

Assessments of parenting and parenting support need

A study of four professional groups

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How health, education and family practitioners assess what support parents might need.

Supporting parents is central to many wide-ranging Government initiatives of recent years. However, despite enormous advances in policy and legislation, we still know relatively little about what affects a key part of delivering services – the ‘consultation’ between parents and practitioners.

This study looks at how a range of health, education and family practitioners make their assessments of parenting and parenting support need. It also considers if and how these ideas were affected by factors such as practitioners’ own experience of being a parent, relationships with their own parents, their ethnicity, social class, disability, and gender and that of the families they are working with.

The project draws on 54 qualitative interviews with practitioners from four professional groups. The study explores:

- the process for assessing parenting and parenting support need;
- views on the nature of ‘good’, ‘good enough’ and ‘risky’ parenting;
- the role played by practitioner and family diversity, reflection and training in this area.

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1 Introduction

The context

Supporting parents as a means to improved child outcomes and as an end in itself is central to many wide-ranging government policy initiatives of recent years. The greater emphasis on preventative work aimed at supporting families in *Every Child Matters* (DfES, 2003) and the Children Act 2004 led to key changes in service delivery such as the development of children's trusts to enable better multiagency collaboration and information sharing. The introduction of the Common Assessment Framework form allows earlier identification of children with 'additional needs', provides a standardised needs-assessment tool and method of co-ordinating services, and creates a more streamlined process for parents requiring support for their children. The roll-out of the provision of extended schools and children's centres have both also served to promote better access to family and parenting support, and the involvement of a broader range of practitioners in delivery of these services.

However, despite enormous advances in policy and legislation, we know relatively little about factors that impact on the central mechanism in service delivery – the parent–practitioner 'consultation' – particularly in what we may call 'mainstream consultations' and 'assessments' in the broadest sense. This is where a practitioner evaluates a family's need for/benefit of additional support rather than focuses on what risk is posed to the child. These are consultations where there are no a priori child protection concerns, crises or critical incidents and which form part of a routine service (for example, health visitor visits) or standard referral process.

This study examines how practitioners in four professions – health visiting, paediatrics, family support and teaching – use subjective and objective elements of 'evidence' to make such assessments in practice. These professions were

selected because they provide a view across a range of mainstream educational, health and social services with different roles and histories in supporting families. In particular, family support workers based in children's centres, and therefore operating in a relatively new context, and reception/infant schoolteachers for whom parenting assessment and family support is a new, emergent role were of interest. There is a dearth of research conducted on these professionals relating to parenting support.

The role of practitioner and family diversity

This study looks at the role of perceived differences and similarities between practitioner and clients, and how these influence the relationships built and decisions made. A key area of diversity explored was ethnicity. In clinical practice, the impact of patient ethnicity on practitioners' decision-making and forms of intervention is considered to be one of the factors that contributes to disparities in care via differential assumptions about factors such as patient social support, likelihood of adherence to treatment and lifestyle and via differences in physician–patient communication and engagement (e.g. van Ryn, 2003; Johnson *et al.*, 2004; van Ryn *et al.*, 2006). In the relatively new areas of family and parenting support, less is known about how ethnicity affects assessment-making. Culture-sensitive parenting assessments and family support are the subject of considerable debate but little practical guidance is available (Dutt and Phillips, 2001; Becher and Hussain, 2003). The challenge for the practitioner is to be knowledgeable and sensitive to cultural values, beliefs and experiences, and understand their influence on behaviours and practices, while retaining a sense of the individual 'uniqueness' of each case (Hussain, 2005).

An important aspect of understanding the role played by diversity and difference is practitioner reflexivity and awareness with regard to how

factors such as ethnicity, culture, social class, gender and disability influence consultations and decision-making. For example, it is well documented that doctors give middle-class patients more information and spend more time discussing preventative health promotion with them than with working-class patients (Taira *et al.*, 1997); and that disabled parents, especially those with learning difficulties, suffer more stereotyping (McConnell and Llewellyn, 2002) and are likely to have their parenting skills measured against much harsher criteria than non-disabled parents (Booth and Booth, 1994). However, the extent to which practitioners are aware of these, seemingly unconscious tendencies to respond is not fully known.

Practitioner as well as client/patient characteristics are, of course, also part of the consultation 'mix', with some known differences in how practitioners operate. For example, in one of the very few studies relating to assessing parenting across racial groups that included practitioner ethnicity as a variable, Berger *et al.* (2005) found that ethnicity of the 'assessor' made a difference to assessments concerning parental warmth and harshness, with white participants significantly more likely than black participants to view these and other key parenting behaviours as problematic. Therefore, a major part of practitioner reflexivity is an appreciation of the role played by own ethnicity, gender, disability and social class in working with families.

Good enough and risky parenting

The complexity of making assessments has been well acknowledged – the Central Council for Education and Training in Social Work (CCETSW, 1991) described assessment of children's circumstances as involving:

... balancing conflicting and sometimes contradictory views of good parenting, good enough parenting and parenting which falls below acceptable standards of care.

However, there is evidence that the basic driving forces and underpinning factors appear to be, if not universal, largely consensual among different professional groups. Wheeler (1992) found that the processes and impacting factors on

assessments made by social workers and health visitors were very similar. In accordance with such findings, work on underlying concepts such as 'good enough' and 'risky' parenting, such as the JRF report by Newman *et al.* (2005) on which this research builds, show that there is more consensus than difference among professional groups as to how to define these terms.

An additional area of interest in the current study was the extent to which personal 'standards' of parenting applied to relatives and friends of the professionals studied might vary, or not, from those standards applied to client families. Daniel (1999) in a study of post-qualifying social work students found participants were certain about this point, with a majority disagreement with the statement that they would use 'lesser standards' to judge the home environments of clients than of themselves and friends because clients had less financial resources to provide toys, books and stimulation to their children. This study explored whether this form of 'universal' standard of parenting was held by a range of other parenting support professionals.

Aims of the study

The purpose of the study was to explore how a range of health, education and family practitioners make their assessments of parenting and parenting support need; and if and how these ideas are affected by factors such as them being a parent, experience of being parented, ethnicity, social class, disability and gender, and that of the families they are working with.

The study explored:

- the process for assessing parenting and parenting support need;
- views on the nature of 'good', 'good enough' and 'risky' parenting;
- the role played by practitioner and family diversity, reflection and training in this area.

Research design and methodology

The data for this project comes from 54 qualitative interviews with practitioners from four professional groups – health visitors, family support workers, paediatricians and nursery/infant teachers – across two geographical areas (see Table 1).

Table 1: Number of practitioners by area

Practitioner group	Area 1	Area 2	Total
Health visitor	9	7	16
Family support worker	7	7	14
Paediatrician	5	5	10
Teacher	8	6	14
Total	29	25	54

The study aimed to explore the views of a range of practitioners working in settings with different ‘client mixes’ with regard to key variables such as ethnicity. Therefore, two geographical areas were selected for the study with reference to census statistics to have, respectively, a high and average/low population of black and minority ethnic (BME) families. Both areas had similarly high deprivation scores/super output areas. Area 1 had a higher than UK average population of black and minority ethnic families and practitioners and area 2 had an average/low population of these groups.

Sample information

The sample was made up of 90.7 per cent ($n = 49$) female practitioners and 9.3 per cent ($n = 5$) male practitioners. The male interviewees were all in the paediatrician group. Nearly half of the sample were

aged 45–54 years. Three practitioners (5.6 per cent) in the sample reported a disability.

Ethnicity and faith

Overall, two-thirds of the sample described themselves as White British (see Table 2), although this differed by sample area; out of the 54 interviews, area 1 had 51.7 per cent white practitioners compared with 92 per cent white practitioners in area 2.

In the study, 55.6 per cent of respondents described their religion or faith as Christian, compared with just under a third who felt that they had no religion or faith.

Marital and parental status

Sixty-nine per cent of practitioners were married or cohabiting; this was highest within the paediatrician group, compared with 17 per cent who described themselves as single and just over a tenth who were divorced or widowed.

Over 80 per cent of practitioners were a parent or carer themselves. Two-thirds had at least one child over the age of 17 years. Four in ten had a child aged between 11 and 16 years, just over a quarter had a child aged between 6 and 12 years and a relatively small number of practitioners (9 per cent) had a child under the age of 5 years.

Only six practitioners (13.6 per cent of the sample) reported that they had a child with a disability.

Sample recruitment, access and ethics

Practitioners were recruited via service managers/heads in clinics, hospitals, schools and children’s centres in the two geographical areas selected for

Table 2: Practitioner group by ethnic group

Ethnic group	Health visitor	Family support worker	Paediatrician	Teacher	Total (% in brackets)
White British	12	11	4	9	36 (66.7)
Black Caribbean	0	3	0	3	6 (11.1)
Black African	3	0	0	0	3 (5.6)
White Irish	0	0	1	1	2 (3.7)
Indian	0	0	2	0	2 (3.7)
Asian Other	1	0	1	0	2 (3.7)
Mixed – Other	0	0	0	1	1 (1.9)
Chinese	0	0	1	0	1 (1.9)
No answer	0	0	1	0	1 (1.9)

the study. Practitioners interested in participating were asked to complete consent forms and return them to the research team to ensure confidentiality of participation. They also completed a monitoring form where they gave information on their age, gender, ethnicity, parental status and disability. This information was used to help select the sample and achieve the optimal range of practitioners (with regard to gender, ethnicity, age and disability diversity) to interview for the study. All documentation made it clear that the study was independent of management structures, that participation was voluntary, that the research was being conducted by an external third party and that it was in no way related to professional review or other processes of staff assessment.

Throughout the study the research team worked to the Code of Ethics of the British Psychological Society. Ethical approval for the research was sought and granted from an NHS national multi-site research ethics committee (MREC) and the local primary care trust (PCT) research and development committees in each area under study, as well as the Family and Parenting Institute's (FPI's) own ethics committee using external peer review.

The interviews

The topic guide for the study was developed with reference to the study objectives and current research literature, and with input from the Project Advisory Group (see the Appendix). It was piloted with seven practitioners by telephone and feedback on the focus and content of the study was also sought from FPI's parents' panel of 140 parents by email.

The interviews were semi-structured, lasting for one to one-and-a-half hours, and were tape-recorded. To allow flexibility of participation respondents were offered the choice of interviews conducted face to face or by telephone. Thirty interviews were conducted over the telephone and twenty four interviews were conducted face to face. The topic guide covered the following areas:

- background and training;
- process of assessing parents' support needs;

- impact of family and practitioner diversity on assessments;
- impact of policy and professional frameworks/legislation on assessment-making;
- beliefs around 'good enough' and 'risky' parenting;
- information and training resource usage and gaps.

The analyses

All interviews were transcribed verbatim. The data was content analysed and categorised using the main topic areas of the interview and other emerging themes.

2 The process of assessing parenting and parenting support need

The four professional groups

Family support workers in the sample were based mainly within, or aligned to, Sure Start children's centres. Their job roles and titles varied widely and encompassed a range of support and experience, including parent support worker, portage worker, special needs support worker and child development worker. Their training backgrounds ranged from formal social work training to more vocational training in childcare. Parents could access the services via a number of channels – self-referrals via the children's centres or referrals from health professionals, schools or voluntary organisations.

Health visitors' teams were based within Sure Start children's centres, GP surgeries and health clinics. Not all teams offered routine assessments following one year. Some areas offered a universal service (i.e. development checks at two years) while others had services targeted at early years or at the most disadvantaged groups. Parents were referred on to health visiting services via new births, new registrations with GPs or self-referral through clinics and children's centres.

Paediatricians in the sample had a range of specialisms including looked after children, child protection, disability and special needs, diabetes, autism and developmental disorders. Parents were usually referred to them via GPs, but also through schools, health visitors and other health professionals.

Teachers in the sample included both nursery and primary school practitioners (working with the 2–7 year age range). Some had designated responsibilities for child protection, special educational needs or pupil support and inclusion, while others had none. Teachers had access to parents via the school, either at drop-off or pick-up times, or meetings, which either were at the request of the school or parent, or were yearly progress meetings.

Perceptions of roles and boundaries

The extent to which respondents viewed their professional roles as encompassing any assessment of parenting or offering family support varied, unsurprisingly, between professional groups.

Family support workers saw both formal and informal parental assessment as a key part of their professional role. Following a referral they would often meet with parents in the family home and collect a wide range of information on the child, parents, family and home situation:

We fill in a developmental checklist to establish exactly where the child is developmentally by talking to the parents ... observing the child, observing their circumstances ... from that quite a comprehensive assessment is made ... looking at all aspects of the dynamics of the family, the extended family, input from other professionals [are] all taken into account.

(Family support worker 2, area 1)

Health visitors also viewed parental assessment as a key part of their role. Meetings with parents would often occur within the family home and a full assessment of the child, family and home environment would be taken:

[We use] the assessment triangle, which is ... looking at the physical environment, the emotional, psychological, support networks, the development of the child, the mother's parenting capacity, financial, housing. It's a comprehensive assessment.

