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Clinical Psychology

Faculty for People with
Learning Disabilities



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Good Practice Guidance for Clinical Psychologists when Assessing Parents with Learning Disabilities

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Foreword

For those of you who might feel anxious about working in this area of work I would like to point out that clinical psychologists are better placed than most to meet the challenge of gauging the influence of learning disabilities on parental competency – which can be inordinately difficult. They are well equipped to define the learning disability classification in relation to parental risk, based on the research evidence. Also, they are used to measuring the efficacy of intervention programmes using pre- and post-baselines and providing opinion on a parent's capacity to generalise and maintain skills over time. History bears witness to the important role that clinical psychologists have played in pioneering research and developing support services and new resources for parents with learning disabilities over the past 30 years. Today, clinical psychologists are greatly valued and their opinions are highly sought from professionals alike, especially within the court arena. However, in this high profile area of work where the stakes are high for these vulnerable families, clinical psychologists can often feel unsupported with much riding on their opinion. Hopefully, this long overdue and much needed *Good Practice Guidance* will bring clarity and uniformity to the work of those dedicated clinical psychologists who are currently involved in assessing and supporting parents with learning disabilities.

Dr Sue McGaw

Consultant Clinical Psychologist, September 2009.

Introduction

This guidance is aimed at clinical psychologists working in the public and private sectors. The need to compile it emerged from a workshop at the British Psychological Society (BPS), Division of Clinical Psychology (DCP) Faculty for Learning Disabilities Advancing Practice Conference in April 2007. Assessing parents with learning disabilities is a complex issue and, anecdotally, many clinical psychologists have commented that they use a range of models, and assessment tools which have evolved as they gain experience and expertise. Other clinical psychologists who are inexperienced in this work have commented that they would like to have more guidance in how to proceed with this task. We have tried not to be prescriptive about how to assess parents, for example, which assessment tools to use and so on, as decisions on which aspects of assessment to focus on will have to be made locally depending on resource availability and configuration of services.

A number of documents have recently been developed providing good practice guidelines for working with parents with learning disabilities, for example, *Finding the Right Support* (Tarleton, Ward & Howarth, 2006) and *Good Practice Guidance on Working with Parents with a Learning Disability* (Department of Health & Department for Education and Skills, 2007). However, these are generic documents and are not aimed at a specific profession or agency. There is a paucity of more specific, practical knowledge required for clinical psychologists working in this area. This document hopes to complement these publications and provides guidance and direction specifically for clinical psychologists when they assess parents with learning disabilities.

Section 1: Overview of the literature

A growing number of people with learning disabilities are becoming parents. This is a largely invisible population (Whitman, Graves & Accardo, 1986). There are no reliable estimates of numbers due to variations in the definition of learning disabilities over time and across services (see, for example, Whitman & Accardo, 1990). Also, many parents with learning disabilities may well not be known to learning disability services (McGaw & Sturmey, 1993). Some services work with people who would not be considered to have a learning disability as defined by international classification systems. For all of these reasons it is very difficult to get an accurate picture of the number of parents with learning disabilities.

In spite of this, international research is beginning to show that the number of parents with learning disabilities is steadily growing (Tymchuk, Llewellyn & Feldman, 1999). Anecdotally there appears to be more referrals to learning disability services for such parents than there were 10 to 15 years ago. Services need to provide effective provision for this client group if people with learning disabilities are to be supported in their role as parents (Human Rights Act, 2000; Department of Health 2001a; Tarleton, Ward & Howarth, 2006). It is recognised that these parents face an increased risk of having their children removed (Department of Health & Department for Education and Skills, 2007; Tarleton, Ward & Howarth, 2006) and that their children can be described as vulnerable.

There is little published evidence regarding the efficacy of interventions, support for these families, and the outcomes for the children in the long term. As a result of a lack of specialist services, these families may not receive the appropriate support that is required to help them achieve 'good enough' parenting, hence it is unclear whether removal rates of children reflect, to some extent, a lack of service provision or evidence of ineffective interventions.

Parents' experiences and factors that influence parenting abilities

A review of the literature on parents with learning disabilities shows that they are more susceptible to poverty, unemployment, victimisation, isolation from extended families and insufficient social supports, all of which impact adversely upon their parenting abilities. In addition, parents with learning disabilities often have poor childhood experiences and poor parenting role models, difficult relationship histories and increased psychological distress, all of which impact upon their ability to cope with the demands of raising children (Andron & Tymchuk, 1987; Dowdney & Skuse, 1993; Edmonds, 2000; Gath, 1988; Llewellyn, 1998; McGaw & Newman, 2005; Whitman & Accardo, 1990).

Researchers agree that parental competence is not related to IQ, except when it falls below the range 55 to 60 (for example, Andron & Tymchuk, 1987; Dowdney & Skuse, 1993) but will be influenced by the complexity of skills to be acquired, the developmental level of the child and the social support available.

Effects on children of having parents with learning disabilities

Genetics and hereditary impairment of intellectual functioning in children

The contribution of genetics to children's intellectual development has received a lot of attention, possibly stemming from long-standing eugenic concerns. Most studies have shown that the incidence of organic aetiologies among children of people with learning disabilities is the same as in the general population. Also, the current consensus is that while rates of learning disability will be higher amongst children of parents with learning disabilities, particularly where both parents are learning disabled, the average IQ of such children will show a regression to the mean (Tymchuk, Andron & Unger, 1987). Moreover, studies which focus on the role of socio-economic factors, such as impoverished environments and the effects of a more restrictive style of parenting, again confound easy conclusions, and question the extent to which heredity factors are responsible for lower IQs (Dowdney & Skuse, 1993).

Development

Children of parents with learning disabilities are vulnerable with regard to having developmental delay, particularly in language and cognitive skills (Keltner, Wise & Taylor, 1999). When compared to mothers without disabilities, mothers with learning disabilities have been shown to be less interactive with their children (Feldman, 1986). However, it has also been shown that mothers with learning disabilities were able to learn more appropriate interactions and that these gains were still noticeable at follow up 20 months later (Feldman, 1993).

There is some evidence that children of parents with learning disabilities do less well at school and have greater incidence of behavioural difficulties when compared to other children from impoverished backgrounds (Feldman & Walton-Allen, 1997).

Risks of child maltreatment and abuse

Children of parents with learning disabilities are susceptible to neglect and abuse (e.g. Schilling et al., 1982). Accardo and Whitman (1990) found that of 226 children in 79 families, 103 (or 45.5 per cent) had been removed from the family home due to neglect, unsafe living conditions or sexual abuse. However, unrepresentative sampling and methodological problems in many studies make it difficult to estimate the real extent of child abuse by this population (Dowdney & Skuse, 1993). For example, some studies looked only at families referred for child development problems or concerns about parenting difficulties (e.g. Accardo & Whitman, 1990), while others have used children being taken into care as an outcome measure, even though this may be for reasons other than abuse and/or neglect (Booth & Booth, 1998).

McGaw and Newman (2005) note that it is rare for mothers with learning disabilities to deliberately harm their children and when abuse does occur it is often by a person known to the mother. Tymchuk and Andron (1994) note that these children are most at risk of 'unintentional neglect' as a result of the parents not knowing what to do with regard to child care tasks.

A number of factors have been associated with increased risk of abuse in the general population (see, for example, Cicchetti & Rizley, 1981) which are applicable to many parents with learning disabilities. These include poor parental childhood experiences, child and family characteristics, and social context. These will be described in turn below.

Poor parental childhood experiences

Parents with learning disabilities are ‘very unlikely to have had experiences in childhood that offered any model of good-enough parenting’ (Gath, 1988, p. 741). Some of the current generation of parents may have been brought up in institutions and may have had little experience of family life. Others may have experienced poor parenting themselves or have led a sheltered and protected family life (Edmonds, 2000; Gath, 1988). As a result, many of them have grown up with ‘inappropriate or non-existent parenting role models, little or no experience of children’s developmental needs, relationship problems and poor financial, living and employment situations’ (Llewellyn, 1998, p.17).

Researchers have documented case histories where sexual abuse has occurred in the childhood and adulthood of parents with learning disabilities themselves (e.g. Andron & Tymchuk, 1987; Turk & Brown, 1992). This is of particular concern as sexual abuse may affect self-esteem and capacity to develop healthy relationships with family members (Mandeville & Snodgrass, 1998; Morton, 2000). In the absence of models of good parenting, ‘experiences such as these are thought to predispose ... [parents with learning disabilities] subsequently to become abusive parents’ (Dowdney & Skuse, 1993, p.32).

Family characteristics

There is little epidemiological data on the rates of single parenthood amongst women with learning disabilities. For those that are married, the quality of the marriage varies enormously. Some studies have found high rates of marital distress and disturbance particularly when both partners have learning disabilities (e.g. Koller, Richardson & Katz, 1988). Koller et al. (1988) have also argued that the status bestowed by marriage leads some women with learning disabilities to tolerate abusive relationships that would not be acceptable to women in the general population. In addition, Gath (1988) warns that ‘the particular combination of a mentally retarded woman with a man with a history of violence and other anti-social behaviour seems to have a high risk of leading to disaster in the family’ (p.742).

Social context

Many parents with learning disabilities share with parents who harm their children the same predisposing factors of difficulties finding employment, poor social supports and social isolation (Andron & Tymchuk, 1987; Edmonds, 2000; Koller et al., 1988; Whitman & Accardo, 1990). It is also argued by Booth and Booth (1995) that many parents with learning disabilities are impoverished due to restricted work opportunities and lack of earning power. They are often targets of harassment and victimisation, and they are ‘in a kind of double jeopardy’ (Booth & Booth, 1995, p.32), consigned by poverty to living on the tough margins of society, yet possessing fewer skills to cope with the extra pressures.

Parent training and interventions

The evidence shows that parents with learning disabilities are capable of love and affection, they can learn and maintain with support a range of parenting skills involving both practical (e.g. child care and housekeeping) and relationship skills. There is evidence to show that using applied behavioural analysis approaches, people with learning disabilities can learn a range of parenting skills involving both practical and relationship skills. Parent training programmes can raise the competency of parents with learning disabilities (see, for example, Craft, 1993; Feldman, 1994; McGaw, 1993; McGaw & Newman, 2005).

Tymchuk, Andron and Rahbar (1988) and Fantuzzo et al. (1986) found that parents with learning disabilities were able to enhance their skills in identifying appropriate action with their children through decision-making and social skills training. Tymchuk et al. (1992) found that the mothers' knowledge in home safety increased as a result of training.

McGaw, Ball and Clark (2002) carried out two studies on the effectiveness of groups for parents with learning disabilities. The first of these examined the effect on self-esteem on parental competency. The results indicate that self-esteem and knowledge of child care improved for mothers with intensive training. The second study evaluated parent's relationships. At the end of the training sessions most of the parents included in the sample reported that they felt more positive about their relationships, and the results also indicated that parents engaged in new activities and their social support networks improved through contact with other parents in the group.

How should interventions be delivered?

The three core components of the Parenting Assessment Manual (PAM) (McGaw, Beckley, Connolly & Ball, 1999; McGaw, 2007) are very helpful in identifying where interventions should be targeted. The PAM assesses parental knowledge, skills and practice. That is, it assesses what knowledge a parent has, what skills they have and whether they use these skills as and when they are required. McGaw (1998) stated that training methods need to be based on task analysis, repetition, modelling, guided practice and the use of positive contingencies to reinforce learning. Verbal instructions will not be enough by themselves. Furthermore, written instructions will need to reflect the reading age of parents (on average around the 7 to 9 year level). In summary, training is more effective when using a combination of:

- Verbal instructions.
- Modelling.
- Physical guidance.
- Feedback (with the use of video playback).
- Reinforcement.
- Pictorial and other visual aids.

In recent years there have been several sets of accessible resources published that can aid teaching and interventions for parents with learning disabilities (see Appendix 2).

Potential areas of difficulty concerning training programmes

Training methods need to be set at the right level of comprehension and understanding. Often parents have no understanding of the terms 'self-esteem', 'child development' and 'routine' (McGaw, 1998). Parents with learning disabilities can also have difficulties generalising information acquired through training to other environments and conditions. For example, Tymchuk (1991) found that whilst mothers' knowledge in home safety increased as a result of training, improvement of their home safety measures was not observed.

Hur (1997) reviewed the literature available on the efficacy of training, and found that some parents' knowledge had improved over the course of training, as tested on a question and answer examination, however, the actual performance of the parents remained the same. Therefore, in order to ensure an accurate assessment of the parents' ability to implement information gained on training programmes, observations should be carried

out to support any verbal accounts of knowledge learnt. Having knowledge does not mean that this is translated into practical skills.

McGaw, Ball and Clark (2002) in their study on self-esteem and parental competency found that group work was less effective on its own than when it was combined with interventions that were based within the home environment. For example, studies indicate that parents need a range of home-based and family centre based programmes in order to improve the chances that information will be generalised and to improve the efficacy of the training on offer. McGaw and Newman (2005) state that ‘the longer and more intense the training the more chance of maintenance. However, long term training is particularly challenging to services because of the cost implications’ (p.55).

It is also important to note that many of the studies have methodological flaws and, therefore, results need to be interpreted with some caution. Furthermore, at present there is no clear operational definition of what constitutes adequate parenting, leading to assessments and services being developed based on overly subjective information (McGaw & Newman, 2005).

In summary, in order for parents with learning disabilities to achieve optimal learning:

- Teaching programmes need to be intensive, individualised and highly concrete.
- Periodic and ongoing long-term support is needed to maintain skills.
- Both maintenance and generalisation of new learning is helped by teaching in real-life settings, preferably their own home, and by the involvement and support of parenting partners.

The success of training is influenced by a number of factors such as maternal interest in, and involvement with, the child, and motivation to learn (Dowdney & Skuse, 1993), the location and nature of the training and the level of ongoing support offered. Training must be consistent and regular. It should take place in real-life settings, preferably the parents’ own home, and involve parenting partners. There must be a positive relationship between the trainer and the parents (Dowdney & Skuse, 1993).

