what may be supporting
the family to function in the way it is, or has done. Completing a genogram
does not have to be a static process, rather fluidity is encouraged, as when
new information is gathered, the genogram can be modified to get a fuller or
more accurate picture of family functioning.

Genograms tend to include at least three generations which encourages
thinking around hierarchy and sub-groups; and more specifically how these
systems interact and operate, together and independently. Thinking inter-
generationally can also promote further understanding of how the family culture, including belief systems and traditions, has developed over time. When completing a genogram, it is important to contextualise the process and help the family to feel safe in divulging what may be considered private information or a family secret.

Consider the following when using a genogram as an assessment tool:

- Who should be involved in the process? Will the information divulged be suitable for different family members, particularly children, to hear in the moment?
- How can it be made into a visual tool to encourage engagement in the process and facilitate connection to patterns? A way to support this could be to complete the genogram on a large piece of paper and use different colour markers to indicate different relationships or relational patterns, for example, domestic abuse in different constellations may be highlighted in one colour. This may help to bring the genogram to life.
- It may be helpful to have some prompts in mind beforehand. The prompts can be used as a starting point; a way of inviting more information.
- Use prompts that help to develop an understanding about the emotional quality of family relationships such as closeness, distance and alliances.
- Include significant people who may not be related, but have contributed to family functioning, for example, as part of the household or providing care for the children, or having significant contact with them.
- Key organisations with whom the family is involved should be included where possible, such as school, Church, Alcoholics Anonymous, but if this makes the genogram so complicated that it is difficult to read, draw up a separate eco-map (refer to Appendix 3)
- Encourage participants to highlight significant life events and how they impacted on family functioning, when they occurred and the lasting legacy.
**Drawing up a three-generational genogram**

Include as a minimum:

- Names of the children in the family; dates of birth/death. Include any siblings, half-siblings or step-siblings not living with the family. Include miscarriages, stillbirths, terminations and adoptions.
- Names of the parents and dates of birth/death
- Any significant intimate relationships of the parents (current or historical); date they started and terminated
- Grandparents (parents of the parents): names and dates of birth/death
- Siblings of the parents: names and dates of birth/death
- Include cause of death where family members have died
- Include any hereditary or genetic conditions in the family

Additional prompts that may be helpful as the genogram is being developed:

- Ask the parents to tell you where they were born (city/village/country) and where their parents/grandparents were born
- If the family migrated to the UK – ask the parents/family how old family members were at the time and what influenced that decision
- Ask the family to tell you if they have maintained connections to their country of origin, and if so, how they do this
- Ask the family how they identify their ethnic origin and what this means for them
- Ask the parents/family to explain to you who currently resides at the family home and their relationship to parents and to the children
- Ask the family to tell you about any other people they identified are involved in the care of, or have a lot of contact with, the children
- Ask the parents to tell you about any changes in household composition (people leaving or joining)
- Weave in prompts that uncover knowledge about the personality traits of family members, past and current occupations, physical and mental health history, drug or alcohol misuse, whether violence is/was a feature in some relationships, any criminal history, any involvement with Children’s Services
• Ask the family to describe how the children in the family get on together
• Ask the family to describe who shares a close relationship and explain their reasons for saying this
• Ask the family to describe who does not share a close relationship and their reasons for saying this
• Ask the family whether family members usually take sides when there is an argument and if so, who usually sides with whom

If the other parent(s) of the child is not involved in the assessment:
• Ask the parent to tell you where the other parent was born and if possible their parents/grandparents; and the parent’s ethnic origin
• Ask the parent to tell you about any significant adult relationships of the other parent such as marriage, cohabitation, civil partnership.

Further guidance on genogram symbols and examples of genograms and an eco-map are included in Appendix 3.
Part Two: Reason for assessment
This should be a concise summary of the reason/context for the parenting assessment i.e. the nature of the Local Authority concerns, and why now. It is important to set out how the concerns relate to any significant harm each child is suffering, or likely to suffer, and the nature of that harm i.e. the impact, or potential impact, on the development of each child – physical, sexual, emotional, social, behavioural and/or intellectual. Where the concern is neglect, the reason for the assessment being undertaken now may be increasing evidence about the cumulative impact of long-standing neglect on the children.

A Chronology should be drawn up and appended to the report. Entries should be succinct, in the third person, and factual. The Chronology should organise and record key incidents and events that are relevant to the assessment. It should focus on significant events in the life of the child, or that have impacted on the wellbeing of the child. It should include interventions or services that have been offered and the outcome. In complex families where difficulties have persisted down the generations, it should identify where there have been concerns about intergenerational abuse, where state intervention has been required in the maternal and/or paternal family, and where children have been removed from parental care. An allegation can be included where relevant, as it is a fact that the allegation was made, but it must be made clear that it was an allegation if not proven.

The parent’s history of parenting the child(ren) can be set out in more detail in Part Eight of the report, where reference may be made to events in the Chronology.
Part Three: Process of the Assessment

Set out clearly the process of the assessment, following the guidance in the report template, so that it is clear to the reader:

- Who has been the lead assessor and how other practitioners have been involved in the assessment or contributed to it
- That the progress of the assessment will be reviewed in individual and practice group supervision
- Who has been interviewed as part of the assessment
- How the assessment process was fair and accessible, outlining what steps were taken to ensure that the assessment was appropriately tailored to take account of the needs of the parent, for example, using an interpreter (including BSL), inviting an advocate to meetings where a parent has mental health difficulties, or using visual assessment aids for a parent with a learning disability
- When and where interviews, observations and any meetings relevant to the assessment took place, and who was involved
- Any impediment to the progress of the assessment, including any problems arising in relation to the parent’s engagement
- Whether any particular tool or test has informed the assessment, for example, the PAM framework or elements of the framework, the Child Neglect Toolkit, the CAPI or other questionnaire/scale/psychometric test, with details of who administered the questionnaire/scale/test, when, and who interpreted the results. Details of any resources used to ascertain a child’s wishes, feelings and views should be set out under Part Five of the report, rather than here
- All other sources of information relevant to the assessment, and any difficulties in obtaining specific information
Part Four: Summary of Conclusions and Recommendations

Practitioners should draft this section once the rest of the assessment report has been written i.e. after completion of the Analysis, and Conclusions and Recommendations sections at the end of the report. The aim is to provide the reader with a succinct summary of the main conclusions and key recommendations. This is in line with the requirements of independent expert assessments prepared in court proceedings.
Part Five: Profile of the Child(ren)

Use a separate heading for each child and include:

- A brief **physical description of the child and his/her presentation**.

- An outline of **the child’s health and development**, including physical health and cognitive/language/emotional/social and behavioural development. You may find it helpful to refer to the outline guide to child development, but account must be taken of any specific needs of the child and their circumstances (refer to Appendix 4). Consider the impact of any genetic factors and any medical condition/disability.

- An outline of **the child’s educational progress**.

- Identify any **specific needs/vulnerabilities and resilience factors**. Identify the parenting each child would need to experience in order to address their specific needs.

- The profile should use multiple sources of information. Information should be gathered from the parent(s) and other adults who know the child well. Include your own observations of the child’s presentation and behaviour. Include the child’s **view of themselves** and their abilities, their self-image, self-esteem and sense of identity – race, religion, age, gender, sexuality and disability may all contribute to this. Include the child’s sense of belonging and acceptance by the family and peer group.

- Consider using the Strengths and Difficulties Questionnaires and the Adolescent Wellbeing Scale where appropriate (refer to Appendix 12).

- **Comment on and analyse as appropriate:**
  - growth and motor development
  - general health and any medical needs, treatment
  - any physical and/or learning disability
  - play, any leisure activities
  - temperament
  - the child’s perception of themselves
  - the child’s sense of identity
  - self-image, self-esteem, and any worries/anxieties
  - self-care skills and developmentally-appropriate independence
o self-harming, hyperactive, impulsive and/or aggressive
behaviour, any drug/alcohol misuse, any involvement of CAMHS
o relationships with parent(s), siblings (e.g. excessive sibling
rivalry, parentified sibling), extended family members, peers and
significant others (as reported by parents and/or the child, and/or
professionals and/or observed by the practitioner)

- Use a range of age-appropriate resources to ascertain the child’s perception of their day to day experiences, their wishes and feelings, and, where the child is of sufficient understanding, their views about their circumstances.

- The concept of sufficient understanding refers to the capacity of a child or young person to comprehend and make informed judgments about issues that affect them. This will be dependent on their chronological age, cognitive development, the complexity of the issues and the influence of associated personal and interpersonal conflicts (Reder et al 2003). Comment on the child’s ability to understand the relevant issues and to communicate their wishes, feelings and views.

- Identify the child’s wishes, feelings and views, and be specific about how and when these were ascertained, including any specific resources used where appropriate.

- Wishes and feelings should include the child’s feelings about their parent(s), siblings, significant extended family members, peers, significant others; and wishes in relation to the future.

- Report the child’s wishes, feelings and views using their words, as far as possible.

- Scanned copies of any of the child’s work indicating their wishes, feelings and/or views should be appended to the report.
Part Six: Parent Profile

Childhood and Adolescence

In order to understand a parent’s current functioning, and the influences on their parenting, it is important to explore their own history, family background and the environment in which they were raised including:

- Their perception of their relationships with each of their primary caregiver(s) as they were growing up
- Their perception of their relationship with each of their siblings
- Their perception of their relationships with members of the wider family, and other significant adults (including step-parents, parent’s partners), as they were growing up
- Positive and adverse experiences in childhood and adolescence, including loss and separation
- Cultural and religious influences and practices

Parents should be encouraged to provide a narrative of their experience of childhood and adolescence. It is important to be sensitive to the emotional demands this places on the parent, and it is usually helpful to start with neutral enquiry, such as where the parent was born and brought up, and what they consider to be significant life events, before moving on to their associated memories, perceptions and feelings in relation to those events and significant relationships.

The aim here is to help the practitioner evaluate the quality of the relationships the parent experienced as they were growing up, how this has influenced their development and their own parenting, provide an opportunity for the parent to reflect on this and evaluate the degree of insight the parent has. Consider for example, is there evidence that the parent’s perceptions of their childhood are distorted? Do they understand the impact on themselves of any abuse or
neglect? Are there entrenched patterns of behaviour and enduring family scripts that affect their lives as adults and their parenting of their children?

What does their experience of separation and loss mean for the quality of their early attachments and resilience? How did their upbringing impact on their self-esteem and feelings of happiness/unhappiness? What impact did the family's culture and practice of religion have, for example, did routines and rituals provide positive guidance and a sense of identity, or did the rules, expectations and practices cause stress or conflict for them? Did their family experience discrimination, and how did they cope with this?

The analysis under this section should consider the quality of care the parent received as a child, the coherence of their account and how this fits with information available from other sources, whether the parent has made sense of their history, and the extent of their insight into how their relationships and experiences as they grew up have influenced their development and their own parenting. Summarise what this means in relation to their parenting capacity.

Prompts may be needed to help elicit parents' memories, feelings and perceptions, and practitioners may find those outlined below helpful. However, any prompts should be adapted according to what is already known about the parent's history, for example, raised by a member of the extended family, or if they were adopted, or if there is a known history of the parent being abused or neglected as a child. Subsidiary questions may be needed to explore the parent's comments further.

*Significant events in childhood*

- Tell me where you were born and where you lived as you grew up
- Tell me who you lived with and who was responsible for looking after you.
• Did your parent(s)/carer(s) go out to work? What job(s) did they do?
• Tell me about anyone else who played an important part in your life as you were growing up?
• Tell me what you think were the important events/things that happened as you were growing up?

**Experience of separation and loss**

• Could you tell me if you experienced separation from, or the loss of, a parent or anyone else who was important to you as you were growing up (loss may be through parental separation, loss of contact with someone, or someone dying). Describe how that affected you.
• If you had a change in primary carer, or lived away from your family at any time as you were growing up, describe how that affected you.

**About the person’s relationship with each of their parents/primary caregivers:**

• Describe your relationship with your mother/father/other carer when you were a young child, using three words or adjectives or phrases. Could you tell me what memories or experiences led you to choose each of those words or phrases?
• When you were upset as a child, what would you do, and what would happen? Describe some examples of this, such as when you were physically hurt, or ill, or upset.
• Tell me who you felt closest to as a child, and can you explain why
• Describe how were you shown affection by your parents/carers
• If you did something well, how did your parents/carers respond?
• Describe how your parents/carers responded when you misbehaved? Tell me what kinds of behaviour you were punished for. What do you remember as being the worst punishment you were given? Do you feel their methods of managing your behaviour were fair?
• Describe some occasions when your parents got angry with you. Describe how you felt.

• Did you ever feel frightened of your parent(s)/carers or that you were not safe? Can you tell me what happened?

• Describe your relationship with your parents/carers when you became a teenager

• Tell me about any contact with your family by Social Services, and can you explain the reason for that.

• Do you consider you were ever physically, emotionally or sexually abused, or neglected while you were growing up, by a member of your family or anyone outside of the family? Can you tell me what happened?

• Are there things from your childhood that still upset you?

About the relationship between the person’s parents/primary caregivers

• Describe the relationship between your parents/primary carers.

• Tell me how they shared the parenting tasks and who made the big decisions, including about money

• Describe what kinds of things they argued about and what happened when they argued. Were they ever violent to each other? Describe how you felt when they argued or were violent

About the relationship with each sibling, half-sibling, step-sibling

• Tell me about your siblings (full or half-sisters/brothers, or step-sisters/brothers).

• Describe how you got on with each sister/brother as you grew up. What are the nicest things you can remember, and the worst?

• How did your sisters/brothers get on with each other?
Do you feel your parents/carers treated you all the same? If not, describe what was different.

**Relationships with wider family members and other significant adults**
- Describe how any other family members or adults were part of your life as you grew up. Tell me about your relationship with them.

**Culture and religion**
- Describe the rules and routines in your family as you were growing up.
- Tell me about any religious or cultural beliefs or practices in your family as you were growing up, for example, religious ceremonies or rituals, attending places of worship, diet.
- How important were these to you/what did these mean for you?
- Do you feel you or your family experienced racism or discrimination, because of the family's cultural background or religious beliefs?

**Perception of self in childhood**
- Describe yourself as a child for example, what was your general mood? what were you good at? what kind of things did you do when you misbehaved? what kinds of things did you worry about or made you afraid?
- Describe yourself as a teenager

**Perception of home and family involvement in the community**
- Tell me about any moves of home as you were growing up
- Describe the area(s) where you were brought up? Did your family have friends locally?
- Describe what your home was like. Where did everyone sleep?
• Was there enough money for food, clothes and toys for everyone, and did the family have heating and light and cooking facilities?
• What kinds of things did you play, and who did you play with? Were you involved in any activities or sports outside the family?

Reflections on childhood
• Overall, what kind of childhood do you think you had?
• Tell me what you think your parents did right when you were a child.
• Would you have wanted them to do anything differently? If so, what?
• What do you think you have learned from your childhood about yourself?
• What do you think you learned from your childhood about being a parent yourself?

Education
Exploration of the parent’s experience of school and education will contribute to an understanding of their overall experience of childhood and adolescence. It may also contribute to an understanding of educational and social opportunities available to them as they were growing up; their emotional, social and behavioural development; how they view education; and provide an indication as to whether a parent may have learning difficulties. Your assessment needs to consider the significance of the information ascertained in relation to parenting capacity.

Areas to explore and consider:
• Type of schooling
• Statement of special educational needs or any special educational provision
• Attendance
- Educational achievements, aptitudes, qualifications and any difficulties in attainment
- Relationships with other children
- Relationships with teachers and other adults in school
- Reasons for changes of school (other than transfer from primary to secondary) for example, re-location from another country, frequent moves, victim of bullying, exclusion
- Attitudes to education/learning

The parent should be encouraged to provide a narrative through open-ended questions such as “Tell me about your time at school” or “How did you get on at school?” with exploration of the responses. Where the parent provides limited information, practitioners may find the following prompts helpful:

- Tell me which schools you went to and what kinds of schools they were
- Tell me about your memories of school. Describe what it was you liked/disliked about nursery/primary/secondary school/college.
- Tell me about your attendance at school. If there were any difficulties associated with attendance - could you tell me the reasons
- Tell me about the reasons for any changes of school
- How did you find schoolwork? Which subjects did you like and could you explain why? Which subjects did you find difficult and could you explain why?
- Tell me about any learning support you had
- Describe your achievements at school. What were you proud of?
- Who would you say encouraged or helped you?
- Tell me about any qualifications/exam passes you achieved
- Describe the part of your school experience you found the most challenging
- Describe your relationships with your teachers and other adults at school. How do you think your teachers would have described you?
Tell me about any times you were in trouble at school
Tell me about your friends at school. What do you think connected you together? How do you think your friends would have described you?
Tell me about any after school clubs or extra-curricular activities you were involved in
Describe any difficulties there were with other children at school
How old were you when you left school? What were your plans when you left?
Tell me about any courses followed/qualifications achieved after leaving school, such as full-time or part-time study/vocational courses or training/re-training
Describe any current or future plans to access any further study/training. Are there any barriers to you pursuing such plans?
Looking back, how would you describe your overall experience of education/learning? Is there anything you would want to change? Would you have done anything differently?

Employment
Exploration of a parent’s history and experience of employment/unemployment may contribute to an understanding of their sense of identity and self-esteem, whether employment is a source of satisfaction or stress; and whether unemployment or barriers/restrictions to employment is a source of stress. Themes may emerge in relation to how a parent relates to others; and their determination and ability to commit to and sustain plans. Current work patterns of the parent(s), and any other adult in the household, should be considered in relation to the impact on the care of the child.

Areas to explore and consider:
• Current work pattern and child care arrangements
• Nature and security of employment (zero/short term contracts, cash in hand)
Duration of periods of employment - how jobs end (short term contracts, parent walked out/fell out with colleagues and/or managers/told to leave)

Any barriers to working (ill-health, disability, restrictions due to immigration status)

How employment/unemployment is viewed

Practitioners may find the following prompts helpful in exploring the parent's history and experience of work:

- Are you currently in work?

_If currently working:_

- Is your work paid or unpaid? Do you have a contract?

- Describe the nature of the work you do and your current job/role. Describe what you like or do not like about your job. Is the work you do different from the ideas you had when you were growing up, and if so, how? What would be your ideal job?

- Tell me about the hours you work and where you work.

- Tell me about any arrangements you make for the care of your child(ren) while you are at work.

- How long have you been in your current job?

- Tell me about your previous jobs (dates if possible) and the reasons those jobs ended. Could you explain what it was about those jobs that meant you liked or disliked doing them? Could you tell me about the reasons those jobs ended.

_If not currently working:_

- Tell me about any work you have done previously (dates if possible). Could you explain what it was about those jobs that meant you
liked/disliked doing them? Could you tell me about the reasons those jobs ended.

- Tell me about any plans to return to work or any form of training. What would be your ideal job?
- Describe any barriers to you finding work

**History of relationships**

Exploration of a parent’s relationship history may assist in understanding how a parent perceives themselves and their expectations of adult intimate relationships, as well as their ability to form and maintain stable relationships. Unstable relationships would include multiple relationship breakdowns, or a history of relationships characterised by repeated infidelity, high levels of conflict and/or domestic abuse or violence (as perpetrator or victim). It is important to explore any patterns that emerge, for example, if the relationship history indicates that a parent has a history of aggressive behaviour within intimate relationships, or indicates that a parent may be vulnerable to abuse, or not discriminating in their choice of partners. The analysis needs to consider how any relationship strengths or problems impact on each child in the family. Where domestic violence is a concern, practitioners should refer to the additional guidance in Section 3, and consider the safety of the children and the non-abusing partner. You may find it helpful to use the Barnardo’s DVRIM and/or the SafeLives DASH Risk Assessment checklist to aid your assessment and/or the Duluth Power and Control wheel. Where a child’s parents are separated, consideration should be given to the arrangements for residence and contact and to what extent the needs of the child are prioritised.

Exploration of the parent’s relationship history needs to be tailored to the structure of the family, sensitive to the family’s particular circumstances and responsive to the parent’s account of their relationship history as it emerges during the interview. The language used needs to be sensitive, and terms such as `domestic abuse` or `domestic violence` may need to be explained. It may be appropriate to explore aspects of the current relationship with both
parents (or parent and partner) together, but where domestic violence is known or suspected, the safety of the non-abusing parent must be considered and a joint interview may not be appropriate.

Your assessment should include the following:

- The parent’s account and perception of their previous relationships (strengths and difficulties) and reasons for these relationships ending
- The parent’s account and perception of their current relationship (strengths and difficulties) and any aspects they feel need to change
- Any collateral information about the parent’s current or previous relationships, including any evidence of domestic abuse or violence (such as information from other agencies, police call-outs)
- Roles and dynamics in the current relationship between the parents (or parent and partner), including direct observation
- How the parental relationship history impacts on each child in the family (be specific and consider positive and adverse effects)
- Parental insight into any difficulties they have experienced in relation to intimate relationships and insight into the impact on the children

**Relationships with previous partners**

The parent should be invited to tell you about all previous significant intimate adult relationships, and exploration should include:

- Who the relationship was with, and at what stage of their life this was
- How they met, and how the relationship developed
- The identity and dates of birth of any children of the ex-partner from previous relationships, the children’s living arrangements and any arrangements for contact
• The identity and dates of birth of any children the parent and ex-partner had together, the children’s current living arrangements and any arrangements for contact with the ex-partner

• The parent’s account of their respective roles in looking after any children who were resident with them, and/or any children spending time with them as part of a contact arrangement

• The parent’s view of the positives and any difficulties in the relationship

• The parent’s account of any form of domestic abuse within the relationship as victim or perpetrator (e.g. nature, severity, frequency, circumstances – including whether any children were in the home – and the nature of any help/support they accessed)

• The parent’s view of how the children may have been affected by any domestic abuse (both at the time and in the longer term)

• Any collateral information indicating domestic abuse in the relationship should be raised and explored if the parent does not refer to it

• How long the relationship lasted, and the parent’s view of why it ended, and how if affected them and the children

• What the parent feels they have learned from their past relationships

Current relationship

The parent should be invited to tell you about their current relationship, and exploration should include:

• How and when they met, and how the relationship developed

• Whether their partner lives at the family home, and if not, how much time their partner is spending at the family home

• The identity and dates of birth of any children of their partner from previous relationships, their living arrangements and any arrangements for contact
The identity and dates of birth of any children they have together, and if any of the children do not live with them, their living arrangements and any arrangements for contact (for example, if a child lives with a member of the extended family, or is placed with foster carers, or has been adopted)

Roles in relation to the running of the home and looking after the children

How important decisions are made in relation to the children and their upbringing

Who manages the family income and how decisions are made about what the money is spent on

The parent’s perception of their partner and how they think their partner would describe them

The parent’s view of the positives and any difficulties in the relationship and how they think their partner would describe their relationship

The parent’s account of the kinds of things they disagree about and what usually happens when they disagree

The parent’s account and view of any form of domestic abuse within the current relationship as victim or perpetrator (e.g. nature, severity, frequency, ‘triggers’, circumstances – including whether any children were in the home – whether substance misuse was involved, whether weapons were used, and the nature of any help/support accessed)

The parent’s view of how the children may have been affected by any domestic abuse (both at the time and in the longer term)

Any collateral information indicating domestic abuse within the current relationship should be raised and explored where this differs from the parent’s account

The parent’s view of the future of the relationship and any plans

Whether the parent considers the relationship needs to change and if so, in what way, and how they think such change could be achieved
Physical health
Include in this section a brief outline of any history of serious injury and/or significant medical condition. Consider any medical reports available. Outline the implications, if any, for the parent in relation to their day to day living, including any emotional impact. Specifically assess whether, and to what extent, any significant medical condition affects/potentially affects the parent’s capacity to meet the needs of the child(ren), but it is important not to assume an adverse effect. If the parent has a life-threatening or terminal illness, consider the potential emotional impact on the parent(s) and the child(ren), and whether appropriate support is available to them.

If an injury or medical condition may be a factor in reducing a parent’s ability to care for their child(ren), subject to the parent’s consent, consideration should be given to further advice and, where relevant, assessment from appropriate health professionals such as GP, Consultant, Occupational Therapy, Physiotherapy. Practical support and services, such as appropriate equipment, environmental adaptations or domiciliary services may provide assistance with aspects of practical parenting. The key points of any health professional’s report should be referred to within the assessment. Explore whether the family is accessing, or wishes to access, support and information through relevant voluntary organisations, for example, the Positive Parenting and Children Project (http://ppclondon.org.uk) which provides support for families living with HIV/AIDS; the Multiple Sclerosis Trust (www.mstrust.org.uk); Arthritis Care (www.arthritisicare.org.uk).

Areas to explore and consider:
- The parent’s perception of their overall physical health
- The nature of any serious injury, when sustained and whether there is any ongoing impact on functioning
- The nature of any significant medical condition, when and where diagnosed, any prolonged hospital admissions, the nature of any ongoing treatment, including medication, prognosis
• Are there any ways in which the parent’s medical condition makes it more difficult for them when carrying out daily activities, including looking after the child(ren)?

• Any emotional impact on the parent and/or other family members

• Explore and consider any factors promoting the resilience of the child and other family members

• The nature of any support available (family and friends, voluntary/professional services or resources)

• Where a child/young person is involved in the care of a parent, assess whether there is any emotional, social and/or educational impact, if any. How is the child/young person supported? Is additional support required, for example, via Southwark Young Carers?

Cognitive ability
Where there is no evidence to indicate any cognitive impairment, state this under this heading.

Where it is known or suspected that a parent has a learning disability or significant learning difficulties refer to the detailed guidance in Section 3. Include any relevant information from the Community Learning Disabilities Team, where appropriate.

Where an assessment of cognitive ability is available include the significant findings and recommendations and, if not included elsewhere, identify how the parenting assessment process was tailored to take account of the parent’s specific learning difficulties. Append any reports in relation to cognitive ability to your report. In your analysis of this section, you need to be specific as to how, and to what extent if any, your assessment indicates that the parent’s cognitive impairment impacts on their capacity to meet the needs of the child(ren), and the evidence for this.
Where it is suspected that a parent has a learning disability or significant learning difficulties and a cognitive assessment is considered necessary to inform the parenting assessment but the parent has not consented to this you should record this. You will need to seek legal advice if the matter is in formal pre-proceedings or care proceedings. You will need to set out in your report the reasons for believing the parent may have learning difficulties and any reason given by the parent for not consenting to a cognitive assessment.

**Mental health**

This section should include an outline of any history of mental health problems and any current problems. Include any diagnosis of Personality Disorder. Include any past or current involvement with mental health services, including hospital admissions, compliance with medication or other treatment/therapy where relevant, parental understanding of any mental health problems. Include any history of violent behaviour, self-harm or suicidal ideation. Consider any impact of mental health problems on parenting, and any impact on the parent-child relationship, and on the safety, health, development and physical, emotional and social well-being of the child. Include and consider the key points of any reports from mental health services, or any independent psychiatric reports in your assessment.

Where a parent is not known to mental health services, but it is suspected that s/he has a mental health problem that is impacting on parenting, talk with the parent about them seeking help from their GP or from adult mental health services. In some circumstances, consideration may need to be given to commissioning an independent psychiatric assessment, subject to the consent of the parent.

**Assessment process**

The parent should be invited to tell you about any mental health difficulties in the past or at the present time. If the parent reports any difficulties sensitively explore with them:

- The nature of any difficulties and whether there has been a formal diagnosis
• When any difficulties started; how long these lasted; whether difficulties have recurred

• The nature of any current difficulties and the parent’s perception of their current mood

• Any history of self-harm, current or past suicidal ideation, or past suicide attempts; any history of violent behaviour, particularly when unwell

• The nature of any treatment (medication, voluntary or compulsory admission to hospital) and/or therapy and/or counselling; any past or current involvement with mental health services; any involvement with voluntary organisations (such as Mind or SANE); any `self-help` strategies; the parent’s perception of the effectiveness of any treatment/therapy/other intervention/support

• The nature of any specific circumstances that seem to `trigger` episodes of mental ill-health or make this worse. Does the parent feel there is a pattern?

• The parent’s perception of how any difficulties have affected them, their partner where relevant and their child(ren)

• The role of any other adults in the care of the child(ren)

• The nature of any informal support (e.g. from wider family/friends/neighbours)

Where the parent describes a history of mental health problems, or where there is collateral information indicating a history of mental health difficulties, refer to the additional guidance in Section 3 as well as the guidance below. The consent of the parent should be sought to contacting their GP, mental health services and other relevant agencies for the purposes of the assessment. Where a parent refuses consent, attempts should be made to ascertain the reason for refusal, but consideration will need to be given as to whether the safety and welfare of the child requires the sharing of information.
The reason for any decision to seek information against the wishes of the parent should be recorded.

In undertaking a parenting assessment where a parent has mental health problems:

- The aim is to assess any impact of the parent’s behaviour and presentation on the child’s experience and on the quality of parenting in relation to the child’s safety and their physical, emotional, behavioural, social and educational development - do not be too distracted by any diagnosis the parent has received

- Ensure effective communication, consultation and joint working between Children’s Services and Adult Mental Health Services in order to facilitate a robust and holistic assessment and ensure that appropriate resources and treatment are available to the parent

- Direct observation of the parent’s mood, presentation and relationship with each child is an important part of the assessment

- Involve the child in a way that is consistent with their age, stage of development and understanding

- Incorporate other elements of the assessment, for example, the parent’s experience of childhood; cultural and religious beliefs; physical health; social circumstances; quality of relationships with others (parent-child, parent-partner, wider family, other adults); any history of substance misuse; any history of domestic violence; history of offending

- Consider the role of the other parent/partner/other family members in the care of the child. Does the other parent/partner or any other member of the household experience mental health problems or other difficulties?

- Consider social and environmental circumstances, such as low income, poor housing, social isolation

- Consider the parent’s cultural background and any religious or spiritual beliefs
• Consider the safety of practitioners and whether a staff safety risk assessment is needed
• Ensure critical reflection in group supervision to avoid the influence of assumptions and stereotyping

Assessing the nature of any potential impact
• Consider the nature, severity and pervasiveness of parental mental health problems. Does it affect all aspects of parenting? Is there a history of violence and/or suicide attempts? Is there evidence of impulsivity?
• Consider the pattern and duration of mental health problems (single or recurrent episodes? unpredicted rapid onset? how long do episodes last? when have the episodes occurred in relation to the child’s life span? (draw a timeline)
• Consider the child’s involvement in and exposure to parental symptoms, for example, violent behaviour, self-harm or suicide attempts. Is the child incorporated into a parent’s delusional thinking or thoughts of self harm? Is the child the direct or indirect target of violent behaviour?
• Consider the parent’s perception of any mental health problems and the degree of insight into their mental health, whether they are able to identify when they are becoming unwell and whether they seek help
• Consider any side-effects of current treatment (e.g. anti-psychotic medication can cause lethargy and drowsiness)
• Consider advice from mental health professionals in relation to the likely effectiveness of any plan for treatment/therapy in modifying the symptoms and behaviours
• Consider the history of engagement with services and compliance with treatment and the reasons for any non-compliance
• Consider how and to what extent other areas of difficulty may be impacting on a parent’s capacity to meet the needs of the child such as substance misuse, learning disability, domestic violence
• Where there is concern about the immediate safety of a child, appropriate safeguarding procedures should be followed

Assessing strengths and protective factors
• Positive and effective engagement with professionals and compliance with treatment plans
• Identify any adults within the family/friend network who provide positive support to the parent and/or the child. Who understands the parent’s condition and is able to identify when the parent is becoming unwell? Who ensures the child is safe and appropriately looked after?
• Identify resilience factors such as the child’s cognitive development, emotional and social maturity and understanding of what is happening. Consider ways in which the child’s resilience might be enhanced
• Identify resilience factors in relation to the parent, such as problem solving skills, positive self-esteem, responsible attitude
• Identify protective factors in the child’s situation, such as the availability of a protective adult to whom the child is attached (e.g. partner, member of the extended family); school attendance; involvement in extra-curricular activities; a reliable plan for the care of the children at times when the parent is unwell; involvement with Southwark Young Carers. Are there additional protective factors that can be put in place?
• Identify the nature of any other support or intervention for the parent/partner/child that is likely to reduce or minimise any identified risks to the child

Analysis
• Be specific about the nature of any harm, or risk of harm, to each child in the family and the evidence for this. Identify what factors are likely to increase or reduce harm
• The analysis needs to be clear in identifying and weighing up the risks, strengths and protective factors. Evaluate the developmental trajectory for the child if the situation remains unchanged. Set out your
assessment of whether any necessary change is likely to take place within a timescale consistent with the developmental needs of the child

Talking with children
It is important to try to sensitively explore with children their experience of living with a parent who has mental health problems and any implications for them, for example:

- Their understanding of their parent’s mental health problems, and their beliefs about what has caused the problems
- Any changes in their parent’s behaviour when unwell
- Any changes in their relationship with their parent when unwell
- Any additional responsibilities they are given or take on
- Whether there are any implications for school attendance or friendships
- How they see the future
- Their feelings - this might include feeling upset, missing a hospitalised parent, frightened, anxious that they are to blame for their parent’s problems, or that they will become ill themselves
- Their wishes and views about their circumstances

Being given age-appropriate information and explanation about their parent’s mental health problems is usually experienced as helpful by children and young people. This can assist a child to understand that they are not the cause of their parent’s illness; help them to recognise changes in the parent and in the parent’s interaction with them when symptoms recur; and help them to respond to questions from other children. Children need the opportunity to ask questions.

Books suitable for children may facilitate discussion, and a list of some of the books available is accessible on the website of the Royal College of Psychiatrists.
Psycho-social functioning
The parent should be invited to provide a description of their general mood; how they perceive themselves including how they think others perceive them (e.g. personality, attributes and abilities); how they feel they relate to others; how they address problems; how they express emotions, such as upset or anger; and whether they usually think before acting. They should be asked to describe how they see the future and any plans they have.

It is important to observe the parent’s presentation and emotional functioning and to consider information from other elements of the assessment, together with any collateral information regarding the parent’s emotional or psychological functioning. It may be helpful to structure your analysis in terms of resilience and vulnerability factors, and how these impact on parenting capacity.

Where a psychological assessment has been undertaken, or a risk assessment using the FRaSA, this will inform your assessment. Where this is not available, and you consider further exploration of aspects of a parent’s emotional functioning is required, the use of selected questionnaires and scales may help to inform your assessment (refer to Appendix 12). However, these should not be relied upon as a sole means of assessing a parent’s psychosocial functioning.

Areas to explore and consider include:

- Self-esteem: a parent with good self-esteem is more likely to be able to approach challenge positively, including the challenges of parenting; they are more likely to be able to re-frame adversity. A parent with poor self-esteem may have low levels of emotional energy; may find child care responsibilities and behaviour management more difficult; they may doubt their ability to effect change.

- Ability to empathise: the ability to empathise is an essential element in understanding and responding to the needs of a child, and to promoting a secure attachment.
- Problem-solving skills: a parent with good problem-solving skills is more likely to be able re-frame adversity, and overcome difficulties in parenting. This may link to self-esteem, the ability to be organised and the ability to think and behave flexibly.

- Rigidity: Parents who are rigid have set attitudes and expectations of children’s behaviour and appearance, and impose these, rather than responding to the emotional needs of a child in the context of particular circumstances. The parent may use physical or psychological coercion to control their children’s behaviour and expression of emotion to make them fit a rigid standard defined by the parent. Children may therefore lack the experience of warmth and affection.

- Impulsivity: This is the tendency to act with less forethought than most other people. It may be characterised by fluctuations in mood, demeanour or behaviour within short periods of time (hour to hour, day to day, week to week), such that their behaviour and reactions are hard to predict. Impulsive people may display both negative and positive over-reactions. Parenting is likely to be inconsistent, chaotic and unpredictable. Such parenting impedes the development of a secure attachment, and may lead to the child experiencing a range of emotional and behavioural difficulties as they grow up. Impulsivity may also lead to disinhibition, interpersonal instability and anti-social behaviour which may also impact on parenting.

- Emotional loneliness: Parents who feel particularly lonely or socially isolated are likely to have low self-esteem, may be under-assertive and may have difficulty coping with their own negative emotions

- Hostility and aggression: Aggressive and violent behaviour can have a significant impact on parenting capacity. It affects a parent’s interpersonal relationships and social interaction. Children may witness violent or abusive behaviour, causing emotional harm, or be subject to physical or emotional abuse themselves. Any history of violent behaviour should be fully explored with a parent. One of the most common research findings is that those with a history of violence
are much more likely to engage in future violence than those with no such history.

- Plans: Consider the feasibility of the parent’s plans. Does the parent feel they are responsible for trying to achieve their plans? Does the parent feel that they should bring about change in themselves, or effect change in their situation in order to meet the children’s needs?

**Use of alcohol and illicit drugs/other substances**

This section should include the parent’s account of any current or past use of alcohol and/or illicit drugs/other substances; an exploration of any substance misuse where this is indicated; any evidence of the impact on parenting, and on the safety, health, development and well-being of the child(ren).

The parent should be invited to tell you about whether they drink alcohol or use any drugs at the present time, or have done in the past. The nature, frequency, amount, pattern and circumstances of any use can then be explored. Explore with the parent any discrepancies between their account and information from other sources.

Refer to the detailed guidance in **Section 3** where there are indications of parental substance *misuse* arising from:

- the parent’s account and/or
- information from the child(ren)/other family members and/or
- other involved agencies and/or
- the nature of any offending history and/or
- police call outs and/or
- tests results for drug/alcohol

It is important to be specific during the assessment and in your report about the nature, extent and pattern of any substance misuse, the impact, any potential risks and strengths. Explore and assess:
• How the parent’s substance misuse affects them, their perception of their substance misuse, their understanding of the impact on themselves and others, their motivation and ability to change, their insight into factors that increase their vulnerability to substance misuse/relapse

• Is the parent meaningfully engaged with treatment/support services to address substance misuse? How effective has any intervention been in reducing harm?

• How does the parent’s substance misuse impact on their ability and availability to meet the child’s needs? Assess the quality of the parent-child relationship. Identify positive aspects of parenting as well as any deficits

• How has the parent’s past or present substance misuse affected the safety, health, development and education of each child? Specify the evidence for this

• How does parental substance misuse impact on family life (relationships; routines and rituals; stability of accommodation; home conditions; provision of food, clothes, warmth)

• Does the other parent/partner or any other member of the immediate or wider family misuse substances?

• The role of the other parent/partner/other family members in the care of the child

• The attitude of the other parent/partner/other family members to the substance misuse e.g. constructive or collusive, is there conflict, is there evidence of a family ‘culture’

• The presence of any other risk factors, for example the co-existence of mental health difficulties, domestic violence, criminality

• Resilience and protective factors

Analyse and summarise the importance of the above in relation to parenting capacity.
Criminal record/police involvement

It is essential to obtain full details of a parent’s criminal record and sentencing, including cautions, warnings, reprimands and outstanding charges. Practitioners should formally request information from the police, preferably in the form of a Police National Computer (PNC) print out where possible, to supplement and check the information given by a parent in interview. A caution means that a person has accepted that they have committed an offence and the police have considered that a caution is an appropriate response, rather than pursuing a prosecution through the Court. Where a parent has a criminal record, it is essential to request information from the Probation Service, as well as the police. Probation pre-sentencing reports are often a valuable source of information. Include any evidence of failure to comply with conditions/sentencing such as bail conditions/ supervision by Probation.

It is important to consider the nature, modus operandi and context of offences. CRIS (Crime Reporting Information System) reports, if these can be obtained from the police, or information from the Probation Service, can often help with this. CRIS reports also provide information about allegations where the police/CPS have considered that there has been insufficient evidence to obtain a conviction if the matter is taken to Court, or where allegations have been withdrawn. It is important to distinguish allegations, which have not been proven, from cautions or convictions. However, if there has been a series of allegations, for example, of assault, it may be of value to ask questions of the parent as to why they think a series of allegations have been made against them. Include any history of police involvement in relation to incidents of alleged/reported domestic violence. Include any history of convictions for cruelty to animals.

Particular attention needs to be given to any convictions for any offences included in the List of Offences that may present a risk, or potential risk to Children (refer to Appendix 11). This replaced the use of Schedule One Offences. The Home Office Guidance on offences against Children (Home
Office Circular 16/2005) advised that the automatic identification of an offender who had been convicted of a Schedule One offence had been insufficient in identifying those who *continue* to present a risk to children. Rather the List of Offences should operate as a trigger to a further assessment to determine if an offender should be regarded as presenting a continued risk of harm to children. Please note that the List of Offences includes offences against adults as well as children, and is not limited to sexual offences, for example, it includes assault and battery, and wounding with intent to cause grievous bodily harm. Where the parent has committed any of the offences included in this list, it is important to explore these in detail in interview with the parent. A parent with a history of violent offences against adults may be assessed as posing a risk of violence to a child, but the risk is likely to be elevated if s/he also has a history of offending against a child (for example, kidnapping).

The parent should initially be asked for their own account of any criminal history. Where the information provided by the parent differs from information from professional sources, it is important to ask the parent for an explanation of this. The assessment process should include an exploration of the parent’s attitude to their history of offending behaviour, and any remediation attempts, such as Probation, or a Drug Rehabilitation Requirement (DRR).

At the end of this section, analyse all the information available in respect of the parent’s forensic history, and summarise the significance of this in relation to the impact on parental capacity. The following are examples of issues to consider, but this is not an exhaustive list:

- Does the criminal history indicate there is a direct risk posed by the person to a child or children in the family through violent behaviour/sexual offending?
- Does the parent accept responsibility for their actions or deny any offences despite conviction? Denial is generally considered to increase
the risk of recurrence and prevents engagement with services that might reduce the level of risk;

- Is there evidence of empathy, or no indication of empathy, with the victim of offences?
- Convictions involving drugs and alcohol provide evidence about parental lifestyle;
- Convictions for drug-dealing may mean the home is an unsafe place for a child;
- Parent-parent or parent-partner offences of violence provide evidence regarding the nature of adult relationships, and may pose a direct or indirect risk to the child through exposure to incidents of domestic violence;
- Is there an impact on parenting of repeated custodial sentences?
- Is the history of offending indicative more generally of antisocial attitudes and behaviour?
- Criminality may be associated with the presence of other risk factors, including psychopathic or antisocial personality disorder, problems with supervision, attitudes that support or condone violence and problems with substance use;
- Offending behaviour and resulting legal problems may cause negative affectivity (i.e. negative emotions such as anger, contempt, disgust, guilt, fear, anxiety) and interpersonal conflict, which in turn may increase the risk of abuse and neglect;
- A history of neglect or assault of an animal indicates further exploration is needed to assess whether this represents an increased risk of neglect or maltreatment of a child (Hackett and Uprichard 2007).

Prompts that practitioners may find helpful:
- Could you tell me if you have ever committed any offences, or had any involvement with the police? Please tell me about any convictions by
the Court, and cautions or warnings by the police with approximate dates, and what sentences you received.

- Could you tell me about any other occasions when the police have been involved, for example if someone has made an allegation against you, but no charges were brought?

*If there is evidence of criminal history:*
- Tell me how old you were when you first started offending. Could you explain for me what led to you beginning to offend?
- Could you tell me about (identify each) offence (i.e. describe what you did)?
- Could you tell me how you think (identify each) offence affected the victim?
- Describe for me what was happening in your life at the time of (identify each) offence
- Could you explain to me how you feel when you think about the offences you have committed?
- Do you have any outstanding charges or court appearances at the moment? If so, are there any bail conditions in place?
- Could you tell me about any counselling you have received or any courses you have attended in respect of your offending behaviour? Explain to me what you feel you learned
- Tell me what impact you think your offending behaviour has had on your relationships with others (e.g. partner, family members)
- Tell me what impact you think your offending behaviour has on your parenting ability
Part Seven: Family Culture, Relationships, Support Network, Social Integration and Resources

Consider how to explore aspects of the family’s identity, roles, relationships and support networks, and whether this can be undertaken during a family meeting/while developing a genogram/drawing up an eco-map. Be mindful that some information may not be appropriate to discuss with the parents in the presence of the children.