(Health visitor 1, area 1)

In contrast, teachers felt that their focus was on the child's health, development or behaviour, rather than on the parents. The specific responsibility of

the teacher within the school had an impact on whether they felt parental assessment was part of their role. Teachers who were the child protection officer, special educational needs co-ordinator or pupil support/inclusion officers felt that parental assessment was part of their role, whereas teachers who did not have these designated responsibilities felt that it played little or no part in their remit:

We are so focused on the well-being of the children, everything gets siphoned through that, so you probably only pick up if someone else in the family needs support in very difficult circumstances.

(Teacher 10, area 2)

Similarly, for paediatricians, the main focus of consultations was on the child rather than on the family or parents:

The children are referred to me, or they come along with medical problems so we see the parents with them. So it's not specifically that parents are referred to me, all I do is see parents in the context of a child's chronic disease ... for example, diabetes involves a large amount of parental education.

(Paediatrician 9, area 2)

However, some paediatricians – for example, those involved in child protection – felt that parental assessment was an important role in their job:

I used to be the designated doctor for child protection ... and I've also done some CAMHS [child and adolescent mental health services] work, so assessing parenting is really integral ... have I had any formal assessment training in it? Probably not, but I've done a lot of training around attachment ... and because of what you do with all these families, you notice things and ... you can sometimes see parenting that's clearly damaging.

(Paediatrician 2, area 1)

How parenting information was collected

Despite whether they felt their roles included some form of parental assessment or not, all four practitioner groups did formally or informally collect and observe a wide range of information regarding parenting capacity. This was often expressed as observations or triggers for concern, rather than formal assessments.

The multiple ways in which practitioners collected parenting information, both verbally and observationally, are summarised in Table 3.

Table 3: Formal and informal methods for collecting parenting information

How information is collected	What information is collected
Discussion(s) with parent	Physical, mental and emotional health of parents; family background and history; wider/extended family; self-defined issues and concerns; own parenting background; employment and social deprivation; family and community resources available; previous support
Consulting other professionals (either pre or post meeting)	Previous contact with services; previous support received; number/type of referrals; previous assessments/observations/reports; ordering additional assessments to be made
Observations of home and physical environment	Basic care; risk and safety factors; other family members present; levels of stimulation; family routines; hygiene and cleanliness; housing and family resources available; substance misuse; interactions between parents and other family members
Observations of child	Health and social development; emotional and behavioural development; interaction with practitioner and other adults
Observations of parent(s)	Engagement with practitioner; attitude towards child; attitude towards identified problems; motivation to change; how parents talk about their child; interactions between parents and other family members
Observations of parent and child	Relationship between parent and child; verbal and non-verbal interaction; how parents talk to their child; emotional warmth and demonstrable affection; guidance and boundaries

Listening to parents' concerns

All four practitioner groups met with parents on a one-to-one basis within the home, school or clinic setting. In these meetings, practitioners would often discuss the physical, mental and emotional well-being of parents, and take a history of the family background, which could include the family structure, employment and social situation, and family and community resources available. This could be done in a more formal assessment – by health visitors, for example – or informally by family support workers:

[I] gauge the parents' attitude towards the children and we talk about how they're feeling, how things are for them, to get an indication of where they are emotionally and where they are around the support for their children ... Sometimes it might be quite a nice pleasant chat, sometimes she might be very tearful and be telling us everything in one big garbled mess ... then we have to sit there and try and pick out little bits that seem ... relevant.

(Family support worker 5, area 1)

Listening to parents' concerns rather than 'going in with an agenda' was a main theme for those professionals whose main role was to assess and support parents:

If you go and visit a family with your own agenda and your own idea about how things should be done then you tend not to get very far ... So, if you speak to a family and they say they've got a particular financial issue, there's no point in banging on about behaviour management, when obviously the financial issue is causing them more worry than the behaviour at that particular time.

(Health visitor 15, area 2)

Consulting with other professionals

Health visitors, family support workers and paediatricians would often consult with other professionals either before or after their meetings with parents. Information might be available beforehand through referral forms from other agencies, or the parents might have had contact with other colleagues within the same team. This information gave a picture of the family in terms

of their previous contact with support services, referrals made and previous assessments, observations or reports. However, the amount of information available could be highly variable:

If I get a referral from a social worker where a child's been known for quite some time, you quite often get a decent amount of social and historical information – education information, information from CAMHS and so on. If ... they're referred from hospital or from GP or school, you get a variable amount of information. It can be half a page of A4 or you can occasionally get one of these CAF [Common Assessment Framework] forms ... [a] statement or report or annual review.

(Paediatrician 2, area 1)

We get the referral form, which has got a list of about twelve ... working objectives that the referrer can tick. So that will be things like help the parent become involved in the child's development, access local services, relieve isolation. So the referral will give us the basic information about the family ... and they give us just a short half an A4 write-up of what the general history of the family is.

(Family support worker 5, area 1)

The information given to practitioners visiting the family home, such as family support workers for example, was often used as part of a risk assessment. However, the information given to practitioners was not always accurate or complete:

I do a risk assessment of the area, just make sure it's safe to go to and it's also dependent on what's on the referral form, so if there's domestic violence involved I've got to find out from the health visitor is it still ongoing ... what's on the form isn't always what you find out when you go in. I've had on the form, 'oh mum's a single parent' but, when we've gone to the door, the dad's there ... so we always go in twos for that, just for my team's safety.

(Family support worker 4, area 1)

Observing the home and physical environment

Practitioners who often visited parents at home (mainly family support workers and health visitors) collected a wide range of information about the home environment, which formed part of their formal or informal assessment. The main observations of the home environment related to risk and safety factors; routine and basic care; other family members and their relationship to the child; levels of stimulation; and housing and family resources available.

Basic care

The level of basic care was highlighted as a key observation that formed part of the assessment process. This centred on cleanliness in the home and basic routines, along with the levels of 'chaos', which could highlight particular issues of concern:

We're looking around at the general state of the home ... not necessarily just the cleanliness but the chaos, if it's very chaotic to me that might indicate that there's things going on in the home. I know in my experience of drug users, their homes are very chaotic, even though they might be swearing that they don't touch anything.

(Family support worker 5, area 1)

Risk and safety factors

For health visitors, in particular, observations would also be made of the risk and safety factors in the home, such as stairs, furniture, fireguards and other potential hazards to the child:

There are things like the environment's unsafe in that I don't have a particular problem with mess but it's when it's hazardous, when there are unsafe things left around, when there's easy access to hazardous materials, those very chaotic households where [you] could break your neck falling down the stairs cos you can't actually see the stairs, those kinds of households in that environment when parents aren't able to understand or function well enough to be able to do anything about that to protect their children.

(Health visitor 11, area 2)

Practitioners would also look at who else lived in the home and their relationship to the child, and observations would also be made of the family resources, such as the amount of food available, space available and where everyone slept:

[I look at] is the child actually safe with the other people in their environment ... with lots of adults coming and going and you don't know who they are.

(Health visitor 13, area 2)

[There's concerns] going into the fridge and there's nothing there and mum's run out of money, which some of them do and doesn't have enough food to give to the child.

(Health visitor 1, area 1)

Play and stimulation

Health visitors were also interested in observing the levels of stimulation for the child, such as the number of toys and books available:

We're looking to see what toys are readily available for a child. So a lot of parents will say, 'oh he's got heaps of toys up in his room but he won't play with anything', but it's what have they got to play with downstairs? And how's that child occupied? Is the telly on all the time? ... you can often tell if there's piles of books around that's always a good sign.

(Health visitor 6, area 2)

It always worries me when you go into a house and there's not a book or a toy in sight, and you think, this child's supposed to behave and the parents may have slightly unrealistic expectations of what a young child can actually achieve.

(Health visitor 13, area 2)

Family routines

Health visitors and family support workers would also observe the level of routine and order within the family home. Observations could be used to

back up parental reports on feeding and bedtime routines:

If the parents are sharing information with us we might be looking for evidence about what supports the things they say that they do, so, if they are saying to us, 'well we've got a good bedtime routine with the children' and things like that, and we might be looking for evidence to support that.

(Family support worker 11, area 2)

Observing the child's health and behaviour

Within the home, school or clinic setting, practitioners monitored the child's health and behaviour as part of their professional role. The main observations related to risk and safety factors in the child; their health and social development; their emotional and behavioural development; and their interaction with the practitioner and other adults. Paediatricians and health visitors often saw children to formally explore their social and health development. Family support workers generally reported less contact with the child and if they had specific concerns would often refer the family to health professionals. Teachers, in particular, were in a unique position to informally monitor changes in children's behaviour over a period of time.

Triggers for concern

Both paediatricians and health visitors reported how they would look for signs of physical neglect and concern in children. They would monitor risk factors in the child that could point to issues of abuse or neglect, such as physical signs of bruises, cuts, rashes, injuries, level of growth, along with basic levels of care such as hygiene, nutrition and appropriate clothing:

The most obvious ones would be physical signs, bruises, cuts, injuries, but also the lack of satisfactory growth in a child, poor state of nutrition, signs of negligence in the childcare, clothing, rashes.

(Paediatrician 4, area 1)

If the child's feet were very dirty, or if you had an immobile child and their fingernails and toes were very dirty, if their clothes were generally

a bit dirty and looked like they hadn't been changed regularly and physical aspects about the child, if they'd got any nappy rash or under-chin rash. In conjunction with these other things, it's not uncommon for babies to get nappy rashes and rashes under their chin, but it's part of a whole picture, so you're not looking at one thing in isolation you're considering a lot of different factors at the same time.

(Health visitor 15, area 2)

A further indicator of child well-being was how the child interacted with the practitioner. For example, one health visitor explained how a child's overfriendliness with strangers gave her cause for concern:

You can often tell from the demeanour of the child, how they respond to me when I came in, are they a little bit wary to start with, then after a little while they warm up and come and investigate what's in my bag and stuff like that and that's quite appropriate, or is it a child that comes over and wants to sit on your lap straight away even though you've never met them before and that always rings a few alarm bells, what's really happening here. It doesn't necessarily mean that there is a problem but is there something around the relationships of this child that is not appropriate?

(Health visitor 13, area 2)

Changes over time

Teachers were in the unique position of being able to monitor children on a daily basis and note any changes in the child's appearance, behaviour or development:

[I would be concerned about] a child whose behaviour has changed quite noticeably, maybe a child that has been fairly confident in the past and had a couple of days where they're a bit clingy or a bit weepy, a child that's being aggressive to other children, maybe a child that has said something that doesn't make quite sense or might send a little alarm bell going off that maybe there's something that you need to know about.

(Teacher 9, area 2)

Observing and recording parents' attitude and behaviour

How parents related to and engaged with practitioners was felt to be a useful marker of their parenting capacity and support needs. In particular, practitioners were looking for positive attitudes from parents that suggested they acknowledged any issues, were engaged with the service and were positively motivated to change:

You'd be looking for a hopeful prognosis that the family accept the need for change, and that they see this is about their child and their family, and that they have an empathy about their child and that their attachment to the child is close and anything that is in deficit can be acknowledged and worked on.

(Family support worker 7, area 1)

It's about gauging the attitude. Some families take the view that okay they're stuck with it, just got to get on with it and others, if you ask them, 'what do you think of diabetes?', they [say] 'it's okay let's get on with it', and if you ask others they seethe with indignation and say they hate it and how terrible it is.

(Paediatrician 9, area 2)

Talking about their child

A small number of paediatricians in the sample highlighted how they felt able to assess parenting by how parents were talking about their child. The language parents used in the consultation also often gave clues to potential parenting issues. Primarily, practitioners were looking for a positive regard, sensitivity and empathy towards children:

I always like to know that parents can see positives in their child. So for instance, if a parent starts to give me a whole litany of negatives, I'd actually ask them, 'What about the child's positive features? What are its strengths? What's it good at?' And I'd expect them to say something. Sometimes, if they say nothing, then either there's something very seriously wrong with the child, but more often than not it's because actually that there's a lack

of positive regard for the child and I think that's a very important element of parenting.

(Paediatrician 8, area 2)

I think that [good parenting] can be ascertained simply by noticing how often parents are making positive or negative comments on the child. It's quite simple and to me that's probably one of the main markers that is more global than watching either the child's behaviour in the clinic or parents' behaviour in the clinic.

(Paediatrician 1, area 1)

Observing the parent and child (and parent-child relationship)

All practitioner groups described how observing the verbal and non-verbal communication between parents and their children could help them to assess the family situation and flag up any potential areas for concern. The main observations related to verbal and non-verbal interaction, and in particular the level of warmth and engagement.

Talking to their child

How parents talked to their child was viewed as an important indicator of the parent-child relationship. Practitioners would informally observe the positive and negative messages given from the parent to the child and concerns would be raised if this communication was mainly negative:

[Parents] would say very negative things. They would say, 'He's a nightmare, he's naughty, he's horrible, he's mad' in front of the child, they would use extremely negative words. They would have their faces looking extremely negative and angry. They would stop or say things to the child in a very negative way. 'Stop that. Don't do that. I didn't say that to you', that kind of tone they would have with the child, which is continually negative. So all that they're saying to you or to the child is negative. You don't have to look for any other markers. That's [a] very cruel fact.