Services

The outcomes for families are improved if services work together in a systematic and co-ordinated approach. Often there can be multiple professionals involved and an important consideration is how to work most effectively without overwhelming a family. Goodinge (2000) found that there was little co-ordination between services which impacted negatively upon families. McConnell, Llewellyn and Bye (1997) recommended that services need to be ‘family centred’ so that the needs of both parents and children are considered.

Services across the UK are varied and in only a few places are there specialist services for this group of people. It can be unclear whether funding to support these families should come from children’s services or adult services, both of which are under enormous pressure. In families where there are one or more parents with a learning disability, they are likely to require help and support on a long-term basis, although the intensity and frequency of that support may vary over time. The Department of Health & Department of Education and Skills (2007) identified the need for long-term support for these families and recommended the pooling of budgets in their recent guidance in order to address this problem.

Rewards of parenthood

Some studies focussing on competencies have found that parents with learning disabilities can successfully raise their children when given the support that matches their needs (Feldman, 1986; Hertz, 1979; Feldman, 1994). These parents also seem to be incredibly resilient in spite of tremendous stresses (Booth & Booth, 1994; Feldman, 1986). Some of the literature also highlights the rewards of parenthood and its associated positive identity. For example, Booth and Booth (1994) suggest that one of the rewards of parenthood for people with learning disabilities is the adult status it brings, increasing the sense of identity with other parents and thus positive perceptions and self-esteem, personal fulfilment, opportunities for integration and loving relationships. They argue that parenthood is something that people accomplish for themselves in the face of opposition from others.

Edmunds (2000) in her study of eight families also described the satisfaction and pride that the women felt in being mothers. A further interesting retrospective study by O'Hara and Martin (2003) looked at outcomes for mothers and fathers with learning disabilities from two cultural groups (English and Bangladeshi). They argued it is cultural practice for Bengali people to see their disabled children get married as it serves to 'strengthen social identity, permitting the person with learning disabilities to adopt adulthood' (p.23). They also note in their sample that none of the children born to 15 Bangladeshi parents with learning disabilities had been fostered or removed in contrast to the English parents but comment that 'it should not be assumed that living within an extended family network is necessarily the most empowering and supportive for the parent with learning disabilities' (p.23).

Removal of Children

Booth (2000) estimated that in the UK, between four and six out of every 10 children born into families headed by a mother and/or father with learning disabilities are removed from the care of their parents, either temporarily or permanently, and looked after elsewhere.

There is limited research on parents' experiences of child removal and the subsequent psychological effects of this. The notable exceptions are Booth and Booth (1994, 2006); and Baum and Burns (2007). Booth and Booth (1994) studied 20 families where the parents had learning disabilities. They reported that 14 of these families had one or more of their children placed in care at some point, and 12 had a child placed in permanent care. Of these, eight were removed at birth and the rest were removed between the ages of 1 and 7 years. They argued that there was a pressing need to understand how the handling of these decisions impacted upon the parents.

Baum and Burns (2007) looked at the experiences of eight mothers with learning disabilities who lost custody of their children. The findings suggested that concern about the women's parenting tend to be raised by other people rather than the women themselves. Many of the women appeared not to understand the process of their children's removal. They said that they felt bullied and victimised by it. All blamed their violent partner or the social workers for what had happened, while some blamed their 'learning disabilities'. All participants commented that they had received inadequate support from both services and their families before and after their children were removed. They all described intense feelings of loss. The psychological impact of this seemed to reinforce their feelings of powerlessness and brought the salience of their learning disabilities into focus.

Key documents

Since the beginning of the 21st century, there have been three key reports in the UK which have inspected services, highlighted areas of positive practice and produced guidance on working with parents with learning disabilities.

Firstly, *A Jigsaw of Services* (Goodinge, 2000), inspected services across the country for all disabled parents (including those with learning disabilities) and found:

- A lack of co-ordination.
- Failure of professional collaboration.
- A gender bias towards women.
- Support services tended to be reactive and crisis-driven which immediately sets up problematic relationships with parents.

Secondly, six years later, Tarleton, Ward and Howarth (2006) in their review *Finding the Right Support* found an increase in positive practice in some services across the UK in relation to empowering parents with learning disabilities, raising awareness of their needs and the development of multi-agency support for these parents. However, in spite of this they noted that 'the numbers of children who are removed from parents with learning difficulties remain distressingly high' (p.88). They also emphasise that parents with learning disabilities often enter the child protection system due to concerns of perceived neglect by services which are often due to the parents' cognitive impairments and the impact of social and economic deprivation rather than the result of abuse. These findings echo the conclusions from earlier research by Booth and Booth (1994).

Thirdly, *Good Practice Guidance on Working with Parents with a Learning Disability* (Department of Health & Department of Education and Skills, 2007) identified five key features of good practice in relation to working with parents with learning disabilities:

- Accessible information and communication.
- Clear and co-ordinated referral assessment procedures and processes.
- Support based on assessments for their needs and strengths.
- Long term support.
- Access to independent advocacy.

Concluding remarks

An overview of the literature has highlighted that there is an increasing number of people with learning disabilities who are becoming parents and that, as a consequence, there is a need for them to access co-ordinated and specialist services. A large number of their children are being removed into care, and this has raised questions about how and whether their parenting skills can be enhanced to a 'good enough' level by training and support. Can a balance be drawn between the limitations of impaired cognitive functioning and the degree to which these limitations can be enhanced or substituted through specialist services and to what extent do past, current social, familial and economic factors play an over-riding role? In the following sections the importance of assessment in differentiating these factors is discussed.

Key Points

- There are an increasing number of parents with learning disabilities becoming known to services. Some 40 to 60 per cent of these parents have their children removed from their care.
- Parental IQ does not predict parental competence unless it falls below 55 to 60.
- Children who have a parent with learning disabilities can be described as vulnerable. They are at risk of developmental delay, particularly in relation to language and cognitive skills, of doing less well at school and having greater behavioural difficulties.
- Studies have shown that parents with learning disabilities can learn and develop their parenting knowledge and skills. There are critical factors to consider in how to most effectively deliver such interventions.
- Parents with learning disabilities are likely to require support on a long-term basis, although the frequency and duration of such support may vary across the child's lifespan.
- 'The best predictor of future parental competency for parents with intellectual disabilities is the quality and frequency of social and practical support available to them on a daily basis' (McGaw, 1998, p.200).

Section 2: The role of the clinical psychologist in the assessment of parents with learning disabilities

Introduction

This section considers the different contexts within which referrals can be made to a clinical psychologist both in the National Health Service (NHS) and independently (the private sector context), the various roles and remits in the assessment process including the context of the parent; and some factors which might constrain the acceptance of the referral. It provides key points and a flow diagram for the typical referral and reporting process which may be helpful as an aide-memoire.

Source of referral

Why are clinical psychologists asked to assess parents with learning disabilities? Clinical psychologists working in this area will have developed (in addition to their generic psychological skills) specific expertise and experience in assessing, understanding and working with people who have learning disabilities. The extent and nature of a person's learning disabilities may have implications on their ability to parent a child and whether or how training and/or support might help to promote or substitute for parenting skills that are not considered to be good enough. It is, therefore, reasonable for a parent to be referred to a clinical psychologist (with known expertise) if there is some evidence or belief that their learning disabilities may be effecting a person's ability to be a 'good enough' parent.

A request for an assessment may be made within the context of either social care or legal proceedings and this will be discussed in what follows.

Social care context

Where parenting difficulties have been identified by primary care workers in the NHS (e.g. midwives, health visitors, GPs), the family (parent(s) and child) are likely to be referred to social services with a view to assessing the needs of the child and, where appropriate, providing the parent with professional support and teaching. The role of the clinical psychologist in this context may be to provide advice and guidance to other professionals working with the family, based on an assessment of the parent's cognitive and adaptive functioning. This advice may clarify the type and focus of teaching and support needed.

It is important to recognise that the lead agency involved in parenting assessments will be the children and families teams within a local authority. The focus of their decision-making and input will be driven by the Children Act (1989) and the welfare of the child, and by a model of dealing with a problem and closing the case. It is important that clinical psychologists working with parents with learning disabilities maintain a balance between parent and child focuses and help other professionals to understand the need for ongoing input, albeit at varying levels, throughout the child's life. This is sometimes insufficiently recognised within the social work framework so that appropriate resources will not always be available.

Legal context

Where a child is considered to be ‘in need’ or ‘at risk’, court proceedings may be intended or underway and requests for an assessment may be directed through the solicitors representing the various parties. The clinical psychologist’s role will, in these instances, be defined by the instructions of the court. Whereas ‘clinical referrals’ (by professionals cited above) may be accepted within the remit of the clinical psychologist’s NHS role, assessments requested by the court will be defined as ‘expert witness’ work and may be optional, according to local NHS Trust policy. Expert witness assessments may present a conflict of interest where a parent already has a clinical relationship with the clinical psychologist or other team member.

The role of the clinical psychologist in a legal context will be to determine whether the parent has learning disabilities (using psychometric tests); whether and how these might affect the parenting difficulties observed by the referrer; and with what level of independence and/or support the parent is able to provide the child with good enough parenting. Through the writing of a report and attendance at court, the role of the clinical psychologist will be to assist the court in reaching a decision as to whether a child should be placed at home or elsewhere, for example, adoptive/foster family, residential care (see Section 4 for further discussion of the issues).

Within both contexts there may be other factors identified that will additionally affect a person’s ability to parent (e.g. sexual offending; mental illness; drugs/alcohol misuse; domestic violence; physical disability; health issues, and characteristics of the child).

The presence of such factors is likely to necessitate referrals to other professionals or networking and consultation with other professionals. It is particularly important for the clinical psychologist to be clear about their expertise and competencies within the court framework as the ‘expert witness’ if the best outcome is to be achieved for the child and family.

Role and remit of the clinical psychologist

Clinical psychologists are likely to be involved in assessing parents with learning disabilities in the following ways:

- (1) Conducting ‘eligibility’ screening for specialist learning disabilities services¹ which will include an assessment of cognitive and adaptive functioning and may also include learning style, memory, literacy and numeracy skills.
- (2) Responding to requests to directly assess parenting skills, including the parent’s life skills, resources and support and child-care skills (McGaw et al., 1998) where there are concerns about the child’s well-being. These assessments may also be requested from clinical psychologists who are independent practitioners (i.e. separated from the NHS services providing local support).

¹ Clinical psychologists should note that recent Department of Health & Department of Education and Skills (2007) guidance states that where a person has so-called ‘borderline’ levels of learning disability, community learning disabilities teams may still be the most suitable service for support given the person’s additional needs associated with parenting.

- (3) Facilitating generic services to fully include parents with learning disabilities in their services (Disability Discrimination Act, 2005; Human Rights Act, 2000; Department of Health, 2008). This may involve the clinical psychologist establishing the parent's strengths and learning needs and providing specialist advice regarding impact of the learning disabilities to other professionals who are assessing parenting skills.

In relation to the assessment, consideration must also be given to the context of the parent such as where they are in their own life cycle, in the parenting life-cycle and in their relationship with a co-parenting partner and family of origin. Referrals may be made at different stages, i.e. when the person with learning disabilities:

- Is pregnant and a parent to be;
- Is a first time parent;
- Has other children at home;
- Has had their previous children removed;
- Is with or without partner;
- Is with or without the support of their family of origin.

The parent(s) context will determine what knowledge and skills need to be assessed, whether there have been previous difficulties and, if so, what intervention helped to resolve them. The parent(s) context will also determine whether the role of the clinical psychologist is to:

- Assess (knowledge and skills);
- Inform and guide (other professionals);
- Explain parenting difficulties within a psychological framework;
- Offer therapeutic support (in the case of child removal).

(See Appendix 1 for helpful questions to ask the referrer in relation to consent, previous assessments, carrying out the assessment, about the child, who is involved and court proceedings to help you to clarify what you are being asked to do.)

Factors constraining acceptance of a referral

Professional context of the clinical psychologist

The response of the clinical psychologist to a referral for a parenting assessment will be determined primarily by their professional context, i.e. whether they are working for the NHS or independently.

NHS context

Within the NHS, wide ranges of service models operate in different geographical areas in assessing or supporting parents with learning disabilities. Whether the assessment is undertaken and, if so, the extent and nature of this will depend on local and NHS Trust policy and what the service is commissioned to provide. Commissioning will vary widely between agencies and areas of the country. Some learning disabilities services are not commissioned to do parenting assessments at all, and here the responsibility may instead be placed with clinical psychologists working in children and family teams.

Where, for example, family assessment centres exist, it may be more appropriate for the clinical psychologist to advise them on how to make their assessment process accessible to the parent with learning disabilities, rather than to conduct a separate parenting skills assessment. Other service models may place more emphasis on the clinical psychologists

conducting the parenting assessment themselves or within a multidisciplinary context, i.e. professionals in child services assessing child care skills and the clinical psychologist from adult learning disabilities services focusing on parental life skills.

The eligibility criteria for accepting a referral is also particularly important for clinical psychologists working within specialist community learning disabilities teams within the NHS. It is generally accepted that a person has to fulfil the three core criteria for learning disabilities as defined by the British Psychological Society guidelines (2001):

- Significant impairment of intellectual functioning (IQ <70);
- Significant impairment of adaptive/social functioning;
- Age of onset before adulthood.

The need to assess these criteria will constitute the first stage of any assessment and will determine whether any other aspects of a parenting assessment are carried out. It may be useful at this stage to screen a referred person using a checklist (e.g. Newham Special Parenting Project, 2005) and have an initial meeting with the person to see if they are likely to be eligible before assessing them more fully. This may not be evident from the information gathered by the referrer.

Private sector context

Within the private sector, irrespective of whether a clinical psychologist is working independently or in a group practice, acceptance of a referral is first and foremost determined by the clinical psychologist's expertise. It is their experience and expert knowledge rather than 'agency policy' or 'service eligibility criteria' that will determine the boundaries around the type of referral they accept. Parenting assessments that are referred to clinical psychologists outside the NHS sector will almost inevitably be made within a legal context either at the pre-hearing stage or during the course of care proceedings. The role of the independent clinical psychologist will, therefore, be primarily as an 'expert witness' and in this context their expertise will be both expected and challenged.