Family Identity

A family’s culture can be individual to them (their particular norms), or sit within a wider context (with others who share similarities such as geographical location, language, traditions and beliefs). Culture can greatly influence how a person views the world in which they live, engages in relationships and raises their children. Therefore, developing a good understanding during the assessment of the family’s cultural values, and the distinct set of expectations and rules of that particular culture, is essential. Over-reliance on cultural explanations for behaviour and circumstances, however, is not helpful. Doing so means that cultural bias develops, with associated stereotyping and assumptions. The focus should remain the impact on the safety and well-being of the child.

If the assessing practitioner is from the same ethnic or cultural background as the family being assessed, it may be easy to make assumptions about shared meaning or understanding regarding cultural norms. However, it is essential to remain curious to ensure that the family is encouraged to communicate freely in support of understanding their distinct family customs and values. If the assessor does not share the same culture as the family, acknowledging difference and inviting them to tell their story will assist in creating meaningful engagement.

Practitioners need to be mindful of how families can be affected by oppression and inequality in relation to factors such as socioeconomic status, race, class, gender, religious ideologies, sexual orientation, age or ability. People may have come from oppressive situations, for example, families who may be refugees from war or political persecution and they may have experienced
threats and violence. Their experiences may influence their perception of authority and their relationship with Children’s Services and the assessing practitioner. Paying attention to difference in the context of oppression can promote better understanding. A helpful way to think about issues pertaining to inequality, and to promote sensitivity in the assessment process, is to incorporate the systemic idea of the Social GGRRAAACCEESSS, originally developed by Burnham (1993) to support understanding around privilege and disadvantage:

- Gender (Sexism)
- Geography (Location)
- Race (Racism)
- Religion (Beliefs/Faith)
- Age (Ageism)
- Abilities (Intellectual/Physical disability)
- Appearance (Physical presentation)
- Class (Social and economic position)
- Culture (Ideas and customs of a particular group)
- Ethnicity (Shared racial, religious, linguistic characteristics)
- Education (Level taught to, equal access to)
- Employment (Work/occupation/unemployment)
- Sexuality (Sexual character)
- Sexual Orientation (Sexual identity/preference/issues relating to homophobia)
- Spirituality (Matters of the soul)

Burnham argued that in the relationship between the assessor and those being assessed, non-verbalised but felt views about power differentials have the potential to impact on engagement and the subsequent outcome of the assessment (Burnham, 1993). By holding the social GGRRAAACCEESSS in mind, the practitioner takes responsibility for exploring what they may bring in relation to the power dynamic in the assessment process. Exploration of this can occur within group supervision, or with the parent(s), when a
tentative, sensitive approach is likely to be helpful as some people may feel uncomfortable with openly addressing issues of disadvantage, power and privilege.

Parents/family members should be encouraged to describe their religious beliefs and practices and how these influence family life. The following prompts may be helpful:

- Do you follow a particular religion, or do you have particular religious beliefs? Describe any ways in which you practice your religion, for example through dietary practices, by attending a place of worship, or participating in services, festivals or religious rituals
- Describe how your religious beliefs and practices affect the way you live, and if they influence the way you bring up your children
- Do you feel you or your family have been discriminated against because of your religion? If so, could you tell me about your experiences?

Parents/family members should be encouraged to describe their cultural values, expectations and traditions and how these influence family life. Practitioners may find the following prompts helpful to explore this further:

- How would you describe your cultural background? What makes your culture unique?
- Describe the parts of your culture that you appreciate. Are there things you would change if you could? If you did something different to the way that is expected within your culture, how would this be viewed by others?
- Describe the importance of “family” in your culture/religion. Tell me about any specific gender roles, and whether any roles or positions in the family are seen as having more status or authority than others
- Describe any ways you think your culture influences how you live your life
• Describe any ways you think your culture influences how you are bringing up your children

• Do you feel you or your family has been discriminated against because of your race, ethnic background or culture? If so, could you tell me about your experiences

• If your child’s other parent is from a different culture, describe the parts of your culture you would want to ensure are a key part of your child’s upbringing. What parts of the child’s other parent’s culture do you want your child to adopt? Describe how you support your child to value both cultures

• Is there anything you think you do not have to tell me because we are from the same/similar culture?

• Is there anything you think I may be missing because I do not share the same culture as you?

Family functioning, organisation and relationships

Exploring with the parents/family members the nature of family rules, the organisation of roles and the relationships within the family promotes an understanding of the way the family functions and how this impacts on each child. Observation is a key element of this part of the assessment. The following are the kinds of prompts that may support such exploration:

• How would you describe your family to someone outside the family?

• Describe the good things about your family

• Describe how your family celebrates an event (e.g. birthday) or an achievement

• Describe the family’s routines (daily, weekly, school holidays)

• Describe the kinds of activities you do together

• Describe any other things you would like to do together
Describe how roles are organised within the family (who is responsible for what). Describe any differences in the roles of each of the children.

Could you tell me what the rules are in your family? Are there different rules for boys and girls? If so, could you describe these? Who makes the rules? Describe what happens if someone does not keep to the rules.

Tell me about any things you would want to change about your family if you could.

**Relationships within the family**

Could you tell me who is like whom in your family? Describe how they are alike.

Describe how the children in the family get on together.

Who would you say shares a close relationship in the family and why do you think this is?

Who would you say shares the least close relationship in the family and why do you think this is?

Who argues with whom in the family? Describe what the arguments are usually about. What happens when people argue? How do these end up?

Describe what happens if someone in the family is feeling unhappy or has a problem. Who helps whom?

**Relationships with wider family/support network**

Consideration of wider family relationships (or the absence of ongoing connection to wider family) promotes understanding of the level and nature of support available to a parent and/or the child(ren) and whether any absence/difficulties/conflicts/hostility in the relationships is a source of stress or tension. Parents should be encouraged to explore their current relationships with their family of origin, how these have changed over time,
and to consider how the quality of the relationships may affect them and their child(ren). The parent’s relationships with their own parents, siblings and wider family during childhood and adolescence may have been explored previously (see Part Six) and this may have already led on naturally to an exploration of current relationships.

Meeting with members of the wider family and observing interaction within the wider family, where this is appropriate, safe and agreed, has the potential to provide insight into the parents’ support mechanisms, patterns of interaction and how conflict is managed or perpetuated.

Other forms of informal support, for example through friends, should be explored with the parents.

The nature of support and services from the professional system should be identified and the parent’s view of this should be explored.

Practitioners may find the prompts below helpful, but these should be sensitively adapted to what is known about the family structure and circumstances:

- Describe your relationship with each of your parents at the present time. How has this changed over time? How often do you see them? Describe your children’s relationship with them. Describe any support you feel either or both of your parent(s) give you (e.g. practical, financial, emotional)
- Describe your relationship(s) with your sister(s)/brother(s) at the present time. Who do you get on with and describe any support they give you
- Describe your relationship with the wider family of your child(ren)’s other parent. Describe your children’s relationship with them. Describe any support they give you
- Describe how any friends/neighbours support you in your parenting role
• Who in your family and friends network do you feel offers you positive encouragement in your parenting role? Who is most likely to notice if you are struggling? Who is most likely to say if they do not agree with your behaviour/actions as a parent?
• Describe any support or services you receive from any professionals involved with you and your family. Describe what you find helpful or unhelpful and can you explain the reasons you feel that
• Describe any support from anywhere else (e.g. Church, Children’s Centre)

Family Scripts
Thinking about family scripts can contribute to an understanding of family culture and relationships. Byng-Hall (1995) defined a family script as “the family’s shared expectations of how family roles are to be performed within various contexts”. He suggested that patterns of interaction in families are repeated, with minor variations, over and over again. He proposed that each member of the family has an “inner family” which helps to determine what goes on in the “outer family” (just as each member of the cast has a script for a play). He suggested that family scripts and attachment relationships are either replicated or corrected through the influence of inter-generational patterns:

• Replicative Scripts: The past is likely to be repeated; the past is made present by bringing scripts for family life from the family of origin
• Corrective Scripts: These are attempts to alter patterns of interaction from the past. For example a parent may be determined not to make the same mistakes as their parents made with them, but then find they are behaving towards their children in the same way

Byng-Hall argues that both of these scripts if followed rigidly do not promote reflection or adaptation to change. He suggests that whilst repetition is unavoidable, nevertheless, each redramatisation of a family “scene” or “drama” brings with it opportunities for finding new solutions and resolving old
problems. He suggests that the aim is for families to develop the capacity for interactional awareness i.e. each family member being aware of the nature of the interaction and how it affects other members; and that a more helpful position to strive for is an Improvised Script, where families adopt a flexible approach to new situations, allowing them to hold on to the more positive adaptive patterns from past generations, whilst integrating new coping mechanisms where needed.

Social Integration and Community Resources

Consider the wider social context in which the family is located and whether this promotes integration or isolation; exploring any factors contributing to disconnection from the local community (such as minority or refugee status) and whether the parent/family has access to religious/cultural support systems that are reflective of, or share similar experiences. Explore the view of the parent/family regarding any potential barriers to accessing community resources, such as discrimination, financial, transport, ill-health or disability. Explore with the parent/family any community resources that may be of potential benefit.

Practitioners may find the following prompts helpful, but these would need to be adapted to the family’s circumstances:

- Describe your neighbourhood and local community
- Do you feel you or your family has been subject to prejudice, harassment, discrimination or victimisation? Could you tell me about your experiences
- Do you think you or your family is isolated? What do you think are the reasons for this?
- Tell me about any community resources/leisure activities the family uses and how often
• Describe any barriers to the family using community resources/leisure activities

• Are there other community resources/leisure activities you feel would benefit members of the family?

Accommodation and home conditions
Practitioners should be mindful of how their own values impact on judgements about home conditions. Use factual descriptions of your observations in your report. Using the Home Conditions Scale may help provide an “objective” starting point to assessing cleanliness (Family Pack of Questionnaires and Scales, Appendix 12). One area of the Child Neglect Toolkit focuses on home conditions and can provide a helpful way of measuring change over time (refer to Appendix 12).

Factors to explore and consider:
• Is the accommodation adequate to meet the needs of the family?
• Is this a stable home, or does the family move frequently?
• Is there security of tenure? is there a tenancy agreement?
• Does the home have basic amenities; does it feel comfortable?
• Are the sleeping arrangements appropriate for the child(ren)?
• Is an appropriate level of privacy available for all family members?
• Do the home conditions pose a risk to the child (e.g. unhygienic, cluttered, hazardous, damp)?
• Does parental lifestyle contribute to the home conditions (substance misuse, transient lifestyle)?
• Is the home excessively clean and tidy such that the environment is sterile or restrictive for the child(ren)?
• Who is responsible for maintaining the home? Are there age-appropriate expectations on the child(ren) to help?
• Are other factors influencing the home conditions such as -
  o parental attitudes arising from their experience of home conditions as they were growing up
- parental physical/mental ill-health, physical or learning disability
- poverty, no recourse to public funds
- landlord failing to maintain the property
- overcrowding
- other people frequently staying at the property

- Does the parent understand any concerns about the home conditions, and how is the parent planning to address these?

Financial circumstances

Financial difficulties can greatly impact on family functioning. A range of factors may contribute to financial difficulties, such as low income, supporting members of the wider family abroad, poor management/prioritisation of finances. It is important to identify whether the family’s financial circumstances are provisional and likely to improve, or critical and indicative of a longer term pattern.

Areas to explore and consider:

- Income (wages, salary, benefits, child maintenance): is the family receiving all the benefits they are entitled to; identify the source and amount of income if the family has NRPF
- Essential outgoings (e.g. rent, utilities, food, clothing)
- Is income sufficient to meet the family’s needs?
- Who is in charge of the finances (who decides how money is spent)? Is there any indication that this may be controlling or coercive in nature?
- Evidence of financial difficulties (debts, unpaid rent)
- Reasons for any financial difficulties (e.g. difficulties with benefit claims; limited income due to NRPF; non-essential expenditure such as drugs/alcohol/gambling/impulsive purchases)
- Impact of the family’s financial circumstances on the children
- Parent’s approach/plan to addressing debts e.g. has specialist help been sought?
Part Eight: Parenting Knowledge, Style and Relationship with the Child

History of parenting

Briefly summarise information regarding the history of parenting of any child not subject to the assessment, for example, where a child resides with another parent or other family member; or where an older child has previously been removed from the care of the parent.

In respect of the child(ren) subject to this assessment, include here positives and concerns in relation to the provision of basic care, meeting the child’s health, developmental and educational needs, their emotional, social and behavioural needs, promoting a positive sense of identity and positive relationships with significant others, including where appropriate a non-resident parent. Consider the extent to which a parent has met any special needs a child has. Include any harmful behaviour by the parent towards any of their children, and the parent’s history of keeping their child(ren) safe, including protection from actual or potentially harmful behaviour by others. Consider provision of stability, including consistent and continuous care, reliable housing, stable partner relationships and keeping in contact with important family members.

Identify any factors that have impacted upon the capacity of the parent to meet the needs of their child(ren) at any stage (e.g. substance misuse, episodes of mental ill-health, learning disability, involvement in a relationship characterised by domestic violence).

Parenting knowledge, style and the meaning of the child

Practitioners should explore the parent’s understanding of the range of a child’s needs; their basic knowledge about child development and developmentally-appropriate activities, self-care skills and age-appropriate independence. The parent’s relationship with each child includes their perception of the child; the meaning of the child, the parent’s reflections on parenting, and the quality of the interaction between the parent and the child.
Practitioners should acknowledge that some children are more difficult to parent than others by virtue of a fractious temperament, high activity levels, illness or disability, or a previous history of being physically or emotionally abused or neglected. Nevertheless, the task of parenting remains that of meeting each child’s particular needs and it is important to assess whether the parent has the capacity to meet those needs with appropriate support.

**Parenting knowledge and understanding**

Parents who understand developmental issues are less likely to be as upset by normal behaviours and more likely to support the child to meet the challenges of each developmental stage. They are more likely to help children cope with and overcome the normal fears and anxieties associated with each stage (Fahlberg, 1991).

Where a parent has been assessed as having a learning disability or significant learning difficulties, the assessment should incorporate a PAM assessment by a practitioner trained in using this framework. A PAM assessment should be used in conjunction with the Southwark Parenting Assessment Framework and should not replace it. It can also be helpful to use selected elements of the PAM Parent Booklet and/or Knowledge Cartoons, in consultation with a practitioner trained in using the PAM Framework, in assessing any parent with vulnerabilities.

Practitioners may find the prompts below helpful in eliciting the parent’s knowledge and understanding of child development.

- Tell me about the different reasons a baby might cry.
- Describe the physical needs a child has as s/he is growing up.
- Describe the emotional needs a child has as s/he is growing up.
- Describe ways in which a child might learn.
- Describe the benefits for a child in going to school regularly.
- Could you give me some examples of the kinds of things you consider to be a child misbehaving?
• Describe how you have dealt with (or would deal with) a child misbehaving at different ages e.g. at 2, 5, 10, and 15 years.
• Describe how a parent might encourage a young child to play.
• Describe ways you can encourage a child to develop a sense of self-confidence and self-esteem.
• Describe ways you can encourage a child to become more independent as they get older.
• Describe how children/young people should be educated about sexual matters.

Parent’s perception of the child and the meaning of the child

When assessing the parent’s emotional relationship with the child, consideration should be given to positive and negative feelings towards the child, and the parent’s ability to understand the basis for those feelings. The parent’s feelings may be influenced by the meaning of the child, which reflects any special psychological significance the child represents because they are, consciously or unconsciously, associated with other significant people or events. Examples might be the child whose birth coincided with the loss of a close family member, whose characteristics remind the parent of another person, or whose conception was unwanted, or conceived through rape/incest. Practitioners need to be sensitive to these possibilities. Some meanings can dominate the parent-child relationship and be associated with maltreatment, such as if a difficult birth left the mother feeling helpless and damaged by the baby, or when the parent perceives the child as failing to make up for emotional deficiencies in their own life. Parents need to demonstrate a genuine interest in the child’s well-being and experiences, and a capacity for empathy with the child. In order to prioritise the child’s needs over their own, the parent must view the child as a person in their own right, who has different needs, emotions, experiences and expectations from them (Reder et al, 2003). Cultural beliefs may also contribute to the meaning of the child, for example, some cultures hold the male child, particularly the eldest, in higher regard, which may have an impact on the parent's feelings towards a female child (Reder & Duncan, 1995).
Practitioners therefore need to consider and assess:

- What are the parent's feelings towards the child?
- What is the meaning of the child for the parent?
- Is there evidence in the way the parent talks about the child that s/he has empathy and is emotionally attuned to the child?
- Is there evidence in the way the parent talks about the child that s/he sees the child as having separate needs, emotions and experiences?
- Is there evidence of scapegoating a child within the family?
- How does the parent consider their own experience of being parented has influenced the parenting of their own children?
- What is the parent's understanding of the impact on the child(ren) of any neglect or abuse they have experienced, including exposure to domestic violence or substance misuse where relevant?
- Is the parent able to reflect on what they could do differently?

Practitioners may find the prompts below helpful when exploring this:

**In respect of each child in the family:**

- Could you describe your child (appearance, personality)
- Does s/he remind you of anyone? In what way?
- Tell me about the pregnancy and birth. Was s/he a planned baby? What was happening in your life at the time?
- Describe what s/he was like as a baby? As a toddler?

**Insight into the child's behaviour and mood**

- How would you describe your child’s mood most of the time?
- Could you describe the kinds of things that make your child happy/upset/angry
- Describe how it makes you feel when s/he is unhappy or angry. How does it affect family life?
- Tell me about your child’s behaviour recently. Has his/her mood or behaviour changed over time and if so, when and in what way? Can you explain the reason for the change?
- Describe how you respond to any difficult behaviour
- Is his/her behaviour different with you than your partner? If so, how?
  How does your partner respond?
- How does any difficult behaviour make you feel? How does it affect
  family life?

Parent’s reflections on parenting

Understanding the parent’s perception of parenting should include an
exploration of how the parent’s own experience of being parented has
influenced their parenting of their own children – whether they see their
parenting as mirroring that of their own parent/carer in childhood, or how it
differs, what they have learned through their own experience of parenting,
whether they have had alternative role models. The following prompts may be
helpful in encouraging parents to reflect on their parenting:

- Do you think parenting is easy or difficult? Could you explain your
  response?
- Describe the good aspects for you of being a parent
- Describe any difficult aspects of being a parent
- Is the experience of being a parent different from how you thought it
  would be? If so, how?
- Describe the most important things you offer your child(ren)
- Describe anything about being a parent you wish you could do better
- Describe how you show your child(ren) affection/comfort.
- Describe the kinds of thing your child(ren) come to you for
- How do you think your parenting of your child(ren) has been influenced
  by the way you were parented as a child? How is your style of
  parenting similar to, or different from the way you were parented?
- Could you tell me what or who else has influenced you in the way you
  parent?
- Describe what you have learned from your own experience of being a
  parent
Observation of parent-child interaction

Observations of parent-child interaction are a key element of the assessment. These may take place in the home, in the community (for example a trip to the park) or at a contact centre where a child is placed away from home. If the observation takes place at home, it is helpful to undertake observations at different times of day or during different activities, for example, when the parent is feeding the baby or putting the children to bed; when the parent is getting a child ready to go to school, or when a child has just returned from school, when the family goes to the park or shopping. Remember, interaction is not the same as “attachment”. Some children who are abused are compliant and easy to please.

The specific focus of observations will depend on the developmental stage of the child, and the guidelines below can be adapted as appropriate. Refer to Appendix 5 for an outline of Attachment Theory and to Appendix 6 for models that may help you structure and reflect on your observations of parent-child or parent-infant interaction.

It is important to note in respect of each child:

- Whether the parent meets the child’s basic care needs in a timely and developmentally appropriate way, for example, feeding, providing food/drinks, nappy-changing, ensuring the child is not too cold or hot.
- Whether the parent is able to ensure the safety of the child, for example, ensuring a child is strapped in a buggy, being alert to hazards in the environment for an active toddler.
- Whether and how the parent shows emotional warmth to the child, and how the child responds. Does the parent place undue demands on the child for a response? Does the parent seem to enjoy being with the child? Is the parent sensitive and responsive to the child’s needs? How does the parent react if the child is upset? Is there evidence of mentalising and recognition of the child’s cues?
- Whether the parent is child-centred and demonstrates interest in the child’s well-being. What is the predominant mood of the parent? Is
the parent focussed on the child, or distracted, bored or withdrawn? Does the parent listen to the child, and to his/her wishes?

- Whether the parent takes responsibility for providing **developmentally appropriate stimulation/activities** for the child and meaningfully engages in age-appropriate play/conversation with the child. Does the parent use age-appropriate language? Is the parent over-protective or over-directive to the extent that this limits opportunities for exploration, learning, autonomy?

- The **child's emotional presentation** – what is the predominant mood of the child? Does the child appear confident and relaxed with the parent? Does the child initiate physical contact, demonstrations of affection, conversation/play, turn to the parent for support/comfort, appear to trust the parent, show indifference or any signs of fear or anger? Does the child express likes and dislikes? Does the child smile readily? Does the child express a range of emotions?

- How clear, effective and consistent is the parent in providing **age-appropriate guidance and behavioural boundaries**? How do the parents reward good behaviour/compliance? How does the parent respond if the child disagrees or has their own opinion? Is boundary setting for example, authoritative, negotiated, manipulative, coercive?

- How the parent **responds to each child as part of a sibling group**, where relevant, and whether the parent is able to attend to the needs of more than one child in the family

- The overall **nature and quality of the relationship between each child and each parent**. Describe your observations of this.

- If you have undertaken specific training to assess the **pattern of attachment** between each child and each parent, identify the evidence for your conclusion (refer to **Appendix 5**)

- The overall **parenting style**, for example, is it child-centred, authoritative and balanced, or authoritarian, critical and intrusive, or disinterested and passive? Consider whether the parent frequently praises or criticises the child? Does the parent try to control the child? Does the parent allow the child to explore and play independently? Are
the parent’s expectations of the child appropriate and reasonable, or inappropriate and excessive? Does the parent let the child speak for themselves or do they speak for them?

At the end of this section, you need to set out your analysis of your observations. Records of observations of parent-child interaction may be appended to the Parenting Assessment Report as appropriate.

At the end of Part Eight, the information from all the above sources in relation to parenting knowledge, style and the parent-child relationship should be evaluated and analysed in terms of what it means for the parent’s capacity to meet the needs of each individual child and the children together.
Part Nine: Understanding of the Local Authority Concerns

Practitioners should assess not only the parent’s understanding of the concerns, but the extent to which the parent agrees or disagrees with those concerns, and where there is disagreement, the basis for that. Where a parent does not understand, or is unwilling to acknowledge, evidence-based concerns, the prospect of change is likely to be more limited. Motivation to do anything differently is unlikely to be present, and a parent is unlikely to engage meaningfully with any service or intervention that may help them to address the concerns.

Practitioners may find the following prompts helpful:

- Tell me your understanding of what the Local Authority is concerned about (Where a parent says they do not know, or gives a limited answer, the practitioner should explain the Local Authority’s concerns, including reference to any expert evidence)
- Could you tell me whether you agree with all or some of the concerns? If so, could you explain to me what you think has been happening that has led to, or contributed to, the concerns (identify these)
- If you disagree with all or some of the concerns, could you tell me what it is you disagree with
- Have you talked to a family member/friend that you trust about the involvement of Children’s Services? Did they express any views?
- Describe any ways in which you think your child(ren) may have been affected by the (identified) concerns? Explore further as necessary, the parent’s understanding of the impact on each child of any specific adverse experiences such as neglect/physical abuse/emotional abuse/sexual abuse/exposure to domestic violence/substance misuse as relevant
- Describe anything you could have done anything differently
- What do you think you could do differently now to make sure your child is protected from harm in the future?
Part Ten: Capacity to Change

A critical element of a parenting assessment is an analysis of what the evidence means in relation to the capacity of a parent to change and whether such change is likely to occur in a timeframe consistent with the child’s developmental needs.

Capacity to change incorporates two elements: the motivation to change and the ability to change. A parent may be motivated to effect change but not have the ability; or they may have the ability to change but lack motivation. In assessing capacity to change, it is imperative that practitioners are honest and even-handed, demonstrate empathy and work collaboratively with parents in order to promote engagement and reduce resistance.

This section needs to consider:

- What needs to change in order for the child’s needs to be met?
- Has the parent meaningfully engaged with the parenting assessment?
- Does the parent understand the need for change?
- What is the parent’s motivation to change and have any resistance factors been identified?
- The nature of support (professional, voluntary agency, family and friends) and interventions previously provided
- How has the parent responded to previous support/interventions? Is there evidence of sustained engagement and improvement or is there a history of limited engagement and/or short-term change only?
- Has the parent worked towards targets for change previously identified (for example at CP conference) and was change achieved?
- Are there identified issues that affect take-up, retention and generalisation of learning?
- Is any further intervention likely to effect change within a timeframe commensurate with the child’s development? What is the evidence to support this view? What is the nature of any intervention/service proposed, the desired outcome and the likely timescale?
- Or what is the evidence to indicate a parent does not have the capacity to change within the child’s timescale?
Motivation and Engagement

The process of change is complex and no single factor should be relied upon as being predictive of meaningful and sustained progress. For example, the extent of a parent’s engagement with services is sometimes cited as predictive of change. However parental participation is not the same as understanding the need to change, or indicative of motivation to achieve permanent change. Reviews of child abuse tragedies have highlighted that some parents have presented as engaged with services, but their engagement has been superficial and without genuine intention to change - referred to as “disguised compliance” or “false compliance” (Reder et al., 1993; Brandon et al., 2008). Horwath and Morrison (2000) developed the model below as a framework to assist in thinking about parental commitment to engagement and implementing change.

<table>
<thead>
<tr>
<th>Genuine Commitment</th>
<th>Tokenism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent recognises the need to change and makes real efforts to bring about these changes.</td>
<td>Parent agrees with the professionals regarding the required changes, but will put little effort into making change work.</td>
</tr>
<tr>
<td>Parents most likely to maximise the use of resources provided to support change.</td>
<td>While some changes may occur they will not have required any effort from the parent.</td>
</tr>
<tr>
<td>Change occurs because of, parental actions.</td>
<td>Change occurs despite, not because of, parental actions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dissent and/or Avoidance</th>
<th>Compliance/Approval Seeking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissent can range from proactively sabotaging efforts to bring about change to passively disengaging from the process.</td>
<td>Parents will do what is expected of them because they have been told to do it.</td>
</tr>
<tr>
<td>One of the most difficult forms of dissent to assess and manage are those parents who do not admit their lack of commitment to change, but work subversively to undermine the process.</td>
<td>Change may occur but has not been internalised because the parents are doing it without having gone through the process of thinking and responding emotionally to the need for change.</td>
</tr>
</tbody>
</table>

Commitment and effort will not only vary from individual to individual, but at different stages of the change process. For example, parents may make a genuine commitment to change at the start of the process, but as the assessment progresses levels of commitment may waver as ambivalence.
returns. Parents who have multiple problems may be motivated to change in one area, but may not have the motivation, or understand the need, to change other aspects of their behaviour.

**Resistance**

There are a number of factors that may make it difficult for practitioners to engage with families, for example, aggression, overt refusal to co-operate, conditional compliance, missed appointments or other forms of avoidance. However, before concluding that a family is resistant to engagement or change, practitioners should:

- Respect the right of parents/carers to challenge any professional's interpretation of events, assessment of their child’s needs or assessment of risk to the child. Challenge, and asserting alternative perspectives, is not necessarily resistance
- Confirm that the parents/carers understand the professional’s concerns and what is expected of them in response. A lack of clarity in relation to expectations and areas that require improvement can blur a parent’s understanding and ability to engage and implement change
- Consider whether there are unintended barriers to engagement that arise as a consequence of an individual’s circumstances, such as mental ill-health, disability, communication difficulties or cultural factors
- Assess what, if any, contribution the approach of the service and/or the nature of the intervention may be making to resistance i.e. could professionals do something differently to achieve engagement?
- Consider whether resource limitations mean that interventions/services are not adequately tailored to meet the parent’s particular needs

Practitioners should make every effort to work effectively *with* parents in ways that maximise their ability to engage and participate. Advocacy for parents may reduce resistance. Forrester et al. (2012) suggest that motivational interviewing techniques may be effectively used to increase parental engagement.
Potential for change

A number of factors, both internal and external, may reduce a parent's potential to change, even when engagement is established. These include:

- A parent’s lack of understanding of the concerns and/or the impact of their behaviours on the child, and/or what is expected of them in response
- Social isolation - inadequate network of support
- Shame and stigma may prevent a parent admitting to themselves or others that there is a problem
- Ambivalence - parents may perceive both positive and negative consequences of overcoming behaviour patterns; or may lack confidence in their ability to change
- Mistrust of professionals (which may be rooted in a parent’s previous negative experience of statutory agencies) and/or a sense of helplessness/lack of agency
- Externalisation of blame – for example: “we were fine until Social Services got involved”
- A history of neglect and abuse, mental ill-health and/or a history of disempowering relationships may engender a sense of helplessness and passivity
- Persistent poverty and poor/unstable housing

Factors that may indicate a positive potential for change include:

- Intrinsic (internal), rather than extrinsic (external) motivation
- An internal locus of control (i.e. a belief that the parent has some control over what happens)
- Events or circumstances in the life of a parent experienced as “turning points” leading to a sudden or gradually realisation of the likely outcome if they do not effect change – for example, the death of a relative or friend from alcohol misuse; pregnancy, the birth of a child, or general maturation – may create windows of opportunity
- The parent is able to identify areas for change that are realistic and within their control
- The parent shows a level of understanding about the extent of the problem and the impact of this on their own and their child’s life
- Consistent evidence over time of parental engagement with different professionals
- Areas of parental functioning that are already working well
- Established coping mechanisms in order to withstand the stress of change

Ward et al (2014) highlight some factors associated with sustained change:
- Positive support networks
- Ongoing, individually tailored intervention
- The establishment of a “virtuous circle”, whereby success in one area leads to success in others.

However, the prospects of sufficient change within an appropriate timeframe may be less likely where:
- A parent remains unwilling/unable to understand or acknowledge identified safeguarding concerns despite sustained effort to explore these with them
- A parent is unwilling to consider the need to change the behaviour associated with identified safeguarding concerns
- A parent faces a combination of problems such as poor mental health, substance misuse and domestic violence
- There is extreme domestic abuse and the perpetrator has a history of pervasive disregard for and violation of the rights of others
- A parent consciously and systematically covers up deliberate abuse
- Children are not protected from perpetrators of sexual abuse
- A parent is unwilling to engage in the assessment

Frameworks to support practitioners in evaluating a parent’s capacity to change, are set out in Appendix 9.
Part Eleven: Analysis

This section requires a clear overall analysis of parental capacity to meet the needs of the child, what needs to change, and the potential for change within a timeframe commensurate with the child’s developmental needs. Where both parents, or a parent and his/her current partner are being assessed, consideration needs to be given to their capacity together to meet the needs of the children, as well as their individual parenting capacity. Where there is more than one child in the family, analyse what the evidence means in respect of the parent’s capacity to not only meet the individual needs of each child, but also whether the parent can meet the needs of the children together. For example, while a parent may be able to successfully care for one child, the nature and demands of another child could be beyond that parent’s capacity.

Key messages from research

Key messages from research provide a helpful context in thinking about the analysis within the assessment, but practitioners will need to focus on the particular circumstances of the individual child and family. The introduction to this handbook collates key messages from research in relation to:

- Potential impact of abuse and neglect
- Factors that affect Parental Capacity
- Factors associated with Future Harm

Developing the Analysis

The template has been designed to promote analysis as the assessment progresses. Analysis identifies the significance of events and information and links different pieces of evidence from different sources. It means considering the questions “how” and “why” not just “what”. Review what the information means in relation to parenting this particular child, and how this impacts on the safety and well-being of this child, not only in the short-term but also in the longer term.
Issues to consider:

- How is an event/issue of significance to the child?
- How has it impacted/might it impact on the child?
- What is likely to happen if the situation remains unchanged in the short and long-term? What is the developmental trajectory for the child?
- What are the current and future risks for the child?
- Can the risks be alleviated/managed? If so, how?
- What changes are required in order that the needs of the child are adequately met?
- What is the evidence for potential change? Or why is change is unlikely to be achieved or sustained?
- Is further intervention/support recommended? How is it envisaged that change will be achieved and monitored?
- How would the child be affected by a delay in a decision being made?

The analysis requires the practitioner to evaluate and make sense of all the information ascertained from multiple sources in the process of assessment. It is necessary to weigh up and consider the inter-relationship between:

- The nature and degree of risk and the impact on the child’s current and future safety and well-being
- The identified vulnerabilities particular to and around the child (child, parents, wider family, community)
- The identified strengths (resilience and protective factors) particular to and around the child (child, parents, wider family, community)
- The capacity of the parent to effect change in a timeframe commensurate with the child’s age and development

Analysis involves balanced professional judgment in weighing up the nature, severity and duration of concerns and risks, and the strength of resilience and protective factors (refer to Appendix 8). Protective and resilience factors do not necessarily mitigate or “cancel out” risk factors.
Systemic thinking is valuable in exploring the interconnections and interactions between different domains of the assessment, in order to achieve a robust and balanced understanding of the child and family’s situation. It is also important to identify themes and patterns in relation to behaviour, needs and risks, which may be intergenerational.

Draw on theory and research, and keep in mind the legal context and statutory guidance. There are a number of research-based texts that provide additional guidance on analysis (Brown and Turney, 2014; Dalzell and Sawyer, 2007; Platt, 2011).

**Drawing on research**
- Use research relevant to the issue being evaluated and analysed, and reference it
- Use reputable, validated research
- Ensure you are familiar with any research you refer to
- Overviews of up to date research can be referred to

Research in Practice can be a valuable resource (Southwark is a partner agency), and recent overviews of research include Cleaver et al. (2011); Brown and Ward (2012); and Ward et al. (2014) all cited in the Reference section of the handbook.
Part 12: Conclusions and Recommendations

Set out your conclusions clearly, based on the evidence and analysis in your report. The conclusions needs to be clear and succinct and should not just repeat the information previously included in the rest of the report, but refer to such information. The conclusions should not include new information.

Set out your recommendations clearly at the end of this section. This should include a summary of any recommendations made previously within the report. If you are recommending any further intervention, include a summary of relevant information such as who will provide the intervention/service and when it will start.
SECTION 3: ASSESSING PARENTS WITH SPECIFIC NEEDS

Assessing parents with a learning disability or significant learning difficulties

This guidance highlights issues to be considered when assessing a parent who has a learning disability or significant learning difficulties.

Definition

The Department of Health (2001) describes learning disability as including the presence of:

- a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with
- a reduced ability to cope independently (impaired social functioning)
- which started before adulthood, with a lasting effect on development.

Some parents may not have a diagnosed learning disability, but may have learning difficulties that have a significant impact on their daily life, for example in relation to their ability to undertake routine tasks and/or the ability to understand abstract concepts. They may not fit the eligibility criteria for support services from the Community Learning Disabilities Team (CLDT), but their learning difficulties may impact on their parenting capacity.

Key guidance

When undertaking an assessment of a parent with a learning disability or learning difficulty, the practitioner should ensure they are familiar with the following key documents:

- The Good Practice Guidance on working with parents with a learning disability (DoH/DfES, 2007)
- Southwark Joint Service Protocol to meet the needs of children and unborn children whose parents have disabilities (Southwark Safeguarding Children Board, May 2007)
Principles underlying good practice

- The welfare of the child is paramount (UN Convention on the Rights of the Child; Children Act 1989)
- Parents with learning difficulties have a right to a family life and are entitled to appropriate help from the State to carry out their parenting role (UN Convention on the Rights of Persons with Disabilities)
- Public authorities have a duty to actively advance equality of opportunity for parents with learning difficulties (Equality Act 2010)

Key features of working with parents with learning disabilities

The Good Practice Guidance identifies five key features in working with parents with learning disabilities:

- Accessible information and communication
- Clear and co-ordinated referral and assessment procedures and processes, eligibility criteria and care pathways
- Support designed to meet the needs of parents and children based on assessments of their needs and strengths
- Long-term support where necessary
- Access to independent advocacy for parents

The need to take account of the above guidance was highlighted in the judgment of His Honourable Mr Justice Baker in the High Court (2011) Kent County Council v A Mother [2011] EWHC 402.

Focus of the parenting assessment

Parental learning disabilities or learning difficulties do not necessarily have an adverse impact on a child’s developmental needs. Parents with a learning disability or significant learning difficulties may need support to develop the understanding, resources, skills and experience to meet the needs of their children, and they may take longer to learn. Such support is particularly needed where the parent experiences the additional stressors of social
exclusion, has a child with complex needs, is experiencing domestic violence, poor physical or mental health, substance misuse problems, and/or has a history of childhood neglect or abuse. In most cases it is these additional stressors, when combined with a parent’s learning disability that are most likely to lead to concerns about the care of their children (London Child Protection Procedures, 2015). Research has also shown that:

- Purposeful abuse by parents with learning disabilities is infrequent and where there are child welfare concerns it is more likely to be in relation to neglect (omission not commission) (Booth et al., 2005)
- People with learning disabilities are at increased risk of mental health difficulties (McGaw et al., 2007)
- People with learning disabilities are more vulnerable to victimisation and forming relationships with partners who may go on to abuse their children (McGaw, 1998)

The primary focus of the parenting assessment should remain that of examining the impact of the quality of parenting on the child or young person’s safety, development and well-being, rather than parental behaviour alone (Daniel, 2004; Cleaver et al., 2004, 2007; Reder et al., 2003). Parenting assessments must identify strengths, skills and protective factors, as well as areas of difficulty (McGaw and Newman, 2005). Critical reflection on the possibility of practitioner bias is essential when undertaking an assessment of a parent with a learning disability or significant learning difficulties, to avoid the influence of assumptions and stereotyping.

**Collaborative working with other services**

Effective joint working between Children’s and Adult’s Services is essential where a parent has a learning disability. Refer to the outline of services for adults with learning disabilities in Southwark at the end of this section.

*Where it is known or suspected that a parent may have a learning disability* their consent should be sought to contact the Community Learning Disabilities...
Team (CLDT). If a parent refuses, a decision should be made and recorded as to whether safeguarding concerns regarding the child and/or the parent, as a vulnerable adult, require that information should be sought without the parent’s consent.

Where a parent is known to CLDT, the aim of such contact is:

- To ensure effective collaborative working
- To consider the level of support being provided and identify any unmet support needs
- To request information that may be relevant to the parenting assessment
- To establish whether there has been an assessment of cognitive and social functioning and to request the outcome
- To consult regarding the planning and process of the parenting assessment to ensure that it is fair and accessible (it is likely to be helpful to invite a professional from CLDT to group supervision when the assessment is being planned)
- To ensure the parent has access to an independent advocacy service

Where a parent is not already known to CLDT, but it is suspected they may have a learning disability, a screening assessment may be completed, to determine whether the person seems to have a learning disability and is eligible for a needs assessment from the CLDT. If the parent refuses referral to CLDT, this should be recorded with any reasons given.

Where the eligibility criteria are not met for a service from CLDT, the team can still be consulted in relation to signposting to other agencies, advice or resources for supporting people who have additional learning needs and in relation to advocacy.

The following factors may indicate that an independent assessment of cognitive and social functioning should be considered:
- Educational history - for example, if the parent required significant extra help at school, attended a special unit or special school, or had a statement of educational needs
- Significant difficulties with literacy – evidence of significant problems with reading or writing, or avoidance of reading or writing
- Difficulties in independent living – for example, shopping, using public transport, implementing a household routine
- Difficulties in providing basic factual information - for example, the child’s date of birth, or in which hospital the child was born
- Difficulties in learning new skills or understanding new or complex information
- History of illness or injury that may have led to difficulties in cognitive functioning such as head injury, or meningitis

Specific areas of cognitive and social functioning can be assessed. IQ scores do not provide an analysis of parenting capacity. Rather, a cognitive assessment can clarify a parent’s level of understanding, how they process and retain information, and the kind of approach/support needed to optimise opportunities for learning; different aspects of memory function may be explored; executive functioning covers a group of skills relating to impulse control and the regulation of social behaviour that may be relevant where parents present with impulsive or angry behaviour; or an assessment of suggestibility may be relevant, for example, where protection or exploitation is an issue. Any recommendations regarding the approach to be used in working with the parent should be taken into account in planning the assessment.

If the parent refuses a psychological assessment when this is considered necessary, this should be recorded and legal advice sought if the matter is in formal pre-proceedings or in proceedings.
More specialist assessments may need to be considered, depending on the needs of the parent, for example, by a neuropsychologist where there is a history of head trauma.

**Dual diagnosis of Learning Disability and Mental Health difficulties**

People with learning disabilities are more vulnerable to developing mental health difficulties due to changes in brain structure and function associated with a learning disability, as well as the social experiences and more limited opportunities for some people with learning disabilities. Identification and diagnosis where there is an existing disability can be complex. The key symptoms of a specific mental illness may well be blurred by the individual’s learning disability, or symptoms may present rather differently. Diagnosis of mental illness often relies on self-report, and problems with communication and comprehension, as well as a lack of introspection skills, may pose a significant challenge for a person with a learning disability in giving an account of their problems.

Where it is known or suspected that a parent who has a learning disability is also experiencing mental health difficulties, or demonstrates challenging behaviour, consent of the parent should be sought to make contact with the Mental Health in Learning Disabilities team at the Maudsley Hospital to see if the parent is, or has been, known to that service, or if it is appropriate for a referral to be made. The team includes psychiatrists and clinical psychologists, and the services include screening assessments, capacity assessments, cognitive assessments, and behaviour support where the person meets the criteria.

**Parenting Assessment Process**

Where it is known or suspected that a parent has a learning disability or significant learning difficulties, the assessment should incorporate a PAM assessment by a practitioner trained in using this framework. A PAM assessment should be used in conjunction with the Southwark Parenting Assessment Framework and should not replace it.
The assessment process should be sensitive, involve the use of language and communication that the parent can understand without “talking down” to them. Practitioners should:

- Take time to understand how the parent best communicates
- Facilitate the attendance of an advocate at meetings
- Explain clearly the professional concerns and the reasons for the assessment. Give information in small amounts. Give concrete examples. Explanations may need to be repeated
- Take time to explain clearly the process of the assessment i.e. what is happening, why, who is doing what, when and where
- Written information should comprise short sentences, in easy to read font (for example, Arial size 14). and supplemented where appropriate with pictures (see Appendix 10 for an example of an accessible pre-proceedings letter which could be adapted)
- During interviews, ensure the parent has understood questions and comments – use simple language, avoid ambiguity and professional terminology/ jargon, make regular checks with the parent that they have understood, encourage them to ask for questions to be repeated if they do not understand; supplement verbal/written information with visual materials
- Where possible, assessments should be undertaken in the parent’s home, if this is where the parent feels most comfortable
- Think about the duration of interviews and build in breaks
- Keep the number of professionals involved to the minimum necessary

**Analysis**

Ask yourself what does the information gathered mean for the child? What impact, if any, does it have?

- Be specific as to how and to what extent, if any, a parent’s cognitive impairment impacts on their parenting and the development and well-being of each child
• Are a parent’s difficulties, for example, related to lack of knowledge, to the acquisition of knowledge and skills, in putting knowledge into practice and/or generalising skills?

• How likely is it that any necessary changes will take place within a timescale consistent with the needs of the child(ren)? What is the evidence to support your assessment in this regard?

• Consider how and to what extent other factors impact on a parent’s capacity to meet the needs of the child(ren)

• To what extent is the support network able to ensure the well-being and developmental needs of the child(ren) are met, if they remain in the care of the parent?

• Have interventions and support services previously offered to the parent been suitably tailored, appropriately targeted, and where necessary long-term?

• Are there other services that would enable the needs of the child(ren) to be met to a good enough standard if they remain in the care of the parent, for example, Shared Care, or Short Breaks; services to promote a child’s resilience?

Recommended resources/websites:

  - Department of Health and DfES, 2007 Good Practice Guidance on Working with Parents with a Learning Disability  
    [www.dh.gov.uk](http://www.dh.gov.uk)

    [www.londoncp.co.uk](http://www.londoncp.co.uk)

  - Southwark Safeguarding Children Board (May 2007) Southwark Joint Service Protocol to meet the needs of children and unborn children whose parents have disabilities.

