



# A procedure for assessing parents' capacity for change in child protection cases

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## Abstract

Decisions of critical importance to families include whether children should be removed from or reunified with their natural parents. Practitioners working in the child protection field contribute to these decisions by assessing the capacity of parents to meet the needs of their children. A cross-sectional assessment of families provides important information about family functioning at one point in time, but is of limited usefulness when the results are equivocal. The assessment of a family's capacity-to-change provides additional information not possible in a cross-sectional assessment, including an evaluation of the parent's motivation and capacity to acquire parenting skills. An assessment of capacity-to-change includes: 1) carrying out a cross-sectional assessment of the parents' current functioning, 2) specifying operationally defined targets for change, 3) implementing an intervention with proven efficacy for the client group with a focus on achieving identified targets for change, and 4) the objective measurement of progress over time including evaluation of the parents' willingness to engage and cooperate with the intervention and the extent to which targets were achieved. The aim of the capacity-to-change through intervention is to determine whether a family has the potential to eventually achieve a minimal level of parenting. Presented is a detailed description of the capacity-to-change procedure and a discussion of related professional issues. Crown Copyright © 2007 Published by Elsevier Ltd. All rights reserved.

*Keywords:* Child abuse; Child protection; Evidence-based assessment; Capacity-to-change

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## 1. Introduction

In 2003 an estimated 3-million referrals were made to child protection services in the USA. Around two-thirds of the referrals justified further investigation and child maltreatment was confirmed in approximately one-third of the cases ([U.S. Department of Health and Human](#)

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Services Administration on Children Youth and Families, 2006). In the light of the negative developmental outcomes for children who suffer maltreatment (De Bellis, 2001; Malinosky-Rummell & Hansen, 1993; Spatz Widom, Marmorstein, & Raskin White, 2006) it is vital that children are protected from abusive and neglectful families, either through removal from the family or by improving the functioning of the family. Clinical psychologists and other professionals working in the child protection field are called on to carry out assessments that contribute to decisions whether children should be removed from or reunified with their natural parents, the appropriate level of contact with parents for children living in out of home care, and the nature and extent of interventions and support families may need to provide adequate care of their children (Budd, 2001).

Useful guidelines have been developed for the assessment of families involved with child protection services (American Psychological Association Committee on Professional Practice and Standards, 1998; Azar, Lauretti, & Loding, 1998; Budd, 2001; Calder & Hackett, 2003). Unfortunately, in practice assessments often fail to meet minimal guidelines of best practice (Budd, Felix, Poindexter, Naik-Polan, & Sloss, 2002; Conley, 2003). For example, Budd et al. (2002) found the referral question and legal decisions or permanency options being considered were often not specified. The assessments of children often relied on single rather than multiple sources of background information and focused on single domains of family functioning (child or parental functioning) with no evaluation of the broader ecological influences on the family (see Belsky, 1993; Cash & Wilke, 2003; Cicchetti & Carlson, 1991; Sidebotham, 2001). Direct observations of parent–child interaction were rarely reported and an opinion on how reliable and believable the parent's reports were was generally not offered, despite the knowledge that bias towards socially desirable responding can severely limit the validity of information provided by parents.

While adhering to best practice guidelines for assessing families in child protection cases is a priority for practitioners concerned about making valid and reliable decisions, a further, and often serious problem with reports, is that they are generally cross-sectional assessments of family life conducted over a brief period of time. Cross-sectional assessments are useful in identifying areas of current concerns in a family, but can be equivocal when risk factors in the family do not clearly outweigh the protective factors. When this is the case decisions will be made under conditions of uncertainty and prone to error and clinician bias (Dalglish, 1988; Munro, 2004). For example, parental substance misuse is a risk factor for child maltreatment although it does not inevitably lead to neglectful and abusive parenting (Dawe et al., 2007). The risk to a child would be reduced if the parent were to receive successful treatment for their substance misuse. However, in the absence of any direct information on how likely an individual parent would be to engage with and respond to treatment, decisions about that parent may well be influenced by biased views on how successful substance misuse treatment is generally. Clearly, directly assessing the parent's response to substance misuse treatment in this case would reduce the uncertainty. It is argued here that in the event that a cross-sectional assessment results in equivocal information about parents, an assessment of the parents' capacity-for-change should be carried out over an extended assessment period (4–6 months). The present paper presents a structured approach to the assessment of parental capacity-to-change that has the potential to contribute important quantitative information to decisions being made about families involved with child protection agencies.

