Risk and parental capacity to change
Aims of this session

- Improve understanding of risk assessment and the use of standardised tools
- Explore the social work role in assessing and enabling parental capacity to change
Risk assessment

- What happened?
- Will they do it again?
- How can I help?
- Can they change?
- Is the child safe at home while they try?
- How will I know it has worked?
What do we know about assessing risk?

• No absolute criteria or legal definitions for assessing risk
• Every child is different
• Single event or combination
• Risks interact
• Protective factors are important
A ‘third generation approach’

Evidence-based actuarial tools + Professional judgement = STRUCTURED PROFESSIONAL JUDGEMENT

Unaided clinical judgement in relation to the assessment of risk of harm, is now widely recognised to be flawed

Barlow (2012)
What tools are in use in your area?

• Evidence points to the potential benefits of using standardised tools

Barlow (2012)
Research based approach to assessing risk of further child maltreatment

This grid is based on research analysis from Jones et al (2006).
Exercise

• In groups, look at the case study and complete the Jones grid
• How would you rate the risk to the children in this family at the time of the EPO application?
Classifying families at risk of harm


**Severe risk:** Risk factors apparent and not being addressed, no protective factors apparent
Parents UNABLE to demonstrate sustained capacity for change; ambivalence or opposition to return by child or parent

**High risk:** Risk factors apparent and not being addressed. At least one protective factor
Parents UNABLE to demonstrate sustained capacity for change; ambivalence or opposition to return by child or parent

**Medium risk:** Risk factors apparent and not all being addressed. At least one protective factor
Parents ABLE to demonstrate sustained capacity for actual change. Parents and child both want return home to take place

**Low risk:** No risk factors apparent or previous risk factors fully addressed, protective factors apparent
Parents ABLE to demonstrate sustained capacity for actual change. Parents and child both want return home to take place
<table>
<thead>
<tr>
<th>threats</th>
<th>early years (birth – 5 years)</th>
<th>middle years (6 – 11 years)</th>
<th>adolescence (12 – 18 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>the big issue:</td>
<td>absence of consistent care, also:</td>
<td>parental disharmony, also:</td>
<td>academic disengagement, also:</td>
</tr>
<tr>
<td>assets</td>
<td>reliable care from parent figure, also:</td>
<td>stability, routine and play, also:</td>
<td>self-efficacy and competence, also:</td>
</tr>
<tr>
<td>family</td>
<td>&quot;Good enough&quot; parenting.</td>
<td>Good parent-child relationships.</td>
<td>Stability at home.</td>
</tr>
<tr>
<td>community</td>
<td>Safe communities.</td>
<td>Friends.</td>
<td>Encouragement to learn new skills.</td>
</tr>
<tr>
<td>interventions</td>
<td>ensuring secure attachment, also:</td>
<td>support from friends and family, also:</td>
<td>enhancing skills and social networks, also:</td>
</tr>
<tr>
<td>family</td>
<td>Check that the mother’s nutrition is adequate throughout pregnancy.</td>
<td>In situations of marital discord, encourage attachment to one parent, the moderation of parental disharmony and ways to play a positive role in the family.</td>
<td>Where parental separation occurs, encourage ways to maintain family social rituals.</td>
</tr>
<tr>
<td>community</td>
<td>Emphasise the need for safe play areas in the home and in the community.</td>
<td>Discuss the potential availability of alternative caregivers.</td>
<td>Encourage support for fathers for both male and female children.</td>
</tr>
<tr>
<td>child</td>
<td>Talk about the benefits of breast feeding to three or preferably six months.</td>
<td>Encourage the take-up of the MMR vaccination.</td>
<td>Help to build supportive long-term relationships.</td>
</tr>
</tbody>
</table>

It is crucial that we recognise that children, the problems they face, and the solutions they require will vary widely. As well as considering the strength of the evidence base, interventions need also be driven by what children and young people want for themselves.

> processes that can both threaten and promote the development of resilience are usually located in the domains of family, the local community and environment, or within children themselves.
Resistance and parental capacity to change
Partnership working

- Tools should only be implemented as part of a broader ‘partnership’ approach
- The quality of the relationship is an essential foundation

Client resistance is not something that solely exists with the client, nor even something that is simply produced by the context of child protection. Rather, it is also to some degree a product of the nature and the quality of the interaction between client and social worker. This is crucial because it puts the spotlight on social worker behaviour as both a potential cause of resistance and also our most important tool for reducing resistance (Forrester et al 2012)
Capacity to change

- Can parents change enough in time for this child?
- How can we help?
- What will change look like?

