LEARNING CURVES

The Assessment of Parents with a Learning Disability

A Manual for practitioners prepared by

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NORFOLK AREA CHILD PROTECTION COMMITTEE

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FOREWORD

This manual was commissioned by Norfolk ACPC following the death of a baby whose mother had a Learning Disability. It was evident that promoting greater awareness of the key issues amongst professionals was an outstanding training target, together with the production of supporting materials.

Penny Morgan is a Consultant Clinical Psychologist with a long-standing interest in the subject area. She is involved in lecturing, research and active clinical work with parents who have a Learning Disability and also acts as an Expert Witness in the legal arena.

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The authors have collaborated to produce a range of materials designed to support those involved in the Assessment of families where one or both parents have a Learning Disability. Although it is aimed, principally, towards Social Workers required to complete family Assessments, it will also be of interest to other professionals working in the area, as well as managers.

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THE ASSESSMENT OF PARENTS WITH A LEARNING DISABILITY

A MANUAL FOR PRACTITIONERS

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LEARNING CURVES

PART 1: UNDERSTANDING WORK WITH FAMILIES WHERE A PARENT HAS A LEARNING DISABILITY

CHAPTER 1

AN INTRODUCTION TO WORKING WITH PARENTS WITH A LEARNING DISABILITY

Many parents with Learning Disabilities are coming to the attention of Social Services. As this group of parents are comparatively "new", their particular difficulties and needs, both as parents and individuals, are often a challenge to understand and meet. Information derived from research is growing slowly and models of good practice are beginning to be established but still we have much to learn. Changing values within society, embodied in such legislation as Valuing People (2001) and the Charter for Human Rights, mean that we must continually re-evaluate our professional stance and Assessment and interventions.

1.1 Background History

It is necessary to study the history of people with a Learning Disability in order to understand current problems in service delivery. People with a Learning Disability have been the subject of much debate and legislation over the last century and into the 21st century, as society's attitudes towards many previously stigmatised groups of individuals have changed.

Atkinson (1997) suggests four key stages in the history of people with a Learning Disability beginning with "segregation". During this period, people with a Learning Disability were known by pejorative terms such as "mental defective" and considered a burden to society. The overriding fear was that any children they may have would be born with similar Learning Disabilities. Therefore, sterilisation - either with or without consent was considered a reasonable option in order to prevent such births.

Atkinson's next period is defined by "expert" involvement. Here a medical model was used to view people in terms of their deficits in cognitive and social skills which were then seen as amenable (to a certain extent) to treatment. This treatment was offered in large institutions and those in the community attended training centres. The view that, given the appropriate support, people with Learning Disabilities would be able to reach maximum potential was essentially

positive. The imposition of this support by the expert and the segregation into specialist environments and institutions was less helpful.

By the 1970s Learning Disability came to be viewed as a social construct. Initially this trend was negative, allowing people with Learning Disabilities to be stereotyped as victims of their difficulties and essentially socially incompetent, more positively also allowed the development of a philosophy of normalisation (Wolfensberger 1972), with its emphasis on valuing people with a Learning Disability as members of our society who have a right to be part of that society and much to offer.

Building upon the philosophy of normalisation and its later variants (for example O'Brien's Five Service Accomplishments), people with a Learning Disability were encouraged to speak for themselves and become self-advocating. With this shift in public and professional opinions, people with a Learning Disability became viewed as individuals with a range of experiences, views and characteristics in their own right.

Edgerton, reviewing attitudes towards the lives of people with a Learning Disability from 1950 onwards reported that during the 50's, "no one in the field would consider that a mentally retarded person should be a parent". In some American states, there was legislation in existence prohibiting marriage between people who were considered "mentally retarded" and compulsory sterilisation was a common practice. Edgerton considers that these attitudes continued well into the 1980's and cites Evans in "The Lives of Mentally Retarded People" – then acclaimed as a balanced and sympathetic view of the rights of people with a Learning Disability. He quotes Evans view that "mentally retarded people should not be parents" and that he had "never met a fellow professional that would challenge that view". At the same time as these views were continuing to be put forward, ideas stemming from Wolfensberger's normalisation philosophy were contributing to fundamental changes in attitudes to and work with people with a Learning Disability.

In Britain, towards the end of the 20th century, large institutions were disbanded with care being offered in a variety of home situations in the community. This varied from more traditional style group homes to shared care and independent living. The accompanying emphasis on choice and control led to a reduction in policies which aimed to control the sexuality of people with Learning Disabilities. If this began a trend of increasing the number of parents with a Learning Disability then it was supported by the Human Rights Act 1998 which includes the "right to a family life". It has been observed that increases in the number of parents with Learning Disabilities have been reported in all countries which have moved towards services based on "ordinary life" principles (King's Fund Centre 1980) and community living. In a survey of 266 Community Nurses, Genders (1998) reported that 62% had parents with learning difficulties on their current or recent caseloads. Similarly, Stevenson (1998) found that most Social Work

practitioners from Children and Family Teams studied had experience of working with parents with Learning Disabilities. In addition at least 60% were currently involved with at least one family where Learning Disabilities was a referral issue. McGaw (1997) estimates that there is a minimum of 250,000 parents with Learning Disabilities receiving input from health and social services in the U.K.

However, other researchers point out that this apparent increase in families headed by a parent or parents with Learning Disabilities may be a result of wider changes in society. For example, Thorpe (1995) suggests that the tendency towards greater intervention by services and increased awareness of Child Protection only highlights families on the margins of competence in an increasingly hostile society.

1.2 The current situation

Families where one or both parents have a Learning Disability now represent a sizeable population with a range of needs which are neither adequately nor coherently addressed by health and Social Services. (Llewellyn et al 1995). Furthermore Booth and Booth highlight the "double jeopardy" parents with Learning Disabilities can face. They are more likely to have to raise their families under conditions of poverty, unemployment, inadequate housing, harassment from neighbours and communities, single parenthood or poor marital relationships. At the same time they are more susceptible to the stress created by these conditions and have poorer coping mechanisms.

Many parents with Learning Disabilities lack good parental models and the secure emotional growth which come from a positive attachment with a main care giver. They may have been in care themselves and subject to a series of moves. As children they may have been labelled by the education system as failing, or have attended special schools where they were segregated from their peer group and often ridiculed. Within mainstream schools they were more likely to be subject to at best teasing, at worst, severe bullying and to have absorbed a sense of inadequacy in their own abilities.

This range of early life experiences are linked with problems in establishing secure child-parent relationships. The addition of cognitive difficulties makes the problems faced in assessing and delivering appropriate services even more of a challenge.

McGaw (1996) reports that less than 25% of pregnancies in this group are planned and it is recognised that Family Planning and Contraceptive Services do not meet the needs of people with Learning Disabilities. People with Learning Disabilities have more unplanned pregnancies than the general population. However, Health Education leaflets on pregnancy, family planning and other health related issues are difficult to understand as the language is complex.

1.3 A support gap

Current methods of service delivery serve to undermine rather than enable parents with a Learning Disability. This includes:

- **The presumption of incompetence** – viewing the parent with Learning Disabilities as primarily unsuited to parenthood and emphasising evidence which serves to fulfil this view
- **A deficiency perspective** – an approach which focuses on a lack of skills rather than what the individual has to offer and how to make the best of these skills.
- **System abuse** – reviews of the literature on parenting by people with learning difficulties (e.g., Booth and Booth 1993, Tymchuk 1990) show that these families often receive "overzealous" Assessment of risks (Social Services Inspectorate 1999) alongside a lack of provision of support services which dooms such families to failure.
- **Competence inhibiting support** – although support may be provided it can be delivered in such a way that parents are deskilled, undermined and confused.
- **Top down priorities** – this is an approach where the professional knows best and parents' views are only given token acknowledgment. This way of working is contrary to the recommendations of working in partnership with parents, implied in the Children's Act 1989.
- **A child centered focus** – although the primary focus is the welfare of the children, the needs of the parents must be considered in this context. Workers must look at how to support and help parents in the discharge of the parental duties (Goodinge 2000).
- **Poor Assessments** – "shortcomings in assessment" have been found by the Social Services Inspectorate with respect to the needs of children and their disabled parents.
- **Conflicting responsibilities** – often families have to accept support and help from the very person who they see as trying to destroy their family life. This in itself brings tension into the relationship between families and professionals.
- **Organisational barriers and team boundaries** - for example, as seen between Children and Families teams and Learning Disabilities teams, strict adherence to eligibility criteria can lead to families falling down a 'black hole' where no service is provided.
- **Blaming the victim** – parents can be seen as "at fault" even though the services that are supporting them are the real source of failure.
- **Crisis driven services** – a service may be provided only at the point of crisis. The response can then be more extreme than necessary.
- **Lack of trust** – many families are distrustful of statutory services. They are worried about where any requests for help may lead, particularly where a history of bad experience of relationships with professionals and services is evident.

- **High drop-out rates** – programs of support can be demanding and keeping a parent's interest and motivation sustained over a period of time is a recurring problem.

So, what sort of services should we be providing in order to follow models of good practice and provide support that is focused yet appropriate? Current research suggests the following:

- **Needs led support** – as well as collecting professionals' views of the family, it is important to consult families about the way in which they wish services to be provided. Even if families feel they have no need for support, it may still be possible to negotiate a creative package which will be acceptable to the family.

- **A specialised response** – it is difficult to make a precise division between parents who are and who are not affected by Learning Disabilities. However, parents with Learning Disabilities share a "commonality of need" which requires specialist knowledge and response.

- **Early identification** – parents are much more likely to accept professional support during pregnancy or following birth than later. Whilst early identification is difficult, early intervention is thought to be more effective, as it enables services to put into place a proactive range of immediate and long term services as needed.

- **Competence led model** – it is argued that more attention should be paid to competence rather than parental deficit. The concept of parental capacity in the Assessment framework material encourages the use of this model.

- **Time** – parents with a Learning Disability need longer to assimilate knowledge and may not be able to understand concepts such as 'good enough parenting' in the way that it is being presented. This often causes frustration on behalf of the individual worker who expects ideas to be grasped and learned within a short space of time. It must be recognised that anybody working with such families will need to use a range of teaching and support techniques over an extended period of time.

These issues are further explored and discussed in the next chapter.

CHAPTER 2

THE ASSESSMENT OF A PARENT WITH A LEARNING DISABILITY

2.1 Expected standards of care

Where the parent has a Learning Disability, one of the main questions that needs to be answered is whether the parent has a lack of basic skills or knowledge, or whether the parent has significant emotional difficulties which impact on their abilities to parent. There may be a combination of these two factors; an understanding of the underlying parenting strengths and weaknesses will enable you to plan an effective Assessment. Booth and Booth (1994) point out that "good parenting" is a vague concept, which lacks a precise definition. They write; "although there is reasonable consensus on the specific dimensions of parenting that are important for child development (Dowdney et al 1985), there is no agreement on what constitutes minimal acceptable standards of good enough child care", (Booth and Booth 1994: 11). These standards are often highly subjective and open to professional interpretation. Therefore it is vital that all parents have clear expectations regarding the standards of care required in each set of circumstances.

2.2 Internal and External Influences Affecting the Assessment

What is of relevance, however, is the limiting effect of poverty and the associated circumstances of the general population i.e. poor housing, limited educational chances, lack of employment, compounded with Learning Disability. People who have been seen as "worthless" by society will have absorbed this point of view and have internalised the idea of himself or herself as a person of little value. This may be borne out by their experience of being parented (as in a harsh, restrictive environment with little or no praise) and education (being seen to fail, bullying and limited support with Learning Disabilities).

Social isolation can be the result of a contribution of poor social skills and/or rejection by the local community. Equally, vulnerable families can be targeted for exploitation – e.g. the neighbour who repeatedly "borrows" money and "forgets" to repay it or the local children who throw stones at the house and run away.

Some people with a Learning Disability become parents before they have had the chance to mature emotionally as an independent and autonomous adult. The risk here is that the parent will have difficulty putting the child's needs before their own, as both seem important.

Some people with Learning Disabilities become parents before they have had the chance to learn what it is like to live on their own. Then they are faced with the joint tasks of learning all about independent living and being a parent as well - a huge set of demands. It is important to answer purely practical questions such as "how does a person look after themselves" in terms of cooking, cleaning, washing etc and then consider how this relates to the child care. It may be helpful at this point to engage with a colleague from Learning Disability Services to offer consultation or to assist with the Assessment.

It may be helpful to consider Schofield (1996) when she writes that the emphasis therefore needs to be, (and is under the Children Act 1989), "less on what parents do and more on what children need, and the observable consequences of parenting in terms of the development of the child". She writes that, "judgment about parental skills would only be made in the context of the observable impact on the child", (Schofield 1996: 88).

Let us then consider what this impact might be. Before doing so, a cautionary note is needed, for as we have seen the term 'Learning Disability' can cover a wide range of characteristics, and therefore one must be very wary of making any generalisations. As McGaw and Sturmey (1994) write; "parents with Learning Disabilities are a heterogeneous group of individuals. Some will not present any significant needs, some will present with relatively simple or transient needs, and still others will present with a complex of inter-related problems which will endure throughout the child's development", (McGaw and Sturmey 1994:37).

It is the latter group social workers are more likely to have contact with, and we will focus on this group, bearing in mind that there are big variations among families where there is a parent with a Learning Disability, in terms of both their characteristics and circumstances. However, we need to be clearer about the possible significant elements which having a Learning Disability entails and their potential impact upon a child's care and development.

2.3 'Common features or problems'

From an overview of the literature available on this subject, including Booth and Booth (1994), Young, Young and Ford (1997), Flynn (1989), Whitman, Graves and Accardo (1989), Tymchuk et al (1987), McGaw and Sturmey (1993) and Gath (1995), 'there is some agreement that certain common features or problems exist. Themes which recur are:

(1) Lack of ability to generalise information.

Young, Young and Ford (1997) write, "much of the learning of people with a Learning Disability is specific both to context and time". They tell us that Learning Disabilities are often associated with, "a limited ability to transfer

learning and adopt strategies as the child develops". They discuss mothers who need physical demonstrations and reminders on a regular basis and who do not automatically adjust parenting styles to changes in a child's development. An example of this was a mother who was following a teaching programme. Her task was to go to the library, choose a book with her son, and then go through the pictures with him. The plan was twofold; to help with attachment, as the activity was to take place on the mother's lap, thereby providing an opportunity for intimate contact and to help with development by looking at books. The parents reported back to the worker after three weeks that the activity was not working. It became apparent that the book had not been changed and the child had become bored with the same pictures. Nobody had explained to the parents that the book needed to be changed.

(2) (Conversely) Tendency to over generalize.

Whitman, Graves and Accardo (1989) give an example of a mother with a Learning Disability who took her sick child to casualty and was told to give the child only clear liquids. No time limit was specified and she was not told when to change back to solids. Three weeks later the infant was admitted to hospital for failure to thrive.

(3) Lack of stimulation

Stevenson (1998) refers to, "lack of verbal interaction with the child" and insufficient cognitive stimulation, especially in the area of play, (Stevenson 1998: 61). McGaw and Sturmey (1993) write, "speech and language development is particularly susceptible to delay in children of mothers with Learning Disability", (McGaw and Sturmey 1993: 47).

(4) Problems with boundary setting

Tymchuk et al (1987) writes, "various studies have found parents with a Learning Disability rarely praise, usually punish and have limited cognitive interactions with their children, as do other parents of the same socio-economic group", (Tymchuck et al 1987: 51).

(5) Lack of perception of children's needs

McGaw and Sturmey (1994) write that mothers with a Learning Disability, "are less likely to show affection, reinforce, support, stimulate and bond with their child in contrast to mothers who do not have learning difficulties", (McGaw and Sturmey 1994: 47). Flynn (1989) tells us, "Assessment of child-rearing practices of people with a Learning Disability highlights concerns about their ability to provide appropriate

environmental stimulation, to perceive their child's needs, discipline appropriately and consistently".

Despite this level of agreement among authors on common "deficits", which can be described among some parents with a Learning Disability, most also accept the relevance of other factors. McGaw and Sturmey (1994) write, "factors such as poverty and the child's IQ may also significantly affect the parent-child relationship", (McGaw and Sturmey 1994: 47), and Gath (1995) writes, "the number, ages and spacing of children can be critical", (Gath 1995: 198) as this could overwhelm a parent who could otherwise cope with a single child.

Booth and Booth tell us, "many of the problems experienced by parents with Learning Disabilities derive more from poverty, poor housing, harassment, victimization and lack of support, than from their own deficits in parental competence", (Booth and Booth 1994: 55); while Whitman, Graves and Accardo (1989) also refer to: "inadequate parenting models, isolation from the extended family, lack of knowledge about public resources and, in many cases, a paucity of "normal" life experiences". They tell us that cognitive limitations and increased emotional vulnerability seem to put people with a Learning Disability, "at higher risk for disorders of parenting", and that, "the capacity to give appropriate loving, caring, nurturance is unpredictable on the basis of intelligence alone", (Whitman, Graves and Accardo 1989: 431). So on what else does it depend?

2.4 'Good – enough Parenting'

The concept of "good enough" parenting is useful here in terms of small children being:

- loved, attended to and cuddled
- kept warm and dry
- reasonably clean
- well and appropriately fed
- given the chance to sleep regularly
- protected from harm

Parents need to understand why these requirements are important to the baby (do not assume that, because links are obvious to you, they will be as clear to all parents) and how to meet these needs in practical terms.

As the child grows, needs change and we must add:

- stimulation, and teaching new skills
- safety and protection in the broader context
- limits around the child's behaviour

- responding adequately to the child's requests and demands.

Although the focus of parenting Assessments is often on caring for a young baby or child, we must remember that the older the child gets, the more complex their needs become. Furthermore, the evidence that a parent is coping is more accessible in the care of a baby or young child.

If a baby has nappy rash, or repeated episodes of sickness, we can focus on hygiene. The well cared-for child will thrive and grow. Later on in development, the situation is not as clear. Behavioural problems - bedwetting, withdrawal or tantrums may be early indications of problems but also may be attributable to other factors, e.g. difficulties at school.

2.5 Past Relationship Experience

While pointing out that, "it is perverse to deny or minimize the significance", of having limited cognitive ability, Stevenson (1998), tells us that some features commonly associated with parents who have a Learning Disability such as, "lack of expressed warmth, love and affection", may have "a more complex and different etiology", (Stevenson 1998: 61).

As with any other parent, it is important to understand what experiences of care-giving were like, and what form of attachments were made during childhood, for as Howe and Hining (1995) write; "past relationship experiences heavily influence the quality and character of people's current interpersonal behavior. If social workers are to work well with clients, they must be understood historically", (Howe and Hining 1995:14). It is, therefore important for us to look at the type of childhood experiences parents have had and to consider the impact of these upon the individual and their care giving. This is a key element in any Assessment for a parent with a Learning Disability and should form the basis of the work.

There are a number of interconnections between cognitive capabilities of an individual and his or her affective experiences and relationships, which affect parenting behaviour. Schofield (1996) writes that for some adults with Learning Disabilities there may be a sense in which they have difficulty in making sense of their own experiences and suggests this may add to the cognitive/emotional mix they bring to parenting. She tells us that recent research into adults' attachment experiences suggest that "adults' ability to understand and reflect on their own relationships with attachment figures has an impact on the quality of their relationships with their children", (Schofield 1996: 51); whereas Dunn (1993) tells us that mothers of children who are securely attached usually "recall their own attachment history with coherence and readiness", (Dunn 1993 : 82).

A feature of Learning Disability is impaired memory which helps support the above argument and may have other implications for the analysis of the Assessment.

Many of the problems parents with a Learning Disability have will be the same as those encountered by other parents. In addition, however, many among the current generation of parents may have spent periods of their childhood or adolescence in institutions and thereby have additional disadvantages. Booth and Booth (1994) write that "a number of parents with Learning Disabilities are very unlikely to have had experiences in childhood that offered any model of good-enough parenting", (Booth and Booth 1994:13), and so positive experiences will have been lacking. Gath (1995) also tells us that, "the ill effects of poor childhood experiences in those of normal intelligence were ameliorated by later good experiences, particularly a stable spouse and good living conditions, but these powerful protective factors are not commonly encountered during the lives of women with Learning Disability", (Gath 1995:195).

