ASSESSING PARENTING CAPACITY GUIDELINES

Adapted by Rhona Wolpert, Editor IMPrint

Dr. Paul Steinhauer was delighted when IMP invited him to present on assessing parenting capacity to audiences in Toronto and Ottawa. Unfortunately, his untimely death meant that this was not to be. When asked to submit an article for IMPrint, he had provided a copy of a paper that he had presented at the Ontario Family Law Judges Association 1997 Annual Conference saying, “I think this is the information you need. Can you can adapt it?” This article is an adaptation of his paper entitled “Conceptual & Pragmatic Issues Involved in Assessment of Parenting Capacity in Child Welfare.”

One of Paul Steinhauer’s major professional goals was to help the child welfare system achieve all that it could and should. Recognizing that many of the most disturbed children and adolescents were permanent wards of children’s aid societies, he determined to find ways to address their psychological needs. These are the children who have learned to mistrust adults rather than to view them as a source of comfort and support. They have learned that letting someone matter means being hurt and abandoned, and they have become resistant to attachment relationships. Some of them have reached this point from having moved in and out of foster care, returning repeatedly to inadequate parents. Others have moved from foster home to foster home, and some have become attachment resistant from remaining too long in a biological family that failed to meet their developmental needs at even a minimally acceptable level.

In considering how long is too long, Dr. Steinhauer referred to the accumulating evidence from a spectrum of neurobiological and developmental sciences regarding early brain development. He emphasized that most of the brain cells responsible for regulating behaviour, thinking and emotions are unconnected at birth, and that their connecting pathways are formed within the first two years of life. The processes of brain maturation are “use dependent” and there are windows of opportunity for developing critical processes such as attachment, self-regulation and language. Dr. Steinhauer noted that if these windows are missed, catching up is a much harder process. Exposure to chronic stress in the early years also decreases the capacity of developing brains to regulate rage, anxiety, impulsivity and aggression. Therefore, it is more effective to protect children from damage than to undo the neurological and psychological effects of early abuse and neglect.

Why The Guidelines Were Developed

Early in his practice as a child psychiatrist in the 1960s, Dr. Steinhauer began collaborating with colleagues in child welfare to develop a system that could make the experience of wards of societies as protective and corrective as possible. In 1988, he spearheaded the Toronto Parenting Capacity Assessment Project, a co-operative project of the Children’s Aid Society of Toronto, the Catholic Children’s Aid Society of Toronto, the Toronto Family Court Clinic, and the Department of Child Psychiatry, The Hospital for Sick Children. The work of this Project was to develop guidelines to help child welfare workers and mental health professionals understand, plan and intervene more successfully with difficult children and families. Each guideline is based on the best empirical and clinical knowledge available at the time of first publishing the guidelines in 1993.

The originators were particularly concerned about the number of infants and children in care for whom it was clear within the first few months of life that their parents would never be able to achieve a level of parenting that would meet their emotional needs. Many of these children routinely spent long periods in foster homes. Often, they became securely attached to their foster parents. When they were finally released for adoption, they were exposed to a traumatic (and systemically caused) separation from the only parents they could remember. This undermined the success of the adoption. The Guidelines were developed as a way to answer three key questions as early as possible:

1. Is this child being parented at or near a level consistent with reasonable well-being and normal development? If the answer is yes, the goal would be to help the parents improve their parenting without removing their child. However, if the family environment is so damaging that leaving the child in this environment is likely to cause permanent neurological and psychosocial damage, we need to ask the next question.

2. What long-term plan is most likely to provide the security and continuity this child needs, and is it realistic to work towards restoring the child to the care of the biological parents within a reasonable time? If not, we need to ask the third question.

3. How soon can we establish, beyond reasonable doubt, that freeing this child for permanent placement in a substitute family capable of providing continuing quality of care and security is a less detrimental alternative than returning the child to biological parents?

The Guidelines provide a tool to gather information needed to answer these questions as quickly and as accurately as possible. They are not a risk scale designed to predict the likelihood of abuse. Rather they are intended to give a broader assessment of overall strengths and weaknesses of parenting, including the potential for abuse and neglect and the capacity for change in response to intervention. They are intended to be an adjunct to
clinical assessment recognizing that workers have varying levels of skill and experience. Professionals are encouraged to use the many definitions of the Guidelines only if they need them and to skip over descriptors in areas with which they are familiar. When in doubt, however, the descriptors can help them reach a decision. Users are advised to perform their own clinical assessment, to organize their findings around the nine parameters of family and parental functioning, and to use the descriptors in selected areas to help complete the picture or clarify any confusion.