  - Working Together with Parents Network  
    - provides lots of information and resources for professionals working with parents with learning difficulties  
    [www.bristol.ac.uk/sps/wtpn](http://www.bristol.ac.uk/sps/wtpn)

  - Pictures on aspects of parenting that can be used when working with parents with learning disabilities  
**CHANGE**

Easy to understand information about all aspects of parenting, including a downloadable information booklet on the court process
www.changepeople.co.uk

*Parents booklet* that tells parents what might happen if Children’s Services feel their child is at risk of harm

Download from nscb publications at www.nscb.norfolk.gov.uk

**Useful contacts in Southwark for parents who may have a learning disability**

Southwark Community Learning Disabilities Team is based on 3 different sites for social services, health, and mental health.

**Learning Disabilities Social Work Team**

Contact: 132 Queens Road, Peckham, SE15 2HP. 02075252333.
learningdisabilitiesduty@southwark.gov.uk

A *social worker* in the learning disabilities team can:

- Complete a *screening assessment* to find out if the person seems to have a learning disability.
- **Assess needs and eligibility** for support from adult social services
- **Provide support** to meet the person’s needs and to enable them to be as independent as possible. For example, provide a support worker to help the person with tenancy related support/accessing the community/work/education, etc.
- Respond to **adult safeguarding** concerns such as, neglect or physical, emotional, financial or sexual abuse.
- **Assess Mental Capacity.** It should be assumed that people have capacity to make their own decisions. However, if there is query about this, a capacity assessment may need to be completed. For example, capacity to consent to sexual relationships.
Community Learning Disability Health Team (Guys’ and St Thomas NHS Foundation Trust)
Contact: 121 Townley Road, East Dulwich, SE22 8SW. 02030497518.
gst-tr.awldhealthteam@nhs.net
The Learning Disabilities Health Team can also complete screening assessments and assess capacity. This team consists of:

- **Speech and Language therapists** who can assess someone’s communication needs. It is likely that practitioners in Children’s Services need to adapt their verbal and written communication for parents who have learning disabilities.

- **Occupational therapists** can assess someone’s functioning skills and help the person to develop those skills to become more independent.

- **Community Nurses** can help to make sure the person accesses health services and understands health issues and procedures. This could include joint work with a midwife or health visitor.

- **Physiotherapists** can assess and support people with their mobility needs.

- **Audiologist** can support people with hearing assessments if they are unable to access generic services.

For more information go to:

Mental Health in Learning Disabilities (MHLD) Team
Contact: Clinical Treatment Centre, Maudsley Hospital, Denmark Hill, SE5 8AZ. Psychology: 02032281060 Psychiatry/CPNs: 0203 228 1054.
referralsmhld@slam.nhs.uk
MHLD can also complete screening assessments and assess capacity. For a parent with a learning disability to be eligible for this service they need to have a mental health issue or behaviour that challenges as well as a learning disability. The team consists of:
- **Clinical psychologists** who provide specialist assessments and interventions including **psychological therapy**. They can complete **cognitive assessments**, but only if the person has a mental health need or behaviour that challenges, as well as a learning disability.

- **Behaviour Support Practitioners** work with the person and their support network to try to understand behaviour and find ways to help improve behaviour.

- **Psychiatrists** work jointly with GP’s to try to ensure the person is getting the right treatment and diagnosis for their mental health needs.

- **Community Psychiatric Nurses** support people in the community with their mental health related needs.

**Independent Advocacy**

Advocacy is really important when Children’s Services are working with parents with learning disabilities. An advocate helps to make sure the person understands the process, accesses the right support and that their views are heard.

Cambridge House provides advocacy for people with learning disabilities in Southwark.

Contact: Cambridge House, 1 Addington Square, SE5 0HF. 020 7358 7000.

[info@ch1889.org](mailto:info@ch1889.org)

If the person does not have a learning disability, but may need support from Adult Services, they can be referred to **Contact Adults Social Care (CASC)** on 02075253324 or [CASC@southwark.gov.uk](mailto:CASC@southwark.gov.uk). CASC can direct you to the right team within Adults Services.
Assessing Parents with Mental Health Problems
This guidance highlights issues to be considered when assessing a parent with mental health problems, including a personality disorder.

Prevalence and context
Mental health problems are common within the general population. It is estimated that mental ill-health will affect one in four adults in the UK at some time in their lives (Royal College of Psychiatrists, 2012). This includes a wide range of mental health difficulties, from mild to severe, and from single episodes to chronic conditions. Around 50% of women and 25% of men will suffer with depression at some point in their lives (DoH 2011a). It is estimated that one person in 250 will suffer from a psychotic illness (DoH 1999). Around 4% of people in the UK are diagnosed with personality disorders (Coid et al., 2006). Approximately 30% of adults with a diagnosed mental illness have dependent children (Ofsted, 2013). A person may have more than one mental health problem, for example depression and anxiety. Mental health problems often co-exist with other difficulties: nearly half of those attending mental health services report alcohol or drug problems; and up to 40% of adults with a learning disability experience mental health problems (Cleaver et al., 2011).

Vulnerability factors
Genetic factors may make a person more vulnerable to some forms of mental illness. Brain damage may cause mental health difficulties. A person who has been subject to trauma or abuse as a child or adult, or where a person has had poor quality early attachments and relationships, is at increased risk of mental health difficulties. Research indicates that lone parents are especially vulnerable to mental health problems, and women are more vulnerable than men, whether parenting alone or with a partner (Tunnard, 2004). Other factors that may increase vulnerability to mental health problems include disability or chronic illness; substance misuse; the experience of oppression or discrimination; asylum-seeking status; significant relationship difficulties including domestic abuse; lack of family/social support; pressures during adolescence; and stressful life events, such as bereavement, divorce, migration, loss of employment. There is evidence that social disadvantage,
such as poverty and poor housing, is associated with a higher than normal incidence of mental health problems (Melzer et al., 2004).

Principles underlying good practice

- The welfare of the child is paramount (UN Convention on the Rights of the Child; Children Act 1989)
- Public authorities have a duty to actively advance equality of opportunity for people with a `protected characteristic`, which includes people with long-term mental illness (Equality Act 2010)
- Parents with mental health problems should have access to independent advocacy where necessary
- There should be effective collaborative working between agencies (Working Together, 2015)

Features of mental illness

For details of the features of specific forms of mental illness refer to the ICD-10 website or the Royal College of Psychiatrists website; and for a detailed overview of the potential impact of specific mental health problems on parenting refer to Cleaver et al. (2011, pp.50-54); Royal College of Psychiatrists (2011); or Rouf (in Calder & Hackett, 2013 pp.229-233).

Potential impact of parental mental health difficulties

Parental mental health difficulties do not necessarily have an adverse impact on a child’s developmental needs. Many parents with mental health problems and their children cope well, particularly if problems are short-lived, infrequent and children can understand what is happening (Royal College of Psychiatrists, 2012). However, all children, including infants and young children, are sensitive to their parent’s state of mind, so that parental mental illness may impact on a child’s developing sense of security and the attachment process (Mayes et al., 1998). Children may experience parental insensitivity, or increased criticism or anger and may experience low self-esteem (Cleaver et al., 2011). Children may feel they are to blame for their parent’s illness, worry they may develop the same illness; feel upset or
frightened; feel ashamed or stigmatised by their parent’s problems; and experience teasing or bullying. Children may withdraw into themselves and become anxious and find it hard to concentrate on schoolwork. They may experience separation and a sense of loss if a parent is hospitalised, particularly where there are repeated admissions. Children may be required to take on caring responsibilities for parents and younger siblings, which may compromise well-being, educational or social development. Children of parents with mental health problems are at increased risk of developing mental health difficulties themselves (Royal College of Psychiatrists, 2012). It is also important to consider the impact on children of secondary factors, such as low income, poor housing and neighbourhood, stressed family relationships and societal prejudice and discrimination.

Where a parent has enduring and/or severe mental illness, or where mental health problems co-exist with other parental difficulties, including substance misuse or domestic violence, children are more likely to be at risk of significant harm (Cleaver et al., 2011). Ofsted’s analysis of serious case reviews from 2007 – 2011 where children had been seriously harmed or died, highlighted that mental illness, drug/alcohol problems and domestic abuse were common themes (Ofsted, 2011). Where parents experience active symptoms of major mental illness, children may be exposed to disturbing or aggressive behaviour; or they may be at risk as a consequence of featuring within a parent’s delusional thinking, or thoughts of self-harm. Particular concern arises where a parent with major mental illness fails to engage or withdraws from engagement with mental health services, or fails to comply with medication.

*Dual diagnosis of learning disability and mental health problems*

Where a person has a learning disability and mental health difficulties, it should be borne in mind that symptoms may be blurred or present rather differently.
**Personality Disorder**

Personality Disorder is a developmental disorder of interpersonal dysfunction, often accompanied by behavioural disorders (Adshead et al., 2004). At times of threat, people with personality disorders become either highly aroused and distressed, or dismissive, withdrawn and emotionally cold (Royal College of Psychiatrists, 2011). It has been postulated that personality disorders have their roots in disturbed attachments and the impact of early negative childhood experiences including emotional, physical and sexual abuse (Fonagy et al., 2003, Crittenden, 2011). The Royal College of Psychiatrists (2011) reports that a substantial proportion of self-reported child abusers are diagnosed with personality disorder and it is a diagnosis commonly made by professionals reporting in child protection proceedings. In cases of child maltreatment, where attempts were made to reunite the families, the presence of antisocial personality disorder in particular made reunification unlikely (Jones, 1987).

The Royal College of Psychiatrists (2011) suggests that adults with personality disorder can struggle with parenting for three reasons (i) having a child will stimulate their own pattern of attachment (ii) their capacity to manage and self-soothe their own arousal is limited, and (iii) they will not be able to soothe their own child’s distress, but instead respond with hostility or fear. This then leads to a vicious cycle, in which the child gets more distressed, and the parent becomes either more frightened or frightening; which in turn makes it likely that the child will become insecurely attached. If the parent feels helpless and hostile, they are more likely to treat their child as an adult or peer, which may then lead to role reversal or attack behaviours. If a parent has experienced maltreatment as child, they are likely to resort to learnt behaviours/modelling with their own children. The presence of personality disorder therefore has the potential to compromise parenting to the same extent as severe mental illness does (Berg-Nielsen et al., 2002; Johnson et al., 2006).

**Factitious Illness by Proxy**

Factitious Illness by Proxy (leading to fabricated or induced illness) is rare but has potentially very serious consequences for a child. Research in Britain indicates that 6% of children died as a consequence of the abuse; and many
of the children who did not die suffered significant long-term consequences including long-term impairment of their physical, psychological and emotional development (McGuire and Feldman (1989); Neale et al. (1991), Bools et al. (1993); Sanders (1995); HM Government guidance 2008; London Child Protection Procedures 2015, Part B3, Section 2). Where Factitious Illness by Proxy is suspected, an assessment by an expert is likely to be needed.

**Summary of factors associated with an adverse impact on parenting capacity**

The following factors have been identified as potentially impacting upon parenting capacity, increasing concerns that a child may be suffering, or likely to suffer significant harm (London Child Protection Procedures, 2015, part B, 29.1.4):

- History of mental health problems that have an impact on the parent’s functioning;
- Unmanaged mental health problems with an impact on the parent’s functioning;
- Maladaptive coping strategies;
- Misuse of drugs, alcohol or medication;
- Severe eating disorders;
- Self-harming and suicidal behaviour;
- Lack of insight into illness and impact on child, or insight not applied;
- Non-compliance with treatment;
- Poor engagement with services;
- Previous or current compulsory admissions to mental health hospital;
- Disorder deemed long term `untreatable`, or untreated within time scales compatible with child’s best interests;
- Mental health problems combined with domestic abuse and/or relationship difficulties;
- Mental health problems combined with isolation and/or poor support networks;
- Mental health problems combined with criminal offending (forensic);
• Non-identification of the illness by professionals (e.g. untreated post-natal depression can lead to significant attachment problems);
• Previous referrals to Local Authority Children’s Social Care for other children.

The London Child Protection Procedures, 2015 (Part B, 29.1.3) indicate that a child may be at risk of significant harm or their well-being affected where a child:
• Features within parental delusions;
• Is involved in his/her parent’s obsessive compulsive behaviours;
• Becomes a target for parental aggression or rejection;
• Has caring responsibilities inappropriate to his/her age;
• May witness disturbing behaviour arising from the mental illness (e.g. self-harm, suicide, uninhibited behaviour, violence, homicide);
• Is neglected physically and/or emotionally by an unwell parent;
• Does not live with the unwell parent but has contact;
• Is at risk of severe injury, profound neglect or death;

Or an unborn child could potentially be at risk of significant harm, or their well-being affected, where
• The mother has any previous major mental disorder, including a schizophrenic disorder; any affective (mood disorder) or schizo-affective disorder; or severe personality disorder involving known risk of harm to self and/or others

**Strengths and protective factors**
The assessment must also include an assessment of strengths and protective factors as set out in the handbook guidance to Part Six of the report.
Core domains for assessment (Mayes et al, 1998)
Recommended resources/websites:

- Southwark Safeguarding Children Board (June 2012) *Southwark Joint Service Protocol to meet the needs of children and unborn children whose parents or carers have mental health problems*

- South London and Maudsley NHS Foundation Trust and Southwark Council *Southwark Mental Health Family Strategy: A review of progress to date and next steps for 2012-2015*

- SCIE: *Care Programme Approach (CPA) Briefing: Parents with mental health problems and their children* April 2008

  Part B Practice Guidance, Section 29
  www.londoncp.co.uk

- Royal College of Psychiatrists (2011) *Parents as Patients: Supporting the needs of patents who are parents and their children* London: RCP


- Royal College of Psychiatrists website has accessible information on mental health problems for professionals, and leaflets for adults and young people
  http://www.rcpsych.ac.uk/expertadvice.aspx

- Royal College of Psychiatrists – list of books suitable to use with young children
  http://www.rcpsych.ac.uk/workinpsychiatry/faculties/childandadolescent/generalinformation/booksforyoungerchildren.aspx#

For details of mental health services in Southwark refer to:

- Adult Mental Health Children’s Safeguarding Manager (Chris McCree) Chris.mccree@slam.nhs.uk; Chris.Mccree@southwark.gov.uk
  Will provide consultation, advice and information.

- Southwark Council’s website for Mental Health Services
  http://www.southwark.gov.uk/info/200398/mental_health/2375/mental_health_services/2
South London and Maudsley NHS Foundation Trust (SLaM)  
www.slam.nhs.uk

Lambeth and Southwark Mind  
http://lambethandsouthwarkmind.org.uk/

The route to most services for adults with mental health problems is through their GP or through the Assessment and Liaison Teams:

- Southwark North Assessment and Liaison team - Camberwell  
  Address: 27 - 29 Camberwell Road, London SE5 0EZ  
  Telephone: 020 7525 2751

- Southwark South Assessment and Liaison team - Dulwich  
  Address: 20-22 Lordship Lane, London SE22 8HN  
  Telephone: 020 7525 1881

Examples of the services available in Southwark for parents who have mental health problems:

- **Parental Mental Health Team**, part of the London Borough of Southwark's Early Help Service, for parents experiencing mental health problems who have children under 5 years.  
  contact Chris.mccree@slam.nhs.uk; Chris.Mccree@southwark.gov.uk

- **SLaM: Mental health specialist mother and baby in-patient services**

- **Specialist Perinatal mental health services working with both King’s and Guy’s and St Thomas’ maternity services**

- **An intensive Health Visiting Project** which Southwark mental health service users are able to access.

- **Family Action Southwark – Newpin.**  
  Supports parents who are the main carer of a child under the age of five. Support includes to reduce isolation, to increase self-confidence, encouraging children to learn through play, to improve a child’s emotional and social skills, and to improve a parent’s ability to play.  
  www.family-action.org.uk

- **Integrated Psychological Therapy Team (Southwark)**  
  This is a specialist psychological therapy service (secondary care) that provides assessment, care and treatment for adults who have a severe mental illness. The service provides a range of individual and psychological therapies within six areas:

  - Cognitive behavioural therapy (CBT)  
  - Family and couple therapy
Perinatal psychotherapy
Psychodynamic psychotherapy: individual and group
Cognitive analytic therapy (CAT)
Trauma focused therapy

Referral is via IAPT or CMHT

Tel: 020 3228 2384/2385/2383/3728/3949

❖ Family and Couples Therapy Service
This service is part of the Integrated Psychological Therapy Team (IPTT) as above. Referral is via IAPT or CMHT

❖ Perinatal Psychotherapy
This service is part of the Integrated Psychological Therapy Team (IPTT) as above. It offers assessment for parent-infant and individual psychodynamic work and channels referrals to other modalities within the borough's IPTT. The service works in conjunction with the Perinatal Psychiatry Out Patient Department at the Maudsley Hospital and liaises with the Parental Mental Health Team, IAPT, CMHT, CAMHS and Social Services.

Enquiries: Tel: 020 3228 2385

❖ Southwark Psychological Therapies Service
This service provides a range of treatments to help people improve their psychological well being without the need for more specialist treatment. Treatment could include guided self-help, counselling, cognitive behavioural therapy (CBT), vocational advice and signposting to local advice and support organisations.

Referrals can be made via a GP, or directly by calling 020 3228 2194 or emailing sptsadmin@slam.nhs.uk

❖ Mental Health in Learning Disabilities Team
Clinical Treatment Centre, Maudsley Hospital, Denmark Hill, SE5 8AZ.
Psychology: 02032281060 Psychiatry/CPNs: 0203 228 1054.
referralsmhld@slam.nhs.uk
Assessing Parents with Neurodevelopmental Disorders: Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder and Foetal Alcohol Spectrum Disorder

It is essential not to make generalised assumptions about any potential impact on parenting capacity, and to be open-minded in your approach to the assessment. Consideration may need to be given to an expert assessment in respect of the parent by a psychiatrist or psychologist with appropriate expertise, to inform the assessment of parenting capacity and to ensure that informed consideration is given to appropriately tailoring interventions and support.

While undertaking the parenting assessment, it is important to assess and evaluate:

- Whether the parent’s condition has any impact on his/her parenting capacity and if so, to be specific as to how, and to what extent, it has an impact on the development and well-being of each child.
- How and to what extent other factors impact on the parent’s capacity to meet the needs of each child.
- To what extent is the support network able to ensure the well-being and developmental needs of the child(ren) are met?
- Have interventions and support services previously offered to the parent been suitably tailored and appropriately targeted, and where necessary long-term?
- Are there other services for the family/parent/child that would enable the needs of the child(ren) to be met to a good enough standard?

Collaborative working with other services

Where a parent has a diagnosis of Autism Spectrum Disorder (ASD), or Attention Deficit Hyperactivity Disorder, or Foetal Alcohol Spectrum Disorder (FASD) it is essential to ensure effective joint working with any involved adult services, including adult mental health services, in order to:
Promote effective collaborative working
Consider the level of support being provided and identify any unmet support needs
Request information that may be relevant to the parenting assessment
Establish whether there has been an expert assessment and to request the outcome
Consult regarding the planning and process of the parenting assessment to ensure that it is appropriately tailored
To ensure the parent has access to an independent advocacy service if required

Assessing parents with Autism Spectrum Disorder
Autism is a neurodevelopmental disorder. It is characterised by difficulties in three areas (the ‘triad of impairments’):

- Social interaction
- Language and communication
- Thought and behaviour

In addition to the triad, many people experience sensory problems and either under-react or over-react to sensory stimuli; over reactions or hypersensitivity may relate to sound, touch, smell and taste or a combination of these.

“Spectrum” means there is variability within and across these areas – ranging from minor difficulties through to difficulties which would mean the individual requires significant support and may not be able to live independently.

Adults on the autism spectrum include individuals with Asperger’s Syndrome, Atypical Asperger’s Syndrome and Pathological Demand Avoidance. Autism Spectrum Disorder is estimated to affect about 1% of the adult population (0.8% males, 0.2% females), although there is evidence to suggest that women in particular are under-diagnosed or mis-diagnosed. The South
London and Maudsley Trust offer a diagnostic service for Southwark residents via referral through a GP.

**Potential impact on parenting**
Research into the impact of autism spectrum disorder on parenting capacity is limited. However, there is evidence to indicate that some adults with autism may have significant difficulties in parenting, based on difficulties associated with the neurocognitive features of autism. Therefore the nature and extent of these aspects of autism should be assessed in order to inform a parenting assessment where a parent has a diagnosis of autism spectrum disorder and where there are concerns in relation to the safety and well-being of a child (Eaton, 2015; Carritt-Baker, 2015).

*Weak central coherence*
Central coherence is the ability to focus on the whole situation as well as the details; to process information in context in order to draw out meaning; to follow through on plans in a variety of areas; to focus on what takes priority and what is important. Many individuals with autism have a tendency to focus on the details rather than the whole picture. This could potentially have implications for child safety.

*Poor cognitive shifting*
People with autism spectrum disorder may have difficulty shifting the scope and focus of their attention; to shift to a different thought or action in response to changes in a situation. Parents frequently have to deal with conflicting demands upon their attention; and often have to redirect their attention under pressure. This may be an area of difficulty, as people with autism may cope with this kind of pressure by walking away, emotionally shutting down, or sudden outbursts of anger, which would then have implications for the care and supervision of a child.

*Poor theory of mind*
People with autism may also have problems understanding that other people have their own plans, thoughts, points of view, beliefs, attitudes and emotions.
This may impact upon a parent’s ability to interpret and appropriately meet the needs of a child. Difficulties in determining a child’s intentions may also impact on boundary setting and behaviour management. Difficulties in reading facial expressions and tone of voice may also mean that a parent with autism struggles to interpret a child’s behaviour.

**Additional challenges**

It has been estimated that up to 70% of people with autism spectrum disorder have a significant degree of cognitive impairment. Many individuals with autism have additional mental health challenges, which may include depression, anxiety, Obsessive Compulsive Disorder, episodes of psychosis, eating disorders, personality disorder and selective mutism. Social communication difficulties may also contribute to unwillingness on the part of a parent with autism to engage with, or to disengage from, services or support networks. They may misunderstand or misinterpret what has been said to them and may consequently withdraw, or react with anger and frustration (Eaton 2015). Research indicates that autistic traits can be inherited, so that a parent with autism may be caring for a child with autism or autistic traits, posing additional potential challenges.

**Capacity to change**

There is limited research evidence available in relation to the capacity of parents with autism spectrum disorder to change where there are significant concerns about the safety and well-being of the child. Consideration may need to be given as to whether an expert assessment is necessary to inform the assessment of capacity to change.

**Recommended resources:**

- Royal College of Psychiatry: free information leaflets
  [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)
- National Autistic Society
  [www.nas.org.uk](http://www.nas.org.uk)
- NICE Guidelines for the Assessment and Diagnosis of Autism in Adults (2011)


Assessing parents with Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is a pattern of behaviour that includes high levels of

- inattentiveness
- hyperactivity
- impulsiveness

that results in significant psychological, social and/or educational or occupational impairment that occurs across multiple domains and settings and persists over time.

Research indicates that there is an interplay between genetic and environmental risk factors that affect the neurobiological basis of the disorder. There is some evidence to suggest that it is more common where there were problems in pregnancy and birth, including premature birth and low birth weight, exposure to drugs or medication in utero, brain infection and exposure to environmental contaminants, in particular lead.

It is estimated that approximately 1-2% of the child population in the UK is affected by ADHD (using the narrower criteria of ICD-10). Research indicates that there are fewer individuals with a diagnosis of ADHD as adults, but this may be related to under-diagnosis.

Potential impact on parenting

ADHD is a part of a spectrum of disorders. 70% of people with ADHD also have other conditions such as generalised or specific learning difficulties which may include dyslexia, language disorders, autism spectrum disorder, dyspraxia, or Tourette’s syndrome. People with ADHD may have additional
mental health difficulties including depression and self-harm and anxiety, and drug misuse is more common in adults with ADHD. As there is a genetic link, there is also an increased likelihood that a parent with ADHD has a child with ADHD, which may pose additional potential challenges.

Inattentiveness may impact on child safety; there may be implications for time-keeping and missed appointments, and for household and financial management; there may be difficulties encouraging a child’s organisational skills.

Where a parent has a diagnosis of ADHD, either as a child or in adulthood, and there are concerns that this may be impacting on the quality of parenting, it is important to encourage the parent to seek and/or engage with appropriate treatment and support.

Where it is suspected that a parent has ADHD, it is important to encourage the parent to discuss their symptoms with their GP initially, who can refer them if appropriate to a psychiatrist. There is a specialist diagnostic and treatment service for adults at the Maudsley Hospital via referral from a GP or psychiatrist where appropriate.

Recommended resources:
- Royal College of Psychiatry – free information leaflets
  [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)
- UK NICE guidelines on ADHD in children, young people and adults

National support organisations
- ADD / ADHD Online Information
  [www.adders.org](http://www.adders.org)
- ADDISS The National Attention Deficit Disorder Information and Support Service
  [www.addiss.co.uk](http://www.addiss.co.uk)
- ADHD Foundation
  [www.adhdfoundation.org.uk](http://www.adhdfoundation.org.uk)
Assessing parents with Foetal Alcohol Spectrum Disorder (FASD)

Foetal Alcohol Spectrum Disorder is a continuum of alcohol-related birth defects, including:

- Foetal Alcohol Syndrome (FAS)
- Alcohol-Related Neurodevelopmental Disorder (ARND)
- Alcohol-Related Birth Defects (ARBD)
- Foetal Alcohol Effects (FAE)
- Partial Foetal Alcohol Syndrome (pFAS)

The number of people in the UK affected by FASD is not known, but international studies indicate at least 1% of the child population is affected.

The effects of FASD can be mild or severe, ranging from reduced intellectual ability and attention deficits to serious physical problems. Behavioural and social difficulties may include:

- Attention deficits
- Memory deficits
- Hyperactivity
- Difficulty with abstract concepts (e.g. maths, time and money)
- Poor problem solving skills
- Difficult learning from consequences
- Poor judgement
- Immature behaviour
- Poor impulse control
- Confused social skills

People with FASD may also have:

- Difficulty translating information from one sense modality into appropriate behaviour i.e. translating hearing into doing, thinking into saying, reading into speaking, feelings into words
- Difficulty generalising information. Links are not automatically formed. Learning happens in isolated clumps and may be unconnected or only loosely connected to other experiences, thoughts and emotions.
• Difficulty perceiving similarities and differences. Without the ability to generalise and make associations, a person’s capacity to compare and contrast, see whole patterns, sequence, predict events and make judgements is affected.

Without appropriate support, people with FASD are at increased risk of developing secondary difficulties such as mental health difficulties, and alcohol and drug problems.

The above information about FASD is drawn from the website of the National Organisation for Foetal Alcohol Syndrome-UK www.nofas-uk.org.

Potential impact on parenting
There are significant differences in the effects of FASD between individuals, and the extent to which these may have any potential impact on parenting capacity. Direct observations of parenting are likely to be an important element of the parenting assessment. The use of the PAM framework, or elements of the framework, may be helpful as part of the assessment.

Recommended resources:
❖ National Organisation for Foetal Alcohol Syndrome UK (NOFAS-UK) www.nofas-uk.org
Assessing parents where substance misuse is a concern

The term `substance misuse` is used in this guidance to refer to the misuse of alcohol and/or illicit drugs and/or misuse of other substances, such as volatile substances, prescription or over the counter medication.

It is important to distinguish between the use of alcohol and/or occasional use of drugs, and the misuse or problem use of substances. Cleaver et al (2011) highlight that:

“… alcohol, and to a lesser extent drug use, is well integrated into the lives of many parents. For example, drinking alcohol is an intrinsic element of most religious ceremonies, festive celebrations, meals and everyday entertainment…The occasional use of alcohol or some…drugs…results in few, if any, lasting adverse effects.”

The Advisory Council on the Misuse of Drugs (2003) defined problem substance use as that which has:

“serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them.”

A person whose use of substances is problematic may not fulfil the criteria for dependence (or addiction), but by definition, substance dependence constitutes problem use. The ICD-10, for use by medical practitioners and clinicians, defines the diagnostic criteria for substance dependence as the presence of three or more of the following, occurring together repeatedly, within the previous 12-month period:

- A strong desire or sense of compulsion to take the substance.
- Impaired capacity to control substance use.
- A physiological withdrawal state when use is reduced or ceased.
- Evidence of tolerance to the effects of substances.
- Preoccupation with substance use.
- Persistent use despite clear evidence of harmful consequences.

(cited in Castleton, 2015, pp.125-126)
Physical and psychological effects associated with substance misuse
Adverse physical and psychological effects, both acute and chronic, associated with substance misuse varies not only according to the different types of substance being used, but the way the substance is used, and whether it is used in combination with other substances. The cultural, social and legal context is also relevant to the impact of substance misuse. The range of potentially harmful effects of alcohol, drugs and other substances is clearly set out in *A summary of the health harms of drugs* (Department of Health 2011).

Barriers to engagement, disclosure and seeking help
It should be borne in mind during an assessment that there is a wide variety of reasons why a parent, or pregnant woman, may not wish to disclose substance misuse, or may not have sought help. Reasons may include denial of a problem; perception of alcohol and/or drug use as a way of coping; feelings of shame; a fear of being judged and of stigmatisation; anxiety about confidentiality; the illegality of some drugs; and fears of the child(ren) being removed. A collaborative approach with parents, wherever possible, with a shared aim of harm reduction is more likely to promote engagement in the assessment. Practitioners should use empathic, reflective listening skills, anticipate resistance, re-frame ambivalence as a potential positive rather than a barrier.

Prevalence
It has been estimated that between 780,000 and 1.3 million children under 16 in the UK are affected by parental alcohol misuse (Alcohol Reduction Strategy for England, 2004) and between 250,000 and 350,000 children are living with a parent with problematic drug use (National Treatment Agency, 2012). These figures are likely to be an underestimate due to the stigma and secrecy associated with substance misuse.
Impact of parental substance misuse on children

Cleaver et al (2011) caution that parental substance misuse *in isolation* does not necessarily mean that children in the family are suffering, or are likely to suffer significant harm:

“To suggest that all parents who suffer from ... problem alcohol/drug use ... present a danger to their children is misleading and dangerous. Indeed, much research indicates that, with adequate support, parents who are experiencing, a single disorder are often able to be effective and loving parents and present little risk of significant harm to children.”

However, there is a significant body of research that indicates that *enduring and/or severe* parental substance misuse may significantly impair a parent’s capacity to meet the needs of a child at all stages of development, particularly where this co-exists with other risk factors, such as significant mental health difficulties and/or intimate partner violence (Harbin and Murphy 2006, Forrester and Harwin, 2008; Cleaver et al; 2011). Approximately a third of all incidents of domestic violence are linked to alcohol misuse with a significant proportion of these witnessed by children (Turning Point, 2006). Nationally, substance misuse has been identified as a factor in approximately 60% of families where children are subject to consideration under Child Protection procedures (Cleaver et al., 2011). Analysis of Serious Case Reviews in England between 2009/2011 showed that parental substance misuse was apparent in 42% of the families (Brandon et al., 2012). In Southwark, data from the Child Protection Monitor Logs from October 2014 to September 2015 (80% completed) indicate that parental alcohol misuse was considered to be a safeguarding issue in about 16% Child Protection Conferences held, and parental drug misuse was considered to be a safeguarding issue in about 21% of conferences held (QA Unit). However, it is not possible to establish from these figures the extent to which parental alcohol and drug misuse co-occurred. In the year April 2014 to March 2015, approximately 18% of care proceedings (10 of 56 cases) issued by Southwark were allocated to the Family Drug and Alcohol Court.
Individuals who misuse substances may present with a range of problems (National Treatment Agency, 2004). Research indicates that a significant proportion of people using drug treatment or alcohol services experienced depression and/or anxiety disorder (Weaver et al. 2004). An association has been identified between substance use and “self-medication” to ease distress arising from depression, anxiety, low self-esteem, domestic violence, or provide relief from negative emotional states (Cleaver et al. 1999; Mental Health Foundation, 2006). A significant number of those using drug and alcohol treatment services report they had previously relapsed because they could not face their emotions in a substance-free state (Phoenix Futures, 2006). Parental substance misuse is often associated with other factors such as poverty and deprivation (poor housing, unemployment and debt). Parents may be involved in criminal activity. Parents experiencing problematic substance use may be affected by other issues such as adverse childhood experiences, which may be more difficult to assess and address if masked by presenting issues associated with substance misuse. It is important not to assume that abstinence or more stable substance use will necessarily result in improved parenting capacity - there may be concerns in relation to parenting capacity that are unrelated to substance misuse.

The way that parental substance misuse affects children is likely to depend on their age and stage of development, any complex needs arising from disability or illness, their resilience, the quality of relationships within the family, with wider family members and significant adults, the presence of a parent or other adult in a caring role who does not misuse substances, and the presence of other adverse or protective factors. The impact of children’s exposure to parental substance misuse can be both immediate and long-term. Where parental capacity is significantly compromised due to substance misuse, there may be multiple effects on the child’s development including health, education, emotional and behavioural development, sense of identity, family and social relationships, social presentation and social skills. Secondary factors may exacerbate the impact, including low income, poor housing and neighbourhood, social isolation and societal prejudice.
Howe (2005, pp183-184) summarises the way in which significant use of alcohol and/or drugs can distort, disrupt and disturb parent-child relationships:

“As drugs and alcohol are mind-altering substances, they seriously tamper with … mind-minded synchrony between parent and child that characterises sensitive, attuned, reciprocal parenting … Emotional availability and understanding disappear. So not only might the parent’s behaviour and manner be odd, confusing and frightening, but also the carer is unavailable to deal with that confusion and fear. The carer causes the distress, does not see it, and fails to repair the relationship … In these conditions, the young child’s distress is likely to escalate and go unregulated. The child can find no behavioural strategy that increases his or her security. Her attachment behaviour is therefore likely to be disorganised … the child feels emotionally abandoned and frightened.”

Potential risks for children
Potential risks to children have been identified as including the following (London Child Protection Procedures, 2015; Southwark Joint Service Protocol, 2014):

- Babies exposed to drugs and alcohol in utero may be born prematurely with a lower birth weight; may suffer physical and neurological damage before birth; may experience symptoms of withdrawal at birth; are at increased risk of death before or shortly after birth, including Sudden Infant Death Syndrome;

- Parent-child bonding may be impeded where newborn babies experience withdrawal symptoms such as high pitched crying and feeding difficulties;

- Babies may experience a lack of basic care and stimulation and be at risk of accidental injury;

- The care and supervision of children may be neglected due to reduced awareness, loss of consciousness, or altered perception of the parent;
• Children may be at risk as a consequence of unsafe storage of injecting equipment, alcohol or drugs and/or medication such as methadone, exposure to contaminated needles and syringes;

• Chaotic lifestyles and unstable accommodation may disrupt children’s routines, relationships and school attendance, affecting social, emotional and behavioural development and educational achievement;

• Children may become socially isolated, and experience stigmatisation or victimisation; they may be unable to confide in others for fear of the consequences;

• Income may be diverted for the purchase of alcohol or drugs, leading to material deprivation and debt;

• Children may be exposed to other adults who are misusing substances and/or to dealers; and to risks associated with the parent’s procurement of drugs; older children may be used as ‘runners’ where parents are dealing;

• Children may perceive parental lifestyle as ‘normal’, which may increase the risk of experimenting with alcohol or drugs at an earlier age;

• Children may have inappropriately high levels of responsibility, which may include the care of younger siblings;

• Parental ability to regulate emotion may be impaired, leading to unpredictable and/or frightening experiences for children;

• Inconsistent physical and emotional availability of the parent will influence the developing child’s pattern of attachment;

• Substance misuse may affect parental mood, mental state or behaviour in ways that may place children at risk of injury, psychological distress, inappropriate sexual and/or aggressive behaviour, including exposure to domestic violence;
• The risks may be increased when parents are withdrawing from drugs due to increased stress/anxiety;

• The risks are likely to be increased where there are mental health difficulties, domestic violence and/or when both parents are misusing substances;

• Children may be at increased risk of separation from a parent due to periods of in-patient detox/residential rehab or imprisonment, or at increased risk of bereavement due the premature death of a parent.

The assessment process
Where there are concerns regarding parental substance misuse, this should be assessed in relation to:

• Any effects on the parent’s ability to look after the child

• Any impact upon the child’s safety, health, development and well-being

• The interplay with the wider family, social relationships and the wider community

In order to develop an analysis of risks and strengths, the assessment should explore and consider:

The parent’s drug/alcohol use/misuse

• History of the nature, extent, pattern of parental use of alcohol and/or drugs
  o when did the parent first drink alcohol/use drugs?
  o when did concerns arise regarding substance misuse (by parent/family/others)
  o what factors may have contributed?
  o is there any evidence of substance misuse in past 12 months (recent) or in the past?
• identify each substance used and whether used in combination with other substances
• route of administration (injection/smoked/snorted/oral)
• immediate/short term effects
• amount and frequency of use, whether decreasing or increasing, regular / intermittent / chaotic use / binge-drinking
• when, where and with whom use of drugs/alcohol takes place (e.g. at home/elsewhere; are other users coming to the home)
• how are drugs procured, any risks associated with procurement
• any substance-related accidents or injuries
• any use of non-prescribed substances during pregnancy

• Any discrepancies between the account given by the parent of their use of substances and evidence/information from other sources (e.g. results of drugs/alcohol testing/information from other agencies)

• How is the use of drugs/alcohol funded?

• The nature of any impact on the parent and their relationships with others
  • their behaviour
  • interaction with partner/children
  • general mood
  • physical/mental health
  • perception and memory
  • employment
  • any offending behaviour/sentences

• The parent’s understanding of the harmful/potentially harmful effects on themselves and others
• How does the parent view their substance use? Do they think anything would be different if their use stabilised/ceased? Do they accept the need to change, and are they motivated to effect change? What are the pros and cons for them of change? How confident are they of their ability to change, and what support do they consider is required? What might prevent/stop them working towards change?

• Extent of parent’s current or past engagement with treatment/specialist services in relation to detox/rehab/relapse prevention/controlled drug use/medication (e.g. methadone, naltrexone, subutex) and the effectiveness of intervention(s)/treatments

• The extent of the parent’s understanding of any triggers and/or destabilising factors likely to increase their vulnerability to substance misuse

• The co-existence of other risk factors such as mental health difficulties, violent behaviour, including domestic violence, and criminality

• The parent’s own experience of being parented

• Identify any family history of substance misuse

• Where the other parent/partner is misusing substances, how does the parent view the substance use of the other parent/partner?

**Impact on the child and family life**

• The nature of any impact on the quality of family life. What is day to day life like for the child? What is positive about family life? Is there anything the child would want to change?

• Does the child witness the parent using drugs/procuring drugs/misusing alcohol? Do they have fears, anxieties associated with this? What is the child’s understanding of drug/alcohol misuse?

• How much is spent on drugs/alcohol per week; how does this impact on the family’s financial circumstances
• Arrangements for storage of drugs/equipment/alcohol; disposal of syringes

• The nature of any impact on each child in relation to:
  o safety and supervision;
  o physical and emotional care;
  o social, emotional, behavioural development;
  o are responsibilities age-appropriate?
  o school attendance and educational achievement;
  o stability of accommodation;
  o home conditions;
  o provision of basic necessities such as food, clothes;
  o health care

**Strengths**

• Resilience and protective factors in respect of the child, the parents, the wider family and community, for example:
  o meaningful parental engagement with specialist support/intervention
  o presence of non-using parent/partner who provides appropriate day to day care
  o child’s access to emotional support from a supportive adult
  o child’s self-esteem/confidence/sense of identity
  o child’s nursery/school attendance
  o child’s engagement in age-appropriate activities outside of the home
  o continuing family cohesion
  o family routines and rituals maintained
Material resources

Availability of relevant drug and alcohol services

Wider family who are aware of substance misuse involved and supportive

`lifelines` for the child

Plans/strategies to protect the child from the impact of substance misuse/reduce harm

Support for the child from significant others/professional network

Practitioners may wish to refer to the SCODA Assessment Framework in relation to problem drug use (Appendix 12).

Sources of information include interviews with the parent(s), interviews with other family members where appropriate, direct work with each child, observations of parent-child interaction, any test results for drug/alcohol use, Local Authority records and information from other agencies, including GP, police, probation, housing and any drug/alcohol support service currently or previously involved.

Where a parent is currently accessing, or has recently accessed support from a drug or alcohol support service, the key worker should be invited to attend group supervision when the assessment is being planned and/or reviewed to promote an effective joint approach. Where a parent has not previously accessed specialist support, consent should be sought to refer them to their GP or an appropriate service for assessment and intervention. Pregnant women should be referred to specialist substance misuse antenatal services.

**Testing for drug/alcohol use**

Consideration may need to be given to testing for drug/alcohol use as part of the overall assessment, but it should be borne in mind that this will not provide
information about the context of what is happening for the parent, the family or the child. Not all substance misuse agencies undertake testing.

**Capacity to change**

The process of change is complex, particularly where there are co-existent difficulties such as mental ill-health. The Cycle of Change model (Prochaska and DiClemente 1982, 1983; outlined in Appendix 9) suggests that change is a cyclical process. It illustrates that substance misuse of often “a chronic, relapsing condition … and at each stage of treatment misusers may relapse and return to previous phases” (DoH 1996, cited in Castleton, 2015). For many people who misuse substances the biggest challenge is not physical detoxification but to sustain recovery – the “psycho-social transformation of beliefs, thoughts and lifestyle that have become intricately linked to substance use” (Castleton 2015). This underlines the importance of engagement with specialist services and mutual support groups (such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous) to support the process and maintenance of change, and reduce the risk of relapse. Frameworks to assist in assessing capacity to change are set out in Appendix 9.

It is important to be clear as to what changes are necessary in order to reduce harm to the child, and the nature of any intervention/services required in order promote change. As well as positive change in relation to parental substance misuse, there may be other changes required in relation to the parent’s ability to meet their own needs and respond appropriately to the needs of the child (Birch, 2015). The likelihood of achieving such change needs to be evaluated together with the likely timescale. This then needs to be considered in the context of the child’s timescale.

The Family Drug and Alcohol Court (FDAC) provides an intensive specialist approach in care proceedings where parental substance misuse is a significant issue. It incorporates a multi-disciplinary service, working to a designated family judge who actively manages the case.
Resources/useful websites

- Southwark Safeguarding Children Board (May 2014) Joint Service Protocol to meet the needs of children and unborn children whose parents or carers have substance misuse problems  
  www.southwark.gov.uk


- Alcohol Concern -  http://www.alcoholconcern.org.uk

- AUDIT - Alcohol Use Disorders Identification Test (basic self-report screening test)  
  http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/?parent=4444&child=4896

- Childhood Neglect: Neglect and parental substance misuse (2011) Produced by Carla Thomas, Child and Family Training/DfE  

- Department of Health (2011) A summary of the health harms of drugs  
  The Centre for Public Health, Faculty of Health and Applied Social Science, Liverpool John Moore’s University, on behalf of the Department of Health and National Treatment Agency for Substance Misuse  
  - Easy to access information about the acute and chronic impact of alcohol, illicit drugs and other substances.

- Family Drug and Alcohol Court  

- Home Office  

- National Treatment Agency for substance misusers  
  http://www.nta.nhs.uk/

- Research in Practice Frontline Briefing: The impact of parental substance misuse on child development (Chart)  
  https://www.rip.org.uk/resources/publications/frontline-resources

- Research in Practice Frontline Briefing: The impact of parental substance misuse on child development (Briefing)  
  https://www.rip.org.uk/resources/publications/frontline-resources

- The Drugs Wheel  
  http://www.thedrugswheel.com/
Local Services

- Lifeline Southwark lifelinesouthwark.org
  From 4 January 2016, an integrated problem drug and alcohol service is being provided by Lifeline (a registered charity) for adults resident in the London Borough of Southwark.

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1 Addington Square
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The nature of domestic violence and abuse
The cross-government definition of domestic violence and abuse is:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”*

*This definition includes so called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group (Home Office 2009)

Domestic Violence is typically understood as the methods used by a person to control another and it is likely to contain one or more of the following behaviours:

Physical violence: acts intended to result in physical pain

Emotional/Psychological abuse: acts intended to humiliate, mock, degrade, put down, insult. It can also include threats to hurt a child, forced isolation from family and friends, encouraging a child to engage in the abuse of the non-abusing parent.
Sexual abuse: coercing another to participate in unwanted sexual acts or to engage in sexual acts with others against their will, forcing unprotected sex for the purpose of reproduction, anything that makes the victim feel sexually violated.

