Neglect and parental substance misuse

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Childhood Neglect: A resource for multi-agency training is available to download from the Child and Family Training website www.childandfamilytraining.org.uk and on DVD-ROM from Bill Joyce, National Training Director, bill.joyce@childandfamilytraining.org.uk

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Parenting and substance misuse

Research carried out as part of the ACMD ‘Hidden Harm’ (2003) estimated:

- 200,000-300,000 children of problem drug users in England and Wales.
- This represents 2-3% of children less than 16 years and is likely to be an underestimate of the true figure.

The Cabinet Office Strategy Unit (2004) estimated:

- Between 780,000 and 1.3 million children are affected by parental alcohol problems.
- However again likely to be an underestimate because of stigma and secrecy. (Harwin, Madge and Heath 2009)

Particular risk factors associated with substance misuse and neglect:

- Parenting alone.
- Being a young mother.
- Having children aged under 3.
- Having more than one child.
- Mother’s psychological state.
- Parental use of class A drugs.
- Domestic violence.
- Deprived socio-economic circumstances.

Impact of parental substance misuse:

“In the presence of a drunk or drugged parent, the child feels emotionally abandoned and frightened.”

“heavy use of alcohol and drugs distort, disrupt and disturb parent-child relationships.” (Howe 2005, p184)

“Substance misuse will have an impact on the individual adult, which may have an impact on their parenting capacity, which in turn might affect the development of the individual child.” (Murphy and Harbin 2003, p355)

Secrecy and denial of parental substance misuse:

- Parents believed that secrecy shielded child from impact of disclosure.
- Parents protected themselves from child’s gaze, anger, disappointment and disapproval.
- Parenting style closed.
- Divisions in family based on who does/does not know.
- Lack of trust prompts fluctuating emotional relationships with children.
- Many parents did not know whether and how to discuss issues with their children. (Hogan 2003; Taylor, Toner, Templeton and Velleman 2008)
- One third of drug users are female.
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- Virtually all are in the reproductive range. (Hepburn 2003)

In England, mean weekly alcohol consumption by children who drink has increased substantially since 1990, for both boys and girls:

- 11 to 15 year-old boys weekly units increased from 5.7 in 1990 to 16.0 in 2008 for boys.
- 11 to 15 year-old girls weekly units increased from 4.7 in 1990 to 13.1 in 2008 for girls. (Fuller 2009; Figure 1)

Pregnancy

Impact of technology

- Process of pre-natal development clearer.
- Fathers more aware of pre-natal developmental process.
- Greater awareness of impact on development of the foetus of drugs and alcohol.

The impact of alcohol and drugs on the developing foetus:

- Drug and alcohol exposed babies are often born premature with a lower birth weight and a lower head circumference than other matched control babies.
- Drug and alcohol exposed babies are often born suffering symptoms of withdrawal from drugs and alcohol used by the mother during pregnancy.
- Physical and neurological damage to the child before birth, this may be especially the case where violence is associated with the mother’s use of drugs or alcohol.
- Greatly increases the risk of death to a baby before or shortly after birth, and sudden infant death syndrome (also known as ‘cot death’).

Beyond Birth

- Although substance misusing adults may have intrinsically good parenting skills – they may be unable to exercise them consistently.
- It is difficult to predict the extent to which parenting can meet the needs of the child in the future especially pre-birth and with newborn babies. (Hart in Phillips 2004, p.257)

Effects on children:

- Hyperactivity, difficulties with concentration, impulsive behaviours and other clinically diagnosed behavioural disorders
- Angry and aggressive behaviours
- Depression, anxiety and low self esteem
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- Rates of psychiatric disorder between 2.3-3.9 times higher than children with families with no drink problems

The child's lived experience:
- Less supervision of the child.
- More punitive forms of child discipline.
- Less discussion and positive involvement with the child.
- More disagreement with partners over discipline.
- Mothers likely to have problems controlling their children.
- Adult offspring of problem drinkers report more traumatic childhood experiences; being less happy; having less cohesive and stable childhood relationships; violent family relationships and high levels of social isolation.
- Often crises in the life of the adult dominate family life. (Hart in Phillips 2004, p.257)
- Family conflict.
- Fear and anxiety.
- Role reversal.
- Secrecy and social isolation.
- Safety and welfare not seen as priorities.
- Neglect of developmental needs.
- Assault.
- Avoidance of professionals and helping agencies.
- Avoidable accidents. (Kroll and Taylor 2003)