So if deprivation and disadvantage continue into adulthood this can have an ongoing impact and effect upon parenting. Polansky (1981) quotes Freud when he writes: "so long as man suffers, he ceases to love. Suffering that occurred in the past leaves its mark in the present", (Polansky 1981: 148). Polansky also refers to, "the psychic energy ordinarily available for investment in child caring", having been, "dissipated" and "overwhelmed by problems of personal survival as a result of massive early deprivations".

Many parents with Learning Disabilities may have had positive childhood experiences from which they will have derived full benefit, however, when parenting problems exist, it is vital that we take full account of parents' backgrounds.

In addition to history it is useful to examine attitudes towards parenting that have been passed on and now have the significance of "rules" which must not be broken - for example "cuddling a baby whenever he cries spoils him".

2.6 Meaning of the Child

Dowdney and Skuse (1993) write: "Parental IQ may be less important than maternal interest in, and involvement with, the child and motivation to change", (Dowdney and Skuse 1993: 41).

The "Meaning of the Child" (Reder et al 1993: 52) to the parent should be explored. A child can mean different things to different parents and many factors can influence the meaning that parents attribute to their children, or to one child in particular. Influences from a parent or family's past may distort relationships in the present, particularly where issues remain unresolved. A

child's personal identity or characteristics may be submerged by a family's expectations of roles or behaviours. In extreme situations children may not be related to as a person in his or her own right but as an object to satisfy their parents' needs.

This is an issue which warrants attention in any family where serious difficulties in parenting or concerns for children have been identified. Parental attitudes may be more relevant than any Learning Disability. It is suggested that many children will be cognitively more able than their parents. McGaw and Sturmey (1993) tell us in a study of mothers with low IQ that it was reported that mothers with children with a higher IQ than themselves were much more likely to have a restrictive and punishing style than mothers with children of a similar IQ. "It may be that a child who is more intelligent than the mother may be perceived as difficult to control and may solicit a more restrictive style of interaction from its parents", (McGaw and Sturmey 1993: 110).

2.7 Assessment Considerations

It is very important to note the heterogeneous nature of the group of people described as having Learning Disabilities and therefore how difficult it is to generalise on their effects on parenting behaviour and impact upon children. It is the minority of children with Learning Disabled parents who experience serious developmental problems, (Schofield 1996: 47) - the type of problems which can be found among this minority are not unique to children whose parents have a Learning Disability. In exploring whether parental Learning Disability does appear to impact upon a child's development and seeking an explanation, it is useful to look at factors that affect child development. Bee (1997) tells us, "to understand children's development, we must understand both change and consistency, both universality and individuality", (Bee 1997 : 33).

We need to take into account what things alter over the course of a child's life, according to age or stage of development and what things stay the same, perhaps personality traits and temperament. We need to consider what things are true for all children, regardless of their situation, culture and so on, and what things are unique to the individual child. We need to be aware that both nature and nurture, biology and upbringing, are involved in all aspects of development and that their relative importance continues to be a matter of great debate. Not only this but nature and nurture may not interact in precisely the same way for every child. "Children with different inborn qualities, (vulnerability or resilience), may be affected differently by the same environment", (Bee 1997: 33).

In our Assessments, then, it is important that we not only take into account family and parental characteristics and circumstances, but we also need to

develop an understanding of the perspective of the child. We need to consider each child individually and look at the interplay of these factors in any child's particular and unique circumstances. When assessing children in families where there is a caregiver with a Learning Disability this is no different.

The Assessment Frameworks [see Chapters 4, 5 and 6] provide a way of examining aspects of children's development in detail, in different contexts and consistently over time, so we can assess whether needs are being met by reviewing the original Assessment and building upon it.

2.8 Maintaining sensitivity to personal situations

The needs of children remain the same, however, circumstances that a child is born into can effect their development. One major issue for children who have parents with a Learning Disability is stigma and oppression that they may face in their dealing with the outside world. It is more likely that they will be teased or bullied by their peers and witness their parents being ridiculed. The following is an extract reproduced with permission from a young man with Learning Disability. It gives some insight into his world and what it was like for him;

"The worst bit was her coat, she always wore the same coat. It was a long, fur coat and she wore it summer and winter. All my mates laughed at her and she laughed with them. I hated that she would laugh at her own weaknesses. I think she had learned that this was better than being shouted at. The teachers would come to the gate and show her off. They didn't know how to talk to her really. But at home it was different, no one teased us there- we had great times. She would make things she had seen on the TV during the day and I would help her. She wasn't very good at cutting out and she would get me to do that. The other bit I hated was the neighbours. They didn't like us and they called mum names. One of them would come round and, sometimes, mum would send me out of the way but I knew what happened. Well, I supposed she needed love too".

The need for a continual balance between parents' rights and needs, and those of the children, is a constant dilemma.

2.9 Pre Birth Risk Assessments

Some learning disabled women will not recognise that they are pregnant until late into the pregnancy (Attard 1988). It is therefore essential, and recognised in Norfolk's Area Child Protection Committee Protocol regarding the risks to unborn children, that early recognition and referral is made to the relevant personnel, both in health and Social Services. Early intervention will provide the best chance to safeguard and promote the welfare of the unborn child. It

is already established that parents with Learning Disabilities require tailored intervention to meet their learning needs and more time to establish the necessary behaviours to meet a newborn baby's needs. It is therefore vital, in the planning stage of any Assessment, to include the midwife, Learning Disability specialist and childcare workers in the Core Assessment and interventions.

2.10 Proceed with care and caution

The material here needs to be applied with care and professionalism. There is a tendency for some of the links made between Learning Disabilities and potential problems with parenting, to be viewed as offering a poor prognosis in terms of parenting ability. This should lead us neither to generalise nor to treat parents with Learning Disabilities any differently from any other parents. Rather, it should encourage us to ensure we improve our techniques in observing and assessing behaviour and relationships. This should lead us to develop ways to work with parents which focus on a child's sense of security, and encourage more secure attachments which will ultimately benefit both parents and children. We may need to accept that parents may need help in the long term and offer that help at various critical intervals dependent upon need.

Parental Learning Disability should be viewed as one among many factors that may, in some instances, impact on children's development. It should be assessed alongside other factors normally considered in any Assessment. Decisions about interventions should not be made based upon this, or any other, parental characteristic alone but upon evidence of impact upon the child. In some instances, as with any other families, it may be felt that to remain with parents would be significantly harmful to children, however such decisions have to always be made on a case by case basis. There must be a clear focus on the welfare of the child and each case must be considered as unique and assessed accordingly. Children, like their parents, must be seen as individuals with rights, including the rights to care and protection, but also wherever possible, the right to be brought up in their own family.

Maybe parental rights issues are taking precedence over children's rights. This is indeed an "ideological minefield", (Stevenson 1998:59). As Thomas (1993) asks, "how can one balance the best interests of the child, which is the need to be brought up in a nurturing environment, with the philosophical principles dictating family integrity"? In writing about parents with a Learning Disability, Stevenson tells us: "a combination of human rights, ideals and sympathy for such parents, associated with uncertainty as to how such change and development is possible, can lead on occasions to situations manifestly harmful to the children continuing too long", (Stevenson 1998: 60). She refers to this issue leading workers into a state of "anxious paralysis". Is it true then

that viewing a parent with a Learning Disability with sympathy can cloud our judgment?

Parents with a Learning Disability need to be supported in a way that is not repressive and discriminatory - special attention must be paid to this to ensure an equitable service. Consideration must also be given to the environment, poverty and discriminatory values. Parents with a Learning Disability have a right to parenthood, just as a child has a right to be brought up within the birth family where possible. Having a Learning Disability is not inherently linked with parenting ability. What it does suggest is that as a parent other support will be needed. This support may come from a range of sources - only some of which are statutory.

2.11 Assessment in Practice

The following chapters consider how the case responsible Social Worker can use the Assessment process so that the end result is accurate, helpful and avoids the value based pitfalls.

Statutory provision is explored, as well as the role of expert witnesses with advice about what expert reports are likely to cover.

Finally, ways of working with families are explained and practical advice about teaching new skills and communicating effectively with parents is given.

There are some suggestions for additional reading, but as this is aimed primarily at the field social worker, we have tried to concentrate on useful rather than theoretical texts. The **Appendices** contain information, lists and questionnaires which can be photocopied for everyday use.

CHAPTER 3

STATUTORY PROVISION FOR ADULTS WITH A LEARNING DISABILITY

3.1 'Valuing People'

Since the publication of the Government White Paper 'Valuing People' in March 2002, significant changes have been made in the way that specialist Learning Disability services are provided. Valuing People sets out an ambitious vision for the 21st Century which focuses on improving the life chances, experiences and opportunities for people with Learning Disabilities, in recognition of the fact that they are amongst the most vulnerable and socially excluded in our society. Underpinning principles of the White Paper are:

- Rights – the recognition of people's legal and civil rights
- Independence – promoting independence is part of the Government's wider modernisation agenda
- Choice – recognising people's rights to make choices about their lives
- Inclusion – being part of the mainstream and being fully included in local communities.

At a national level, a Learning Disability Task Force will advise the Government on implementation of the White Paper.

At a local level, partnership boards are being established. The membership of these partnership boards includes representatives from health, Social Services, education, housing and leisure. The boards must be organised so that people with a Learning Disability and their representatives can take full part. These boards are responsible for local planning and implementation of the White Paper recommendations.

There are eleven major objectives contained within the paper; one area, "fulfilling lives", refers specifically to parents with a Learning Disability. It states that "partnership boards should ensure services are available to support parents with a Learning Disability" as well as highlighting the importance of staff training and appropriate Assessment of families.

Services for people with a Learning Disability are continuing to change, both locally and nationally. Nationally, the trend is to close large institutions and instead support the majority of people with a Learning Disability in their community setting.

3.2 Community Learning Disability Teams

The first point of contact with statutory services for most people with a Learning Disability will be through the Community Learning Disability Teams. These are joint teams comprising health and Social Services personnel with a range of training and skills. The composition of teams varies from area to area, which affects the range of interventions offered, but a core service of social work, nursing, psychiatric and psychological Assessment, can be expected. Each team will have its referral criteria. Some teams have a "cut-off" point of an IQ score at or below 70 in their referral criteria. This is generally felt to be bad practice as a diagnosis of Learning Disability should never be made on a basis of cognitive functioning alone, and "cut off" scores can sometimes be used to exclude clients from services. (For further information on diagnosis of a Learning Disability see Chapter covering Psychological Reports). Community Learning Disability Teams usually work with adults only, but age of transition varies.

In any one Community Learning Disability Team the following disciplines will usually, but not always, be represented:

3.2.1 Social Work – Social Workers in the team are concerned with the Assessment of the social care needs of people with Learning Disabilities and to purchase packages of care from providers to meet this need. As they work with adults with a Learning Disability, as distinct from the social worker attached to the Child and Family Team, parents with Learning Disabilities may have, or may be able to seek, access to a Social Worker in their own right. If this is the case, a Social Worker can be helpful, referring on to other members of the team for Assessment and advice and commenting on the social needs of the adult. Social Work assistants help to support adults with a Learning Disability in their community setting and can, with negotiation, be included in work with parents with a Learning Disability.

3.2.2 Community Learning Disability Nursing – Community Learning Disability Nurses are qualified nurses with specific knowledge in the Learning Disabilities field. Their principal area of expertise is with respect to health care issues. However, there is an increasing trend for specialism within teams, for example a Community Learning Disabilities Nurse, who has specific expertise in mental health, will be able to advise on mental health issues. There may also be a Community Learning Disability Nurse with a special interest in parents with a Learning Disability. If this is the case it is likely that the team will be active in providing support training and education for parents with a Learning Disability which can be accessed through this member of staff.

3.2.3 Occupational Therapy – Occupational Therapists and their assistants are concerned with overall Assessment and enabling practical, social and work skills. They also provide an Assessment service for specialist equipment. The advice

of an Occupational Therapist can be sought for information about the practical day to day skills of a parent – how to cope with everyday routines such as cooking, laundry and how skills can be taught and enhanced.

3.2.4 Creative Arts Therapy – Creative Arts Therapists work through a variety of media for example art, music and drama to enable people to express feelings and emotions within a safe therapeutic environment. The main focus is the process experienced during sessions which gives people experiences which may be of benefit physically, emotionally and socially.

3.2.5 Dietetics – Dieticians attached to the Learning Disabilities Team will be aware of the special needs of the client group. They will give advice about healthy eating, diet and food allergies, as well as making nutritional Assessments and providing advice about feeding difficulties.

3.2.6 Speech and Language Therapy – The core role of the Speech and Language Therapist is the promotion of communication. This is done through individual Assessment and treatment programmes, as well as working with groups and assessing communication environments and needs. Speech and Language Therapists are key figures in the establishment of "total communication". This refers to an overall therapeutic environment where the best communication possible is actively encouraged.

3.2.7 Psychology – a Clinical Psychologist will assess and advise on problematic behaviour or events outside a medical model. Psychological models are derived from research and applied to the individual to explain problems and indicate appropriate treatment programmes. Psychologists undertake psychometric Assessment of a variety of cognitive processes and will be able to confirm a diagnosis of Learning Disability.

Counselling psychology uses the relationship established between counsellor and client in order to affect the therapeutic process. The counsellor works collaboratively with the person, helping him or her to gain an understanding of lifestyle and relationships within an holistic model.

3.2.8 Psychiatry – Psychiatrists will assess and advise on problematic behaviours or events within a medical model. They will use an Assessment and Treatment programme, which includes diagnosis and potentially prescription of medication. Psychiatrists have specific expertise in the field of mental health and can diagnose the presence/absence of a Learning Disability, although sometimes a psychological Assessment will be required.

3.2.9 Physiotherapy – Physiotherapists are concerned with the maintenance and improvement of movement and mobility. These physiotherapists working

within a Learning Disability Team will have specific expertise in those conditions affecting people with multiple disabilities.

3.3 Referring to the Community Learning Disability Teams

Although the specialist services offered to people with a Learning Disability has been more clearly defined by government, there remains considerable variation at a local level. There is no substitute for liaison between teams working in social services based Child and Family settings and joint (health and social services) adult Learning Disability teams. Contact your local team at their base. If in doubt, information about the team and their base should be available from the client's General Practitioner.

Familiarise yourself with the relevant sections of Valuing People and the local teams' referral criteria. Find out what specialist services the team provide and discuss referral routes with the Team Manager. You may be able to negotiate or instigate individual or group work on behalf of your client involving one or a combination of the professions mentioned above. If no service at all is on offer, then this constitutes a significant gap in provision, which should be highlighted for higher level management consideration.

3.4 Dual diagnosis (Learning Disability and mental health problems)

It is only relatively recently been generally accepted that people with a Learning Disability may also have coexisting mental health problems. Moreover, having a Learning Disability may predispose a person to develop a mental illness. The two main reasons for this are physiological – changes in brain structure and function associated with a Learning Disability may also result in increased vulnerability to mental health and social problems – the life experiences and opportunities of a person with Learning Disabilities may also result in increased vulnerability to the development of mental illness.

People with an existing Learning Disability are encouraged to use mainstream services (General Practitioner, mental health services) where appropriate. However, it must also be recognised that 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. Problems with communication and comprehension as well as a lack of introspection skills limit the extent to which people with a Learning Disability can give a good account of their problems. Within the Community Learning Disability Team there are several professionals with skills in both Learning Disabilities and mental health areas. One of the main functions of the Consultant Psychiatrist will be diagnosis and work with mental illness within Learning Disabilities. Clinical

Psychologists, too, will have experience in both areas and be able to offer appropriate advice and treatment. There may also be a Community Nurse with dual qualifications in Learning Disabilities and mental health who will be able to offer support, advice and individual work. In some teams these core professionals have formed a separate mental health team with a specific function of working with clients who have a dual diagnosis and offering specifically tailored intervention and follow-up.

3.5 Coping with everyday living

Some people with Learning Disabilities become parents before they have had the chance to learn what it is like to live on their own. They are then faced with the joint task of learning all about independent living as well as being a parent – a huge set of demands. It is important to answer purely practical questions such as "how does a person look after his or her self", in terms of cooking, cleaning, washing etc and then considering how this relates to the family situation. Answers to some of these questions will be evident during a home visit and by talking to both parents. More in-depth Assessment of the parent's practical abilities can be undertaken by an Occupational Therapist specialised in Learning Disabilities. The Occupational Therapist will consider the thinking processes involved as well as any specific physical problems that are evident. They will be able to recommend either a further Assessment or appropriate teaching.

3.6 Assessment of cognitive ability

All too often, discussions around the presence/absence of a Learning Disability are centred on intelligence testing and IQ scores. As we have emphasised elsewhere, a diagnosis of Learning Disability is made on the basis of consideration of cognitive ability, social presentation and adaptive behaviour. Cognitive Assessment therefore can be one part of the diagnosis of a Learning Disability.

However, Assessment of cognitive ability by a Clinical Psychologist also gives valuable information about how the individual learns. An Assessment of cognitive ability need not necessarily be limited to IQ scores alone. A variety of standardised Assessment tools exist, looking at areas such as memory, concentration and attention, and literacy skills. When seeking an Assessment, it is useful to consider the areas you wish to know about. For example, an Assessment of literacy skills will be essential if you are using written information with the parent. In a teaching program it is helpful to know whether the parent has any specific memory problems and how you might facilitate the learning and remembering process. Before requesting a lengthy cognitive Assessment remember it can be an uncomfortable and demoralising process for the parent and should be used to obtain strictly relevant information.

3.7 Assessment of Communication and Language skills

People with mild or borderline Learning Disability can often present with fluent speech, incorporating jargon and technical terms in their phrases. Although this presents as apparently sophisticated, some phrases have been learnt as a whole with their meaning poorly understood. This is particularly true of an adult who has attended mainstream school where, as a survival skill, they have learnt to mask any problems. They may be adept at appearing to understanding and utilise specific words or phrases in order to appear to be coping. Cognitive Assessment by a psychologist will give an indication of these problems. A more detailed Assessment from a Speech and Language Therapist who specialises in Learning Disabilities will give a clear picture of language difficulties and communication styles.

3.8 Community Networks and Accommodation

An Adult Learning Disability Social Worker will have in-depth knowledge of community facilities available for people with a Learning Disability. They will be able to facilitate access to a range of support services within the statutory private and voluntary sectors as well as programmes of further education. As specialist facilities may not always be appropriate for a parent with a Learning Disability, support in accessing general community facilities is also important.

3.9 Emotional support and counselling

Community Learning Disability Nurses will be able to offer direct support and advice to the parent with a Learning Disability. Like the Adult Learning Disability Social Worker, they will also have an in-depth knowledge of the range of specialist community facilities that are on offer to the family. Specific support around personal health and safety issues, as well as emotional difficulties, can be offered by the Community Nurse. He or she will also be able to advise about further referral within the Team for more severe problems, for example, complex emotional difficulties.

PART 2 CONDUCTING THE ASSESSMENT PROCESS

CHAPTER 4

THE ASSESSMENT PROCESS

Securing the well-being of children by protecting them from all forms of harm and ensuring their developmental needs are responded to appropriately are the primary aims of Government Policy. A key process in achieving these aims is effectively identifying children's needs and then taking appropriate action to meet them.

4.1 The Framework for Assessment

The **"Framework for the Assessment of Children in Need and their Families"** has been issued to help achieve this. The primary purpose of the Framework is "to ensure that referral and Assessment processes discriminate effectively between different types and levels of need, and produce a timely service response". A revised issue of **"Working Together to Safeguard Children"** was published alongside the "Framework", and is a guide to inter-agency working to safeguard and promote the welfare of children.