Clinical psychologists working in the private sector are also independent in another sense. Through their joint instruction by all parties working on behalf of the child and the parents, their lack of agency membership puts them in a unique position to be an independent observer of, and participant in, the process of assessment. Through observation and interview across the agencies they are able to look at the position of the family as a whole and appraise previous and potential input and resources without being determined by the view of, or concerned about future working with, a particular agency or service.

Competencies and ethics

The clinical psychologist's response to referrals will also depend on their own skills and whether, for example, they have access to the parenting assessments (see Section 3 on assessment).

The expertise of clinical psychologists working both within the NHS and independently will be defined by their training and subsequent clinical experience. Broad-based generic training provides clinical psychologists with a wide-ranging understanding of clinical and psychometric work. However, it is the specific experience of clinical psychologists working in this specialty which will enable them to assess whether a person has learning disabilities, the nature of those learning disabilities and the impact they are likely to have on the

person's ability to parent. Other considerations are whether social, emotional, psychological factors might underlie the presenting difficulties. Clinical psychologists' further training and experience will also determine whether they are also able to comment on the family dynamics (i.e. the relationship between two parents and/or the parent and child) and/or to assess the children and other adults without learning disabilities who may be involved. Clinical psychologists are responsible at all times for practicing within the limits of their own competencies.

Time frame for assessment

Competing referrals and their related time frames for completing assessments will similarly limit psychologists within the NHS and those working independently. The extent and nature of the assessment will also determine the time frames.

Within the context of a legal framework, the time frame for needing an assessment to be completed will be determined, on the one hand, by the court timetable and, on the other hand, by the age of the child, in terms of their future placement. The clinical psychologist needs to be clear and realistic about what they can achieve within a specific time frame and, if necessary, to refer on to another service or clinical psychologist if they cannot complete this.

Role of the clinical psychologist after the assessment is completed

Assessment at whatever level will lead to a report that will inform, contribute to final decisions and prepare the way for other kinds of psychological intervention depending on the outcome. A parent's level of cognitive and adaptive functioning may be outside the limits which will enable them, with or without support, to care adequately for their child. Other external factors may counteract a parent's ability to care for a child. Both these conclusions may lead to the removal of the child from the care of its parent(s) and to the clinical psychologist working therapeutically with a parent to address the loss.

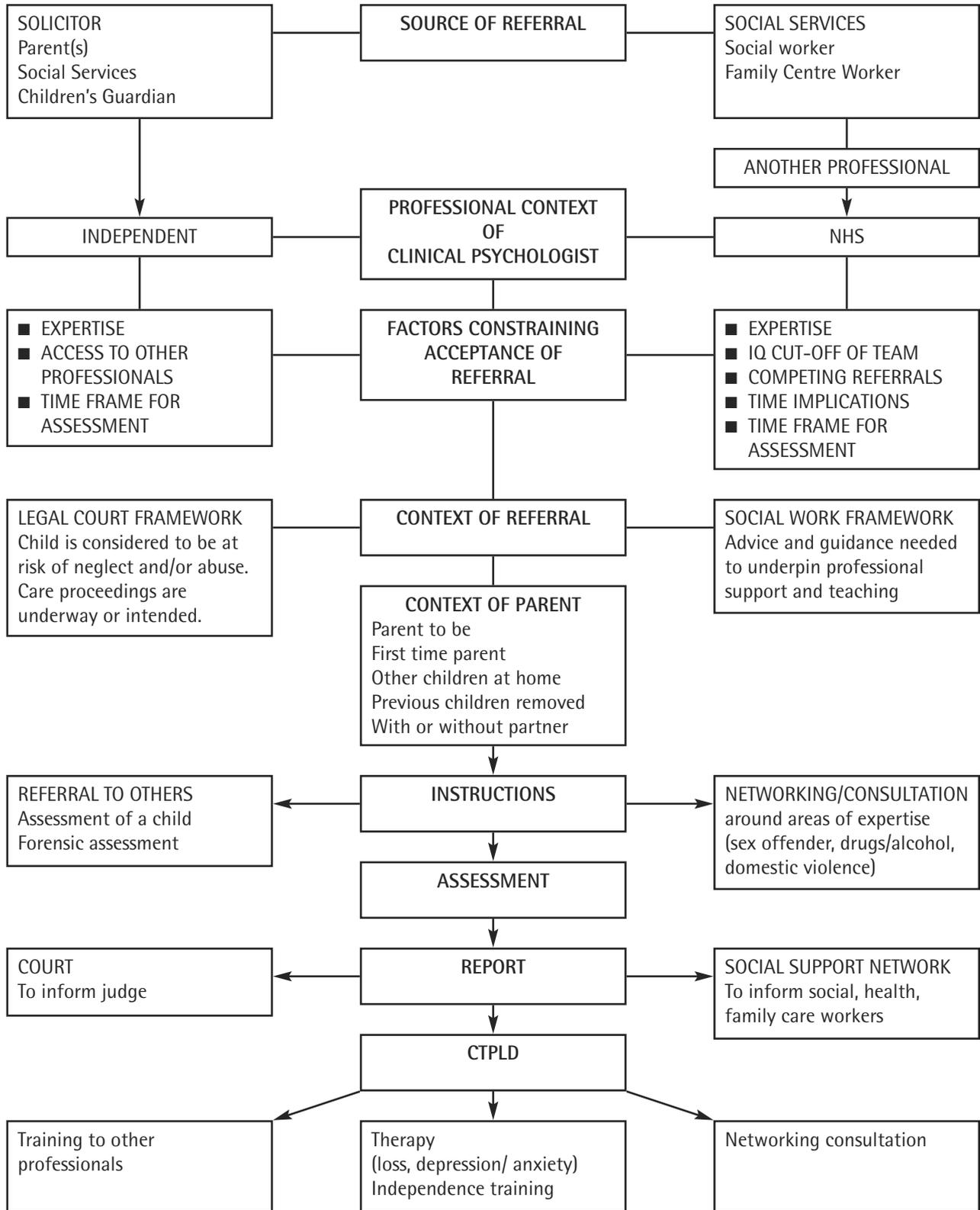
A parent may not respond to or make progress through the teaching of skills, and a role for the clinical psychologist may be to review the parameters around the teaching to ensure maximum appropriateness and efficacy and to clarify why the input is not successful. A parent may retain custody and go on to care for their child with support. The clinical psychologist may play an important role in determining and monitoring the level and nature of that support, ensuring that skills continue to build and are not undermined.

See Table 1 for a flow chart of the referral and reporting process.

Key Points

- Many different professionals may be involved in the system around the parent(s); they may have different time frames, agendas and ways of working.
- The NHS service model in your area will have a significant impact on your role.
- Requests for an assessment may come from a variety of sources, predominantly from a social care or legal context.
- Acceptance of a referral will be determined by the professional and organisational context in which we work, by our expertise and competencies, by time frames and by the parents' context.
- You may be asked to advise about the nature of the parents' learning disabilities and the impact of this on a parenting assessment, in order to assess the parent with learning disabilities' parenting skills.
- Make sure you work within the limits of your own training and competence.
- Be clear about your role from your first contact with the referrer and communicate this clearly to others. Be aware of potential role conflicts.
- Assessment should be conducted in the place and with the people that the parent(s) feel most comfortable with.
- Make sure the parent(s) have consented to the assessment and understand its potential consequences.
- Be clear about what you can do within a specified period of time.
- Whatever your role, you should consider the emotional support needs of the parent(s) and take steps to meet these or engage others to do so if more appropriate.

Table 1: Flowchart for referral and reporting process.



Section 3: Assessment

Introduction

This section is divided in two parts. The first part, ‘The process of assessment’, focuses on the issues that need to be taken into account when accepting a referral for a parenting assessment and introduces a model to guide that process and the tools that might be used. The second part, ‘The assessment report’, provides a structure for writing a parenting assessment report and defines both the nature of the content as well as the usefulness and constraints around drawing conclusions and recommendations.

A. The process of assessment

As a starting point, it is worth reiterating the importance of ascertaining what our role may be with a parent with learning disabilities. It is critical to clarify with the referrer the purpose of the psychological assessment. Requests for parenting assessments as part of routine clinical practice can often be vague and unclear. Is the purpose to determine whether a person has a learning disability and would, therefore, be eligible for certain services? Is it for therapeutic involvement or is it for an expert witness instruction to provide an independent opinion for the courts? Where an assessment is required for court rather than for clinical purposes, it is important to refer to local NHS Trust policy on conducting assessments on parents in care proceedings. As a consequence, it may be necessary to redirect the referrer to a chartered clinical psychologist with experience of working with adults with learning disabilities outside of the NHS Trust.

Requests for parenting assessments often reflect a high level of anxiety within the wider system supporting these families and, thereby, referrers often seek answers to very complex, and at times, unrealistic questions. Clinical psychologists can feel pressured to provide all the answers. It is important to maintain perspective. What are your skills/expertise? What can you realistically achieve within the given time scales and what can be deduced from the results of the assessment? Do not be afraid of stating the obvious.

It is, therefore, important to make clear at the outset what information the assessments you undertake will produce and whether there are any limitations to the conclusions you can draw. It is not unusual to get requests for cognitive assessments as a result of the falsely held belief that IQ can by itself predict parenting competence. Similarly, if the children are in foster care and the parent has limited access to the children through contact, it is important to state that any assessment of parenting skills/abilities will be limited as a result of these circumstances.

Ideally, where the referral relates to an unborn child, assessments should begin as soon as the pregnancy is identified.¹ It is important to be clear what the limits of pre-birth assessments might be, i.e. you will be unable to comment on actual parenting skills. In clinical practice, however, referrals in early pregnancy do not always happen and

¹ Department of Health & Department for Education and Skills (2007) guidance clearly states that ‘identification of needs should start when a pregnancy is confirmed’ and as soon as it ‘becomes apparent that a parent has a learning disability, a referral should be made to adult learning disabilities services’. This is irrespective of whether any concerns have been expressed about the family’s abilities to parent their child. Earlier assessments of the supports that are needed and proactive approaches can prevent avoidable difficulties occurring later on.

assessments are often requested later on in pregnancy, or shortly after the birth. These requests are often identified as being urgent. The stage of pregnancy/age of the baby, the effects of stress on cognitive and other performance and other factors pertinent to the timing of the assessments may need to be considered and commented upon.

In Table 2, the flowchart on aspects of assessment indicates what paths different assessments may take. In reality, it is often the case that several different questions are being posed to the clinical psychologist and as a result they may find themselves following several pathways for the same client. Furthermore, a comprehensive and more effective assessment is more likely to be achieved if the assessment of the parent with a learning disability is multi-disciplinary and across agencies (Department of Health & Department for Education and Skills, 2007). With the correct support, many parents with learning disabilities are able to parent safely and to a 'good enough' standard. It is important that their skills and abilities are assessed in their own right and not compared to an ideal or perfect model of parenting.

Consent and confidentiality

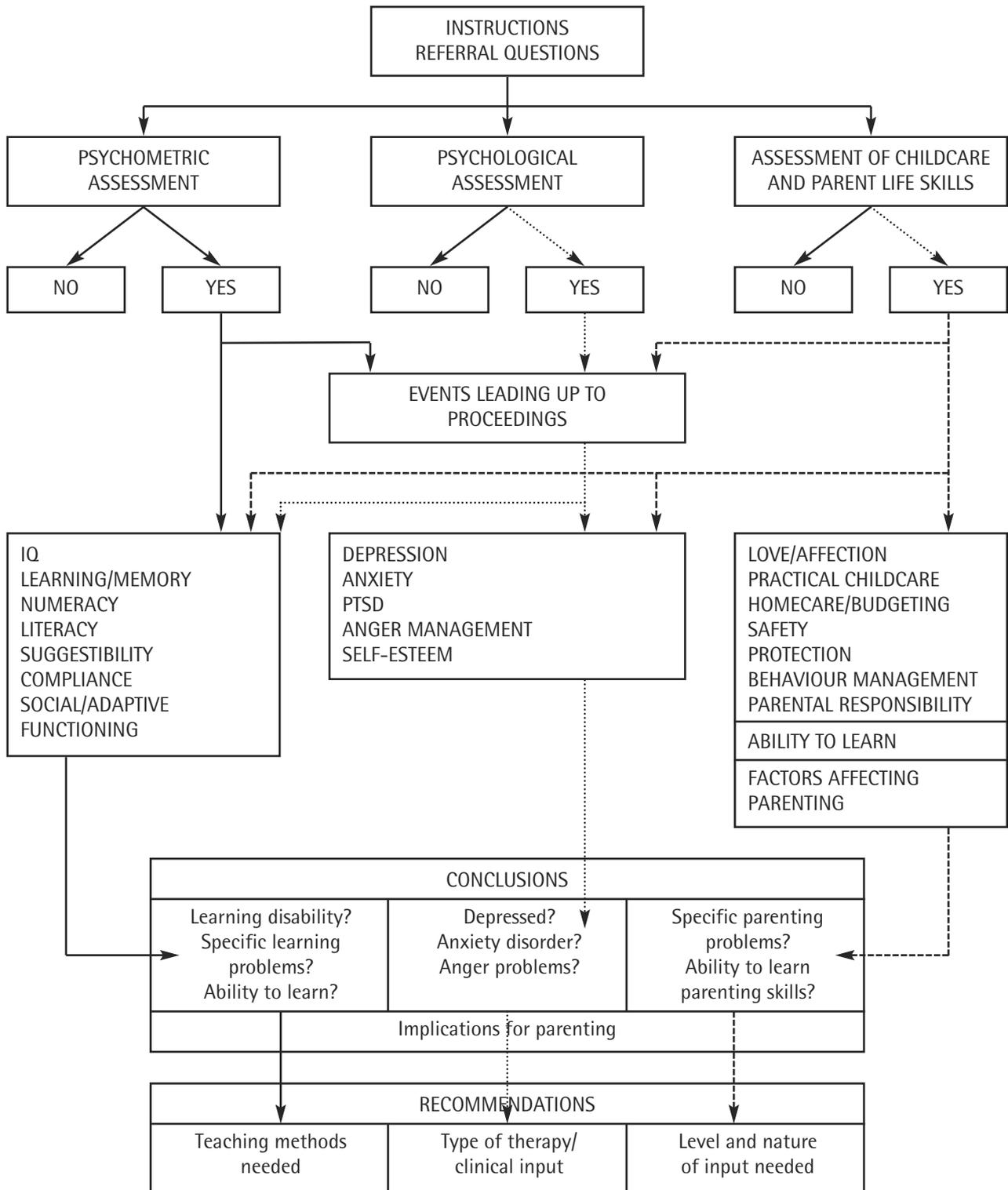
As in all clinical practice it is essential and good practice to gain informed consent from the individual being assessed. This should cover the nature of the assessment, how long the assessment may last, and who will receive the final report. This process will be facilitated by having a clear plan agreed with the referrer around which areas you will be assessing. This information should be clearly documented in clinical notes and/or other correspondence. It is also important to clarify the limits of confidentiality and you may wish to communicate this in writing with the individual(s) being assessed in a format appropriate to their literacy skills. Furthermore, there needs to be a careful balance between maintaining client confidentiality and communicating important clinical information to other professionals. When working as an expert witness there can be no guarantee of confidentiality. Any information gathered during the assessment may be divulged to the court and the court can subpoena clinical notes and reports and these instructions will override the limits of confidentiality (see Section 4 for further information).