<table>
<thead>
<tr>
<th>Commitment to change</th>
<th>Effort</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
<td>HIGH</td>
</tr>
<tr>
<td></td>
<td>Genuine Commitment</td>
</tr>
<tr>
<td>LOW</td>
<td>LOW</td>
</tr>
<tr>
<td></td>
<td>Approval Seeking</td>
</tr>
<tr>
<td></td>
<td>LOW</td>
</tr>
<tr>
<td></td>
<td>Compliance / Imitation / Tokenism</td>
</tr>
<tr>
<td></td>
<td>LOW</td>
</tr>
<tr>
<td></td>
<td>Dissent / Avoidance</td>
</tr>
</tbody>
</table>
For example....

<table>
<thead>
<tr>
<th>Commitment to change</th>
<th>Effort</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
<td>HIGH</td>
</tr>
<tr>
<td></td>
<td>Families genuinely doing and saying the ‘right’ things, for the right reasons – regardless of whether a professional is watching. Identify own solutions</td>
</tr>
<tr>
<td>LOW</td>
<td>LOW</td>
</tr>
<tr>
<td></td>
<td>Clients agree wholeheartedly, may be effusive in their praise and gratitude. Report they have tried everything suggested – but no change is evidenced</td>
</tr>
<tr>
<td>LOW</td>
<td>HIGH</td>
</tr>
<tr>
<td></td>
<td>Clients seemingly comply, but not for right reasons and without engaging. Eg attend parenting groups to ‘get the s/w off their back’ and don’t attempt the techniques suggested</td>
</tr>
<tr>
<td>LOW</td>
<td>LOW</td>
</tr>
<tr>
<td></td>
<td>Clients are overtly hostile, or actively disengage / block s/w involvement – eg fail to attend meetings, won’t answer the door, are hostile in interactions</td>
</tr>
</tbody>
</table>
Stages of Change: a health warning

Stages of Change incorporating Seven Steps of Contemplation
(based on Prochaska and DiClemente, 1982 and Morrison, 2010)

- Pre-contemplation: Seeing no reason to change. Fearful/defensive/angry/denial/helpless: unwilling to acknowledge reality.
- Contemplation: Considering pros and cons, preparing, but no firm commitment (see box on the following page).
- Determination: Deciding to change, underpinned by an understanding of why and how.
- Action: Actively pursuing change, making effort to break habits and create new ones.
- Maintenance: Consolidating and sustaining, integrating change in daily life.
- Relapse: Returning to some or all old habits – more than just lapse.
- Seven Steps of Contemplation:
  1. accept there is a problem
  2. take some responsibility
  3. see discrepancy between behaviour and how would like to be
  4. believe things must change
  5. see that can be part of the solution
  6. feel can make a choice
  7. can see next steps and prepare for action
Assessing parental capacity to change requires

**Step 1**
Working out what is going on now

**Step 2**
Agreeing what needs to change

**Step 3**
Offering help (of a kind that we know works)

**Step 4**
Measuring what changes as a result

*Harnett and Dawe 2007*
Goal attainment scaling

- Work with parents to set specific, jargon free targets
- Clarity about consequences
- Requires use of evidence-informed intervention
- Actual observed change is measured
- Consequences are followed through
Essential infrastructure

- Structured professional judgement accepted by social workers, managers and legal representatives

- More use of standardised tools in practice and in supervision

- Support for partnership working with families

- Support for action when goals not reached

- High quality training, CPD and supervision

- Regular service audits of decision-making processes: e.g. EM Tool 12
The way forward

• ‘reposition social workers as trusted professionals playing the central role in care proceedings, which too often of late has been overshadowed by our unnecessary use of and reliance upon other experts. Social workers are experts...CAFCASS officers are experts’

Sir James Munby, President of the Family Division
Further reading

• Returning Home from Care: what’s best for children? NSPCC
• Case Management and Outcomes for Neglected ChildrenReturned to their Parents Farmer and Lutman (2010)
• Decision Making within a Child’s Timeframe DfE (2012)