## 2. Assessment of capacity-to-change

The steps in an assessment of capacity-to-change include: 1) a cross-sectional assessment of the parents' current functioning, 2) specifying targets for change derived from an assessment of

current strengths and deficits in the family, 3) implementation of an intervention with proven efficacy for this client group with a focus on achieving clearly specified targets for change, and 4) objective measurement of changes in parenting. The aim of the capacity-to-change assessment procedure is to directly assess the extent to which the parent's have the motivation and ability to move towards a minimal level of parenting (see [Greene & Kilili, 1998](#)) and to clarify the level of further intervention and support that would be needed to eventually achieve and maintain a minimal level of parenting. The essential components of the capacity-to-change assessment procedure are described in more detail below.

### *2.1. Step 1: Cross sectional assessment of the parents' current functioning*

A cross-sectional assessment of family functioning is the starting point of the capacity-to-change assessment procedure. This should include an assessment of any problems in child and parental functioning and the quality of parent–child relationship. The assessment of the children in the family aims to determine any physical problems or developmental delays in daily living skills, and cognitive, emotional, social, and behavioral functioning. Problems in these areas may indicate special needs of the child the parent should be aware of. If no problems are identified in any area of child functioning it is difficult to argue that the parents, if they have been the primary carers of the child, do not possess a minimal level of competence. An argument that the parents are incapable of meeting the child's needs would require evidence that the child is at risk of future harm due to the current functioning of the parents (for example as a result of a parents relapse to illicit drug use). Assessment of parents should include historical information about the individual parents, including their own abuse history, intellectual functioning, adaptive and social functioning, personality and emotional functioning, knowledge, and attitudes and beliefs about childrearing ([Budd & Holdsworth, 1996](#)).

Standardized psychological tests provide useful information to supplement other sources of information. Unfortunately, in practice conclusions about parental functioning are based on the results of a limited range of tests measuring constructs that may have little direct relevance to parenting ([Brodzinsky, 1993](#); [Budd et al., 2002](#); [Budd & Holdsworth, 1996](#)). The use of standardized psychological tests can be justified when a sound model of parenting guides their use. For example, within an ecological framework, measures of parental psychological functioning (e.g., depression, anxiety, substance misuse), stress and social support would be very relevant. Increasingly, measures of parenting are being developed that measure various dimensions of family functioning (e.g., [Abidin, 1995](#); [Milner, 1986](#)). There is, however, no empirical evidence to support the routine use of a specific battery of tests when assessing parenting competence. In fact, even if a battery of tests were recommended, in the absence of agreed clinical cutoff scores, inconsistency in the interpretation of the results is likely to result from practitioners imposing idiosyncratic criteria when interpreting results. In an assessment of capacity-to-change, standardized psychological tests provide objective measurement of family function against which change can be assessed. The absolute value of individual test results is of less importance than the extent of change and whether the change is clinically significant. This is discussed in further detail below.

An assessment of the quality of parent–child interactions is recommended as a standard procedure in cross-sectional assessments ([Budd & Holdsworth, 1996](#)). These observations provide a different context in which to observe the parent that might highlight strengths or weaknesses not observed in an interview situation, and also provides an index of the parent's attempt to demonstrate their best parenting skills (2001; [Budd, 2005](#)). A number of structured

observation methods exist that quantify the quality of the parent–child interaction. Coding systems such as the Dyadic Parent–Child Interaction Coding System II (DPICS II: [Eyberg, Bessmer, Newcomb, Edward, & Robinson, 1994](#)) record the frequency of discreet parent and child behaviour. Changes in the frequency count of these behaviors before and after treatment can provide a measure of change. However, observing the frequency of discrete behaviors can be difficult in naturalistic settings particularly when there are several children present ([Budd, 2005](#)). Ratings of more global constructs of parenting, such as the sensitivity and responsivity of the parents, is often more practical. The Emotional Availability Scales ([Biringen, 2000](#)) provides a rating on several dimensions, including parental sensitivity, parental structuring, parental nonintrusiveness, parental nonhostility, child responsiveness and child involvement. Ratings are recorded once at the end of an observation period. As with the DPICS II, the Emotional Availability Scales require training to ensure reliability of the observations. [Hynan \(2003\)](#) provides a detailed overview of additional issues involved in conducting valid and reliable observations of parent–child interaction in the context of a child protection or child custody assessment. Recommended procedures to ensure reliability of the observations include conducting at least two observation sessions with the family and using independent observers. As the aim of the capacity-to-change assessment is to assess change before and after treatment, observations should be carried out under similar conditions when establishing a baseline level of parent–child interaction and when assessing change at post-intervention.