(Paediatrician 1, area 1)

How the parent talks to the child, are they quite negative, are they always telling them off or is it quite a positive relationship, well stimulated, cuddles? Just touchy feely things.

(Health visitor 14, area 2)

Demonstrable affection

Practitioners looked for demonstrable care and affection, positive body language and eye expression, and the willingness of the child to turn to their parent for encouragement, support and praise:

You're observing interaction, you're observing eye contact, the way the child is being held, the way that the child is being spoken to, the sorts of language, the kind of praise, encouragement, the body language, how free the children are and how uninhibited or how controlled they are.

(Family support worker 9, area 2)

[I'm looking for] symbols of bonding between the child and the mother. The eye contact, the willingness to be physically in touch with the mother. The willingness to turn to mother for encouragement, for support, for praise.

(Paediatrician 4, area 1)

Practitioners also observed how parents handled their child's requests and needs – either positively with confidence and with personal involvement or negatively with a degree of detachment:

We are looking at how mum is handling the child's requests, whether she does that with confidence or lack of it. Whether she does it with real personal involvement, sense of involvement or there is a degree of detachment.

(Paediatrician 4, area 1)

I look for the relationship between the parent and the child, so is the parent responding to the child's needs? Are they reasonably sensitive? Can they pick [up] when their child

is distressed? What do they say to them when they are distressed? Do they get a cuddle?

(Health visitor 13, area 2)

Concerns would be noted if practitioners observed negative non-verbal interaction between parent and child. This could include emotional detachment from either the parent or the child, or little interaction between them:

An example I can think of is a parent who [often] greeted or left a child without showing any kind of affection, just [saying], 'Go on, in you go' or picking up time, 'Come on you', or instantly swearing and shouting at them, even if the child has got a picture in their hand or something to show them, it's ignored and they're pulled along ... I think you do pick [that] up.

(Teacher 9, area 2)

Looking at the relationship between a parent and a child can tell you an awful lot ... just watching when parents come to collect their children at the end of the day, the way that they greet them, the way that the child is and you can see an early identification of ones that there are going to be problems with in future ... pleased to see you, being there on time, that's a biggie in our school ... There's the extreme where they just come in and they are on their mobile phone and carry on talking and just don't do anything.

(Teacher 8, area 1)

How assessment information was used

Practitioners were able to formally and informally collect a wide range of information regarding parenting. However, how this information was used varied according to perceived roles and boundaries in relation to assessment and support. Family support workers and health visitors used the parenting information collected in order to offer a wide range of ongoing support to families, as well as signposting parents to other services and as part of the Common Assessment Framework. Paediatricians might note parenting issues within

the consultation, but some felt that they did not have many structured ways of looking at parenting or incorporating the information into their assessments of children. Many paediatricians felt that they could offer only a limited amount of support to parents outside of their clinical remit, but would often refer parents on to other agencies for support such as other health services or voluntary organisations. Similarly, teachers observed a wide range of child and parenting behaviour. How and if this was noted or acted upon varied depending on the teacher's role within the school, their relationship with parents and their confidence to address any issues.

Monitoring over time

Practitioners were aware that observations made might not offer a full account of the family situation. Health visitors and family support workers highlighted that observations in the home environment that caused concern were often discussed with colleagues and monitored over time rather than any immediate action being taken with the family:

There is one family that I had to do ... a catch-up visit and it was the cleanliness that made me feel a bit uncomfortable. There was evidence of drug use, cannabis, and then they'd made an effort to clean up a bit, but it was when you looked in the doll's house and there was an ashtray that had been spilt in the doll's house, and underneath the coffee table was just filthy ... It wasn't a major cause for concern because the family had been known to us before, and they were an awful lot worse before, and [a colleague] said by the sounds of things they are ten times better than they were before and we will just keep an eye and go from there.

(Family support worker 12, area 2)

A lot of times you have to make assessments over families over a period of time, if you can. If you go in and things are absolutely horrendous then that would be a different story, but if things are just not great and you'd want to build a relationship with the family

and understand what life is like for them and continue to see how things were going.

(Health visitor 15, area 2)

For those families who were perceived to be functioning less well, but who were not a safeguarding concern, many health visitors felt there were difficulties in offering support. Differences in perceptions of adequate levels of care were mentioned with regard to working with other professional groups, such as social services. In such cases a longer established relationship was often needed to monitor and support the family:

[I've] been into some families where there has been cause for alarm where you've had to refer to social services where there's been three children in the house ... and there's a toddler on the floor, dog faeces all over the carpet, nowhere safe to sit down, the eight month old is picking up crisps off the floor and eating them, not nice at all ... There's families who are on a fine line as well who do care for their children and they are well cared for and they might be appropriately clothed but standards in the home are not bad enough for social services to pick them up but they are a cause for concern for the health visiting team. So they're the families probably that cause you probably in a way more work because you need to keep an eye on what's happening if they need the support, whereas children on the other end of the spectrum who are looked after if you like, who are under the care of social services, are more likely to maintain a good level.

(Health visitor 10, area 2)

Teachers in the sample informally collected a wide range of information from children and parents. However, outside of child protection concerns, there were few clear guidelines as to what action they could and should take. If changes were noticed in a child's appearance or behaviour, teachers would either discuss the issue with colleagues or managers or would often casually approach the parents:

[We're] not going to rush straight to child protection or something, but just a little chat with the parent first ... So we'd just bring it

up quite casually with the parent to begin with and we'd just say in quite a friendly manner, 'I've just noticed this last couple of days I just wonder if it's something that's happened at home or whether you could shed any light on this for us?', and very often there is and suddenly something will come out.

(Teacher 9, area 2)

I wouldn't tackle every parent and every child who looks a bit scruffy ... cos I know that some families are just more laid back about it perhaps, so I would always be careful, but it would have to be beyond certain points ... it's like scruffiness in itself it doesn't bother me but I suppose there's a point beyond which cleanliness is an issue for the child in the social terms ... and then I wouldn't do it on my own either, obviously I would always be discussing this with colleagues, with the head and so on. So it's at that point where we feel we have to make an approach for the child's sake really.

(Teacher 14, area 2)

However, some teachers feared crossing the professional line in approaching the parent with concerns:

I think for me the main problem is all those grey areas where you do get just a feeling that there's something wrong but you've got no real evidence other than maybe a child who seems miserable in school, isn't very sociable, or is overly aggressive and you feel well there must be some reason for this and that can be very tricky because I suppose in a way you feel is it my right to query the parent when I don't really have any evidence?

(Teacher 10, area 2)

Providing family support

All practitioners felt that they offered some 'low'-level support, such as a listening ear, verbal endorsement or some advice, but there were differences in terms of other support offered.

Family support workers saw themselves as offering longer-term support to parents, which was often a mixture of crisis management and preventative work and was demand led. They felt

that they had enough flexibility in their role to tailor support to individual families in terms of both the type of support offered and the length of time given to families:

I tend to ask them what they want from us, rather than saying straight in, 'I can do this, this and this' ... It's quite nice in that we have the flexibility to be able to do that.

(Family support worker 12, area 2)

It could be someone to talk to if they're new in the area and they don't know where any of the services are, we can support them in putting them into contact. So it could be they don't know how the school system runs in this country if they've come from abroad, so you support them in accessing that, putting their children's names down. Could be something as simple as trying to find a GP or a dentist ... So it's getting the information on that for them and helping them fill out the forms and even going along with them to find the place where they need to go to.

(Family support worker 4, area 1)

I think once you get in and start working there's no other agency that's going to go and take mum to a mother and toddler group ... your social worker's not gonna do that, they're just going to come round and see you and go, whereas we will, even if it's going out for a cup of coffee, if that's what mum really wants to do, then we'll go out for a cup of coffee and sit and have a chat. It could be as simple as that.

(Family support worker 3, area 1)

The level of support offered by health visitors varied across sample areas. In some areas parents were supported from the antenatal period onwards, while in others they were supported only in the first few months following birth, unless there were any specific concerns. Health visitors felt that they offered longer-term relationships rather than a brief intervention and the support offered was varied and often demand led, with a mixture

of crisis management and preventative support, along with signposting on to other agencies and professionals:

Some families they just need to talk, so it would be a listening visit ... and to see if there can be any other supports within the community that the family would be willing to access, like some of the toddler groups, cos sometimes they feel they're the only one with a toddler that's not eating or sleeping, so you would encourage them to come out of the home into more of the community groups, where they could build their own network of support.

(Health visitor 16, area 2)

Teachers felt that they offered limited family support as part of their role. The level of support offered varied depending on the teacher's role within the school and whether they worked in an extended school. Also the age group of children had an impact – teachers of younger children (foundation stage) reported more contact with parents and involvement in family support than those who worked with older children. All teachers were willing to refer parents on to other agencies such as CAMHS, children's centres or local voluntary organisations. Often parents would be referred on to the school's designated officer for child protection, pupil support, special educational needs or pupil inclusion:

I don't think we can provide all the support that some parents need. I think we can obviously do the educational stuff and model and show parents what a good parent does in terms of supporting education ... [but] if they needed regular support I would signpost them to ... the [school's] children's well-being co-ordinator.

(Teacher 14, area 2)

Many teachers did offer very informal levels of support in their brief interactions with parents either before or after school, but some teachers had quite a modest view about whether this contact with parents could be viewed as a form of parental support:

I'm not sure we are offering support, but it's only because we aren't really aware that it's

needed and with some families of course we sometimes do offer support but we get rejected then if they don't want our offers of support ... there is one particular mother that I feel I'm supporting because she's just been through a bad divorce and is quite upset a lot of the time, and she's also got a very difficult child that I think she's finding difficult to handle at home and I mean the only support I'm offering her is to ... give her information about what's happening with her child in school and which sadly is quite often bad behaviour, but ... it's allowing her someone to talk to and admit to that, gosh, life's a bit hard at the moment ... we can chat for ten minutes after school and suggest strategies that she might be able to use with her boy at home and although she does quite often cry I think it's something isn't it?

(Teacher 10, area 2)

One teacher also highlighted a lack of awareness and confidence in referring parents on to other agencies for support or to parenting classes:

I don't feel in a position able to [refer parents on] and I know there are lots of these classes out there but ... I'm not aware that I can make any direct referral to them for parents.

(Teacher 8, area 1)

Although, in one area, it was seen as a future goal for the school to be able to take on a more supportive role to parents:

It is a big wish list of mine to actually get this more sort of embedded into school and as part of my role ... and my office is now near the reception, people do tend to find me ... I have had parents come in to say to me, 'it's really good cos we always know we can come and talk to you' ... so a lot of it will be I suppose reassurance allaying fears and anxieties and then trying to find an appropriate source of advice if I haven't got the answers.

(Teacher 1, area 1)

The professional boundaries between paediatricians and parents could be seen to be more structured than with other professional groups in that parents were often referred with a

specific problem or concern. Paediatricians did not generally see their main role as offering support to families because of a lack of time, the financial implications of offering support to individuals and a recognition that there were other professional groups who were more experienced and able to provide family support:

We try to be supportive to families and one of the ways we do that is by trying to adapt their therapy to what is best for that individual family, but that's obviously a very medical approach, it doesn't address the psychological needs ... we're very conscious in our work of the fact that we can't support families as much as we want to, as much as we feel they deserve and need, and that's as much as anything an NHS resource issue.

(Paediatrician 9, area 2)

It would be nice to do a bit more of the therapeutic stuff. I feel like a lot of what I do is information gathering and less time is spent actually doing positive work with families but because of the way in which we work at the moment you need to be seeing those families on a more regular basis than we are because of the throughput of children into the service. You're lucky if you can see them two or three months later, let alone a week later, so I think we're just not set up to work in that way and I think there are other people who are better skilled, that's their primary role so I'd like to think that we complement those people rather than we should necessarily take over that role.

(Paediatrician 7, area 2)

The support that was offered was seen as limited to a listening ear, giving advice or referring parents on to other agencies:

[I can give] some advice and verbal endorsement but not much more than you would get in a clinical encounter. I think there's a potential risk of offering something that you can't really deliver on ... it's much more important that I do the paediatric medical bit, the clinical bit well, and offer whatever support and advice and guidance that goes along

with that. I think [family/parenting support] requires a much more intensive input, more frequent visits, longer time and more kind of engagement if you like with the family than I've got the time or resources to offer.

(Paediatrician 8, area 2)

Paediatricians did feel in a position to refer parents on to other agencies for support, although this differed depending on their role and the specialist area that they worked in. A small number highlighted the lack of support services available:

Part of the problem we have is that we do not have any useful psychological or psychiatric support for children or families. There is no access to psychology for children with chronic disease in [area 2]. It's absolutely appalling and disgusting.