Financial abuse: includes withholding finances, not being permitted to work, having money taken away.

Coercion, threats and intimidation: includes statements made with the purpose of eliciting fear, bullying, stalking and other forms of harassment. Stalking is a particular pattern of behaviour, usually found, but not exclusively, in relation to intimate partner violence, relationship breakdown or unrequited relationships.

Domestic violence is not gender specific, rather it can be seen in multiple contexts regardless of age, class, ethnicity, culture, sexuality or religious beliefs. The impact of domestic violence should not be minimised or explained away because of these factors.

Prevalence

- Domestic abuse and violence is under-reported. People aged 25 years and under are more likely to report domestic abuse.

- Research and statistical information indicates that women are more at risk of domestic violence. The British Crime Survey showed that 6% of women were victims of domestic abuse in the year 2008-9 compared with 4% of men. Domestic violence accounts for between 16% and 25% of all recorded violent crime. In any one year, there are 13 million separate incidents of physical violence or threats of violence against women from partners or former partners (Home Office, 2004; Dodd et al., 2004; Dobash and Dobash, 1980; Berry, 1995; Walby and Allen, 2004) On average, two women a week are killed by a current or former male partner in the UK (Office for National Statistics, 2015).

- The most dangerous time for a woman is when she is trying to escape from her abuser (Richards, 2003; Monckton Smith et al., 2014).
• 30% domestic violence begins or escalates during pregnancy and it has been identified as a prime cause of miscarriage and stillbirth (Mezey, 1997; Lewis et al., 2001).

• Research into the prevalence of domestic violence in same sex relationships is limited. Surveys of lesbians and gay men indicate that between 25% and 38% specifically saw themselves as having experienced domestic abuse at some time in a same sex relationship (Henderson, 2003; Donovan et al 2006) Many victims in same sex relationships do not report domestic abuse to the authorities, as they expect an unsympathetic response. Sexuality may be used as a means of control particularly by women, for example, of a partner who has not made public her sexual orientation (Donovan et al, 2006).

• Research suggests a correlation between animal cruelty, household violence and child abuse within the family (see for example, Bell, 2001; Hackett & Uprichard, 2007).

• Around one in five children in the UK have been exposed to domestic violence (Radford, L et al (2011).

Risks to children

• Exposure to domestic abuse or violence can negatively impact on a child’s physical and emotional wellbeing, cognitive development and behavioural presentation (Humphreys 2006; Stanley 2009). The definition of harm in the Children Act 1989 was extended by the Adoption and Children Act 2002 to include “impairment suffered from seeing or hearing the ill-treatment of another.” The harmful impact on a child is likely to be compounded if the child experiences other forms of maltreatment, including neglect.

• Research has shown that there are elevated levels of child physical abuse and child sexual abuse in families where domestic violence is a feature (Hester et al, 2007; Farmer and Pollock, 1998; DoH, 2010) Research also shows that the severity of the violence (usually against the mother) is predictive of the severity of abuse to the children.
Domestic abuse was found to be a risk factor in 63% of Serious Case Reviews undertaken in the UK from 2009-2011 (Brandon et al, 2012).

The London Child Protection Procedures (2015) identifies the risks to children living with domestic violence as including:

- The child being abused as part of the abuse against a parent:
  - Being used as pawns or spies by the abusive partner in attempts to control the other partner;
  - Being forced to participate in the abuse and degradation by the abusive partner.

- Emotional abuse and physical injury to the child from witnessing the abuse:
  - Hearing abusive verbal exchanges between adults in the household;
  - Hearing the abusive partner verbally abuse, humiliate and threaten violence;
  - Observing bruises and injuries sustained by a parent;
  - Hearing screams and pleas for help;
  - Observing the abusive partner being removed and taken into police custody;
  - Witnessing a parent being taken to hospital by ambulance;
  - Attempting to intervene in a violent assault;
  - Being physically injured as a result of intervening or by being accidentally hurt whilst present during a violent assault.

- Negative material consequences for a child of domestic violence:
  - Being unable or unwilling to invite friends to the house;
  - Frequent disruptions to social life and schooling from moving with their mother fleeing violence;
Hospitalisation of a parent and/or permanent disability.

**During the assessment process, consideration should be given to the following:**

- In order not to place sole responsibility on the non-abusive parent to protect the children, Farmer and Owen (1995) and Stanley (1997) recommend that both parents (or parent and partner) are involved in the assessment process. However, consideration must be given as to whether it is necessary to meet with each partner individually rather than together, for safety reasons.

- When assessing the couple together, careful thought must be given to how conversations about violence in the relationship can safely occur to ensure the victim is not subjected to more violence as a result.

- Stanley and Humphreys (2006) suggest that when meeting with a couple together where domestic violence is a concern, two practitioners should attend sessions to ensure the perpetrator does not have scope for intimidation or manipulation.

- Because separation can be a dangerous time for the victim of domestic violence this may influence their engagement.

- Analysis of the perpetrator’s childhood experience, their history of schooling and employment, relationship history, offending history, any history of mental health difficulties and/or substance misuse (alcohol misuse in particular has a strong correlation with domestic violence) will contribute to an understanding of their relationship to aggression, possible triggers and likely reactions during times of stress, and what may be contributing to sustaining the abusive behaviour. Previous experience of trauma (such as persecution, involvement in war) may increase vulnerability to violence towards a partner.

- Analysis of the victim’s childhood experience and family scripts (including issues relating to culture and gender), their history of intimate relationships, any offending history, any history of mental health difficulties and/or substance misuse, will contribute to an understanding of their vulnerability to abuse, their motivation to stay in the
relationship, and their ability to protect themselves and access professional support.

- Information from partner agencies, such as the police, GP, school and housing providers is essential where domestic violence is suspected, particularly in relation to the frequency and intensity of incidents.
- The intimidating nature of the relationship: what has the victim been told by the perpetrator will happen to them if they leave the relationship? Has this influenced their engagement, motivation and sense of agency?
- Domestic violence may have a direct impact on the non-abusive parent in a way that impedes parental capacity, for example, through sustaining serious injury. They may also be physically prevented from fulfilling their parental role by the abuser.
- Domestic violence may also diminish the capacity of the non-abusive parent to protect the children because they become so preoccupied with their own survival within the relationship they are unaware of the effect on the children.
- Practitioners also need to consider the potential psychological impact of domestic violence on the non-abusive parent that might include
  - Loss of self-esteem and self-confidence as an individual and parent;
  - Feeling emotionally and physically drained, and distant from the children;
  - Not knowing what to say to the children;
  - Inability to provide appropriate structure, security or emotional and behavioural boundaries for the children;
  - Difficulty in managing frustrations and not taking them out on the children;
  - Inability to support the children to achieve educationally or otherwise
Research indicates that domestic violence potentially impacts on the victim's mental health, increasing their vulnerability to Post-traumatic Stress Disorder (PTSD). The extent of PTSD varies between individuals and may occur whilst the victim is still in the abusive relationship or after it has ended, and it may be long-lasting. It may include flashbacks and sleep disturbance, emotional blunting, detachment from other people, anhedonia, (inability to feel pleasure), acute bursts of fear or panic, anxiety and depression, suicidal ideation, eating disorders and substance misuse (Barron, 2004; Bowstead (2000); Golding (1999); Humphreys et al 2003; Hidden Hurt, 2011). Previous experience of trauma may exacerbate the impact of domestic violence.

Impact of domestic violence on children

- The impact of domestic violence on children will depend upon such factors as the severity and nature of the violence; the length of time the child is exposed to the violence; factors such as the child's gender, ethnic origin, age, disability, socio-economic and cultural background; the warmth and support the child receives from the non-abusive parent, siblings and other family members; the quality of the child's wider relationships and social networks; and the child's capacity for and actual level of self protection (Department of Health 2010)

- Children exposed to domestic violence may demonstrate externalised behaviours and can be more aggressive and anti-social, whilst other children demonstrate internalised behaviours or symptoms of trauma such as anxiety, depression, somatisation, clinginess towards the victimised parent. Children exposed to domestic violence have an elevated risk of Post-traumatic Stress Disorder. Children may become socially isolated and school performance may be adversely affected through lack of concentration. Many children do not disclose their
experience of domestic violence and so changes in presentation may be unnoticed or misinterpreted (Department of Health 2010).

The analysis of risks and strengths

- Consider the needs of the perpetrator, victim and the children with regards to supporting change and recovery.
- Potential resilience factors and strengths within the family need to be considered when evaluating risk, including ways in which the protection of the children has been prioritised.
- In what ways will the non-abusive parent be able to protect if they leave the relationship?
- Who in the extended family is able to support the management of risk?
- What are the static, dynamic and acute dynamic risk factors? Risk factors include violence during pregnancy, threats to seriously harm or kill the victim or children, suicidal ideation, use of weapons, the proprietoriness of the perpetrator, drug and alcohol misuse and sexual jealousy. Have the perpetrator’s previous relationships been violent – is this a recurring pattern?
- Have previous legal restrictions/boundaries been ignored?
- Is the perpetrator able to take responsibility for their aggressive/violent behaviour and show remorse about the impact of their aggression on the victim and the child(ren)? Have they been able to demonstrate empathy?
- Has the perpetrator previously engaged in, or are they currently prepared to engage in, a programme that addresses their abusive behaviour? Failure to complete treatment, or being dismissed before completion of treatment, is a risk factor for the reoccurrence of violence.
- Is the victim willing to engage with a programme for victims of abuse?
- Is there a robust safety plan in place for the non-abusing parent and for the child(ren)?
Local services
For advice, or to make a referral for support, contact local services that provide assessment and intervention. A comprehensive up to date directory of services is available at www.southwark.gov.uk/domesticabuse

- Bede House, Starfish Project: Support for people affected by domestic violence and hate crimes.
  Email: RA@bedehouse.org.uk  Telephone: 0207 2379162

- Mozaic, St Thomas’ Hospital: Confidential and independent support, advice and information for women experiencing domestic violence.
  Telephone: 0207 188 7710/0207 188 9181

- Solace Advocacy and Support Service for Southwark (SASS): Offers perpetrator and victim programmes and 1-1 support for children - refer to SASS information for Professionals
  Email: southwark@solacewomensaid.org  Telephone: 0207 593 1290

- DeafHope UK: A specialist Domestic Abuse service for deaf women and their children established by SignHealth charity.
  www.signhealth.org.uk/deafhope  email deafhope@signhealth.org.uk
  Telephone: 07970 350366

Resources:

- Protocol for joint working between Children’s Social Care and Solace Advocacy and Support Service (SASS) – provides details of the services provided by SASS and the referral process.

- The power and control wheel (Domestic Abuse Intervention Programme) – note this relates to abuse against women perpetrated by male partners
  www.theduluthmodel.org

- SafeLives – previously CAADA – helpful source of information and resources including the DASH Risk Assessment Checklist and guidance
  www.safelives.org.uk

- Barnardo’s Domestic Violence Risk Identification Matrix (DVRIM) (Appendix 12). A tool that assists in the assessment of risk to children who are exposed to domestic violence.

AVA (Against Violence & Abuse) Good practice guidance and resources  www.avaproject.org.uk

SECTION 4: APPENDICES 1-12
Appendix One:

Parenting Assessment Report Template

Parenting Assessment

in respect of

Insert name(s) of parent(s)/carer(s) being assessed

Concerning the child(ren)

Insert name(s) of child(ren)

Author(s) of report

Insert name(s) of Social Worker(s)

Date of report:

Insert date report completed

Use Arial 12 font and 1.5 line spacing

Ensure that each paragraph under each Part is numbered consecutively

e.g. under Part Five - 5.1, 5.2, 5.3 etc

Insert any references at relevant points in your report

using footnotes, or at the end of your report.

NB Delete all guidance in blue from the finalised report
Qualifications of the author of the report

I, (insert name) am a qualified Social Worker. Insert qualifications with dates.
I have been employed by the London Borough of Southwark Children’s Service since (insert date). I currently work within the Safeguarding Service, based at Sumner House, Sumner Road, London SE15 5QS. Insert role e.g. I have been the lead Social Worker for (insert names of the child(ren) since (insert date).
Part One: Framework of assessment

Subject(s) of the assessment

1.1 *Insert the names of parents/carers and child(ren) who are the subjects of the assessment, their dates of birth and the legal status of the child(ren) where appropriate (e.g. ICO, Child Arrangements Order in favour of xx)*

Family structure

1.2 *Insert details of significant family members including the subjects of the assessment*

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<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Gender (M/F)</th>
<th>Relationship to child</th>
<th>PR (Yes/No)</th>
<th>Current Address</th>
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</thead>
<tbody>
<tr>
<td>AA</td>
<td>xx.xx.xx</td>
<td>F</td>
<td>Mother of xx</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BB</td>
<td>xx.xx.xx</td>
<td>M</td>
<td>Father of xx</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CC</td>
<td>xx.xx.xx</td>
<td>M</td>
<td>Father of xx</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Child 1</td>
<td>xx.xx.xx</td>
<td>M</td>
<td>Son of (name of mother) and (name of father)</td>
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<td></td>
</tr>
<tr>
<td>Name of Child 2</td>
<td>xx.xx.xx</td>
<td>F</td>
<td>Daughter of (name of mother) and (name of father)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DD</td>
<td>xx.xx.xx</td>
<td>F</td>
<td>Maternal grandmother</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Insert or attach a 3-generational genogram*
Ethnicity, cultural and religious identity and linguistic background

1.3 Briefly set out racial and ethnic heritage, religious and cultural identity of family members, and their first language. Identify as appropriate immigration status, noting specifically if status is unresolved. Does the parent hold a passport and is it up to date?

Explore and consider any implications arising from racial background, ethnicity, religious and cultural identity, and linguistic background at relevant points throughout the assessment.

Part Two: Reason for the assessment

2.1 Identify concisely the reason for this parenting assessment i.e. the nature of the Local Authority concerns (what we are worried about) and how these relate to any significant harm the child is suffering, or is likely to suffer (physical, emotional, developmental, social, sexual, neglect)

Attach a chronology identifying significant events in the life of the child(ren), or that have impacted on the wellbeing of the child(ren).

Part Three: Process of assessment

3.1 This assessment has been undertaken by insert name(s) and professional role(s) of the assessor(s) between insert dates when assessment was carried out (to and from). Southwark Children’s Services has adopted a systemic approach to social work practice. The aim is to work collaboratively with families and the professional systems that support them. Social workers are based in small Practice Groups, managed by an Advanced Practitioner and supported by a Clinical Practitioner, who is qualified as a psychologist or therapist. The Social Worker assigned to lead a parenting assessment coordinates the assessment, undertakes assessment tasks and authors the report. Other members of the Practice Group, or in some
instances, members of other Practice Groups within the Safeguarding Service, may undertake specific pieces of work with the family that contribute to the assessment. The planning, process and progress of all parenting assessments are discussed regularly at Practice Group supervision. In undertaking this assessment I have worked closely with xxx (e.g. xx, Clinical Practitioner; and/or xx, Social Worker from the Team for Children with Disabilities and Complex Needs).

3.2 Include here a brief outline of how the assessment process was tailored to take into account any accessibility factors, such as language, physical or sensory disability, communication difficulties, known or suspected learning disability or learning difficulties, any other relevant factor.

3.3 Identify here any tools, scales or questionnaires used for the purposes of assessing the parent(s), or which have informed the assessment, for example, list any psychometric tests administered (include a brief outline of the scale or questionnaire, date of administration, who administered and interpreted it) and attach the outcome of any tests as an appendix to the report where appropriate. Identify under Part Five (rather than here) any methods/resources used in direct work with the child(ren) to ascertain their wishes and feelings.

Sources of information

Interviews with the parent(s) and meetings with the child(ren), and if appropriate any meetings with the family group:

3.4 Set out individual and joint interviews with parents/partners, and meetings with children, and where appropriate any meetings with some or all members of the family together (include date, venue and approximate duration).

Identify any difficulties arising in relation to scheduled meetings, including any the parent(s) failed to attend and reasons given.
Observations of parent-child interaction:

3.5 **Set out observations of parent-child interaction (include date, duration and venue).**

Identify any difficulties arising in relation to scheduled observations, including any the parent(s) failed to attend and reasons given.

Interviews with members of the wider family/significant others:

3.6 **Set out interviews with named family members/significant others (include date and nature of contact, such as home visit, phone call)**

Consultation with professionals/agencies:

3.7 **Set out any consultation with other professionals/agencies, including any family support intervention services such as SFFT (include date and nature of contact). Where a child has a disability or complex needs this would include the Team for Children with Disabilities and Complex Needs; and where a child is placed in care, this would include the foster carer/residential staff.**

Other sources of information:

3.8 **List other sources of information e.g. London Borough of Southwark Children’s Services records, including any single assessment and risk assessment/other Local Authority records/reports from school/ GP/ Health Visitor/Hospital/ CAMHS/Probation/Police etc (include the date of each report)**

Information not reviewed:

3.9 **Only include if appropriate. Identify any information you were not able to obtain that you consider may be relevant to the assessment, and the reason why it is not available (e.g. if a parent has refused consent for a report to be provided by their GP).**

**Part Four: Summary of Conclusions and Recommendations**

4.1 **Summarise succinctly the conclusions of the assessment and any key recommendations.**
Part Five: Profile of the child(ren)

*Use a separate heading for each child*

*Give a brief description of each child.*

*Identify any specific needs/vulnerabilities (physical/developmental/communication/educational/emotional/social/behavioural) and resilience factors. Some of this information should be available within a recent single assessment. Consider using the Strengths and Difficulties Questionnaires and the Adolescent Wellbeing Scale where appropriate.*

*Identify the parenting each child would need to experience in order to address their specific needs.*

*Include the wishes and feelings of each child, their feelings towards their parents and other family members/their perception of themselves and their sense of identity, and where the child is of sufficient understanding, their views. Make clear how the child’s wishes and feelings were ascertained, with an outline of any methods/resources used in direct work, taking account of any special needs. Attach a scanned copy of any work completed by the child to your report.*

**Name of eldest child subject to this assessment**

5.1

**Name of second child subject to this assessment**

5.2

Part Six: Profile of the parent(s)

*Consider each heading in respect of each parent/carer being assessed.*

*Refer to Appendix 12 of the Parenting Assessment Handbook for questionnaires, scales and other tools to consider using in relation to each section below.*
When summarising the importance of the information in relation to parenting capacity under each heading, draw from any risk factors identified in the FRaSA as appropriate.

**Childhood and adolescence**

6.1 Include an exploration of the parent’s own history and family background, their experience of being parented and by whom; their perception of their relationships with their primary caregiver(s), siblings and other significant family members, as they were growing up; positive and adverse experiences from childhood/adolescence, including loss and separation.

Consider the parent’s own account, the degree of coherence in their narrative, and how this fits with information available from other sources.

Summarise the importance of this information in relation to parenting capacity.

**Education**

6.2 Do not list every school, but summarise the parent’s educational experience e.g. positive educational experience or frequent changes of school; consistent or poor attendance; special educational provision; friendships; victim of bullying; exclusions; age on leaving school; qualifications achieved at school, during further education or vocational training.

Summarise the importance of this information in relation to parenting capacity.

**Employment**

6.3 Summarise the parent’s experience of employment e.g. nature and duration of periods of employment; job satisfaction/dissatisfaction;
periods of unemployment; any recent job loss; any barriers to employment.

Summarise the importance of this information in relation to parenting capacity.

History of relationships

6.4 Include the parent’s account of any previous adult intimate relationships, including their view of the relationship, any children from the relationship, how long the relationship lasted and why it ended. Include any collateral information about previous relationships.

Include the parent’s account and view of any current relationship, including whether they think anything needs to change. Consider respective roles, satisfaction with the relationship, how the partners interact with each other, who manages the family income, and whether there have been any incidents of domestic abuse.

Where there is reported domestic abuse, what is the parent’s account and understanding of this (as victim or perpetrator). Include any collateral information about the current relationship.

Consider whether there are patterns evident in the history of relationships.

Summarise the importance of this information in relation to parenting capacity.

Physical Health

6.5 Briefly outline any serious injuries and/or significant medical conditions. Outline the impact on the parent’s day to day functioning, if any, and the nature of help/support required. Refer to any medical report(s).

Summarise the importance of this information in relation to any impact on parenting capacity.
Cognitive ability

6.6  Include if there are any known or suspected learning difficulties.

Include the specific results of any testing of cognitive ability and performance, and any report/information from the Community Learning Disabilities Team where appropriate.

Summarise the importance of the above in relation to parenting capacity.

Mental health

6.7  Include any known history of mental ill-health, any involvement with mental health services, compliance with medication or other treatment in the past and present where relevant, any history of violent behaviour, self-harm or suicidal ideation. Explore the parent’s insight into their mental illness, and their ability to identify when they are becoming unwell and to seek help. Include the support system available to the parent and the child(ren) if they become unwell. Include the main findings of any reports from the Community Mental Health Team, and any independent psychiatric reports (including in relation to any diagnosed Personality Disorder).

Summarise the importance of this information in relation to parenting capacity.

Psycho-social functioning

6.8  Include here the parent’s perception of themselves, their general mood, how they express their emotions (e.g. anger), how they relate to others, their plans for the future.

Include any observation/assessment of the parent’s emotional/psychological presentation and functioning. Refer to the results of any psychometric testing where appropriate. Include the main findings of any psychological report.
Summarise the importance of this information in relation to parenting capacity.

**Use of alcohol and illicit drugs/other substances**

6.9 Include the parent’s account of their history of use of alcohol and any illicit drugs or other illicit substances. Include the results of any testing for drugs/alcohol misuse; and any other evidence of known/suspected misuse such as police call-outs. Where there are indications of substance misuse, be specific about the nature, extent and pattern of substance misuse. Be specific about any impact or potential impact on the child(ren). Identify the risk factors, resilience and protective factors. Assess the parent’s motivation and ability to change. Has the parent meaningfully engaged with relevant services and what has been the outcome?

Summarise the importance of this information in relation to parenting capacity.

**Criminal record/police involvement**

6.10 Include a full but concise history of the parent’s criminal record and sentencing (include cautions, warnings, reprimands and outstanding charges).

Include any evidence of failure to comply with conditions/sentencing e.g. with bail conditions/ supervision by probation.

Include any history of police involvement in relation to incidents of alleged/reported domestic violence.

Include an exploration of the parent’s attitude to their history of offending behaviour and any remediation attempts.

Summarise the importance of this information in relation to parental capacity.
Analysis of Part Six

6.11 Analyse the information in relation to the profile of the parent, summarising what the information means in relation to that parent’s capacity to care for the children who are the subject of the assessment.

Part Seven: Family Culture, Relationships, Support Network, Social Integration and Resources

Family Culture, Relationships and Support Network

7.1 Describe family rules, organisation of roles, distribution of power, routines and rituals.

Describe the nature of interaction and relationships between family members, including inter-sibling interaction.

Consider family identity, cohesion and belief systems, including any cultural/religious practices; family scripts. Describe family activities and how special occasions/events are celebrated.

Consider the nature of support, or any difficulties/hostility from extended family. Include the outcome of any Family Group Conference.

Consider the nature of support and services from the professional network and parental engagement with these.

Social integration and community resources

7.2 Include a brief description of how the parents view their neighbourhood and how settled they see the family as being; whether family members use community resources such as Children’s Centres, youth clubs, leisure activities.

Accommodation and home conditions
7.3 Include a brief description of the housing circumstances of the family and the home conditions including any safety issues, and an outline of the living arrangements, including sleeping arrangements, and whether these are suitable for the child(ren).

Financial circumstances

7.4 Include a brief outline of income and significant expenditure, source of income, any debts, and if so, how these are being managed.

Analysis of Part Seven

7.5 Analyse the information in Part Seven and what this means in relation to the parent’s ability to care for these children.

Part Eight: Parenting Knowledge, Style and Relationship with the Child

Consider the following headings in respect of each parent/carer being assessed:

History of parenting

8.1 Briefly summarise information regarding the parenting of any child not subject to this assessment, for example, where a child resides with another parent or other family member; or where an older child has previously been removed from the care of the parent.

In respect of the child(ren) subject to this assessment, set out the positives and concerns in relation to basic care and protection from harm (include any harmful behaviour by the parent towards the child), meeting emotional and behavioural needs (including guidance and boundaries and any particular needs the child has), meeting developmental and educational needs (including any special needs the child has). Include the parent’s attitude to routine and any specialist health care.
Parenting knowledge, style, and the meaning of the child

8.2 Include and consider:

Parenting knowledge and understanding (include understanding of the range of a child’s needs, and basic knowledge about child development, age appropriate activities, self-care skills and age-appropriate independence).

Where a child has particular health needs, disabilities or other complex needs, include the parent’s understanding and knowledge of the impact of the disability on the child and how to meet that child’s specific needs.

Parent’s perception of each child, has this changed over time as the child has developed (e.g. was the child seen as “easier” when a baby?). Does the parent demonstrate emotional attunement with the child as they talk about and interact with him/her?

Parent’s perception of what parenting means; who are the role models for the parent?

How the parent considers their own experience of being parented has influenced their parenting of their children.

Parent’s understanding of the impact on the child(ren) of any neglect/physical abuse/emotional abuse/sexual abuse/DV/substance misuse as relevant.

Is the parent able to reflect on what they could do differently?

Observation of Parent-Child Interaction

Basic care

8.3 Describe how the parent meets each child’s physical care needs. Is this in a timely and developmentally appropriate way?

Ensuring safety

8.4 Describe how the parent ensures the safety of the child(ren). Is this in accordance with the child’s abilities and stage of development?
Emotional warmth

8.5 Describe how the parent responds to each child individually and as part of a sibling group where relevant. Look for evidence of mentalising, recognition of physical and emotional cues. Describe the parenting style, for example is it tending towards child-centred, passive, critical or authoritarian. Describe how the children respond to their parent’s behaviour.

Stimulation

8.6 Include developmentally appropriate verbal and physical stimulation. Note the quality of play and how engaged the children are with their parents. Is there any evidence of over-protective/over-directive behaviour that limits opportunities for exploration, learning and autonomy?

Guidance and Boundaries

8.7 Describe how the parents set boundaries e.g. is boundary setting authoritative, negotiated, manipulative, or coercive? How effective/consistent is the parent? How do the parents reward good behaviour/compliance?

Relationship between each child and parent

8.8 Set out your assessment of the quality of the relationship between each child and each parent, identifying the basis on which you reached that assessment. If you have been specifically trained to assess the pattern of attachment between a child and parent, you can describe the attachment between each child and each parent identifying the basis for your assessment.

Analysis of Part Eight

8.9 Analyse the information in relation to the history of parenting, parenting knowledge, style and the meaning of the child for the parent, your observations and evaluation of parent-child interaction and relationships, summarising what the information means in relation to
each parent’s capacity to care for the children individually, and/or
together if relevant, and/or with their current partner if relevant.

Part Nine: Understanding of the Local Authority’s concerns

9.1 Set this out in relation to the core issues of the case and the degree to
which the parents agree/disagree with the concerns. Outline what the
parent is prepared to do to ensure the safety and wellbeing of the
child(ren).

Part Ten: Capacity of parent(s) to change

10.1 Consider whether the parent has engaged meaningfully with this
assessment. Consider any issues in respect of motivation and
resistance to change, both positive and of concern.

Set out the nature of support (professional and informal) and
interventions previously provided. How has the parent responded to
previous support/interventions? Has the parent worked towards targets
for change previously identified and was change achieved? Is there
evidence of sustained engagement and improvement, or is there a
history of limited engagement and/or short-term change only? Are there
issues that affect take-up, retention and generalisation of learning?

Include your assessment as to whether any further intervention is likely
to effect change. If so identify the nature of the intervention/service,
the desired outcome and the likely timescale.

Summarise your analysis of the parent’s motivation and ability to effect
and sustain any changes that are necessary to meet the needs of the
child(ren), the likely timescale and whether that is within a timescale
commensurate with the developmental needs of the child(ren).
Part Eleven: Analysis

11.1 Set out your overall analysis of the parent’s capacity (individually and/or together with the other parent/current partner where appropriate) to meet the needs of each child within the child’s timescale.

Consider Adversity, Resilience, Vulnerability and Protective Factors in respect of the child(ren), parents and wider family/community.

Summarise and balance the strengths and skills of the parents, and the difficulties and concerns.

What would be the benefits to the child(ren) of remaining in the care of the parent(s)/returning to the care of the parent(s)?

What would be the risks to the child(ren) of remaining in the care of the parent(s)/returning to the care of the parent(s)?

Can the parents effect the necessary changes and meet the needs of the child(ren) within the developmental timescale of the child(ren).

Part Twelve: Conclusions and Recommendations

12.1 Set out your conclusions and recommendations clearly and succinctly.
<table>
<thead>
<tr>
<th>Name of assessor</th>
<th>Professional role</th>
<th>Signature</th>
<th>Date</th>
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<th>Professional role</th>
<th>Signature</th>
<th>Date</th>
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<tr>
<th>Name of Advanced Practitioner/Practice Group Lead</th>
<th>Signature</th>
<th>Date</th>
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Appendices:

Appendix 1: Chronology

Appendix 2: Genogram

In addition, appendices might include, for example:

Appendix 3: Risk assessment

Appendix 4: Results of any questionnaires/scales

Appendix 5: Work/drawings completed by the child(ren)

Appendix 6: Records of observation of parent-child interaction
Parenting Assessment Agreement

between

London Borough of Southwark

and

Insert names of parent(s)/carer(s) who are the subject(s) of the assessment

Concerning

Name(s) of child(ren) and date(s) of birth

NB Delete guidance in blue from the agreement once drafted
**Reason for the assessment**

*Set out the reason for the assessment, for example: Care proceedings, formal pre-proceedings. Give a brief outline of the Local Authority concerns.*

- Where the assessment has been directed by the Family Court within proceedings, the Parenting Assessment report will be filed with the Court.
- Where there are no current Family Court proceedings, the assessment report may be filed with the Court in the event of any future proceedings.

**Summary of the areas to be assessed**

- The development and experiences of each child in the family
- The parent(s) background and their life experiences, including their childhood, education and employment, past and present adult relationships, their physical and mental health, any learning needs, any history of misusing drugs or alcohol, any history of offending
- The parent(s) knowledge and skills relating to their parenting capacity
- The relationships between family members
- The family’s financial and living circumstances
- The family’s support network
- The parent(s) understanding of the professional concerns
- The parent(s) capacity to change

**The Assessors**

*Give details of who will be leading on/involved in the assessment.*

(Insert name), Social Worker, employed by the London Borough of Southwark, will lead on the parenting assessment. (Insert name) will be supported by their line manager (insert name) and other members of the social work Practice Group, who may carry out specific pieces of work. (Insert name) will be responsible for preparing the final report. (Insert name) will receive regular group and individual supervision throughout the duration of the
assessment and will have regular access to a Clinical Practitioner for the purpose of support and guidance.

**Timescale of the assessment**

*It is expected that the assessment will be completed in ten weeks, including eight weeks for interviews/meetings and two weeks for the completion of the report, with relevant sections being drafted as the assessment progresses.*

It is planned that the parenting assessment will take \( x \) weeks to complete from (insert agreed start date) and the report will be completed by (insert date). An agreed schedule of proposed meetings will be provided to the parent(s).

**During the assessment Southwark Children’s Services agrees to do the following:**

- Be transparent about the assessment process and seek the views of the parent about their experience of the process
- Try to share information in a sensitive and respectful way
- Be sensitive to, and respect difference with regards to gender, race, religion, age, ability, culture, class, ethnicity, sexuality and spirituality
- Try to present verbal or written information in a way that can be understood by the parent
- Where needed, arrange for an interpreter to attend all interviews and observations that take place as part of the assessment
- Ensure that the methods used during the assessment process take account of any particular needs of the parent, including any learning difficulties
- Take account during the assessment process of any identified needs arising from the family’s religious, cultural or ethnic background
- Arrange transport if this is necessary to enable a parent to attend a particular session that takes place away from the home
- If a parent identifies a need for additional support during the assessment, the lead assessor will consider how this need may be met
- Arrive at assessment sessions on time
• If a session has to be rearranged, adequate notice will be given whenever possible
• Respond to any immediate child protection concerns in accordance with its duty to safeguard children

At the end of the assessment, Southwark Children’s Services agrees to:
• Go through the report and explain the conclusions and recommendations
• Provide each parent/carer with a copy of the assessment report, unless the assessment has been directed by the Court, in which case it will be filed with the Court and copies provided to the legal representatives of the parents

During the assessment (insert name(s) of parent/carer) agrees to the following:
• To attend all pre-arranged assessment sessions on time. If (insert name(s) of parent/carer) is late or unable to attend a session, they will let the Social Worker know as soon as possible
• To participate in all sessions
• To conduct themselves in a respectful manner
• Not to attend any session under the influence of illegal drugs or alcohol
• To seek clarification and raise concerns in an appropriate and timely way
• To arrange adequate childcare for the duration of the session when necessary
• Insert any necessary additional expectations
Contact with extended family members/other connected persons

Discuss with the parent/carer(s) the reasons why it is considered that meeting with identified members of their wider family network may be helpful, providing it is considered appropriate and safe to do so. Where a parent/carer does not consent to members of the extended family being contacted, the reasons should be ascertained if possible. In the absence of consent, contact with members of the extended family should only be pursued where there is evidence that the child would be at risk of significant harm if such contact was not made. The relevant manager should be consulted, and the reasons recorded. If extended family members are approached it is important to ensure cultural sensitivity, and to ensure that the right of the parent/carer and the child(ren) to confidentiality is maintained.

*Each parent/carer should be asked to sign a separate consent form in relation to contact with members of the extended family/other connected person.*

Contact with extended family members/other connected persons

*(Name of parent/carer)* consents to the Local Authority contacting the following members of their extended family/other connected person for the purposes of this assessment:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to parent/carer</th>
<th>Address</th>
<th>Contact number(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Signed ………………………………………………………………………………….

Name of Parent/Carer …………………………………………………………….

Date …………………………………………………………………………………
Contact with other agencies/professionals working with the family

Discuss with the parent/carer(s) expectations around obtaining information from the agencies/professionals who work with them, where such information is not already available to Children’s Services, or is not up to date. Share with them Southwark’s policy and government guidance regarding information-sharing between agencies. Be as transparent as possible about which agencies/professionals you plan to approach and the type of information that will be requested. All reasonable efforts should be made to obtain consent from the subjects of the assessment prior to approaching other agencies. If consent is not given, establish the reasons for this, but inform the parent/carer(s) that the Local Authority has a duty to safeguard the child and that a decision will need to be made by the Local Authority as to whether it is necessary to seek information from other agencies without consent. This decision should be made in consultation with the relevant manager and the reasons recorded.

Each parent/carer should be asked to sign a separate consent form in relation to each agency/professional which can be forwarded to the agency/professional.
Contact with other agencies/professionals working with the family

(Name of parent/carer with PR) consents to the Local Authority requesting information for the purpose of this assessment as set out below:

*Insert additional relevant agencies as appropriate, e.g. Hospital, Adult Mental Health Services, Community Learning Disability Team, CAMHS, SFFT, Solace, agency providing support with substance misuse, NRPF team.*

<table>
<thead>
<tr>
<th>Name of agency/Professional</th>
<th>Information to be requested</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practitioner</td>
<td>Information regarding the physical and mental health of the parent relevant to the assessment of parenting capacity. Information regarding the health of each child.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Visitor</td>
<td>Child health and development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursery</td>
<td>Progress and development of the child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School</td>
<td>Educational and social progress of the child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police</td>
<td>Whether family members are known to the police - to include a record of any call-outs, cautions and/or convictions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Probation Service</td>
<td>Information regarding any involvement by Probation Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td>Information relating to the tenancy, and any housing issues relevant to the assessment of parenting capacity</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signed ……………………………………………………………………………..
Name of Parent/Carer ……………………………………………………………
Date ……………………………………………………………………………..

I have discussed the parenting assessment process with (insert name of parent/carer) and believe s/he understands what the assessment involves.

Signed ……………………………………………………………………………..
Name of Social Worker …………………………………………………………
Date ……………………………………………………………………………..
CONSENT TO CONTACT OTHER AGENCIES

Name  ____________________________________________

Date of Birth  _______________________________________

Address  ____________________________________________

Relationship to child/ren  _____________________________

<table>
<thead>
<tr>
<th>Name of child</th>
<th>Date of birth</th>
<th>Address</th>
<th>PR?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

I understand that during the parenting assessment, Southwark Social Services may wish to contact (insert name of agency/professional) in order to obtain information to help inform the assessment.

I give my permission for such information to be sought and placed on Southwark Social Services records.

Signed  ____________________________________________

Date  ____________________________________________
<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>VENUE</th>
<th>IN ATTENDANCE</th>
<th>AREAS FOR EXPLORATION</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>
SAMPLE ASSESSMENT SCHEDULE

The schedule below is an example only. The assessment schedule must be drawn up to take account of the family’s particular circumstances and the nature of the concerns. It should be reviewed and amended as necessary as the assessment progresses.

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>VENUE</th>
<th>IN ATTENDANCE</th>
<th>AREAS FOR EXPLORATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>08.10.15</td>
<td>10.30 am</td>
<td>Family home</td>
<td>Ms A (mother)</td>
<td>Agreement and planning meeting.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mr B (father)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mr B’s advocate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Social Worker</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Clinical Practitioner</td>
<td></td>
</tr>
<tr>
<td>12.10.15</td>
<td>11.30 am</td>
<td>Family home</td>
<td>Ms A Social Worker</td>
<td>Ms A’s understanding of professional concerns.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ms A’s personal and family history, including her upbringing, schooling and employment.</td>
</tr>
<tr>
<td>15.10.15</td>
<td>10:30 am</td>
<td>Sumner House</td>
<td>Mr B</td>
<td>Mr B’s understanding of professional concerns.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sumner Road</td>
<td>Mr B’s Advocate</td>
<td>Mr B’s personal and family history, including his upbringing, schooling and employment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Social Worker</td>
<td></td>
</tr>
<tr>
<td>20.10.15</td>
<td>1.30 pm</td>
<td>Family home</td>
<td>Ms A Social Worker</td>
<td>Review of previous session</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ms A to complete Adult Well-being Scale (Family Pack)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ms A’s physical and mental health, any substance misuse, any history of offending.</td>
</tr>
<tr>
<td>DATE</td>
<td>TIME</td>
<td>VENUE</td>
<td>IN ATTENDANCE</td>
<td>AREAS FOR EXPLORATION</td>
</tr>
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<td>------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ms A to complete a Strengths and Difficulties Questionnaire (Family Pack) in relation to each child.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>How does Ms A perceive the children and their needs?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>What does parenting mean to Ms A?</td>
</tr>
<tr>
<td>22.10.15</td>
<td>10.30 am</td>
<td>Sumner House</td>
<td>Mr B</td>
<td>Review of previous session.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sumner Road</td>
<td>Mr B`s Advocate</td>
<td>Mr B to complete Adult Well-being Scale (Family Pack)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Social Worker</td>
<td>Mr B`s physical and mental health, any substance misuse, any history of offending.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mr B to complete a Strengths and Difficulties Questionnaire (Family Pack) in relation to each child.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>How does Mr B perceive the children and their needs?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>What does parenting mean to Mr B?</td>
</tr>
<tr>
<td>03.11.15</td>
<td>10.30 am</td>
<td>Family home</td>
<td>Ms A</td>
<td>Ms A and Ms B’s relationship, roles and responsibilities.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mr B</td>
<td>Accommodation, neighbourhood, financial circumstances.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mr B`s advocate</td>
<td>Support network – informal and professional.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Social Worker</td>
<td>Draw up an eco-map.</td>
</tr>
<tr>
<td>05.11.15</td>
<td>4.00 pm</td>
<td>Family home</td>
<td>All family members</td>
<td>Draw up a family genogram. Exploration of family culture, religion, family identity. Family relationships.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Social Worker</td>
<td>Use of community resources.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Clinical Practitioner</td>
<td></td>
</tr>
<tr>
<td>DATE</td>
<td>TIME</td>
<td>VENUE</td>
<td>IN ATTENDANCE</td>
<td>AREAS FOR EXPLORATION</td>
</tr>
<tr>
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<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>09.11.15</td>
<td>10.30 am</td>
<td>Family home</td>
<td>Ms A</td>
<td>Parents’ knowledge and understanding of child development.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mr B</td>
<td>Parents’ understanding of how to meet the individual needs of each child in the family.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mr B’s advocate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Social Worker</td>
<td></td>
</tr>
<tr>
<td>12.11.15</td>
<td>4.00 pm</td>
<td>Family home</td>
<td>All family members</td>
<td>Observation of the parents and children together</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Social Worker</td>
<td>Activity to be agreed in advance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Clinical Practitioner</td>
<td></td>
</tr>
<tr>
<td>19.11.15</td>
<td>1.30 pm</td>
<td>Primary School</td>
<td>Child M</td>
<td>Individual direct work with Child M and Child N</td>
</tr>
<tr>
<td></td>
<td>2.30 pm</td>
<td></td>
<td>Child N</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Social Worker</td>
<td></td>
</tr>
<tr>
<td>24.11.15</td>
<td>10.30 am</td>
<td>Family home</td>
<td>Ms A</td>
<td>With the agreement of Ms A and Mr B, discuss the support MGM and wider family are able to offer all members of the family.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mr B</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mr B’s Advocate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MGM</td>
<td></td>
</tr>
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<td></td>
<td></td>
<td>Social Worker</td>
<td></td>
</tr>
<tr>
<td>27.11.15</td>
<td>1.30 pm</td>
<td>Primary School</td>
<td>Child M</td>
<td>Individual direct work with Child M and Child N</td>
</tr>
<tr>
<td></td>
<td>2.10 pm</td>
<td></td>
<td>Child N</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Social Worker</td>
<td></td>
</tr>
<tr>
<td>01.12.15</td>
<td>4.00 pm</td>
<td>Family home/in the community</td>
<td>All family members</td>
<td>Observation of parents and children together. Activity to be agreed in advance.</td>
</tr>
<tr>
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</tr>
<tr>
<td>DATE</td>
<td>TIME</td>
<td>VENUE</td>
<td>IN ATTENDANCE</td>
<td>AREAS FOR EXPLORATION</td>
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<td>------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>03.12.15</td>
<td>10.30 am</td>
<td>Family home</td>
<td>Ms A</td>
<td>Review the family's response to support and intervention previously provided. Parents` views about what needs to change now, how they envisage they will bring about change, what future support/intervention they believe would assist them.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mr B</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mr B`s advocate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Social Worker</td>
<td></td>
</tr>
<tr>
<td>17.12.15</td>
<td></td>
<td>Parenting Assessment Report to be completed</td>
<td></td>
<td>Review of parenting assessment process.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Arrange date to discuss the report once completed.</td>
</tr>
</tbody>
</table>
Appendix 3: Developing a genogram and ecomap

The following are the standard symbols used when generating a genogram:

**Standard Symbols for Genograms**

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>Lesbian, Gay, Bisexual, Transgendered Person</td>
</tr>
<tr>
<td></td>
<td>Birth Date</td>
</tr>
<tr>
<td></td>
<td>Age Inside Symbol</td>
</tr>
<tr>
<td></td>
<td>Death X Death Date</td>
</tr>
<tr>
<td></td>
<td>Index Person</td>
</tr>
</tbody>
</table>

- **Marriage**
- **Living Together or Affair**
- **Lesbian Couple**
- **Gay Couple**
- **Mental Separation**
- **Divorce**
- **Back together after Divorce**
- **Person's Relationship to Professional or Institution**

**Children: List in birth order beginning with the o**

- **Biological Child**
- **Foster Child**
- ** Adopted Child**
- **Stillbirth**
- **Miscarriage**
- **Abortion**
- **Fetal Twins**
- **Identical Twins**
- **Fertility**

**Drug or Alcohol Abuse**

**Suspected Abuse**

**In Recovery from Drug or Alcohol Abuse**

**Serious Mental or Physical Problem**

**Drug/Alcohol Abuse and Physical or Mental Problem**

**Symbols Denoting Interactional Patterns between People**

- **Positive**
- **Distant**
- **Close**
- **Close-Hostile**
- **Focused On**
- **Fused**
- **Hostile**
- **Hostile Directed**
- **Fused Hostile**
- **Cut Off**
- **Abuse (Physical or Sexual)**

The Multicultural Family Institute [http://multiculturalfamily.org](http://multiculturalfamily.org)
Some rules to remember

- A parental couple who are currently in, or who previously shared an intimate relationship, is denoted by a horizontal line connecting them. An unbroken line is used to signify marriage, whereas a perforated line is used to signify cohabitation or commitment without marriage. Significant previous intimate relationships should be included, especially if children were a result of the relationship. Two short left directed (forward slash) vertical lines denote divorce, and one indicates separation.