[Budd and Holdsworth \(1996\)](#) argued that an important component of an assessment of parenting capacity is to consider the parent’s response to any prior intervention that has been offered in an attempt to improve their parental functioning. Successful interventions would include persuading parents to engage in treatment for mental health or substance misuse problems, improved child management skills following parent training, or an increased capacity and initiative to deal with life stressors. Unfortunately it is rare that the extent of change in response to prior treatment is formally assessed. Whether parents benefited from prior help is more likely to be an estimate based on retrospective, ad hoc information. The capacity-to-change model, on the other hand, provides a prospective assessment of the parent’s capacity to benefit from an intervention.

In summary, the first step in a capacity-to-change assessment is to carry out a cross-sectional assessment according to best practice guidelines. The assessment should include standardized psychological tests and direct observation of parent–child interaction that provide baseline measures of family functioning.

## *2.2. Step 2: Specifying targets for change*

A significant contribution of the capacity-to-change assessment procedure is to identify the unique problems facing individual families that can be targeted for assessment. Goal Attainment Scaling (GAS; [Kiresuk, Smith, & Cardillo, 1994](#); [Ogles, Lambert, & Fields, 2002](#)) is a procedure developed to measure change in specific and unique behaviors that do not lend themselves to measurement using standardized psychological assessment instruments. The GAS procedure involves identifying goals for change that can be operationally defined, observed, and monitored over time (ideally by multiple, independent informants such as parents, teachers, foster carers). For each goal, the GAS procedure involves developing a five-point outcome rating scale that defines the extent of change observed over the assessment period. Specifically, a rating of three defines a successful outcome, while the full scale ranges from much less successful (rating of 1) to much more successful than expected (rating of 5). An example of a GAS outcome rating scale is

provided in the Appendix. While the development of GAS outcome rating scales is fairly simple, problems can arise, from, for example, setting goals that are too easy or difficult, or specifying overlapping values across the levels of the scale. Guidelines are available to assist in developing appropriate GAS scales (see Kiresuk et al., 1994; Ogles et al., 2002).

It is important to ensure that the identified targets for change are clinically meaningful. Demonstrating a parent's ability to achieve trivial targets is unlikely to influence decisions about the family. For example, improving the child management skills of a parent that continues to misuse substances may influence a decision to increase access when a child is in out of home care, but may have little impact on a decision to reunite the parent and child. A case conference involving relevant professionals and family members is often an appropriate venue to arrive at a consensus on whether the identified targets for change are clinically meaningful. Specific changes are likely to be perceived differently depending on specific family circumstances and the purpose of the assessment. The goals set should be manageable as well as meaningful. Goals that require substantial behavior change may be overwhelming for the parents, effectively setting the family up for failure. Agreement on the meaningfulness and manageability of targets can be facilitated by asking each party to rate each goal on a five-point scale of meaningfulness and manageability (see Appendix) and discussing any discrepancies until consensus is reached. The three most manageable goals rated as at least "Quite meaningful" by all parties are targeted in the capacity-to-change procedure.

It should be noted that the original development of the GAS procedure included a procedure for calculating a standard score statistic. The psychometric properties of this procedure have recently been questioned (MacKay, Somerville, & Lundie, 1996) and cannot be recommended. Nevertheless, the clinical utility of the GAS procedure in specifying flexible and individualized treatment goals has received recent support in the child and family area (Doss, 2004; Kazdin, 2005). As Ogles et al. (2002) argued, the individualized assessment of the GAS procedure provides an important, but not sufficient, source of information to measure change.

### *2.3. Step 3: Implement an intervention with proven efficacy for this client group with a focus on identified targets for change*

Failure to promote change in an individual family may due to the ineffectiveness of the intervention used rather than the motivation or ability of the families to change. Evidence that interventions targeting multi-problem, high-risk parents are sufficiently powerful to produce change is therefore essential in interpreting the results of a capacity-to-change assessment. A recent meta-analysis of 23 studies using parent-training to reduce or prevent physical and emotional child abuse and neglect concluded that this form of intervention was moderately effective in promoting improvement in child rearing attitudes, child rearing behavior, and parental emotional adjustment (Lundahl, Nimer, & Parsons, 2006). Delivering parent training in the home resulted in better outcomes than when the interventions were only clinic based. Interventions that focused on teaching specific child management techniques were most effective in changing child-rearing practices, but less effective in changing other aspects of parental functioning. Individualizing the interventions to the specific needs of families was also found to enhance outcomes.