(Paediatrician 9, area 2)

3 Factors impacting on assessment and decision-making

Developing relationships with families

Environment

One of the key factors that impacted on the practitioner–parent relationship, the type of information collected and how it was perceived was the location of the consultations. Parents were seen to be more relaxed within the home environment, for example, with fewer time pressures, although within the home environment certain tensions could come into play:

I think it's highly complex and involved because ... I always think it's a real privilege to enter somebody's home and to be invited in and ... there's sort of unwritten things about being a bit of a guest, but we're not really a guest because we might not be naturally invited ... I don't mean it's strained but there's a lot of things that you're holding together when you do that visit because you're going in and you're asking very personal questions.

(Health visitor 6, area 1)

In contrast, the clinic or school settings were largely seen as a more artificial environment in which to meet with parents. Some paediatricians felt that it could be a disadvantage seeing parents in a clinic environment, although they acknowledged that home visits were not always feasible:

It's really quite time consuming to visit homes ... I will accept that very often you get quite unique information by visiting homes, but it's just not practically possible really.

(Paediatrician 8, area 2)

Paediatricians were particularly aware that the professional relationship between doctor and parent could be quite different from other

practitioner groups; and that parents' behaviour within the clinic could be attributable to the stresses of the environment and appointment rather than an indicator of their parenting capacity:

The situation here can be a bit artificial. In the clinic-based situation, when parents are bringing their child and it is sometimes hard to be too certain about it. Even about your observation of something, because we're aware the parents are anxious when they're bringing their child in, they've got a question, they're worried about something, that they get worried about what you say to them, what you ask them and they often feel that as if you're implying that they have done something to the child.

(Paediatrician 1, area 1)

Teachers who would monitor children on a daily basis were also cautious about generalising from their observations:

I don't judge parenting, you cannot judge parenting because ... how children behave in a set establishment is completely different sometimes to how they behave at home.

(Teacher 2, area 1)

Time and engagement

Benefits of longer-term engagement

The time available for practitioners to spend with parents was, unsurprisingly, also seen to have an impact on their relationship with them and on the assessment process. Longer-term relationships, involving several meetings with parents, were the province mainly of family support workers, and also health visitors, but only in some areas and teams. These practitioners described their role as working in partnership with parents, developing a relationship based on trust, offering empathy and support to parents:

[I] ask them about what is going on. How they think they're managing. Do they get a lot of support? How is their mood and mental state? Do the couples support each other? And these are the things that people will tell once you've built a relationship with them ... people aren't going to tell you their life story the first time you ever meet them, particularly if they've had a negative experience of health visiting or your service in the past.

(Health visitor 15, area 2)

Family support workers in particular felt that they had the capacity to build up strong relationships over time and to be flexible in the support that they offered:

I think we seem to go that extra mile [more] than a lot of people, maybe health visitors or social workers ... I know obviously they're restricted in their time, but I think, when people deal with us, you're able to develop a more personal relationship and I think they place a lot of trust in us that they wouldn't place in other professionals because ... you're able to develop a stronger relationship over time.

(Family support worker 3, area 1)

Developing a longer-term relationship with parents enabled practitioners to place any problems observed within the wider context of previous knowledge of the family:

If you know the family is quite clean, and then you go in one day and you find the place in a mess, and obviously that triggers off [that] something's going on cos you know what the mum is like. You know she's very good at keeping the place clean, the children clean and then all of a sudden she comes to the door and she's still got her dressing gown on and then you know something's up.

(Family support worker 4, area 1)

Some parents do come in and something's happened at home with their partner or something and you notice the change because you see the parents every day, you notice little changes.

(Nursery teacher 5, area 1)

Challenges of short-term engagement

For paediatricians basing most of their assessments on clinic consultations, it could be difficult to assess whether problems were pervasive:

I feel sometimes we just skim the surface because we don't have the resources and time to do more than that ... Our clinic appointments are a drop in the ocean ... you get an impression about what's going on but ... it's not a very in-depth assessment cos we don't go home, we rely on the information that's given to us.

(Paediatrician 7, area 2)

In short, one-off consultations, time was limited and the main focus had to be on the child's behaviour and development rather than on parenting. However, if further information was seen to be important for an assessment, paediatricians would spend more time gathering parenting information:

I think a lot of paediatricians tend to do the basic minimum that gets a job done because we've got so much other demands on our time. So sometimes an assessment of parenting is a quick, one-off, ten-minute appointment in the clinic and you sort of get an impression. As long as that's good enough to know, to answer basic questions, then we wouldn't go into it [parenting] in any great depth. So if for instance I'm being asked about a child whose behaviour's difficult and who has some symptoms of attention deficit disorder, I'd be interested a little bit to know about the basic kind of standard of parenting in terms of consistency and supervision, but not a lot, just a little bit really ... If on the other hand I get a request from a court for a detailed report, paediatric assessment, then I'm going to take a lot more time and attention and get a whole lot more information around assessing parenting and the effects of that on the child because that's what's required.

(Paediatrician 8, area 2)

Many teachers in the sample also reported a lack of time to develop relationships with parents and to offer any support:

From the point of view of the teacher it's so often not knowing what to do but actually having the time to do it with a class of 30 ... We've got one child for example at the moment who never wants to go home and is the one that we're concerned about and we are there for them, but because of the structure of the curriculum even with 4 and 5 year olds I am constantly under pressure to be teaching this, this and this every day and yet I feel most of my time is taken up with either dealing with behavioural problems or emotional problems or indeed physical problems ... that is the stress of the job for me, feeling I'm spreading myself too thinly over a number of equally important functions.

(Teacher 10, area 2)

For teachers who did not feel that they had the time or were able to develop strong relationships with parents, there were concerns that, if problems did occur, they could be difficult to address and could threaten parent–school–teacher relationships if the wrong approach was taken:

We do see some difficulties with some children in school but in the end they can always take their children to a different school and if you antagonise them enough they will do that. So you have to tread a fine line with them and be specific that you're focusing on the needs of the child rather than interfering in their own lives too much.

(Teacher 10, area 2)

Blurring of the parent–practitioner relationship

For family support workers in particular, there were many advantages to spending time with parents to develop supportive relationships. Many in this group felt that they were able to develop a different, less formal, relationship with parents than other professionals such as health visitors or social workers. However, there were some concerns reported that this could, for some, lead to a blurring of the client–practitioner relationship and an over-reliance by parents:

You don't cross the professional line because sometimes they become too reliant on you

... at the end of the day you're a professional going in to work with them and you can take things further if you actually feel they're not meeting their child's needs ... you can befriend them but you're not actually going in there as a friend and you don't give them your private home number so they can ring you at weekends, because some parents want that.

(Family support worker 10, area 2)

Families don't see us in the same light as health visitors or social services, we get more information out of them, but we always have to say to them, 'If it's something we have got to report, we're duty bound to report it, so are you sure you want to be telling me this?'

(Family support worker 4, area 1)

Difficulties and challenges

Working with parents who were difficult to engage or develop a relationship with was highlighted as a major challenge faced by practitioners. One group of families who were described as particularly challenging were those who actively blocked any relationship-building between the practitioner and parent. Those parents who had been involved in a high number of interventions in the past, particularly related to the involvement of social services, were highlighted:

I think probably families who have had a range of issues and maybe a range of professionals coming to work with them are the hardest to engage with. Just because normally ... they've had quite bad experiences with different people, so they don't trust you.

(Family support worker 3, area 1)

A further challenge for practitioners related to those parents who were perceived to be unwilling to accept that there was a problem and/or were unmotivated to change:

When I think of some of the general development ones ... the ones who are so damn sure that there's nothing wrong with their kid and/or it'll all come right on the night. When their child has significant needs, autism or language delay ... I find that quite hard.

(Paediatrician 2, area 1)

Practitioners also highlighted challenges when working with parents who could not or would not give them reliable information:

I think parents who aren't honest with you can be very difficult. I have recently been working with a family, or trying to work with a family, where both mum and dad really find it very difficult to give you an accurate account of what is happening, and it is so hard, they'll reassure you that something is happening and it's positive and, this particular family they are drug users, and there is just a whole catalogue of misleading professionals ... and it is difficult because you constantly come away questioning whether what you've been told is actually accurate.

(Health visitor 13, area 2)

Role of gut instinct

The role of gut instinct was seen to be important for many practitioners in the assessment process, particularly health visitors and family support workers, although mainly in the early stages of meeting a family. Instinct was seen to have developed over time from experience, knowledge and practice:

Gut instinct is something that grows really over time, over practice and experience, so when you've been in several situations and you start seeing common factors between them ... It's all that unconscious data, if you like, that you collect in your brain and all the knowledge you have from theory and ... evidence-based practice that really inform that gut instinct.

(Family support worker 11, area 2)

It's a very informal and I know it's a hit and miss thing but just living and working here and being around families and having children growing up in this area and having had quite a few years' experience in the kind of work that I do, you do operate on feelings and it can influence the way I approach people ... comparing children and remembering something that might have happened with a

family a couple of years ago and then if I see a child who's presenting in a similar way or has a family that's a similar make-up I might think, 'Oh yes, now, that's what we did that time'.

(Teacher 1, area 1)

Gut instinct was seen as having several benefits, such as directing questions or investigations if practitioners had a hunch about something:

I think sometimes that can be the thing that makes you ... perhaps stay a little longer or search for the right thing to say or look a bit harder at what's going on.

(Health visitor 11, area 2)

I think instinctively you know the parents who come in, they need a lot of help, but because of pride and because they don't want people to think bad of them ... initially they'll not tell you the whole truth, they'll not tell you how really bad their situation is ... I met a parent the other day, she just came in off the street, just wanting to know what we [do] here and I suspected she didn't have her papers, but she didn't want me to know ... I could really tell that she was scared ... I developed a relationship with her and then in the end she told me the truth and she was living in dire conditions. She was actually sleeping on the floor with her baby with no carpet. It was just a [friend's house] and this friend was really treating her badly ... I didn't know her situation was that bad, but I knew instinctively when I met her that there was issues and she wasn't telling me the whole story.

(Family support worker 6, area 1)

Sometimes [you] just get this feeling that there's something not quite right here ... I remember going to visit somebody a few years ago and ... the mother and the father were staying in the father's flat and he had no duvet but nothing else on the bed and it didn't look like the bed had just been stripped, it looked like that was probably how he slept ... those little things that indicate that somebody's not quite managing things okay and it turned out

that he had serious mental health problems and nobody had told me that.

(Health visitor 2, area 1)

Although gut instinct was viewed as important, practitioners also stated that hunches should not be relied on in isolation. Several practitioners gave accounts of cases where their initial gut reaction had been incorrect, particularly in cases where there had been a blurring of the parent–practitioner relationship:

I have had one family where I've realised that my instinct at the beginning was wrong. It was a mum, her child had been taken into care and they were doing a reunification, and my initial [reaction was], 'Yeah, she really wants him back; she is going to do everything she can'. This child is now up for adoption ... I realised that I'd let the professional relationship sort of ... go and mum was a bit too close to me, and I stepped back and thought, 'Well hang on a minute, you're not her friend, you're there to support and give a bit of advice.' So I took a step back out of it but, no, my instinct on that was wrong.

(Family support worker 12, area 2)

For other practitioners, gut reaction was relied on more as they became more experienced:

When I first started, even though I would have a gut reaction or an instinct, I didn't follow it, because I would think I've got to follow this referral through and I would go through the whole procedure and probably find out at the end that my gut reaction was right and I do think with experience that I've tended to now trust my instincts a lot more and because of a lot of wasted time, a lot of wasted visits I do tend to trust my gut instinct.

(Family support worker 5, area 1)

Other practitioners expressed concern that gut reaction could be influenced by the parent–practitioner relationship and was simply a subjective reaction, with no basis in evidence. Therefore it was important to analyse and reflect on what practitioners had observed:

I think gut reaction does play a part but you do then have to analyse why it is. Is it gut reaction because actually you're just drawing on a whole load of experience and you can actually evidence that gut reaction? Or is it gut reaction because basically you like or dislike the person sitting in front of you? Or is it something else?

(Paediatrician 8, area 2)

Confidence in assessment and decision-making

A further issue that could have an impact on practice was practitioner confidence in assessment and decision-making. Few practitioners claimed to have complete confidence in all situations, although increased experience and continual reflection were viewed to be the most important factors:

I don't think anybody really feels confident or comfortable entirely because it's such a complicated area and I think that anybody that does it to any extent comes to learn that they get it wrong quite a lot ... I think that actually it would be potentially dangerous to feel confident and comfortable but ... I think that somebody who's got 25 or more years' experience in paediatrics has to feel to a certain extent that they are as good at this as anybody else is. So, if I'm uncertain or unsure about a family or my assessment, then what I feel about that is, not that I'm lacking in knowledge or experience, but actually this is a difficult one to assess.

(Paediatrician 8, area 2)

[I'm] never 100 per cent, but the more experience that you get, the easier it gets.