Cultural issues

When carrying out parenting assessments, it is important to be aware of different cultural, educational and life experiences. These issues need to be sensitively explored and taken into account when interpreting the results of cognitive assessments and when commenting on an individual's parenting, practices and beliefs. Some assessments may warrant the use of interpreters.

As in any clinical assessment, care needs to be taken in these situations and it needs to be clear in the report when an interpreter was used. When using interpreters it is recommended that there is a pre-assessment meeting with the interpreter to explain the nature of the assessment and their remit. In some cases, it may be beneficial to interview the interpreter around specific cultural expectations and practices, for example, the age of leaving school in a certain country. It is also important to agree beforehand whether the interpreter will be providing you with 'word for word' translation or a wider interpretation of the assessment.

Table 2: Aspects of assessment



Gender and co-parenting issues

Referrals for parenting assessments are often directed specifically at mothers, particularly where the child's father is either unknown or unwilling/unable to be involved. However, parenting assessments 'should ideally include fathers or other men involved in the family (even when they are not the child's father), to establish any positive or negative contributions they are making to the household and the extent to which they are promoting or inhibiting the well-being of the child or children' (McGaw & Newman, 2005, p.32). This is especially relevant when children are affected by the father's presence or thought to be 'at risk' from them in some way. Also, there may be other members of the parent's extended family and their peer group who contribute a negative or positive influence on their parenting. Where appropriate, their contribution should be evaluated, either directly or indirectly, as part of the assessment.

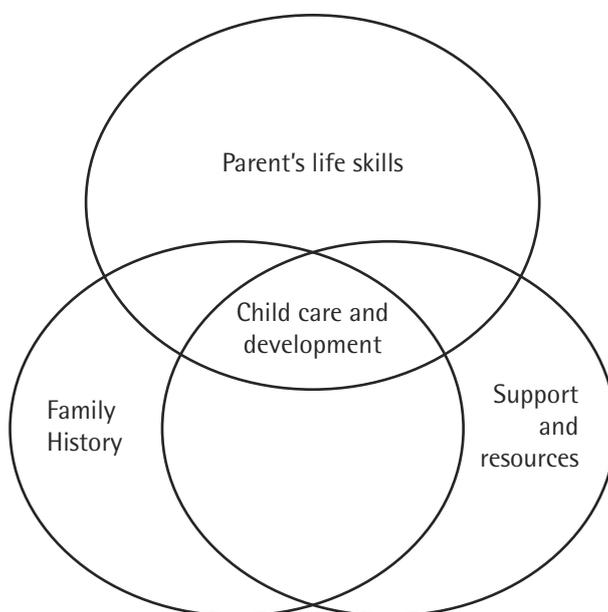
Model of assessment

McGaw and Sturmev (1994) developed the Parental Skills Model (PSM) to guide the assessment of parents with learning disabilities. Their model describes a number of areas which are seen as predictors of parenting skills. These are parent's life skills, family history, support and resources, and child care and development.

Parent's Life Skills

Assessment of a parent's life skills may include the following.

Figure 1: The Parenting Skills Model (PSM) (McGaw & Sturmev 1994).



- ***An assessment of a person's level of cognitive functioning.*** This may include a measure of general intellectual ability, memory and learning abilities, executive abilities and/or literacy and numerical skills. These results are then interpreted with the aim of making links between the identified strengths and deficits, how these might manifest themselves in everyday behaviour, and recommendations for compensatory strategies.

In certain circumstances some of these tests may already have been completed with the individual for other reasons. For example, the individual may already have completed an assessment of general intellectual ability to ensure that they are eligible for services from a community learning disabilities team. Ideally there should be an interval of 12 months between assessments because of practice effects.

When choosing which tests to administer, consideration should be given to the resources available, the cognitive abilities assessed by the specific test, the reliability and validity of the test, whether the test has normative data for people with learning disabilities, the cultural bias of any test, any impact of physical or sensory difficulties, as well as ease of administration and practical restraints in terms of where the testing may need to take place. These factors may need to be commented upon in the final report.

There is a risk, when reporting test results in reports, that they may be misinterpreted and misunderstood by non-psychologists. Depending upon the remit of the assessment and who the report is being circulated to, it may be beneficial to describe the range of abilities of a person within the report. It is good practice to state confidence intervals as well as specific results.

The results of formal tests can be used to comment on an individual's learning style, for example, whether they learn best using visual or verbal material, whether repetition is beneficial and so forth. Additional information around optimal learning styles can also be gained via more informal methods such as observing how the individual completed the tests, asking the individual how they have learnt how to do certain tasks in the past, and what they have found has helped them to learn new skills previously.

- ***An assessment of self-care, domestic abilities, and community living skills, and safety within the home.*** There are a number of structured interviews that can be completed with the individual or with others who know them well which can help highlight where specific support or skills training is required. This is an important area to be assessed, although it may not always need to be completed by the psychologist. The results of cognitive assessments in combination with assessments of daily living skills are used to define whether or not an individual has learning disabilities.
- ***Assessment of the individual's emotional needs,*** for example, previous life experiences, current and past depression, anxiety or trauma, current mental state, self-esteem, anger management, emotional maturity and emotional need. In some cases the additional opinion of a psychiatrist may be warranted.
- ***Assessment of other factors, such as social, economic, cultural and diversity issues*** that might be pertinent to how an individual functions in everyday life.

Family history

This is likely to include information about the individual's childhood and family background and may need to include information about the person's biological as well as their social family if the individual was fostered, adopted or lived in care. The information gathered is likely to include whether the individual was exposed to appropriate child rearing models in the past, potential future/actual support for the parent from within the family structure, as well as experiences of neglect, abuse or trauma in the individual's life that may need addressing.

Parental support and resources

'The best predictor of future parental competency for parents with intellectual disabilities is the quality and frequency of social and practical support available to them on a daily basis.'

(McGaw, 1998, p.200)

Perhaps one of the most critical factors in supporting parents with learning disabilities in being 'good enough' parents is what support is available to them on a long-term basis. The nature and duration of this support may vary across the child's life. An assessment of these factors is likely to consider the training resources available to the parent, the availability and use of professional and informal (e.g. family, friends, etc.) support, as well as an examination of the risk factors surrounding the individual's ability to parent. This would, for example, include their own childhood experiences and family history, in addition to current issues of safety and risk.

Child care and development

This will include assessing the adequacy of physical care, affection, security, responsibility, guidance and control, and stimulation provided by the parent(s). It is likely that other professionals will also be involved (e.g. health visitor, children's workers, social workers, etc.). Whereas the clinical psychologist may be involved in assessing the parent's knowledge of child development and baby care, the other professionals may have more opportunities for making detailed observations or be involved in practical assessments.

Alongside considering those aspects of the Parenting Skills Model you may be assessing, it is important to be familiar with the *Common Assessment Framework (CAF)* (Department for Education and Skills, 2005). The CAF is designed to enable practitioners across all agencies to follow a uniform process and produce consistent assessments that can be shared and understood by other agencies. The clinical psychologist's assessment is likely to contribute to this framework and will be informed by it.

Assessment tools

There are a number of resources that have been specifically designed to help in the assessment of parenting skills. Some, but not all, of these have been designed for use with people with learning disabilities. The tools for assessments listed in Table 3 are not exhaustive, but cover a range of different areas, some of which may be useful, depending on the individual being assessed and the remit of the assessment. The following is a summary of some popular parenting assessment tools:

The Parenting Assessment Manual (PAM) (McGaw, S., Beckley, K., Connolly, C. & Ball, K., 1999; McGaw, S. 2007) has been developed from the Parenting Skills Model as a resource that can be used in assessing vulnerable parents' parenting skills. This is a wide ranging

functional and multi-dimensional parenting assessment focusing on assessing parents' knowledge (ability to acquire and maintain knowledge), skills (ability to transfer knowledge to skills) and practice (ability to maintain and generalise skills). The assessment incorporates observations, questionnaires (written and visual aids) and structured interviews as well as a parent history. Where possible the PAM is best completed using a multi-agency approach.

Within the broad framework of the Parenting Skills Model, the PAM breaks down parenting skills into three domains, namely parental knowledge, quality of skills and frequency of practice. It assesses what someone knows about aspects of child care, whether they have the skills required to carry out 'good enough' parenting skills and if they use these skills consistently. Any assessment of parenting skills contains an element of subjectivity and the PAM does not completely reduce this. What it does provide is a systematic framework that can be used in part or as a whole by a wide range of professionals assessing parenting skills.

To complete the PAM in its entirety can involve a very lengthy assessment. It is possible to use parts of it if there are specific areas of concern. Using the PAM is not solely the domain of clinical psychologists and requires some level of prior training. *The Parenting Assessment Manual* (2nd ed., McGaw, 2007) has since been expanded to take into account cultural diversity.

Additional parenting assessment materials include:

The HOME Inventory (Home Observation for Measurement of the Environment) (Caldwell & Bradley, 1984) which focuses on the responsiveness of the mother, levels of discipline, the physical environment, toys and other stimulation provided within the home.

First Steps to Parenthood (Young & Strouthos, 1997). This is a manual designed to assess knowledge pertinent to parenting where one or both parents has a learning disability. The manual provides a collection of structured interviews that aim to assess an individual's knowledge of child development, from pregnancy to adolescence.

Tymchuk Questionnaires (Tymchuk, 1990, 1991). These are non-standardised checklists which measure knowledge and skills in dealing with common household emergencies (e.g. fires, cuts, or scalds). For each emergency situation, the interviewer asks whether the person has a basic understanding of the problem, how often it has happened to them, what they would do to deal with that emergency, and what not to do. It also assesses home dangers within the living environment. This allows the clinician to ascertain what dangers are/are not present within the home and whether a child would be able to access them. Both instruments were designed for use for people with learning disabilities.

Parenting Stress Index (PSI) (Abidin, 1995). This is a self-report instrument (designed as a screening and diagnostic assessment technique) to identify parent and child systems which are under stress. The domains measured are stresses related to child characteristics, parental characteristics, and situation and demographic factors. It was not designed for use with people with learning disabilities and so may need to be used in a non-standardised way.

Key Points

- Clarify the purpose of the psychological assessment.
- Explain what information the assessments will produce and whether there are any limitations.
- Maintain perspective, matching content of assessment to skills/expertise and time-frames.
- Gain client consent and maintain a balance between client confidentiality and communicating information to others.
- Be aware of when it might be inappropriate to assess a parent.
- Use the Parental Skills Model (PSM) to guide the assessment.
- Be aware of different cultural, educational and life experiences and beliefs.

Table 3: Tools for assessment.

Area of functioning	Tests available*
Family history/ life experiences	Interview Case notes
IQ	Wechsler Adult Intelligence Scale (4th ed.) (WAIS-IV) (Wechsler, 2010). Wechsler Abbreviated Scale of Intelligence (WASI) (Wechsler, 1999a). Leiter International Performance Scale (2nd ed.) (Roid & Miller, 1997).
Life skills (social and behaviour functioning) Learning and memory	Adaptive Behaviour Assessment System (2nd ed.) (ABAS-II) (Harrison & Oakland, 2003) Vineland Adaptive Behaviour Scales (2nd ed.) (Sparrow, Cicchetti & Balla, 2005) Wechsler Memory Scale (3rd ed.) (WMS) (Wechsler, 1999b). Warrington Recognition Memory Test (Warrington, 1984). Adult Memory and Information Processing Battery (Coughlan & Hollows, 1985). Rivermead Behavioural Memory Test (RMBT) (Wilson, Alderman, Burgess, Emslie & Evans, 2008). Rivermead Behavioural Memory Test for Children (RMBT-C) (Wilson, Ivani-Chalian & Aldrich, 1991). Doors and People Test (Baddeley, Emslie & Nimmo-Smith, 1994).
Executive abilities	Subtests from Behavioural Assessment of Dysexecutive Syndrome (Wilson, Alderman, Burgess, Emslie & Evans, 1996). Behavioural Assessment of the Dysexecutive Syndrome for Children (BADS-C) (Emslie, Wilson, Burden, Nimmo-Smith & Wilson, 2003). The Cambridge Executive Functioning Assessment (Ball, Holland, Treppner, Watson & Huppert, 2008). Trail Making Test (Partingdon & Leiter, 1949).
Literacy	Neale Analysis of Reading Ability (3rd ed.) (Neale, 1999). Wechsler Objective Reading Dimension of the Wechsler Individual Achievement Test (2nd UK ed.) (WIAT) (Wechsler, 2005). Wide Range Achievement Test (4th ed.) (WRAT-4) Wilkinson & Robertson, 2006) (reading and spelling). Reading a tabloid newspaper headline and text. Reading safety instructions such as on a bottle of bleach.
Numeracy	BAS Basic Arithmetic Skills Test (2nd ed.) (Elliot, Smith & McCulloch, 1996). WAIS-IV Arithmetic subtest (Wechsler, 2010). PAM (budgeting section) (McGaw, Beckley, Connolly & Ball, 1999; McGaw, 2007). Wide Range Achievement Test (4th ed.) (WRAT-4) Wilkinson & Robertson, 2006) (written arithmetic).
Emotional/psychological functioning	Beck Depression Scale (2nd ed.) (Beck, Steer & Brown, 1996). State-Trait Anxiety Scale (Spielberger, 1983). Glasgow Anxiety Scale (Mindham & Espie, 2003). Glasgow Depression Scale (Cuthill, Espie & Cooper, 2003). State-Trait Anger Expression Inventory 2 (Spielberger, 1999).
Self-esteem	Culture Fee Self-esteem Inventory (2nd ed.) (Battle, 1992).
Mental health	Mini PAS-ADD (Moss, 2002) (if an informant is available). Brief Symptom Inventory (Derogatis, 1975). Brief Symptom Inventory self-report with assisted completion (Kellett, Beail, Newman & Mosley, 1999; Kellett, Beail, Newman, & Frankish, 2003).
Adult attachment	Adult attachment interview (3rd ed.) (George, Kaplan & Main, 1996). Bene Antony Family Relations Test (Bene & Anthony, 1985).
Parenting skills	Parenting Assessment Manual (PAM) (McGaw, Beckley, Connolly & Ball, 1999; McGaw 2007). HOME Inventory (Caldwell & Bradley, 1984). First Steps to Parenthood (Young & Strouthos, 1997). Assessing emergency responses (Tymchuk, 1990). Assessing home dangers an safety precautions (Tymchuk, 1991). Royal Society for the Prevention of Accidents (RoSPA) (www.rospace.com).
Parent-child relationship	Observation. Assessment of child.
Parental coping	Parenting Stress Index (3rd ed.) (PSI-3) 36-item short form (Abidin, 1995).
Support networks: Professional, Extended family Peer group	Interview Case notes

*There are a number of resources that have been specifically designed to help in the assessment of parenting skills. Some, but not all, of these have been designed for use with individuals with learning disabilities. The resources listed in the Table are not exhaustive, but cover a range of different areas, some of which may be useful, depending on the individual being assessed and the remit of the assessment.