- The male parent is placed on the left and the female parent on the right.
- Children are placed below the parental relationship, oldest to youngest being positioned from left to right.

- Exact dates are significant, for example, dates of birth, dates of death, start and end dates of relationships
- A line is drawn around family members who currently live together.
- Organisations that are significant to family functioning and/or provide support are drawn in close proximity to the relevant family member, but if this makes the genogram so complicated that it is difficult to read, draw up a separate eco-map
Example of a basic genogram
Example of a complex genogram
Example Eco-map

Alcohol Support Services

Imam

Mo 39

Aliya 31

Mo Jnr 6

Sofi 3

Neighbour

Solicitor

Mosque

Midwife

School

Nursery

DV support Service

KEY - ECOMAP

——— A strong connection

——— A weak connection

Points towards the direction of flow, energy, interest

=//=//=//= A stressful relationship
**Appendix 4: Brief Guide to Child Development**

**Physical Development 0 – 16 Years**
- Fine motor skills involve small intricate movements undertaken by the fingers, for example holding a pencil. Gross motor skills involve larger movements developed by the larger muscles that control the spine, legs, arms, neck, feet and hands, for example crawling, jumping, kicking a ball.
- A child’s physical development is generally sequential – children tend not to skip stages
- Children gain control of their bodies at different rates, therefore no two children will develop at the same rate

<table>
<thead>
<tr>
<th>Age</th>
<th>Fine Motor Skills</th>
<th>Gross Motor Skills</th>
<th>Appropriate Caregiver Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 months</td>
<td>Watches hands</td>
<td>Lifts head and chest</td>
<td>Consistently meets basic needs</td>
</tr>
<tr>
<td></td>
<td>Clasps and unclasps hands</td>
<td>Waves arms symmetrically</td>
<td>Provides a safe and stimulating environment</td>
</tr>
<tr>
<td></td>
<td>Can momentarily grasp objects (e.g. rattle, adult finger)</td>
<td>Kicks vigorously, alternating occasionally</td>
<td>Provides developmentally-appropriate toys</td>
</tr>
<tr>
<td></td>
<td>Moves head to look around</td>
<td></td>
<td>Provides appropriate supervision</td>
</tr>
<tr>
<td>6 months</td>
<td>Reaches for a toy or human face</td>
<td>Holds arms to be lifted up</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Puts objects into mouth</td>
<td>Rolls over from front to back</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Follows adults across room</td>
<td>Sits with support in cot or buggy</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Head is erect when held in sitting position</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>9 months</td>
<td>Deliberately drops objects by releasing them</td>
<td>May attempt to crawl or move by rolling</td>
<td>Consistently meets basic needs</td>
</tr>
<tr>
<td></td>
<td>Grasps objects using finger and thumb</td>
<td>Sits unsupported on floor 10 mins</td>
<td>Provides a safe environment conducive for learning and exploration</td>
</tr>
<tr>
<td></td>
<td>Transfers objects from one hand to the other</td>
<td>Pulls to stand with support</td>
<td>Provides stimulation</td>
</tr>
<tr>
<td>12 months</td>
<td>Uses index finger and thumb to pick up small objects (pincer grasp)</td>
<td>Sits well</td>
<td>Provides developmentally-appropriate toys</td>
</tr>
<tr>
<td></td>
<td>May point to something using index finger</td>
<td>Crawls rapidly</td>
<td>Encourages mobility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>May be able to stand alone</td>
<td>Provides appropriate supervision</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Walks round furniture stepping sideways</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Walks with one or both hands held</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>18 months</td>
<td>Attempts to use a spoon to feed self</td>
<td>Walks unaided</td>
<td>Consistently meets basic needs</td>
</tr>
<tr>
<td></td>
<td>Builds a tower of around three blocks</td>
<td>Climbs up on a toy/adult chair</td>
<td>Provides a safe environment</td>
</tr>
<tr>
<td>Age</td>
<td>Fine Motor Skills</td>
<td>Gross Motor Skills</td>
<td>Appropriate Caregiver Response</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------------------</td>
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<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>• Scribbles&lt;br&gt;• Holds cup&lt;br&gt;• Points to distant interesting objects</td>
<td>• Walks upstairs with hand held&lt;br&gt;• Moves down the stairs on their bottom or tummy</td>
<td>conducive for learning and exploration&lt;br&gt;Provides stimulation and developmentally-appropriate toys and games&lt;br&gt;Introduces different activities to assist in the development of new skills&lt;br&gt;Appreciates attempts to complete tasks independently&lt;br&gt;Provides appropriate supervision</td>
</tr>
<tr>
<td>24 months</td>
<td>• Draws circles and dots&lt;br&gt;• Competently uses a spoon to feed themselves&lt;br&gt;• Zips up and unzips</td>
<td>• Runs&lt;br&gt;• Climbs on furniture&lt;br&gt;• Jumps in place with both feet&lt;br&gt;• Squats to rest/play</td>
<td></td>
</tr>
<tr>
<td>30 months</td>
<td>• Likely to have established hand preference&lt;br&gt;• Does simple puzzles&lt;br&gt;• Builds a tower of 7 blocks&lt;br&gt;• Learning to unbutton things</td>
<td>• Kicks a large ball&lt;br&gt;• May be able to use a tricycle&lt;br&gt;• Can do a broad jump (jumps forwards with both feet together)&lt;br&gt;• Push and pull large toys</td>
<td></td>
</tr>
<tr>
<td>3 years</td>
<td>• Washes and dries hands with help&lt;br&gt;• Holds crayon and attempts to draw a face&lt;br&gt;• Paints ‘pictures’</td>
<td>• Runs forwards and backwards&lt;br&gt;• Throws a ball&lt;br&gt;• Rides tricycle&lt;br&gt;• Climbs stairs alternating feet</td>
<td>Consistently meets basic needs&lt;br&gt;Provides a safe environment conducive for learning&lt;br&gt;Provides stimulation and developmentally-appropriate toys, games, equipment&lt;br&gt;Encourages development of new skills&lt;br&gt;Supports practice of new skills&lt;br&gt;Provides opportunities for new skills to be used&lt;br&gt;Appreciates attempts to complete tasks independently&lt;br&gt;Provides age-appropriate supervision</td>
</tr>
<tr>
<td>4 years</td>
<td>• Buttons/unbuttons clothing&lt;br&gt;• Draws person with trunk, legs, head&lt;br&gt;• Cuts out simple shapes&lt;br&gt;• Draws very simple house</td>
<td>• Hops on one foot&lt;br&gt;• Aims and throws a ball&lt;br&gt;• Walks on a line&lt;br&gt;• Can run on tiptoe</td>
<td></td>
</tr>
<tr>
<td>5 years</td>
<td>• Forms letters&lt;br&gt;• May be able to write own name&lt;br&gt;• Counts five objects correctly</td>
<td>• Skips on alternate feet&lt;br&gt;• Chases and dodges others&lt;br&gt;• Runs confidently avoiding obstacles</td>
<td></td>
</tr>
<tr>
<td>6 – 8 years</td>
<td>• Joined-up handwriting&lt;br&gt;• Drawings are more detailed&lt;br&gt;• Ties and undoes shoelaces</td>
<td>• Uses a bicycle or roller skates&lt;br&gt;• Balances on a beam</td>
<td></td>
</tr>
<tr>
<td>8 – 11 years</td>
<td>• Engages in more intricate tasks&lt;br&gt;• Less concentration is needed, allowing talking and activity to happen at the same time</td>
<td>• Increased co-ordination&lt;br&gt;• Developing the ability to strategise during games</td>
<td></td>
</tr>
<tr>
<td>11 – 16 years</td>
<td>• Increased strength in hands allowing for tasks that require more strength</td>
<td>• Takes part for longer in more energetic games as body develops</td>
<td></td>
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</tbody>
</table>
Social, emotional and behavioural development 0 – 16 Years

- Different factors impact on a child’s social, emotional and behavioural development such as temperament, disability, birth order

- It is important to develop a broad picture of the child’s social, emotional and behavioural development and not solely focus on ideas of what is “normal”. The stages below are approximate.

<table>
<thead>
<tr>
<th>Age</th>
<th>Child</th>
<th>Appropriate caregiver response</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4 weeks</td>
<td>• Looks at faces transiently</td>
<td>• Provides sensitive care, thinking about the baby as a separate and unique person</td>
</tr>
<tr>
<td></td>
<td>• At 3-4 weeks smiles selectively in response to voice of primary caregiver</td>
<td>• Is attuned to the needs and rhythm of the baby (synchrony, dance of attunement)</td>
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<tr>
<td></td>
<td>• From 3rd week human voice may soothe the baby</td>
<td>• Develops reciprocal interactions e.g. vocalisation, mirroring of facial expressions</td>
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<tr>
<td></td>
<td></td>
<td>• Responds appropriately and promptly to the baby’s needs and cues</td>
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<tr>
<td></td>
<td></td>
<td>• Is reliably available</td>
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<tr>
<td></td>
<td></td>
<td>• Provides physical contact and comfort</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Engages in eye contact and smiles frequently</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Changes voice tone when talking to the baby</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Provides stability of routine and environment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Begins to affirm the child’s sense of self-efficacy through games such as peek-a-boo, pat-a-cake</td>
</tr>
<tr>
<td>1-3 months</td>
<td>• Smiles responsively to human face</td>
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</tr>
<tr>
<td></td>
<td>• Fixes eyes on primary caregiver when feeding</td>
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<tr>
<td></td>
<td>• Uses vocalisation to interact socially</td>
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<tr>
<td></td>
<td>• May smile spontaneously</td>
<td></td>
</tr>
<tr>
<td>4-6 months</td>
<td>• Smiles readily at most people</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Smiles at image in mirror</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reaches for the human face (and toys)</td>
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<tr>
<td></td>
<td>• 50% children of this age like to play peek-a-boo</td>
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<tr>
<td></td>
<td>• Most children at this stage are able to play alone with age-appropriate toys for short periods of time</td>
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<tr>
<td>6-9 months</td>
<td>• Onset of ‘stranger anxiety’</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Most children of this age reach out for familiar people</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Difference in interactions with various family members</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Shows desire to be picked up and held</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pats mirror image</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Plays peek-a-boo</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Begins to respond to own name</td>
<td></td>
</tr>
<tr>
<td>9-12 months</td>
<td>• Actively tries to get attention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Repeats performances for attention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Sociable with family, shy with strangers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Beginnings of self-identity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Capable of varying emotions e.g. fear, anger, anxiety</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Becoming aware of emotions in others</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Child</td>
<td>Appropriate caregiver response</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 12-15 months | • More demanding, assertive and independent  
• Poor emotional equilibrium  
• Vocalising replaces crying for attention  
• Sense of “me” and “mine”  
• Reacts when primary caregiver(s) leave | • Provides sensitive and responsive care, being aware of the child’s cues  
• Initiates demonstrations of affection  
• Responds to the child’s overtures, including affectionate overtures  
• Provides effective comforting  
• Offers continual praise and encouragement  
• Promotes self-esteem  
• Initiates positive interaction  
• Engages in reciprocal interaction  
• Accepts expressions of autonomy  
• Affirms the child’s sense of self-efficacy  
• Provides positive role-model  
• Anticipates possible sources of frustration  
• Sets age-appropriate behavioural limits  
• Uses developmentally-appropriate methods to deal with unwanted behaviours, such as distraction methods  
• Provides consistent routines  
• Provides stable environment  
• Provides opportunities for socialisation with other children e.g. attending parent and toddler groups |
| 15-18 months | • More claiming of “mine”  
• Beginning distinction between “you” and “me”  
• Concentrated interest, but wary of strangers  
• Resistant to changes in routine  
• Autonomy may be expressed as defiance  
• Imitates and mimics others  
• Solitary or parallel play with other children  
• Shows or offers toys |                                                                                                                                             |
| 18-24 months | • Starts to distinguish between self and others, but general belief that objects belong to them – no concept of things belonging to others  
• More social with primary caregiver(s) and family members  
• May show both clingy and resistant behaviour  
• Plays alone but likes to be near adult  
• Follows caregiver |                                                                                                                                             |
| 2 - 3 years  | • Most children learn to separate without undue anxiety from primary caregiver(s)  
• Easily frustrated and prone to tantrums  
• Wants to be the focus of adult attention and struggles when it is directed elsewhere  
• May start to understand sharing  
• Shows pity, sympathy, modesty and shame |                                                                                                                                             |
| 3 - 4 years  | • Follows simple rules by imitation  
• Can articulate wishes  
• Enjoys being around other children and engaging in co-operative play  
• Will attempt to help adults with tasks  
• Develops the ability to “lie”, but also to negotiate |                                                                                                                                             |
| 4 - 5 years  | • Can play with other children without the direction of adults  
• Beginning to understand the need for rules |                                                                                                                                             |
<table>
<thead>
<tr>
<th>Age</th>
<th>Child</th>
<th>Appropriate caregiver response</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Begins to show perspective taking - empathy</td>
<td>• Encourages friendships and provides opportunities for child to be with friends (e.g. out of school activities)</td>
</tr>
<tr>
<td></td>
<td>• May argue with parent's requests</td>
<td>• Accepts expression of negative feelings</td>
</tr>
<tr>
<td></td>
<td>• Self-sufficient when at home</td>
<td>• Gives clear messages about behaviours that are approved of and disapproved of</td>
</tr>
<tr>
<td>5-11 years</td>
<td>• Values friendships, &amp; friends becoming influential</td>
<td>• Explains impact of behaviour on others</td>
</tr>
<tr>
<td></td>
<td>• Copies behaviour (negative and positive) of other children</td>
<td>• Comments on positive behaviour as well as negative</td>
</tr>
<tr>
<td></td>
<td>• Understands the need for rules and fair play</td>
<td>• Provides activities and age-appropriate responsibilities to help children develop self-help skills and sense of self-efficacy</td>
</tr>
<tr>
<td></td>
<td>• Enjoys games with rules</td>
<td>• Uses praise and encouragement to promote self-esteem</td>
</tr>
<tr>
<td></td>
<td>• Can share and compromise</td>
<td>• Provides space to talk about things that matter to the child</td>
</tr>
<tr>
<td></td>
<td>• Knows difference between right and wrong</td>
<td>• Provides opportunities for the child to develop their own interests</td>
</tr>
<tr>
<td></td>
<td>• Able to pause to think before action</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Develops a range of self-help skills</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Develops sense of identity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Learning social roles/cultural values</td>
<td></td>
</tr>
<tr>
<td>11-16 years</td>
<td>• Onset of puberty affecting physical, emotional and behavioural development (girls: average age 11 years, boys: average age 12 years)</td>
<td>• Sets appropriate limits</td>
</tr>
<tr>
<td></td>
<td>• May demonstrate extreme emotional shifts</td>
<td>• Encourages self-control</td>
</tr>
<tr>
<td></td>
<td>• Increased influence of friends and peers</td>
<td>• Has reasonable expectations about household responsibilities</td>
</tr>
<tr>
<td></td>
<td>• Develops more cohesive sense of identity – may follow/reject parent/community values</td>
<td>• Promotes self-esteem and self-confidence through praise, encouragement and positive comment</td>
</tr>
<tr>
<td></td>
<td>• May want to express individuality through appearance</td>
<td>• Encourages attempts at age-appropriate independence, supporting the young person to negotiate their own boundaries</td>
</tr>
<tr>
<td></td>
<td>• Increased interest in sexual matters</td>
<td>• Shows affection</td>
</tr>
<tr>
<td></td>
<td>• Explores issues and questions about sexuality and sexual orientation; gradually develops sense of sexual identity</td>
<td>• Shows interest in and acceptance of young person's friends</td>
</tr>
<tr>
<td></td>
<td>• Capacity for insight increases</td>
<td>• Shows interest in school performance</td>
</tr>
<tr>
<td></td>
<td>• Starts to develop goals for the future</td>
<td>• Shows interest in activities</td>
</tr>
<tr>
<td></td>
<td>• Transitions from dependence on family to more independent functioning</td>
<td>• Demonstrates trust and “belief” in the adolescent</td>
</tr>
<tr>
<td></td>
<td>• Risk-taking/experimental behaviour may emerge</td>
<td>• Provides a secure base</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stands by the adolescent if in trouble</td>
</tr>
</tbody>
</table>
Communication and language development 0 – 16 Years

- *From birth, babies will tune into sounds*
- *Children move on to develop the key skills of communication and progress to the use of language as a way of making themselves understood and getting their needs met.*

<table>
<thead>
<tr>
<th>Age</th>
<th>Child</th>
<th>Appropriate Caregiver Response</th>
</tr>
</thead>
</table>
| 0 - 6 months   | - Cries if uncomfortable/to gain carer’s attention  
- Makes eye contact  
- From 1 month coos in response to carer talking  
- Responds to tone of voice and inflection primary carer  
- By 6 months repeats sounds, squeals, laughs and chuckles | - Makes good eye contact  
- Provides running commentary  
- Uses repetitive phrases  
- Responds to vocalisation                                                                                           |
| 6 - 18 months  | - Babbles with expression  
- First words spoken from 12 – 18 months.  
- Responds to own name  
- Shouts/points to attract adult’s attention | - Makes good eye contact  
- Provides running commentary  
- Actively listens to the child                                                                                       |
| 18 - 36 months | - Dramatic growth in vocabulary and grammar  
- Starts to hold simple conversations  
- Points to body parts  
- Responds to simple requests  
- Asks many questions beginning `what?` `where?`  
- Able to follow stories and repeats songs and rhymes | - Engages in conversation with the child  
- Allows the toddler time to think and respond  
- Reads and sings to the child                                                                                       |
| 3 - 5 years    | - Imitates adult speech  
- Asks many questions, incl meaning of words by 4 years,  
- By 4 years speech intelligible to strangers  
- Rapidly expanding vocabulary  
- Forms sentences | - Shows patience when child asks same or similar questions  
- Helps the child use language as a means of expression  
- Asks open questions to facilitate descriptive responses.  
- Actively listens to the child  
- Engages in conversation with the child  
- Reads with the child  
- Supports the child to use language to convey their emotional world                                                  |
| 5 - 11 years   | - Expresses self clearly  
- Enjoys jokes  
- Puts feelings into words  
- Tells stories from memory | - Engages in dialogue with the young person                                                                   |
| 11-16 years    | - Continued development of communication and fluent language skills  
- Increasing use of peer influenced “coded” language                                                                 |                                                                                                               |
Cognitive Development - Play and Learning

- Cognitive development is the process of thinking, organising information and learning abstract concepts
- Memory, perception, concentration, attention, imagination and creativity are all part of cognitive development

<table>
<thead>
<tr>
<th>Age</th>
<th>Child</th>
<th>Appropriate caregiver response</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 6 months</td>
<td>• Explores using hands and mouth</td>
<td>• Engages in play with the baby</td>
</tr>
<tr>
<td></td>
<td>• Watches adults</td>
<td>• Engages in face to face contact</td>
</tr>
<tr>
<td></td>
<td>• Recognises familiar faces</td>
<td>• Mirrors baby’s facial expressions</td>
</tr>
<tr>
<td></td>
<td>• By 3 months follows movements of large and smaller objects</td>
<td>• Provides objects for the baby to fix their gaze on and reach out for, such as mobiles, baby gym</td>
</tr>
<tr>
<td></td>
<td>• By 6 months fixes gaze on nearby small objects</td>
<td>• Provides developmentally-appropriate toys</td>
</tr>
<tr>
<td>6-12 months</td>
<td>• Repeats movements</td>
<td>• Engages in play and games, such as peek-a-boo, pat-a-cake</td>
</tr>
<tr>
<td></td>
<td>• Enjoys games like peek-a-boo</td>
<td>• Provides safe and appropriate items for baby to touch, taste, feel, see and listen to</td>
</tr>
<tr>
<td></td>
<td>• Explores toys alone</td>
<td>• Talks about what the child sees, hear, feels, smells</td>
</tr>
<tr>
<td></td>
<td>• Learns through senses</td>
<td>• Provides developmentally-appropriate toys and books</td>
</tr>
<tr>
<td></td>
<td>• Recognises familiar routines</td>
<td>• Provides safe opportunities for exploration of the environment</td>
</tr>
<tr>
<td></td>
<td>• Responds to familiar pictures</td>
<td></td>
</tr>
<tr>
<td>12 -18 months</td>
<td>• Learns through trial and error</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Repeats actions they have enjoyed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Deliberately drops toys and watches them fall</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Can play alone and talks to self</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Notices other children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Explores environment energetically</td>
<td></td>
</tr>
<tr>
<td>18- 24 months</td>
<td>• Imitates other children and adults</td>
<td>• Provides developmentally-appropriate toys and books</td>
</tr>
<tr>
<td></td>
<td>• Carries out repetitive actions</td>
<td>• Provides opportunities to be with other children</td>
</tr>
<tr>
<td></td>
<td>• Turns pages of book</td>
<td>• Provides opportunities for the child to develop their imaginative skills</td>
</tr>
<tr>
<td></td>
<td>• Does simple puzzles</td>
<td>• Encourages the child to embed newly learned skills through repetitive games</td>
</tr>
<tr>
<td></td>
<td>• Points to body parts and objects named by adults</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Child</td>
<td>Appropriate caregiver response</td>
</tr>
<tr>
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<td>-------------------------------------------------------------------------------------------------</td>
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</tbody>
</table>
| 2 - 4 years | • Starting to develop reasoning skills  
  • Able to concentrate for longer periods  
  • Recognises shapes, colours  
  • Plays imaginatively/pretends  
  • Begins to count  
  • Initiates own play activities | • Provides a variety of stimulating activities  
  • Provides opportunities that offer age-appropriate challenge to promote skill development  
  • Provides age-appropriate toys, games and books  
  • Provides sorting activities to facilitate the making of connections |
| 4 – 6 years | • Can remembers past events and understands ‘future’  
  • Starts to develop reasoning skills based on experiences  
  • Develops writing and reading skills  
  • Counts with increased understanding  
  • Understands simple rules of games  
  • Plays co-operatively | • Supports and encourages regular school attendance  
  • Promotes friendships  
  • Provides developmentally appropriate toys, games and books  
  • Promotes an interest in reading  
  • Provides games that promote adherence to rules and turn taking  
  • Provides opportunities for the development of interests/leisure activities  
  • Shows interest in the child’s interests/activities  
  • Provides opportunities for creativity  
  • Shows interest in school performance and encourages achievement of educational potential  
  • Engages in conversation and encourages age-appropriate discussion and debate |
| 6 - 8 years | • Shows reasoning skills  
  • Able to think about several things at once  
  • Understands the need for rules  
  • Makes up their own games that have rules  
  • Plays board games with understanding and skill  
  • Plays competitive games but does not always cope with losing  
  • Learns to tell the time |                                                                                                       |
| 8 - 11 years | • Develops confident literacy skills  
  • Begins to develop logical reasoning to solve problems  
  • Understands relational terms such as weight and size  
  • Uses information from one situation and transfers it to another  
  • Begins to understand abstract concepts  
  • Able to consider all aspects of a situation  
  • Enjoys discussion and debate  
  • Creative in role play, writing and drawing  
  • Develops interests/leisure activities  
  • Understands the value of coins |                                                                                                       |
<table>
<thead>
<tr>
<th>Age</th>
<th>Child</th>
<th>Appropriate caregiver response</th>
</tr>
</thead>
</table>
| 11 - 16 Years | • Develops abstract thinking  
• Learns to use deductive reasoning  
• Increased planning ability  
• Questions sources of information  
• Makes sense of how information relates to them in their world | • Provides opportunities for discussion and debate  
• Shows an interest in school performance and encourages achievement of educational potential  
• Promotes open communication  
• Is attuned to signs of potential stress and provides emotional support at such times |

The development guidelines are drawn from:
<table>
<thead>
<tr>
<th>Factors that may impact on child development</th>
<th>Potential Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early childhood environment</td>
<td>There is increasing evidence that early childhood environment, and the first three years of life in particular, play a major role in shaping children's neurobiological, cognitive, social, emotional and behavioural development (Barlow and Scott 2010, Brown and Ward, 2012). A key feature of a child's early environment is their relationship with the primary caregiver. Children who experience sensitive and responsive caregiving are more likely to develop a secure attachment pattern. The available and sensitive parent provides a secure base that promotes trust in their availability, thereby allowing the child to explore and learn, confident that s/he can return to the secure base when needed.</td>
</tr>
<tr>
<td>Abuse and Neglect</td>
<td>There is extensive and growing evidence showing how the experience of abuse and neglect at any age or stage of development can have a negative impact on a child’s physical, cognitive, social, emotional and behavioural development that can last into adulthood (see Ward et al, 2014, p.44). Abuse and neglect during the first three years of life is now considered to be particularly harmful due to the impact on the child’s neurobiological development and on the attachment process (see Ward et al, 2014; Howe, 2005). As the child grows, maltreatment can have an adverse effect on self-esteem, emotional regulation, social skills and the ability to engage in learning. Abused and neglected young children may exhibit behavioural difficulties such as aggression, or cognitive issues, including delayed language development.</td>
</tr>
<tr>
<td>Family structure/family circumstances</td>
<td>The child’s relationship with the adults and siblings they live with impacts on development. Factors such as a child’s birth order, or the number of children in the household, may also impact on how they develop. Poverty and poor housing conditions have an adverse impact on development. Life events can also be influential, for example, bereavement, parental separation/divorce and starting/changing schools can all impact on emotional and social development. Whilst intelligence may be genetically determined, environmental factors can</td>
</tr>
</tbody>
</table>
play a significant part in cognitive development. The “rubber band” hypothesis suggests that genetic factors may set the limits for potential cognitive functioning; but environmental factors determine to what extent developmental potential is achieved.

| Parenting Style | It has been suggested that parenting styles have an impact on a child’s social, emotional and behavioural development (Baumrind 1971,1991; Maccoby and Martin,1983; Calder & Hackett 2013, p. 351 -354) but it is important to be mindful that family relationships and parent-child interactions are influenced by cultural context (Triandis, 2001).

Authoritative parenting (firm but reasoned control, encouragement, praise, responsibility, warmth and love) – children who have experienced this type of parenting tend to have high levels of self-esteem and self-reliance.

Authoritarian parenting (controlling, demanding, little warmth, discipline, confrontational) – children who have experienced this type of parenting may show impaired learning and problem-solving abilities and increased dependence on adult control and guidance (Hess and McDevitt, 1984) with poorer levels of self-esteem and self-reliance (Barber 1994); they can lack interactive social skills and may present as subdued or aggressive.

Permissive parenting (undemanding, non-controlling, but warm and affectionate) – children who have experienced this type of parenting may be less self-reliant, may accept less responsibility and lack self-regulatory ability, demonstrating higher levels of impulsivity, and may be aggressive.

Neglectful parenting (where a parent may be physically or emotionally unavailable) – children who have experienced this type of parenting may have poor levels of self-esteem and self-regulatory abilities and show high impulsivity and low levels of academic achievement.

| Significant medical conditions | Long-term medical conditions may impact on a child’s development, particularly where frequent or long-term hospitalisation is required, as children may have more restricted access to learning and peer group relationships, as well as facing physical challenges. |
| Learning disability/physical disability/complex needs | Aspects of a child’s development may be delayed due to a learning disability or significant learning difficulties, physical disability or complex needs such as ASD or ADHD. It is important to recognise that there may be barriers to the child accessing the same social and educational opportunities as non-disabled children; and families may face additional stressors such as socio-economic disadvantage, lack of respite, discrimination. |
Appendix 5: Overview of Attachment Theory

Attachment theory provides a useful framework for thinking about the nature of the relationship between a child and parent/caregiver, and can be helpful in making sense of why a child may be behaving in certain ways as part of a holistic approach to the parenting assessment. The term “attachment” is commonly used to describe the child’s enduring connection to the parent or significant others involved in their care. It refers to the child’s sense of security and safety when in the company of a particular adult (Wittmer, 2011). “Bonding” is commonly used to describe the parent’s link with the child (Fahlberg, 1994).

Practitioners who have undertaken specific training in the assessment of attachment are likely to be able to provide a profile of the child’s attachment based on observation of the current parent-child relationship together with background information derived from other sources about the child’s history and experiences (including disruptions in care), their overall development, the history of the parent, the parent’s attachments and the meaning of the child for the parent. The profile of a child’s attachment can contribute to an assessment of the child’s current and future emotional needs, and the capacity of the parent/carer to meet their needs.

Where specific training in assessing attachment has not been undertaken practitioners should describe the behaviour and presentation of the child and of the parent/carer during observed interaction. On the basis of their observation, the practitioner should analyse the nature of the strengths in the relationship and any concerns, together with information from other sources including the history and experiences of the child, their overall development and the history of the parent, their functioning and the meaning of the child for the parent. Examples of frameworks for the observation of parent-child interaction are set out in Appendix 6.

The key points of attachment theory and patterns of attachment are summarised below. These are based primarily on the descriptions of attachment theory set out by David Howe (2006) and as part of the Secure Base Model, developed through research by Gillian Schofield and Mary Beek at the University of East Anglia (Schofield and Beek 2006; www.uea.ac.uk/providingasecurebase). The Secure
Base Model was originally developed to support foster carers and adoptive parents in providing reparative parenting by focussing on the different dimensions of caregiving in order to promote attachment. Elements of the model can, however, be adapted to parenting assessments and details of the model can be accessed via the link above.

**Outline of Attachment Theory**

- Infants are biologically programmed to seek proximity to parents/carers for care and protection.
- Infants attract the attention of parents/carers by behaviour such as
  - cooing, smiling, reaching out
  - crying or fretting.
- The available and sensitive parent provides a secure base that settles and soothes the baby and promotes trust in their availability, thereby allowing the child to explore and learn, confident that s/he can return to the secure base when needed.
- Through the process of prompt and appropriate responses to attachment behaviours, the baby's survival is ensured and his/her emotional, social and physical development is also enhanced and maximised in the context of the relationship.
- The infant forms internal mental representations of the self, of others and of relationships. These lead to internal working models - sets of beliefs and expectations that influence behaviour - children begin to organise their attachment behaviour to increase the availability, proximity and responsiveness of their carers and to reduce fear and anxiety. These models are established in the first few years of life and as children get older models retain some flexibility, but become increasingly resistant to change.
- The infant and child adapt to the particular kind of caregiving experience by developing an attachment pattern to maximise their opportunities for receiving care and protection from close adults.
- Different patterns of secure and insecure attachments emerge in the context of different caregiving experiences. Within each pattern there is a range of characteristics.
• Ainsworth et al (1978) described four caregiving dimensions -
  o sensitivity vs insensitivity (to the baby’s signals)
  o acceptance vs rejection (of the baby’s needs)
  o co-operation vs interference (with the baby’s ongoing behaviour)
  o psychological and physical availability/accessibility vs ignoring/neglecting (the baby’s needs)

• The Secure Base Model incorporates a fifth caregiving dimension of promoting family membership, helping children to belong

• An attachment relationship in childhood is not necessarily a close or loving relationship - children also form attachments to parents or caregivers who are insensitive, or who abuse and frighten them. Secure and insecure attachments may be equally “strong”.

• Children can form multiple attachments.

• Attachments can form at any age and stage but are affected by previous relationships.

• There is a degree of continuity of attachment patterns from infancy to childhood to adolescence, but a major feature of this continuity is likely to be the continuity of care from caregivers who continue to reinforce the child’s pattern by their style of caregiving.

• Where children experience life events that disrupt that pattern of caregiving, whether for better or for worse, then the child’s attachment pattern may change.

**Sensitive caregiving**

Barnett (2015) sets out the following elements of sensitive caregiving, based on the ABC of attachment described by Siegel and Hartzell (2003):

**Attunement**: “A state of emotional connection whereby a caregiver’s internal states (thoughts, feelings) become harmonious with those of their child. It is often achieved through contingent exchanges of non-verbal communication such as facial expressions, emotional intensity, tone of voice, body posture and timing. When the caregiver takes responsibility for establishing attunement with their child, the child is likely to feel understood.”
**Balance:** “Through attunement with the parent/caregiver, the child is facilitated to regulate their physical self (body) as well as their emotions and thoughts. A secure attachment allows the child to tune in to the caregiver’s sense of balance and this is called co-regulation.”

**Coherence:** “This is a sense of meaning that children come to acquire through their relationship with a sensitive and present caregiver in which they are able to come to feel both internally integrated and interpersonally connected to others.”

Hughes (1997) described contingent communication as a “dance of attunement”

Miens et al. (2001) highlighted the importance of mind-mindedness in the parent/carer i.e. a capacity to be interested in what the child is thinking and feeling, to see things from the child’s point of view, and to communicate this to the child. They argued that this is significant in promoting mind-mindedness in the child as they develop, helping the child to regulate their feelings and their behaviour.

Attachment theory suggests that attachment patterns are associated with characteristic patterns of behaviour as described in the table below:
**Attachment pattern**

**Secure**

**Incidence:** 60-70% infants

This is an organised strategy of attachment in the context of sensitive and responsive caregiving.

In adolescence/adulthood this pattern is referred to as autonomous/free to evaluate.

**Child**

Internal working model of self as lovable, others as loving and available, and relationships as reliable.

Infants/young children:
- tend to explore freely, monitoring the caregiver’s accessibility during exploration.
- may initially cling to the caregiver when a stranger is present, but then engage with the stranger providing the caregiver is present.
- are obviously upset when a caregiver departs, and usually calmed when the caregiver returns.
- may be comforted to some extent by other people but shows a clear preference for the caregiver.

Children tend to:
- trust others
- seek comfort when distressed
- understand mixed emotions in self and others, and show empathy
- display a range of negative and positive emotions
- manage and regulate emotions and behaviour
- display pro-social behaviour; and be socially competent
- pause before acting, think flexibly, and draw on a range of coping strategies
- have good self-esteem, self-confidence, and self-efficacy
- be hopeful and optimistic
- show resilience

**Parent/Caregiver**

Available, accepting, sensitive.
Responds appropriately, promptly and consistently to child’s needs.
Supportive of exploration, effectiveness and cooperation; and promotes a sense of belonging.
### Attachment Pattern

<table>
<thead>
<tr>
<th>Insecure</th>
<th>Child</th>
<th>Parent/Caregiver</th>
</tr>
</thead>
</table>
| Avoidant | Insecure 
Incidence 15-20% infants | Infants and children adapt to rejecting, insensitive caregiving by *deactivation of attachment behaviour* i.e. shutting down on their feelings and becoming self-contained and self-reliant; avoiding direct expression of emotions and demands to avoid driving their caregiver away. | Rejects emotional demands, minimises child's feelings. Tends to impose their view of how a “good” child should be, being intrusive and insensitive to the child’s needs. May provide practical care and protection, but is not supportive of emotional closeness or exploration. |

In adolescence/adulthood, this pattern is referred to as *dismissing*.

**Insecure Avoidant**

<table>
<thead>
<tr>
<th>Child</th>
<th>Parent/Caregiver</th>
</tr>
</thead>
</table>
| Insecure 
Incidence 15-20% infants | Infants and young children: |
| | • show little or no distress on separation from caregiver, and ignore caregiver on reunion e.g. looking away, turning away, remaining occupied with toys |
| | • treat stranger similarly to caregiver |
| | • with less extreme avoidant patterns some distress, proximity seeking or anger may briefly appear but is rapidly succeeded once more by avoidance |
| | • with more extreme avoidant patterns, expressions of distress and anger are absent |

**Children:**

- tend to be less likely to seek help or comfort from their caregiver
- tend not to understand emotions in themselves or others, so have limited empathy
- tend to be rational but rigid thinkers
- tend to be compliant, with high levels of anxiety about getting tasks “right”
- tend to have poor self-esteem, self-confidence and self-efficacy

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Insecure ambivalent (or resistant)

Internal working model of the self as unlovable, others as inconsistent and unreliable, and relationships as enmeshed and entangled.

Incidence:
10-15% infants

This is an organised strategy, adaptive to an unpredictable, insensitive, kind of caregiving.

In adolescence/adulthood, this pattern is referred to as preoccupied or enmeshed.

Infants and children adapt to unpredictable caregiving by hyperactivation of attachment behaviour – attempting to increase the caregiver’s responsiveness by increased displays of distressed behaviour such as crying, fretting, whining, clinging, attention seeking/provocative/fractious/demanding behaviour. They are preoccupied with the caregiver’s availability, seeking contact but resisting angrily when it is achieved.

Infants and young children tend to:
- explore little in the presence of the caregiver and initiate limited interaction with the environment or adults
- be wary of strangers even when the caregiver is present
- not easily calmed by a stranger
- distressed on separation from caregiver and does not settle on reunion (mixture proximity-seeking with resistance, or passive and clingy)

Children tend to:
- show poor levels of concentration;
- rely on emotion rather than reason;
- have difficulty reflecting on and regulating emotions and behaviour, leading to impulsivity; seek relationships but are demanding and needy/possessive
- tend to have poor self-esteem, self-confidence and self-efficacy blame others

Inconsistent, uncertain and unpredictable

The caregiver is preoccupied with their own needs and uncertainties and whether or not they believe the child loves and values them, rather than thinking about the child’s own needs and feelings.

The caregiver demonstrates poor sensitivity, and is slow to notice the child’s signals of distress.
<table>
<thead>
<tr>
<th>Attachment Pattern</th>
<th>Child</th>
<th>Parent/Caregiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insecure</td>
<td>Internal working model of the self as unlovable and helpless, of others as hostile and helpless, and of relationships as unpredictable and frightening.</td>
<td>Disconnected/withdrawal/ unavailable</td>
</tr>
<tr>
<td>Disorganised (controlling)</td>
<td>The infant seeks comfort from a caregiver who is also the source of fear. As a result, they remain in a state of high anxiety. The infant cannot find an effective strategy to feel safe, which leads to confused behaviours, and infants may appear dazed.</td>
<td>Frightened/helpless and/or frightening behaviour</td>
</tr>
<tr>
<td>Incidence</td>
<td>5-10% infants</td>
<td>Hostile/negative towards child</td>
</tr>
<tr>
<td>This is a disorganised attachment pattern</td>
<td>Toddlers show contradictory behaviour patterns, for example gazing away while being held; or approaching the caregiver and then turning away. Young children may show hypervigilance or 'freeze' in the presence of the caregiver.</td>
<td>Insensitive/ poor ability to mentalise</td>
</tr>
</tbody>
</table>
| Studies suggest that up to 80% of maltreated children may have a disorganised attachment pattern (Van Ijzendoorn et al. 1999; Barlow & Scott 2010). | Children tend to have difficulty:  
  - regulating emotions  
  - dealing with stress/anxiety in the presence of the caregiver  
  - communicating with others  
  - concentrating and sustaining attention | May have unresolved loss/childhood trauma |
| However, not all children who have a disorganised pattern of attachment will have been maltreated. | Older children tend to develop strategies to try to gain control, either through excessive role reversal in relation to the caregiver or by becoming hostile and punitive (Shemmings 2011). However, feelings of fear and anxiety remain unresolved. | |
| In adolescence/adulthood, this pattern is referred to as unresolved | Maltreated disorganised children may also show symptoms of dissociation – cutting off from experience, and creating distance. Research suggests disorganised attachments in childhood increase the risk of mental health problems in adulthood (Green and Goldwyn, 2002). | |
Additional considerations

- Whilst the categories of attachment may be useful in understanding different attachment patterns, it should be understood that they are not entirely discrete entities and many children will follow a mixed pattern of attachment behaviours with elements of several styles present (Brown and Ward, 2012).

- Attachment theory refers to patterns of behaviour i.e. it is necessary to consider the nature, duration, severity and frequency of the behaviours observed in the parent and the child. Secure and socially competent children can display behaviours at particular times that may appear to be of concern and it is important to consider alternative explanations for disturbing behaviours. Some behaviour may be developmentally appropriate, such as a temper tantrum for a 2-year old, and/or contextually variable, for example a child displaying anxious behaviour in an unfamiliar environment.

- It is vital that the assessing practitioner understands that sensitive caregiving does not mean parents must achieve parenting perfection. The concept of “good-enough” caregiving was originally developed by Winnicott (1965). It is not feasible for a caregiver to always respond immediately to a baby’s signals of discomfort, and it is inevitable that there will be times when the caregiver misreads the baby’s signals, but if the baby has learned to trust that the caregiver will be available, s/he gradually learns to manage the wait and the process of emotional regulation starts to develop (Schofield and Beek, p 52)

- Attachment is a reciprocal process between the parent and the child. It is therefore important to consider how child factors may be affecting parent-child interaction (Fahlberg, 1994). For example:
  - Premature babies generally do not respond to environmental stimuli in the same way as full-term babies. They may have decreased awareness of internal discomfort and may have problems signalling
their discomfort. In addition, premature babies may not experience continuous parental contact that would usually promote bonding on the part of the parent and attachment on the part of the child.

- Genetic factors may make a baby more irritable or “fussy”. Some babies appear overly sensitive to environmental stimuli, or do not like certain holding positions, or can be difficult to comfort.
- Babies and children with significant disabilities may show some delay in their ability to exhibit attachment-related behaviours such as smiling, approaching and vocalisation (Barnett et al. 1999). Babies with significant sensory disabilities or cognitive impairment may require extra help from the parent to establish synchronous interaction, and creative use of all the senses is likely to be needed with additional focus on predictability and rhythm, although the route to secure attachment appears to be the same (Goldberg, 2000; Schofield and Beek, 2006). There is some evidence that children with autism spectrum disorder may demonstrate less secure attachment patterns in the context of impairments in social interaction (van Ijzendoorn, 2007).

- When thinking about attachment patterns, it is important to take into account cultural traditions and different family structures, so that consistent and reliable caregiving may be given by other adults as well a parent, and a child may form multiple attachments.
- Social-cultural theorists emphasise the importance of social influences on a child’s behaviour and their developing sense of self and belonging, highlighting the influence of factors such as race, religion, ethnicity, socio-economic status and gender.
- Ecological systems approaches view child development as resulting from the complex interactions between a child and his/her environment, emphasising that child well-being is influenced by the characteristics of the individual child plus family, social, cultural and political factors.
Appendix 6: Observation of Parent-Child Interaction

Practitioners should think about the purpose of parent-child observations, how to structure the sessions (for example, free play, family activity or outing in the community), and how to record and analyse their observations. Practitioners can use specific tools in which they have received training, such as the CARE Index, or Video Interaction Guidance. Below are other examples of tools that practitioners may find helpful when thinking about and recording observations of parent-child interaction. Records of observations may be appended to the Parenting Assessment report. What the observations mean in relation to parenting capacity needs to be evaluated and analysed in the report.

Fahlberg’s Observation Checklists

The following observation checklists can provide a simple, but effective reminder of what to look for during observations of parents and children of different ages. They were developed by Vera Fahlberg (1991) based on concepts of how patterns of interaction promote attachment between child and parent and bonding between parent and child.

The arousal-relaxation cycle (Fahlberg 1991, adapted by Schofield and Beek, 2006):

[Diagram of the arousal-relaxation cycle]

- Child experiences a physical and/or psychological need
- State of relaxation
- Child thinks – I am safe, caregiver is available
- Satisfaction of physical/psychological needs
- Secure Base
- Trust
- Attachment
- Caregiver thinks – what may the child feel and need?
- State of high arousal
- Child is free to play and explore
The cycle is triggered by the infant’s need. It is completed by the parent responding in a way that meets the need, alleviating the infant’s discomfort and soothing him/her. Repeated successful completion of this cycle helps the child to develop trust and a sense of security and to become securely attached to his/her primary carer. Some parents fail to respond consistently to the infant’s overtures in ways that meet the child’s needs so the cycle is not completed. The cycle is also not completed if the infant does not, for some reason, signal their discomfort. For example, irritable or highly sensitive infants, babies with complex needs, premature babies and infants exposed to drugs in utero (particularly cocaine and crack cocaine) may not respond in the same way to environmental or internal stimuli, or may not signal their discomfort.