Impact of recovery:

It's like I'm used tae daen all the tidying and the cooking and like telling [siblings] when tae be in and who no tae hang about with and who no, where no to go ... And my mum's started daen that and ... it's like a kind of conflict between us now because she's like saying “you’re 17, I’m the mum”. (Bancroft et al. 2004, p10)

Within their communities:
- The market for stolen goods ...can help people living in extreme poverty.
- Friends and family of dealers often share in their profits by receiving help to pay rent, buy groceries or clothes or repair their car.
- Children, sometimes as young as twelve acted as runners for dealers, because they were less likely to be stopped by the police. (Campbell 2006, pp.11-12)
Assessing motivation and willingness to change

Central to assessment

- Assessment of parenting capacity.
- Assessment of parent-child interaction.
- Assessment of parental readiness and capacity to change.

A goal of assessment:

‘to identify the extent to which parents have the capacity to see the experience from the child’s point of view and to realistically appraise what might need to change for the child to thrive in their care.’ (Donald and Jereidini 2004, quoted in Barlow with Scott 2010)

Assessment of parenting capacity:

- Recognition of the child’s needs.
- Awareness of the potential effects of relationships.
- Ability to take responsibility for own behaviour.
- Capacity to avoid dangerous, impulsive acts.
- Acceptance by the abusive parent(s) of their responsibility.
- Awareness by the parent(s) of the effect of their own experience.
- Provision of physical and emotional care appropriate to child’s developmental status.
- Confirm the evidence of harm to the child due to neglect.
- Establish the level of acceptance of, and responsibility taken by the parents for the harm.
- Record the assessed parenting capacity and the parents’ response.
- Draw out parents’ responses to negative aspects of parenting capacity.
- Plan to address the child’s future safety, therapeutic needs and, where appropriate, reunification.

Assessment of parent – child interaction

- Sensitivity of parent towards the child.
- Control of parent’s emotions, for example, covert or overt hostility.
- Responsiveness of the adult towards the child.
- The infant’s cooperativeness.
- The infant’s compulsivity.
- The infant’s ‘difficultness’ and passivity.

Assessment of willingness to change

- Capacity has two elements: ability and motivation.
- Each parent is an individual with different motivation and ability to change. It is crucial that assessment involves both, as one parent could negatively influence and undermine change in the other.
Intentions to change are complex and should not be confused with willingness to work with a particular practitioner or particular programme. Professionals need to recognise the changing context in which assessment takes place. It is only by assessing the family over time that it is possible to discover the parental and familial capacity to change.

Steps in assessment

- Assessment of parents' functioning including an assessment of their interaction and relationship with their child(ren).
- Specification of targets for change that should include the unique problems facing the family.
- Implementation of interventions that addresses all aspects of family functioning with goals tailored to address specific areas of family functioning.
- Objective measures of changes over time including standardised tests pre- and post-intervention and evaluation of parents' willingness to change.

Comprehensive model of change:

- Useful tool for child and family assessment.
- Change is a matter of balance.
- For effective change, professionals should assess and work with the parent or carer at the stage the parent has reached in their readiness to accept or deny the need to change. (Prochaska and DiClimente 1982)

Information processing

- This model evolved from research on neglectful parents to develop theory on how and why neglectful behavior occurs.
- Identifies 4 stages at which parents could fail to respond to signals of children's needs.
- Failure at each stage represents a different type of neglect. (Crittenden 1993)

Parents could fail to respond to children's need for care because:

- did not perceive the signal
• interpreted the signal as not requiring a parental response
• knew that a response was needed but did not have a response available or
• selected a response but failed to implement it.

In practice: disorganised neglect

Implications for engagement:
• develop trust, express empathy, be predictable
• mirror feelings
• introduce alternative strategies
• long-term.

In practice: emotional neglect

• Opposite of ‘disorganised’ families.
• Materially advantaged but failure to connect emotionally.
• Children know their roles, respond to clear rules, often do well at school - physical needs are met but not emotional needs.
• Absence of feelings - lack of empathic responses from parents.
• Results in children learning to block expression of feelings and awareness of feelings .
• Children may appear falsely bright, self-reliant but have poor social relationships.
• Children may become carers - role reversal.

Implications for engagement:
• Families appear superficially successful – but do not require less professional involvement.
• Help parents learn to use other sources of support.
• Teach parents to engage with children emotionally.
• Provide structured support with clear rules and roles.