The Assessment Framework tells us that Assessment must be:

- child centred;
- rooted in child development;
- ecological (holistic) in its approach;
- ensure equality of opportunity;
- involve working with children and families;
- build on strengths as well as identify difficulties;
- inter-agency in its approach to Assessment and the provision of services;
- a continuing process, not a single event;
- carried out in parallel with other action and providing services;
- grounded in evidence based knowledge.

All Assessments must ensure:

- The welfare of the child is safeguarded and promoted throughout the Assessment, planning, provision of service and reviewing processes.

- The child's wishes and feelings are ascertained and given due consideration.

- Children and their families fully understand and are involved in the Assessment, planning, provision of service and reviewing processes.

- Children and their families receive a service which is compliant with the Children Act 1989 and associated regulations and guidance, in particular "Working Together" 1999 and the "Framework for the Assessment of Children in Need" 2000; the Data Protection Act 1998; the Human Rights Act 1998; the Access to Health Records Act 1990; the common law duty of confidentiality; and the Race Relations Act 2000; codes of professional practice.

- The racial, religious, cultural, linguistic and any special needs of children are promoted.

4.2 Domains

All Assessments will be in accordance with the domains set out in the Assessment Framework, namely: the child's developmental needs; the capacities of parents or caregivers to respond appropriately to those needs; and, the impact of wider family and environmental factors on parenting capacity and children.

4.3 Analysis, Judgement and Decision Making

The information gathered should be appropriate and should be analysed in order to inform effective decision-making. The Assessment should result in:

- an analysis of the needs of the child and the parenting capacity to respond appropriately to those within their family context;

- identification of whether, and, if so, where, intervention will be required to secure the safety and well being of the child or young person;

- a realistic plan of action (including reasons for the decisions made and services to be provided), detailing who has responsibility for action, a timetable and a process for review;

- a record of decisions placed on the child's file.

4.4 Protocols, Policies and Procedures

There are protocols between Adult Services and Children and Families Departments that will assist with Assessments. This is referred to as “JIGSAW”, published in 2003. There are also protocols for the agencies involved to follow in regard to Pre-Birth Risk Assessment and should be read in conjunction with this document.

4.5 The Role of Supervision and Planning

Staff working directly with children and families and those who manage them should be knowledgeable, confident and able to exercise professional judgement. Supervision or Professional Support should address the following, in order to assist with the Assessment process:

- the process of the Assessment itself;
- the timing and relevance of making the child and family Assessment;
- practice which recognises the diversity of family lives, traditions and behaviours;
- information about the children and the parents or caregivers, and its analysis;
- what further information is needed and how it will be obtained;
- the need for any immediate action or services;
- the plan for work with the child and family, and allocation of resources;
- the provision of services of intervention and their likely impact on child and family members;
- involvement/contact with staff in other agencies;
- the review of progress, of earlier understanding of the child and families situation and of the action/intervention plan.
- maintaining consistency of approach
- resolving difficulties with engaging parents
- resolving conflict (for example between the needs of the parents and the needs of the child)

4.6 Planning the Assessment

All Assessments should have a written plan: not to plan is to plan to fail. This is especially true when working with parents with a Learning Disability, as the process is the same but extra thought and knowledge will help avoid dangerous pitfalls.

The consent of the child/young person and/or parent must be obtained before starting the Assessment. Also, at this stage, consider which agencies and professionals should be involved.

4.7 The Core Assessment

A Core Assessment should include:

- interviews with the child and family as appropriate;
- ensuring the child is always seen - usually alone;
- involvement of other agencies in gathering information;
- consultation with managers;

- making a record of analysis;
- a decision on further action/no action, and rationale;
- sharing the record of decision and rationale with family;
- sharing the record of decision and rationale with other agencies;
- a record of views of the child/young person and/or family and any points of correction;
- if the child is assessed as being "in need" – drawing up a written plan with clear objectives and timescales.

A copy of the Core Assessment should normally be given to the family or reasons recorded for not doing so.

At the conclusion of the Core Assessment, there should be an analysis of the child's needs and parent's ability to meet the child's needs. If necessary a written "Child in Need Plan" should be drawn up in consultation with the child/young person and/or their family.

CHAPTER 5

SAFEGUARDING CHILDREN IN NEED

5.1 Children who are suffering or are likely to suffer significant harm

Some children are in need because they are suffering or likely to suffer significant harm. Concerns about maltreatment may be the reason for referral of a family to Social Services, or concerns may arise during the course of providing services to a family. Under such circumstances, the Local Authority is obliged to consider initiating enquiries to find out what is happening to a child and whether action should be taken to protect a child. This obligation is set out in Part V Section 47 of the Children Act 1989 (*Protection of Children*):

This section of the Act requires Local Authorities to consider if action is necessary. To make enquiries implies the need to assess what is happening to a child. The procedures for such action to be followed are laid down in *Working Together to Safeguard Children* (1999). Where there is reasonable cause to suspect that a child may be suffering or is at risk of suffering significant harm, section 47 (9)(10)(11) places a duty on any local authority. This includes:

- any local education authority;
- any housing authority
- any health authority, special health authority, National Health Service Trust or Primary Care Trust; and
- any person authorised by the Secretary of State to help a Local Authority with its enquiries. In addition, the Police have a duty and a responsibility to investigate criminal offences committed against children.

It is important to emphasise that the Assessment should concentrate on the harm that has occurred or is likely to occur to the child as a result of child maltreatment, in order to inform future plans and the nature of services required. Substantial research evidence suggests that the health and development of children, including their educational attainment, may be severely affected if they have been subjected to child maltreatment (Varma (ed), 1993; Adcock and White (eds), 1998; steps should be taken to safeguard and promote children's welfare. The duty to both safeguard and promote the child's welfare continues throughout the process of finding out whether there are grounds for concern that a child may be suffering or is at risk of suffering significant harm, and deciding what action should be taken. Services may be provided to safeguard and promote the child's welfare (under Part III of the Act), while enquiries are being carried out, or, after protective action has been taken while an application is being made for a Care or Supervision Order (under Part IV).

5.2 Significant Harm and Learning Disabilties

Section 17 of The Children Act 1989 introduced the positive principle of safeguarding the welfare and promoting the upbringing of children by their families. It states that the prime responsibility for the upbringing of children rests with parents: the State should be ready to help parents discharge that responsibility, especially where doing so lessens the risk of family breakdown.

The presence of a Learning Disability should never be a reason for not considering the use of Section 17. Clearly limited understanding may make the process of a child and family enquiry and subsequent Assessment more difficult to complete, but limited understanding should not be confused with “difficult, non compliant or lack of co-operation with the Assessment". It helps to think about the engagement process, and how best to reassure the family, explain the process, and how best to engage an Advocate if possible. Be very careful about language: only introduce a couple of new ideas at every meeting; consider what theories you are using in your work, and how this might have to be adapted to assist with the Assessment.

5.3 Local Authority Duties Under The Act

Section 17 - it shall be the general duty of every Local Authority to:

- safeguard and promote the welfare of children within their area who are in need, and
- so far as is consistent with that duty, promote the upbringing of such children by their families
  by providing a range and level of services appropriate to those childrens' needs.

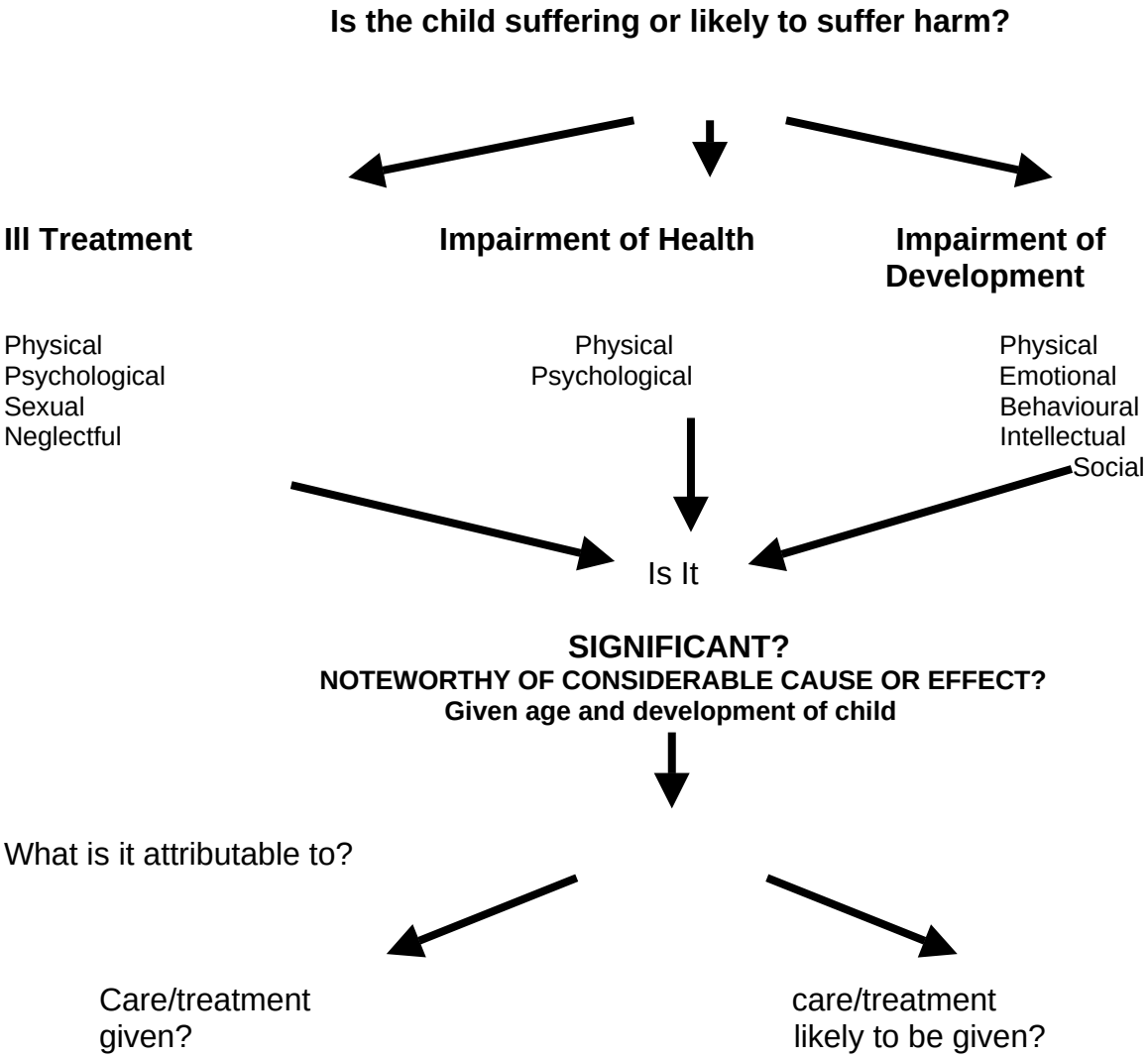
Section 47 - Where a Local Authority is informed that a child who lives, or is found, in their area –

- is subject of an Emergency Protection Order (EPO)
- is in police protection: or
- have reasonable cause to suspect that a child who lives, or
- is found in their area is suffering, or
- is likely to suffer, significant harm,

the Local Authority shall make such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

5.4 Significant Harm

By general definition **Significant Harm** is the ill treatment or impairment of the health and development of a child that is serious, noteworthy or important.



5.5 Child Protection Enquiry/Investigation

If at any time there is concern that a child may be suffering, or is likely to suffer significant harm, there must be a Strategy Discussion and Child Protection Procedures must be followed.

At the conclusion of a Section 47 Enquiry, the Social Services Manager will, in consultation with relevant agencies, decide whether or not the child has suffered or is likely to suffer significant harm. If so, an Interim Protection Plan should be drawn up in consultation with the family and other agencies. Initial Child Protection Conferences should be held within 15 working days of the Strategy Discussion.

If the outcome of the Section 47 Enquiry is that the situation does not warrant further action under Section 47, a decision about whether or not to complete the Core Assessment should be made in consultation with relevant agencies and with the agreement of the family.

5.6 Child in Need Plans

At the conclusion of the Initial and/or Core Assessment, there should be an analysis of the child's needs, parenting capacity and environmental factors that impact on parenting capacity to meet the child's needs. If necessary, a written "Child in Need Plan" should be drawn up in consultation with the child/young person and/or their family.

The Plan should be based in the needs of the child and set out clearly; containing:

- the aims and objectives of the intervention;
- intended outcomes;
- actions and services planned;
- who has responsibility for the different actions;
- timescales for implementation and review;
- what will happen if key elements of the plan are not followed.

The process of compiling and presenting plans should be as creative as possible. Aim to use parents' strengths and interests (photos, pictures, video) making sure the end result is easily understood, meaningful and likely to be used.

The plan made with a parent with a Learning Disability should be reviewed on a regular basis. Reviews should focus on whether the child's needs are being met, with adjustments to the plan as required. It should be remembered that as a

child's developmental needs change then the plan must be adjusted to meet these needs. A parent with a Learning Disability may not recognise the changing needs and adjust behaviour without a new plan. The idea of life-long help may need to be explored.

5.7 Changing the Child in Need Plan

To ensure these plans are changed appropriately; the following steps should be taken:

- Formal consultation/preparation with the child, family/carers and relevant agencies prior to the Review Meeting.
- Consideration of the child's developmental stage, by completion of a reassessment of the appropriate areas.
- The views of the child/parents/carers should be recorded.
- Ensure that there is a record of the review and this is circulated to all relevant parties.
- Ensure that plans and Assessments are updated following reviews.
- Careful explanation of decisions made during the Review/meeting follows this meeting.

The above is taken from Norfolk County Council Social Services Dept Assessment Framework implementation. As the Assessment remains essentially the same for every parent and family, we have to adapt the framework for parents with a Learning Disability.

CHAPTER 6

APPLYING THE ASSESSMENT FRAMEWORK

6.1 The Core Assessment

The Core Assessment undertakes to establish a full understanding of the family to an extent that decisions can be made about:

- The extent of the risk to which the child(ren) are exposed
- The range of services needed to maintain the child(ren) within the family
- Any action which is needed to safeguard and promote the welfare of the child(ren) including removal from the family.

In order to achieve this, the tool uses processes for collecting information in a systematic way. These processes are designed to obtain core information and provide consistent quality of understanding of that information.

The tool also provides additional Assessment material that can be used as appropriate for the specific needs of the family. For example, there is a guide for the Assessment of family members where alcohol abuse may be a significant feature.

6.2 Assessing the whole family

The Assessment requires that all members of the family be assessed. It must take account of the unique characteristics of the family; and its accuracy depends upon good preparation, good observation and productive interviews.

The information required to assess children in need and their families is contained with the *Framework for the Assessment of Children in Need and their Families* (Department of Health 2000).

6.3 Planning the Assessment

It is essential to plan all Assessments thoroughly and prepare the order of the Assessment.

There is essential information required and the gathering of this information needs to be carefully considered. The following list may help organise the gathering of information.

- Family structure/genogram. It is helpful to complete this on a large piece of paper to aid the people being assessed with a visual format. Be imaginative - use play-houses or figures with children.
- Chronology. Read all the old files; ask various agencies to send you a chronology of their involvement.
- Childhood experience. Essential for parents with a Learning Disability as they are likely to have experienced a range of issues that may impact upon their personality and presentation as an adult.
- Perception of self vs perception of ideal self. It may help to try a "miracle question", such as "if there was a magic wand, what one thing would you really ask for". Relate this to a "live" situation in order to help you understand someone's position in society and perception of self.
- History of alcohol or drug misuse, any long term prescribed drugs.
- Any involvement with the Police/Courts.
- A health profile for each significant person within the family.
- Previous relationships/present relationships
- Parenting strengths and areas of weakness. (see parenting capacity questionnaire)
- Child care and Child Protection
- The home environment
- Finances and budgeting
- The child/children
- Their development, education, personality etc
- Capacity to implement new ideas
- Capacity to generalise

If followed, these points will help to build a picture of the family that will fit into the domains of The Assessment Framework and help complete a Core Assessment.

6.4 Conducting the Assessment interviews

The plan should therefore look at the domains and could consider the list above, and then consider how best to conduct the interviews. List who needs to be seen, consider the venues and the timing of sessions. (It is important with parents who may have a limited capacity to concentrate and where Learning Disability is an issue. It must be remembered that parents who become tired are unlikely to give a true picture of themselves, and the risk of alienation becomes real. Engagement with parents with a Learning Disability must be carefully thought through, as must the use of language).

The Assessment Plan should include which sessions are to be undertaken jointly with the adults, and which need to be individual. It may be appropriate to prepare the plan in consultation or conjunction with the family, and the use of videos where parents have limited reading skills can be of benefit. The plan should be available for the family to agree.

The plan must include individual and joint sessions. Thought should be given to setting these sessions up as responses to questions and questionnaires can be less helpful if the people being assessed have time to discuss their answers. There may be a high level of expressed emotion in some sessions; this cannot be planned for, but must be acknowledged, and a judgement reached if the person becomes distressed.

Involvement of the family in the planning process should identify the precise arrangements for each session, and it is recommended that the issue of the support of partners/adults is resolved at this initial stage.

6.5 Cultural and Ethnic considerations

It is good practice to ensure that families from different ethnic backgrounds have representatives from those backgrounds as part of the Assessment Team, preferably involved in working directly with the family. A parent with a Learning Disability may also need an advocate at times to assist them with the process. This needs to be checked out with the family beforehand, because of the possibility of any sensitivities. Where language is problematic, workers may need to recruit 'interpreters'

6.6 Providing time for the Assessment

Remember, working with people with Learning Disabilities takes time - time to plan; time to engage; time to carry out the interviews and time to feed back. It is essential that we find this time for this particular client group.

Time for observation should be included in the Assessment, as this provides the opportunity to look at interactions and relationships. This 'space' is more easily achieved if there are two workers involved in the Assessment. Time to watch a parent play with a child is essential and can be very revealing as it gives a good indication of an ability to play with or play alongside a child.

It may be helpful when assessing a parent with a Learning Disability to talk to relatives or friends to gain further insight into their everyday behaviour and attitudes. This should be agreed before the Assessment begins.

It may be helpful to consider which other professionals can help with the Assessment and agree this with all involved as part of the planning process. It is essential to have some understanding of parental cognitive functioning; engaging a psychologist who specialises in Learning Disabilities will achieve this.

The way in which these issues are negotiated and agreed with the family can often set the tone of the whole Assessment process and engagement with the family. If the family feels marginalised or excluded from the process, they may be resentful or resistant. The workers must ensure that the Assessment is

planned to ensure that the family is given every opportunity and is not ‘set up’ to fail.

6.7 Recording the Assessment

The recording of Assessment with parents with a Learning Disability should also be carefully considered. If literacy is a problem, consider other format, eg video or audio.

6.8 Developing a Working Agreement

A good plan leads to a working agreement with the family. This should be recorded as a Written Agreement. Again, it may be useful to video an agreement if literacy is an issue - or use picture prompts. This has the benefit of being able to be used and referred back to. It will help to provide each of the parties with an understanding of all the elements of the Assessment. It should explain what would happen, and when. Assessment can be a frightening and threatening experience to families, and it follows that if Social Services are involved, there must be some degree of concern expressed regarding children. An Agreement may help alleviate some of the parental anxiety and seek to reassure the family being assessed: again, an advocate may be helpful with this process.

An agreement can help with practical tasks, such as dates and times. Attendance may be an issue if not considered, as the use of public transport may be an issue, or punctuality may be affected by the inability to tell the time. The assessors should attempt to reassure the family as much as possible and should be prepared to include issues which are important to the family. Families must not, however, be made promises or given false optimism in order to encourage co-operation.