(Health visitor 15, area 2)

The impact of roles and boundaries on confidence

Many teachers in the sample did not view their role as assessing parenting and felt a lack of confidence and wariness in making any judgements. Some teachers felt uneasy about using the term 'assessment'. Instead they viewed

their role as making an observation that other professionals could then use in their assessments:

I wouldn't feel confident in making an assessment ... I think what I'll be doing is simply reporting back an observation, so I will be confident in reporting back an observation that we've noticed that say [a child] smells of wee, [that] kind of thing will be an observation and I would take it very carefully and see what the parents said to me about that and be very careful indeed about making an assessment ... I can alert people to what I've observed but I don't feel qualified to assess. Same as, and even when I was doing the CAF [Common Assessment Framework] ... it was more about writing down the family's story as the family told it and it wasn't really ... [an] assessment.
(Teacher 14, area 2)

Parent 'presentations'

In one-off or infrequent visits, there were particular concerns that the behaviour observed might not be representative of how the family actually was, but rather how the parents 'presented' themselves in the parent-practitioner meetings:

We're only seeing them for these snapshots, you're never quite sure ... are they doing that because they want to impress you and because they think the child needs to show off and tell you at 2 that it knows its colours or something ... it is hard and it is a ... worry.
(Health visitor 6, area 1)

Sometimes I feel ... I have got a right picture of what's going on but other times I don't feel very confident at all. I think, 'Gosh I'm sure there's a whole lot of other stuff that I'm missing and someone's not telling me.'
(Paediatrician 7, area 2)

The ability to reflect on initial personal responses to families

A small number of practitioners felt that their relationships with parents could influence their assessments of their parenting, either positively or negatively:

I'm experienced enough to know that I don't always get it right ... when I was training I did some psychiatry and the chap that I was attached to said, 'when you don't like a family you need to take that and reflect on it and think about what it is in you and them that makes it not work' and I think that's a really good bit of advice because you do meet people that you don't care for and unpicking that emotion is really a helpful part of a consultation.
(Paediatrician 6, area 2)

We've had some families where there's been concerns about ... feeding and in fact, as time has gone by, it's become apparent that what you thought might have been a parenting problem essentially turns out actually the child has a specific developmental problem. I can think of other cases where I've felt that parenting was just about acceptable but actually, as time has gone by, it's become clear that it was totally unacceptable really and I was not exactly deluding myself, but was perhaps kind of influenced by the fact that the parents were personable people.
(Paediatrician 8, area 2)

There were also concerns reported that, in developing a longer-term relationship with parents, practitioners could become 'acclimatised' to the parents' behaviour and could miss potentially risky behaviour:

I visit one particular family at the moment where conditions in the home, particularly, and the financial situation, there's been ongoing difficulties for the last four years and I've actually been their health visitor for the last four years and the worry there is that you become acclimatised or accustomed to the way that they live, so I don't feel particularly shocked or troubled when I see the way that the children live because I'm used to it, and I always try and see things with fresh eyes, as it were, and with that family I absolutely need to draw on other professionals' experiences as well.
(Health visitor 15, area 2)

Working in [area 2] for such a long time ... you can lose sight of what is and the norm for me was not great level of hygiene, not really poor but somewhere in the middle, and that became the norm and then when you're moving into a different area and you often go to a house ... and things are the other extreme and then that becomes your norm so you're getting a picture of, actually, yes, this is safe, this is acceptable, it might not be acceptable for you to the way you live but you have to put that aside about how you live your life, and there is a fine line at the end of the day, is it safe for this child to be in this environment? ... but when you're visiting families in a certain area or a certain type of home you can lose sight a bit of what's normal if you're not aware of it.

(Health visitor 10, area 2)

4 Practitioners' views of 'good enough' and 'risky' parenting

'Good enough' and 'risky' parenting

A previous report on practitioners' assessments of 'good enough' parenting found a general consensus on the basic principles underpinning parenting (Newman *et al.*, 2005). In this study, many similarities were found in what practitioners felt were the most important aspects of parenting.

We wanted to explore how professionals thought about 'good enough parenting' and 'risky parenting' and how (and if) they applied these concepts in practice. When examining practitioners' views around parenting it became clear that there was a wide range of beliefs held with few theoretical frameworks used. Practitioners' views of parenting were taken from training, their professional experience and knowledge, along with their personal experience. There was a consensus among all practitioner groups on the basic principles underpinning parenting and what elements were most important, but also a recognition that families often had their own values, beliefs and structures. This wide range of practices was felt to constitute different but still safe and acceptable care for children within the boundaries of the law:

You can't put a judgement on [good enough parenting], as long as there's no child protection issues, as long as your child's not being hurt, then there's no right or wrong answer.

(Family support worker 3, area 1)

The term 'good enough' presented challenges to many respondents. Some felt it was a difficult term to unpick or describe, a few were completely unfamiliar with the phrase (particularly some teachers and family support workers who had no child protection or social work background) and some felt uncomfortable using or thinking about it when working with parents:

You can never use that term [with parents], I'd get shot. Do you do good enough parenting? They wouldn't let us back in the house. I think what we help parents to do is [find] another way of dealing with issues and I think that's what it is ... but we don't use that term in our work.

(Family support worker 4, area 1)

However, when examining practitioners' accounts further, four main themes emerged from their perceptions of good enough parenting:

- meeting the child's health and developmental needs;
- putting children's needs first;
- providing routine and consistent care;
- parental acknowledgement of and engagement with support services.

These will each be addressed in turn along with corresponding themes raised around the concept of 'risky' parenting.

Minimum criterion – meeting the child's health and development needs

There was a general consensus on what was good enough or acceptable parenting across the sample. Good enough parenting for many in the sample was seen as the minimum criterion that they would accept, rather than what would be desirable, or the standards that they would expect in their own family. At this minimalist level, good enough parenting was seen as providing unconditional love and affection, and meeting the child's most basic needs for food, safety and physical care:

I think there's that baseline ... those basic things of the stimulation, the love, the warmth ... they're basic needs that human beings need to survive.

(Family support worker 10, area 2)

First off that the parents love their children, care for their children, but may not necessarily have the best home conditions, the conditions may be a little grubby, they may be boisterous, they may not have a lot of possessions, but the family is a unit and parents obviously love and care for their children ... they're providing basic care for them, adequate warmth, food, it might not be the food I would like them to see, but they're getting food, that the children, if they're of school age, go to school on a regular basis, that the children do have actual clean clothes to wear, even if they're not brand new clothes.

(Health visitor 16, area 2)

I think it's a pretty subjective thing, the whole concept behind it is rather vague ... I guess you're talking about the lowest common denominator really.

(Paediatrician 8, area 2)

For other respondents, the idea of 'good enough' was problematic in that it focused on the absolute minimum for the child to survive and less on the nurturing and development of the child:

Good enough to me that doesn't sound good enough. That sounds like it's good enough, it'll do, it does the job, the child's fed, clothed, sent to school, nursery ... Good enough is good enough because obviously if you do an exam and it's good enough you'll pass, but is a pass good enough to go and get a degree? No it's not.

(Teacher 7, area 1)

Risky parenting – neglecting basic needs

When looking at how practitioners defined 'risky' parenting, we found some differences

depending on whether they had involvement in child protection work. For those practitioners, safeguarding issues were prominent – particularly, although not exclusively, among the health visiting group and family support workers who had a background in social work. Risky parenting was strongly linked with vulnerable families and families of concern:

Risky parenting is back into the vulnerable families, the families of concern ... We're talking about people who are not functioning very well themselves so if they can't function very well themselves then they're not really going to be very good at bringing up their kids.

(Health visitor 4, area 1)

Here parents were seen as neglecting the basic needs of children for food, hygiene, safety and basic care. However, the issue of risky parenting for many was wider and encompassed an array of parenting behaviours that professionals might assess as challenging or of concern, such as parental drug and alcohol misuse, domestic violence and mental health issues.

Children's needs first and meeting emotional needs

A key theme to emerge in defining the most positive parental attributes was that parents tried their best within their means to put their children's needs ahead of their own. This included spending time with children, listening to children and providing consistent care:

I think it's trying your best. It's not always about things you can give your children ... I think more importantly it's spending the time with your children and listening to them, giving them attention.

(Family support worker 4, area 1)

Good parenting would mean that the parents or the carers themselves regard their family as the first priority.

(Paediatrician 4, area 1)

A further important aspect of what was viewed as 'good enough' related to meeting the child's emotional needs, including the demonstration of love and affection, a high level of warmth and positive regard, along with a low level of criticism:

I think the most important thing is that there's a feeling of warmth in the family and that the children are positively encouraged and for me when it stops being good enough [is] when the level of criticism becomes out of kilter with the level of positiveness and that I feel if children are being constantly criticised and their achievements are never noticed or they're ignored then that's when alarm bells start ringing.

(Paediatrician 7, area 2)

The parent has to have a positive view of the child. Parents need to be able to make the child feel good.

(Paediatrician 1, area 1)

Risky parenting – lack of empathy and ability to put child's needs first

In contrast, risky parenting was seen as a lack of empathy towards the child and parents not putting the child's needs before their own. This was a particular concern among parents who were experiencing poor mental health or using drugs and alcohol:

Parents who have issues going on in their own lives, such as depression, or poor mental health, or difficult relationships and they can't prioritise their children's needs over their own needs or parents where there are drug and alcohol misuse and they prioritise their need for that over the needs of their child.

(Health visitor 15, area 2)

Emotional attachment between parent and child was seen to be an important aspect of good enough parenting but a necessary rather than sufficient criterion. Difficulties for practitioners lay in weighing up the relative importance of emotional and practical aspects of parenting in order to assess what was good enough parenting:

I can think of a child at the moment where the dad clearly adores this little boy and this boy clearly adores the dad, but I have to say that is probably about as good as it gets. The dad doesn't keep the child's health appointments, he drives him around in a car with no seat belt let alone a car seat on, he's not the cleanest boy and I really struggle with that because it's the fact that this boy has some emotional attachment that's a really big positive. But the fact that he wanders off apparently, they went on an outing with a family centre and the dad lost him. So is that good enough? I don't think that's good enough.

(Health visitor 6, area 1)

Providing routine and consistent care

Practitioners throughout all professional groups felt that parental availability and consistency was a key factor in good enough parenting:

You expect a certain amount of organisation, you expect a certain amount of consistency ... I think there's a lot more interest in attachment now and it's this kind of inconsistency of emotional response to the child that seems to be the thing that can be particularly harmful and damaging. If the parent's response is predictable and not too negative, then the child can adapt to that much better than they can when they don't know what they're gonna get back.

(Paediatrician 8, area 2)

For some respondents, providing consistent care also encompassed parents taking responsibility for their child, being in control and setting clear limits and boundaries. These aspects of parenting were often influenced by practitioners' own beliefs and practices as a parent, as well as their professional knowledge and experience:

I do believe in a bit of discipline personally ... it's parents' job to tell children when it is time to sleep, time to eat, what they should eat or what should be a treat ... So discipline [is] important to me, or is my belief as a parent.

(Paediatrician 10, area 2)

You can actually see a child that's absolutely running rings round the parent, to the point where you almost feel that that child could be putting themselves into danger ... So a child who habitually, for example, leaves the school and you see them just run straight ahead and across a road and they're not called back to hold a hand or something or they arrive at least three, four minutes before the parent and the parent just says very offhand, 'Oh he always runs away from me and across that road'.

(Teacher 9, area 2)

Risky parenting – 'chaos' and a lack of routine

The term 'chaotic' was often used by professionals where family households were seen to be frantic, disorganised and with no routine or order for children:

Families where there's completely no routine at all, where children never know when they're gonna get their next meal, though a meal may come and they may not be starving but they're not quite sure when it's gonna happen ... and there is absolutely no routine for a child.

(Family support worker 7, area 1)

Problem acknowledgement and engagement with support services

The notion of acceptance and having realistic expectations of their child, especially if they had special needs or a disability, were highlighted as part of good enough parenting:

[Parents] have realistic expectations of their child because children with disabilities and special needs, it's not just about how the child's developing normally, sometimes it is about that this child is going to be different and so that they have realistic expectations that, maybe if a child has some disability, they're not going to be walking at 18 months like other children.

(Family support worker 7, area 1)

Seeking help when necessary and being able to engage and co-operate with professionals and support services were also seen as key aspects of good enough parenting:

Parents who attend appointments I think is good and seek help when necessary from a health visitor or a doctor.

(Health visitor 1, area 1)

I used to think things like regular attendance at appointments and compliance with medication were good benchmarks for good enough parenting for children who have additional needs, but increasingly I'm not convinced that they are very good benchmarks. I think what's positive is when people tell you the truth and sometimes it's not the truth you want to hear and I think when you know that you have a relationship with those people so that when there is a need for help they will ask for help.

(Paediatrician 6, area 2)

Risky parenting – not recognising problems and unwillingness to engage

Unwillingness to recognise problems or engage with professionals was seen by some as risky parenting:

There are people that we never see ... the ones that don't turn up to parents' evenings, children are constantly late, lots of unauthorised days or unauthorised absence. Parents who send their children to school on their own, even some of the young ones ... and then parents who really don't engage when things go wrong and we want to offer help. I guess all of those are risky.