In practice: depressed neglect

• Classic neglect: parents appear withdrawn with dull affect.
• Uninterested in professionals, appear unable to understand and unmotivated.
• Love their children - but do not perceive their needs or believe anything will change.
• Present as passive and helpless.
• Parents have shut down both cognition and affect.
• Parents may feed, change and move children but rarely respond to signals from the them.
• Children may give up when there are no responses - become silent, limp, dull and depressed.

Implications for engagement:
Children benefit from access to responsive and stimulating environments, for example, day care.

Parents need to learn to express feelings - practice smiling, laughing, soothing.

Parent education unlikely to be successful if backed by threats or punitive strategies.

Medication may help but beware side-effects.

Needs a longer term, supportive approach.

Tools to support assessment:
- CARE Index (Crittenden 1981)
- HOME Inventory (Cox and Walker 2000)
- The Family Assessment Pack of Questionnaires and Scales (Department of Health 2000)

Assessing parenting response to change

Four categories are identified:
- genuine commitment
- tokenism
- avoidance and/or dissent
- compliance (Howarth 2000; 2009)
Working effectively with families where there is parental substance misuse

Key principles

- The safety and welfare of the child is the most important consideration - all adult and children’s services should work together in the best interests of the child.
- Doing nothing is not an option.
- Involve children, young people and parents at all stages.
- Children and parents should get the right kind and level of help at the right time.
- The level of impact on the child should determine the level of action – do as much or as little as necessary. (Fife Partnership 2008)

‘The task when planning for children is not only to examine the quality of the parenting now, but also to predict how it will develop in the future.

This is a particular challenge when working with substance misusing parents, who may have intrinsically good parenting skills but be unable to exercise them consistently.’ (Hart 2004 p260)

Factors to consider

- Substance misuse usually linked with other family difficulties - poverty, poor physical and mental health, poor housing, offending and unemployment - therefore a multi-agency response is often required.
- Parents who misuse substances can be capable of looking after their children.
- The impact on children within the same family can be different.

Services should approach parents who have problems with substance misuse in the same way that they approach parents who have other problems that affect the child’s health and wellbeing. (Fife Partnership 2008)

The crisis in an adult’s life can often dominate.

Although adults who misuse substances may have intrinsically good parenting skills – they may be unable to exercise them consistently.

There can be difficulties in predicting the extent to which parenting can meet the needs of the child in the future especially the case for unborn/new born babies. (Hart 2004)

A child living with substance misusing parents needs…
The ante-natal period
- Preparing parents to establish routines and practices that a newborn baby will need. Focus on:
  - Increasing the ability of the parent to meet the child’s needs.
  - Developing the motivation of the parent to improve parenting skills.
  - Providing opportunity to practice caring for the baby. (Horwath 2008)

The challenge of changing
- Pregnancy is a window of opportunity for parents to make changes and parents may experience a range of feelings:
  - empathic concerns for the developing foetus
  - guilt as a response to not achieving change
  - anxiety relating to realisation of limited coping skills
  - fear of potential lapse or relapse
  - increased difficulty in accessing mainstream services
  - changing relationships between parents
  - uncertainty about impact of birth upon other children within the household. (Petersen and McBride 2002)

Meeting the baby’s needs
- It is the moment by moment meeting of the (baby’s) needs which promotes and gives a sense of security. This involves:
  - recognising their needs
  - helping the child to communicate their needs
  - meeting these needs. (Howe 2005)

School age children’s needs
Consider developmental needs in relation to:
- home security and stability
- secure attachments
- positive school experiences
- positive achievements – socially or academically
- opportunities to play and socialise
- whether the basics are in place – food, shelter, warmth and safety. (Cleaver, Unell and Aldgate 2011)

Young people’s needs
- Consider developmental needs in relation to:
  - relationships and appropriate role models
  - risky behaviours – safe sex, injuries and risk taking behaviour related to drinking or substance misuse
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- emotional problems – self harm, suicide, self blame, guilt etc
- isolation from friends and adults outside the home
- young carers – compromising own needs in favour of responsibility for dependent parent/carer/sibling. (Cleaver, Unell and Aldgate 2011)

What children say they want
- Don’t want to be ‘different’ from their peers.
- Want consistency.
- To keep attachment with their parents.
- Stimulation that promotes their development.
- Certainty about important aspects of their lives – care givers, placements, school and so on.
- Friendships.