The Assessment Agreement should include:

- an explanation of the reason for the Assessment
- the responsibilities of the workers
- the responsibilities of the parents, children and any other persons
- details of the sessions, including dates, times, venues and any special arrangements
- arrangements for the cancellation of sessions
- a time-scale for the Assessment in line with Assessment Framework
- an explanation of how disputes and disagreements will be resolved
- contingency arrangements
- a description what will happen to the Assessment

6.9 The Genogram or family structure

Whilst some workers prefer to compile a family tree to include information as far back as family members can remember, this may prove difficult with parents with a Learning Disability, as poor memory may be an issue. The use of other family members to assist may be appropriate, and may help a parent learn about their family make up, thus assisting with the client's sense of identity A choice should be offered regarding recording the information dependent upon preferred learning style i.e. visual, written, video, or tape recording.

When exploring family composition, account should be taken of feelings that may arise when those being assessed talk about family members who are deceased. The person's emotions and distress should be responded to appropriately.

Useful questions to ask are:

- What are your grandparents' names?
- What are your parents' names? (Clarify relationships)
- Do you have brothers or sisters?
- How old is he/she?
- Where does he/she live?
- Who does he/she currently live with?
- How often do you see him/her? (Think about support offered)
- What is your current relationship with him/her, has it always been like this?
- Is there anyone else important to you?

Then build on the replies given with open questions, to begin a family history. You may want to consider if another family member being present to help with dates etc will hinder the process. You may need to complete some research before the interview.

6.10 Chronologies

The Chronology records the person's life from birth to the present time. The information may be obtained from a variety of sources.

There are two types of Chronology discussed here. The first is a professional chronology taken from files and reports. The second is a personal chronology taken from all caregivers.

A detailed understanding of the person's childhood and adult life is required, because the experiences which people have provides workers with clues and information about their present skills, abilities, knowledge and understanding. Attitudes and beliefs are frequently rooted in childhood experiences. The Chronology, therefore, will act as a cross-reference for the information provided; and will also assist in introducing and exploring key personal issues.

6.11 Record Based Chronology

There may be generational files, which should be read and relevant portions added to the Chronology to assist understanding of the family dynamics.

Records will detail past problems, interventions and results - possibly giving ideas about effective and ineffective ways of working with an individual or family.

Records will also clarify patterns of behaviour over time, both in terms of the parents' behaviour and habitual familial functioning. Pivotal relationships within families may be identified as well as significant experiences (past abuse, loss etc).

We must be sensitive to the difficulties that some people have when recounting their background. Memories may be distressing; the person with Learning Disabilities may have difficulty remembering dates and sequencing events coherently. The plan for the Assessment may help here, especially if ground rules have been set about 'time out' if the person becomes distressed, and what support they might find helpful. Other family members may be able to contribute to a person's life story - although care must be taken that others do not become over intrusive and "take over" the Chronology.

Throughout this and all sessions, the worker must provide a climate which enables the information to be collected in a manner which encourages the person's feelings, views and opinions to be expressed and valued.

A non-directive approach allows the person to recall their childhood and memories in their own way and in their own words. Gaps in the information can be clarified subsequently. Note should be taken of what is *not* reported during this free recall phase. Information may have been forgotten, blocked or withheld.

6.12 Personal Chronology

When compiling a personal Chronology the following are some useful questions to ask,

- Where were you born?
- What is the first thing you can remember?
- What else do you remember?
- And then what?

Trying to encourage free narrative encourages a version of events without lots of direct questioning. If the person finds it difficult to begin some prompting questions may help.

- Do you remember any of your brothers or sisters being born?
- Do you remember starting school?
- Do you remember? (mention a significant known incident in the person's childhood)

6.13 Focusing on Childhood memories

The above questions give a reference to the person's age at the time and allow a re-focus on the memories.

Once the person has reported their childhood and adult life, the worker may wish to re-focus on events that have been missed and discuss these. Information from case files and case histories will assist with this process.

Once a Chronology has been obtained, the worker should return to the person's childhood and look in more details at experiences and perceptions. The person should be encouraged to talk freely about their childhood rather than provide short responses to questions. Ask subsidiary questions, where comments need clarification.

Explore with the person comments they make which might give insight into their experiences. For example, 'I was treated differently from my brothers and sisters.' Explore examples of this, which might give clues to:

- Whether the treatment was different
- Whether or not the person's perception is distorted, i.e. the treatment was the same and the perception is wrong
- To what extent any differential treatment affected the care the person received
- How the person feels about that now
- If the treatment was different, what would the person do to avoid that with their children?
- Can they make any links for themselves between the care they received and the type of parenting they are able to provide. This might be difficult for a parent with a Learning Disability to achieve, unprompted, as they may find making such links difficult. However this will provide valuable insight into the person's world and how they make sense of it.

The person's perception of each adult who played an important part in their lives helps to gain a full understanding of the level of care they received and also what they learned about being a parent from these people. Workers should first of all list the adults whom the person remembers as being important – 'important' because of good memories and bad memories.

6.14 Noting significant events

It may also be helpful to complete a time line listing significant events. Be imaginative with the presentation, as just talking may be difficult and the use of paper and drawing or videos or play may be more helpful.

Remember that the ability to give an account of a life history will vary tremendously from person to person. Some people will be able to give a good and detailed narrative, whilst others will appear to have no coherent "story". Variable degrees of prompting will be needed to match this. Where a parent has major problems with the chronological process, it is helpful to have completed a record based Chronology first, in order to have a sequential list of prompts.

6.15 Parenting - Where do the problems lie?

If a parent is having problems with parenting, the origins of these problems are not necessarily the same.

Firstly, the parent can lack basic knowledge. They may have had little contact with children in their lives and not known how to hold a new baby, make up bottles or consider safety issues, simply because they have never been shown, and cannot access the necessary information. Here, we need to make a practically based Assessment of life skills and knowledge about babies and children. As it is likely that a lot of teaching will be involved, an Assessment of learning style and cognitive ability will be helpful so that you can present information at the right level; or access an appropriate group.

Secondly, a parent can appear to have basic knowledge, but be unable to put it into practice. This is a more complex situation and requires further exploration. Some suggestions about why this may happen are:

- Although the parent can say what to do, they do not understand how to put this into practice, requiring a different and more active form of teaching based on modelling and role-playing rather than instruction.

- The parents have their own ideas of what to do but are confused by a number of professionals and family members each giving their own idea of how to complete a task. Here we need to ensure consistency across all those offering support to the client.

- The parent may have low levels of motivation due to life circumstances or early emotional experience. Here we need to look at natural supports and motivations in the environment e.g. partner, maternal grandmother.

Thirdly, a parent may have good knowledge of childcare, but seems unwilling or unable to put this into practice.

This is most likely to be due to problems associated with emotional understanding rather than a parent's knowledge base. We need to look at the parent's own profile of emotional need and try to address this. The key question here will be, will the parent put the child's needs before their own emotional agenda?

6.16 Using Observations

The best and most useful observations of the family are made by those who are normally in contact with the family. This is because their presence as an observer is less likely to alter the dynamics and behaviour of the family. So think about a home carer or health visitor who may be able to assist.

Observations should be centred around behaviour - for example, compare these 2 descriptions:

- **"Johnny was anxious throughout"**

- **"Johnny was anxious throughout because he was unusually restless and couldn't concentrate on his favourite toy".**

The second description is clearer and more helpful as it gives context and meaning to the behaviour.

Observations should avoid value judgements and inferences. If you need to make an inference, back it up with observed information.

Expert witnesses may need to observe the family as part of their reporting brief. Although this creates an essentially artificial situation, these experts are usually well used to observation of families and can make helpful inferences which contact supervisors are less likely to report.

6.17 Communicating with clarity

Where levels of understanding are limited – for example, by Learning Disability – workers should use only words which the person understands (simple rather than complex language). Regular checks should be made to ensure that the person understands the issues being, discussed.

Adults with a Learning Disability may benefit from the presence of a supporter during sessions; this should be respected. Although we may worry about the potential influence and interference of a supporter, this is balanced by the

benefits gained when a person feels more relaxed, and therefore more likely to engage with the worker.

The family should be encouraged to ask for questions or comments to be repeated if they do no understand. Workers should avoid using professional terminology or jargon. Family members who do not understand questions may either become frustrated or disengage from the Assessment process. People who feel they are being patronised or 'talked down to' are likely to be angry or feel that decisions have already been made. All of these responses are likely to contaminate the accuracy of the Assessment.

6.18 Keep communication open ended

Wherever possible, questions should be open-ended and so require a narrative response from the person rather than closed. For example, if a family member is asked 'do you become angry often?', they will answer either 'Yes' or 'No'. Alternatively, if the question is, 'How often do you become angry?' the person is more likely to provide a narrative response, which will be more informative. The interview then becomes more of a discussion that a question-and-answer session. Direct questions should only be considered as a follow-up to the person's initial reply or if a specific response is required.

In using an open-ended approach to questions, a sequence should be used. for example, when looking at the issue of anger the following sequence of questions might be asked:

- What things make you angry?

The worker then waits for the person to list the things that cause anger. Where clarification is needed to any of the answers, it is sought. For example if the person replies, 'people who interfere', the worker might want to explore further by asking as a subsidiary question, 'Who are the people who interfere who make you angry?' or 'In what ways do people interfere that make you angry?' In some situations both subsidiary questions may be appropriate. The worker then moves on to:

- When was the last time you were angry and what happened?
- Describe the most angry you have been in your life and what happened?
- How often do you feel angry?
- What do you normally do when you are angry?
- What do you do to try and control your anger?
- Would you like to be angry more often or less often?

If information is already known using direct questions may help.

- You lost your temper with your partner last week, could you tell me about that?

Planning these questions beforehand will help the Assessment process and ensure that simple language which is clean and easy to understand is used. It may help to try them out on your co-worker. Other emotions, states or sets of circumstances can be explored in a similar way.

6.19 Referencing the referral

Once this information is gathered it is helpful to include a section regarding the current referral. Give details of what brought the referral about; why was it accepted; what help has been offered, what has worked what has been less successful. This will help set the scene for the reader and help inform the next part of the Assessment.

6.20 Beginning the analysis

At the end of each section of the Assessment Framework an analysis should be undertaken to balance parental competence and areas for improvement. Whilst completing these sections, bear the following in mind:

- What is required to meet the child's health, emotional and educational needs
- How far are these needs being met
- How can we provide any extra services
- How will we measure any resulting changes

These ideas (and more - this is not an exhaustive list) will be drawn out in your final Care Plan.

Also, at this stage, consider the guidance issued by the Department Of Health. Assessing Children in need and their Families (DoH 2000).

CHAPTER 7

DEVELOPING THE ASSESSMENT

7.1 The Domains of the Assessment framework

This part of the Assessment aims to provide a description of the child's developmental needs. The goal is to assist the reader in constructing a mental picture of the child. Full descriptions of the child, in terms of physical and emotional development, as well as personality, with examples drawn from observation, will be helpful.

The domains of the Assessment Framework can be linked with the various questionnaires at the back of this work. Alternatively, your own style of interview and questions can be developed.

7.2 Health

The heritability of Learning Disabilities is by no means a straightforward subject. Many eminent researchers have failed to agree on the extent to which, for example, intelligence is genetically linked. Therefore, as professionals working within the area, we need to be very careful about the inferences that we make. Having said that, if a child's parents have a Learning Disability, then there will be a genetic predisposition towards developing later problems greater than in the rest of the population. However, this is not inevitable - IQ tends towards the mean and it is quite possible that two parents with Learning Disabilities will have a very able child (this situation in turn will bring its own questions and difficulties).

Care must be taken not to confuse inherited disabilities with neglect issues. Paediatric and psychological Assessments may be required to clarify.

Developmental delay will be exacerbated by the following:

- lack of environmental stimulation in terms of physical provision
- lack of stimulation in terms of interaction with the parent
- inappropriate diet (the effect of poverty on the family diet will need to be considered as well as parental understanding of dietary needs)
- repeated minor illnesses: for example, where hygiene in the home is poor, a child may be subject to repeated episodes of diarrhoea.
- Genetically linked illnesses, for example, epilepsy.

The completion of a health profile on each child is essential; we need to fully understand the health requirements of each child before we can begin to assess

the extent to which the parent with the Learning Disability can meet those needs and the help that will be required.

Bear in mind that the parent may need help with reading appointment letters, keeping those appointments, travelling to clinics etc.

7.3 Education

The child's educational needs will be assessed as one would for any other child. Given the predisposition towards developing learning problems, particular attention should be paid to the extent to which the school has followed through any educational concerns.

The part that the parent plays in the child's educational development is also of great interest. We need to bear in mind that a parent with learning difficulties is very likely to have had negative experiences at school and may regard schools and their staff as daunting and threatening places and people. It is very easy for a professional to suggest phoning the headteacher for a discussion, but this may be a very frightening experience for a parent with Learning Disabilities to undertake.

We can collect "hard" facts, for example, the child's attendance at school and the frequency with which the parents attend parent/teacher interviews, but we also need to collect "softer" information, such as: what are the problems in getting the child to and from school? It may be that a child is consistently late because their mother wishes to avoid meeting other parents in the playground whom she feels "look down on me". We may need to negotiate a change in time or situation of teacher/parent interviews or arrange for a friend or advocate to attend as well.

With the older child, homework can be a bone of contention. If the parent with a Learning Disability cannot contribute they may, as a form of self-protection, dismiss the homework as "unimportant". The child could be similarly dismissive or could become angry and contemptuous of their parents' ability to help. We need to be able to help families set up structures with schools (homework clubs, alternative helpers) in order to circumvent such difficulties.

Parents with Learning Disabilities can be encouraged to provide educational opportunities outside the home if they understand the idea of education as broader than simply reading and writing. So, family outings, involvement of the extended family and use of local facilities such as libraries can all be encouraged.

Overall, in this section, we are trying to gain an understanding of the ability of a parent to provide stimulation, to ensure that their child's educational needs are met and their ability to support the child's education.

7.4 Emotional and Behavioural Development

The emotional needs of children are complex and ever changing; therefore, careful Assessment will be required. The aim of the Social Work Assessment is not to provide a detailed analysis of the child's attributes and behaviour - this is best left to other professionals. Rather, we are trying to determine whether the child is happy and relaxed in the parents' care, able to express their emotions and respond to limit setting by their carers. We need to look at the child/parent dynamics, in particular, attachment, and use this information to "flesh out" our description of the child.

Observation of the parent and child together, in different situations, is the best way of gathering information about their relationship. The child and parents can also be interviewed separately for their thoughts and perceptions on the matter, but it is always important to see how what is said happens in everyday life. The sorts of things we will be looking for are:

- how does a parent praise the child and how often does this occur
- how does a parent distract a child from negative behaviour
- how does a parent deal with direct opposition
- who makes the decision about the child - the child or the parents
- what is the child's predominant mood
- what is the parent's predominant mood when (s)he is in the presence of the child
- any specific difficulties

7.5 Identity

A child whose parent has a Learning Disability will have a similar experience of forming and building upon identity as any other child. However, as the child grows and develops, they may have confused feelings about their parents being "different". Their family's relationship to the local community may be strained - the family could be stigmatised by the local community or lacking opportunities due to poverty. Children may be singled out for teasing or bullying by their peers. Careful consideration of the way in which a child is developing a sense of identity is required, both in terms of themselves as an individual and in terms of positive regard for their family

7.6 Family and Social Relationships

We have already discussed the need for a full family history - it is also helpful to include social relationships within this. Take particular account of family supports that exist and consider how to consolidate these supports. It is likely that long-standing support comes from the extended family. Remember, they will be

around long after Social Services or Health withdraws! The family is also a good source of information. They may be able to supply information that a parent with a Learning Disability has forgotten, or have a different view.

The areas that can be covered in this part of the Assessment are as follows:

- does the child have continuity of care?
- do they have at least one stable relationship with an adult (this could be a supportive grandparent or aunt or uncle)?
- does the child see significant members of the family?
- is the child liked, does he or she respond positively to their parents?
- are they easily comforted and can the parents "read" the signs or cues of the child?
- does the parent initiate closeness with the child?
- are they able to keep the child in mind when out of sight or when they are doing other things?
- are they able to assist the child to build positive peer and neighbourhood relationships?
- is there a consistency with the routine?

7.7 Social presentation

This concerns a child's growing understanding of the way in which appearance, behaviour and the respect of any impairment perceived by the outside world creates an overall impression. It includes appropriateness of dress for age, gender, culture and religion: cleanliness and personal hygiene as well as verbal and non-verbal behaviour. Appropriate social presentation depends very much upon the availability of advice from, and the example or "model" set by, parents or caregivers about presentation in different settings.

This can be a complex area to understand, as social rules are unwritten and absorbed throughout life. Parents with a Learning Disability may themselves have had poor social models (being brought up in an institution, for example) or have difficulty learning the "rules" and working out what to do in different situations.

A young man's life story comments: ***"I didn't like it when we went to school, Mum always wore a long, fur coat and insisted on hanging on to me right up to the gate. She was so embarrassing; she would then kiss me goodbye. She liked me dressed in shorts even in the winter. All the other kids had long trousers but I turned up every day in shorts. It made me good at fighting though. They called me names and called my Mum "dippy" so I hit them. I never had many mates at school until I learned to hide my Mum from them".***

When considering social presentation, the main points to consider are:

- does the child appear well cared for?
- is their appearance and behaviour acceptable?
- can they communicate with others?
- is the parent aware of acceptable standards of dress and behaviour for themselves and their child?

7.8 Self care skills

Self care skills, too, are dependent upon our understanding of what is acceptable and is learnt from role models. They are also very much dependent upon opportunity. If a child with nocturnal enuresis cannot wash in hot water in the morning, or is not taught to do so, then he or she will smell at school. A dual consideration of parental values and facilities available is needed asking:

- how does the parent present (clean, tidy etc)?
- how does the child present?
- are the child's self care skills appropriate for their age?
- is good self care valued in the house?
- do the facilities in the home support good self care (soap, clean towels, hot water etc)?

7.9 Basic Care

Firstly we need to take a general view of the basic care that a parent is able to provide. Parents need to make sure that children are well fed (including drink), reasonably clean, warm, dry, have a sleep routine and feel loved and wanted. Parents need to know how to meet these needs in practical terms as well as having some understanding of why they are important.

You will be able to highlight general strengths (for example, providing lots of emotional warmth in the form of cuddles) as well as areas where support is needed (for example, a parent who has difficulty remembering tasks to be done, highlighting the need for a system of prompts to be developed). We know from research findings that new learning, memory and ability to generalise are all likely to be problem areas. The existence of these general difficulties can be explored in the early stages of Assessment.

The ability to generalise is important in the acquisition of skills and interpreting instructions or tasks. We all generalise all of the time, interpreting our world and how to make the best of it in different circumstances that may be new to us. This does not necessarily occur naturally where people have a Learning Disability.

One worker at a Family Centre reported: ***"I was working with a mum to expand the range of meals she was able to cook for her family. As we were working on healthy eating, she chose to grill some items and produced some lovely meals for her family at the Centre. Later on, I went to visit her at home to go over some of the steps we had learned. At the Centre, we had used an eye level gas grill. Hers was electric and in the oven so she hadn't felt confident enough to try out any of our new ideas".***

7.10 Ensuring Safety

Ensuring safety can be a complex area for parents with Learning Disabilities to get to grips with, as both generalisation and problem solving skills are involved. At the simplest level, basic safety rules can be learnt - for example, don't let children in the kitchen whilst you are cooking, or, don't eat berries from the garden without asking an adult first. However, other safety issues, for example understanding why a broken stairgate may be more dangerous than no stairgate at all, or understanding why a Schedule 1 Offender who appears to be a "helpful friend" may be a danger to children. As well as exploring understanding of various issues with the parent, it is important to see how they protect their child on a day to day basis.

7.11 Emotional Warmth

A thorough Assessment of the attention behaviour of the adult to the child and the way in which the child responds to this behaviour is a critical part of any social work Assessment. From the parents' point of view, we are concerned with their interaction with the child. In the case of a younger child, how the sometimes subtle cues are responded to. In the case of an older child, we are looking at the parents' ability to assume the role of responsible parent by setting and keeping boundaries for their child, helping them regulate their behaviour and ensuring their child's emotional security.