B. The assessment report

The content of the assessment report will be determined by the focus of the assessment itself. Table 2 (Aspects of Assessment) outlines three main areas that might be addressed, either separately or jointly. The remit of the assessment will depend on the nature of the referral or instructions given and the report should focus only on that remit. This section is comprehensive and addresses a wide remit. It does not aim to prescribe the content of all reports but to address and highlight the various issues that could arise. A report summary can be found in Table 4 at the end of this section.

Setting the context of the report

Prior to writing your report, you will have established your role vis-à-vis the parent with a learning disability (see Section 2) and your referral agency. Consent to undertake a parenting assessment and to write a report will have been agreed by the parent or directed by the court. Irrespective of whether your role is defined as professional or expert witness³, it is important to remember that the report may be laid before the court should care proceedings in respect of the child(ren) be initiated. When writing the report it is also important to keep in mind who you are writing the report for. In terms of understanding what the report says, the client is the parent, the group of involved professionals and the court (judge, solicitor and barrister). Each professional will draw conclusions from the report and apply them relative to their own bias in terms of making their arguments for and against the continued care of the child by its parent and relative and the way they feed the conclusions back to the parent. The degree to which each professional can understand the jargon of clinical psychology reports will vary. It is, therefore, important to avoid jargon where possible and to be very clear in the report about what you are concluding so as to avoid inconsistency around interpretation of conclusions. A lack of clarity and understanding could lead to the parent being disadvantaged in the way his/her skills/deficits are viewed or to future input to the parent being, or continuing to be, inappropriate or insufficient.

Writing the report

(1) Instructions

Who is instructing you?

What do they want you to assess?

This first paragraph of your report is very important. It outlines why you are writing this report and what questions you are expected to answer. It also determines the context of your report. Is this a clinical referral which may lead you or a colleague to work practically or therapeutically with the parent(s) or in a guiding role with other professionals? Or are you being instructed by the court with a view to helping the judge make a more informed decision about whether the parent(s) can continue to care for the child?

By accepting the referral or instructions you will have already given due consideration to what is appropriate for you to assess in the context of your expertise (skills base); employment status (contextual constraints); and your available time relative to the timetable of either the court or the child's developmental stage. It is important to remember that where there are concerns about a parent's ability to care for their child

³ 'An expert witness is a person who, through training, study or experience, is able to furnish the Court, tribunal or oral hearing with scientific or technical information which is likely to be outside the experience and knowledge of a judge, magistrate, convenor or jury. The expert's role is to assist the Court and not the party(ies) instructing them.' (*Psychologists as Expert Witnesses*, British Psychological Society, 2007)

there are likely to be care proceedings, irrespective of the stated nature of the referral. Your report will then be placed before the court and you will have to defend its content and the expertise upon which your conclusions are based according to the rules of civil procedure (an up-to-date version of these is obtainable from your instructing solicitor).

The content of this section is thus a statement of who is making the referral and a list of what the instruction questions are.

(2) Process of assessment

What did you do to conduct the assessment?

It is important that your referrers have a clear understanding of what you did to conduct your assessment and why. Your sources of information determine the limits of the conclusions you can make, define the boundaries of your expertise, and alert the referrers to the need to refer to other experts for areas you cannot assess.

When defining the structure and process of your assessment, it is important to take account of the different perspectives that prevail. Irrespective of whether this is a clinical or court referral, it is important to respect the legal perspective of the Children Act (1989) which seeks to place the welfare of the child uppermost, but to reconcile this with the preferred option of placing the child(ren) within the context of the biological family where possible and appropriate. The role of the clinical psychologist in relation to the parent(s) with learning disabilities will lead you to focus on their needs. In this role you can use your expertise to redress the balance of other professionals whose role it is to focus on the child. However, it is important to recognise that you need to take account each member of the family system and the effect of parenting on the child.

In this section therefore, you need to list who you have interviewed, who you have observed and what documentation you have been given to read.

(3) Events leading up to proceedings

Why is this person's parenting being called into question?

This section summarises the history of the case so far and establishes the background for why a parent's care of their child(ren) is being called into question. Whilst such a summary may exist in other documents such as social worker reports, it may not include all the events that you might consider important. The events that have taken place and subsequently led to a referral to you, or to the removal of children, constitute a background against which you begin to understand the views and input of other professionals, to create a contextual framework for your assessment and thereby formulate hypotheses about the person and their parenting which will guide you about how to structure your assessment.

(4) Psychometric assessment

What tests did you use and why?

The aim of this part of the assessment is to determine whether, and to what degree, a parent has a learning disability or specific learning difficulties and the likely effect these will have on their ability to care for their child. Using core tests of IQ, memory and learning, numeracy and literacy, executive skills, suggestibility and compliance (see Section 3A), you can provide a clear picture of a person's functioning. In reporting the results of the tests it is important to be clear, understandable by the parent (maybe with assistance), and other professionals who may not know the jargon, and have relevance to the question at hand.

The results need to be put in the context of a person's educational and employment history and compared to any previous psychometric assessments, explaining any differences that may be found. The results also need to be put in the context of what the research evidence says about level of functioning and the implications for parenting, namely that people with an IQ below 60 have generally been found to be unlikely to be able to provide adequate and safe parenting, whereas it is generally accepted that, for people whose level of intelligence is above this cut-off point, it is important and necessary to take other factors into account. This forms the predictive evidence (i.e. possible competence) against which to measure a person's actual, observed, parenting skills (i.e. performance).

This section needs a description of the tests used and the rationale for using the tests. The results should be explained with scores either tabled within the body of the text or in an appendix. Research evidence should be outlined and the results interpreted in the context of this evidence. This sets the scene for the next section.

(5) Assessment of parenting skills

What is the current and past evidence of the person's parenting skills?

The comprehensive assessment of a person's parenting skills is very time-consuming. It requires assessment over an extended period of time in order to assess basic skills and knowledge, to gauge responses to different situations, and to measure change. It requires frequent input and observations. There are standardised and/or structured measurements (see Section 3A) to guide elements of the assessment. It is, however, debatable whether such a comprehensive assessment falls within the remit of a clinical psychologist or is feasible within their professional/employment context. In addition, it is likely that other professionals (e.g. social workers, family care workers, contact supervisors, foster carers and health visitors) will, albeit in a fragmented way, have gathered this knowledge over time.

The remit of your assessment and the reporting of the assessment focus on your specific expertise around learning difficulties and requires you to focus on whether any deficits/risks in the way a person cares for their child can be explained by their learning difficulties and whether there is capacity for change and improvement. Your role is, therefore, to find out about the current and past evidence of a person's parenting and look at that evidence,

not in absolute terms, but in light of the person's cognitive functioning.

Information about current and past parenting can be gathered by:

- Reading reports.
- Interviewing other professionals who are in contact with the parent(s).
- Observing the parent(s) with their child(ren) in different contexts.
- Interviewing the parents to get their views on their strengths and weaknesses.

The evidence can then be summarised under the following headings:

- (i) Provision of love and affection (cueing in to child's needs, responding to child's needs, ability to comfort, attachment of child to its parent).
- (ii) Practical child care skills (feeding, bathing, nappy-changing, clothing and so on).
- (iii) Housekeeping and budgeting skills (maintenance of home, preparation of meals, paying bills, shopping).
- (iv) Provision of an optimal environment for child development (play and stimulation, moral and behaviour guidance, skills teaching).

- (v) Practical safety (indoors, outdoors).
- (vi) Protection (emotional, physical and sexual safety).
- (vii) Boundary-setting and behaviour management.
- (viii) Parental responsibility (immunisations, medical appointments, school attendance, home stability, continuity of parenting, and so on).

The summaries should provide a clear picture of what the parent does and does not know or do and, where appropriate, what the response of the child is to the parents' behaviour. The behaviours observed and commented on would relate to general expectations of good enough parenting. Where information is not available, you may need to undertake an assessment of an identified gap in knowledge or skills.

The task of the clinical psychologist is then to consider whether the person's child care skills are consistent with, or explained by, those skills predicted by your cognitive assessment and the research evidence. In commenting it is important to underpin opinions with observations and it is useful to have a summarising paragraph at the end of the section.

(6) Assessment of parents' ability to learn

Is there evidence of learning by the parent in response to input given?

The first task in this section is to summarise the teaching and support that has been given by professionals. This might be specific teaching sessions in a family centre or more general advice given by GPs, health visitors, contact supervisors, and family care workers. How often does this teaching happen? Where does it happen? What does it consist of? What are the teaching goals? Is the input relevant to the stated goals? Does it take place within a group or is it individually geared to the parent with the learning disability? Is the input by the various professionals co-ordinated so as to be consistent? Does it fit in with family beliefs around child care and any specific advice given by the extended family or peer group? Has the mode of input been informed by learning disability expertise (research, field professionals)? Do the 'teachers' have an understanding of learning disabilities?

It is important to describe the input and support in detail in order to decide whether this is consistent with research findings about the nature, frequency and location of input, and whether the input is appropriate to the needs of a parent with learning disabilities. If it is not, it is difficult to judge a person's ability to learn. Very often social workers will describe the input given as 'intensive'. This tends to be judged by the amount of time professionals put in to a family rather than by the nature of the input and its appropriateness to the parent. This needs to be clarified so that suggestions can be given as to how the input might be better structured. Equally the conclusions of other professionals working with the parent(s) often restate what research evidence already tells you to expect as weaknesses, thereby indicating a lack of understanding and appropriate goal-setting.

In brief, the research findings described in Section 1 show that in relation to parenting skills, people with learning disabilities are capable of love and affection. They can learn and maintain, with support, practical skills in relation to both child care and housekeeping. People with learning disabilities do, however, have difficulty providing an optimal child-rearing environment because of their level of cognitive development, concrete thinking, inability to generalise learning, and communication deficits. Their children have been found to be at risk of developmental delay, especially in relation

to language, through lack of stimulation and social interaction. They are also more likely to behave reactively rather than pro-actively to situations which will affect their ability to predict the consequences of their own and their children's actions and to protect them both physically and psychologically. Without direct guidance they will have difficulty in keeping pace without the constantly changing needs of a young child. Learning disabled parents also tend to be more restrictive and use punishment rather than praise.

In relation to teaching and learning, research indicates that, in accordance with behavioural analysis approaches, teaching programmes need to be intensive, individualised, and highly concrete in order to achieve optimal learning, taking into consideration the learning environment, the process of teaching, active not passive learning, repetition and rehearsal, consistency of teaching approach and feedback/criterion of success. Periodic and ongoing long-term support is needed to maintain skills, and both maintenance and generalisation of new learning is helped by teaching in real-life settings, preferably in the parents' home, and by the involvement and support of parenting partners. (See Section 1 for further information.)

In summarising and evaluating the teaching and support given and whether the parent(s) shows evidence of learning you need to consider:

- Is the degree of learning consistent with your test predictions?
- Is the input appropriate to the learning difficulties of the parent and does it take account of the predictive evidence (research, your tests)?
- Under what circumstances (level of support/input) does the parent function best?
- What factors appear to make parenting more difficult?

At this stage in your report it is important to answer the question of a parent's ability to learn, not to give guidelines for future input.

(7) Factors affecting parenting

Are there any other factors that might affect a person's parenting skills?

A person's ability to care for a child can be affected by a number of different factors other than, or in addition to, learning difficulties. These may be external to the parent or inherent within the parent and/or child(ren). They may be amenable to change or not and need to be compensated for or managed. It is important to try and differentiate between the impact of a person's learning difficulties and the impact of other factors on their ability to care for a child.

The following are the main factors that are likely to impact on a person's ability to use or develop their parenting skills.

■ *Childhood experience*

A person's own experience of being parented and living within a family will provide parenting, home-making and relationship role-models that the new parent will use in relation to their own partner and child(ren). These role-models may be positive or negative and will create a set of beliefs that need to be explored in order to understand the behaviour of the person you are assessing. It is also important to take account of any abuse, neglect, separation, loss, and traumatic life-events that have occurred in the parent(s)' childhood as these experiences will determine the degree to which their own emotional and psychological needs have been met and they are emotionally available to their child(ren).