Chaffin and Schmidt (2006) identified several interventions that have a sufficient evidence base to be considered promising treatments for physically abusive families. The first, Parent Child Interaction Therapy (PCIT) is derived from an intervention originally described by Hanf (1969) and latter developed by Forehand and McMahon (1981) and adapted by (Eyberg & Robinson,

1982). Parents are instructed to use limit-setting and time-out to deal with inappropriate behavior, and encouraged to attend to and reward positive child behaviors to promote positive child behavior and improve the parent–child relationship. Urquiza and McNeil (Urquiza & McNeil, 1996) reported that PCIT held promise as an intervention for improving parent–child relationships in physically abusive families, although the authors noted that parental substance abuse and psychopathology, severe marital discord, and a lack of parental motivation limited effectiveness.

In addition to interventions that specifically target abusive and neglectful families, parenting interventions developed for substance misusing parents (parents known to display a high rate of child maltreatment; Dawe et al., 2007) have been successful in improving family functioning (Catalano, Gaine, Fleming, Haggerty, & Johnson, 1999; Luthar & Suchman, 2000). Successful interventions have generally adopted a multi-systemic approach to address multiple problems in the family. For example, the Parents Under Pressure program (PUP) considers influences on family functioning across ecological domains as potential targets for intervention, including parental psychological functioning, child functioning, the parent–child and marital relationships, social support networks, housing, child care, and lifestyle. This program, evaluated with parents displaying both substance misuse and child protection concerns, sets individualized goals for each family tailored according to the problems displayed by the family. A series of single case studies and a randomized control trial found that the program resulted in significant reductions on self-report measures of child abuse potential, parenting stress and child behavior and social problems (Dawe & Harnett, 2007; Dawe, Harnett, Rendalls, & Staiger, 2003).

On the basis of the literature reviewed above it can be concluded that interventions targeting multi-problem families can be effective in promoting change in the short-term. When assessing a parent's capacity-to-change it is essential that an empirically supported intervention is used. The recommended intervention would be one that addresses multiple domains of family functioning, is delivered in the home, includes individualized goals, and is tailored to address the specific problems of individual families.

#### 2.4. Step 4: Assessment of change

Evaluation of a family's capacity-to-change includes an evaluation of the following assessments: 1) standardized tests administered pre- and post-intervention, 2) direct observation of changes in parent–child interaction, and 3) results of the GAS procedure.

The standardized psychological tests administered pre- and post-intervention are included to provide an objective measure of change in different domains of family functioning. A statistic that has been developed to gauge whether change on a standardized test is clinically significant is the Reliable Change Index (RCI). The RCI is a statistic that, if exceeded, indicates that the change in pre- and post-intervention scores is unlikely to be due to chance. As the RCI is calculated using the standard error of measurement and reliability coefficients of tests, tests that have published these values can be used to calculate RCI (Bauer, Lambert, & Nielsen, 2004; Jacobson & Traux, 1991). The RCI can be used with standardized measures of parent–child observation. Results of the GAS procedure are based on the predefined rating scale as outlined above.

### 3. Issues in the assessment of capacity-to-change

Assessments of parenting aim to assess the *minimal* level of parenting capacity sufficient to protect the safety and well being of the child (Budd & Holdsworth, 1996). In the absence of an

agreed standard of parenting against which to judge the parenting capacity of an individual parent (Budd & Holdsworth, 1996; Greene & Kilili, 1998) assessments of parenting capacity involve judgments about a family, taking into account individual factors such as the family's socio-economic and cultural background, access to resources and the parenting attitudes and child-rearing practices of the wider community (Budd, 2001). As these are somewhat subjective, the case conference allows those involved to specify targets for change that take into account the socio-economic and cultural context of the family.

Assessments of parenting capacity carried out in the home environment can be difficult to conduct when there are distractions such as TV, music, or computer games operating and friends or neighbors arriving while an assessment is being carried out. Managing the environment to eliminate these distractions is important to maximize the reliability of the assessment. Where a family is living in a household that includes non-family members, the extent to which non-family members are included in the assessment will depend on their role and influence on the children in the family. Further, assessments of parenting capacity are often carried out within the context of an adversarial legal context. Under these conditions it is understandable that parents motivated to present themselves in a good light will show a bias toward socially acceptable responses on self-report measures (Budd, 2001). Assessment instruments such as the faking-good index of the CAPI can detect biased responding (Carr, Moretti, & Cue, 2005), but may lead to the unhelpful conclusion that the assessment is not a valid reflection of the parents actual capacity to parent. An unfortunate consequence of this scenario is that the parents attempt to present themselves in a positive light through a genuine, albeit naïve, motivation to retain custody and parental rights of their children might be interpreted as a sign of their unwillingness to cooperate or deliberately mislead. The capacity-to-change assessment model directly assesses the parents' motivation for change by providing an opportunity to work towards clearly specified targets that have been judged to be meaningful.