Attachment theory [see Chapter 12] gives us a way of thinking about the child/parent relationship and helps us think about devising strategies for repairing relationships. Attachment theory is well established and recognised but tends to be used as an aspect of Assessment rather than used as the basis of a therapeutic tool. Other points to consider are the potential impact of specific needs on the family (health/mental health/specific disabilities) and geographical stability as demonstrated by the number of house/home moves made in a year. Where relationships appear complex and hard to disentangle, initial observations can be made and more in depth reports commissioned from other professionals.

7.12 Stimulation

This refers to promoting a child's learning and intellectual development through encouragement and cognitive stimulation and promoting sound opportunities. It

includes facilitating the child's cognitive development and potential through interaction, communication, talking and responding to the child's language and questions, encouraging and joining the child's play and promoting educational opportunities. The parent can facilitate good stimulation by making the most of opportunities presented e.g. encouraging participation in school trips, having friends from school to the home, joining clubs as well as through direct contact with their child.

7.13 Guidance and Boundaries

Here we are exploring the way in which the parent enables the child to regulate his or her own emotions and behaviour. The key parental tasks are demonstrating and modelling appropriate behaviour and control of emotions and interactions with others. Guidance involves setting boundaries, so that the child is able to develop an internal model of moral values, 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. It also includes social problem solving, anger management, consideration for others and effective discipline and shaping of behaviour.

7.14 Stability

We need to ensure that the child is protected within a sufficiently stable family environment to enable him or her to develop and maintain a secure attachment to the primary care giver(s). This is a condition for optimal development.

An exploration of family stability includes: ensuring secure attachments are not disrupted, providing consistency of emotional warmth over time and responding in a similar manner to the same behaviour. We need to ask if parental responses change and develop according to the child's developmental progress. Contact with family members and significant others gives a further dimension of family stability as well as a consideration of relationships within the family network.

Additional Family Factors

7.15 Family History and Functioning

Family history includes both genetic and psychosocial factors. Family functioning is influenced by who is living in the household and how they are related to the child; significant changes in family/household composition; history of childhood experiences of parents; chronology of significant life events and their meaning to family members; nature of family functioning, including sibling relationships and

their impact on the child; parental strengths and difficulties, including those of an absent parent; the relationship between separated parents.

7.16 Wider Family

Who are considered to be members of the wider family by the child and the parents? This includes related and non-related persons and absent wider family. What is their role and importance to the child and parents and in precisely what way?

In families where one or both parents have a Learning Disability, the paternal and maternal mothers can be extremely influential figures in the family dynamic. The maternal mother, in particular, can be a positive supporting influence where relationships are good; she can also be undermining and divisive where relationships are poor. It is worth taking extra time to define the role of these figures within the family and to try to stabilise their influence during any programme of support.

Additional Environmental Factors

7.17 Housing

People with Learning Disabilities are not necessarily good at demanding even a basic standard of accommodation for themselves or their families. They might find it difficult to deal with rules and regulations or to be assertive with housing officials. We need to ask questions such as: does the accommodation have basic amenities and facilities appropriate to the age and development of the child and other resident members? Is the housing accessible and suitable to the needs of disabled family members?

These questions include the interior and exterior of the accommodation and immediate surroundings. Basic amenities include water, heating, sanitation, cooking facilities, sleeping arrangements and cleanliness, hygiene and safety and their impact on the child's upbringing.

7.18 Employment

Seek information about who is working in the household, their pattern of work and any changes. What impact does this have on the child? How is work or absence of work viewed by family members? How does it affect their relationship with the child? Also include the child's experience of work and how it impacts on their life.

7.19 Family Financial Resources

Examine the available income over a sustained period of time, asking is the family in receipt of all its benefit entitlements? Is there sufficiency of income to meet the family's needs? How are resources available to the family used? Are there financial difficulties which affect the child?

7.20 Family's social Integration

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

7.21 Community Resources

Describe all facilities and services in a neighbourhood relevant to the family. This might include primary health care, day care and schools, places of worship, transport, shops and leisure activities. Also relevant are the availability, accessibility and standard of resources, the impact of this as well as the impact on the family.

7.22 Contacts

It is good practice to keep a written record of the progress of contacts. Most departmental policies will require their contact supervisors to do so. If you have a large number of contacts to collate, and several contact supervisors, having the format available on line to be completed by word processor, rather than by hand, is very worthwhile in terms of time saved reading and deciphering comments.
Experts will often request contact sheets enabling them to compare their visit with others (if one is made). Contact sheets will also give a view over time of the family's progress.

CHAPTER 8

SPECIALIST CONTRIBUTIONS TO THE ASSESSMENT

8.1 Psychological Reports

Where parents have apparent learning problems, the most relevant specialist report to request, at least initially, is from a psychologist. A profile of learning strengths and areas of difficulty can be given, as well as a definitive diagnosis of Learning Disability.

8.1.1. Diagnosis

Diagnosis of Learning Disability, according to internationally agreed criteria (DSM4 as ICD10) is made following consideration of three main factors:

1. Cognitive abilities - usually measured by IQ scores
2. Adaptive behaviour - how does the individual cope with day to day routine, tasks of self care
3. Social maturity - a consideration of how the individual functions in his or her social environment

Therefore, someone with a low IQ who functions well on a day to day basis, and whose social behaviour is well developed and appropriate may be diagnosed as having specific learning difficulties, such as dyslexia or specific language difficulties, rather than a Learning Difficulty.

8.1.2 Intelligence Quotient (IQ)

IQ (Intelligence Quotient) scores are sometimes seen as a controversial measure, seeking to artificially "categorise" people without regard to their strengths as a person.

Booth and Booth make the point that so-called "normal" parents are not subject to IQ tests before they have children. It can be tempting to overemphasise the role of IQ scores. They appear to be a tangible item in what can be a confusing situation, but should always be interpreted in context, by a skilled practitioner.

A diagnosis of Learning Disability can be helpful, in that it gives us a way of understanding a parent's behaviour, or perhaps lack of progress, and may open the door to a range of support services.

An IQ test covers a range of cognitive skills and will give a profile of the individual's strengths and weaknesses. Sometimes, further examination of a particular area may be indicated, for example, memory skills.

8.1.3 Literacy Skills

It is often useful to have an Assessment of literacy skills so that those working with a parent can present material in a format they are confident the parent is able to understand and use.

People with a Learning Disability, who feel that they did badly in school, will underestimate their own literacy skills. Phrases like "I can't read" often occur when, on closer examination, a parent can read and write simple words. This means that lists and single word prompts become a possibility for household tasks and routines, as well as bolstering the individual's opinion of their ability to be effective.

8.1.4 Cognitive Ability

A whole range of well-recognised tests exists for looking in detail at specific areas of cognitive functioning and is available. However, as testing is stressful for the person concerned, (although some people actively enjoy the challenge), a balance between utility of information and intrusiveness must be achieved. For example, different areas of memory function may be explored - short versus long term memory, or suggestibility may be considered - this is the extent to which a person is swayed by other's opinions, especially where protection or exploitation is an issue. Executive functioning covers a group of skills relating to impulse control and the regulation of social behaviour. Exploration of these skills may be relevant where impulsive or angry behaviour presents problems. In general, however, it will be the psychologist undertaking the psychometric testing who will highlight appropriate areas for exploration.

The role of the Social Worker is to ensure that an appropriately skilled practitioner is involved, and to highlight areas of debate or specific questions to be answered.

8.1.5 Attitude Tests and Questionnaires

As well as evaluating cognitive skills, a range of other attitudes can be examined. Attitude tests about relevant issues - (being a parent; children’s behaviour; how I feel about myself) can be included in the Assessment.

Many tests also include a distortion index that will indicate an extreme style of responding - for example giving consistently positive responses or seemingly random answers.

Basic screening tests to ascertain emotional or mental health status can also be used. These are designed to elicit, for example, thoughts consistent with a

generalised anxiety or depressive disorder. They are used to confirm clinical presentation rather than as a diagnostic tool.

Personality tests have a mixed press. Some psychologists include personality testing in their reports: others do not. There is professional debate about the reliability of these tests. The results must be carefully interpreted and relate to the day to day presentation of the individual.

8.1.6 Clinical Presentation

Psychometric testing alone does not give a clear picture of any individual. Psychological reports will also contain sections relating to the history and current behaviour of the person.

The history is important from a psychological perspective as it details not only the individual's past experience, but also the way they have responded to and reflected on that experience. A good social work history can be immensely helpful at this point, as many people with Learning Disabilities have difficulty remembering the events in detail and sequencing these events. Although history taking can seem repetitive and therefore unnecessary, a psychological perspective will be brought to bear upon the information given and related to the current situation.

8.1.7 Mental Health

Some psychologists will deal with mental health issues: this will depend on the orientation and experience of the professional concerned. It is useful to discuss this beforehand. If mental health difficulties constitute the primary problem, then it may be appropriate to contact a consultant psychiatrist.

8.1.9 Associated Disorders

Disorders such as epilepsy or Aspergers Syndrome/Autistic Spectrum Disorder are often associated with Learning Disability. Comment can be made on the likely effect of these disorders have on all aspects of parenting behaviour.

8.1.10 Interventions

Following the Assessment process, a psychologist will also be able to include recommendations for treatment and intervention in the report. These may relate to the parent, child or whole family. In order that these recommendations are as effective as possible, information from the Social Work team about the work being undertaken (and previous interventions) with the family is essential. A locally based psychologist may well become involved with the support of the family on a longer-term basis.

8.1.11 Treatability

If individual therapy is, or has been, recommended, then it is a good idea to request an Assessment of how likely it is that the individual will respond to this process - ie their treatability. For therapeutic intervention (rather than skills teaching) to be successful, the following factors should be considered:

- Is the parent able to acknowledge that care-taking problems have occurred?
- Does the parent demonstrate at least partial ownership of his/her contribution to the problems?
- Does the parent appear internally motivated to work on his/her problems (ie that parent him/herself wishes to engage in therapy rather than being instructed by an external party)?
- Can the parent see professionals as potential sources of help, even though relationships with some professionals may have been strained during the Assessment process?
- Has there been any diagnosis of final psychiatric disorder which would have implications for type of treatment and likely progress?

8.1.12 Relationships with Significant Others

Power dynamics within partnerships can be explored - research recognises that marriages between more able men and women with Learning Disabilities are more common than the converse. Of course this does not necessarily mean that the relationship will be strained, but the more able partner can abuse power.

Where one parent has a Learning Disability, the partner's history, including any police record, can be critical. Particular risk has been identified where the parent with the Learning Disability is submissive and the partner has a history of psychopathy or violence.

When both parents have a Learning Disability, multiple difficulties may be apparent, but the parents are more likely to have formed a strong alliance against the injustices of the outside world. However, in some cases, this strong alliance can reinforce unhelpful attitudes/behaviours.

The maternal grandmother can emerge as an important figure in families where one or both parents need support. Positive family relationships can do much to provide emotional support lacking in the parental relationship and foster successful parenting. Difficulties relating to gaining autonomy in adolescence, however, can leave "fall out" in the adult daughter/mother relationship; the mother can remain a constant critic or rival.

Other mentors can emerge from the extended family or from friendship networks. It is necessary to explore the effect of support offered, answering the question - does this person enhance or inhibit parenting?

8.2 Expert reports

If it seems likely that legal proceedings will be undertaken, then you may wish to consider commissioning an expert report. Sometimes identifying an expert can be difficult, as professionals with relevant medico-legal experience can be scarce. It is now usual to employ a single expert under joint instructions – this has the advantage of limiting the number of interviews the family has to undertake, and avoids multiple expert opinion that occasionally confuses rather than clarifies the picture.

All professionals are obliged to report on their involvement with clients or patients as appropriate. The provision of medico-legal reports, however, is not obligatory and establishing relationships with interested and appropriately qualified professionals is an essential (although largely unrecognised) part of the Assessment process.

It is important to consider carefully the expertise required and particular care should be taken before employing more than one expert, as there may be an overlap in expertise.

If you are not familiar with the individual expert's work, it can be useful to discuss with him or her the kinds of questions you are likely to be asking and whether the expert feels able to cover these points in the ensuing instructions.

The following paragraphs summarise the main expert roles and opinions available. These are general summaries only, and individual professionals may well have specific areas of expertise or interest.

Child Psychiatry

Child Psychiatrists will consider diagnosis of biological, genetic or mental health problems. They will comment on the treatment management and prognosis for children with these problems. Child Psychiatrists can also advise on the likely outcomes of particular parenting styles, and also the likely effect of parental difficulties on children, for example, substance misuse, mental illness.

Psychiatry (Learning Disability)

Psychiatrists in Learning Disabilities (sometimes use the title Psychiatrist in Developmental Disability.) will comment on specific disorders associated with Learning Disability and the potential effect on parenting. Issues connected with

dual diagnosis i.e. Learning Disability and mental health problems; therapeutic interventions; management and potential outcome can also be discussed.

Learning Disability consultants with a particular interest in forensic psychiatry can comment on inter-personal aggression and a history of sexual abuse or offending.

General Adult Psychiatry

Adult psychiatrists do not usually offer a direct Assessment of the adult's ability to parent (this is the province of the Child Psychiatrist). They will comment on the diagnosis, treatment and likely outcome of mental illness and personality disorder as well as providing an overall view of how any diagnosed disorder is likely to affect parenting behaviour and the ability of the parent to look after a child.

Addiction Psychiatrist

As with general adult psychiatrists, Addiction Psychiatrists do not usually offer Family Assessments or an Assessment of parenting skills. They are general adult psychiatrists with additional training and expertise in substance abuse. They can offer comment on problematic (or otherwise) substance use, any interaction with other diagnosed problems, for example mental health difficulties, likely treatment regimes and related outcome and the potential affect of particular patterns of substance use on parenting behaviour.

Forensic psychiatry

Again Forensic Psychiatrists will not offer Assessments of parenting skills. They are trained specifically and separately from adult psychiatrists in forensic psychiatry. Their areas of expertise include Risk Assessment, serious mental illness and working within the criminal justice system. Comment on diagnosis, treatment and likely outcomes in these areas can be expected along with consideration of how any specific conditions will affect parenting abilities.

Paediatrics

Paediatricians consider all aspects of a child's general developmental progress and can comment on the effect of this on their health. Paediatricians can also consider the emotional consequences of harm as well as the effects of all forms of abuse both in the short and long term.

Information, Assessment, diagnosis and recommendations are based on history, health information, such as hospital admissions and childhood illnesses, from all sources available.

Clinical Psychologists (Children)

The Clinical Psychologist who specialises in working with children will comment on development, behaviour and Assessment, including psychometric Assessment. They can comment on developmental delay (including cognitive Assessment); emotional and behavioural problems (including conduct disorders); parent/child relationships (including attachment and bonding), young offenders and Assessment of overall need.

Clinical Psychologist (Learning Disability)

Working arrangements differ across areas, so that some clinical psychology services will accept referrals of children as well as adults. In other areas, separate 'Children With Disabilities' services exist, or alternatively Children with Learning Disabilities are covered by general Children's Services.

Clinical Psychologists in Learning Disability will comment on the degree of Learning Disability, any associated conditions and the overall likely effect this will have on the family. Specific cognitive difficulties such as memory problems and poor literacy can be commented on, as well as a range of psychological problems such as: Post Traumatic Stress Disorder; bereavement; attachment; risky behaviour and vulnerability to exploitation. Treatment needs and prognosis can be summarised and fitness to plead assessed.

Forensic Clinical Psychology

Will comment on, or undertake a Risk Assessment of a range of offending behaviours (including fire setting, sex offending and aggression and violence); use Psychometric Assessment when this is indicated. They will also make treatment recommendations and comment on prognosis.

Clients with a forensic history and Learning Disability are usually referred to the Learning Disability Service.

Clinical Neuropsychology

Neuropsychology is a study of the way the brain works and how damage (eg road traffic accident) can interrupt normal functioning in specific ways. Complex Assessment may require someone with particular expertise in this area.

Most Child Psychologists will undertake some neuropsychological Assessments. However, in complex cases, specific expertise in this area can be sought. This will be indicated in their CV.

Counselling Psychology

Counselling Psychology is a relatively new profession. Increasing numbers of Counselling Psychologists are employed in the NHS or undertake private practice. Counselling Psychologists are skilled in offering a range of psychological therapies and are able to offer insight into options and evaluations in this area. Many also have areas of special interest or expertise (e.g. Learning Disabilities, the effects of childhood sexual abuse, post traumatic stress disorder, relationship breakdown, eating disorders etc). There are areas of overlap with clinical psychology, and Counselling Psychologists are often employed within Departments of Clinical Psychology.

Educational Psychologists

Educational Psychologists will comment on educational issues: the psychology of teaching and learning, and advising on situations where children are failing to learn effectively or where behaviour difficulties impede progress.

Reports in care proceedings from educational psychologists will focus on:

A child's progress in school; a child's educational needs, if changes in school placement are required; concern about behaviour in the school setting and fears and anxieties or emotional disturbance, which compromise educational progress.

CHAPTER 9

DRAWING CONCLUSIONS

9.1 Beginning the Analysis

Now all the information has been gathered, with perhaps some interview material, completed questionnaires and observation data. The next job is to make sense of the information and assess the risk. This needs to be done systematically with research used as evidence.

You are likely to have a great deal of material, so analyse each section separately and bring the main points of these analyses together in a conclusion with recommendations.

The checklists can be used to organise the information that has been gathered. We need to consider the response to each set of questions that has been asked and the effect the response has on the child's development. What we are trying to determine is whether the care afforded a particular child will promote their welfare or protect them from harm. If we link each piece of information to the child's development, then this will evidence how a child's welfare will be promoted or how they will be protected from harm. This is a time-consuming section of the Assessment: in order to complete the work to a good standard, clear enough space in your timetable.

9.2 Expert Opinions

Expert opinions are submitted at different stages of the Assessment. The social work analysis must be kept up to date with the expert views. Ideally, read reports as they come in, and consider how the views expressed affect your conclusions. If it seems that major differences of opinion are likely to occur, then a meeting of the professionals, with face to face discussion of the relevant issues, can be helpful. Remember that any informal discussions with an appointed expert must be noted, and a copy of the substance of the discussion distributed to the other parties.

9.3 Drawing Conclusions

9.3.1. Assessment of the parent

When evaluating the information you have gathered, ask the question "and the impact on the child is …….?" Write this down with comment and professional opinion and make sure you are up to date with the relevant research (use it where appropriate). Your report should include consideration of the following:

- the ability to change behaviour or acquire new skills.
- whether changes can occur within the child's timescale.
- the person's presentation throughout the interviews and make comment. Were they co-operative, did they show any level of understanding into their problems or did they lack insight? Was there any level of aggression? If so, what risk to children do they present?
- were any sessions difficult? If so, why?
- levels of co-operation and whether this was different in this Assessment from other Assessments.
- the person's usual range of behaviour.
- the main effect of the Learning Disability and the parents' behaviour
- what this means with respect to their ability to manage relationships and care for children, including any Child Protection concerns
- significant issues in regard to violence or aggression and the impact this has on the child.
- the person's self esteem.
- how the person manages in the community.
- the person's relationships (both current and historical).
- issues from the parent's childhood.
- their role models.
- their education.
- the extent to which their needs were met as children.
- the positives they have brought from childhood. Are links made between this and present parenting patterns?
- attachment behaviour and how this affects everyday behaviour (child and parent).
- if the parent experienced significant harm as a child- how might this affect behaviour?
- the parent's experience of disciplinary methods (punitive, positive, non existent).
- how the parenting the adult received affects them as adults. How is this expressed?
- whether the parent's expectations of childhood are realistic
- whether the parent has sufficient understanding of the child's overall needs, both now and in the future
- is the parent able to meet these needs?
- the parent's understanding of hazards - is this sufficient?
- the parent's ability to meet the child's emotional needs.
- the strengths and deficits in the adult's parenting style (a detailed description, with example).
- whether there is anything within the parenting capacity that would leave the child at risk of significant harm or their welfare jeopardised.