Listening to children

‘It is only through hearing the voices of children and young people that the totality of their experience can be considered...We need to know and understand the reality of the lives they lead...’ (Kroll and Taylor 2003, p305)

Approaches to working with families where there is parental substance misuse
- Recognise issues of loss and low self-esteem.
- Expect a detached engagement style.
- Understand ambivalence as a response to loss of control.
- Be aware of complex motivational forces involved in relinquishing, or controlling, long-standing dependent behaviour

Supporting parents to establish stability
- rituals
- roles and responsibilities
- routine
- communication
- social life
- finances
- relationships and interaction.

Features of effective interventions to support parents that misuse substances
- Sourcing and giving clear information.
- Assertive action on behalf of children.
- Establishing healthy, supportive networks.
- A commitment to inclusion; based on realistic expectations.
- Recognising the potential for the parent to recover, but also recognising what that might mean for the child.

Barriers to engagement
- Families close off contact with those outside the family.
• Family members view alcohol and/or drugs as a way of coping.
• Problematic types of attachment or dependence on substances develop.
• Defensive barriers protect the family from stigma and social exclusion.
• Same barriers keep professionals away. (Taylor, Toner, Templeton and Velleman 2008, p38)

Multiple expectations
• In practice, recovery will mean different things at different times to each individual person with problem drug use.
• There is no right or wrong way to recover. Recovery is about helping an individual achieve their full potential – with the ultimate goal being what is important to the individual, rather than the means by which it is achieved.

Recovery for the child
‘Recovery is about restoring or establishing for the child a sense of self and a sense of control, to allow her or him to break free of the feeling of helplessness…

…Safety is critical to recovery.’ (Tomlinson and Philpot 2008, p114)

What do children need?
• recognition of their needs
• help with attachment to parents
• appropriate treatment for trauma. (Cairns and Stanway 2005, p51)

This means:
• taking a holistic approach
• appreciating the lived experience of the child
• appreciating what has become ‘normal’ for the child because of parental substance misuse
• appreciating that children may have to re-learn how to ‘be’ themselves if parents stop taking drugs.

Protective factors for the child
• Presence of a stable adult figure and close positive bond with at least one adult in a caring role (e.g. parents, older siblings, grandparents).
• A good support network beyond this.
• Little separation from the primary carer in the first year of life.
• Parents’ positive care style and characteristics.
• Being raised in a small family.
• Larger age gaps between siblings.
• Engagement in a range of activities.
• Individual temperament.
• Positive opportunities at times of life transition.
• Continuing family cohesion and harmony in the face of the misuse and its related effects.
Resilience created by protective factors

- Deliberate planning by the child that their adult life will be different.
- High self-esteem and confidence.
- Self-efficacy.
- An ability to deal with change.
- Skills and values that lead to good use of personal ability.
- A good range of problem-solving skills.
- Feeling that there are choices.
- Feeling in control of own life.
- Previous experience of success and achievement.

Messages from research

- Limited evidence about the efficacy of interventions that aim to support families affected by parental substance misuse.
- The studies that have been undertaken indicate that some interventions have positive effects on knowledge, attitudes and behaviours of children and parents.
- Intensive, family focused interventions are proving to be effective in improving outcomes.
- Particularly, interventions that include a strong therapeutic alliance between practitioner and parent or child are helpful.
- Services targeting the child, parent and the family as a whole are needed. (Mitchell and Burgess 2009)
Appendix 1 – Adults who misuse substances

Introduction

Hidden Harm (Home Office 2003) estimates that there are between 250,000 and 350,000 children of problem drug users in the UK. The report also showed that the parents with the most serious drug problems and the most chaotic lives are the least likely to be living with their children. In this handout, we look at the impact on children of parental problem drug use in more detail. This has been a particularly neglected area for research, with most of the limited number of studies being conducted in the US and only a handful in the UK. Nevertheless, these and other work in the fields of alcohol misuse and mental health enable some important conclusions to be drawn.

Problem drug use has serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them. Several features of problem drug use in the UK are of particular importance for their potential impact on children. Crises can occur at any time, for example due to overdose or injecting-related infection, or due to arrest and imprisonment or eviction.

Of equal importance are the longer-term effects of drug taking over months or years for physical health, for example chronic illness due to HIV or hepatitis C infection, and for employability, income and relationships. The consequences of problem drug use for users themselves are thus extremely wide-ranging and variable. What about the impact on their children?