The positive interaction cycle

This cycle can be initiated by the parent or child. It highlights the importance of social interaction in the development of attachment between child and parent, and bonding between parent and child.
Observation checklist

Birth to one year

Does the child …?
- o appear alert?
- o respond to people?
- o show interest in the human face?
- o track with the eyes?
- o vocalise frequently?
- o exhibit expected motor development?
- o enjoy close physical contact?
- o signal discomfort?
- o appear to be easily comforted?
- o exhibit normal or excessive displeasure?
- o appear outgoing or seem passive and withdrawn?
- o have good muscle tone?

Does the parent …?
- o respond to the infant’s vocalisations?
- o change voice tone when talking to or about the baby?
- o engage in face-to-face contact with the infant?
- o exhibit interest in and encourage age-appropriate development?
- o respond to the child’s cues?
- o demonstrate the ability to comfort the infant?
- o enjoy close physical contact with the baby?
- o initiate positive interactions with the infant?
- o identify positive qualities in the child?
### One to five years

#### Does the child ...?
- explore his/her surroundings?
- respond positively to parents?
- keep him/herself occupied?
- show signs of reciprocity?
- seem relaxed and happy?
- look at people when communicating?
- show emotions in a recognisable manner?
- react to pain and pleasure?
- engage in age-appropriate activities?
- use speech appropriately?
- respond to parental limit-setting?
- demonstrate normal fears?
- react positively to physical closeness?
- show a response to parental separation?
- note the parent’s return?
- exhibit signs of pride and joy?
- show signs of empathy?
- show signs of embarrassment, shame or guilt?

#### Does the parent ...?
- use disciplinary measures appropriate for the child’s age?
- respond to the child’s overtures?
- initiate affection?
- provide effective comforting?
- initiate positive interactions with the child?
- accept expressions of autonomy?
- see the child as positively “taking after” a family member?
- seem aware of the child’s cues?
- enjoy reciprocal interactions with the child?
- respond to the child’s affectionate overtures?
- set age-appropriate limits?
- respond supportively when the child shows fear?
Primary school years

**Does the child …?**
- behave as though he/she likes him/herself?
- show pride in accomplishments?
- share with others?
- accept adult-imposed limits?
- verbalise likes and dislikes?
- try new tasks?
- acknowledge mistakes?
- express a wide range of emotions?
- establish eye contact?
- exhibit confidence in his/her own abilities?
- appear to be developing a conscience?
- move in a relaxed manner?
- smile easily?
- look comfortable when speaking with adults?
- react positively to parent being physically close?
- have positive interactions with siblings and/or peers?

**Does the parent …?**
- show interest in child’s school performance?
- accept expression of negative feelings?
- respond to child’s overtures?
- provide opportunities for child to be with peers?
- handle problems between siblings with fairness?
- initiate affectionate overtures?
- use disciplinary measures appropriate for child’s age?
- assign the child age-appropriate responsibilities?
- seem to enjoy this child?
- know the child’s likes and dislikes?
- give clear messages about behaviours that are approved of and disapproved of?
- comment on positive behaviours as well as negative
Parent-infant interaction
The following components of positive parent-infant interaction have been found to promote secure attachment (see Brown and Ward 2012, p.60). Observations of parents and infants can evaluate the presence (or absence) of these kinds of interactions:

- **Sensitivity/attunement**: the use of eye contact, voice tone, pitch and rhythm, facial expression and touch to convey synchronicity with the infant
- **Mind-mindedness/reflective function/mentalisation**: a parent’s capacity to experience their baby as an intentional being with their own personality traits, strengths and sensitivities
- **Marked mirroring**: when a parent shows a contingent response to an infant such as looking sad when the baby is crying
- **Containment**: when a parent uses touch, gesture and speech to take on an infant’s powerful feelings and make them more manageable
- **Reciprocity**: turn-taking
- **Continuity of care**: providing infants with sufficient continuous caretaking from a small number of carers to enable them to become securely attached

Perceptiveness, Responsiveness and Flexibility
This has been developed on the basis that a key element of parenting is the need to be adaptable (Commonwealth of Australia 2004). There are three main themes to adaptability: perceptiveness, responsiveness and flexibility. Observations can evaluate the extent to which the parent demonstrates these characteristics:

- **Perceptiveness**: the parent’s awareness of what is happening around the child, and their ability to infer the child’s needs and wants, and reasons for the child’s behaviour
- **Responsiveness**: the extent to which parents connect with their children; the ability of a parent to be sensitive to the child – to express warmth, respond with affection and adjust his or her behaviour based on the child’s reactions and needs
- Flexibility: the ability of a parent to respond in different ways according to the needs or demands of specific situations. Problems arise when parents lack alternative ways of responding, or get stuck in an ineffective pattern of responding and are unable to alter it.
Appendix 7: Involving Children with Disabilities and Complex Needs in the assessment

Where there is a child or children with disabilities in the family, practitioners need to be sensitive to the needs of the particular child and how to involve them in the assessment process, and to be alert to the general research findings about the incidence of harm and the reasons for the increased vulnerability of disabled children. It is essential to work collaboratively with the team for Children with Disabilities and Complex Needs.

Children with disabilities and complex needs include children with physical, sensory and/or learning disabilities, or neurodevelopmental disorders such as autism spectrum disorder.

Incidence of harm
The available UK evidence indicates that children with disabilities are at significantly greater risk of abuse, and that the presence of multiple disabilities appears to increase the risk of both abuse and neglect (Working Together, 2015).

Increased vulnerability
Children and young people with disabilities may be more vulnerable to being abused for a number of reasons, including:

- Experience of discrimination and lack of opportunity may damage their sense of self-esteem and self-worth
- Over-identification by professionals with a parent can lead to a reluctance in accepting abuse/neglect is taking place, or seeing it as attributable to the stress of caring for a disabled child
- Possible indicators such as a child’s mood, behaviour, illness or injury that would give cause for concern for a non-disabled child, may be assumed to relate to a disabled child’s condition
- An increased dependency on parents/other adult carers for practical assistance and intimate personal care
- Less capacity to resist or avoid abuse due to cognitive or physical limitations
• Speech, language and communication needs which may make it more difficult to tell others what is happening
• Children with profound and multiple disabilities may rely solely on behavioural communication, and professionals may not understand how the child communicates distress, anxiety and fear
• Social isolation
• Less access to a trusted adult

Involving the child in the assessment
It is a requirement, as well as good practice, to ensure that appropriate arrangements are made to establish the wishes, feelings and views of children with complex needs or communication difficulties (Human Rights Act 1998; Children Act 1989 as amended by the Children Act 2004):

Practitioners need to identify the communication needs of the particular child and seek specialist advice from the team for Children with Disabilities and Complex Needs in order to access appropriate resources and/or someone with the relevant communication skills (which might include someone who is trained in Makaton, BSL, PCS); and ideally someone with whom the child or young person is already familiar, such as a teacher.

Helpful Tips
• Plan sessions and provide a range of appropriate materials
• Ensure the environment where you meet is communication friendly – think about space, light, layout and noise levels
• Allow extra time for the child to listen and think
• Use simple language, and support any communication with visual cues, gestures, diagrams and pictures
• Allow extra time for the child to communicate with you
Resources

- Triangle is an independent organisation based in Brighton, with expertise in children and young people with a wide range of complex needs and disabilities. [www.triangle.org.uk](http://www.triangle.org.uk)


- *Safeguarding Disabled Children practice guidance 2009*. This includes a summary of the research evidence about the vulnerability of disabled children to abuse. Triangle contributed to the guidance and it is free to download from [www.triangle.org.uk/catalog/resources](http://www.triangle.org.uk/catalog/resources)

- Communication Systems 2012. Triangle’s accessible summary giving details of 20 of the most common communication options used with children in the UK (e.g. BSL, Makaton) free to download from [www.triangle.org.uk/catalog/resources](http://www.triangle.org.uk/catalog/resources)

- The Makaton Charity. Makaton uses signs, symbols and speech to help people communicate. Signs are used, with speech, in spoken word order. This helps provide extra clues about what someone is saying. Using signs can help people who have no speech or whose speech is unclear. Using symbols can help people who have limited speech and those who cannot, or prefer not to sign. The Makaton shop has a range of useful resources including some free downloadable resources [www.makaton.org](http://www.makaton.org)


- Widgit – has a range of products using symbols to aid communication [www.widgit.com](http://www.widgit.com)
Appendix 8: Risk, Resilience and Vulnerability

The assessment of risk
“A risk is a hazard that is not completely understood and therefore can only be forecast with uncertainty. Identifying a risk incorporates notions of nature, severity, frequency, imminence and likelihood – not just probability of harm …Risk is context specific. It is never known but estimated” (Hart et al 2003).

Family Risk and Safety Assessment (FRaSA)
The Family Risk and Safety Assessment is a risk assessment framework developed for Southwark Children’s Services. When undertaking a parenting assessment, a risk assessment may already have been undertaken, and this will inform the analysis, as well as elements within the body of the assessment, but practitioners should ensure the risk assessment is up to date. If a risk assessment has not been undertaken, the FRaSA will provide a valuable resource in thinking about and evaluating the risks identified during the parenting assessment.

Key messages from research
The Scottish National Risk Framework (2012, p.18) includes a helpful summary of key messages in relation to risk:

- Once a person has been a perpetrator of an incident of abuse or neglect, there is an increased probability that their behaviour may recur
- People can change but there is a need to anchor any signs of change against any identified historical or current risk factors to offset against any tendency for over-optimism
- The likelihood of recurrence is increased by the degree to which the functioning of the perpetrator and their partner is impaired by substance abuse and other issues such as mental health, disability etc.
- If a partner is active or complicit within the abuse or neglect, the possibility of recurrence is increased. Conversely, a partner who is actively opposed to the abuse can lower the risk of recurrence
People who are violent in any context are more likely to behave in a violent manner with their children than someone who never uses violence as a means of coping with difficulty.

If the parents/carers perceive children as objects, or merely as extensions of themselves, there will be a higher probability of the recurrence of abuse or neglect than if the children are viewed as individuals in their own right.

The greater the vulnerability of the child, the greater the further probability of being exposed to abuse or neglect.

The higher the level of stress experienced by the family, the greater the probability of being exposed to further abuse or neglect.

Risk factors

Risk indicators are those factors that are identified in the child’s circumstances or environment that may constitute a risk, a hazard or a threat to the safety or well-being of the child/young person. The table below, based on the Scottish National Risk Framework (2012), provides a summary of generic risk factors in respect of the child, parent, wider family and community that have been identified as relevant when evaluating the nature and degree of risk in respect of an individual child i.e. these are potential risk factors to consider and explore further if present.

These risk factors should not be used as a checklist, but as a guide to assist structured professional judgement. Evidence of risk factors does not necessarily mean the child will be harmed, but clusters or patterns of risk factors may increase likelihood; and it is when these factors are assessed to impact on the child's development, safety and well-being, that harm, or the risk of harm, can be identified.
<table>
<thead>
<tr>
<th>The Child</th>
<th>Parent/Carer</th>
<th>Wider family/community/environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Premature birth/ low birth weight</td>
<td>• Parent under 21 years</td>
<td>• Family socially isolated</td>
</tr>
<tr>
<td>• Early prolonged separation at birth</td>
<td>• Poor parenting skills</td>
<td>• Absence of social supports/networks</td>
</tr>
<tr>
<td>• Baby born with substance withdrawal (NAS)</td>
<td>• Poor understanding of child’s needs</td>
<td>• Problems within extended family</td>
</tr>
<tr>
<td>• Very young – highly dependent (birth – 5 years)</td>
<td>• Lack of empathy</td>
<td>• Illness within extended family</td>
</tr>
<tr>
<td>• Cries frequently, difficult to comfort</td>
<td>• Unrealistic expectations of child (age &amp; stage)</td>
<td>• Conflict within extended family</td>
</tr>
<tr>
<td>• Difficulties in feeding/toileting</td>
<td>• Unable and/or unwilling to meet child’s needs</td>
<td>• Substance misuse within extended family</td>
</tr>
<tr>
<td>• Periods of separation from parent/primary caregiver</td>
<td>• Poor attachment</td>
<td>• Family – frequent changes of address</td>
</tr>
<tr>
<td>• Adopted or step-child</td>
<td>• Evidence of rejection towards the child</td>
<td>• Home environment chaotic, unsafe</td>
</tr>
<tr>
<td>• Fostered</td>
<td>• Lack of interest in child</td>
<td>• Concerns about sleeping arrangements</td>
</tr>
<tr>
<td>• Child developmental delay</td>
<td>• Threats/requests to have the child accommodated</td>
<td>• Family history of poor engagement with services</td>
</tr>
<tr>
<td>• Child mental health difficulties</td>
<td>• Child perceived as difficult and/or labelled by parent</td>
<td>• Discriminated within community victim/perpetrator</td>
</tr>
<tr>
<td>• Child learning disabilities</td>
<td>• Prioritises adult needs over child’s needs</td>
<td>• Culturally inappropriate behaviours</td>
</tr>
<tr>
<td>• Child behavioural difficulties</td>
<td>• Inappropriate rigid attitudes towards child</td>
<td>• Neighbourhood characterised by offending/violence</td>
</tr>
<tr>
<td>• Difficult temperament</td>
<td>• Partner is not biological parent of child</td>
<td>• Neighbourhood characterised by poverty</td>
</tr>
<tr>
<td>• Health issues requiring ongoing medical treatment</td>
<td>• New partner - background is unknown</td>
<td>• Housing quality poor</td>
</tr>
<tr>
<td>• Engaging in self-harm</td>
<td>• Parental resistance/limited engagement</td>
<td>• Lack of community services</td>
</tr>
<tr>
<td>• Involved in substance misuse</td>
<td>• Refuses workers access to child</td>
<td></td>
</tr>
<tr>
<td>• Anti-social behaviour/relationships</td>
<td>• Parents masking the reality of the situation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No shared understanding of concerns</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Child’s account minimised/not believed by carer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Physical illness which</td>
<td></td>
</tr>
<tr>
<td>The Child</td>
<td>Parent/Carer</td>
<td>Wider family/community/environment</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Involved in offending</td>
<td>• Impairs parenting ability</td>
<td></td>
</tr>
<tr>
<td>• Evidence of sexually inappropriate behaviour</td>
<td>• Mental illness which impairs parenting ability</td>
<td></td>
</tr>
<tr>
<td>• Poor relationship with parents</td>
<td>• Substance misuse which impairs parenting ability</td>
<td></td>
</tr>
<tr>
<td>• Fearful of parent/caregiver</td>
<td>• Physical disability which impairs parenting ability</td>
<td></td>
</tr>
<tr>
<td>• Outwith parental control</td>
<td>• High stress levels such as poverty, isolation, loss</td>
<td></td>
</tr>
<tr>
<td>• Child not seen by or given chance to talk to workers</td>
<td>• Parents’ parenting was poor/abusive</td>
<td></td>
</tr>
<tr>
<td>• Contested contact and residence issues</td>
<td>• Low self-esteem</td>
<td></td>
</tr>
<tr>
<td>• Repeat victim</td>
<td>• Poor life skills and problem solving abilities</td>
<td></td>
</tr>
<tr>
<td>• Historical abuse of siblings by carers</td>
<td>• Poor impulse control</td>
<td></td>
</tr>
<tr>
<td>• Direct or indirect exposure to domestic abuse</td>
<td>• Difficulty with communication</td>
<td></td>
</tr>
<tr>
<td>• Recurrent history of statutory or child protection measures</td>
<td>• Lack of trust towards workers and others</td>
<td></td>
</tr>
<tr>
<td>• Poor school attendance</td>
<td>• History of multiple relationships</td>
<td></td>
</tr>
<tr>
<td>• Young Carer</td>
<td>• Carer continually defers to partner for response</td>
<td></td>
</tr>
<tr>
<td>• English is not first language of child</td>
<td>• History of domestic violence</td>
<td></td>
</tr>
<tr>
<td>• More than 4 children in the family</td>
<td>• History of community violence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• History of violence/aggression towards workers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Parents in conflict over custody or residence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Inability/unwillingness to make use of supports</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Breaches of legal orders/agreement - criminal/civil</td>
<td></td>
</tr>
</tbody>
</table>
Risk factors may be in the past, or recent/present. Risk factors can be categorised as static (unchangeable in that they cannot be influenced by new circumstances or interventions) or dynamic (risk factors that change over time, and are therefore more amenable to management). The dynamic risk factors that are quite stable and change slowly are often referred to as stable or chronic risk factors. Those that change rapidly are known as acute dynamic risk factors or “triggers” (Department of Health 2007).

There is some evidence from research (for example, Appleyard et al., 2005) to indicate that outcomes for children are worse where there is “cumulative risk” i.e.

- The presence of multiple risk factors
- Multiple occurrence of the same risk factor or
- The accumulating effects of ongoing adversity

For detailed guidance in relation to risk factors and the assessment of risk, please refer to the Southwark Family Risk and Safety Assessment (FRaSA) handbook.

In undertaking a parenting assessment, it is necessary to weigh up and consider the inter-relationship between:

- the nature and degree of risk and the impact on the child’s current and future safety and well-being
- the identified vulnerabilities particular to and around the child (child, parents, wider family, community)
- the identified strengths (resilience and protective factors) particular to and around the child (child, parents, wider family, community)

Adversity, Vulnerability, Resilience and Protective Factors
The Resilience/Vulnerability Matrix (Daniel, Wassell and Gilligan (2010) can be a useful aid in thinking about and organising the factors giving rise to concern (adversity and vulnerability) and the strengths that may improve outcomes (resilience and protective factors).
Resilience and vulnerability are generally internal characteristics. Adversity and protective factors are generally factors that are external to the child.

**Resilience-vulnerability matrix**
*(Daniel, Wassell and Gilligan, 2010)*

**Adversity**
Adversity is the experience of life events and circumstances (stressors) that pose a threat to, or challenge healthy development.

Newman (2004) classified three types of adversity based on the nature and duration of the stressor:
- Indicators of high-risk status, like low birth weight
- Chronic stress, such as living with substance misusing parents
- Extreme trauma such as disaster, sudden death of close relative, sexual abuse

It can also be helpful to distinguish between
- Intrafamilial adversity in which parents are implicated (such as child abuse, neglect, domestic violence)
- Individual challenges (such as the onset of a serious illness) and
• External adversities (such as being in a motor accident)

Where parental behaviour contributes to the adversity, their role in overcoming it is likely to be more limited or problematic.

Examples of adversity include:

• Child being subject to maltreatment
• Serious illness/serious accident
• Bereavement
• Parental relationship instability/Domestic violence
• Victimisation/bullying/racism in neighbourhood/at school
• Asylum-seeking status
• Employment problems/loss of job
• Unsuitable accommodation/becoming homeless
• Living in poverty
• Parental mental health – active symptoms of major mental illness
• Child living with parental substance misuse

_Vulnerability factors_

Vulnerability factors are characteristics of the child, the parents, and the wider family/community which render the person more susceptible to a threat i.e. vulnerability factors elevate the impact of adverse factors.

Child maltreatment is not caused by a child’s vulnerability - rather the vulnerability factors describe which children and young people are more likely to be at risk of abuse or neglect.

Examples of vulnerability factors include:
<table>
<thead>
<tr>
<th>Child</th>
<th>Parent/Family</th>
<th>Wider Family/Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Unwanted or unplanned pregnancy</td>
<td>• Harmful behaviour within family including inter-personal aggression and</td>
<td>• Lack of extended family support</td>
</tr>
<tr>
<td>• Difficult birth</td>
<td>violence, emotional or psychological abuse, and neglect</td>
<td>• Poor support networks</td>
</tr>
<tr>
<td>• Born with substance withdrawal</td>
<td>• Poor partner relationships/multiple relationships/domestic abuse</td>
<td>• Social isolation</td>
</tr>
<tr>
<td>• Child born at time of crisis/traumatic event</td>
<td>• Single parent household</td>
<td>• No access to community resources</td>
</tr>
<tr>
<td>• Very young child</td>
<td>• Young parent under 21</td>
<td>• Subject to racism/other oppressive behaviour</td>
</tr>
<tr>
<td>• Developmental impairment or disabilities</td>
<td>• Parent abused as a child</td>
<td></td>
</tr>
<tr>
<td>• Child behaviour problems</td>
<td>• Disability/chronic ill-health that significantly affects day to day</td>
<td></td>
</tr>
<tr>
<td>• Passive, withdrawn child</td>
<td>functioning</td>
<td></td>
</tr>
<tr>
<td>• Evidence of insecure attachments</td>
<td>• History of major mental illness</td>
<td></td>
</tr>
<tr>
<td>• Child finds it hard to make and keep friends</td>
<td>• Personality Disorder</td>
<td></td>
</tr>
<tr>
<td>• Child previously abused or neglected</td>
<td>• Family history of substance misuse</td>
<td></td>
</tr>
<tr>
<td>• Child resembles a “hated” partner or spouse</td>
<td>• History of offending</td>
<td></td>
</tr>
<tr>
<td>• Asylum seeking child</td>
<td>• Early maladjustment, including history of violent behaviour as child</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Minority status/Asylum-seeking</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Lack of insight</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Rigidity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Impulsivity</td>
<td></td>
</tr>
</tbody>
</table>
Protective Factors

Protective factors are factors or circumstances that mitigate or moderate the effects of risk. They act as `buffers` to the negative effects of adverse experience.

Examples of protective factors include:

- Good health in child/parent
- Good cognitive ability in child/parent
- Material resources
- Regular health and developmental monitoring for young child
- Regular nursery or school attendance
- Involvement in leisure activities
- Older child able to keep self safe
- Presence of a non-abusive partner
- Parent’s adaptation to own experience of childhood abuse
- Supportive extended family
- Child has access to at least one supportive adult
- Parent acknowledges the concerns and accepts responsibility
- Parent demonstrates motivation to change
- Engagement with appropriate resources/services
- Family has stable accommodation and lives in a safe, secure neighbourhood
- Good community networks

Resilience

Definitions of resilience:

- Normal development under difficult circumstances (Fonagy et al., 1994)
- The ability of some individuals to maintain healthy functioning in spite of a background of disadvantage commonly associated with poor outcomes (Ghate and Hazel, 2002)
- Developing well despite risk status or exposure to adversity (Masten and Powell, 2003)
Resilience is dependent upon a child’s developmental stage, and can change over time. Resilience is not only dependent on the characteristics of the individual, but is influenced by family, community, cultural and environmental factors.

Examples of resilience factors include:

<table>
<thead>
<tr>
<th>Individual</th>
<th>Relationships (parent/family/wider family)</th>
<th>Community/Cultural/ Environmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Secure attachment to a caregiver</td>
<td>• Stable, nurturing caregiver</td>
<td>• Child has access to education</td>
</tr>
<tr>
<td>• Self-esteem</td>
<td>• Family routines/rituals</td>
<td>• Academic achievement</td>
</tr>
<tr>
<td>• Positive sense of belonging</td>
<td>• Stable family environment</td>
<td>• Positive teacher influence</td>
</tr>
<tr>
<td>• Positive sense of identity</td>
<td>• Open communication within family</td>
<td>• Peer group acceptance</td>
</tr>
<tr>
<td>• Positive temperament</td>
<td>• Appropriate emotional expression</td>
<td>• Supportive adults available to child and parents</td>
</tr>
<tr>
<td>• Sense of humour</td>
<td>• Empathy/emotional support for child</td>
<td>• Cultural and/or spiritual identity</td>
</tr>
<tr>
<td>• Goals and aspirations</td>
<td>• Affectionate bonds within the family</td>
<td>• Good community resources (e.g. childcare)</td>
</tr>
<tr>
<td>• Good cognitive ability</td>
<td>• Parental supervision</td>
<td>• Access to services to support/assist</td>
</tr>
<tr>
<td>• Ability to solve problems</td>
<td>• Cohesion/sense of family identity</td>
<td>• Community opposed to racism/exclusion</td>
</tr>
<tr>
<td>• Good communication skills</td>
<td>• Ability to problem-solve</td>
<td>• Access to material resources</td>
</tr>
<tr>
<td>• Ability to deal with change</td>
<td>• Flexibility</td>
<td>• Access to a healthy environment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Security in one’s own community</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Access to recreation</td>
</tr>
</tbody>
</table>
The identification and balancing of risks, vulnerabilities and strengths in relation to the particular child, family and wider community will assist the practitioner in organising and evidencing their analysis and conclusion. In doing so, practitioners need to scrutinise the quality of the protective factors. It is important to identify those protective factors which mitigate the risks to the child and distinguish these from positives or strengths which may not be sufficient to alleviate the specific risks to the child. For example, parents may attend a parenting course and may try to implement their learning, which would be positive and show motivation to change. However, if this is not actually effective in addressing the identified problems in their parenting, it cannot be described as protecting the child from risk.
Appendix 9: Assessing Capacity to Change

Parenting capacity assessments are complex, not assisted by the lack of clarity around what defines “good-enough” parenting. Parenting capacity is dynamic and is dependent upon context and circumstances. Furthermore, not all children are equally vulnerable to adverse circumstances, but conversely, where a child has experienced emotional damage as a consequence of abuse or neglect they may require reparative parenting i.e. the parenting role has to be “good enough” to meet the particular needs of the child (Golding and Hughes 2012). Where parenting has not previously met the child’s needs, assessment needs to focus on whether the parent has achieved the necessary changes cognitively, emotionally and behaviourally, or has the potential to achieve those changes within a timescale commensurate with the child’s development.

Capacity to change is made up of two elements - ability and motivation - and assessment needs to consider both these elements, alongside the evidence regarding known risk factors and the needs of children at different developmental stages. The following summary of parental factors that need to be considered is adapted from Williams et al. (2015, pp. 226-227):

- Does the parent demonstrate the skills and knowledge to care, protect, nurture, stimulate and provide boundaries for the child?
- Where a parent is vulnerable, for example, to mental health or learning difficulties, is the child, other adults, the community and the resources sufficiently present and robust to meet the needs of the child?
- Does the parent demonstrate understanding and genuine acceptance of the impact of their role in harming the child?
- Does the parent demonstrate an understanding of the child’s cognitive, emotional, behavioural response to being harmed?
- Does the parent have the ability to repair any damage they or the circumstances have caused to the child?
- Does the parent demonstrate genuine effective attunement with their child and “mind-mindedness” for their child?
Does the parent demonstrate a meaningful intention to change and have they engaged in the process of change? Is there both behavioural evidence (first order change) and psychological evidence (second order change)?

Does the parent demonstrate an ability to have an open and transparent relationship with professionals?

Are maladaptive behaviours that compromised parenting no longer in evidence, or sufficiently minimised (drug and alcohol, dysfunctional or violent relationships, mental health)?

Has the parent addressed their own developmental trauma, or is there evidence of the development of a consistent narrative about past trauma?

Have practical issues that undermine the quality of parenting been addressed, such as housing, financial circumstances, employment and education for the parent and the child, and is community support sufficient?

Are the protective factors understood and assessed as being genuinely sufficient to mitigate future risk?

In addition, it is important to evaluate service factors, for example:

- Have appropriate interventions been offered or trialled with the family?
- Have goals been set conjointly with the parent where possible?
- Were the goals specific, realistic and time-limited with appropriate methods of assessing change?

**Cycle of Change Model**

Psychological models of change may provide some assistance in understanding the processes of change when individuals *intentionally* overcome adverse behaviour patterns, the most well-known being Prochaska and DiClemente`s Trans-Theoretical Model, also known as the Cycle of Change (Prochaska and DiClemente, 1982, 1983; Prochaska and Prochaska, 2002). Although originally developed to understand the process of smoking cessation, the model has also been applied where there are child welfare concerns, in order to understand parents` readiness for change (Morrison, 2010). The model is based on the premise that change is a matter of balance, and that people change their behaviour when there are more motivational forces in favour of change than in favour of the status quo. Thus motivating people to change
involves positively weighting, increasing or establishing motivators for change, whilst actively removing, decreasing or re-framing barriers to change, whether material, or psychological, individual or environmental. The model proposes two key principles:

- A person must go through several stages before they successfully action and maintain lasting change
- Change is cyclical – A person will have a range of feelings at different times about their risk behaviours and it can involve several attempts before they achieve lasting change:

**Diagram:**

- **PRE-CONTEMPLATION**
  - Defensive/denial/projecting blame/depressed/unaware of the problem.
- **CONTEMPLATION**
  - Weighing up the pros/cons. Start of change process.
- **DETERMINATION**
  - Informed decision to change.
- **ACTION**
  - Rehearsing new thinking, behaviours, relationships.
- **MAINTENANCE**
  - Sustaining/ internalising new behaviour.
- **LAPSE OR RELAPSE**
  - Return to some/all old behaviours. Give up or start again.
- **Exit**
  - Give up or Decide not: Exit.
The model proposes the following six stages of the change process:

**Pre-contemplation**: The parent is unaware of their problems or will not acknowledge them. They may feel coerced or threatened to change their behaviour. They may demonstrate some change, but once the pressure no longer exists they are highly likely to revert to previous behavioural patterns.

**Contemplation**: The parent considers the possibility that there is a problem and weighs up the pros and cons of change. The authors identify seven stages of contemplation:

- Accepting there is a problem
- Accepting some responsibility for that problem
- Having some discomfort about the problem
- Believing that things must change
- Seeing themselves as part of the problem
- Making a choice to change
- Seeing the next steps towards change

**Determination**: At this stage, parents should be able to identify:

- The nature of their problem and the effect on the child
- Changes they wish to/should make
- Specific goals to achieve
- How they will co-operate with professionals to achieve the goals
- Rewards of meeting the goals
- Consequences if change is not achieved

**Action**: The parent makes modifications to their behaviour, and makes efforts to address the problem. However, action does not necessarily equate with psychological change.
Maintenance: Behavioural changes are consolidated, and coping strategies are tested out over time. Parents should be working on relapse prevention and to stabilise/internalise change.

Lapse and relapse: Change is seen as cyclical i.e. as coming from repeated efforts, re-evaluation, renewal of commitment and incremental successes. Attempts to modify chronic problem behaviour may not succeed first time, and lapses may occur. Lapses occur when parents get themselves into high risk situations. If this occurs they need to activate the relapse prevention plan. However, some parents will relapse and exit the cycle of change, reverting to previous behaviours, or they may re-enter the cycle at an earlier stage. In a child safeguarding context, the risks associated with relapse may be high for the child.

However, some research casts doubt on the empirical basis for the existence of the stages proposed by this model (Littell and Girvin, 2002). Ward et al. (2014) suggest that while this model may be helpful as part of the broader assessment of the parent’s readiness to change, it is too simplistic on its own to assess capacity to change in the context of safeguarding concerns:

- The model does not indicate whether an individual parent is likely to change, or sustain progress in the long term
- There are difficulties in translating the model into a child protection context in which coercion plays a part
- Parents who maltreat their children are likely to have complex and multi-faceted problems that may not fit into a single-stage classification

Use of motivational interviewing techniques
Motivational interviewing has been developed in practice with adults who misuse substances. Forrester et al. (2012) suggest that motivational interviewing skills and concepts can also be effectively used to increase parental engagement and promote change where there are child protection concerns. However, they emphasise that key adaptations are necessary, in particular ensuring that the focus remains on the child’s safety and welfare, whilst attempts are made to engage the parent and elicit
“change talk” to resolve ambivalence about behaviour change. Change talk is “any talk about change by the client, whether that be recognition that a problem exists, increasing confidence that it can be resolved or a commitment to actually make a change in behaviour” (p.125). They suggest that a factor that may contribute to parental resistance is the conduct of the social worker. In order to reduce this, they highlight the need to use the skills of good listening, such as positive non-verbal communication, empathic listening, the use of open questions, affirmation of positives and strengths, and the regular use of reflection (statements by the practitioner that try to represent their understanding of the parent’s viewpoint). A randomised controlled trial of motivational interviewing in child protection work in the UK is currently underway. To learn more, refer to Miller and Rollnick (2013), Forrester et al. (2012) and the Research in Practice briefing on Engaging Resistant, Challenging and Complex Families (2012).

**Goal Attainment Scaling**

Harnett (2007) advocated a model that evaluates the attainment of goals over a specified period of time, during which evidence-based services are provided to ensure parents have the optimum opportunity to make necessary changes. In summary, he describes four elements:

- Assess the parents’ current functioning using a range of standardised tests and direct observation of parent-child interaction
- Specify targets for change, identifying clear jargon-free goals for behaviour change, the aim being to work collaboratively with parents to identify meaningful and manageable (achievable) goals that can be operationally defined, observed and monitored over a specified timeframe
- Implement an effective (evidence-based) intervention that addresses the multiple needs of the particular family, with a focus on achieving the specified targets for change
- Evaluate parental capacity to change by re-administering the standardised tests used previously, evaluating the extent to which the identified goals have been achieved using the Goal Attainment Scaling procedure, and direct observations of changes in parent-child interaction
For each goal, a five-point outcome rating scale is developed. Harnett (2007) provides the following example:

**Goal 1: Become more engaged with the school**

**Description:** Becoming more involved with the school lets your child know you are interested in their schooling and allows you to talk to teachers about your child’s progress.

**Goal scaling:** Specification of outcomes for each level of outcome. Start by defining a successful outcome.

- **Much less successful than expected**
  - 1 Helping out at school for at least 1-2 hours each week one time in a month

- **Somewhat less successful than expected**
  - 2 Helping out at school for at least 1-2 hours each week 2 or 3 times a month.

- **Successful outcome**
  - 3 Helping out at school for at least 1-2 hours a week, four times a month. This can include being a teacher’s aide in the classroom, working in the school canteen, supervising swimming, helping on school outings

- **Somewhat more successful than expected**
  - 4 Helping out at school for 3-4 hours each week for a month

- **Much more successful than expected**
  - 5 Helping out at school for 5 or more hours each week for a month. This might include getting involved in other school activities such as the Parent-Teacher Committee.

A range of standardised questionnaires and scales that could be used with this model are included in Appendix 12. The Signs of Safety approach is consistent with this model.

**The C-Change model**

Platt and Riches (2015), based at the Centre for Family Policy and Child Welfare at Bristol University, have been developing a framework to support the assessment of parental capacity to change. The practice manual, with materials and examples of standardised measures, is currently in press. Wilkins and Farmer (2015) have also
developed a new framework for reunification practice, in partnership with Bristol University, incorporating elements of the C-Change model.

The C-Change model is based on two elements of assessment:

- Factors affecting the parent’s capacity to change their behaviour to safeguard the child i.e. how the parent approaches behaviour change, and the barriers and facilitators of that change
- The extent of change achieved in response to appropriate intervention and support to address target difficulties, within a timescale consistent with the child’s developmental needs.

Platt and Riches argue that assessment of factors affecting behaviour change alone would omit potential insights from past behaviour, and that assessment of actual change alone would not provide explanation of what helps and hinders change. They suggest that assessment of both elements provides a more dynamic assessment and a stronger basis for intervention to facilitate further change.

C-Change part one: assessing barriers to and facilitators of change
The framework identifies five factors that affect behaviour change, and it is suggested that gathering and analysing information in relation to these factors will indicate what may help to facilitate, or act as a barrier to change. Where a number of behavioural changes are required, each change should be considered individually in relation to the factors affecting that change. In respect of a two-parent family, the factors affecting change need to be considered separately for each parent but with consideration of the dynamic between the couple and the influence of that dynamic on capacity for change.

Priority and relevance
How much of a priority for the parent is making the necessary changes in their behaviour? How relevant to the parent is the intended behavioural change in comparison to other pressures the parent may face?
Knowledge and skills
Parents need to understand the intended changes that are required of them in order to safeguard their child, and they need to have the ability to carry out the identified behavioural changes. It is necessary to consider what skills and knowledge are required to underpin those changes, and the assessment needs to consider whether any gaps can be addressed within the child’s timescale, as part of the package of intervention, or if not, why this is not possible. Intervention needs to be appropriately tailored to the needs of the individual parent.

Motivation and intentions
It is suggested that four aspects of motivation should be considered as part of the assessment:

- **Needs and expectations:** What is the value of any change to the parent? Does the parent consider the change will meet their needs (i.e. be of benefit overall)? Does the parent expect to achieve change? How consistent is the parent’s intention to change?

- **Attitudes, beliefs and feelings:** How does the parent view services? Does the parent recognise their own difficulties? What are their beliefs about the consequences of their own behaviour? What are the parent’s attitudes to their children and how they should be brought up?

- **Identity and social role:** What is the effect on a person’s motivation of their sense of identity within their social and cultural context?

- **Confidence and self-efficacy:** What is the parent’s perception of their ability to effect the necessary changes? To what extent does the parent believe they are able to control their own behaviour and life events (sense of self-efficacy)?

Habits and automatic reactions
This refers to ‘automatic’ behaviours prompted by situational triggers i.e. where the same response has become ‘habitual’ in terms of frequency of occurrence over time, for example, a physical response to a child’s difficult behaviour. Such ‘automatic’ responses to triggers can override positive intentions. Where such behaviours have a detrimental impact on the child, it is important to assess the strength of the ‘automatic’ response and whether, through intervention, this is amenable to change to a more positive way of responding.
Contextual factors

The framework focuses on contextual factors that impinge directly on the individual parent’s capacity to change and how these factors interact with facilitators of change and barriers to change. These factors might include for example, parental circumstances (such as a parental history of maltreatment; being a victim of domestic violence); social support network (friends and family may encourage a parent to work through difficulties, or may hinder positive change); and organisational and resource factors (such as the availability of appropriately tailored resources/interventions; practitioner skills; staff shortages).

C-Change part two: assessment of actual change

The second part of the C-Change assessment is the gathering of evidence of actual change that draws on goal attainment scaling approach (Harnett, 2007).

Platt and Riches emphasise that the outcome of the assessment of capacity to change needs to be analysed in relation to the overall assessment of the risks to the child and whether parental capacity to change outweighs the risks to the child.

Reflective Parental Functioning

A helpful conceptual framework to think about assessing a parent’s capacity to change is outlined by Birch (2015). She points out that the risk factors identified as reducing parenting capacity compromise the parent’s “ability to focus, understand and act upon the needs of the child” (p.98). She suggests that parents therefore need to demonstrate an improvement in their capacity for “reflective parental functioning”, a concept based on the theory of mentalisation i.e. there needs to be an improvement in their ability to think reflectively and make sense of their own and their child’s thoughts and feelings.

Birch argues that an improvement in reflective parental functioning could potentially lead to other changes, such as the parent’s ability to respond appropriately to their child’s needs and to their own needs, and to effect behavioural changes in those areas that are impairing their parental capacity. She identifies the following factors for consideration when assessing whether a parent’s ability to think reflectively about their child has improved:
• Behavioural change
• Change within the parent’s relationship with themselves and
• Changes in the parent’s relationship with their child.

*Behavioural change*

Assess changes in parental behaviour relevant to the identified concerns, for example:

• Reduction in substance misuse
• Decrease in incidents of domestic violence
• Increase in medical appointments for the child being kept
• Increase in the number of appointments kept with the CPN

Behavioural change on its own does not necessarily indicate psychological change, and such change may not be permanent. However, behavioural change is an “objective” measure that may give some indication of the potential for change.

*Change in the parent’s relationship with themselves*

Assess whether the parent has been able to demonstrate positive change in the way they look after their own needs. As well as the kinds of behavioural changes referred to above, examples of this might be:

• Spending more time with other people
• Spending time on activities that strengthen physical or mental health
• Improved presentation, including appearance and living environment
• Improved sleeping and eating patterns
• Greater awareness of their feelings, and the significance of their own emotional health for themselves and others
• Greater insight into their own vulnerability and need for support
• Improved self-esteem and valuing themselves as a parent
• Improved mechanisms for coping with stress
• Improved sense of self-efficacy
• Improved ability to think flexibly and constructively about their problems and how to solve these
Change in the parent's relationship with their child

Assess whether the parent has been able to demonstrate positive change in their relationship with their child. This includes:

- Sensitivity to what their child needs and does not need
- Responsiveness to their child’s needs
- Perception of their child and his/her abilities
- Attitude to their child
- Expectations of their child and their child’s behaviour

Skilled and sensitive interviewing of parents and children, combined with observation of the quality of a parent's interaction and relationship with a child, are necessary to inform the assessment of change in this area. Possible tools that can be used to support observations of parent-child interaction are included in Appendix 6. Where practitioners are trained in the use of the CARE Index and/or the Meaning of the Child interview, these tools will also support this element of the assessment.

Practitioners, with appropriate training/consultation, may find it helpful to use some of the psychometric tests included in Appendix 12 to support assessment of aspects of a parent’s functioning, including the Emotional Loneliness Scale, the Self-Esteem Questionnaire, the Interpersonal Reactivity Index, the Impulsivity Scale, and the Locus of Control Scale.
Appendix 10: Example of an accessible letter for parents with learning disabilities

The letter below is an example of a letter for a parent with learning disabilities. This one is to inform a parent of pre-proceedings, but it provides ideas about the way to set a letter out, the language to use, and the use of pictures.

Letter before proceedings (accessible version)

PLEASE DO NOT IGNORE THIS LETTER. TAKE IT TO A SOLICITOR NOW.

Southwark Children’s Services
Sumner House
Sumner Road
SE15 5QS

Contact:
Direct line:
Email:
Date

Address……

Dear……………………

This is a letter from Children’s Services about your unborn baby. It is being sent to you before court proceedings.

Please ask someone to help you read and understand the letters.

Children’s Services are worried about your unborn baby. This letter is about how you can avoid going to court.
The concerns Children’s Services have for your baby were talked about at the meeting you went to on…………….. They are also written about at the end of this letter.

We need a plan to make sure the baby will be safe.

We need to work together and you need to follow the plan.

If you do not follow the plan, we will go to court. This is because we need to make sure your baby is safe.

There will be another important meeting soon.

We will talk about what you need to do to keep your baby safe

We will talk about how we will support you with this.

We will tell you what will happen if we are worried that your baby is not safe.
The meeting will be on ..........................

at ........................

It will be at Sumner House, Sumner Road, SE15 5QS

Please call the social worker ............ on.............to let them know if you can come to this meeting.

Please take this letter to a solicitor.

A list of solicitors has been sent with this letter.

You should ask the solicitor about getting free legal advice.

You do not have to have a solicitor but it would be helpful.

Please ask the solicitor to come to the meeting on ........................

Your solicitor needs to know who the legal contact is at the Local Authority.

The contact is:

........................................

........................................
If you do not answer this letter or do not come to the meeting, we will go to court. This is because we have to make sure the baby is going to be safe.

…………….. talked to you about what would happen if your baby cannot be cared for by you. If you cannot care for your baby Children’s Services would try to arrange for your baby to be cared for by your family, if this is best for your baby.

At the meeting we will talk to you and your solicitor about who would look after your baby if the court decides it is not safe for you to.

We look forward to meeting with you and your solicitor.

If you do not understand this letter please call social worker ……………. on ……………..

Please let ……………. know if you need help with transport to get to the meeting.

Yours sincerely,

……………………

Pre-Birth Team
Why are Children’s Services worried?

We are worried because we do not know how your learning disability will affect how you will care for your baby.

This needs to be assessed.

We are worried because we do not know whether your physical disability will make it difficult for you to meet your baby’s needs.

This needs to be assessed.

We are worried about how your finances will be looked after. We are worried because your partner ……….has taken your money in the past.

We know that your partner is important to you and he is the baby’s father.

We want to know that you will put the baby’s needs before him.

We are worried that there is not a clear plan for where you will live when the baby is born.

We know this is being addressed by the Adult Learning Disabilities Team.

What will Children’s Services do to help?

Children’s Services will get in touch with other services to support you when needed.

This will be in the Child Protection Plan.
We will assess your ability to care for your baby. We will provide support as needed.

What do you have to do so that you do not have to go to court?

You need to come to the meetings with Children’s Services to talk about our concerns.

Please bring your solicitor to the meeting.

You need to continue to see the social worker……………………… and let her see your baby.