- specific difficulties in acquiring information (usually related to the Learning Disability) such as poor memory, literacy skills, understanding of language.
- Can the parents change behaviours or learn new ones within the child's timescales?
- Does the parent accept responsibility for the concerns that have been raised?
- Can the parents recognise the strengths in the parenting style?
- What capacity do they have to change?
- What desire do they have to change?
- is the couple's relationship conducive to change (in the case of an established relationship)?
- Are there appropriate local services available to support change?
- Are there long-term supportive measures that can be put in place? It is important to try and predict the future and what behaviours, skills and strengths will be needed in the future.
- What support systems exist within the family or neighbourhood?
- Is the family likely to accept support?
- Is the family, with support, able to care for this child?
- Describe the services that will assist, the expected outcome and how change will be measured, monitored and maintained.

9.3.2 Assessment of the Child

In this section focus on the child's or children's needs and how they will be met

Use the welfare checklist for your basic framework, and summarise:

- the age, sex and background of each child
- the ascertainable wishes and feeling of the child
- the physical and emotional needs
- the likely effect of any change
- any harm they have suffered or are likely to suffer

Then, more detailed information should be included, for example:

- if the child has been harmed in any way, describe the harm and the associated risks as well as what would need to happen for these risks to be lowered
- comment on whether this child likely to be harmed again
- what is seen as protective behaviour
- describe the appropriateness of the child's daily routine

- is the child seen as difficult to look after?

- is this child perceived as different i.e. gender, paternity, personality, difficulty?
- does the child/ren have a positive relationship with an adult?
- is there a consistent appropriate environment?
- is there good enough physical care?
- is there appropriate use of boundaries and control?
- is there evidence of emotional warmth?
- is the child securely attached to the parent?
- does the child present particular difficulties the adult does not recognise?
- does the adult prioritise the child's needs over their own?
- does the adult have the necessary skills and abilities to parent this child?
- is there anyone to compensate for any areas of weakness?
- describe any financial issues that impact on the welfare of the child
- describe any relationship difficulties
- are the child's physical and developmental needs being met?
- is the child meeting his/her developmental milestones? If not, why not? Is this attributable to the care they receive? If so, describe what evidence you have to support this.
- describe the child's environment, their bedroom and their clothing
- describe stimulation and availability of toys and outside stimuli i.e. nursery
- describe speech and language (the child's as well as his/her opportunities for language stimulation)
- does the child display any behaviours that would give rise to concern?

Finally, consider carefully:

- what arrangements will best serve the interests of this child?

These lists are not exhaustive. Thought needs to be given to the meaning of information gathered, and its significance for the child in question. The analysis is the most testing part of the Assessment. Seek appropriate supervision, use the skills of other, more experienced team members and discuss the conclusions and recommendations in depth before finalising your report. A good analysis, conclusion and plan can only be achieved if a clearly defined process has been undertaken. Working with families where one or both parents have a Learning Disability is complex. This complexity means that time must be allocated for a thorough Assessment with valid and helpful conclusions. Only a good, thorough and accurate Assessment will allow us to offer appropriate support to families and help promote the welfare of children.

PART 3 POSITIVE INTERVENTIONS WITH CHILDREN AND FAMILIES

CHAPTER 10

TEACHING AND LEARNING

We have already discussed how people with Learning Disabilities have often experienced failure in their lives. This is particularly true when we come to any teaching or learning situation. Many parents will have found their formal education at school at the very least challenging, and it may have put them off any formal learning solutions for life. However, all parents, whether they have Learning Disabilities or not, have to learn a whole new range of skills: they may have to unlearn old fashioned or inappropriate methods, and as the child keeps on growing, the application of these skills changes.

Specific strategies for teaching skills to people who have a variety of learning problems are well established. These include breaking down tasks into steps, or task analysis, use of positive feedback, errorless learning and use of recording. Providing conditions conducive to learning is in some ways at least as important as the techniques themselves. This can sometimes be difficult in a busy family home.

10.1 Setting conditions for teaching

Four conditions are important for learning. These are:

- **Accurate Assessment** i.e. having a good idea of your starting point and at least an outline of the skills and abilities of each parent. This will include literacy skills and any particular memory problems.
- **Freedom from distractions** – as far as possible creating a learning environment where the parent can concentrate on what is being taught. Some negotiation may have to take place within the family to provide these conditions, for example, an agreement that families and friends will not be allowed to drop in during the session time.
- **A positive attitude** – this refers to the attitude of both the parents and those providing any support or teaching. Parents, it must be remembered, may well have a negative attitude to any formal learning situation and some ingenuity by those setting up the teaching situation may be required.
- **Clear and accurate goals** – parents are often unclear about what is expected of them. Developing clear and accurate goals enables everyone concerned to understand what is expected and also allows definition of when a task has been achieved as the goal is reached.

- ♦ Goals must be both achievable and meaningful for the parents. Constant changing of goals can be confusing and demotivating. If new goals are necessary, they must be re-negotiated and clarified with the parent.

10.2 Planning

A range of well established teaching methods are available to ensure that information is communicated in a methodical and understandable way.

Understanding how individuals learn and acquire new information and how to measure and assess learning outcome plays an important role in any teaching process.

Planning is needed for the context of social work intervention and workers need to think about:

- What skills are needed for the parent to acquire "good enough parenting"?
- How will this information be broken down for the individual so they can understand it (i.e. on paper, visual, practical, observational)?
- How long should sessions last and what is the frequency and duration of such meetings?
- What type of work should be set between each session to facilitate self-learning?
- When should the sessions end and the Assessment of good enough parenting be concluded?

10.3 Motivation to learn

In the statutory context, the "Learning Contract" between Social Worker and client is not the same as a person in college or work where the goal of study/training is a certificate.

The end goal in a statutory relationship represents the joint and negotiated aims of parents, Social Worker and allied professionals. This end goal is achieved through careful and thorough Assessment and intervention where indicated. At the end of this process, good enough parenting is demonstrated.

Motivating people to understand situations and learn the information presented to them, presents a difficult task for people teaching skills to those with Learning Disabilities.

Rogers (1996) describes three types of adult learning situations:

Learning orientated – where the individual is interested in a subject and is wishing to continue this process. Most clients will not fit into this category as the intervention from Statutory Agencies arises from external concerns raised around their parenting skills.

Activity Orientated – where the individual attends a programme because it meets a range of needs that are mainly personal growth. Again, personal desire to change plays an important role in understanding and acquiring of skills and learning.

The social work intervention with parents is most likely to be described as **Goal orientated.**

Orientation	**Intentions**	**Learning process**	**Continuation at end of programme?**
Goal orientated: end product.	Achievement: problem solving/attainment	Learning most in certain specific areas	Process ceases on successful Assessment of parenting ability; or Assessment of "not good enough" parenting.

In this sense a Social Worker would assess the strengths and deficits in parenting and consider, in the analysis of this information, how best to achieve the desired outcome or goal, the intention being to engage the parent in an individually tailored programme that will focus on problem solving. This method relies upon motivation, and an ability to learn in specific areas. The learning is reviewed and the child's developmental need reassessed taking account of the newly established teaching. This should help evidence successful learning or a re-appraisal of the desired outcome.

This model can work equally well with People With Learning Disabilities. However, it needs to take account of the difficulties that this group has with generalisation and developmental new situations given the ever-changing needs of children.

10. 4 Teaching skills

In order to teach new skills, or alternative skills to parents, the workers will need to understand how the individual learns best. This will involve an Assessment of the person's capacity to understand information and how he or she can be supported in the process of acquiring new skills, asking:

- Does the parent have the skills I am assuming?(e.g. reading)

- Does the parent understand what I am saying? (use of verbal concepts).

If the parent does not have the above skills, how can you present information that is understandable – do you need to make use of Makaton, use of pictures, photos in presenting information?

10.5 Task analysis

This is probably one of the best-known techniques and involves breaking each target down into small steps that are then taught in a planned, sequential way. As the number of steps varies for the same target, according to the needs of the individual, the way the task is taught can be tailored to different people's learning needs.

There are many different ways to break down a task into steps and there is no "right" way. It is important that everybody concerned should agree on the basic way the task is to be performed. For example, when teaching a mother to use a steriliser, it emerged that between the parents, her parents and professional workers, there were many different ways in which a steriliser could be used; each person tends to assume their method to be the only one! Therefore a task analysis approach should look something like this

1. Identify how the overall task is to be taught
2. Identify an end goal
3. Identify one or more targets part way through the task – this would depend on how lengthy the task is.
4. Fill in the task analysis with sub-steps, work through the task yourself and place them in logical sequence.

There are three main methods of teaching sequences based on task analysis, **chaining, shaping and fading**, although in practice they are often combined.

10.5.1 Chains

When we sit by a parent encouraging and praising them at each stage, we are in a way, using step by step rewards. However, at some point the parent has to discover the importance of completing the whole sequence. This will be understood more easily if we reward increasingly large "chains" for each act. First one step, then two together, then three etc.

In chaining, the task is broken down in precise actions and the steps are ordered. The task is then usually taught by starting with the last step first. Backward chaining is often used in preference to forward chaining as it ensures the individual completes the task and this success in itself can provide further motivation.

For example, using backward chaining to help a parent teach their child to dress:

Step 1 **:** Choose a task eg putting on a jumper

Step 2 **:** Break the task down –

1. Put the jumper on the child, giving help with head and sleeves, leaving the child to pull the jumper down, with lots of praise.
2. Put the jumper on the child giving help with head, one sleeve and beginning the next sleeve, leaving him to push his arm in and pull the jumper down. Praise.
3. Put the jumper on the child, giving help with head, one sleeve and encourage the child to put the other arm in and pull the jumper down. Praise ……and so on.

Backward chaining is particularly useful for teaching self care skills such as washing, teeth cleaning and dressing. Steps are as big or as small as you want them to be and geared to the individual's progress.

10.5.2. Shaping

In shaping, the whole task is broken down into steps so that each step represents something a little closer to the final skill. For example:

In working with a parent who is trying not to shout and swear at his or her child, you might accompany the parent and child on a trip to the local playground. The parent then deals with the child by shouting a bit and swearing only once. You could say something like "I can see you're trying really hard to do what we said earlier – that's brilliant". Next time you would talk to the parent about building on this and praise an even better attempt as "great" whilst remaining neutral about a return to normal behaviour; "today seemed hard – let's try again tomorrow". This continues until you reach and stay at the identified goal.

10.5.3 Fading

Fading refers to the amount of assistance or prompting which is reduced at each step until the final step involves completion of the task unassisted. The assistance can be physical, gestural or verbal prompts. These, used simultaneously, can result in confusion, as the individual may not be able to attend to them all at once. The timing of when to fade out the prompts is crucial to ensure that the individual does not become too dependent on them.

Delayed prompting can also be used where the assistance or cue is delayed until the individual has had the opportunity to respond appropriately.

10.6 Errorless learning

Errorless learning is a teaching procedure that does not allow the individual to make mistakes. It is based on the assumption that success can provide powerful motivation in itself. More recent research on memory has also shown that if the right memory traces are laid from the start then learning is likely to be quicker and more reliable. Errorless learning is a technique which people often use intuitively but it can be less commonly used in a planned and systematic fashion. In errorless learning the task is organised such that mistakes cannot be made. This involves planning and setting up tasks involved for example.

10.7 Positive feedback

Positive feedback can take many forms: for example, praise, empathy, or a hug. Achievement of a task has its own intrinsic rewards. When you are telling somebody how well you think they have done, it is important that they recognise in your tone of voice and non-verbal communication that this is positive. Muttering the word “good” can be missed, ignored or simply seen as confusing communication. It is likely that, if your relationship with parents is positive, you will be nearly as pleased as they are with achievement and your genuine enthusiasm will show through your actions. Some parents are so unused to being praised or told that they are doing the right thing, they may take time to recognise and respond to this kind of praise.

If parents are not responding to your positive comments as you hoped, then it is worth taking time out to discuss how they feel about praise and positive feedback. It may be that you have to tone down your response while they get used to the new idea of feeling valued and positive about themselves.

Praise for achievements the parent does not value will appear condescending and is unlikely to motivate the parent further.

10.8 Checks to make

Think carefully about any teaching plans - make sure you are being practical and consistent. It may be helpful to ask the following questions:

- Will I need to break the task down into little steps?
- What are the steps?
- Are they small enough and easy enough?
- How can I write the steps down so that it’s easier to remember?
- What can I do if the parent cannot manage the first or last step, even if I have broken down the steps? Maybe the step is too big, maybe he needs me to lead him through it again.
- How am I going to make teaching this task attractive to parents? How am I going to motivate them?

- What shall I count as success? In other words, when am I going to praise? Does the action have to be absolutely perfect?
- Is anything likely to get in the way of the message being clear?
- Knowing myself and the relationship I have with the parent, what are the kind of mistakes I am likely to make in making my messages clear?
- Where and when am I going to carry out my teaching? Why, when, how often?
- Is this something I really feel I can handle or does anything about it worry me?
- Who else needs to be involved in the teaching? Do they understand and agree with the way I am doing it?
- Who could I get to watch me to check that this is happening as I intend it to?
- How am I going to keep notes of my work (make it simple!)?

10.9 Memory

Memory problems are often associated with Learning Disabilities. You will need to design your work with parents so that there are built in strategies to aid memory, and consider the following:

- Decide a joint agenda for teaching to keep motivation high
- Use clear, simple language
- Keep instructions short
- Break down long tasks into small steps
- Be aware that memory is affected by emotional state
- Provide a calm teaching environment and try not to introduce emotive topics
- Ensure you have the parent's attention and encourage concentration by providing a quiet environment
- Use a system of prompts – this could be pictorial, ticks or crosses, or written or visual e.g. video depending on the parent's skills and interests.
- Teach the same task in the same way – liaise with other staff eg health visitors to ensure this.
- Teaching in the parent's own environment is most helpful – the cooker at the Family Centre may not be the same as the one at home!
- Use repetition and role play to get ideas across
- Check that the parent has understood what you have been saying – for example you might ask him to talk you through the various steps you have been discussing.
- Consider the frequency of and intervals between sessions. If you have long gaps, you will need to start with a recap and you must expect that things will be forgotten.

10.10 Contracts and Charts

Contracts and Charts provide useful feedback and also work as memory aids. You can also encourage parents to praise themselves (or each other) on successful completion of a contract/chart.

Contracts

For example:

Kevin had many parenting skills but lacked motivation. This caused problems within the family and led to friction between himself and his partner.

A contract was used to enable Kevin to see the tasks he was being asked to do, to remind him to complete the tasks and to involve the other members of the family.

Contract of Responsibility

For: **Kevin Smith**

Date **1.1.00**

Aims

For Kevin to use his cooking skills and give Tina a break

Agreement

1. On Tuesday, Thursday and Saturday mornings Kevin will decide with Tina the meals he will cook that day.

2. They will then go to the local shop and buy any food needed together.

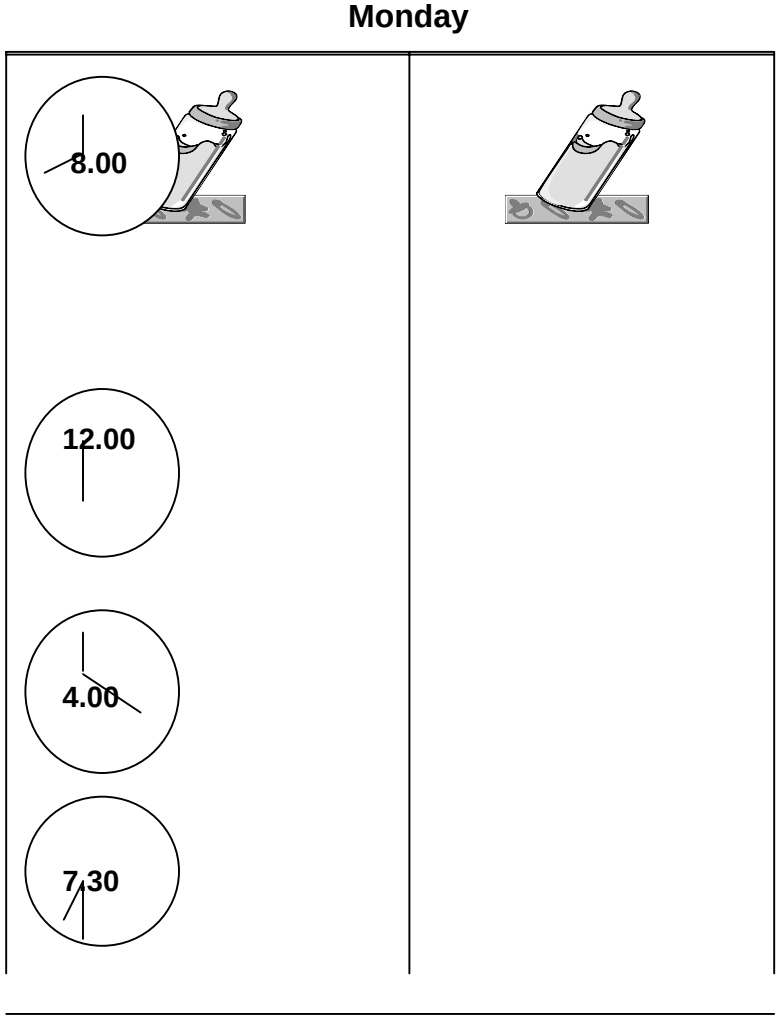
3. Kevin will cook the evening meal on those days. The boys will wash up.

Agreement signed ……

Review date **……**

Charts

Tina had difficulty remembering whether she had fed her baby. A tick chart was fixed to the fridge each day as follows:



Tina ticked the chart after each feed, and she was able to show the Health Visitor how much the baby had drunk each time.

Use of Video

Couples can record their contracts on video to play to each other and themselves. This is a more interesting way to make a contract but can also be used as a reminder later!

Video footage can also be used to give feedback about successful parenting. This also creates opportunities for praise and discussion of further activities or goals.

CHAPTER 11

PLAY AND WORKING THROUGH PLAY

11.1 The importance of play

Play is recognised as an integral part of children's lives. In the child's development, play is the natural mode of learning and interacting with others. Through play, the child attempts to understand the rules and regulations of the adult world and transforms reality through developing symbolic representations of that world. The child also learns how to regulate anxiety by being provided with opportunities to role-play and explore early emotional behaviour.

In the dysfunctional family, play can be used to rebuild the child and parent's sense of self worth and strengthen relationships. Both the child and parent may need to learn the purpose and function of play and the breadth and diversity of possible play behaviours.

Abused and neglected children's play behaviours have been studied by many researchers from various theoretical orientations, including behavioural, psychodynamic, neurological, cognitive development and family systems. These studies have contributed to identifying seven characteristic behaviours exhibited by a maltreated child during play. These include the following:

i) developmental immaturity
ii) opposition and aggression
iii) withdrawal and passivity
iv) self-deprecation and self-destruction
v) hypervigilance
vi) sexualised behaviour
vii) dissociation

11.2 Formal therapy and play

Therapeutic work with families does not necessarily include play. However Keith and Whitaker (1981) argue that "….families change less and more slowly when children are not part of the therapy process", and Gil (1994) says "when play is included in family sessions, clinicians treat children as equally important family members, with valuable information to provide and to assimilate".

The use of stories and mutual storytelling, role-play, drawings, puppets, drama, writing, sand play, clay and other forms of creative and expressive arts are all useful forms of helping families break the mould of silence. Children need confirmation that they are contributing members of the family and by so doing they are engaged in the process of addressing the issues in family therapy.

Whilst most family therapists do engage as many family members as possible, it is, of course, recognised that there are times when it is not practical or safe to include everyone. Good judgement and fairness need always be considered when formulating a therapeutic plan but it is important that therapy should be inclusive or exclusive for the right reasons.

The systemic orientation of family therapy implies, if not necessitates, that all members of the family be included in the therapeutic process. Several of the early family therapists incorporated play. Satir, Minuchin and Haley also emphasised the significance of play in their work with families. Clearly, communication with young children is unique and many family therapists are unprepared effectively to interact or feel comfortable with this age group. The systemic focus of family therapy is reason enough to warrant the use of play in this context. Because for most children, especially the young, play is their primary form of communication, overlooking the modality reduces the systemic nature of family therapy.