(Teacher 1, area 1)

Good enough and risky parenting – a matter of degree and perception

The notion of risky parenting was not always defined as a fixed state but rather practitioners felt that they needed to ascertain whether the 'risky' behaviour was a one-off occurrence, episodic or regular behaviour. Many recognised that parenting was a challenging role and many parents, including practitioners themselves, had off days or periods when perceived bad parenting could be episodic or momentary:

There's far more good enough parents than there ever are parents who are struggling and sometimes people go into crisis and come out of crisis, their parenting probably takes a dip but it doesn't fritter away.

(Health visitor 4, area 1)

I think we've all done some kind of risky parenting in our lives, whether you're deemed a good or a bad parent. Even something as simple as you're running down to the rubbish chute just to chuck away the rubbish and leaving the kids upstairs for two minutes. Everyone's done that, doesn't matter where you come from, everybody's done that one way or another, you've just been fortunate that nothing bad's gone wrong at the time, but it's still risky.

(Family support worker 4, area 1)

In perceiving risky parenting as, potentially, a transitory state, many practitioners felt that it was dangerous to make any instant judgements about 'bad' parenting until they had a full and accurate picture of the family circumstances, ideally monitored over a period of time. In the example below, a full understanding of the parent's health allowed perceived 'risky' parenting behaviour to be placed in a wider context of the family situation:

[I've] got a family, mum's got Lupus and it's affecting her limbs quite bad and the worker's gone in and reported back to me the child's hair was smelling, the child's clothes were grubby, cos at the time the washing machine hadn't come ... so she couldn't use her hands because they were all infected. So she couldn't put her hands in water ... So if you just took a snapshot you would just say the mum's not looking after the child, but because we knew the background it's mum's illness that is affecting the care of the baby ... So I think you have to take each family by family, you can't make a snap judgement or general judgement across that.

(Family support worker 4, area 1)

In making assessments of good enough and risky parenting, practitioners often reported that their role was to monitor, observe and ultimately weigh up the balance of risk and safety factors:

We had one family where mum had mental health problems, so you've got a risk factor in mum, but you have the safety factor of dad and grandma, who moved in, so your balance was ... there is a cause for concern, but it's not a great one because you've got dad and grandma, so you have the good enough parenting.

(Family support worker 12, area 2)

Risky parenting to me would be that if the factors of concern, things that I think that weren't working in order to protect a child, were far greater than the safety factors.

(Family support worker 11, area 2)

I think there's a lot of fluidity and I think a lot of that depends on family structure. If you come from a culture, and I don't just mean ethnicity, where you have a highly supported extended family then a very young, very inexperienced, possibly substance-using mum has a lot of buffers around her so that that child can be raised well enough ... I think you have to think about the wider picture around any child not just mother, father, child in isolation.

(Paediatrician 6, area 2)

Universal or flexible criteria?

A main theme across all professional groups was the notion of fluidity and flexibility when assessing parenting; differences among different communities and cultures needed to be taken into account:

I couldn't tell you what good enough parenting is ... everybody has different parenting styles. As I say to the families, we don't have a tick chart that says, 'Yes, yes, yes that's it you're a brilliant parent'. Everybody develops their own style of parenting and there is not a wrong or right way.

(Family support worker 3, area 1)

Good enough parenting, that's gonna be different for everyone ... You might have

parents that give everything to their children materially and some people might think they aren't good parents cos they look after their material needs, but emotionally they don't give anything to the child, and you might have a family that's got no money but time and attention and love is lavished on that child, but, because they might not have the latest fashions or the latest gadgets, people might think [they're] not a good parent cos they ain't got no toys or whatever.

(Family support worker 4, area 1)

When assessing parents there was a need to take into account cultural and social differences and in particular how children were functioning within that environment:

I wouldn't say [good enough parenting is] universal because I think families, depending on cultures, are quite different ... I would say, if we were looking at things like hygiene and personal looking after yourself, I think culturally a lot of us are very different, because in my culture let's say certain ... things, how we would wash ourselves and things might be very different from another culture and say then we might say, 'oh they're not very clean', but that's their culture ... some years ago when I was working in a school we had a family who, they just didn't really believe in changing their clothes very often and that was just them and so obviously some people saw them as being dirty but if that's your culture and that's normal within your family and you see that as okay.

(Family support worker 1, area 1,
Black Caribbean)

You need to be very careful because I think there are some aspects of parenting in other countries which I don't think are positive for children ... but it doesn't necessarily produce children who have significant problems, but we might think it is a bit harsh and uncomfortable ourselves, so I think it's looking at the whole picture and looking at how the child's managing within that environment that's important.

(Paediatrician 7, area 2, white)

5 The impact of practitioner and family diversity

Impact of personal experience

Parental status

Just over 80 per cent of respondents were a parent or carer themselves. Practitioners felt that it was inevitable that their personal experiences would have an impact in their work, although this became less important once they had increased professional experience.

For some practitioners, openly sharing their personal experiences of parenting had a positive impact on the practitioner–parent relationship:

I have some understanding of both being a paediatrician and being a father of things that I feel work and don't work. So I do share those things with parents.

(Paediatrician 1, area 1)

I will always tell my families that I have a child of my own ... you've got that common ground with them ... you know what it's like to be a parent [and] the stresses and strains of going on with it.

(Family support worker 3, area 1)

Having the experience of being a parent was also seen to 'normalise' parenting behaviours, provide a clearer understanding of the challenging nature of parenting and make practitioners more realistic about what parents could do and achieve:

It enables you to be more sensitive to the emotional content ... so that ... when people are talking about being very tired or at the end of their tether, you might be able to identify with those things and it helps you see things that maybe if you haven't had those experiences you might interpret as more risky.

(Family support worker 11, area 2)

I've become a bit more realistic about how easy or difficult it is ... whereas before you have children you go in there all guns firing and expect parents to be able to do as you say.

(Paediatrician 7, area 2)

Some practitioners felt that sharing their own experience of parenthood helped them build better relationships with families:

It helps me to connect with the families cos they'll come in or talk about something and I'll say, 'Oh yeah my son does this', so I ... use it to try and humanise myself a bit so that ... [they think] I'm someone they can talk to rather than worry about.

(Paediatrician 7, area 2)

Others deliberately avoided this in order to maintain professional boundaries, particularly when they felt that their own experiences as a parent differed from many of the families they worked with:

I'm a little reluctant about personal experience because kids are so different and mine are so privileged, frankly ... it's too easy to be patronising even when you're trying to be sympathetic ... I also think actually that I need to keep some boundaries.

(Paediatrician 2, area 1)

Reflecting on own parenting experiences

Working with parents led many practitioners to reflect on their own parenting behaviour. Many felt that the parenting standards and criteria that they considered were acceptable within their own lives and those of the parents they worked with were often different. They thought it was unrealistic to impose these standards on parents who lived in different financial and social circumstances:

I have quite high expectations of myself as a parent and things that I think are very important in terms of raising a child and ... I can't expect other people to sustain that sort of level who might have five children and be an only parent.

(Family support worker 11, area 2)

Practitioners in the sample who were not parents themselves felt that this did not have an impact on their role once they had developed professional experience. Many drew on their professional experience, personal experience of being parented or knowledge of family and friends. Some mentioned that they had felt a lack of confidence and insecurity in their role when they first began practising. However, they felt this lack of emotional involvement could also enable them to see issues and problems more clearly:

With some families there are comments ... certain families might see it as a, 'well she doesn't know what she's talking about, she hasn't even got any kids'.

(Health visitor 10, area 2)

I haven't had my own children ... that sometimes makes me feel a little insecure ... it has advantages not having had children yourself as well ... I can step back ... but it's very black and white and I haven't got that emotional tie and ... if I'd had my own children I probably would see the other side of the coin.

(Family support worker 13, area 2)

Impact of culture and ethnicity

Impact on assessments

Respecting and responding to cultural differences between families was highlighted as being an important aspect of the professional role. Some anxieties and uncertainties were expressed in assessing parenting, as practitioners feared a breakdown in the relationship if they were misunderstood by parents or seen as too judgemental:

An African or West Indian family may discipline their child in a very different way to what I

would discipline my child ... you have to be aware of respecting that that's all they've known and ... we've now come to ... you don't smack your child or beat your child and it's how do you get that across to somebody who's always known that without offending them. It's about treading carefully ... you've just got to be very aware cos you only need to say one thing wrong and that can completely kill the relationship.

(Family support worker 3, area 1, white)

Many practitioners highlighted the diversity that they had observed within ethnic and cultural groups, but they were very aware of the dangers of making judgements and assumptions about parents or being too lenient in particular cases. They were open to learning about cultural differences when assessing the strengths and needs of families, and also respectful of the many diverse ways of bringing up children. However, practitioners, regardless of geographical area or professional group, highlighted the difficulties and challenges they faced in assessing whether particular parental practices were the cultural norm or individual parenting beliefs and behaviours, particularly if they involved parenting practices that the practitioner was unfamiliar with:

It can be very difficult when you're met with things that you're not quite sure whether they're fairly typical beliefs and expressions, which are associated with fairly normative good enough parenting, or are basically barking mad and it's nothing to do with the cultural difference ... That's always this double-edged sword ... are we being too lenient or too judgemental? It's really tricky.

(Paediatrician 2, area 1, female, white)

We've got so many different children from different countries ... it is very hard for an individual teacher to be aware of any potential implications ... sometimes they come from countries where children don't start school till six or seven and they may have this belief that schooling ... is less important and that may be why they don't think it matters if they bring their

children in late ... all the time you're thinking is it just this individual family or is there some cultural beliefs going on here?

(Teacher 10, area 2, female, white)

The importance of taking into account the issues of disadvantage as well as ethnicity was highlighted:

I think [ethnicity] definitely has an impact ... [but] most of the Afro-Caribbean parents that I see are from poor socio-economic backgrounds ... They're just struggling parents. It's not just ethnicity.

(Paediatrician 1, area 1, male, Indian)

Shared identities and experiences

For some practitioners, sharing an identity with clients was seen to facilitate the practitioner–parent relationship, leading to increased trust:

I think the fact that I am non-white makes it easier in some respects because we have something in common and ... building up of trust just comes a lot easier.

(Family support worker 6, area 1, female, Black Caribbean)

It could also provide a better understanding of the cultural context of a family's support needs. For example, one health visitor highlighted how a shared identity and cultural background enabled her to reach a parent who her colleagues had felt unable to support:

In a lot of ways I feel I can reach [black parents] easier than a white person would ... one Nigerian woman who came on the caseload ... she was depressed because of housing ... I must confess I was a bit hard on her ... If she was a white client coming to me, I would treat her a little bit differently from the way I did, but thank god I did, because it worked ... I said to her, 'You're from Africa, I see that, I know you don't have any benefit system in Africa, but here you're privileged to have that. Why don't you take advantage of it? You can find a job and, once you get a job and you pay your rent, they'll be able to rehouse you quicker.' ...

She needed to hear those hard words ... and that was the pulling factor or pushing force for her ... I put into place a cultural orientation of whichever client I'm working with ... I was able to take her back to her roots in a subtle manner.

(Health visitor 3, area 1, female, Black African)

Physical punishment

Physical punishment and discipline were the issues mentioned most frequently in relation to cultural challenges faced by practitioners, particularly in area 1 where there was an ethnically diverse population. Respondents often understood the parents' points of view on a personal level but needed to separate this from their professional role. For some, a shared ethnic or cultural identity helped with this:

African and West Indian families' ... culture is ... 'I got beat when I was younger, didn't do me any harm' and from a personal point of view I can see where they're coming from ... [but] you've got to try to help them to understand [that they need] to find different ways of dealing with [their] child's challenging behaviour.

(Family support worker 4, area 1, female, Black Caribbean)

Mild physical chastisement had been used within my family ... I do share the points of view of some families who see verbal chastisement as well as physical chastisement as perfectly acceptable, but I don't agree that it's acceptable any more. So I would be able to explain to the parents that, 'Well I used to do this, but there's no need to do that because I've learned to do things differently'.

(Paediatrician 4, area 1, male, Asian)

However, for some, sharing a perceived ethnicity or culture with parents could conflict with a practitioner's professional role:

Obviously in this country it is illegal to hurt somebody ... if a parent was to say that in front of me, what I'd have to do is say, 'when we're here, we can't use those words'

... they might [say], 'what kind of a black person are you?' ... You might have the same background, you might even have the same beliefs, but here you have to be in the professional capacity, so you just have to set the ground from the beginning.

(Teacher 7, area 1, female, mixed race)

Others were less confident in imposing what they saw as a 'personal choice', providing no professional safeguarding thresholds were crossed:

I don't believe in smacking children ... yet I know families who believe very strongly in a smack ... I don't think they're any worse parent than I because they choose to use that method, but it's not something maybe I would do, so I think that you do have to tailor certain things to different cultures and people's beliefs and backgrounds ... if it's legal, then it's okay to do it.