■ *Physical and psychological factors*

This section needs to take account of any health factors, both physical and psychological, that may have an impact on parenting. Here you will need to include the results of any psychological tests or psychiatric reports relating to depression, anxiety, anger, self-esteem, etc. The effects of such conditions may be transient, episodic, fluctuating or permanent (e.g. pain, epilepsy, physical disability, depression, personality disorder, PTSD, and schizophrenia) and each may carry risks in relation to the care of a child. Each condition can be described in terms of its ‘predictive’ effect on parenting (i.e. what we know about the effects of the illness) and this effect needs to be compared with the ‘actual’ or observed effect on parenting and what coping strategies a parent is able to employ. Drugs, alcohol and other addictions are also likely to have a high impact on a person’s ability to care for a child. Again there needs to be a comparison between the predictive and actual effect of these conditions on parenting.

■ *Co-parenting partner*

When a person has learning disabilities, his/her difficulties in parenting can often be compensated for, and their parenting skills enhanced by, the help of a more able parenting partner. Equally, a negative co-parenting relationship can hinder both the acquisition and application of parenting skills. Referrals for assessment usually focus on the mother of the child unless there is a long-established co-parenting partnership. The issue of who is the co-parenting partner in its widest sense needs to be addressed. Who else within the family or social network plays an important care role and to what extent does this person or people help or hinder the primary parent with learning disabilities in his or her care of the child(ren)? Is the person absent, so that an apparent partnership leaves the learning-disabled parent with a lone task? Is the parent deskilled by the partner, verbally or behaviourally? Does the partner present risks (abuse, addiction) to the child that the parent has to safeguard against? Is this within his/her ability?

■ *Number and characteristics of child(ren)*

The number and characteristics of the child(ren) in question is very important. The evidence shows there is an increased incidence of abuse and neglect in families with three or more children. In relation to people with learning disabilities, the evidence shows that the level of care decreases the more children there are. Whereas one child can be a focus of attention, two or more children require a level of multi-tasking that may be beyond a parent with learning disabilities. You also need to ask whether the child(ren) have characteristics or disabilities that would make parenting harder (e.g. medical problems), require specialist parenting (e.g. developmental delay) or trigger inappropriate reactions in parents (e.g. behaviour problems). Can the parent be helped (e.g. by Portage, physiotherapy, child psychology) to overcome these problems? Are the difficulties shown by the child(ren) due to poor parenting or inherent within the child?

■ *Informal support network (extended family, peers)*

In the same way that the extended family will have shaped a person’s own later parenting style during childhood, so in adulthood the extended family can continue

to provide negative or positive role models. For example, sexual abuse within the family will impact on the person's parenting or there may be dependency problems that place an extra burden of care on the parent. On the other hand, the family may be able to provide practical and emotional support that enables the parent with the learning disability to care for the child. You need to establish who the extended family are, the level of contact the parent has with them, the level of interdependency and support (financial and emotional) and what risks they may pose to the child. Similarly, a parent's peer group may help or hinder. The peer group may also be parents but they, too, may also have learning difficulties so it is important to explore whether they help or hinder.

■ *Formal support network*

It is likely that any parent with learning disabilities will require some long-term input and the level of that input will depend on their level of learning difficulties, independence skills and prior experiences. Having explored the support that might be provided by the co-parenting partner or within the informal support network, you need to look at what professionals within the formal support network can provide. What resources can be provided by the Local Authority (family care workers) and health professionals (health visitor, therapists) in the short-term and the long-term? To what extent does the availability of resources match the needs of the parent with learning disabilities and what risks would a lower level of availability carry for the care of child(ren)?

■ *Ability of parent(s) to work with professionals*

Support may be available but to what extent are the parents prepared to work with professionals? To what extent are they prepared to comply with appointments (social work, medical, educational) and if not, why not? Is there a lack of understanding about why they are asked to do things? Does the relationship de-skill or patronise the parent, or does the parent have a particular problem with authority and the need to be independent? Are the working relationships the same for all professionals or does it work well for some and not for others and is it evident why? An exploration of the ability of parents to work with professionals is crucial as this is likely to be necessary if they are to retain care of their child(ren).

■ *Previous experience of children being removed*

Have the parents had previous experience of children being removed, either directly or indirectly through their own extended families or peer group? To what extent has this experience affected their ability to engage with services and professionals? Do they hold beliefs that the previous experience will predetermine the current situation? Does this affect their current behaviour and level of engagement? Have they resolved feelings of grief, anger and anxiety related to the loss of a child? Are there particular places (e.g. family centres) or people (social workers, health visitors) associated with the previous removal who are currently involved? Have the consequences of the previous removal had negative (closed adoption) or any positive (ongoing contact) consequences?

(8) Conclusions

What are my answers to the instructions given?

The content of this section will depend on the specific questions that you have been asked, each question forming the heading of a subsection. Previously you have been fact-finding, now you have to give an opinion. Always respond to the instructions given, drawing on the facts you have found through testing, interviewing and reading, to back up your opinion. Use graphs and tables where this is useful to illustrate comparative data. Remember any report you write may be used in court should care proceedings be initiated. You are there to help the referring professional to work with the parent(s) or to help the judge to make a decision about the ability of the parent(s) to continue caring for their particular child. It is not your role to pre-empt the judge's decision by saying whether a parent should care for their child. It is not your role to advocate for the parent. You are an expert in the field of learning disabilities whose role is to inform the other professionals as to whether the referred person has learning disabilities and what would be the impact of their learning difficulties, and any other psychological difficulties they may have, on parenting a child.

(9) Recommendations

In your role vis-à-vis helping the referring professional or helping the judge, it is useful if you can offer specific guidelines around the following areas.

- Has there been an appropriate level of assessment? What gaps are there? How should they be assessed and by whom?
- What methods of teaching would enhance learning generally in a learning-disabled parent, specifically for the parent(s) you have assessed? What do the goals of teaching need to be?
- Can any psychological disadvantages be changed through clinical/therapeutic input? If so, how should this happen (medication, type of therapy) and what is the likely timescale for achieving change? Would the clinical input make it more or less difficult for the parent to care for their child?
- What level of input and support (frequency, location, intensity, timescale) would be necessary to achieve and maintain over time a 'good enough' level of parenting?

(10) Statement of compliance

At the end of an expert's report there must be a statement that: (a) the expert understands his/her duty to the court; and (b) he/she has complied with that duty (see Civil Procedure Rules Part 35 Experts and Assessors Her Majesty's Court Services). The guidance for *Psychologists as Expert Witnesses* (British Psychological Society, 2007) suggests the following wording:

Statement of compliance

I understand my duty as an independent expert witness is to the court. I have complied with that duty. This report includes all matters relevant to the issues on which my expert evidence is given. I have given details in this report of any matters that might affect the validity of this report. I have addressed this report to the court.

Statement of truth

I confirm that insofar as the facts stated in my report are within my knowledge I have made it clear which they are and I believe them to be true, and that the opinions I have expressed represent my true and complete professional opinion.

Feeding back

As highlighted in the introduction, your report will be read by a number of people that may include the referring social worker or solicitors, the parent and co-parenting partner, the extended family, friends, and the court judge. In view of the nature of the assessment report it is more likely that the referrers will feedback the conclusions to the parent(s) but there is the issue of whether you, as the writer of the report, feedback individually to the parent and how you should do this. As with any report, the feedback can be written or verbal. In the case of a parenting assessment, which has implications for the future care of the child, it is important for any verbal feedback to be read out from a written summary that can be distributed to the referrers so that there is consistency and no room for disagreement. The summary should be written in clear, simple language. It should include your findings and your conclusions and what you have recommended in terms of future action.

Key Points

- Define your professional context and recognise the constraints.
- Define your expertise and do not go beyond it.
- Define the limits of your ability to respond to the referral questions re: time, nature of assessment.
- Compare competence (predictive evidence from research) with performance (observed evidence) in relation to ability to learn and parenting.
- Consider other factors that may affect parenting and their relationship to learning disability.
- Answer the referral questions.
- Be aware of consent and feedback issues.
- The aim of the report is to inform and improve the input of others in supporting the parent and to help the judge determine a parent's future potential for 'good enough' parenting.

Table 4: Report summary.

SUMMARY OF ASSESSMENT REPORT			
SECTION HEADINGS	AIM OF SECTION	CONTENT OF SECTION	RESOURCES USED
1. INSTRUCTIONS	Statement of what are you being asked to assess.	List of instruction Questions	
2. PROCESS OF ASSESSMENT	Describe what you did to make the assessment.	Observations Psychometric tests Interviews Documentation read	
3. EVENTS LEADING TO REFERRAL OR CARE PROCEEDINGS	Summarise why the parent's ability to care for their child(ren) is being questioned.	Document history of preceding events	
4. PSYCHOMETRIC ASSESSMENT	To determine whether and to what degree a parent has a learning disability or specific learning difficulties and the likely effect on parenting skills.	IQ Learning/memory Literacy/numeracy Suggestibility and compliance	Own assessment Previous assessment by other psychologist
5. ASSESSMENT OF PARENTING SKILLS	Summarise and comment on current and past evidence of the person's parenting skills.	Provision of love and affection Practical childcare skills Housekeeping/ budgeting skills Provision of environment for child development Practical safety Protection Boundary-setting Behaviour management Parental responsibility	Reported evidence from professionals working with the family Own evidence from observations Own evidence from interviews with professionals working with the family
6. ASSESSMENT OF PARENTS' ABILITY TO LEARN	Summarise and evaluate the teaching and support given by professionals/family. Consider whether there is evidence of learning by parent in response to input.	Nature and frequency of input and support Appropriateness of input and support relative to a parent with learning difficulties Evidence of learning and whether it is consistent with test predictions.	Research evidence Test evidence
7. OTHER FACTORS AFFECTING PARENTING	Consider whether there are other factors than learning ability that may affect the person's ability to parent.	Childhood experience Health factors Co-parenting partner Number/characteristics of children Informal support network Formal support network Ability of parent to work with professionals	
8. CONCLUSIONS	Respond to the questions contained within the instructions.		
9. RECOMMENDATIONS	Provide guidelines as to whether and how the parent might be helped to enhance their ability to care for their child.	Methods of teaching Level of future support Ability to change through input Need for further assessment	

Section 4: The legal context

Introduction

This section focuses on the assessment of parents with learning disabilities in legal rather than clinical contexts. An explanation is given about the child protection system and the court structure in which the legal process takes place and there is further discussion about the role of the clinical psychologist within this.

It is important to note the differences between primary legislation (Acts of Parliament. e.g. The Children Act, 2004) and secondary legislation (statutory instruments. e.g. Family Proceedings Rules) in England, Wales, Northern Ireland and Scotland. The information provided here only relates to England and Wales. Those seeking detailed guidance about Northern Ireland and Scotland should consult the relevant authorities in those domains.

A. Assessment of parents with learning disabilities within a legal framework

When the Local Authority (LA) makes an application to initiate care proceedings (Public Family Proceedings), the assessment of parents with learning disabilities will take place within a legal framework. The role and expectations of the clinical psychologist within this will vary significantly depending on whether they are acting as a *professional witness* (i.e. completing the assessment as a treating clinician within/on behalf of statutory services) or as an *expert witness* (i.e. directly commissioned by the court as an independent clinician). Regardless of this, it is important to understand the child protection context, the extent and nature of the role, the expectations of the interdisciplinary court-related professionals and the procedures and processes associated with Family Proceedings.

Universal services

Current primary legislation provides all children and parents with statutory entitlement to a range of health, education and community services. *Every Child Matters* (Department for Education and Skills, 2003) and the *Children's National Service Framework* (Department of Health, 2004) enjoins all professionals to work together to achieve positive outcomes for children. If any professional involved with a child has concerns the *Common Assessment Framework* (Department for Education and Skills, 2005) is a nationally standardised approach to conducting an assessment of the needs of a child and deciding how they should be met on a multi-agency basis.

Child in Need

The responsibilities of LA social workers in relation to children are set out in the *Children Act 1989*; the *Children (Leaving Care) Act 2000* (Department of Health, 2001b); the *Youth Justice and Criminal Evidence Act 1999*; the *Adoption and Children Act 2002*; the *Children Act 2004*; and the *Children and Young Persons Act 2008*. Of particular importance is the obligation to make an assessment of whether a child is 'in need' (i.e. the child is unlikely to experience a reasonable standard of health or development without assistance, or their health or development is likely to be significantly impaired without assistance, or if they are disabled).

Assessment Framework

When a child is, or may be, ‘in need’ an assessment should be carried out by a social worker using the *Framework for Assessment of Children in Need and their Families* (Department of Health, 2000). Assessments should cover the following three domains:

- The child’s developmental needs.
- The capacities of parents/carers to respond to these needs.
- The impact of wider family and environmental factors on parenting capacity and on children.

A *Child in Need plan* should outline the support that the child and family need and how it will be delivered in order for the child to attain a reasonable level of wellbeing and development. Such assessments must also assess whether there is evidence that a child is suffering, or is likely to suffer, ‘significant harm’ due to parental acts or omissions and whether the concerns are such that the formal child protection processes should be followed.

Child Protection

The *Children Act 1989* introduced a single coherent framework placing the welfare of the child as its central consideration. The Act has been subject to many updates, procedural changes and additions but the core principles and concepts remain intact including *Parental Responsibility* (PR) and ‘significant harm’ being the threshold triggering compulsory intervention.

Section 47 of the Act gives the LA a duty to make enquiries to decide whether action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm is necessary. When the LA is alerted to concerns which may constitute significant harm, a *strategy meeting* should be convened within three days of being alerted and this meeting will decide whether to proceed with a *Section 47 Investigation*. If this concludes that concerns are likely to meet the significant harm threshold, a *Child Protection Case Conference* (CPC) should be convened within 15 working days.

The CPC will determine if the ‘significant harm’ threshold has been met after considering all of the facts presented. If threshold is met the CPC formally makes the child subject to a *Child Protection Plan* (rather than the previous entry onto the At Risk Register). The CPC will identify a *Core Group* of Professionals to develop, oversee, manage, and implement the Plan. The Core Group at a minimum should meet to review the Plan on a monthly basis. The Initial *Review Child Protection Case Conference* will take place after three months with subsequent Conferences six monthly (as a minimum). A *Pre-Birth Conference* is a Child Protection Conference that takes place owing to concerns that the baby will be at risk of significant harm and/or where another child in the family is already subject to a Child Protection Plan.