An assessment of capacity-to-change should not set up false expectations of success. The assessment of capacity-to-change is appropriate in cases where the assessment is equivocal and thus unable to predict the parents' ability to make changes. It can be expected that a proportion of families will fail to achieve agreed targets for change. For example, Dawe and Harnett (2007) found that 36% of the families who participated in the PUP program who were high risk at the outset of the study remained at high risk for child abuse and neglect post-treatment. While interventions can be effective in improving the functioning of physically abusive and neglectful families, it is not inevitable. Parents should be made aware that the assessment of capacity-to-change is an opportunity to demonstrate their motivation and ability to work towards clearly specified targets and that genuine effort will be provided to facilitate change. Regular monitoring of progress with feedback to parents will highlight the difficulties a family is having in achieving targets throughout the assessment process. When this occurs, a decision that the parents will not achieve a minimal level of parenting within an acceptable timeframe for the child has, at least, been a transparent process.

#### **4. Future research directions**

Despite research showing that child protection assessment reports often fall short of best practice guidelines (Budd, Naik-Polan, Felix, Massey, & Eisele, 2004; Conley, 2003), a study conducted in the UK found that 73% of recommendations made by a specialist child protection assessment team were followed by the court (Jamieson, Tranah, & Sheldrick, 1999). These studies, however, do not address the impact of the assessments on families, and, in particular the

development of the children involved. Addressing this issue requires longitudinal studies that are methodologically difficult and expensive to execute. However, given the importance of the assessments, it is essential that there is an evidence base to justify specific assessment models. A fruitful area of study would be to compare the extent to which decisions and recommendations made following a cross-sectional assessment are modified following a capacity-to-change assessment. Other areas that could be evaluated include the extent to which families feel involved and supported by different assessment procedures, and the confidence of practitioners and other stakeholders that the results of the assessment are reliable and valid. In being proactive in helping families achieve targets for change, it would be predicted that the capacity-to-change assessment would result in decisions being made more quickly and with greater confidence in the decisions. In the absence of empirical evidence, this remains speculative. If a capacity-to-change assessment is initiated soon after the family's involvement with child protective services, it may be possible to reduce the number of children being removed into out of home care. Again, this is a measurable outcome that lends itself to systematic research.

## 5. Conclusion

The capacity-to-change assessment procedure is a method for evaluating the capacity of parents to meet the needs of their child in situations where the current information about a family is equivocal. Information about the motivation and capacity of parents to change in the short-term in response to a brief intensive intervention should more accurately predict the future functioning of the family. If so, the capacity-to-change procedure will increase confidence in the decisions that either longer term plans for ongoing support for the family or that for parents found to have limited capacity for change, that other permanency options should be considered for the child. Research on the role of the capacity-to-change assessment procedure in the child protection system is warranted to determine whether the procedure can improve the decision-making process in the child protection field.

## Appendix A. Goal outcome rating form

### Goal 1

Name: Become more engaged with the school

Brief description: Becoming more involved with the school lets your child know you are interested in their schooling, allows you to talk to teachers about your child's progress, and can make you feel good for doing something important!

Completed by:

		Goal Scaling: Specification of outcomes for each level of outcome. Start by defining a successful outcome
Much less successful than expected	①	Helping out at school for at least 1–2 hours each week one time in a month
Somewhat less successful than expected	②	Helping out at school for at least 1–2 hours each week 2 or 3 times in a month
Successful outcome	③	Helping out at school for at least 1–2 hours a week, four times a month. This can include being a teachers aide in the classroom, working in the school canteen, supervising swimming, helping on school outings
Somewhat more successful than expected	④	Helping out at school for 3–4 hours each week for a month

Much more successful than expected	⑤	Helping out at school for 5 or more hours each week for a month. This might include getting involved in other school activities such as the Parent-Teacher Committee				
Meaningfulness	Not at all ①	Slightly ②	Moderately ③	Quite ④	Extremely ⑤	
Manageability	Meaningful Not at all ①	Meaningful Slightly ②	Meaningful Moderately ③	Meaningful Quite ④	Meaningful Extremely ⑤	
	Manageable	Manageable	Manageable	Manageable	Manageable	

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