The Guidelines are a tool to help improve clinical assessments in terms of case-planning and decision-making. While this includes the assessment of future risk, this is a subjective assessment based on clinical intuition and not on objectives scales. All tools have their strengths and weaknesses and are only as successful as the skill and expertise of the person using the tool and the time and care taken to apply the tool. Therefore, appropriate training, supervision and consultation are necessary. Paul Steinhauser devoted much of the last years of his practice to providing training, supervision and consultation regarding use of the Guidelines across Canada.

Overview of the Guidelines

The nine guidelines are divided into four sections that focus on the context (guideline 1), the child (guideline 2), the child-caregiver relationship (guidelines 3 & 4), and the parent(s) (guidelines 5 to 9). The fifth section is the resulting family parenting profile on which decisions and plans can be based.

Guideline 1A deals with parents' life experiences and feelings related to being immigrants or members of a marginalized minority group. This guideline was added at the request of those involved in field testing the first draft guidelines. The items explore parents' experiences and attitudes that may be affecting their parenting. They also help to bridge cultural or ethnic gaps between the client and assessor.

Guideline 1B is an environmental scan of current stressors commonly experienced by families including problems with housing, health, economic circumstances, the legal system, adult-relationship and child management. Research shows that the effects of stress are cumulative. This means that coping with four or more chronic stressors increases the likelihood of adverse effects ten-fold. This guideline facilitates the identification of stressors and allows exploration of ways to reduce the family's stress to tolerable levels that enable them to cope better.

Guideline 2 guides the assessment of a child's developmental status in order to determine responses to neglect (e.g. failing to thrive physically, falling behind in psychosocial development) and to provide a baseline to assess change. Many children improve dramatically when placed in a nurturing foster home. This suggests that the delay was likely related to the lack of nurturing or stimulation in their family. Some children, however, can fall so far behind that they require more than a few weeks of nurturing to catch up. Still others have biological reasons for their delays, and some may actually lose skills when they enter foster care in response to removal from a primary attachment figure. Often, it is a combination of factors rather than any one alone that affects the child's developmental status.

Guideline 3 is designed to provide an estimate of the child's predominant attachment strategy. This represents the child's capacity to trust adults and turn to them for help in times of distress. A child's attachment strategy is very different from how well the child plays with a particular adult. The guideline provides a simple series of observations to help develop a picture of the child's overall attachment style. It also addresses a parent's style of attachment to his or her own parents. Research has shown that this is predictive of the kind of attachment that can be anticipated between parent and child.

Guideline 4 provides a way to systematically record observations of current parenting ability and how well parents are able to meet their child's basic needs. Are they able to see the child as an individual with needs of his or her own, or do they project their own unresolved needs on to the child or subordinate the child's needs to their own? How effective are their skills in setting limits? This guideline can be useful in establishing goals for parent education and in monitoring progress towards these goals in response to intervention.

Guideline 5 deals with the parent's impulse control within the context of the parent-child relationship. How able is the parent, when upset, to control his or her feelings rather than to explode verbally or physically in a way that is inappropriate, frightening or damaging? A lack of impulse control is associated with a higher risk of physical and/or emotional abuse.

Guideline 6 addresses the parent's acceptance of responsibility. Some parents believe that their parenting is not a problem, despite evidence to the contrary. Refusing to accept responsibility, they tend to blame someone else for their difficulties (often a child's aid worker). Such parents usually do not have the motivation to improve their parenting. This guideline is crucial in predicting the capacity for change. However, it should be used with caution as some parents deny responsibility but then behave responsibly, while others are facile at admitting responsibility but their behaviour does not change. The guideline is designed to help determine to what extent parents genuinely accept responsibility. Like all other guidelines, it contains both a strength and a weakness dimension and focuses on what is right as well as on what is wrong with the parenting.