Public Family (Care) Proceedings

This is the legal process by which the LA applies to court for a public law order which will determine how the needs of the child are met. In England and Wales there is no single ‘family court’, rather three distinct tiers of court that deal with cases depending on complexity. Each of these can make the same orders as any other court in the hierarchy (with a few exceptions), all are subject to appeals and all operate under the same

procedures (e.g. Practice Directions) that are specific to Family (as opposed to other civil proceedings) as devised by the Family Division of the High Court of Justice.

All applications for public law orders are made at the lowest tier, i.e. the **Family Proceedings Court** (Magistrates' Court), presided over by either Lay Magistrates, supported by legal advisors, or District Judges. More complex cases are immediately, or at any point during the proceedings, transferred to the nearest **County Court** that is a designated **Care Centre**. The care centres are presided over by District Judges or Circuit Judges. Each care centre has a **Designated Family Judge** residing over more complex cases and providing guidance and leadership to others operating within family proceedings. **The Family Division of the High Court** presided over by High Court Judges and led by the President of the Family Division deals with the most complicated family cases.

To grant an order the court has to be satisfied that **Threshold Criteria** are met: (a) *that the child concerned is suffering, or is likely to suffer, significant harm*; and (b) *that the harm, or likelihood of harm, is attributable to:*

- (i) *the care given to the child or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him/her; or;*
- (ii) *the child's being beyond parental control.*

The following definitions are worthy of note in this context:

Harm – *'ill-treatment or the impairment of health or development including for example, impairment suffered from seeing or hearing the ill-treatment of another'*/**Ill-treatment** – *'sexual abuse and forms of ill-treatment which are not physical'*/**Health** – *'physical or mental health'*/**Development** – *'physical, intellectual, emotional, social or behavioural development'*/**Significant** – *'considerable, noteworthy or important'*.

Before making a public law order not only do the threshold criteria need to be met but the court must consider the following principles: **Paramourncy principle** – the child's welfare shall be the court's paramount consideration; **Delay principle** – any delay is likely to prejudice the welfare of the child; **No-Order principle** – the court shall not make an order unless it considers that doing so would be better for the child than making no order at all.

It is also necessary for the LA to provide the court with a cogent **Interim Care Plan**, detailing how the child's identified needs will be met including issues of where and with whom they should reside, health and educational provision and contact arrangements with family members. The court is required to consider and approve the interim care plan and will, if necessary, insist on changes being made prior to granting any order.

Legal Representation

Once the LA has applied for a public law order, a number of individuals become **Parties** to the proceedings, that is, they become formally represented and recognised by the court as having an interest in the case. This automatically includes all those with PR and the child themselves but others have to apply to become parties, for example, a parent without PR or wider family members (e.g. grandparents). It is not uncommon for care proceedings to have four or more parties, all with their own legal representatives.

Of particular note is that the child has their own solicitor acting separately from family members via the **Tandem Model**, whereby a **Children's Guardian** is appointed directly by the

court to advise on welfare issues and instruct the solicitor on behalf of the child. Children's Guardian's have a social work background but are employed/commissioned by a separate organisation (*Children and Family Court Advice and Support Service (Cafcass)* www.cafcass.gov.uk) to act independently of the LA and ensure the welfare issues are promoted and the voice of the child is heard.

Each party normally appoints a **Solicitor** specialising in public family law who provides legal advice, guidance and administrates the procedural elements of the case under the instruction of their client. The child would automatically be allocated a solicitor and a Children's Guardian who work closely together.

During court hearings, especially more complex cases, the solicitor is likely to appoint a **Barrister**, to help represent their client and provide a fresh perspective on the strengths and weaknesses of a case.

The LA advises all relevant individuals to instruct their own solicitor but this advice is not always followed and it is not uncommon to have some family members unrepresented. It is possible for individuals to be a **Litigant in Person**, that is, to have a right of audience within the courtroom but they technically remain legally unrepresented.

A common issue with many parents in care proceedings is the question of whether they have the **Capacity to Instruct** their solicitor, that is, whether they have sufficient understanding of the proceedings and potential consequences to make informed choices. Psychologists and psychiatrists are frequently asked by the court to undertake capacity assessments to ascertain the level of understanding and give an opinion as to whether the individual can effectively instruct their solicitor or whether a **Litigation Friend** needs to be involved to instruct on their behalf. The **Official Solicitor** to the Supreme Court is the litigation friend of last resort if no other individual can be identified to take on this role and will proceed with the case on the basis of their judgement of the best interests of the individual without capacity, although they do take into account the wishes of the individual in question. The individual will often retain the services of their original solicitor, but they will take their instruction from the official solicitor rather than the individual directly.

Public Law Orders

There are a number of different orders that the court may grant.

Emergency Protection Order: Grants PR to the LA, authorising the removal of the child to a place of safety, or preventing the child's removal from a place of safety, and lasts up to eight days (although can be extended)

Interim/Full Care Order: Places a child in the care of a designated LA and which allows shared PR with the parent(s). Under such an order the child has an Interim/Final Care Plan detailing where and with whom they will reside including with parents, other relatives, foster care or residential units. An Interim Care Order needs to be renewed every month throughout the proceedings but once a Full Care Order is granted (normally at the end of proceedings) this order will last until the child is 18-years-old.

Supervision Order: Places a child under the supervision of a designated LA but does not give it PR. This means that the social worker has a statutory duty to supervise, monitor and advise on care. Most supervision orders are for one year but can be shorter or extended up to three years.

Within care proceedings other orders are also granted including:

Residence Order: Sets-out where and with whom a child should live. It confers PR to the holder of this order if it is not already held (e.g. grandparent) but can only be made in exceptional circumstances once the child is 16. Under this order parents retain/share PR but the LA does not.

Special Guardianship Order: A 'half-way house' granting a non-parent carer residency of the child up to the age of 18 years BUT with rights to exercise PR to the exclusion of anyone else with PR. Typically these are granted when the child is going to be placed away from parents on a permanent basis but adoption is not appropriate.

Contact Order: An order requiring the individual with whom a child lives, (or is to live) to allow the child to visit or stay with the individual named in the order. An order often contains specific details such as times and days.

Where the child will live

The court will consider all options and then decide which of the above orders best match the needs of the child and their carer's situation. The LA is obliged to undertake a *viability assessment* of any family member or friend put forward to assess suitability and make recommendations as to the most appropriate legal framework therein. These are often twin tracked, alongside assessments of the parents to avoid delay in the final decision.

Adoption, the legal process by which a child becomes a permanent and full member of a new family is an option open to a LA when planning for a child in their care. Once all alternative avenues have been exhausted, the LA starts their internal procedures for an adoptive placement but also has to apply to the court for a **Placement Order** which authorises them to place a child with chosen prospective adopters. An **Adoption Order** can only be applied for once the child has been living with the prospective adopters for a period of time (from 10 weeks to one year depending on circumstances). An adoption order gives PR to the adopters and extinguishes the PR which any person or LA has for the child. After that, legally the child is as if born as a child of the adopters.

The Public Law Outline

From April 2008 all care proceedings became regulated by the **Public Law Outline** (PLO) in an effort to move away from an adversarial culture to a problem solving one. It divides up the proceedings into pre-proceedings work and four distinct stages, with clear objectives of what should be achieved and target times for the completion of each stage. The times given are targets and do not necessarily represent the time scale achieved in practice.

The PLO introduced an **Overriding Objective** requiring the court to deal with cases justly having regard to the welfare issues involved; and the concept of the **Timetable for the Child**, emphasising the need to control the assessment and investigation process in line with the social, care, health and educational steps that the child is likely to take during the proceedings.

Pre-proceedings: The LA has to complete a pre-proceedings checklist detailing the documents they are expected to have prepared prior to the application (e.g. core assessment, chronology). This ensures the LA provides evidence of attempts to engage with the family and that they have given ample opportunity to resolve difficulties.

Stage 1 – Issue and First Appointment (Day 1 to 6):

The process by which the LA files the application with the court. A first hearing is expected by Day 6 in order for all parties to agree the Timetable for the child and make necessary arrangements to progress based on *position statements* of each party.

Stage 2 – Case Management Conference (within 45 days):

To identify key issues in the case and give full case management directions, including detailed scrutiny of the care plan/timetable for the child and to identify what assessments/expert evidence is required to address the key issues and from whom these will be sourced.

Stage 3 – Issues Resolution Hearing (between week 16 and 25):

To resolve and narrow issues and identify remaining key issues requiring resolution. Agree methods to achieve this.

Stage 4 – Final Hearing (within 40 weeks):

To determine any remaining contested issues between parties and for the Judge to hear all relevant evidence relating to these. Oral evidence would typically follow the order of the LA's evidence, both factual (e.g. social worker) and any expert witness evidence; the parents/other respondent's evidence; and the children's guardian's evidence. Each being subject to *Examination in Chief* (questioned by lead advocate), then *Cross Examination* (questioned by advocates of other parties) and *Re-Examination* (questioned by lead advocate once again). At the conclusion of the Final Hearing the court will give a *Judgement* setting out the reasons for the decision made.

With regard to expert witness evidence there is an accompanying *Practice Direction – Experts in family proceedings relating to children*, which was issued in April 2008. This guidance supersedes all previous guidance relating to expert evidence in family proceedings and can be found at:

www.hmcourts-service.gov.uk/cms/files/Experts-PD-flagB-final-version-14-01-08.pdf

B. The role of the clinical psychologist within the legal process

The British Psychological Society published *Psychologists as Expert Witnesses: Guidelines and Procedure for England & Wales* (2007), which provides a detailed description of the role of the expert witness. If a clinician is considering doing reports for court this is essential reading alongside the most recent Practice Directions.

It is crucially important that clinical psychologists familiarise themselves with the processes and procedures of the court proceedings they are involved with, whether as a professional or expert witness. There are different processes and rules that apply to criminal, civil and family courts and different aspects of the same case may be in parallel proceedings, e.g. family relating to the children's welfare and criminal related to alleged abuse.

Clinical psychologists acting as an expert witness can do so independently, or as part of their main employment (with the employer receiving the fees). It is vital that boundary issues are considered and conflicts of interest avoided in either case, including issues of previous knowledge/involvement with the client/their close family; and being the lone psychologist in a statutory service that may be the only local resource for future referral of

the client. In both scenarios being instructed as the expert witness would be contra-indicated.

As highlighted in Section 3, it is critically important to be clear what is being asked, by whom with what associated expectations and demands. Clinical psychologists also need to be clear what is within their professional expertise and what is possible given any constraints that are imposed (see Section 2 for further discussion).

As an expert witness, the clinical psychologist will negotiate with an instructing solicitor. Often a case is instructed jointly, which means that all parties in the case have agreed to instruct you and the total cost of your bill is divided between the parties. This reduces the need to have multiple experts on the same case. Clinical psychologists can also receive sole instruction (from one solicitor only) which is when only one party instructs you.

Solicitors will require an up-to-date copy of a Curriculum Vitae, an outline of fees (including travel times, mileage, hourly rate, daily rate for court attendance) and an estimate based upon the questions posed of the likely time required to complete the assessment. Solicitors will also want to agree the time scale for the submission of the report.

The overriding duty of the expert witness is to be of assistance to the court and the report belongs to the court NOT the psychologist or client and cannot be disclosed to anyone outside of the court arena without court/parties permission. Psychological reports are often disclosed to the individual's GP or local statutory services to access services/treatment and the expert may or may not be consulted in this regard.

The expert witness is independent of any of the instructing parties and must provide an expert opinion based upon their assessment. This is very different to normal clinical work which may involve advocating on behalf of the client but such actions would be wholly inappropriate within the role of an expert witness. Given these differences it is essential to seek supervision and guidance to ensure compliance and deeper understanding of a complex role.

Within the context of the public family court proceedings other experts may have been instructed and meetings set-up in order to clarify or minimise discrepancies between expert views. These may take place indirectly through written communication or directly by telephone or meeting. Where a meeting is called, it is usual for the solicitors to be present, the minutes of which are always kept and made available to the court.

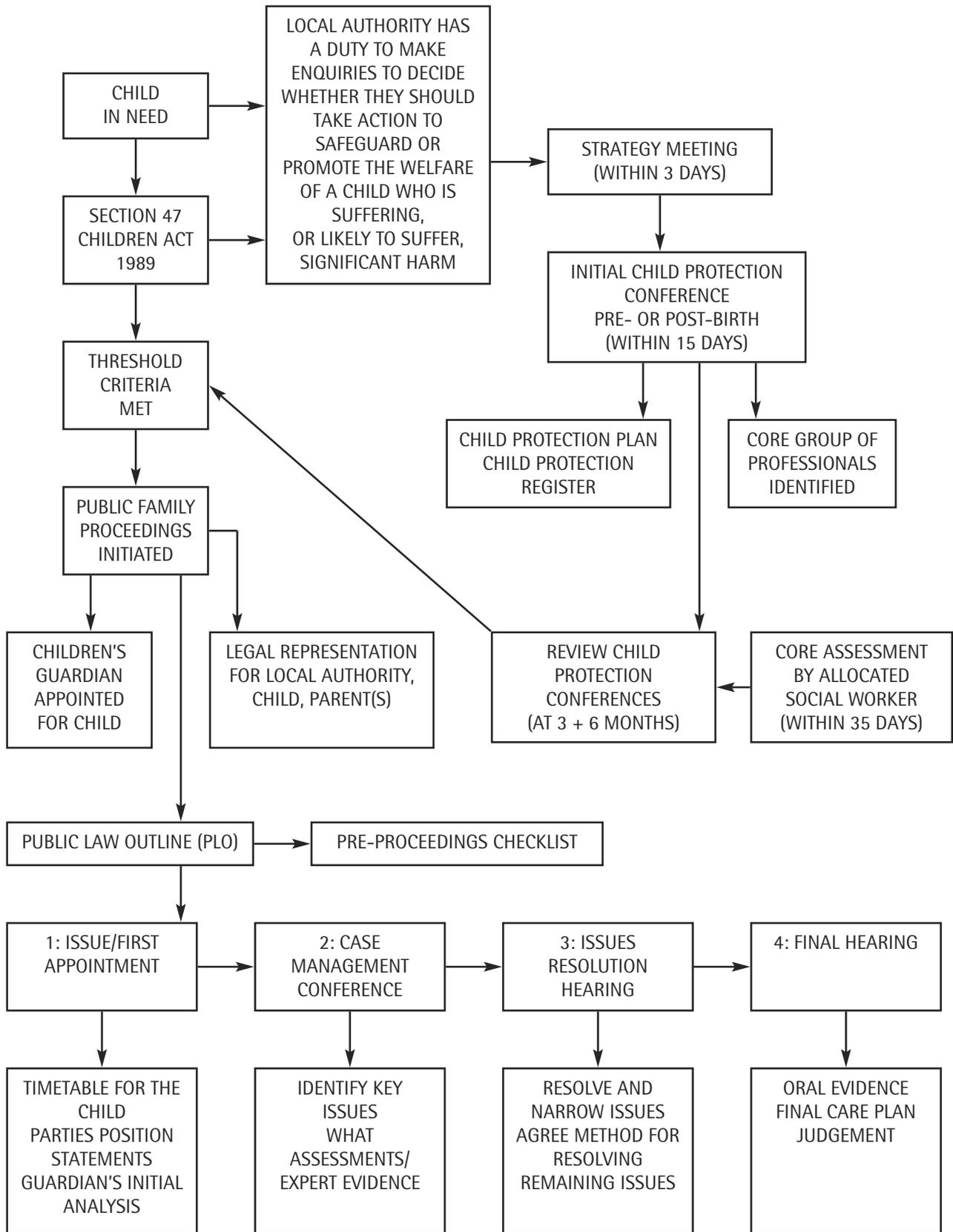
Only a proportion of court reports result in attendance at court being required, but if a clinical psychologist agrees to do a report they **MUST** be prepared to attend and will need training in giving oral evidence. There are training courses and resources available to help prepare (see Section 5).