At the meeting you will be asked to talk about how your baby will be kept safe.
Appendix 11: List of Offences that may present a risk, or potential risk, to children

In relation to offenders, Home Office Guidance (‘Guidance on offences against Children’, Home Office Circular 16/2005) explains how those who present a risk to children should be identified. The circular explains that the present method of automatically identifying as a risk to children an offender who has been convicted of a Schedule One offence fails to focus on those who continue to present a risk. The new list of offences contained in the circular (see the List of Offences below) can be used to identify those who present a risk, or potential risk, to children and should operate as a trigger to a further assessment to determine if an offender should be regarded as presenting a continued risk of harm to children.

Taken from Home Office Circular 16/2005

Murder
Manslaughter
Infanticide
Kidnapping
False Imprisonment
Assault or battery
Indecent exposure - Section 4 Vagrancy Act 1824
Indecent exposure - Section 28 Town Police Clauses Act 1847
Conspiring or soliciting to commit murder - Section 4 Offences Against the Person Act 1861
Administering poison, or wounding, with intent to murder - Section 11 Offences Against the Person Act 1861
Threats to kill - Section 16 Offences Against the Person Act 1861
Wounding and causing grievous bodily harm: Wounding with Intent - Section 18 Offences Against the Person Act 1861
Wounding and causing grievous bodily harm: Inflicting bodily injury - Section 20 Offences Against the Person Act 1861
Maliciously administering poison - Section 23 Offences Against the Person Act 1861
Abandonment of children under two - Section 27 Offences Against the Person Act 1861
Assault occasioning actual bodily harm - Section 47 Offences Against the Person Act 1861
Child stealing - Section 56 Offences Against the Person Act 1861
Drunk in charge of a child under 7 years - Section 2 Licensing Act 1902
Cruelty to children - Section 1 Children and Young Persons Act 1933
Allowing persons under 16 to be in brothels - Section 3 Children and Young Persons Act 1933
Cruelty to children - Section 1 Children and Young Persons Act 1933
Give / cause to be given intoxicating liquor to a child under 5 years - Section 5 Children and Young Persons Act 1933
Exposing children under seven to risk of burning - Section 11 Children and Young Persons Act 1933
Prohibition against persons under 16 taking part in performances endangering life and limb - Section 23 Children and Young Persons Act 1933
Infanticide - Section 1 Infanticide Act 1938
Rape - Section 1 Sexual Offences Act 1956
Procurement of a woman by threats - Section 2 Sexual Offences Act 1956
Procurement of a woman by false pretences - Section 3 Sexual Offences Act 1956
Administering drugs to obtain or facilitate intercourse - Section 4 Sexual Offences Act 1956
Intercourse with a girl under 13 - Section 5 Sexual Offences Act 1956
Intercourse with a girl under 16 - Section 6 Sexual Offences Act 1956
Intercourse with defective - Section 7 Sexual Offences Act 1956
Procurement of defective - Section 9 Sexual Offences Act 1956
Incest by a man - Section 10 Sexual Offences Act 1956
Incest by a woman - Section 11 Sexual Offences Act 1956
Buggery where the victim is under 16“ - Section 12 Sexual Offences Act 1956
Abuse of position of trust: sexual activity with a child
Meeting a child following sexual grooming etc.
Arranging or facilitating commission of a child sex offence
Child sex offences committed by a children or young persons
Causing a child to watch a sexual act
Engaging in sexual activity in the presence of a child
Causing or inciting a child to engage in sexual activity
Sexual Activity with a Child
Causing or inciting a child under 13 to engage in sexual activity
Sexual assault of a child under 13
Assault of a child under 13 by penetration
Rape of a child under 13
Causing a person to engage in sexual activity without consent
Sexual assault
Abuse of Trust
Recovery of missing or unlawful held children
Abduction of Child in Care/ Police Protection... take away/induce away/assist to run away/ keep away
Possession of indecent photographs of children
Inciting girl under 16 to have incestuous sexual intercourse
Misure of Drugs Act 1971
Inciting girl under 16 to have incestuous sexual intercourse - Section 54 Criminal Law Act 1977
Indecent photographs of children - Section 1 Protection of Children Act 1978
Offence of abduction of a child by parent - Section 1 Child Abduction Act 1984
Offence of abduction of child by other persons - Section 2 Child Abduction Act 1984
Possession of indecent photographs of children - Section 160 Criminal Justice Act 1988
Abduction of Child in Care/ Police Protection... take away/induce away/assist to run away/ keep away - Section 49 Children Act 1989
Recovery of missing or unlawfully held children - Section 50 Children Act 1989
Abuse of Trust - Section 3 Sexual Offences (Amendment) Act 2000
Traffic in prostitution - Section 145 Nationality, Immigration and Asylum Act 2002
Rape - Section 1 Sexual Offences Act 2003
Assault by penetration - Section 2 Sexual Offences Act 2003
Sexual assault - Section 3 Sexual Offences Act 2003
Causing a person to engage in sexual activity without consent - Section 4 Sexual Offences Act 2003
Rape of a child under 13 - Section 5 Sexual Offences Act 2003
Assault of a child under 13 by penetration - Section 6 Sexual Offences Act 2003
Sexual assault of a child under 13 - Section 7 Sexual Offences Act 2003
Causing or inciting a child under 13 to engage in sexual activity - Section 8 Sexual Offences Act 2003
Sexual Activity with a Child - Section 9 Sexual Offences Act 2003
Causing or inciting a child to engage in sexual activity - Section 10 Sexual Offences Act 2003
Engaging in sexual activity in the presence of a child - Section 11 Sexual Offences Act 2003
Causing a child to watch a sexual act - Section 12 Sexual Offences Act 2003
Child sex offences committed by a children or young persons - Section 13 Sexual Offences Act 2003
Arranging or facilitating commission of a child sex offence - Section 14 Sexual Offences Act 2003
Meeting a child following sexual grooming etc. - Section 15 Sexual Offences Act 2003
Abuse of position of trust: sexual activity with a child - Section 16 Sexual Offences Act 2003
Abuse of position of trust: causing or inciting a child to engage in sexual activity - Section 17 Sexual Offences Act 2003
Abuse of position of trust: sexual activity in the presence of a child - Section 18 Sexual Offences Act 2003
Abuse of position of trust: causing a child to watch a sexual act - Section 19 Sexual Offences Act 2003
Sexual activity with a child family member - Section 25 Sexual Offences Act 2003
Inciting a child family member to engage in sexual activity - Section 26 Sexual Offences Act 2003
Sexual activity with a person with a mental disorder impeding choice - Section 30 Sexual Offences Act 2003
Causing or inciting a person, with a mental disorder impeding choice, to engage in sexual activity - Section 31 Sexual Offences Act 2003
Engaging in sexual activity in the presence of a person with a mental disorder impeding choice - Section 32 Sexual Offences Act 2003
Causing a person, with a mental disorder impeding choice, to watch a sexual act - Section 33 Sexual Offences Act 2003
Inducement, threat or deception to procure sexual activity with a person with a mental disorder - Section 34 Sexual Offences Act 2003
Causing a person with a mental disorder to engage in or agree to engage in sexual activity by inducement, threat or deception - Section 35 Sexual Offences Act 2003
Engaging in sexual activity in the presence, procured by inducement, threat or deception, of a person with a mental disorder - Section 36 Sexual Offences Act 2003
Causing a person with a mental disorder to watch a sexual act by inducement, threat or deception - Section 37 Sexual Offences Act 2003
Care workers: sexual activity with a person with a mental disorder - Section 38 Sexual Offences Act 2003
Care workers: causing or inciting sexual activity - Section 39 Sexual Offences Act 2003
Care workers: sexual activity in the presence of a person with a mental disorder - Section 40 Sexual Offences Act 2003
Care workers: causing a person with a mental disorder to watch a sexual act - Section 41 Sexual Offences Act 2003
Paying for the sexual services of a child - Section 47 Sexual Offences Act 2003
Causing or inciting child prostitution or pornography - Section 48 Sexual Offences Act 2003
Controlling a child prostitute or a child involved in pornography - Section 49 Sexual Offences Act 2003
Arranging or facilitating child prostitution or pornography - Section 50 Sexual Offences Act 2003
Causing or inciting prostitution for gain - Section 52 Sexual Offences Act 2003
Controlling prostitution for gain - Section 53 Sexual Offences Act 2003
Trafficking into the UK for sexual exploitation - Section 57 Sexual Offences Act 2003
Trafficking within the UK for sexual exploitation - Section 58 Sexual Offences Act 2003
Trafficking out of the UK for sexual exploitation - Section 59 Sexual Offences Act 2003
Administering a substance with intent - Section 61 Sexual Offences Act 2003
Committing an offence with intent to commit a sexual offence (in a case where the intended offence was an offence against Section 62 Sexual Offences Act 2003
Trespass with intent to commit a sexual offence (in a case where the intended offence was an offence against a child) - Section 63 Sexual Offences Act 2003
Exposure - Section 66 Sexual Offences Act 2003
Voyeurism - Section 67 Sexual Offences Act 2003
Trafficking people for exploitation - Section 4 Asylum and Immigration (Treatment of Claimants, etc.) Act 2004
Causing or allowing the death of a child or vulnerable adult - Section 5 Domestic Violence, Crime and Victims Act 2004

A reference to an offence in this list includes:
- a reference to an attempt, conspiracy or incitement to commit that offence, and a reference to aiding, abetting, counselling or procuring the commission of that offence.
- unless stated otherwise, the victim of the offences listed above will be under 18.
- cautions for the offences listed above also apply.
# Appendix 12: Questionnaires, Scales and Tools

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<td>Designed to measure the tendency to give Socially Desirable Responses (SDR) also known as “Faking good”</td>
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<tr>
<td>(Paulhus, 1998)</td>
<td></td>
</tr>
<tr>
<td>Questionnaire/ Scale/Tool</td>
<td>Purpose</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>CAPI</td>
<td>To screen for parent’s potential for physical child abuse</td>
</tr>
<tr>
<td>Other tools to support the assessment process</td>
<td></td>
</tr>
<tr>
<td>PAM Framework</td>
<td>To support the assessment of parents with a learning disability or significant learning difficulties and to record changes over time.</td>
</tr>
<tr>
<td>SCODA Assessment</td>
<td>To support the assessment of problem drug use</td>
</tr>
<tr>
<td>Questionnaire/ Scale/Tool</td>
<td>Purpose</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>DVRIM</td>
<td>To aid information gathering and analysis of level of risk to children where domestic violence is a concern</td>
</tr>
<tr>
<td>Child Neglect Toolkit</td>
<td>To aid the assessment of aspects of neglect and to record changes over time</td>
</tr>
</tbody>
</table>
The Family Pack of Questionnaires and Scales

Framework for the Assessment of Children in Need and their families - pack

A Bentovim and A Cox 2000
DoH 2000

The Family Pack includes the following questionnaires and scales:

Strengths and Difficulties Questionnaires
The Parenting Daily Hassle Scale
Home Conditions Scale
Adult Wellbeing Scale
The Adolescent Wellbeing Scale
The Recent Life Events Questionnaire
The Family Activity Scale
The Alcohol Scale

The questionnaires/scales and associated guidance can be downloaded from the shared drive (link to be inserted):

or via the archived Department of Health Publications website.

Psychometric Tests/Scales

Good Practice Points in the Administration of Psychometric tests and Scales:

1. Check the literacy skills of the respondent to ensure that they can read and understand the questionnaires.

2. If they cannot read or lack confidence in their reading you might decide to read the questions out and score the forms for the respondent. Ensure when doing so that there is no suggestive tone in your voice or body language.

3. Responses must be the respondent’s own. If they do not understand a word or phrase by all means explain the word or phrase. Avoid rephrasing the question or giving alternative versions. If they do not understand the question and cannot answer, make a note of this.

4. Always sit with the respondent whilst they complete psychometric questionnaires. That way you are on hand if they have difficulties but also ensure that the responses are their own. Do not give questionnaires as “homework”.

5. When a questionnaire is complete, check to ensure that no items have been missed out accidentally or purposely.

6. When scoring tests, do so in a quiet area where it is easy to concentrate.

7. Before using a questionnaire for the first time, the assessor should run through the test as a “dry” run. This well help with familiarisation and anticipation of any potential difficulties the proposed respondent may encounter.

8. The assessor can use these tests at their discretion. If under confident in using the test or uncertain of its relevance to the assessment, simply do not use it.
PERSONALITY INVENTORIES PROFILE: 
DESCRIPTIONS OF MEASURES

SELF ESTEEM/SELF DEROGATION (SE)
High scores indicate good self esteem

EMOTIONAL LONELINESS (EL)
This scale detects variations in loneliness that occur in everyday life. Individuals with high scores for emotional loneliness often have low self esteem, are under assertive and have difficulty coping with their own negative emotions.

LOCUS OF CONTROL (LOC)
The extent to which a person feels that events are contingent upon their behaviour and the extent to which they feel events are controlled externally. High scorers may blame their problems on circumstances and see little reason to make changes and may fail to take responsibility; high scorers believe their lives to be more subject to chance occurrences and other people’s wishes.

EMPATHY SCALES (INTERPERSONAL REACTIVITY INDEX)

1. Perspective Taking (PT): The ability to assume cognitively the role of another
2. Empathic Concern (EC): Feelings of warmth, compassion and concern for another
3. Fantasy (FS): The ability to identify with fictional characters
4. Personal Distress (PD): Addresses the experience of anxiety and negative emotions resulting from feelings of distress of another person. The individual has difficulty coping with negative feelings rather than identifying with them per se.

Note: Sex differences are reported to exist for each subscale, with women tending to score higher than men on each subscale (Davis, 1980).
PERSONALITY INVENTORIES PROFILE

Standard Scores, Mean = 50, SD= 10 based on 81 non-offending British adult males.

<table>
<thead>
<tr>
<th>%</th>
<th>SE</th>
<th>EL</th>
<th>LC</th>
<th>PT</th>
<th>EC</th>
<th>FS</th>
<th>PD</th>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>19-28</td>
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<td>70</td>
<td>48-54</td>
<td>22-27</td>
<td>27-28</td>
<td>26-28</td>
<td>23-28</td>
<td>16-18</td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>41-47</td>
<td>17-21</td>
<td>22-26</td>
<td>22-25</td>
<td>17-22</td>
<td>12-15</td>
<td></td>
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<td>50</td>
<td>34-40</td>
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<td>18-21</td>
<td>18-21</td>
<td>11-16</td>
<td>8-11</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>6-7</td>
<td>27-33</td>
<td>5-10</td>
<td>14-17</td>
<td>14-17</td>
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<td>9-13</td>
<td>10-13</td>
<td>0-4</td>
<td>0-3</td>
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<td>4</td>
<td>13-19</td>
<td>5-8</td>
<td>5-9</td>
<td></td>
<td></td>
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<td>0-12</td>
<td>0-4</td>
<td>0-4</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Inventory Measure</th>
<th>Self Esteem</th>
<th>Loneliness</th>
<th>Locus of Control</th>
<th>Interpersonal Reactivity Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Esteem</td>
<td>Emotional Loneliness</td>
<td>Locus of Control</td>
<td>Perspective Taking</td>
<td>Empathic Concern</td>
</tr>
<tr>
<td>Raw Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Personality Inventories Profile

Self-Esteem Questionnaire (SE) and scoring instructions
**QUESTIONNAIRE (SE)**

Name………………………………………………………………

Date……………………………….

Please answer the following questions by ticking in the column for ‘yes’ or ‘no’

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Do you ever wish you were someone else?</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Do you like the sort of person you are?</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>At an election, would you vote for someone you knew very little about?</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Do you often feel ashamed of yourself?</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Do you understand yourself?</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Do you have a low opinion of yourself?</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>If you could get into the cinema without paying, and be sure you weren’t seen, would you probably do it?</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Do you think you can make a success of your life?</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Are things all mixed up in your life?</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Do you like to know some important people because it makes you feel important?</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Are you happy with the way you are?</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>When you are not feeling well, do you sometimes feel annoyed?</td>
<td></td>
</tr>
</tbody>
</table>
Questionnaire: Self-Esteem/Self Derogation Scoring Instructions

The questionnaire contains eight items relating to self-esteem. Each of the **ticked** items shown below scores one point (Ignore items 3, 7, 10 & 12). Write the total score on the Personality Inventories Profile in the Raw Score box and then circle the appropriate value on the Profile.

---

**QUESTIONNAIRE 5**

Name: ........................................................................................................

Date: ........................................................................................................

Please answer the following questions by ticking in the box for 'yes' or 'no'

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you ever wish you were someone else?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you like the sort of person you are?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. At an election, would you vote for someone you knew very little about?</td>
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<td></td>
</tr>
<tr>
<td>4. Do you often feel ashamed of yourself?</td>
<td></td>
<td></td>
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<td>5. Do you understand yourself?</td>
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</tr>
<tr>
<td>8. Do you think you can make a success of your life?</td>
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</tr>
<tr>
<td>9. Are things all mixed up in your life?</td>
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<tr>
<td>10. Do you like to know some important people because it makes you feel important?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Are you happy with the way you are?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. When you are not feeling well, do you sometimes feel annoyed?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---
Personality Inventories Profile:
Emotional Loneliness Questionnaire (EL) and Scoring Instructions

(Revised UCLA Loneliness Scale, Russell et al 1980)
Questionnaire (EL)

**Scale:**
INSTRUCTIONS: Indicate how often each of the statements below is descriptive of you.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel in tune with the people around me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. I lack companionship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. There is no one I can turn to</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. I do not feel alone</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I feel part of a group of friends</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. I have a lot in common with the people around me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I am no longer close to anyone</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. My interests and ideas are not shared by those around me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. I am an outgoing person</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. There are people I feel close to</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. I feel left out</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. My social relationships are superficial</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. No one really knows me well</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. I feel isolated from others</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. I can find companionship when I want it</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. There are people who really understand me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. I am unhappy being so withdrawn</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. People are around me but not with me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. There are people I can talk to</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20. There are people I can turn to</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Emotional Loneliness Scale Scoring Instructions:

Score all items as 1, 2, 3, 4 according to which response has been indicated except for items 1, 5, 6, 9, 10, 15, 16, 19, 20. These are all reverse scored ie: (4 = 1, 3 = 2, 2 = 3, 1 = 4).

Add up the score

Enter the score into the Raw Score of the Personality Inventories Profile, then circle the appropriate value in the Profile above.
Personality Inventories Profile:

Locus of Control Questionnaire (LOC)

and Scoring Instructions
Questionnaire (LOC)

We want you to answer the following questions the way you feel. There are no right or wrong answers. Don’t take too much time answering any one question, and do try to answer them all.

One of your concerns during the test may be, what should I do if I can answer both yes and no to a question? It’s not unusual for that to happen. If it does, think about whether your answer is just a little more one way than the other. For example, if you’d assign a weighting of 51% to “yes” and assign 49% to “no”, mark the answer “yes”. Try to pick one response for all the questions and not leave any blanks.

Circle “yes” or “no” next to each item. Be sure to put your name and the date on our answer sheet. Thank you.

1. Do you believe that most problems will solve themselves if you just don’t fool with them?
   YES   NO

2. Do you believe that you can stop yourself from catching a cold?
   YES   NO

3. Are some people just born lucky?
   YES   NO

4. Most of the time do you feel that getting good marks at school meant a great deal to you?
   YES   NO

5. Are you often blamed for things that just aren't your fault?
   YES   NO

6. Do you believe that if somebody studies hard enough he or she can pass any subject?
   YES   NO

7. Do you feel that most of the time it doesn’t pay to try hard because things never turn out right anyway?
   YES   NO

8. Do you feel that if things start out well in the morning it is going to be a good day no matter what you do?
   YES   NO

9. Do you feel that most of the time parents listen to what their children have to say?
   YES   NO

10. Do you believe that wishing can make good things happen?
    YES   NO

11. When you get punished does it usually seem it's for no good reason at all?
    YES   NO
12 Most of the time do you find it hard to change a friend’s (mind) or opinion?  
   YES  NO

13 Do you think that cheering more than luck helps a team to win?  
   YES  NO

14 Did you feel that it was nearly impossible to change your parents mind about anything?  
   YES  NO

15 Do you believe that parents should allow children to make the most of their own decisions?  
   YES  NO

16 Do you feel that when you do something wrong there's very little you can do to make it right?  
   YES  NO

17 Do you believe that most people are just born good at sports?  
   YES  NO

18 Are most of the other people your age stronger than you are?  
   YES  NO

19 Do you feel that one of the best ways to handle most problems is just not to think about them?  
   YES  NO

20 Do you feel that you have a lot of choice in deciding whom your friends are?  
   YES  NO

21 If you find a four leaf clover, do you believe that it might bring you good luck?  
   YES  NO

22 Did you feel that whenever you did your homework or not has much to do with what kind of marks you get?  
   YES  NO

23 Do you feel that when a person your age decides to hit you there’s little you can do to stop him or her?  
   YES  NO

24 Have you ever had a good luck charm?  
   YES  NO

25 Do you believe that whether or not people like you depends on how you act?  
   YES  NO

26 Did your parents usually help you if you asked them to?  
   YES  NO

27 Have you felt that when people were angry with you it was usually for no reason at all?  
   YES  NO
28  Most of the time, do you feel that you can change what might happen tomorrow by what you do today?  
    YES  NO

29  Do you believe that when bad things are going to happen they just are going to happen no matter what you try to do to stop them?  
    YES  NO

30  Do you think that people can get their own way if they just keep trying?  
    YES  NO

31  Most of the time do you find it useless to try to get your own way at home?  
    YES  NO

32  Do you feel that when good things happen they happen because of hard work?  
    YES  NO

33  Do you feel that when somebody your age wants to be your enemy there’s little you can do to change matters?  
    YES  NO

34  Do you feel that it is easy to get friend to do what you want them to?  
    YES  NO

35  Do you usually feel that you have little to say about what you get to eat at home?  
    YES  NO

36  Do you feel that when someone doesn’t like you there’s little you can do about it?  
    YES  NO

37  Did you usually feel that it was almost useless to try in school because most other children were just more clever than you were?  
    YES  NO

38  Are you the kind of person who believes that planning ahead makes things turn out better?  
    YES  NO

39  Most of the time do you feel that you have little or no say about what your family decides to do?  
    YES  NO

40  Do you think it is better to be clever than to be lucky?  
    YES  NO

Name:

Date:
## Locus of Control Questionnaire Scoring Instructions

Each of the following circled responses scores one point. Add the scores and write the total score on the Personality Inventories Profile in the raw score box, then circle the appropriate value on the Profile.

### Assessment Questionnaire 3

Please answer this questionnaire by circling the answer that best fits how you feel. There are no right or wrong answers. Please do not take too much time over any one question, and please answer them all.

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Do you believe that most problems will solve themselves if you just don’t foo with them?</td>
<td>✔</td>
<td>☐</td>
</tr>
<tr>
<td>2</td>
<td>Do you believe that you can stop yourself from catching a cold?</td>
<td>✔</td>
<td>☐</td>
</tr>
<tr>
<td>3</td>
<td>Are some people just born lucky?</td>
<td>✔</td>
<td>☐</td>
</tr>
<tr>
<td>4</td>
<td>Most of the time do you feel that getting good grades at school meant a great deal to you?</td>
<td>✔</td>
<td>☐</td>
</tr>
<tr>
<td>5</td>
<td>Are you often blamed for things that just aren’t your fault?</td>
<td>✔</td>
<td>☐</td>
</tr>
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<td>6</td>
<td>Do you believe that if somebody studies hard enough he or she can pass any subject?</td>
<td>✔</td>
<td>☐</td>
</tr>
<tr>
<td>7</td>
<td>Do you feel that most of the time it doesn’t pay to try hard because things never turn out right anyway?</td>
<td>✔</td>
<td>☐</td>
</tr>
<tr>
<td>8</td>
<td>Do you feel that if things start out well in the morning that it’s going to be a good day no matter what you do?</td>
<td>✔</td>
<td>☐</td>
</tr>
<tr>
<td>9</td>
<td>Do you feel that most of the time parents listen to what their children have to say?</td>
<td>✔</td>
<td>☐</td>
</tr>
<tr>
<td>10</td>
<td>Do you believe that wishing can make good things happen?</td>
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<tr>
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21 If you find a four leaf clover, do you believe that it might bring you good luck?

22 Did you feel that whether you did your homework had much to do with what kind of grades you got?

23 Do you feel that when someone your age decides to hit you, there's little you can do to stop him or her?

24 Have you ever had a good luck charm?

25 Do you believe that whether or not people like you depends on how you act?

26 Did your parents usually help you if you asked them?

27 Have you felt that when people were mean to you it was usually for no reason at all?

28 Most of the time, do you feel that you can change what might happen tomorrow by what you do today?

29 Do you believe that when bad things are going to happen they are just going to happen no matter what you try to do to stop them?

30 Do you think that people your age can get their own way if they just keep trying?

31 Most of the time do you find it useless to try to get your own way at home?

32 Do you feel that when good things happen, they happen because of hard work?

33 Do you feel that when somebody your age wants to be your enemy there's little you can do to change matters?

34 Do you feel that it's easy to get friends to do what you want them to?

35 Do you usually feel that you have little to say about what you get to eat at home?

36 Do you feel that when someone doesn't like you there's little you can do about it?

37 Did you usually feel that it was almost useless to try in school because most other children were just more clever than you were?

38 Are you the kind of person who believes that planning ahead makes things turn out better?

39 Most of the time, do you feel that you have little to say about what your family decides to do?

40 Do you think it's better to be clever than to be lucky?
Personality Inventories Profile:

Interpersonal Reactivity Index (IRI)

Questionnaires and Scoring Instructions

1. Perspective Taking
2. Empathic Concern
3. Fantasy
4. Personal Distress
IRI QUESTIONNAIRE

Name: 

Date:

The following statements ask about your thoughts and feelings in a variety of situations. For each item, show how well it describes you by choosing the appropriate number on the scale at the top of the page. When you have decided on your answer, fill in the space following the item. READ EACH ITEM CAREFULLY BEFORE RESPONDING. Answer as honestly and as accurately as you can.

<table>
<thead>
<tr>
<th></th>
<th>Nothing like me</th>
<th>A little like me</th>
<th>Quite like me</th>
<th>Like me</th>
<th>A lot like me</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I daydream quite often about things that might happen to me</td>
<td>________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I often feel quite sorry for people less fortunate than me</td>
<td>________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I sometimes find it difficult to see things from another person’s point of view</td>
<td>________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Sometimes I don’t feel very sorry for other people when they are having problems</td>
<td>________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I can really relate to the feelings of characters in a good book</td>
<td>________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>In emergency situations I feel nervous</td>
<td>________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I don't usually get emotional (e.g. frightened or weepy) when I watch a film or TV drama</td>
<td>________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I try to look at everyone’s side of an argument before I make a decision</td>
<td>________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>When I see someone being bullied or 'ripped off' I feel a bit protective towards them</td>
<td>________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>I sometimes feel helpless when I am in the middle of a very emotional situation</td>
<td>________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>I sometimes try to understand my friends better by imagining how things look from their point of view</td>
<td>________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Becoming extremely involved in a good book or film is unusual for me</td>
<td>________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>When I see someone get hurt I stay calm</td>
<td>________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Other people’s bad luck does not usually upset me very much</td>
<td>________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>If I am sure I'm right about something I don't waste time listening to other people's arguments</td>
<td>________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Response</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-------------</td>
<td>----------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>After seeing a character on TV or in a film I have felt as though I was like that person</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>17</td>
<td>Being in a tense emotional situation scares me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>When I see someone being treated unfairly I sometimes don’t feel very much pity for them</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>I am usually pretty good at dealing with emergencies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>I am often quite touched by things I see happen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>I believe that there are two sides to every question and try to look at them both</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>I would describe myself as a pretty soft-hearted person</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>When I watch a good film I can very easily put myself in the place of the leading character</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>I tend to lose control during emergencies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>When I am upset at someone I usually try to ‘put myself in his shoes’ for a while</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>When I am reading an interesting story I imagine how I would feel if the events in the story were happening to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>When I see someone who badly needs help in an emergency, I go to pieces</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Before criticising somebody, I try to imagine how I would feel if I were in their place</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Interpersonal Reactivity Index (Empathy Scales)**

**Scoring Instructions**

Enter the raw scores on the Personality Inventories Profile, and then circle the appropriate value on the Profile.

### INTERPERSONAL REACTIVITY INDEX

<table>
<thead>
<tr>
<th>Perspective Taking</th>
<th>Empathic Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item No</td>
<td>Raw Score</td>
</tr>
<tr>
<td>3*</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>15*</td>
<td>14*</td>
</tr>
<tr>
<td>21</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>N = 7 Total =</td>
</tr>
</tbody>
</table>

### Fantasy

<table>
<thead>
<tr>
<th>Personal Distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item No</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>16</td>
</tr>
<tr>
<td>26</td>
</tr>
<tr>
<td>N = 7</td>
</tr>
</tbody>
</table>

* Reverse Scoring

<table>
<thead>
<tr>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>
Impulsivity Scale (BIS-11)


Questionnaire and Scoring Instructions
**BIS-11**

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
</table>

**Instructions:** people differ in the ways they act and think in different situations. Below is a list of statements that measure some of the ways in which you act and think. Do not spend too much time on any statement but decide how much the statement applies to you. **Please answer quickly and honestly by circling the number that best describes you according to the scale below.**

- 1 = rarely or never applies to me
- 2 = occasionally applies to me
- 3 = often applies to me
- 4 = almost always or always applies to me

<table>
<thead>
<tr>
<th>Statement</th>
<th>rarely or never</th>
<th>occasionally</th>
<th>often</th>
<th>almost always or always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I plan tasks carefully</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. I do things without thinking</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. I make up my mind quickly</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. I am ‘happy-go-lucky’ (easy going)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I don’t ‘pay attention’</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. I have thoughts that race through my mind</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I plan trips well ahead of time</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. I am self-controlled</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. I concentrate easily</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. I save regularly</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. I get ‘squirmy’ (fidgety) at plays, lectures or talks</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. I am a careful thinker</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. I plan for job security</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. I say things without thinking</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. I like to think about complex problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. I change jobs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. I act on impulse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. I get easily bored when solving thought problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. I act on the spur of the moment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20. I am a steady thinker</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21. I change residences (ie, where you live)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22. I buy things on impulse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23. I can only think about one thing at a time</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24. I change hobbies</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>25. I spend more than I bring in</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>26. I often have irrelevant thoughts when I’m thinking</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Statement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>27</td>
<td>I am more interested in the present than in the future</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28</td>
<td>I am restless at the theatre or lectures</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>29</td>
<td>I like puzzles</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30</td>
<td>I am future oriented</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
### BIS-11 scoring

Take the completed test sheet and fill in column 2 using the marked scores for the items in column 1 (which have to be reversed). Tick off the items on the test sheet as you go.

Then enter the reverse scores for column 2 in column 3, ie: \(4 = 1, 3 = 2, 2 = 3, 1 = 4\).

Then transfer the reverse scores from column 3 into the appropriate boxes in the remaining three columns.

Then fill in the remaining boxes using the marked scores from the test sheet.

Add up each of the columns. Add up the totals from the columns to give the total BIS score (see below).

<table>
<thead>
<tr>
<th></th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>raw score</td>
<td>reverse score</td>
<td>non-planning</td>
<td>motor impulsiveness</td>
<td>attentional impulsiveness</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>7</td>
<td>7</td>
<td>3</td>
<td>6</td>
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<td>30</td>
<td>29</td>
<td>29</td>
<td>30</td>
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</table>

**Subscale totals**

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<tr>
<th></th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Subscale totals</strong></td>
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<td></td>
</tr>
</tbody>
</table>

**TOTAL BIS SCORE ________

### SUB-SCALE NORMS

<table>
<thead>
<tr>
<th>non-planning</th>
<th>motor impulsiveness</th>
<th>attentional impulsiveness</th>
<th>total impulsiveness</th>
<th>percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>35</td>
<td>25</td>
<td>22</td>
<td>75</td>
<td>85</td>
</tr>
<tr>
<td>30</td>
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<td>27</td>
<td>21</td>
<td>18</td>
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<td>21</td>
<td>17</td>
<td>14</td>
<td>55</td>
<td>15</td>
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<tr>
<td>Total BIS score</td>
<td>percentile</td>
<td>meaning</td>
<td>rating</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>------------------</td>
<td>---------------------------------------------------</td>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td>75 or above</td>
<td>at above 85th</td>
<td>only 15% of respondents are more impulsive</td>
<td>Very, very impulsive</td>
<td></td>
</tr>
<tr>
<td>70-74</td>
<td>at or above 70th</td>
<td>30% of respondents are more impulsive</td>
<td>Very impulsive</td>
<td></td>
</tr>
<tr>
<td>65-70</td>
<td>at or above 50th</td>
<td>50% of respondents are more impulsive</td>
<td>Impulsive</td>
<td></td>
</tr>
<tr>
<td>60-64</td>
<td>at or above 30th</td>
<td>70% of respondents are more impulsive</td>
<td>Only Slightly impulsive</td>
<td></td>
</tr>
<tr>
<td>55-59</td>
<td>at or above 15th</td>
<td>85% of respondents are more impulsive</td>
<td>Not very impulsive</td>
<td></td>
</tr>
<tr>
<td>54 or below</td>
<td>below 15th</td>
<td>over 85% of respondents are more impulsive</td>
<td>Not at all impulsive</td>
<td></td>
</tr>
</tbody>
</table>
Other Tools

to support the Assessment Process
SCODA Assessment Framework

Framework for assessing problem drug use and impact on parenting

This assessment framework has been adapted and expanded from guidelines produced by the Standing Conference on Drug Abuse (SCODA 1997)

Children in the family - provision of good basic care

- How many children are in this family?
- What are their names and ages (wherever possible include dates of birth)?

For each child:

- Is there adequate food, clothing and warmth for the child? Is height and weight normal for the child's age and stage of development?
- Is the child's health and development consistent with their age and stage of development? Has the child received necessary immunisations? Is the child registered with a GP and a dentist? Do the parents seek health care for the child(ren) appropriately?
- Does he or she attend nursery or school regularly? If not, why not? Is he or she achieving appropriate academic attainment?
- Does the child present any behavioural problems, or emotional problems? Does the parent manage the child's distress or challenging behaviour appropriately?
- Who normally looks after the child?
- Are children engaged in age-appropriate activities?
- Are there any indications that any of the children are taking on a parenting role within the family (e.g. caring for other children, excessive household responsibilities etc.)?
- Is the care for the child consistent and reliable? Are the child's emotional needs being adequately met?
- Is there a risk of repeated separation for example because of periods of imprisonment (e.g. short custodial sentences or fine default)
- How does the child relate to unfamiliar adults?
- Are there non-drug using adults in the family readily accessible to the child who can provide appropriate care and support when necessary?

Describing parental drug use

(identify sources of information, including conflicting reports)

- Is the drug use by the parent
  - experimental?
  - recreational?
  - chaotic?
  - dependent?
- Does the user move between these types of drug use at different times?
- Does the parent misuse alcohol?
- Does the parent use alcohol concurrently with other drugs?
• How reliable is current information about the parent's drug use?
• Is there a drug free parent, supportive partner or relative?
• Is the quality of parenting or childcare different when a parent is using drugs and when not using?
• Does the parent have any mental health problems alongside drug use? If so, how are mental health problems affected by the parent's drug use? Are mental health problems directly related to drug use?

Accommodation and the home environment
• Is the family's living accommodation suitable for children? Is it adequately equipped and furnished? Are there appropriate sleeping arrangements for each child, for example does each child have a bed or cot, with sufficient bedding?
• Are rent and bills paid? Does the family have any arrears or significant debts?
• How long have the family lived in their current home / current area? Does the family move frequently? If so, why? Are there problems with neighbours, landlords or dealers?
• Do other drug users share or use the accommodation? If so, are relationships with them harmonious, or is there conflict?
• Is the family living in a drug using community?
• If parents are using drugs, do children witness the taking of the drugs, or other substances?
• Could other aspects of drug use constitute a risk to children (e.g. conflict with or between dealers, exposure to criminal activities related to drug use)?

Procurement of drugs
• Where are the children when their parents are procuring drugs or getting supervised methadone? Are they left alone? Are they taken to unsuitable places where they might be at risk, such as street meeting places, flats, needle exchanges, adult clinics?
• How much do the parents spend on drugs (per day? per week?) How is the money obtained?
• Is this causing financial problems?
• Do the parents sell drugs in the family home?
• Are the parents allowing their premises to be used by other drug users?

Health risks
• Where in the household do parents store drugs?
• Do the children know where the drugs are kept?
• What precautions do parents take to prevent their children getting hold of their drugs? Are these adequate?
• What do parents know about the risks of children ingesting methadone and other harmful drugs?
• Are they in touch with local agencies that can advise on such issues such as needle exchanges, substitute prescribing programmes, detoxification and rehabilitation facilities? If they are in touch with agencies, how regular is the contact?
If parent(s) inject:

- Where do they keep injecting equipment? In the family home? Are works kept securely?
- Do they share injecting equipment?
- Do they use a needle exchange scheme?
- How do they dispose of syringes?
- What do they know about the health risks of injecting or using drugs?

Family and social supports

- Do the parents primarily associate with other problem drug users, non-drug users or both?
- Are relatives aware of parent(s) drug use? Are they supportive of the parent(s)/ the child?
- Will parents accept help from relatives, friends or professional agencies?
- Is social isolation a problem for the family?
- How does the community perceive the family? Do neighbours know about the parents drug use? Are neighbours supportive or hostile?

Parents perception of the situation

- Do the parents see their drug use as harmful to themselves or to their children?
- Is there evidence that the parents place their own needs and procurement of drugs before the care and welfare of their children?

Do the parents know what responsibilities and powers agencies have to support and protect children at risk?


Barnardo`s Domestic Violence Risk Identification Matrix (DVRIM)

The DVRIM is now widely used in the UK and is incorporated within the London Children’s Safeguarding Board Child Protection Procedures. The guidance below is drawn primarily from those procedures.

The DVRIM is designed to identify and assess the level of risk to children/young people from domestic violence. It also identifies the level of risk of to the mother from a male perpetrator, incorporating adult focussed risk factors that identify the nature and level of the perpetrator's violence and abuse. It is consistent with the SafeLives DASH risk assessment checklist and risk assessment models used by the police, MARAC and MAPPA.

Potential benefits of the model

- To identify risks to children and young people from domestic violence.
- To identify what is known and what is suspected.
- To identify gaps in information.
- To promote the `visibility` of all the children in the household.
- To provide consistent analysis of risk and facilitate communication.
- To show changes in the level of risk (increase or decrease) in the light of new information or over time.
- To assist in decision-making and planning intervention for children, non-abusing parents and perpetrators.

Using the matrix

Ensure you use the most up-to-date version of the matrix. An electronic copy of the DVRIM can be downloaded from the shared drive (link to be inserted). The DVRIM and guidance can also be downloaded from the LSCB Child Protection Procedures (Part B3, Section 27, Appendix 1).

The DVRIM should be completed in respect of each child in the household - risk factors, vulnerabilities and protective factors may differ for each child.
The DVRIM can be completed with the mother if she is willing to do this. Care must be taken to do this sensitively and in a safe environment. The DVRIM can also be completed by practitioners on the basis of all the information available from relevant sources.

The DVRIM uses four threshold scales that indicate the degree of seriousness of each cluster of incidents/circumstances. The scales also indicate the level of intervention likely to be required to support and safeguard the children:

- **Scale 1**: Assesses there is a moderate risk of harm to the child identified. This indicates that a child in this situation is likely to have additional needs (as defined within the CAF).
- **Scale 2**: Assesses there is a moderate to serious risk of harm to the child identified. It indicates that a child in this situation is likely to have additional needs (as defined within the CAF).
- **Scale 3**: Assesses there is serious risk of harm to the child identified. Protective factors are limited and it indicates that the child may have suffered or is likely to suffer significant harm.
- **Scale 4**: Assesses the domestic violence as severe. Protective factors are extremely limited and it indicates that the child is likely to have suffered significant harm.

Factors are grouped into three categories:

- **Evidence of domestic violence**
  - This is the most significant determinant of the scale of risk – attention is drawn to severity, frequency, pattern and duration of domestic violence (moderate through to severe).
- **Risk factors/potential vulnerabilities**
  - These are the factors that may increase the risk of children suffering significant harm through domestic violence.
- **Protective factors**
  - Protective factors may help to mitigate risk factors and potential vulnerabilities.
Factors that increase vulnerability and/or the level of risk

- Duration of the domestic violence incident and severity of the domestic violence and abuse
- The younger the child the higher the risk to their safety: where any child is under the age of seven this raises the level of risk, as young children do not have the ability to implement safety strategies; babies under 12 months old, including an unborn child, are likely to be at significantly increased risk of harm. Upgrade the level of risk taking account of the children’s age where appropriate.
- Where the child, or the mother, has special needs
- Where the child or the mother is from a black or minority ethnic community consider any additional vulnerabilities
- Interlinking risk factors: substance misuse, mental health problems, adult learning difficulties, neglect/parenting problems, age disparity between the victim and abuser

The matrix should be worked through systematically:
Tick ‘Y’ if known to be present or ‘S’ if suspected.
Any tick in Scale 3 indicates a serious level of concern.
Any tick in Scale 4 indicates a severe level of concern.
Where there are ticks under more than one scale heading, the risk to the child should be judged to be at the higher level.
Bear in mind that information not currently known could significantly raise the threshold of risks to the child.
CHILD NEGLECT TOOLKIT

Acknowledgements
This toolkit is based on the Child Neglect Toolkit used by Islington LSCB. It was initially developed by Jane Wiffin on behalf of Hounslow LSCB, and has been further refined by Brent LSCB and adapted by Islington LSCB. The original concept of the Graded Care Profile came from work undertaken by Dr Leon Polnay and Dr O P Srivastava at Bedfordshire and Luton Community NHS Trust and Luton Borough Council.

Introduction
Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care givers); or
- ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to a child's basic emotional needs. (Working Together 2015)

The Child Neglect Toolkit
The Child Neglect Toolkit has been designed to inform assessment, planning and decision-making where there are concerns that a child's physical and/or emotional needs are being neglected. It helps to put concerns into context and identify strengths as well as areas of difficulty. It is a tool that can be used with parents to facilitate discussion.
The toolkit focuses on five key areas of need (derived from Maslow’s hierarchy of needs) and considers the extent to which children’s needs are being neglected and/or the needs of their parents/carers are taking precedence. The toolkit details indicators and possible impacts on the child with four specific ratings where 1 is child-focused care giving, and 4 is child’s needs not considered. Whilst the toolkit provides a scoring structure, it still requires the professional judgment of the practitioner.

The five key areas of need are:
1. Physical care
2. Health
3. Safety and supervision
4. Love and care
5. Stimulation and education.

Area 6 focuses on parental motivation to change.

By working through each area and scoring individual sections, strength and concerns can be identified. Columns 3 and 4 are cause for concern. The summary sheet has the potential to be used to track improvements, deterioration or ‘drift’.