(Family support worker 7, area 1, female, white)

At the other end of the spectrum, a few respondents felt that cultural practices were sometimes used as an excuse or justification for particular parental behaviour:

Often people say things about cultural things about using physical punishment and that being an area of difficulty ... I've found it used as a reason but I don't ever accept that really because I don't think a culture exists that finds it acceptable to hurt children.

(Health visitor 2, area 1, female, white)

In area 2, which had a very low BME population, some practitioners expressed difficulty in assessing parenting within the travelling community, who were sometimes perceived as having fewer routines and boundary settings, and as being quite suspicious and less engaged with professionals:

Some of the things I would suggest would seem absolutely ridiculous to them ... I think [they] worry about services being judgemental towards themselves, not really understanding where they're coming from, and some of their

beliefs and views I don't understand and have to try and get my head round.

(Health visitor 15, area 2)

Language

In both areas, language issues were highlighted as posing particular challenges when practitioners were trying to assess and support families. Language difficulties could prevent parents accessing services; and the need for interpreters could have a detrimental effect on the parent-practitioner relationship making it harder to pick up the more subtle verbal and non-verbal cues of parental emotional difficulties and mental health issues. Confidentiality, impartiality and professionalism could also all be affected if the interpreter was known to the parent(s.)

Impact of gender

Contact with fathers

The sample of practitioners interviewed was largely female. Respondents were asked whether they felt gender had an impact in their work with families. The majority acknowledged that their contact with families was largely via the mother. Overall few of the four practitioner groups had regular contact with fathers. Even when fathers were present in the meetings, it was felt that they often did not engage fully with the practitioner and support on offer:

Usually [fathers are] at the new birth visit ... but sometimes they just say, 'we'll leave you to it' and they leave the room. I don't really have much to do with fathers on the whole.

(Health visitor 1, area 1, female)

Engaging both parents

One paediatrician described how he felt more comfortable working with mothers. This was seen to simplify the process of assessment:

I think that paediatricians are always much more comfortable working with mothers because our experience is that they tend to be more engaged and involved with the childcare ... it's hard enough as a paediatrician because you've got the child as the patient and the parent or parents as third party in this process.

If you then have two parents and maybe even grandparents who all bear a different kind of relationship to the child and to you, it can all become quite complicated.

(Paediatrician 8, area 2, male)

However, working with both parents was seen by most practitioners as the key to better assessments and support-giving. Engaging with fathers was, therefore, considered an important aspect of making a complete assessment of the family situation, supporting the family and bringing about change in behaviour:

If you've got a mum that wants to try things and dad's saying, 'That's a load of old rubbish' ... mum won't change but, if you can get the father on board and convince him [to] try something different, then the mums tend to follow what the fathers are doing.

(Health visitor 16, area 2, female)

Many practitioners, particularly health visitors and family support workers, described how they would like to improve the services and support on offer to fathers. One family support worker felt that the largely female workforce in health visiting and family support may have had a negative impact in engaging fathers. A number of children's centres were actively seeking male support workers to support fathers.

Interestingly, though, fathers were seen by some as less able to give a detailed account of developmental problems and so these practitioners felt that, when they worked only with fathers, they were not getting a full history regarding the child and family:

When fathers come with their children, there's a whole lot of developmental history that they're really not as aware of as mothers ... I very rarely get as in-depth a history from a father, even if the father then becomes the child's main carer, there are lots of areas that they just haven't clicked into.

(Paediatrician 7, area 2, female)

Impact of social class

Working with disadvantaged and affluent families

A number of practitioners within the family support and health visiting groups viewed themselves as working class and felt that they shared similar backgrounds with many of the parents they worked with. These practitioners felt that they related well to less affluent parents and understood their difficulties and worries around money and housing. Some described how they felt it was harder to relate to more affluent middle-class parents:

I feel I can't relate to [some middle-class families], I feel that some of my clients feel that they can't relate to me because I come from such a different background or have a different way of looking at things ... It's my own personal attitude ... do I want to be what I consider to be wasting my time visiting people that can go and see their paediatricians ... when I know that there's many more vulnerable families out there that ... you can't always get time to go and visit, it's that frustration.

(Health visitor 2, area 1)

It was widely reported by all practitioner groups that, regardless of their own background, they felt more demands were made of them by more affluent, better educated parents:

I did work in a very affluent area at one stage and I found that quite demanding because they had a terrific number of ridiculous questions, and that was quite trying, and they had big expectations from the health visitor ... and they would complain if you didn't give them exactly what they wanted.

(Health visitor 1, area 1)

In assessing parenting, a small number of practitioners felt the problems faced by parents in different socio-economic circumstances could have an impact on the parenting issues that they faced. Examples were given of parents in different socio-economic circumstances who could be perceived to be neglectful of both their child and their responsibilities:

I get the feeling that many examples [of risky parenting] are more in low socio-economic status and the reason for it is that it's a vicious circle ... I'm not saying no caring parents in that group. I'm saying there is more chance of finding that sort of family ... But in high-income groups, sometimes the problem could be parents are too busy making money and the child is then not feeling supported.

(Paediatrician 10, area 2)

profession and took steps to reduce the impact of this. This was particularly highlighted by paediatricians and more mature practitioners:

There are some families who are so deprived or so easily intimidated that I have dressed down when I went to see them ... I do think about that sometimes and think about my style because you can be intimidating.

(Paediatrician 2, area 1)

When assessing parents and defining their need for support, practitioners highlighted the importance of presenting solutions in a way that was meaningful for clients:

I think that you have to be aware of prejudices and boundaries within your dealing with people because they have their own ideas about child rearing and their own experiences and [for] a lot of people it's a historical thing, how they were brought up, they'll have their mum and their nan saying, 'you don't want to do that ... and you had such and such and you've been fine and ... we had a good hiding and was sent to bed without supper and it never did us no harm'.

(Health visitor 4, area 1)

I've been lucky, I've had a good upbringing and education where some of the parents haven't, but I always want them to feel comfortable ... but I am aware that there is that slight difference ... if I say I am going on holiday I think I shouldn't have said that because some of these parents will never have that opportunity.

(Family support worker 13, area 2)

Shared identities and experiences

Having a perceived shared background and experience was often seen to be helpful in developing a relationship with families and an understanding of what was required to improve their circumstances:

I feel that I relate very well to my clients, a local girl born in a council house ... and have always recognised my roots ... I've lived on benefits in the past so I can relate to that, I know how difficult it is. I promote a lot of going back to learning because that's what I did, I went back to studying and [I'm] forever pushing that to people.

(Health visitor 12, area 2)

Impact of age

The sample of practitioners ranged from age 19 to over 55. For younger practitioners, aged below 25, mainly within the family support worker and teacher roles, age was seen to be an issue when they had first started practising. This related to a concern that they would not be viewed by parents as being in a position of knowledge and authority:

When I was younger I was much aware of my age and that people probably didn't have the confidence and trust in me to know what I was doing.

(Family support worker 13, area 2, age 25–34)

As I've got older and I've got more experienced ... I hope that I'm more understanding of the difficulties, certainly ten or 15 years ago I didn't really understand what the impact of having a child was like on someone's life.

(Paediatrician 7, area 2, age 45–54)

Perceived status of practitioner

Practitioners were very aware of the power and status they might be perceived to have in their

Many practitioners within the sample were more mature and had grown-up children. This was seen to be an advantage when relating to some younger parents:

With a younger parent ... I would say to them, 'I'm going to talk to you how I would if you were my own daughter' because I have teenage daughters ... yes I've got to be professional but also show them that yes I've got a young daughter too and, if she was doing exactly the same thing that you're doing or had difficulties, that's how I would be dealing with it.
(Family support worker 1, area 1, age 45–54)

Impact on assessments

When asked about how they felt age impacted on parenting assessments, many practitioners, particularly health visitors and family support workers, felt that younger parents were often in need of more support and encouragement:

Teenagers ... need nurturing so you really need to understand and come down to their level, they need a lot of support, they need a lot of encouragement ... if it's a teenager you may go in weekly, whereas a mature mother with all her social support around, maybe just once in six months or once in three months.
(Health visitor 5, area 1)

However, younger parents could be difficult to engage, especially if there were extended family members involved:

A lot of the young mums are ... difficult to engage sometimes ... and they're usually quite well supported by their mothers so it's almost like a mother gathers them in ... [and] you're seen as little bit of a threat.
(Health visitor 12, area 2)

Differences in the support required by parents of different ages were highlighted. For example, one health visitor felt older parents often required support around confidence and reassurance, whereas, for many younger parents, there were concerns around routine-setting for children:

Older parents ... often struggle with confidence and will need more support around that ... whereas the youngsters ... they tend to lead slightly more chaotic lives and ... helping them to establish routines for their children can be

quite difficult, because they don't really have routines for themselves.
(Health visitor 13, area 2)

Finally, it was acknowledged that all parent age groups were diverse with different attitudes and experiences. Personality and individual differences were viewed as one of the main reasons for positive or negative engagement:

Older parents can be quite defensive because they think well we're older than you ... I know better than you, so won't take my opinions anyway or ... value what I say, but then some of the young mums think that you might be patronising sometimes, they can be quite defensive and then other people can really welcome the support, so there is a mix.
(Teacher 13, area 2)

Impact of disability

Not all practitioners within the sample regularly worked with families where the child or parent had a disability. A few of the family support workers and paediatricians in the sample specialised in disability and special needs. In the health visiting group, families who had complex health needs were often referred to specialist health visitors. Similarly, in schools, parents with special needs were often contacted by the designated SENCO (special educational needs co-ordinator) in the school. Six practitioners within the sample reported that they had a child with a disability or special needs. This could have a positive influence on the parent–practitioner relationship when sharing personal experiences.

Impact on assessments

Practitioners acknowledged that parents with disabilities or those caring for children with disabilities often needed a more intense approach and relationship over time:

If there is a learning difficulty [you need to] make sure that they understand what you're doing and what you're saying and sometimes that has to be broken down, make it simpler and clearer and repeated more often ... you

have to tread a little bit more carefully and it's a bit slower.

(Family support worker 14, area 2)

I have my parents longer because the children don't develop ... along the normal development stages ... some parents you'll support until they go into school, but then when these children go into mainstream schools they're still coming up with lots of problems.

(Family support worker 10, area 2)

However, the extended relationships developed between parents and practitioners could lead to over-reliance on support services. One challenge described by a family support worker related to the need to keep boundaries and guidelines in place:

I think sometimes also my parents can become a bit too reliant because their need is so great ... I can get three or four phone calls in a day ... I have to be strong ... and just [go] over the rules and boundaries again.

(Family support worker 10, area 2)

By contrast, other practitioners described parents of disabled children who were very self-sufficient and proactive, and made demands from health services:

Some families are extremely self-sufficient, by the time you see them they've decided who they want to engage with and who they don't ... there's a pretty good parent underground and they talk with each other and they make those choices ... particularly the families of children with Down's syndrome ... they're very robust networked and they're a scary bunch, they tell you what they're going to have.

(Paediatrician 6, area 2)

Supporting parents of children with disabilities and special needs was seen as qualitatively different from supporting parents in general. The extra demands on parents to take on a 'therapeutic' role with their child and practitioners' need to encourage them to do this were highlighted:

We [are] asking the parent to ... take up the therapy role with the child ... some parents that I've talked to have said to me that they would rather just be a good parent, loving parent, rather than become a therapist or a teacher for the child. These are different roles ... a father once said to me that doing that makes him see the child as a disabled child, rather than his own loving child.

(Paediatrician 1, area 1)

Disability and cultural diversity

When discussing work with parents of disabled children, the issue of cultural diversity was highlighted. Practitioners felt that parental acceptance of disability could vary widely and that some cultures were less able to acknowledge and accept disability within their family, creating challenges in assessing and supporting families:

A lot of cultures find disability very difficult to deal with and ... some cultures feel that it's judgement on them and that they must have done something wrong ... I had a Malaysian family where they didn't ever ... tell the mother-in-law that the child had Down's syndrome ... the son was terrified of losing face and that creates lots of issues around how they're functioning as a family ... there are quite a number of parents who actually are in denial [and] there's an awful lot of work that has to be done around acceptance ... and helping them to understand what they need to do to maximise the child's development.

(Family support worker 2, area 1)

6 Information and training

Parenting information sources

Practitioners were asked about knowledge or information sources that helped them in their work on assessment-making and parenting and family support. There was wide use of resources from the Department of Health and the Department for Children, Schools and Families, along with resources from local authorities and primary care trusts. Many practitioners also had access to regular email updates and local and national policy information was often received from managers and professional leads within their organisations. In area 1, monthly and weekly local forums and meetings were highlighted as an important way to access information on local developments. In addition, practitioners within the sample also felt that there were several means of accessing parenting information, such as professional journals, books and online search tools such as Google. It was also common for practitioners to go to their colleagues who had an interest or specialism in a particular field for advice and information regarding specific issues. Supervision sessions, where used, were also seen as an important means to find out information and to discuss particular cases.