According to Gil (1994) "when clinicians exclude children, part of the family system remains unengaged". The reason to focus on children's play is simple. Play is the child's medium of communication, hence is replete with opportunities for gaining a deeper understanding of a child and his/her family". She goes on to say that "children can communicate on many more dimensions than adults, hence clinicians can benefit greatly from observing, listening and decoding their myriad communications". In 1961, according to Gil (1994), Ginott referred to play as a way of talking in which toys are the child's words. Play provides the "adult a window through which to observe the child's world".

11.3 Play and therapeutic intervention

However, asking a child to play is not a sufficient therapeutic request, for play in itself will not likely produce change. How the therapist intervenes and uses the play is significant. As noted in Gil (1994), Schaefer (1993) identifies seven general characteristics of play:

i) play is characterised by internal versus external motivation
ii) the child is more concerned about the play activity itself than the outcome or successful completion of the activity
iii) positive feelings accompany play
iv) the child is actively involved and often becomes so engrossed in play as to lose awareness of his/her time and surroundings
v) play has an "as if" or non-literal quality
vi) play gives the child freedom to impose novel meanings on objects and events
vii) play is different from exploratory behaviour……it tries to answer the question, "What can I do with this object?"

Schaefer also discusses the "curative properties of play" through a conceptualisation of therapeutic factors including "overcoming resistance, communication, mastery, creative thinking, abreaction, role-play (an advanced form of pretend play), fantasy, metaphoric teaching, attachment formation, relationship enhancement, enjoyment, mastering developmental play, and game playing. For example, group drawings or a family sand tray, may determine how members of the family interact and negotiate their place (Gil 1994).

11.4 Learning how to play

Often, because of early life experiences, or simply forgetting the process, adults have to relearn how to play, and particularly how to play with the children in their presence. There are models such as **filial therapy** (Guerney 1997), **theraplay** (Jerberg and Booth 1999), and **floor time** (Greenspan 1992) that help parents interact on a level with their children that engages the child in activities that are more conducive to their methods of communicating.

11.4.1 Filial Play

VanFleet, Lilly and Kaduson (1999) describe filial play as "…..a psycho-educational intervention in which the therapist trains and supervises parents to hold special child-centred play sessions with their own children, thereby engaging them as partners in the therapeutic process, empowering them to be the primary change agents of their own children". They also note that "after a passive, helpless experience of trauma, children have a compelling need to rework actively the dramatic elements of the trauma in their play". Change occurs as the parents learn new skills, gain a greater understanding of their children through their play, and are motivated to resolve some of their own issues when they are triggered through the play sessions.

11.4.2 Theraplay

Theraplay (Jernberg and Booth 1999) is another form of engaging parents in play with their children but is more directive than filial therapy. The parents first observe the therapist with the child and then become co-therapists in the process. There are four dimensions in theraplay:

i) Structure
ii) Engagement
iii) Nurturing
iv) Challenge

According to Jernberg and Booth (1999), "The goal of treatment is to enhance attachment, self-esteem, trust and joyful engagement and to empower parents to continue on their own health-promoting interactions learned during the treatment sessions".

11.4.3 Floor time

Another approach to encouraging parents to engage their children in play is called floor time. Greenspan (1992) states that the goal of floor time is "to enable children to form a sense of their own personhood -–a sense of themselves as intentional, interactive individuals". Again the parents are asked to follow the child's lead in play but are more active in the process than in filial therapy.

11.5 Parents with a Learning Disability and play

When one, or both parents have a Learning Disability, the family system experiences significantly more stress and conflict than is usual. Parents with a Learning Disability tend to adapt more negative parenting styles, be restrictive and inflexible rather than enabling and adaptable and are at increased risk from experiencing depression and anxiety.

Parents with a Learning Disability can show a limited range of play behaviours. This may be for a number of reasons. Parents coming from an emotionally deprived background may themselves have experienced few opportunities to play and experience a wide range of stimulation. Poor opportunities for play linked with a Learning Disability mean that the child is less likely to explore and discover play in the absence of adult guidance. When this child becomes a parent therefore, his other internal working models about the need for play and how it might be encouraged are limited.

A core feature of play, particularly social play, is creativity and imagination. As we know parents with a Learning Disability find it difficult to think tangentially, their ability to create play situations may be limited. Parents may expect that providing a toy is sufficient to ensure play. They will need to be shown different ways of using a particular toy to encourage play, and be prompted to follow the child's lead. It is important to establish there is no "proper" way of using a particular toy, although safety concerns should be discussed.

Play can be messy and create extra work for the supervising parent. When a parent has a Learning Disability, clearing up after an untidy play session can seem to be an overwhelming or discouraging task. Although a wide range of stimulation should be encouraged, and a certain amount of messiness and clearing up tolerated, it may be best to leave very messy games, such as finger painting, to a an alternative setting, for example, playgroup, or confine games such as water play to the bathroom where clearing up is much easier.

Some parents, particularly those who have low self esteem or social anxiety, may feel uncomfortable about talking to, singing to, or playing with their baby or child. They may feel embarrassed and shy or feel that by playing they are themselves being childish and inappropriate. Here a trusting open relationship between the person discussing play and the parent is important. Modelling appropriate play

behaviour and play alongside the parent, showing that you don't mind being silly/embarrassed, is helpful.

The family culture to which the parent belongs may be one that actively discourages play. Here the attitude of the grandparents, particularly the maternal grandmother, as she may have either a particularly positive or negative influence on the family is an important consideration. Discussing the role of play and emphasising the child's enjoyment, together with the opportunities for learning and exploration can be helpful here. Providing role models through groups and friendships will help demonstrate how other parents play with their children.

As parents with a Learning Disability may have inaccurate or inappropriate expectations of their children, they may expect a very young child to play on his own, and quietly, for quite some time. Appropriate expectations with respect to play are important from the point of view of complexity, toys and concentration.

As we have noted before, parents with a Learning Disability are more likely to be on benefits or have low income and live in a physically poor wider environment. Helping the parent to identify safe playgrounds, appropriate play groups, toy libraries and where it is and is not safe for a child to play are important pieces of work to be undertaken. If there is a garden it should be secure and safe and parents can be encouraged to contact landlords to overhaul fencing and clear rubbish.

11.6 Play without bought toys

Toys help, but often the most interesting kind of play comes from parents simply being there and using what environment provides.

11.7 Lap play

This is particularly important for the younger child, and simply involves establishing a variety of methods of one to one communication between the parent and child. The child may be on the parent's lap or cuddled up close. Pointing, making faces, looking through a catalogue are all good ways of communicating. Action games are good because both the words and the actions become familiar and remind the child or each other. Action rhymes also give the child a sense of anticipation and sequence. The child feels "I know what's coming next" and gains a sense of control. Finger games encourage ability to concentrate on a series of actions and encourage fine motor skills and eye co-ordination.

Turn taking and talking games for example, with a toilet roll tube doubling up as a telephone, are good for older children.

11.8 Bath and water play

Baths and water form a part of everyday life for babies and young children and, as well as keeping clean, provide good opportunities for play. It is important that the child feels safe and secure at bath time and play should always be gentle. Squeezy bottles and empty kitchen containers (washed out of course) make free toys in the bath. For the older child plastic straws are also fun.

Outside of bath time, water play can still be a separate play opportunity using either the bath as a safe container for easy cleaning or buckets of warmed water outside in the summer. Safety is particularly important during water play sessions and a parent must ensure that the child is fully supervised.

11.9 Free play

The need for play using gross motor skills, walking, running, jumping, is often underestimated, particularly for the active child. The balance between allowing this play and maintaining a safe environment for the child can be difficult to achieve but should be on the agenda. If there is no garden, identify safe places for free play (parks etc) and work at some rules (e.g. stand well away from the swings).

CHAPTER 12

ATTACHMENT

12.1 Attachment Theory

Attachment theory has been a powerful influence on child psychiatry, psychotherapy, and psychotherapy research. Bowlby (1988) first suggested that attachment to others has an ethnological basis, producing behaviours that are driven by a need for relationships rather than food or sex. Attachment behaviours have an important function in bringing infants into close proximity to their main carers. "Proximity" here refers to psychological closeness. Three types of attachment behaviour, although expressed in a variety of ways with different people, can nevertheless be recognised throughout life. When people want emotional closeness or experience distress, they will either:

- Behave in a socially appealing manner
- Send out distress signals designed to invite attention and concern
- Actively approach and seek out others for the things that they believe close relationships could or should provide

This attachment, or proximity seeking, behaviour has obvious benefits for the child – protection from danger, the supply of food or social interaction. Bowlby proposed that attachment behaviours increased in response to anxiety, thereby acting as a kind of homeostatic mechanism for modulating this emotion.

Any attachment figure can modulate anxiety in a number of ways: by acting as an emotional container, by providing information, and by providing consistent input. With emotional (or effective) containment, the primary caregiver helps the baby to develop a capacity to think and tolerate anxiety by using her own mental processes to tolerate, understand and negotiate the baby's experience of the world and themselves. In this way, the baby's anxiety and distress is reduced and they are able to experience safety and predictability.

Children who experience continuous, regular or high levels of anxiety, for whatever reason, will have less time and energy to explore. The suppression of exploratory behaviour is likely to have adverse developmental consequences, as exploration is a fundamental part of the learning process. Where exploratory behaviour is inhibited, the child has fewer opportunities to learn how their environment works: this in turn suppresses cognitive development.

In psychological terms, secure attachment relationships allow the developing individual to construct 'internal working models' of himself and others, based on the interaction between himself and the attachment figure. These models

provide a framework for cognitive processing of perceptions, events and relationships, and the development of belief systems and cognitive schemata. As the child grows, these internal working models interact with their experience. During early childhood, internal models are flexible and are modified by experience later; repeated experiences make internal models more stable – they then become internal cognitive structures. A range of early experiences, therefore, is likely to affect the formation of internal working models.

12.2 Attachment Patterns

The nature and quality of attachment has been studied in infants by looking at their behaviour in an unfamiliar situation. Overall maternal sensitivity is defined by Ainsworth as the mother's ability and willingness to try to understand behaviours and emotions from her baby's point of view. Parents who are insensitive, rejecting, interfering or emotionally unavailable present their children with a psychological problem and they attempt to deal with this by developing an appropriate strategy that reflects the quality of the attachment relationship. The result is a limited number of distinct attachment patterns:

1. Self – (loved, effective, autonomous and competent) + other people (available, co-operative and dependable) = secure attachment patterns
2. Self - (unloved but self-reliant) + other people (rejecting and intrusive) = avoidant attachment patterns
3. Self - (low value, ineffective and dependent) + other people (neglecting, insensitive, unpredictable and unreliable) = ambivalent attachment patterns
4. Self – (confused and bad) + other people (frightening and unavailable) = disorganised attachment patterns

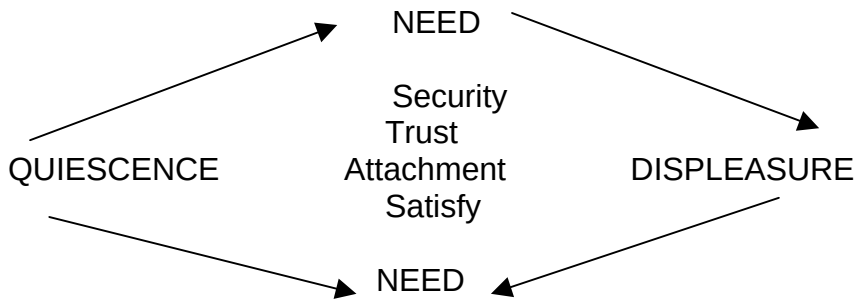
Clear examples of their attachment patterns only appear as distinct categories in extreme cases. It is far more likely that a mix of patterns and interactions will be observed, although a "typical" interaction style may be identifiable.

The presence of insecurity, fear and ambivalence in a child is not the same as identifying a consistent attachment pattern. It is also important to remember that having a secure attachment is not necessarily the only route to secure adulthood (but it does increase the chances). Many people cope with their emotional life in the context of insecure attachment. Attachment style is one factor that must be interpreted alongside other critical factors such as history, need and environment.

12.3 Reciprocal relationships

Fahlberg discusses the reciprocal relationship between a child and a caregiver. The adult's sensitivity and response to the child's signals reduces discomfort and

enables the child to develop trust, security and attachment. This is referred to as the 'arousal – relaxation cycle'.



[The arousal-relaxation cycle (Fahlberg 1994)].

From Fahlberg's model, the child's unmet needs create high levels of arousal. The child cannot then attend to its environment which, in turn, interferes with learning and development.

Bowlby (192) argued that children develop a sense of their own separateness only by having a secure base from which to explore their world. This sense of oneself as a separate entity is necessary for the child to be able to understand the perspective of other people, and so develop empathy.

In adults, security of attachment style has been assessed by analysis of memories of parenting, recalled in a semi-structured interview, for example, (Adult Attachment Interview (AAI); Main and Goldwyn, 1989). Three insecure attachment styles have been described: dismissing, preoccupied and unresolved following trauma or loss.

12.4 Long term implications of insecure attachment.

Could early insecurity of attachment be a risk factor, predisposing factor or causative agent of later psychiatric disorder? Most developmental researchers would argue for an interactional model of development. Rutter (1995) suggests that failure of early attachment may be a risk factor for later adult psychiatric disorders by interacting with other vulnerability and resilience factors to increase or decrease the risk of psychiatric disorder in adulthood.

Most research has been retrospective rather than prospective and has studied attachment histories in vulnerable subjects. For example, depression in adulthood is associated with the loss of an attachment figure in early life (Brown and Harris, 1978), and hostility from parents (Parker, 1983). Disturbances of attachment have been found in patients with major psychiatric illnesses, such as schizophrenia or manic-depressive illness (Dozier, 1990) and other disorders, such as pathological bereavement reactions (Parkes, 1991). A meta analysis

found that insecure attachments were over-represented in clinical populations (Van Ijzendoom and Bakermans Kranenburg, 1996).

12.5 Interventions

Attachment theory and research suggest that attachment behaviour can change in response to interpersonal experience (Fonagy at al, 1996).

Vulnerable children may be protected by contact with one consistent parenting figure, and the presence of a confiding relationship is a protection against depression (Brown and Harris, 1978). Treatment approaches that take account of attachment needs, behaviours and bonds are increasingly being used with clinical populations.

An example of a recent intervention in the 'Circle of Security' (Marvin, Cooper, Hoffman and Powell, 2002) which is a 20-week, group-based parent education and psychotherapy programme designed to shift maladaptive patterns of attachment-care-giving interactions in high-risk caregiver-child dyads. Based upon attachment theory, current research on early relationships, and object relations theory, caregivers are encouraged:

- To increase their sensitivity and appropriate responsiveness to the child's signals in relation to exploration and the need for comfort
- To increase their ability to reflect on their own and their child's behaviour, thoughts and feelings regarding their attachment-care-giving interactions
- To reflect on experiences in their own histories that affect their current care-giving patterns.

Early results from this group work suggest overall positive benefits for both parent and child.

12.6 Attachment theory and Learning Disabilities

Outcomes from studies on the formation of attachment in children with a Learning Disability are relevant to parents with Learning Disabilities because of the increased likelihood that their own attachment history was disrupted. Literature on adult attachment suggests that attachment styles can continue into adulthood and will have a long term affect on relationships including the parent/child relationship.

Many factors influence the attitude which parents develop towards their Learning Disabled child. These influences include:

- The severity of the infant's disability and the presence of additional life threatening impairments:
- The hopes and expectations of the parent;

- The way in which the news of the disability is broken, and the reception the infant receives from both professionals and the extended family. Initial rejection of an infant who has a Learning Disability is not uncommon and can be poorly handled by professionals.

Following the crisis of diagnosis, the characteristics of the child also play a role in the attachment cycle, in determining the threshold for discomfort, the child's ability to signal discomfort and how easily they are soothed. This places demands on the parent to be able to understand their child's communications and to have sufficient knowledge to meet these. When parents fail to respond appropriately in identifying and satisfying their children's needs, the arousal-relaxation cycle is disrupted. When this happens, Fahlberg argues that children have difficulty forming attachments to their caregivers. In extreme circumstances, the infant may stop expressing these altogether where these are not met.

Parents with Learning Disabilities therefore are more likely to have poor attachment relationships themselves together with a limited understanding of how to make and maintain a relationship with their child. In addition, parents with Learning Disabilities often have histories of experienced failure in a range of areas including academic, employment, financial and social. For people with such a history, there are implications for self-esteem and perceived self-efficacy. Where the parent's own history of attachment was insecure, the parent's interaction with the child, where the child responds positively to the parent, may be self-fulfilling as the parent begins to look to the child to meet his or her emotional needs.

Research suggests that "role reversal" can occur where parents with a poor history of attachment look to a child for emotional support. If such a role reversal occurs, it has implications for not only attachment but also discipline and meeting health needs.

Research dealing directly with the formation of attachments in children with Learning Disabled parents is scarce. Booth and Booth's (1998) qualitative interview study of 30 people who grew up with Learning Disabled parents found preliminary evidence that, like children with non-Learning Disabled parents, factors that promote resilience include characteristics of the child's personality, family characteristics and external supports. Personality based resilience factors reflected characteristics associated with secure attachments – sociability, responsiveness to others and an outgoing nature, a readiness to take on responsibility. Family factors were those that would be expected to foster secure attachments including expressed warmth and mutuality, stability and security. Factors from the wider social network, reflecting social interactions, were more likely to be achieved by people with reciprocal social relationships that reflect secure attachments, confidence and self esteem. Although Booth and Booth do not directly address the issue of attachments, they demonstrate that some

children who grow up with learning disabled parents are able to achieve secure attachments.

Crittenden (1996) concludes that children with parents who have Learning Disabilities appear at particularly increased risk of attachment problems, as levels of attunement and responsiveness between family members tends to be low. Parents can have limited understanding of their children's needs, particularly the need for stimulation and interaction. However, with age and increased mobility, some young children begin to react hyperactively in an attempt to provoke some kind of stimulation. Many others become apathetic and increasingly listless. Displays of heightened attachment behaviour including anger and emotional demands, only seem to make otherwise under involved care-givers feel more helpless and frustrated and even more likely to with draw from the relationship.

Research detailing therapeutic work primarily aimed at changing attachment behaviours, whether in the child or the adult, where the parent has a Learning Disability, is extremely limited. Group or individual project work tends to be "task orientated", perhaps because the immediate and obvious tasks of caring for a child need to be achieved.

LEARNING CURVES

CLOSING WORDS

The aim of this manual is to provide practitioners with basic practical and theoretical information relating to families where one or both parents have a Learning Disability. Its contents relate primarily to the Social Work Assessment process, highlighting the major issues: some ideas for follow up interventions are also included. The contents are not exhaustive, and for those interested in the field, further reading is recommended.

This work should be read in conjunction with a number of other documents:

- The Jigsaw protocol - an agreement between the agencies involved with families where one parent has a chronic illness or disability
- Valuing people (DoH 2001) - this explains the government's long term plans for services for people with a Learning Disability
- Assessing Children in Need and their Families (DoH 2000) - this explains the Department of Health structure for the Assessment of children in need and their families
- Every Child Matters (DoH 2004) - deals with the development of an integrated service for children to ensure a "brighter future".

The right of a person with a Learning Disability to experience family life and parenthood is well established. It is also accepted that a proportion of these parents will need support in order to fulfil their role as parents. Service provision in many areas, however, has not caught up with this philosophy - provision tends to be piecemeal and inconsistent with backup and training for staff erratic. This means that when problems occur, finding appropriately skilled support is not always easy. Often hard pressed services in a bid to reduce caseloads will actively exclude parents who have mild levels of Learning Disability as "too able".