It is important to note that the child neglect toolkit can be used as one element of a parenting assessment. It does not replace other elements of the parenting assessment process and specific concerns about the behaviour, personality or history of the parent/carer may not be reflected in the child neglect toolkit and should not be dismissed on the basis of positive `scores`. 
## PHYSICAL CARE: Food

<table>
<thead>
<tr>
<th>1) Child focused care giving.</th>
<th>2) Adult focused care giving.</th>
<th>3) Child’s needs are secondary to adults.</th>
<th>4) Child’s needs are not considered.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child is provided with appropriate quality of food and drink, which is appropriate to their age and stage of development. Meals are organised and there is a routine which includes the family sometimes eating together. Children’s special dietary requirements are always met. Carer understands importance of foods.</td>
<td>Child is provided with reasonable quality of food and drink and seems to receive an adequate quantity for their needs, but there is a lack of consistency in preparation and routine. Children’s special dietary requirements are inconsistently met. Carer understands the importance of appropriate food and routine but sometimes their personal circumstances impact on ability to provide.</td>
<td>Child receives low quality food and drink, which is often not appropriate to their age and stage of development and there is a lack of preparation or routine. Children’s special dietary requirements are rarely met. The carer is indifferent to the importance of appropriate food for the child.</td>
<td>Child does not receive an adequate quantity of food and is observed to be hungry. The food provided is of a consistently low quality with a predominance of sugar, sweets, crisps and chips etc. Children’s special dietary requirements are never met and there is a lack of routine in preparation and times when food is available. Carer hostile to advice about appropriate food and drink and the need for a routine.</td>
</tr>
<tr>
<td>1) Child focused care giving.</td>
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<td>3) Child’s needs are secondary to adults.</td>
<td>4) Child’s needs are not considered.</td>
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</tr>
<tr>
<td>The accommodation has all essential amenities such as heating, shower, cooking facilities, adequate beds and bedding and a toilet and is in a reasonable state of repair and decoration. Carer understands the importance of the home conditions to child’s well-being.</td>
<td>The accommodation has some essential amenities, but is in need of decoration and requires repair. Carers are aware of this, and have taken steps to address these issues. The accommodation is reasonably clean, but may be damp, but the carer addresses this. Carer recognises the importance of the home conditions to the child’s sense of well-being, but is hampered by personal circumstances.</td>
<td>The accommodation is in a state of disrepair, carers are unmotivated to address this and the child has suffered accidents and potentially poor health as a result. The look is bare and possibly dirty/smelly and there are inadequate amenities such as beds and bedding, a dirty toilet, lack of clean washing facilities and the whole environment is dirty and chaotic. The accommodation smells of damp and there is evidence of mould.</td>
<td>The accommodation is in a dangerous state of disrepair and this has caused a number of accidental injuries and poor health for the child. The look is dirty and squalid and there is a lack of essential amenities such as a working toilet, showering/bathing facilities, inappropriate and dirty bed and bedding and poor facilities for the preparation of food. Faeces or other harmful substances are visible, and house smells. The accommodation smells strongly of damp and there is extensive mould which is untreated and the carer is hostile to advice about the impact of the home circumstances on child’s well being.</td>
</tr>
</tbody>
</table>

PHYSICAL CARE: Quality of Housing
## PHYSICAL CARE: Stability of Housing

<table>
<thead>
<tr>
<th></th>
<th>Child focused care giving.</th>
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<th>Child’s needs are not considered.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Child has stable home environment without too many moves (unless necessary). Carer understands the importance of stability for child.</td>
<td>Child has a reasonably stable home environment, but has experienced house moves/new adults in the family home. Carer recognises that this could impact on child, but the carer’s personal circumstances occasionally impact on this.</td>
<td>Child does not have a stable home environment, and has either experienced lots of moves and/or lots of adults coming in and out of the home for periods of time. Carer does not accept the importance of stability for child.</td>
<td>Child experiences lots of moves, staying with relatives or friends at short notice (often in circumstances of overcrowding leading to children sleeping in unsuitable circumstances). The home has a number of adults coming and going. Child does not always know these adults who stay over. Carer is hostile about being told about the impact on child of instability.</td>
</tr>
</tbody>
</table>
## PHYSICAL CARE: Child’s clothing

<table>
<thead>
<tr>
<th></th>
<th>Child focused care giving.</th>
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<th>Child’s needs are not considered.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Child has clothing which is clean and fits appropriately. Child is dressed appropriately for the weather and carers are aware of the importance of appropriate clothes for the child in an age appropriate way.</td>
<td>Child has clothes which are appropriate, but are sometimes poorly fitting, unclean and crumpled. The carer gives consideration to the appropriateness of clothes to meet the needs of the child in an age appropriate way, but their own personal circumstances can get in the way.</td>
<td>Child has clothing which is dirty and crumpled, in a poor state of repair and not well fitting. The child lacks appropriate clothes for the weather and does not have sufficient clothing to allow for regular washing. Carer(s) are indifferent to the importance of appropriate clothes for the child in an age appropriate way.</td>
<td>Child has clothes which are filthy, ill fitting and smelly. The clothes are usually unsuitable for the weather. Child may sleep in day clothes and is not provided with clean clothes when they are soiled. The carer is hostile to advice about the need for appropriate clothes for the well being of the child.</td>
</tr>
<tr>
<td>1) Child focused care giving.</td>
<td>2) Adult focused care giving.</td>
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<td>4) Child’s needs are not considered.</td>
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<td></td>
</tr>
<tr>
<td><strong>Animals</strong> are well cared for and do not present a danger to children or adults.</td>
<td>Animals look reasonably well cared for, but contribute to a sense of chaos in the house.</td>
<td>Animals not always well cared for or ailments treated.</td>
<td>Animals not well cared for and presence of faeces and urine in living areas.</td>
<td></td>
</tr>
<tr>
<td>Children are encouraged to behave appropriately towards animals.</td>
<td>Animals present no dangers to children or adults and any mistreating of animals is addressed.</td>
<td>Presence of faeces or urine from animals not treated appropriately and animals not well trained.</td>
<td>Animals dangerous and chaotically looked after.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The mistreatment of animals by adults or children is not addressed.</td>
<td>Carers do not address the ill treatment of animals by adults or children.</td>
<td></td>
</tr>
</tbody>
</table>
**PHYSICAL CARE: Hygiene**

<table>
<thead>
<tr>
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</tr>
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<tbody>
<tr>
<td>The child is clean and is either given a bath/washed daily or encouraged to do so in an age appropriate way. The child is encouraged to brush their teeth and head lice, skin complaints etc are treated appropriately. Nappy rash is treated appropriately. Carers take an interest in the child’s appearance</td>
<td>The child is reasonably clean, but the carer does not bath/wash the child regularly and/or the child is not consistently encouraged to do so in an age appropriate way. The child does not always clean their teeth, and head lice and skin conditions etc are treated in an inconsistent way. Nappy rash is a problem, but parent treats if given encouragement and advice.</td>
<td>The child looks unclean and is only occasionally bathed/washed or encouraged to do so in an age appropriate way. There is evidence that the child does not brush their teeth, and that head lice and skin conditions etc are not treated appropriately. Carer does not address concerns about nappy rash and is indifferent to concerns expressed by others. Carers do not take an interest in child’s appearance and do not acknowledge the importance of hygiene to the child’s wellbeing.</td>
<td>The child looks dirty, and is not bathed or washed or encouraged to do so. The child does not brush teeth. Head lice and skin conditions are not treated and become chronic. Carer does not address concerns about nappy rash and is hostile to concerns expressed by others. The carer is hostile to concerns expressed by others about the child’s lack of hygiene.</td>
</tr>
</tbody>
</table>
### HEALTH: Safe sleeping arrangements and co-sleeping for babies

<table>
<thead>
<tr>
<th>1) Child focused care giving.</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Carer has information on safe sleeping and follows the guidelines.</td>
<td>Carer has information on safe sleeping, but does not always follow guidelines, so bedding, temperature or smoking may be a little chaotic and carer may not be aware of sleeping position of the baby. (Be aware this raises risk of cot death).</td>
<td>Carer unaware of safe sleeping guidelines, even if they have been provided.</td>
<td>Carer indifferent or hostile about safe sleeping guidance. Sees it as interference and does not take account of beds and bedding, room temperature, sleeping position of the baby and smoking. (Be aware this raises risk of cot death).</td>
</tr>
<tr>
<td>There is suitable bedding and carers having an awareness of the importance of the room temperature, sleeping position of the baby and carer does not smoke in household. Carer aware of guidance around safe co-sleeping and recognises the importance of the impact of alcohol and drugs on safe co-sleeping.</td>
<td>Carer aware of the dangers of co-sleeping and recognises the dangers of drugs and alcohol by the carer on safe co-sleeping, but this is sometimes inconsistently observed. Sleeping arrangements for children can be a little chaotic.</td>
<td>Carer ignores advice about beds and bedding, room temperature, sleeping position of the baby and smoking. (Be aware this raises risk of cot death).</td>
<td>Carer hostile to advice about safe sleeping and the impact of carer’s drug and alcohol on safe co-sleeping for the baby.</td>
</tr>
<tr>
<td>There are appropriate sleeping arrangements for children.</td>
<td></td>
<td>Carer does not recognise the importance of safe co-sleeping or the impact of carer’s alcohol/drug use on safety. Sleeping arrangements for children are not suitable and carer is indifferent to advice regarding this.</td>
<td>Sleeping arrangements for children are not suitable and carer is hostile to advice regarding this.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Carer not concerned about impact on child.</td>
<td>Carer not concerned about impact on child or risks associated with this, such as witnessing adult sexual behaviour.</td>
</tr>
</tbody>
</table>
HEALTH: Seeking advice and intervention

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Advice sought from professionals/ experienced adults on matters of concern about child’s health.</td>
<td>Advice is sought about illnesses, but this is occasionally delayed or poorly managed as a result of carer difficulties.</td>
<td>The carer does not routinely seek advice about childhood illnesses but does when concerns are serious or when prompted by others.</td>
<td>Carer does not attend to childhood illnesses, unless severe or in an emergency.</td>
</tr>
<tr>
<td>Apointments are made and consistently attended.</td>
<td>Carer understands the importance of routine care such as optical/dental but is not always consistent in keeping routine appointments.</td>
<td>Dental care and optical care are not routinely attended to. Immunisations are not up to date, but carer will allow access to children if home visits are carried out.</td>
<td>Childhood illnesses allowed to deteriorate before advice/care is sought.</td>
</tr>
<tr>
<td>Preventative care is carried out such as dental/optical and all immunisations are up to date.</td>
<td>Immunisations are delayed, but eventually completed.</td>
<td>Carer does not ensure the child completes any agreed programme of medication or treatment and is indifferent to the impact on child’s wellbeing.</td>
<td>Carer hostile to advice from others (professionals and family members) to seek medical advice.</td>
</tr>
<tr>
<td>Carer ensures child completes any agreed programme of medication or treatment.</td>
<td>Carer is inconsistent about ensuring that the child completes any agreed programme of medication or treatment, but does recognise the importance to the child, but personal circumstances can get in the way.</td>
<td></td>
<td>Routine appointments such as dental and optical not attended to, immunisations not up to date, even if a home appointment is offered.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Carer does not ensure that the child completes any agreed programme of medication or treatment and is hostile to advice about this from others, and does not recognise likely impact on child.</td>
</tr>
</tbody>
</table>
HEALTH: Disability and illness

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Carer positive about child’s identity and values him/her.</td>
<td>Carer does not always value child and allows issues of disability to impact on feelings towards the child.</td>
<td>Carer shows anger and frustration at child’s disability. Often blaming the child and not recognising identity.</td>
<td>Carer does not recognise child’s identity and is negative about child as a result of the disability.</td>
</tr>
<tr>
<td>Carer complies with needs relating to child’s disability.</td>
<td>Carer is inconsistent in their compliance with needs relating to child’s disability, but does recognise the importance to the child, but personal circumstances get in the way.</td>
<td>Carer does not ensure compliance with needs relating to child’s disability, and there is significant minimisation of child’s health needs.</td>
<td>Carer does not ensure compliance with needs relating to child’s disability, which leads to deterioration of the child’s well-being.</td>
</tr>
<tr>
<td>Carer is proactive in seeking appointments and advice and advocating for the child’s well-being.</td>
<td>Caregiver accepts advice and support but is not proactive in seeking advice and support around the child’s needs.</td>
<td>The carer does not seek or accept advice and support around the child’s needs, and is indifferent to the impact on the child.</td>
<td>Carer hostile when instructed to seek help for the child, and is actively hostile to any advice or support around child’s disability.</td>
</tr>
</tbody>
</table>
## SAFETY & SUPERVISION: Safety awareness and features

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>Carer aware of safety issues and there is evidence of safety equipment use and maintenance</td>
<td>Carer is aware of safety issues, but is inconsistent in use and maintenance of safety equipment, and allows personal circumstances to get in the way of consistency.</td>
<td>The carer does not recognise dangers to child and there is a lack of safety equipment, and evidence of daily dangers to the child. Carer indifferent to advice about this and does not recognise or acknowledge the impact on the child.</td>
<td>Carer does not recognise dangers to the child’s safety and hostile to advice regarding this, does not recognise the importance to the child, and can hold child responsible for accidents and injuries.</td>
</tr>
</tbody>
</table>
SAFETY & SUPERVISION: Supervision of the child

<table>
<thead>
<tr>
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<th>3) Child’s Needs are secondary to adults.</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Appropriate supervision is provided in line with age and stage of development. Carer recognises the importance of appropriate supervision to child’s well-being.</td>
<td>Variable supervision is provided both indoors and outdoors, but carer does intervene where there is imminent danger. Carer does not always know where child is and inconsistent awareness of safety issues when child away from home. Shows concern about when child should be home. Carer aware of the importance of supervision, but does allow personal circumstances too impact on consistency.</td>
<td>There is very little supervision indoors or outdoors and carer does not always respond after accidents. There is a lack of concern about where child is or who they are with and the carer is inconsistently concerned about lack of return home or late nights. Carer indifferent to importance of supervision and to advice regarding this from others.</td>
<td>Complete lack of supervision. Young children contained in car seats/pushchairs for long periods of time. The carers are indifferent to whereabouts of child, and often do not know where child is or who they are with, and are oblivious to any dangers. There are no boundaries about when to come home or late nights. Carer hostile about advice from others regarding appropriate supervision and does not recognise the potential impact on children’s wellbeing.</td>
</tr>
</tbody>
</table>
### SAFETY & SUPERVISION: Handling of baby / response to baby

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Carer responds appropriately to the baby’s needs and is careful whilst handling and laying the baby down, frequently checks if unattended. Carer spends time with baby, cooing and smiling, holding and behaving warmly.</td>
<td>The carer is not always consistent in their responses to the baby’s needs, because their own circumstances get in the way. Carer is a bit precarious in handling and is inconsistent in supervision. Carer spends some time with the baby, cooing and smiling, but is led by baby’s moods, and so responds negatively if baby unresponsive.</td>
<td>Carer does not recognise the importance of responding consistently to the needs of the baby. Handling is precarious and baby is left unattended (bottle left in the mouth). Carer does not spend time with baby, cooing or smiling, and does not recognise importance of comforting baby when distressed.</td>
<td>Carer does not respond to the needs of the baby and only addresses issues when carer chooses to do so. There is dangerous handling and the baby is left dangerously unattended. The baby is strapped into a car seat or some other piece of equipment for long periods and lacks adult attention and contact. Carer hostile to advice to pick baby up, and provide comfort and attention. Carer does not recognise importance to baby.</td>
</tr>
</tbody>
</table>

- 313 -
## SAFETY & SUPERVISION: Care by other adults

<table>
<thead>
<tr>
<th>1) Child focused care giving.</th>
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<tbody>
<tr>
<td>Child is left in care of a vetted adult. Never in sole care of an under 16. Parent/child always aware of each other’s whereabouts. Out of necessity a child aged 1-12 is left with a young person under 14 who is familiar and has no significant problem for no longer than necessary as an isolated incident.</td>
<td>Child 0-9 year old is sometimes left with a child age 10-13 or a person known to be unsuitable. Parents unsure of child’s whereabouts. Carer inconsistent in raising the importance of a child keeping themselves safe from others and provides some advice and support. Carer aware of the importance of safe care, but sometimes is inconsistent because of own personal circumstances.</td>
<td>Child 0-7 year old is left with an 8-10 year old or an unsuitable person. Child found wandering and/or locked out. Carer does not raise awareness of the importance of child keeping themselves safe from others and provides no advice and support. Carer is indifferent to the importance of safe care of the child and leaves the child with unsuitable or potentially harmful adults and does not recognise the potential risks to the child.</td>
<td>Child 0-7 year old is left alone or in the company young child or an unsuitable person. Child often found wandering and/or locked out. Carer does not provide any advice about keeping safe, and may put adult dangers in the way of the child. Carer hostile to advice or professional challenge about giving safe care and impact of children being left with unsuitable and/or unsuitable or dangerous adults.</td>
</tr>
</tbody>
</table>
### SAFETY & SUPERVISION: Responding to adolescents

<table>
<thead>
<tr>
<th>1) Child focused care giving.</th>
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</thead>
<tbody>
<tr>
<td>The adolescent’s needs are fully considered with appropriate adult care. Where risky behaviour occurs it is identified and responded to appropriately by the carer.</td>
<td>The carer is aware of the adolescent’s needs but is inconsistent in responding to them. The carer is aware that the adolescent needs appropriate care but is inconsistent in providing it. Where risky behaviour occurs the carer responds inconsistently to it.</td>
<td>The carer does not consistently respond to the adolescent’s needs and recognises risky behaviour but does not always respond appropriately.</td>
<td>The adolescent’s needs are not considered and there is not enough appropriate adult care. The carer does not recognise that the adolescent is still in need of guidance with protection from risky behaviour i.e. lack of awareness of the adolescent’s whereabouts for long periods of time or seeking to address either directly or by seeking support of risky and challenging behaviour. The carer does not have the capacity to be alert to and monitor the adolescent moods for example recognising depression which could lead to self harm.</td>
</tr>
</tbody>
</table>
**SAFETY & SUPERVISION: Traffic awareness & in-car safety**

<table>
<thead>
<tr>
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<tr>
<td>Baby/Infant is well secured in pram/pushchair. Where a toddler is walking their hand is held safely. 3 – 5 yrs old are allowed to walk without holding hands, but are close and in vision. 5- 8 yr olds are allowed to cross with 13+ year old. Child taught traffic skills as per developmental needs.</td>
<td>Baby/infant not always secured in pushchair and 3- 5 yr old not fully supervised. 7yrs onwards are allowed to cross with another young child alone and 8 yrs old crosses regardless of suitability. Child given some guidance about traffic skills.</td>
<td>Baby/infant not secured in pushchair and 3- 5 yr old dragged along with annoyance or left to follow behind alone, with supervision. Under 7’s onwards are allowed to cross road alone. Child not taught traffic skills.</td>
<td>Babies/infants are unsecured in pram/pushchair and carer is careless with pram. There is a lack of supervision around traffic and an unconcerned attitude. Lacks understanding of why teaching traffic skills might be important for the child.</td>
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</tbody>
</table>
**LOVE AND CARE: Parent/carer’s attitude to child, warmth and care**

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<tr>
<td>1)</td>
<td><strong>Child focused care giving.</strong> Carer talks warmly about the child and is able to praise and give appropriate emotional reward. The carer values the child's cultural identity and seeks to ensure child develops a positive sense of self. Carer responds appropriately to child's needs for physical care and positive interaction. The emotional response of the carer is one of warmth. Child is listened to and carer responds appropriately. Child is happy to seek physical contact and care. Carer responds appropriately if child distressed or hurt.</td>
<td>Carer talks kindly about the child and is positive about achievements most of the time but allows their own difficulties to impact. Carer recognises that praise and reward are important but is inconsistent in this. Carer recognises child’s cultural identity and is aware of the importance of ensuring child develops a positive sense of self, but sometimes allows personal circumstances to impact on this. Child is main initiator of physical interaction with carer who responds inconsistently or passively to these overtures. Child not always listened to and carer angry if child seeks comforts through negative</td>
<td>Carer does not speak warmly about the child and is indifferent to the child’s achievements. Carer does not provide praise or reward and is dismissive of praise from others. Carer does not recognise the child’s cultural identity and is indifferent to the importance of ensuring that the child develops a positive sense of self. Carer seldom initiates interactions with the child and carer is indifferent if child attempts to engage for pleasure, or seek physical closeness. Emotional response is sometimes brisk or flat and lacks warmth. Can respond aggressively or dismissively if child distressed or hurt.</td>
<td>Carer speaks coldly and harshly about child and does not provide any reward or praise and is ridiculing of the child when others praise. Carer is hostile to advice about the importance of praise and reward to the child. Carer hostile to the child’s cultural identity and to the importance of ensuring that the child develops a positive sense of self. Carer does not show any warmth or physical affection to the child and responds negatively to overtures for warmth and care. Responds aggressively or dismissively if child distressed or hurt.</td>
</tr>
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<tr>
<td>Carer understands the importance of consistent demonstrations of love and care.</td>
<td>emotions such as crying. Does not always respond appropriately if child distressed or hurt. Carer understands the importance of demonstrations of love and care, but own circumstances and difficulties sometimes get in the way.</td>
<td>hurt. Carer indifferent to advice about the importance of love and care to the child.</td>
<td>Carers will respond to incidents of harm if they consider themselves to be at risk of involvement with the authorities. The emotional response of carers is harsh, critical and lacking in any warmth. Carer hostile to advice about the importance of responding appropriately to the child.</td>
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</table>
## LOVE AND CARE: Boundaries

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<tr>
<td>Carer provides consistent boundaries and ensures child understands how to behave and to understand the importance of set limits. Child is disciplined appropriately with the intention of teaching proactively.</td>
<td>Carer provides inconsistent boundaries and uses mild physical and moderate other sanctions. The carer recognises the importance of setting boundaries for the child, but is inconsistent because of own personal circumstances or difficulties.</td>
<td>Carer provides few boundaries, and is harsh and critical when responding to the child’s behaviour and uses physical sanctions and severe other sanctions. Carer can hold child responsible for their behaviour. Carer indifferent to advice about the need for more appropriate methods of disciplining.</td>
<td>Carer provides no boundaries for the child and treats the child harshly and cruelly, when responding to their behaviour. Carer uses physical chastisement and harsh other methods of discipline. Carer hostile to advice about appropriate methods of disciplining.</td>
</tr>
</tbody>
</table>
**LOVE AND CARE: Adult arguments and violence**

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<tr>
<td>Carers do not argue aggressively and are not physically abusive in front of the children. Carer has a good understanding of the impact of arguments and anger on children and is sensitive to this.</td>
<td>Carers sometimes argue aggressively in front of children, but there is no physical abuse of either party. Carer recognises the impact of severe arguments on the child’s wellbeing but personal circumstances sometimes get in the way.</td>
<td>Carers frequently argue aggressively in front of children and this leads to violence. There is a lack of awareness and understanding of the impact of the violence on children and carers are indifferent to advice regarding this.</td>
<td>Carers argue aggressively frequently in front of the children and this leads to frequent physical violence. There is indifference to the impact of the violence on children and carers are hostile to advice about the impact on children.</td>
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</tbody>
</table>
## LOVE AND CARE: Young caring

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<td>1</td>
<td>Child contributes to household tasks as would be expected for age and stage of development.</td>
<td>Child has some additional responsibilities within household, but these are manageable for age and stage of development and do not interfere with child’s education and interfere minimally with leisure/sporting activities.</td>
<td>Child has onerous caring responsibilities that interfere with education and leisure activities. Carer indifferent to impact on child.</td>
<td>Child has caring responsibilities which are inappropriate and interfere directly with child’s education/leisure opportunities. This may include age inappropriate tasks, and/or intimate care. The impact on the child’s well being is not understood or acknowledged. Carer is hostile to advice about the inappropriateness of caring responsibilities.</td>
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<tr>
<td></td>
<td>Does not take on additional caring responsibilities.</td>
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<td>Carer recognises the importance of appropriateness regarding caring responsibilities.</td>
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## LOVE AND CARE: Positive values

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<td>Carer encourages child to have positive values, to understand right from wrong, be respectful to others and show kindness and helpfulness.</td>
<td>Carer inconsistent in helping child to have positive values, to understand right from wrong, be respectful to others and show kindness and helpfulness.</td>
<td>Carer does not teach child positive values. Is indifferent to issues of right and wrong, kindness and respect to others.</td>
<td>Carer actively encourages negative values in child and has at times condoned anti-social behaviour.</td>
</tr>
<tr>
<td>Carer understands importance to child’s development.</td>
<td>Carer aware of importance to child’s development, but not always able to impose framework.</td>
<td>Carer does not understand importance to child’s development.</td>
<td>Carer indifferent to the impact on child’s development.</td>
</tr>
<tr>
<td>This includes an awareness of smoking, underage drinking and drug misuse as well as early sexual relationships.</td>
<td>Carer has variable awareness of smoking, underage drinking and drug misuse as well as early sexual relationships.</td>
<td>Carer gives little advice about smoking, underage drinking and drug misuse as well as early sexual relationships.</td>
<td>Carer indifferent to smoking, underage drinking and drug misuse, and early sexual relationships. No advice given, and may, at times, have encouraged some of these activities.</td>
</tr>
<tr>
<td>Carer gives clear advice and support.</td>
<td>Carer gives some advice and support.</td>
<td>Carer does not monitor the watching of inappropriate materials or playing inappropriate games and is indifferent about the impact on the child.</td>
<td>Carer(s) allows child(ren) to watch inappropriate TV/film material and inappropriate computer games.</td>
</tr>
<tr>
<td>Carer ensures child does not watch inappropriate films/TV or play with computer games which are inappropriate for child’s age and stage of development.</td>
<td>Carer aware of need to monitor child watching inappropriate material and playing inappropriate computer games, but is inconsistent in monitoring because of own personal difficulties and circumstances.</td>
<td>Is hostile to advice about inappropriateness and to the impact on child (s) wellbeing.</td>
<td>Is hostile to advice about inappropriateness and to the impact on child (s) wellbeing.</td>
</tr>
</tbody>
</table>
**LOVE AND CARE: Adult behaviour**

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<tbody>
<tr>
<td>Carer does not talk about feelings of depression / low mood in front of the children and is aware of potential impact. Carer does not misuse drugs or alcohol.</td>
<td>Carer does discuss feelings of depression and low mood, but does not discuss suicide and is aware of the impact of parental mood on children, but their own mood or circumstances means there is inconsistency in awareness of this. Carer uses drugs and alcohol, but ensures that this does not impact on child.</td>
<td>Carer talks about depression and suicide in front of child and is unaware of potential impact on child. Carer indifferent to advice about the importance of not talking about this issue. Carer misuses drugs and/or alcohol, and is not aware of impact on child.</td>
<td>Caregiver has attempted suicide in front of child. Carer can hold the child responsible for feelings of depression and is open with the child and/or others about this. Carer is hostile to advice focussed on stopping this behaviour and carer does not recognise the impact on the child. Carer misuses drugs and alcohol and does not ensure that this does not impact on the child and this impacts on safety and wellbeing. Carer hostile to advice about this.</td>
</tr>
</tbody>
</table>
## LOVE AND CARE: Substance misuse

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<tr>
<td>Alcohol and drugs are stored safely, if in the home. The carer models low consumption or does not drink or use in front of the child. The carer’s use does not impact on the child in terms of carer’s emotional availability and provides consistency of care or they have physical ability to care or respond to the child. The carer is able to respond to emergency situations should they arise appropriately. The carer talks appropriately about substances to the child, being aware of the child’s development, age and understanding. The carer is aware of the impacts of substances on an unborn child and follows.</td>
<td>The carer believes it is normal for children to be exposed to regular alcohol and substance use. The carer maintains boundaries and routines but these are changed and/or adapted to accommodate use at times. The carer understands the importance of hygiene, emotional and physical care of their child and arranges for additional support when unable to fully provide for the child. Finances are affected but the child’s needs are generally met. The mood of the carer can be irritable or distant at times. The carer is aware of the impact of substances on an unborn child but inconsistently follows.</td>
<td>The carer lacks awareness of the impact their substance use has on their child and is inconsistent in their engagement with specialist agencies. The carer’s use leads to an inconsistency in caring and the child takes on inappropriate responsibilities at home. The carer needs support in order to manage their use during pregnancy and lacks awareness on the impact this may have on their baby in terms of immediate and medium to long term future. Substances can be accessed by the child. The child’s access to appropriate medical or dental care is delayed and education is disrupted.</td>
<td>The carer holds the child responsible for their use &amp; blames their continual use on the child. The carer significantly minimises and is hostile to advice around their use or refuses to acknowledge concerns. The carer involves the child in their using behaviour (i.e. asking the child to get the substances or prepare the substances). The carer refuses antenatal care or does not attend care offered. The carer cannot respond to the child’s needs or shows little awareness of the child’s wellbeing (i.e. attending school). There is an absence of supportive family members or a</td>
</tr>
<tr>
<td>Recommendations regarding the child’s wellbeing.</td>
<td>Recommendations regarding the child’s wellbeing.</td>
<td>The finances are affected and the carer’s mood is unpredictable.</td>
<td>social network. The child is exposed to abusive or frightening behaviour of either the carer or other adults (i.e. delusions/hallucinations). Education is frequently disrupted. The carer does not recognise and respond to the child’s concerns and worries about the carer’s circumstances.</td>
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</tr>
<tr>
<td>Appropriate antenatal care is sought.</td>
<td>Alcohol and substances do not impact on the family finances. The child’s needs are fully met and a wide network of family and supportive others are involved.</td>
<td>The finances are affected and the carer’s mood is unpredictable.</td>
<td>social network. The child is exposed to abusive or frightening behaviour of either the carer or other adults (i.e. delusions/hallucinations). Education is frequently disrupted. The carer does not recognise and respond to the child’s concerns and worries about the carer’s circumstances.</td>
</tr>
<tr>
<td>Alcohol and substances do not impact on the family finances.</td>
<td>The child’s needs are fully met and a wide network of family and supportive others are involved.</td>
<td>The finances are affected and the carer’s mood is unpredictable.</td>
<td>social network. The child is exposed to abusive or frightening behaviour of either the carer or other adults (i.e. delusions/hallucinations). Education is frequently disrupted. The carer does not recognise and respond to the child’s concerns and worries about the carer’s circumstances.</td>
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### STIMULATION & EDUCATION: Unborn and 0-2 years

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<tr>
<td><strong>Unborn</strong></td>
<td>The mother acknowledges the pregnancy and seeks care as soon as the pregnancy is confirmed. The mother attends all her antenatal appointments and seeks medical advice if there is a perceived problem. She prepares for the birth of the baby and has the appropriate clothing, equipment and cot in time.</td>
<td>The mother attends antenatal clinic and prepares for the birth of her baby, but she is acutely aware of her mental health or substance misuse problems which could negatively impact on her unborn baby.</td>
<td>The mother is unaware of the impact her mental health and/or substance misuse problems on the unborn child.</td>
<td>The mother does not attend any antenatal clinic appointments; she ignores medical advice during the pregnancy. She has nothing prepared for the birth of her baby. She engages in activities that could hinder the development, safety and welfare of the unborn.</td>
</tr>
<tr>
<td><strong>0-2 Years</strong></td>
<td>The child is well stimulated and the carer is aware of the importance of this.</td>
<td>There is inadequate stimulation and the baby is left alone at times because of carer’s personal circumstances and this leads to inconsistent interaction. Carer is aware of the importance of stimulation, but is inconsistent in response.</td>
<td>The carer provides the baby with little stimulation and the baby is left alone unless making serious and noisy demands.</td>
<td>The carer does not provide stimulation and the baby’s mobility is restricted (confined in chair/pram). Carer gets angry at the demands made by the baby. Carer hostile to advice about the importance of stimulation and paying attention to the baby’s needs for attention and physical care.</td>
</tr>
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<tr>
<td>The child receives appropriate stimulation such as carer talking to the child in an interactive way, as well as reading stories and the carer playing with the child. Carer provides all toys that are necessary. Finds a way even if things are unaffordable (uniform, sports equipment, books etc). Outings: Carer takes child to child centred places locally such as park, or encourages child in an age appropriate way to make use of local resources.</td>
<td>The carer provides adequate stimulation. Carer’s own circumstances sometimes get in the way because there are many other demands made on the carer’s time and there is a struggle to prioritise. However, the carer does understand the importance of stimulation for the child’s well-being. The child has essential toys and the carer makes an effort to ensure appropriate access to toys even if things are unaffordable, but sometimes struggles. Outings: Child accompanies carer wherever carer decides, usually child friendly places, but sometimes child time taken up with adult outings because of carers needs.</td>
<td>The carer provides little stimulation and does not see the importance of this for the child. The child lacks essential toys, and this is not because of financial issues, but a lack of interest or recognition of the need. Carer allows presents for the child but the child is not encouraged to care for toys. Child may go on adult oriented trips, but these are not child centred or child left to make their own arrangements to play outdoors in neighbourhood.</td>
<td>No stimulation is provided and carer hostile to child’s needs or advice from others about the importance of stimulation. The child has no toys and carer may believe that child does not deserve presents. No toys, unless provided by other sources, gifts or grants and these are not well kept. No outings for the child, may play in the street but carer goes out locally e.g. to pub with friends. Child prevented from going on outings with friends or school.</td>
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## STIMULATION & EDUCATION: School

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<tr>
<td>Carer takes an active interest in schooling and support at home, attendance is regular.</td>
<td>Carer maintains schooling but there is not always support at home.</td>
<td>Carer makes little effort to maintain schooling.</td>
<td>Carer hostile about education, and provides no support and does not encourage child to see any aspect positively.</td>
</tr>
<tr>
<td>Carer engages well with school or nursery and does not sanction missed days unless necessary.</td>
<td>Carer struggles to link with school, and their own difficulties and circumstances can get in the way.</td>
<td>There is a lack of engagement with school. No interest in school or homework.</td>
<td>Total lack of engagement and no support for any aspect of school such as homework, outings etc.</td>
</tr>
<tr>
<td>Carer encourages child to see school as important.</td>
<td>Can sanction days off where not necessary.</td>
<td>Carer does not recognise child’s need for education and is collusive about child not seeing it as important.</td>
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<tr>
<td>Interested in school and support for homework.</td>
<td>Carer understands the importance of school, but is inconsistent with this and there is also inconsistency in support for homework.</td>
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<tr>
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<td>Carer encourages child to engage in sports and leisure, if affordable.</td>
<td>Carer understands that after school activities and engaging in sports or child’s interests is important, but is inconsistent in supporting this, because own circumstances get in the way.</td>
<td>Child makes use of sport through own effort, carer not motivated and not interested in ensuring child has equipment where affordable.</td>
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<tr>
<td></td>
<td>Equipment provided where affordable, or negotiated with agencies/school on behalf of child.</td>
<td>Does recognise what child is good at, but is inconsistent in promoting a positive approach.</td>
<td>Does not recognise the value of this to the child and is indifferent to wishes of child or advice from others about the importance of sports/leisure activities, even if child is good at it.</td>
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<td></td>
<td>Carer understands the importance of this for child’s wellbeing.</td>
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<td></td>
<td>Recognises when child good at something and ensures they are able to pursue it.</td>
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**STIMULATION & EDUCATION: Sport and leisure**
### STIMULATION & EDUCATION: Friendships

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<tr>
<td>This is supported and carer is aware of who child is friends with.</td>
<td>Carer aware of need for friends, does not always promote, but ensures friends are maintained and supported through opportunities for play etc. Aware of importance to child.</td>
<td>Child finds own friendships, no help from carer unless reported to be bullied. Does not understand importance of friendships.</td>
<td>Carer hostile to friendships and shows no interest or support. Does not understand importance to child.</td>
</tr>
<tr>
<td>Aware of safety issues and concerns.</td>
<td>Fully aware of the importance of friendships for the child.</td>
<td></td>
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</tr>
<tr>
<td>Carer aware of need for friends, does not always promote, but ensures friends are maintained and supported through opportunities for play etc. Aware of importance to child.</td>
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### STIMULATION & EDUCATION: Addressing bullying

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<tr>
<td>Carer alert to child being bullied and addresses immediately.</td>
<td>Carer aware of likelihood of bullying and does intervene when child asks.</td>
<td>Carer unaware of child being bullied and does not intervene.</td>
<td>Carer indifferent to child being bullied.</td>
</tr>
<tr>
<td>Carer aware of likelihood of bullying and does intervene when child asks.</td>
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## Parental Motivation for Change:

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<tr>
<td>1</td>
<td>Carer is concerned about children’s welfare; wants to meet their physical, social, and emotional needs to the extent he/she understands them. Carer is determined to act in best interests of children. Has realistic confidence that he/she can overcome problems and is willing to ask for help when needed. Is prepared to make sacrifices for children.</td>
<td>Carer seems concerned about children’s welfare and claims he/she wants to meet their needs, but has problems with own pressing circumstances and needs. Professed concern is often not translated into effective action, but carer expresses regrets about own difficulties dominating. Would like to change, but finds it hard. May be disorganised, does not take enough time, or pays insufficient attention; may misread ‘signals’ from children; may exercise poor judgement.</td>
<td>Carer is not concerned enough about children’s needs to change or address competing demands on their time and money. This leads to some of the children’s needs not being met. Carer does not have the right ‘priorities’ when it comes to child care; may take an indifferent attitude. There is lack of interest in the children and in their welfare and development.</td>
<td>Carer rejects the parental role and takes a hostile attitude toward child care responsibilities. Carer does not see that they have a responsibility to the child, and can often see the child as totally responsible for themselves or believe that any harm that befalls the child is the child’s own fault and that there is something about the child that deserves ill treatment and hostile parenting. May seek to give up the responsibility for children.</td>
</tr>
</tbody>
</table>
## Child Neglect Toolkit Summary

Child’s name: ________________________________ Dob: ___________
Practitioner: ________________________________ Date: ___________

<table>
<thead>
<tr>
<th>Developmental Need</th>
<th>Score</th>
<th>Examples/evidence of impact child/young person</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AREA 1: PHYSICAL CARE</strong></td>
<td></td>
<td></td>
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<tr>
<td>Food</td>
<td>1</td>
<td></td>
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<tr>
<td>Quality of housing</td>
<td>2</td>
<td></td>
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<tr>
<td>Stability of housing</td>
<td>3</td>
<td></td>
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<tr>
<td>Child’s clothing</td>
<td>4</td>
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<tr>
<td>Animals</td>
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<tr>
<td>Hygiene</td>
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<tr>
<td><strong>AREA 2: HEALTH</strong></td>
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<tr>
<td>Safe sleeping arrangements and co-sleeping for babies</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Seeking advice and intervention</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Disability and illness</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td><strong>AREA 3: SAFETY and SUPERVISION</strong></td>
<td></td>
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<tr>
<td>Safety awareness and features</td>
<td>1</td>
<td></td>
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<tr>
<td>Supervision of the child</td>
<td>2</td>
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<tr>
<td>Handling of baby/response to baby</td>
<td>3</td>
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<tr>
<td>Care by other adults</td>
<td>4</td>
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<tr>
<td>Responding to adolescents</td>
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<td>Traffic awareness and in-car safety</td>
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<td><strong>AREA 4: LOVE and CARE</strong></td>
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<tr>
<td>Parent/carer’s attitude to child, warmth and care</td>
<td>1</td>
<td></td>
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<tr>
<td>Boundaries</td>
<td>2</td>
<td></td>
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<tr>
<td>Adult arguments and violence</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Young caring</td>
<td>4</td>
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<tr>
<td>Positive values</td>
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<tr>
<td>Adult behaviour</td>
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<tr>
<td>Substance misuse</td>
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<td>AREA 5: STIMULATION and EDUCATION</td>
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<tr>
<td>Unborn</td>
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<td>0-2 years</td>
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<td>2-5 years</td>
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<tr>
<td>School</td>
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<tr>
<td>Sport and Leisure</td>
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<td>Friendships</td>
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<tr>
<td>Addressing bullying</td>
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<tr>
<td>PARENTAL MOTIVATION FOR CHANGE</td>
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</tbody>
</table>
SECTION 5: REFERENCES AND RECOMMENDED READING

** denotes Recommended Reading


Appleyard, K., Egeland, B, van Dulmen, M., & Srouge, L. (2005) ‘When more is not better: The role of cumulative risk in child behaviour outcomes’ *Journal of child Psychology and Psychiatry* 46 (3) 235-245


Barnard, M and Barlow, J 2003 ‘Discovering parental drug dependence: silence and disclosure’ *Children and Society* 17 (1) 45-56


Brown, R and Ward, H (2012) *Decision-making within a child’s timeframe: An overview of current research evidence for family justice professionals concerning child development and the impact of maltreatment* Childhood Wellbeing Research Centre


Byng-Hall, J (1985) `The family script: a useful bridge between theory and practice’ *Journal of Family Therapy* 7 (3) 301-305


**Department of Health (2000) Framework for the Assessment of Children in Need and their Families


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Department of Health (2011a) No Health without Mental Health: A Cross Government Mental Health Outcome Strategy for People of All Ages. London: DoH


Farmer, E. and Lutman, E. (2009) *Case Management and Outcomes for Neglected Children Returned to their Parents: A Five Year Follow-up Study* Report to the DCSF, School for Policy Studies, University of Bristol


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Hidden Hurt: Domestic Abuse information (2011) www.hiddenhurt.co.uk


**HM Government (2015): Working Together to Safeguard Children, A guide to inter-agency working to safeguard and promote the safety of children, Department for Education

HM Government (2015): Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers


Howe, D (2006) ’Developmental attachment psychotherapy with fostered and adopted children’ Child and Adolescent Mental Health 11, 3, 128 -134


Hughes, D (1997) Facilitating developmental attachment: The road to emotional recovery and behavioural change in foster and adopted children Aronson


LSCB *London Child Protection Procedures* 5th edition 2015, B3 Section 1 Children with Disabilities [www.londoncp.co.uk](http://www.londoncp.co.uk)

LSCB *London Child Protection Procedures* 5th edition 2015, B3 Section 2 Fabricated or Induced Illness [www.londoncp.co.uk](http://www.londoncp.co.uk)

LSCB *London Child Protection Procedures* 5th edition 2015, B3, Section 27 Safeguarding children affected by domestic abuse and violence [www.londoncp.co.uk](http://www.londoncp.co.uk)

LSCB *London Child Protection Procedures* 5th edition 2015, B3 Section 28 Parents who misuse substances [www.londoncp.co.uk](http://www.londoncp.co.uk)

LSCB *London Child Protection Procedures* 5th edition 2015, B3 Section 30 Parenting Capacity and Learning Disability [www.londoncp.co.uk](http://www.londoncp.co.uk)

LSCB *London Child Protection Procedures* 5th edition 2015, B3, Section 32 Animal abuse and Links to Abuse of Children and Vulnerable Adults [www.londoncp.co.uk](http://www.londoncp.co.uk)


Main, M, & Hesse, E, (1990) Parents` unresolved traumatic experiences are related to infant disorganized attachment status. Is frightened or frightening parental behaviour the linking mechanism? In M. Greenberg, D. Cicchetti & E. M. Cummings (Eds.) *Attachment in the preschool years* (pp. 161-182). Chicago, IL: University of Chicago Press.


National Treatment Agency (2004) Enhancing outcomes


Office for National Statistics (ONS) (2015) citing the Homicide index from the Home Office, Figure 2.5

Ofsted (2013) *What About The Children? Joint Working Between Adult and Children’s Services When Parents or Carers Have Mental Ill Health or Drug and Alcohol Problems* Manchester: Ofsted

Ostler, Teresa (2008) *Assessment of Parenting Competency in Mothers with Mental Illness* Baltimore: Brookes Publishing Co


Richards, L (2003) *Findings from the Multi-agency Domestic Violence Murder Reviews in London* Prepared for the ACPO Homicide Working Group 26th August 2003 Published by the Metropolitan Police


**Royal College of Psychiatrists (2011) *Parents as Patients: Supporting the needs of patients who are parents and their children* London: RCP


**Schofield, G and Beek, M, 2006 *Attachment handbook for foster care and adoption* London: BAAF [www.uea.ac.uk/providingasecurebase/the-secure-base-model](http://www.uea.ac.uk/providingasecurebase/the-secure-base-model)


Shemmings, D. (2011) *Attachment in Children and Young People. (Frontline briefing)* Dartington: Research in Practice


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** Williams, B et al (Ed) Capacity to Change: Understanding and Assessing a Parent’s Capacity to Change Within the Timescales of the Child, Jordan Publishing,


London Borough of Southwark Protocols

Southwark’s Children’s and Families Trust, Southwark Safeguarding Children Board (April 2012) Information sharing governance framework: For agencies working with children, young people and families in Southwark

Southwark Safeguarding Children Board (May 2007) Southwark Joint Service Protocol to meet the needs of children and unborn children whose parents have disabilities.

Southwark Safeguarding Children Board (May 2014) Joint Service Protocol to meet the needs of children and unborn children whose parents or carers have substance misuse problems.

Southwark Safeguarding Children Board (June 2012) Southwark Joint Service Protocol to meet the needs of children and unborn children whose parents or carers have mental health problems.

Protocol for joint working between Children’s Social Care and Solace Advocacy and Support Service (SASS) – provides details of the services provided by SASS and the referral process.

Statutory/strategic guidance

Court Orders and pre-proceedings for Local Authorities Department for Education, 2014


Commission for Social Care Inspection (February 2009) Supporting disabled parents – a family or a fragmented approach


National Working Group on Child Protection and Disability 2003; DCSF 2009

SCIE briefing 14 Helping parents with learning difficulties in their role as parents

Case Law

Re L (Care: Threshold Criteria) [2007] 1 FLR 2050, para 50.