Growth and development

In order to understand the potential impact of parental drug use on the child, the complexity of the process of growth and development needs to be recognised. This
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depends on many interacting biological and social factors that can be grouped under three headings:

- conception and pregnancy,
- parenting; and
- the wider family and environment.

Common features of problem drug use

Physical

major injecting-related problems, for example abscesses, blood-borne virus infections, overdose, accidental and non-accidental injury.

Psychological

- priorities dominated by drugs
- drug ingestion usually a daily event and an essential requirement for everyday functioning
- unpredictable and irritable behaviour during withdrawals
- chronic anxiety, sleep disorders, depression, suicidal behaviour
- post-traumatic stress disorder
- serious memory lapses.

Social and interpersonal

- family break-up
- loss of employment
- unreliability
- chronic or intermittent poverty
- rejection by former friends and community
- victim or perpetrator of physical, psychological or sexual abuse
- eviction and homelessness
- need to engage in property, crime, fraud, drug dealing or prostitution to pay for drugs
- association with other persistent offenders.

Financial

- constant requirement to find large sums of money to pay for drugs
- substantial debts
- inability to pay for basic necessities.

Legal

- arrest and imprisonment
- outstanding warrants and fines
- probationary orders.

How a baby develops during pregnancy is affected by a number of factors, of which the most important are:

- genetic endowment
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- the mother’s general health and nutritional status
- foetal nutrition during pregnancy
- exposure to drugs and other toxins
- exposure to infection
- exposure to external trauma.

Parenting embraces a wide range of activities that directly or indirectly affect the wellbeing of the child. The most important of these are:

- basic care
- ensuring safety
- emotional warmth
- stimulation
- guidance and boundaries
- stability.

There are also many aspects of the wider family and environment, which can influence children’s experiences in one way or another. These include:

- family history and functioning
- the extended family
- housing
- employment
- income
- family’s social integration
- community resources.

The way the child develops thus depends on a wide range of influences. How these affect the child can be considered under four headings or dimensions. These are:

- health
- education
- emotional and behavioural development
- identity
- family and social relationships
- social presentation
- self-care skills.

A child’s needs and capabilities change over time, as do the potentially harmful experiences to which he or she is exposed and the consequent harm. Factors that might help to protect the child may also change over time.
Appendix 2 – Addiction and dependence

Addiction, drug or alcohol - Repeated use of a psychoactive substance or substances, to the extent that the user (referred to as an addict) is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means.

Typically, tolerance is prominent and a withdrawal syndrome frequently occurs when substance use is interrupted. The life of the addict may be dominated by substance use to the virtual exclusion of all other activities and responsibilities. The term addiction also conveys the sense that such substance use has a detrimental effect on society, as well as on the individual; when applied to the use of alcohol, it is equivalent to alcoholism.

Addiction is a term of long-standing and variable usage. It is regarded by many as a discrete disease entity, a debilitating disorder rooted in the pharmacological effects of the drug, which is remorselessly progressive. From the 1920s to the 1960s attempts were made to differentiate between addiction; and “habituation”, a less severe form of psychological adaptation. In the 1960s the World Health Organization recommended that both terms be abandoned in favour of dependence, which can exist in various degrees of severity.

Addiction is not a diagnostic term in ICD-10, but continues to be very widely employed by professionals and the general public alike. See also: dependence; dependence syndrome.

Dependence (F1x.2.) - As a general term, the state of needing or depending on something or someone for support or to function or survive. As applied to alcohol and other drugs, the term implies a need for repeated doses of the drug to feel good or to avoid feeling bad. In DSM-III-R, dependence is defined as “a cluster of cognitive, behavioural and physiologic symptoms that indicate a person has impaired control of psychoactive substance use and continues use of the substance despite adverse consequences”. It is roughly equivalent to the dependence syndrome of ICD-10. In the ICD-10 context, the term dependence could refer generally to any of the elements in the syndrome. The term is often used interchangeably with addiction and alcoholism. In 1964 a WHO Expert Committee introduced “dependence" to replace addiction and habituation*.

The term can be used generally with reference to the whole range of psychoactive drugs (drug dependence, chemical dependence, substance use dependence), or with specific reference to a particular drug or class of drugs (e.g. alcohol dependence, opioid dependence).
While ICD-10 describes dependence in terms applicable across drug classes, there are differences in the characteristic dependence symptoms for different drugs. In unqualified form, dependence refers to both physical and psychological elements. Psychological or psychic dependence refers to the experience of impaired control over drinking or drug use (see craving, compulsion), while physiological or physical dependence refers to tolerance and withdrawal symptoms (see also neuroadaptation). In biologically-oriented discussion, dependence is often used to refer only to physical dependence.