People who otherwise are able to look after themselves as independent adults, when faced with the complex demands of parenting may find that they need support and should not be excluded from services because a specific area of skills does not fit predetermined criteria. Research on the placement of children indicates that they thrive but best within the birth family where possible. Therefore our Assessment of parents, and approaches to support must be thorough, perhaps incorporating radical or lateral approaches. There are occasions where parents are not able to provide good enough care for their children, again Assessments must be thorough and balance the competing needs of the parents and children.

The use of Advocates in achieving this balance is both helpful and good practice. Specific organisations are becoming skilled at training advocates and facilitating advocacy relationships. If an Advocate in the role of supportive and critical friend is to be appointed, this should be at the time of referral rather than when things start to go wrong.

Both Valuing People and Every Child Matters point to the central role of user involvement and consultation in developing services. There is a real danger that the families we are discussing will have no voice in any services - "too able" for mainstream Learning Disability services and "inappropriate" for Children's services and consequently may be overlooked. User involvement groups need to find ways of ensuring that their voices are heard in the development of services.

What Next

The White Paper on children's services strengthens the case for the working together of agencies. The sharing of information, collaboration in Assessment planning and intervention is vital and should be a directive from senior managers in all the agencies involved. The benefit of multi-agency working cannot be emphasised enough, as to work effectively there needs to be input from social work, education, health and voluntary agencies to provide a joined-up approach to service provision. The current model for short-term intervention is not helpful. A parent with a Learning Disability may require assistance at significant times during their children's childhood, including puberty and adolescence.

In short there should be less emphasis on late intervention which at times results in separation for children and parents and more emphasis on early identification, intervention and plans to keep children and their parents together where possible.

APPENDICES

Appendix 1

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Appendix 2 GOOD PRACTICE POINTERS

(Taken from Booth and Booth 1994 - Parenting Under Pressure) for the full text see pp112-124

1. Be wary of assuming that parents with Learning Disabilities do not have the same feelings of care and affection for their children as other parents or that their family bonds are weaker.

2. Parenting is about more than children rearing.

3. Be wary of adopting too narrow a view of the parenting task.

4. Assessment, intervention and support must have regard to the functioning of the family as a unit.

5. The parent/child relationship may be worth supporting even when a parent cannot meet all the developmental needs of the child.

6. The need for belonging on the part of the children may outweigh any deficit that outsiders see in the competence of their parents.

7. Beware of seeing parents' needs only in terms of their Learning Disabilities.

8. Beware of the danger of segregated services leading to segregated needs and segregated lives.

9. Practitioners should take care not to undermine the socially valued aspects of the parenting role.

10. Practitioners should organise services and support so that parents experience being competent and feel in control.

11. Service providers must be ready to accept that parents with learning difficulties are likely to exert heavy demands on their resources.

12. Practitioners must be aware of their capacity for exacerbating the stress in families and augmenting the problems that they face.

13. Practitioners must seek to avoid seeing parents only through the distorting mirror of existing services.

14. The attitude of practitioners towards parents is as important as their actions: how support is delivered matters as much as what support is delivered.

APPENDIX 3 ASSESSMENT TOOL 1

ASSESSMENT TO USE WHEN PARENTING SKILLS ARE GOOD ENOUGH AND PROBLEMS ARE NOT CLEAR

ACCEPTANCE OF PARENTING ROLE

1. Does the parent provide basic essential physical care?
2. Does the parent provide age appropriate emotional care?
3. Does the parent encourage development of the attachment dynamic?
4. What is the parent's attitude toward the 'task of parenting'?
5. Where does the parent see the main responsibility for parenting to lie?
6. Is the child expected to be responsible for his/her stimulation / regulation / protection?
7. If there are problems – does the parent acknowledge them?
8. Does the parent agree with the need for change?

RELATIONSHIP WITH THE CHILD

9. What are the parent's feelings towards the child?
10. Does the parent empathise with the child?
11. Does the parent view the child as a separate person with his/her own needs?
12. Are the child's essential needs given a high priority?
13. What is the meaning of the child to the parent?

FAMILY INFLUENCES

14. How does the parent reflect upon his/her own parenting experiences?
15. Is the parent able to sustain a supportive relationship with a partner?
16. If there are chaotic relationships in the family, is the child ever involved?
17. What is the child's contribution to the parenting process?
18. How does the parent perceive his/her child's attitude is towards him/herself?
19. How well does the family unit deal with stress?

INTERACTION WITH EXTERNAL NETWORKS

20. What support networks are available?
21. How does the parent access these?
22. What is the usual pattern of the parents' relationships with professionals?

POTENTIAL FOR CHANGE

23. What is the potential of benefit from therapeutic help?
24. What responses have there been to previous efforts to help?

Appendix 4 Assessment Tool 2

Initial Assessment (Child) Interview Framework

INTERVIEW

Information about each child **NAME:** **RELATIONSHIP:**

	YES [If yes-evidence?]	**NO**	**DON'T KNOW**
Was the child planned?			
Was the child premature?			
Were there any particular problems with the birth?			
Was the child's birth weight low?			
Is there any evidence of failure to thrive?			
Does the child suffer from any physical, sensory or Learning Disability?			
Has the child reached his/her milestones?			
Does the child have a history of multiple carers?			
Is there a history of separation from parents?			
Has the child had periods in care?			
Is there any evidence of attachment difficulties?			
Does the child's behaviour give cause for concern?			
	YES	**NO**	**DON'T KNOW**
Has the child been frequently referred to the GP or hospital?			

Have any referrals to the GP or hospital been inappropriate?
Is the child referred to by carers as being difficult, demanding, naughty or aggressive?
Is the child non-attending at school or arriving late at school?
Is the child ever inappropriately dressed?
Does the child ever look tired or neglected?
Does the child have responsibilities beyond his/her age?
Has the child ever been reported re CP issues?
Have other professionals concerns about the child's welfare?
Has the child ever complained about the care received at home?
Information about the family
Does the family feel isolated?
Is the family targeted or exploited by the local community?
Are there friends or neighbours who offer positive support?
Are family members supportive of each other?
Is the family suffering from stress?
Does the family have an adverse reaction to stress?
Does the family present as disorganised?
Are family roles child centred?
Is the house dirty?
YES NO DON'T KNOW
Is the house cluttered with rubbish?

Are there safety concerns within the home?
Have any agencies such as Environmental Health been involved?
Have professionals expressed concerns lately?
Has there been significant professional involvement?
Have professionals ever felt intimidated?
Have members of the family refused to work with professionals in
the past?
Does the family acknowledge any CP concerns?
Is there any evidence of violence within the family?
Are there any children under 18 years living away from the family home?
Have children previously been removed from this family or from adults who are presently members of the family?
Are any children being “Looked After” by LA?
Have there been any previous CP concerns, including any investigations?
Has previous professional intervention resolved any of the above problems?
Can the parent/caregiver show insight into the child’s world?
Can the parent make and sustain change?
Can the parent or caregiver generalise and respond to daily challenges?

Adapted from McGaw

POTENTIAL IMPACT ON CHILD OF PRIMARY AND SECONDARY BEHAVIOURS WHERE A PARENT HAS A LEARNING DISABILITY	
Parental Behaviour	**Potential impact on child development (in addition to attachment problems)**
Self preoccupation	Neglected
Emotional unavailability	Depressed, anxious, neglected
Practical unavailability	Out of control, self reliant, neglected, exposed to danger
Frequent separations	Anxious, perplexed, angry, neglected
Threats of abandonment	Anxious, inhibited, self blame
Unpredictable/chaotic planning	Anxious, inhibited, neglected
Irritability/over reactions	Inhibited, physically abused
Distorted expressions of reality	Anxious, confused
Strange behaviour/beliefs	Embroiled in behaviour, shame, perplexed, physically abused
Dependency	Caretaker role
Pessimism/blames self	Caretaker role, depressed, low self esteem
Blames child	Emotionally abused, physically abused, guilt
Unsuccessful limit setting	Behaviour problem
Marital discord and hostility	Behaviour problem, anxiety, self blame
Social deterioration	Neglect, shame

Adapted from the work of Rutter

Appendix 5 Assessment Tool 3

Parent/Carer Interview Framework

Information about each of the adults in the home			
NAME:			
RELATIONSHIP			
	YES	**NO**	**DON'T KNOW**
Was s/he a victim of abuse as a child?			
Was the abuse over a long period?			
Did s/he witness abuse as a child?			
Did s/he witness family violence as a child?			
Did s/he have a difficult childhood?			
Was s/he in care?			
Did s/he have multiple carers as a child?			
Did s/he present difficult behaviour as a child?			
Did s/he present difficult behaviour as an adolescent?			
Has previous professional involvement resolved any of these issues?			
Is s/he under 18 years of age?			
Does s/he present difficult behaviours?			
Has s/he had employment difficulties?			
Is s/he unemployed?			
Has s/he a history of alcohol or drug abuse?			

Is the alcohol or drug abuse of long standing?			
Has s/he had failed attempts to detoxify?			
Are her/his friends also alcohol or drug abusers?			
Does s/he still abuse alcohol or drugs?			

	YES	**NO**	**DON'T KNOW**
Has s/he a history of serious mental health problems?			
Has s/he a personality disorder?			
Does s/he suffer from any degree of Learning Disability which could affect ability to care for children safely?			
Has s/he a history of violent behaviour within relationships?			
Has s/he ever been convicted of an offence of violence?			
Has s/he ever served a prison sentence for violence?			
Has s/he previously assaulted a child?			
Has s/he ever neglected or ill-treated a child in any way?			
Has s/he been a member of a household where a child has been neglected or ill-treated in any way?			
Are concerns held about her/his care of children?			
Does s/he place her/his own needs above those of children?			
Is there a lack of insight into the child's needs?			

	YES	NO	DON'T KNOW
Is there a failure to anticipate the child's needs?			
Is there a lack of concern for the child?			
Is there a lack of emotional warmth towards the child?			
Does s/he have a poor child care focus?			
Does s/he present a negative attitude to the child?			
Does s/he scapegoat any of the children?			
Does s/he have unrealistic expectations of the child?			

	YES	NO	DON'T KNOW
Does s/he have poor knowledge about child care and child development?			
Does her/his behaviour have a negative impact on the child?			
Does s/he expose the child to the risk of significant harm?			

Appendix 6 Assessment Tool 4

Parenting Capacity Questionnaire

To use these questionnaires, you must ask the following supplementary question for each answer.

Is there evidence to support the parent's answer linked to child development and the needs of the child?

For example, to confirm that the parent/carer is able to recognise the signs and symptoms when a child is ill – the evidence would be that Ms Bloggs took their child to GP following their awareness of a chesty cough. This is evidence of meeting the child's health needs.

Parent/carer is able to recognise signs and symptoms when child is ill

Parent is able to take appropriate action when child is showing signs of illness

Parent can take child's temperature

Parent takes appropriate action to reduce temperature

Parent is able to use medicines appropriately

Parent recognises and deals with nappy rash

Parent recognises and deals with cradle cap

Parent recognises and deals with teething problems

Parent keeps appointments for developmental checks e.g. dentist, optician, health visitor

Parent educates teenager about body

Parent educates teenager about drugs/alcohol/smoking

Parent ensures that teenager has taken appropriate medication for illness

Parent allows teenager to arrange own medical appointments

Parent advises teenager on sexual health matters

Parent sterilises feeding equipment

Parent changes nappies appropriately

Parent disposes of dirty nappies

Parent takes equipment for nappy changing when going outside home

Parent prepares items necessary for wash/bath time

Parent ensures child is bathed/washed appropriately

Parent ensures that child's hair is brushed/combed

Parent ensures that child's nails are cut

Parent ensures that child's teeth are brushed

Parent encourages child to sit on potty for a few minutes

Parent encourages child to wash and wipe hands after using the toilet/potty

Parent encourages child to wash/bath self without guidance

Parent encourages child to blow their nose when necessary

Parent encourages child to sort own clothes for washing

Parent encourages child to put away clean clothes

Parent prompts teenager when necessary to carry out personal care

Parent dresses child appropriately for cold/warm weather

Parent ensures child has adequate bedding/bedclothes to keep warm at night

Parent ensures the temperature of the child's bedroom is suitable

Parent encourages child to wear appropriate clothing to school

Parent encourages child to choose clothes to suit weather conditions

Parent makes eye contact with baby for 5 seconds

Parent smiles at baby once during visit

Parent carries out child-care routines calmly and without fuss

Parent responds to child's cues for physical care ie food/drink/toilet/sleep

Parent spontaneously makes physical contact with child

Parent comforts child when upset

Parent deals with accidents calmly and without fuss

Parent initiates age appropriate games with child

Parent praises child for efforts

Parent spends time talking to child about his/her day

Parent deals with child's nightmares effectively

Parent listens to child when upset and suggests positive actions

Parent helps child to mix with other children

Parent helps child to develop own interests

Parent involves child in decision-making

Parent ensures that child's bedroom is bright, well-lit and decorated

Parent provides age-appropriate toys/games

Parent displays appropriate pictures/posters on child's bedroom wall

Parent shows colourful picture books to child

Parent encourages child's access to a variety of age appropriate television programmes/videos/computers

Parent takes child on outings at least twice a week e.g. shopping, walking, visiting friends

Parent encourages child to paint/draw

Parent displays child's art work in the house

Parent is able to recognise signs and symptoms when child is ill

Parent is able to take appropriate action when child is showing signs of illness

Parent takes appropriate action to reduce temperature

Parent is able to use medicines appropriately

Parent recognises and deals with nappy rash

Parent recognises and deals with cradle cap

Parent recognises and deals with teething problems

Parent keeps appointments for immunisations

Parent keeps appointments for developmental checks e.g. dentist, optician, health visitor

Parent allows teenager to take own medicines under supervision

Parent educates teenager about body

Parent educates teenager about drugs/alcohol/smoking

Parent ensures that teenager has taken appropriate medication for illness

Parent allows teenager to arrange own medical appointments

Parent advises teenager on sexual health matters

Parent sterilises feeding equipment

Parent changes nappies appropriately

Parent disposes of dirty nappies

Parent takes equipment for nappy changing when going outside home

Parent prepares items necessary for wash/bath time

Parent ensures child is bathed/washed appropriately

Parent ensures that child's hair is brushed/combed

Parent ensures that child's nails are cut

Parent ensures that child's teeth are brushed

Parent encourages child to sit on potty for a few minutes

Parents encourages child to wash and wipe hands after using the toilet/potty

Parent encourages child to wash/bath self without guidance

Parent encourages child to blow their nose when necessary

Parent encourages child to wash/bath self but checks afterwards

Parent encourages child to sort own clothes for washing

Parent encourages child to put away clean clothes

Parent talks to child about the things they see and do

Parent responds positively to child's questions

Parent describes and praises child's behaviour and actions

Parent teaches child names of different body parts

Parent asks child to name pictures of animals/objects/activities in book

Parent teaches child simple manners e.g. "please"; "thank you"

Parent spends time helping child to read

Parent explains words outside child's repertoire

Parent takes child to local library

Parent encourages child to play a musical instrument

Parent shares jokes with child

Parent spends time each day exchanging news with child

Parent encourages child to engage in public speaking e.g. plays, debates, presentations

Parent encourages child to keep a diary/journal

Parent discusses current events with teenager

Parent exchanges point of view with teenager

Parent praises child for appropriate behaviour

Parent manages child's disruptive behaviour

Parent listens and reassures child when upset

Parent removes child from unsafe situations when child is agitated

Parent tries to distract child when disruptive

Parent tells child when he/she is misbehaving

Parent warns child/teenager of consequences of continuing with inappropriate behaviour/breaking house rules
Parent ignores child if inappropriate behaviour continues
Parent is consistent in responding to inappropriate behaviour
Parent responds positively to child (e.g. hugs/praises child) well after tantrum has finished
Parent enforces family rules
Parent communicates basic family rules to child/teenager
Parent is consistent in enforcing family rules/boundaries
Parent would be consistent in applying consequences if family rules are broken
Parent limits amount of time child spends watching TV/Computer games/videos/Internet
Parent ensures child spends adequate time on school homework
Parent is able to provide a suitable environment
Parent is able to suggest some reasons why babies might cry
Parent can suggest a different kind of play/attention a newborn baby may need
Parent can suggest that they might know when a baby may need something
Parent can suggest that they might know when a toddler may need something
Parent can suggest that they might know when a teenager may need something
Parent shows awareness of the risk of fire
Parent aware of sleeping position of newborn babies
Parent aware of safety issues around bedding and mattress
Parent aware of safety issues when bathing a baby/child
Parent aware of NOT prop feeding
Parent aware of engaging child at mealtimes
Parent aware of safety issues in kitchen
Parent aware of safety issues regarding medicine/tablets/cleaning materials

Was the pregnancy planned?
How did the parents feel about the pregnancy? Can they describe these feelings?
Was father supportive during the pregnancy?
Was the pregnancy a positive time for the mother?
Who gave support during the pregnancy?
What kind of relationship is envisaged with the new baby?
What are the greatest concerns of the parent(s) about this baby?

Parent aware of child's moods and feelings
Parent aware of how the child reacts to strangers
Parent able to show empathy with the child when hurt or distressed
Parent addresses child by name
Parent able to offer comfort by giving physical contact
Parent successful in getting the child to do as they are told
Parent responds appropriately if the child is disobedient
Parent has realistic expectations of the child's behaviour
Parent is able to supervise the child effectively
Parent able to encourage child to play with siblings or other children
Parent demonstrates appropriate adult relationships
Parent is able to demonstrate not being in a domestically violent relationship
Parents able to co-operate with other adults
Parents able to co-operate with professionals
Parent able to demonstrate that they can appropriately manage to:

- Shop
- Prepare food
- Cook
- Provide a balanced diet
- Launder family's clothes and bedding
- Maintain a clean house

- manage a budget

- Are aware of where they can go for help - ie benefits agency; GP; CAB

- Have a daily routine for self and child

Parents have suitable housing

Parents can describe what suitable housing is

Parents can describe social integration in the community and what that means for them and their children

Parents are accepted by the local community

Parents can describe accessible service within their local community which help meet their needs

Parents can describe how they use these services

*Taken from the work of McGaw, Calder and Fowler

Appendix 7 Assessment Tool 5

Do you need an Assessment to find out if a parent has a Learning Disability?

Tick box if present

1. HISTORY

- usually a fairly reliable indicator

Self report

attending Special school
special unit in mainstream
needing extra help at school ☐

Family/Other Agencies

information about Special Education
needing lots of help at school
being slow generally

2. BACKGROUND INFORMATION

Providing vague or naïve information about basic facts (eg not certain which hospital their child was born in, how long partner has been around, birth dates of children, type of schooling child receives) ☐

3. LEVEL OF SUPPORT

Is evident that another person has a major role providing help/advice to the family (eg help with filling in forms, shopping, arranging housing, using public transport) ☐

4. LITERACY

Significant problems with writing ☐

A reluctance to write in presence of others

Writing address, but misspelled, postcode absent

Reading words but with limited understanding only

Avoiding reading/writing tasks ("I haven't got my glasses")

5. TRAVEL

Problems travelling on public transport

Always comes to appointments with another adult ☐

6. APPOINTMENTS

Erratic appointment keeping ☐

- early, late, wrong day, odd excuses

7. FINANCE

Problems managing money ☐

- trouble giving change for a note
- problems estimating cost
- running out of money quickly on a regular basis

8. ROUTINE

Being overwhelmed by day to day routine ☐

Difficulty in sending child to school with kit needed

Coping with household routine

Difficulty prioritising demands and activities

9. STRATEGIES

Using lots of explanations/excuses for problems - eg "his glasses are at home" or "I lent my thermometer to a friend" ☐

10. CHILD CARE

Difficulties with child care ☐

- following a routine
- predicting dangers
- seeming to be always telling the child off
- inappropriate feeding
- apparent inability to praise child

- child appearing to look after parent

11. Significant illness or injury which may have caused a problem with cognitive functioning, ie head injury, meningitis oxygen starvation ☐

If several boxes have been ticked, then you should refer for further Assessment