Guideline 7 helps to assess adult behaviours affecting parenting and is concerned with the parents' mental health. Part A assesses potential strengths that may help the parents improve their parenting. Part B presents 11 clusters of the types of mental health problems common in parents within a child welfare population. A scan of the descriptors can help pinpoint, for example, a parent who may be depressed. Part C can help determine whether and to what extent the parent's illness is affecting parenting. Having a mental health problem or a developmental delay does not automatically mean that parenting is inadequate. Only the effects of the illness on parenting, if any, are relevant, and input from appropriate mental health consultants may be needed to determine this.
Guideline 8 deals with the parent’s manner of relating to society and the availability of and response to non-professional sources of support. Part A explores who is there (extended family, friends, neighbours, religious community, self-help groups, etc.) to help and support the family and how the parent is able to use these supports. Part B looks for a pattern of chronic problems relating to social agencies and authority figures, not only child protection workers in a position to remove their child, but also employers, the school principal, family doctors, the welfare department etc. Such a generalized pattern is rooted in the parent’s personality style rather than in an understandable resentment of a children’s aid society intruding into their life.

Guideline 9 is designed to highlight repeating patterns in parents’ use of clinical interventions that can help predict the likelihood of substantial improvements in parenting in response to future interventions. The best predictor of how someone will respond to a future intervention is the pattern of response in the past. To determine this, the guideline reviews all known past agency contacts, the regularity of attendance, the participation, the changes made and sustained, and whether the service received was appropriate to the needs of the family. Even if there is no previous agency involvement, the level of cooperation during the assessment process can provide useful information.

The Family Parenting Profile is derived by summarizing ratings from each guideline considered relevant to the case together with conclusions drawn from the clinical assessment.

Issues Involved in Assessing Parenting Capacity

Dr. Steinhauer believed that an assessor’s clinical skill and experience, the conscientiousness and time taken to do a proper assessment, and the awareness of what the guidelines can and cannot do, are more important than the professional discipline of the assessor. To learn to use the guidelines effectively requires regular practice. Supervision with a professional experienced in their use is important to help incorporate the thought process and principles inherent in the guidelines. With experience, the Guidelines ultimately save time by helping the assessor to “work smarter”.

Dr. Steinhauer regularly spent time with people who used the Guidelines to discuss problems they were having and how best to interpret their findings. He emphasized that no single factor determines parenting capacity, except in rare cases. The more evidence there is supporting a pattern, the more confidence there is in the assessment. To do a thorough assessment means seeing the child alone, with each of the parents, with the parents together, with the foster parents, and with childcare staff.

Thorough assessments are time-consuming. However, knowing a family too well can make decisions more difficult because the helping relationship established over time may compromise or distort judgement and undermine objectivity.

An adequate assessment depends on the cooperation and openness of parents who do not deliberately mask their behaviour to improve their chances of obtaining the outcome they want. When current assessments are consistent with a thorough, accurate review of the historical record, the assessment is probably more valid. A time-limited assessment is suspect without a thorough review of the historical record, as well as external corroboration.

There is considerable risk in leaving a young child on hold for months or years while waiting to see if their parents can change lifelong patterns of behaviour and parenting (for example substance abuse or child neglect). Four guidelines help predict capacity for change: Guideline 9 notes response to past attempts to improve parenting; Guideline 6 notes the extent to which parents accept responsibility and acknowledge a need to improve their parenting; Guidelines 7 notes willingness to be treated for a chronic mental health or health problem; and Guidelines 1B indicates the number of stressors (four or more chronic stressors that cannot be relieved would mean a higher rate of interpersonal problems). More caution is needed the first time a parent’s capacity has been questioned. A repeated pattern in past parenting is the best predictor of future behaviour, if behaviour typical of the past is still evident. The younger the child, the greater the risk of waiting to see if parents can change. So a definite decision must be reached as soon as reasonably possible.

Some parents make significant changes in their personal lives, usually with help from a skilled worker and supportive community. This, however, does not necessarily mean that their parenting will improve. Sometimes, returning children to a parent creates a source of stress that might undermine gains the parent has made as an individual. Thus, a decision to return a child when there is no evidence of improved parenting capacity can be dangerous and should be made with caution.

It is important to remember that the guidelines are based on a selection, compilation and organization of the best theoretical and clinical knowledge available at the time of their development, and their reliability has not been established empirically.

We owe Dr. Steinhauer a debt of gratitude for his work in developing and refining these guidelines. It is hoped that practitioners in the field can use and build upon this work so that the best possible outcomes can be achieved for our youngest and most vulnerable children.