Dependence or physical dependence is also used in the psychopharmacological context in a still narrower sense, referring solely to the development of withdrawal symptoms on cessation of drug use.

In this restricted sense, cross-dependence is seen as complementary to cross-tolerance, with both referring only to physical symptomatology (neuroadaptation).

Appendix 3 – motivation to change

Assessment of motivation to change

In an increasingly pressured and target-driven environment, working to avoid ‘drift’ is seen as beneficial both in terms of effective use of resources and better outcomes for children and young people. However, chronic neglect may require long-term intensive support and the difficulties which agencies have in responding to the needs of neglected children can result in a revolving door of service provision (Tanner and Turney in Taylor and Daniel 2003) and a tendency towards a ‘start again’ mentality (Brandon et al 2008) where a ‘clean sheet’ approach is taken to every fresh referral.

If drift is to be avoided then practitioners need to be clear about what changes they are measuring, how they will be measured and what will be done as a consequence of change or a lack of change. Howarth (2007) advises that a parent’s capacity to meet a child’s needs is dependent on:

- opportunity
- ability
- motivation

All three aspects should therefore be considered in an assessment of neglect. Assessment of motivation and capacity for change is particularly challenging and two models can help practitioners establish a picture of these variables more clearly and accurately.

Some parents may appear to want to change or may say that they want to change but their behaviour, particularly their behaviour towards the child, is no different. Change in parenting capacity is personal level change and is unlikely to be achieved just by teaching parenting skills (Donald and Jureidini 2004).

Given that such change is of significance for both the child and the parent, it is important that the assessment of the degree of change is both accurate and thorough. Horwath and Morrison (2001) provide a model for assessing the extent to which there is genuine motivation to change. Motivation is plotted on two dimensions of effort and commitment to change:
Assessing Motivation


High effort and high commitment to change is genuine commitment to change.

For example, I know it’s important for Lee to go to nursery so I get everything ready in the evening so we don’t have to rush in the morning.

High effort and low commitment to change is compliance imitation or approval seeking.

For example, I get her to nursery at 9.30am because that is what is written in the care plan.

Low effort and high commitment to change is tokenism.

For example, I’m happy for Lee to go to nursery as long as you fetch her and bring her back in a taxi.

Low effort and low commitment to change is dissent or avoidance.

For example, The nursery seems to be doing more harm than good; he comes back really tired so why bother?

External motivators are not nearly as effective as internally held motivators. The adage ‘You can take a horse to water but you can’t make it drink’ aptly captures the reality that the greater the internal force for change, the better the future prognosis and vice versa. Calder (2002, p371) suggests that the following questions may be helpful for parents to consider:

- Why is it important that I change?
- Do I have the ability to change?
- What does change really mean?
- What will I have to do that I can’t do now?
- What will I not have to do that I do now?
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- Who can help me change in what way?
- What (if anything) have I tried to change in the past and was it successful?

A continuum of motivation (Calder 2002; Morrison 1991) addresses a range of motivational statements, from External motivators (‘I don’t have any problems’) along a continuum to a series of increasingly internalised motivators, culminating in the Internal motivator which expresses a clear commitment to change (‘I want to change’).

**Continuum of Motivation**

One of the few really effective ways of gauging whether parents are able and willing to change within a timescale that is appropriate for the child is to monitor very closely whether the child’s lived experience has improved on a day-to-day basis (Daniel and Rioch 2007). Who is in a position to provide this kind of monitoring? How can they be supported to gather and make sense of these observations so as to allow an accurate assessment of change?

A model of change is highlighted in Calder (2003), based on the Cycle of Change by Prochaska and DiClemente, (1992) reflecting the process of change and indicating stages of change and points at which the participant might exit from the change process and what their exit indicates.

A version of Prochaska and DiClemente’s original model is provided below. This model is useful in providing a means of evaluating the changes an individual has made or has yet to make. It also reminds us that change is a natural cycle with clear stages which should be worked through in sequence to attain a healthy and potentially abiding state of change.
Research and links

Publications


**Tools and resources**

Assessing families in complex child care cases using The Family Assessment (training course)


Assessing parenting and the family life of children (training course)