Expert witness work with parents with learning disabilities can be distressing and/or challenging work, particularly if children are removed. Clinical psychologists working in learning disability services often experience dissonance between the person with a learning disability and the needs of the child. It is useful to talk to other clinical psychologists who have acted as expert witnesses and essential to ensure that adequate supervision is in place for any court work undertaken.

Key Points

- Clarify at the outset whether you are being given a clinical referral or being asked to provide an assessment as an independent expert witness?
- Where a child is considered 'at risk' of significant harm, public family proceedings may be instituted and a public law order granted by the court which will influence where a child lives, who has parental responsibility and the nature of future contact between the child and its parent(s).
- Where public family proceedings have been initiated the clinical psychologist will usually be directed by the court and the assessment report will be deemed as expert witness work.
- As an expert witness the clinical psychologist will negotiate with an instructing solicitor and be subject to court timescales and rules.
- There is no confidentiality and all discussions must be recorded.
- If you agree to do a court report you **MUST** be prepared to attend court.
- Your role in court is to help and inform the court and in particular the decision maker(s)/Judge.
- Clinical psychologists need skills in giving oral evidence to court.
- Clinical psychologists need specialist support and supervision relating to content, presentation and court process.

Table 5: The Child Protection Process.



Section 5: Supervision and training

Introduction

This Section looks at the necessary components of supervision and training in relation to carrying out parenting assessments. It is not intended to be prescriptive but recognises both the emotional and ‘expert’ aspects of assessing parents with learning disabilities and the impact that the assessment will have on the outcome for the family.

The assessment of parenting, particularly when it takes place within a child protection context and thereby has long-term implications for the placement of a child, is a skilled task that requires a sound knowledge base and expertise. It can also be a very stressful task, particularly where it is necessary to appear as an expert witness in court. Irrespective of whether the clinical psychologist is working within an agency context or independently, it is, therefore, recommended for both these reasons that there is access to supervision and training.

Supervision

Supervision is a fundamental part of a clinical psychologist’s work when working with parents with learning disabilities, as it is with any aspect of clinical work undertaken by a clinical psychologist. Supervision of parenting assessments can take place within supervision sessions that the clinical psychologist already receives where an existing supervisor has the necessary experience and expertise required to carry out this type of supervision. Where this is not the case, supervision will need to be sought externally. As this may have cost implications, a discussion will need to take place with the relevant managers and/or heads of department before being set up. The local Special Interest Group (SIG) for clinical psychologists working in learning disabilities may be of some assistance in suggesting names of local clinical psychologists with the necessary experience and expertise who may be willing to offer supervision. Reference could also be made to the *Directory of Expert Witnesses* (www.bps.org.uk) which provides a list of names of clinical psychologists who work as expert witnesses.

What can supervision offer?

1. *Help to define the context and focus of the assessment.*

- At the point where a clinical psychologist is considering whether to accept a case and what form any psychological work may take it is useful, as a first step, to discuss with a supervisor the nature of the concerns (reason for referral), the context of the referral and the most useful way to proceed.
- Concerns around child protection issues and procedures need to be discussed and kept in mind during the assessment process.
- Concerns around the potential conflict of interest between clinical and expert witness roles also need to be considered.

2. *Provide information about tools for assessment, the process of assessment (where, when and how) and current research on parenting.*

- Parenting assessments are not standard. Assessment tools are not all standardised for parents with learning disabilities and need to be selected and sometimes tailored to

meet individual needs. There should be discussion around which tests are appropriate to the assessment and the limitations they may have in drawing evidence-based conclusions.

- Where should a person be assessed? In your office? In their home? At their solicitor's office? And who may be present? What are the circumstances that will determine the location?
- What does the current research tell us about parents who have learning disabilities? How will this enable us to formulate hypotheses to guide our assessment and validate our conclusions? Discussion with an informed supervisor can make this clearer and more focused.
- Where the request for an assessment constitutes a clinical referral there may be support available in the form of training or opportunities to shadow other clinical psychologists. This is not possible with expert witness assessments as each person involved has to be directed by the court.

3. Enable the clinical psychologist to maintain the agreed focus of assessment.

- There may be other complexities that impinge on the assessment that need to be discussed and expert guidance sought elsewhere, for example, in cases where there is domestic violence, drugs and alcohol abuse or post-natal depression.
- Due account needs to be taken of the wider network. Other professionals will be doing assessments which may be a source of knowledge about the client. The network may also seek to draw the clinical psychologist into meetings and supervision will help to clarify the value and appropriateness of involvement.

4. Enable the clinical psychologist to formulate conclusions and recommendations based on the assessment results and their context of research.

- To what extent do the results of the assessment fit with research predictions and what recommendations could be made about future input to the parent(s)?
- What and with whom should clinical and/or assessment information be shared?
- Are there boundaries around confidentiality? What if any restrictions can or should be placed over the use and dissemination of assessment information?

5. Provide psychological support and understanding relevant to the clinical psychologist's interaction with parents and the necessary conclusions.

- Support may be necessary to enable the clinical psychologists to think about their own life cycle, their views on what constitutes 'good enough' parenting and their own personal circumstances, and how these might affect the process of assessment and their conclusions.
- The experience of working with parents who face the very real threat that they will lose the right to parent their child may have an emotional impact on the clinical psychologist.
- Discussing and airing possible fears around having to appear in court as a witness. The clinical psychologist may not feel confident or appropriately skilled to appear in court.

Training

Where an assessment takes place within a legal framework, it may be necessary for a clinical psychologist to appear in court and answer questions relating to their assessment report. To enable the clinical psychologist to do this with ability and confidence it is necessary to have guidance and training in:

- Writing court reports;
- Giving evidence in court.

This can, to some extent, be provided by an appropriately qualified supervisor but it is also useful to attend training courses that will provide a first-hand experience of being cross-examined under oath by solicitors and judges. Such courses are provided through the British Psychological Society, other non-psychology agencies (e.g. Royal College of Psychiatry) and private organisations (e.g. Bond Solon).

Key Points

- Supervision is a key component to working with parents with learning disabilities.
- Work needs to take place early on in supervision to clearly define the role of the clinical psychologist.
- The supervisor can help to think about and keep in mind the child protection issues and procedures and be realistic about what work can be offered.
- Identifying areas where the clinical psychologist has anxieties and does not feel confident or competent can also be discussed sensitively in supervision.
- Clinical psychologists need to be aware of the research on parents with learning disabilities.
- Clinical psychologists need training in giving evidence in court.

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Section 7: Appendices

Appendix 1: Questions to ask the referrer before assessing parents with learning disabilities

Consent

- Is/are the parent(s) aware of the referral?
- Has/have the parent(s) being referred consented to the referral?
- Is parental consent informed by a good understanding of why they have been referred? How has the referrer established this?
- How do(es) the parent(s) view the referral? What is their understanding of why they have been referred to learning disabilities services? What does 'learning disability' or 'learning difficulty' mean to them?

Previous assessments

- Have there been any previous assessments of this person's learning strengths and needs or of their parenting skills?
- Do any previous assessments need to be released from court?
- How can any previous assessments be accessed? (e.g., through a request from social services legal department on your behalf)

Carrying out the assessment

- Where is the best place for any assessment to be carried out?
- Has/have the parent(s) any supporters or family that would help the process of assessment?
- Is there anyone who should not be contacted?
- Will translation or interpreting services be needed? Are there any other cultural or diversity factors which should be taken into account?

About the child

- How old is the child or how many months into the pregnancy is the mother?
- Is a child protection plan in place? Are care proceedings underway? Is the child identified as a child in need? Are there issues relating to safeguarding children?
- Is there any known domestic violence in the home?

Who is involved?

- Do(es) the parent(s) have an independent advocate? (independent advocacy should always be provided where children are the subject of a child protection plan/care proceedings)
- Do(es) the parent(s) have a social worker?
- Do(es) the parent(s) have/need an appropriately skilled key worker?
- Do(es) the parent(s) have a solicitor acting for them?

Court proceedings

- Is a report needed for court?
- What is the time frame for the assessment and report?
- Can different aspects of the parenting assessment be completed within different time frames? (e.g. an assessment of strengths and special learning needs within a specified shorter period or a comprehensive parenting assessment within a specified longer period).

Appendix 2: Parent Training Resources

1. Additional Parenting Resources

CHANGE. You & Your Baby 0–1 year. www.changepeople.co.uk.

CHANGE. You & Your Baby 0–1 year. Picture Bank. www.changepeople.co.uk.

CHANGE. You and Your Little Child 1–5. www.changepeople.co.uk.

CHANGE. You and Your Little Child 1–5. Picture Bank. www.changepeople.co.uk.

CHANGE. Planning a Baby. Website: www.changepeople.co.uk

CHANGE. My Pregnancy, My Choice. Website: www.changepeople.co.uk

Parenting Skills Cards (available from British Institute of Learning Disabilities: www.bild.org.uk)

McGaw, S & Smith, K. (1998). *Parenting Skill Cards: Children Need Healthy Food. British Institute for Learning Disabilities. Set 2.*

McGaw, S. & Tornabene, A. (2000). *Parenting Skill Cards: Children Need to be Clean, Healthy & Warm. British Institute for Learning Disabilities. Set 3.*

McGaw, S. & Valentine, D. (2002). *Parenting Skill Cards: Children Need to be Safe. British Institute for Learning Disabilities. Set 4.*

McGaw, S. & Tornabene, A. (2000). *Parenting Skill Cards: What is Love? British Institute for Learning Disabilities. Set 5.*

Parenting Booklets (available from British Institute of Learning Disabilities: www.bild.org.uk)

McGaw, S. (1995). *'I want to be a good parent...'* British Institute of Learning Disabilities.

McGaw, S. (1995). *Children need healthy food. British Institute of Learning Disabilities. Set 2.*

McGaw, S. (1995). *Children need to be clean, healthy and warm. British Institute of Learning Disabilities. Set 3.*

McGaw, S. (1995). *Children need to be safe. British Institute of Learning Disabilities. Set 4.*

McGaw, S. (1996). *Children need love and to learn right from wrong. British Institute of Learning Disabilities: Set 5.*

2.Suggested Further Reading

Factors impinging on parenting|

Campion, M.J. (1995). *Who's fit to be a parent?* London: Routledge

Reder, P. & Lucey, C. (Eds.) (1995). *Assessment of parenting psychiatric and psychological contributions.* London: Routledge.

Reder, P., Duncan, S. & Lucey, C. (Eds.) (2003). *Studies in the assessment of parenting.* Hove: Brunner-Routledge.

Abuse and neglect of children

Iwaniec, D. (1995). *The emotionally abused and neglected child: Identification, assessment and intervention.* Chichester: John Wiley & Sons.

Mullender, A., Hague, G., Imam, Umme, Kelly, L., Malos, E. & Regan, L. (2002). *Children's perspectives on domestic violence.* London: Sage Publications.

Renvoize, J. (1995). *Innocence destroyed: A study of child sexual abuse.* London: Routledge.

Contact, adoption and fostering

Howe, D. (1998). *Patterns of adoption: Nature, nurture and psychosocial development*.

Oxford: Blackwell Science.

Mullender, A. (1999). *We are family: Sibling relationships in placement and beyond*.

London: BAAF.

Neil, E. & Howe, D. (2005). *Contact in adoption and permanent foster care. Research, theory and practice*. London: BAAF.

Sinclair, I. Wilson, K., & Gibbs, I. (2005). *Foster placements: Why they succeed and why they fail*.

London: Jessica Kingsley Publishers.

Law

Herbert, M. (1996). *Working with Children and the Children's Act*. Leicester: BPS Books.

3. Web links

The Children Act 1989 is available at:

www.opsi.gov.uk/acts/acts1989/ukpga_19890041_en_1

Department of Health (2000). *Framework for Assessment of Children in Need and their Families* is available at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003256)

[PublicationsPolicyAndGuidance/DH_4003256](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003256)

Department for Education and Skills (2006). *The Common Assessment Framework Working Together to Safeguard Children* is available at:

www.everychildmatters.gov.uk/workingtogether/

Family Justice Council

www.family-justice-council.org.uk/system_childprotection.htm

London Safeguarding Children Board (2007). *London Child Protection Procedures* (3rd ed.) is available at: www.londonscb.gov.uk/

Easy Guide for parents about Court, published by Change

The Court and Your Child: When Social Workers Get Involved is available at:

www.bristol.ac.uk/norahfry/right-support/download/socialworkers.pdf

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