It was widely reported that respondents felt that they only had time to find out information that had a direct relevance to their current role. For a few, it was difficult to keep abreast of changes – for example, one teacher highlighted the difficulty in absorbing changes and developments in relation to her profession in terms of other agencies and policy guidelines.

Assessment tools

The use of parenting assessment tools varied both between and within professional groups. Some used the Common Assessment Framework, Department of Health frameworks, Caring Index

assessment tool, Solihull Child and Family Support Model (a tool to support early intervention and multiagency working), Edinburgh Postnatal Depression Scale or internally designed/produced assessment and referral forms. There was a small number of teachers, paediatricians and health visitors in the sample who did not use any formal parenting assessment tools or frameworks.

Health visitors referred mainly to Department of Health frameworks, although with some flexibility and subjectivity. For those who were very experienced, the frameworks were only referred to rather than used systematically or, in some cases, they were not felt to be needed at all. In area 2, many health visitors had been trained in and were beginning to use the Solihull Child and Family Support Model. It was common for assessment tools to be used flexibly alongside professional and personal experience. Many teachers reported using their own specific educational assessment tools, such as special educational needs assessments, rather than tools designed specifically for parenting assessment, although some teachers reported they had received training on the Common Assessment Framework. Paediatricians in the sample used few formal tools for assessing the parent–child relationship or observing parental behaviour. Instead, any observations or triggers for concern would be informally noted.

Common Assessment Framework

The Common Assessment Framework (CAF) is a standard approach in England for conducting an initial assessment of the needs of the child and young person and deciding how they should be met. It has been developed for use by practitioners in all agencies so that they can communicate and work more effectively together. The CAF aims to promote more effective, earlier identification of additional needs, particularly in universal services, and to provide a simple process for a holistic

assessment of a child's needs and strengths, taking account of the role of parents and carers and environmental factors on their development.

CAF training

The Common Assessment Framework had been used by some but not all practitioners in the sample. All were aware of the Framework and the majority had received some training. However, there was fragmented usage of the CAF between practitioner groups, within groups and between areas and individual teams. Many practitioners had attended training even if they had not yet used the Framework in their professional role. It was described by some as a short course that did not leave them with enough confidence to use the Framework in practice, although the training enabled some respondents to meet and collaborate with other professional groups. The importance of experienced colleagues who could guide practitioners in using the Framework initially, was highlighted.

Positive aspects

The Common Assessment Framework was used mainly as a referral mechanism rather than as an assessment tool only. In addition, some health visitors used the CAF alongside other assessment tools. For those practitioners who were using the CAF a number of positive outcomes were expressed. The main benefit related to cases involving large numbers of agencies. The assessment form was seen to be a helpful tool in gathering interagency information systematically on one form and promoted the quick co-ordination of parent support:

It's a quick way of getting together the group of people ... and any support that is needed into that family fairly quickly and it just co-ordinates everything, whereas before ... the school had one piece of information [and wasn't] always aware that ... maybe a health visitor or somebody else ... had some concerns as well, but now the CAF ... brings that together much quicker ... before it gets to the point of ... child protection.

(Teacher 9, area 2)

The Framework was also praised by some respondents as positively involving parents at all stages in the process. This streamlined system meant that parents would have to tell their stories only once rather than the previous system where parents would have to give the same information to multiple professionals. The process for collecting information from parents was also praised as being more open and transparent for parents:

The ones I have done actually feel that someone is listening to them and actually something might come of this.

(Health visitor 12, area 2)

Challenging aspects

Although the process was seen to benefit many parents, there were concerns raised when the Framework was used with less co-operative parents. To complete the form, practitioners needed to obtain parents' consent, which could be difficult to obtain. For example, one teacher highlighted the difficulty in gaining parental consent to refer their child to educational welfare services:

Often the families that we are referring to ... educational welfare to do with attendance and punctuality, they are the parents that are most difficult to engage with and you can't use a CAF form to refer on unless you've got parental consent and input and that's hard ... it's such a big bulky form parents get nervous about it.

(Teacher 8, area 1)

For some practitioners, this meant that the information had to be 'presented' in a very particular way in order to gain the parents' trust and assistance:

You've got to get the family's consent, and then they have a copy of what's on the form, so you have to be careful what you put on the form.

(Family support worker 4, area 1)

The time it took to complete the assessment form was seen as an issue for some in the sample,

particularly in relation to families with a number of children or in cases that involved families where there were parental mental health or learning disabilities. It was also hoped that the Assessment Framework would speed up the referral process; however, this was not the experience of one health visiting team. A further issue reported related to multiagency working, particularly how the form was completed by other professionals. In some cases delays were reported when forms were incomplete or incorrect. In some areas, it was common for the Common Assessment Framework to be used by only certain agencies. This fragmented usage led to problems in multiagency working. For example, one school in area 1 explained how they would often make referrals to speech and language services, community paediatricians and mental health services (CAMHs), but found that these agencies were not yet using the CAF forms.

Barriers to using CAF

Not all practitioners in the sample were using the Common Assessment Framework. There were some health visiting teams, teachers, paediatricians and family support workers who had not yet begun to use the form. A few health visitors and teachers expressed a reluctance to use the Framework, as it was seen as an extra burden, which they felt did not add anything new to their existing practice:

I haven't filled any in cos I think we're doing it anyway and it hasn't become culture yet here in my office ... I don't know anyone else in my [area] that has ... filled one out and I don't think we've been encouraged to particularly.

(Health visitor 7, area 1)

The Common Assessment Framework was used by only a very small number of paediatricians in the sample. Many reported receiving the form with referrals, but few reported completing the form themselves. A small number had received training on using the Framework and could see the benefits of incorporating the CAF into their working practice. However, they reported that it did not fit in with their current working practice, mainly because of the limited time spent with parents:

[With] a patient, we get 25 minutes and follow-up is about 15 minutes ... there is no time for any such formalised tool to be used in the way we are working now and it's unlikely to improve. If anything, we will be asked to see more and more patients in less and less time.

(Paediatrician 10, area 2)

However, one medical team in area 1 was currently developing its own version of the CAF form for use in its own specialist field.

Training and support needs

Health visitors

Health visitors had mandatory annual child protection training as part of their roles. Alongside this, a number of specific training courses were mentioned by practitioners, such as the Common Assessment Framework, Solihull Child and Family Support Model, parental substance misuse, attachment, mental health, postnatal depression, domestic violence and other specific training about parenting programmes – for example, Positive Parenting, Incredible Years/Webster-Stratton programmes. Health visitors saw it as their responsibility to identify their training needs and to find appropriate courses. This was often done through supervision, appraisal and personal development plans. Health visitors also referred to supervision sessions with their managers or peers as giving them further advice and training in aspects of parenting assessment. As it was acknowledged that practitioners were largely responsible for identifying their own training needs, some mentioned other barriers, particularly if they worked part-time or had family commitments. An important aspect of access to training related to the time and financial resources available to health visiting teams, with many teams currently experiencing staff and resource shortages.

Health visitors were asked whether there was any specific training relating to parenting capacity and assessment that they would find helpful. Many of them mentioned training regarding parent–family interactions, including counselling skills, communicating with parents and specifically how to engage with parents to move them on. Increased supervision was also seen as important.

In area 1, where there was a highly diverse population, training gaps focused on specialist issues such as immigration, benefits advice and housing. In area 2, a small number mentioned that they would like training on assessing mothers with mental health problems. There was also an identified need for more training and support concerning working with families from different cultures and ethnicities.

Family support workers

As part of their role, family support workers also received annual safeguarding training. There was also ongoing internal training available for practitioners. In area 1, training brochures from local agencies were circulated regularly. The training available in both areas was wide-ranging including child protection, disabilities and special needs, child development and working with families who have English as their second language. Like health visitors, it was seen to be the responsibility of individual practitioners to identify relevant training courses. In area 2, one team was able to access full training programmes via its lead project. Although there were a large number of training courses available to family support workers, there were concerns raised that the training was neither advanced nor personalised enough to be helpful. For family support workers in the sample the main training gaps were principally around early foundation years training, language, disability and special needs, and local multiagency working.

Paediatricians

Regular training for paediatricians also involved risk assessment and child protection. Other training available focused mainly on the specific management of health issues and supporting parents in that role rather than training on parental assessment and support.

There were a number of training courses available to practitioners, although many were seen to be generic. Most of the respondents referred to peer review and supervision as providing the most useful training and support. Training gaps identified related mainly to social aspects of families and parenting, motivation and family dynamics, neglect and sexual abuse, understanding of different cultures and assessing

emotional abuse. Some respondents also highlighted the need for further training in using the Common Assessment Framework. For some paediatricians, there was a recognised need for training on assessing families as well as assessing children:

We should all have further training around looking for parenting. So, when one sees a marker, rather than just leaving it at that, further exploring, having some evidence-based or some structured way of looking at parenting would be helpful cos we don't have it.

(Paediatrician 1, area 1)

Teachers

As with all the practitioner groups studied, child protection training had been widely undertaken by the teachers sampled. Both internal and external training, including disability, mental illness and special needs, were available to teachers. Like the paediatrician group, the training available was focused mainly on working with children rather than with parents.

We have training around child protection, risk assessment and care ... more about working with the child rather than work with parents ... but there's no training here that I'm aware of [on] working with the parents.

(Teacher 12, area 2)

A couple of teachers working in extended schools had also attended training on organising and running parenting groups. For some teachers, the main challenges were not a lack of suitable training courses, but more a shortage of time to attend them. A further concern was raised about applying the training within the classroom environment. The main training gaps identified by teachers were counselling and working with parents in different situations.

More training should be around counselling parents, being with parents, offering support and how to deal with parents in need of more support ... how to talk to them, how to approach them and how to deal with the situations that they throw at you.

(Teacher 6, area 1)

7 Conclusion

This research aimed to broaden our knowledge of how different practitioner groups assess parenting support needs and how this process is influenced by both family and practitioner diversity. It looked at very personal and individual responses to, and factors influencing, working with families but highlights a number of important general issues for policy, practice and research:

Differences in focus and perception of assessment-making

Despite differences in their professional roles all groups did, either formally or informally, collect and observe a wide range of information regarding parenting. This process was described as an ‘assessment’ by some groups, namely health visitors and family support workers, and ‘observations’ or ‘triggers for concern’ by others, mainly paediatricians and teachers. Paediatricians and teachers perceived their main focus to be, respectively, on the physical health and social and educational development of children rather than their families.

The role of gut instinct and experience

How practitioners perceived and made sense of their observations could also be influenced by factors such as gut instinct and practitioner confidence. Gut instinct constituted a kind of interface where professional and personal factors and objective and subjective observations met. It was felt by some to be a form of internalised professional knowledge and expertise. Most practitioners, especially those who had been in their professions longer, felt comfortable listening to gut instinct, albeit with caveats that there was always a need to be open to alternative views and observations. In particular, family support workers and teachers gave examples of using this to pick

up on parents who were depressed or where other problems were surfacing in families. While formal assessment-making is clearly focused on gathering what are considered to be objective observations, this study shows that more could be done to support professionals in the fine-tuning of their ‘gut instincts’ in order to pick up more subtle messages from families in need of support.

Roles, boundaries and the fear of damaging relationships

The importance of maintaining professional and personal boundaries, and managing sometimes conflicting roles was a theme running through many of the interviews. Health visitors and family support workers, in particular, highlighted the tension involved in simultaneously taking on supporting, monitoring, referring and authoritarian roles in their work with families. Reflection, supervision and professional support/advice were seen to be particularly important in resolving and managing these different elements of practice.

In the case of teachers, perceived lack of expertise in assessing and supporting families was, in some cases, further confounded by anxieties around the boundaries of the teaching role and fear of ‘damaging’ relationships with parents. In particular, some teachers said they lack guidelines on how and when to intervene. This needs addressing and support for teachers in this area should be formalised, as it may constitute a serious barrier to families receiving support and accessing services.

It is interesting to note that the fear of damaging parent–professional relationships is widely held and is a barrier not only to work with parents but also to research in this area. This project originally proposed conducting observations of consultations as a tool to aid interviews with practitioners but, despite overwhelming support for this approach from

practitioners and their managers, an NHS ethics committee would not grant approval. It feared that such observations might damage practitioner–parent relationships, particularly in the case of teachers.

A broad consensus on good enough and risky parenting

Not all respondents felt comfortable with the term ‘good enough’ parenting and some felt strongly that it was not a concept they would use in their work. However, there was a broad consensus among different practitioner groups about what constituted good enough parenting – basic care and safety, love and affection, putting children’s needs first, providing routine and consistent care, and, when there were difficulties experienced, acknowledgement and engagement with support services. These findings correspond closely with those of Newman *et al.* (2005).

Perceptions of risky parenting centred around three main themes – putting self before child, a lack of parental control and responsibility, and a lack of routine and order. Risky parenting was, therefore, largely the polar opposite of good enough or good parenting (two concepts that were not clearly distinguished across the sample).

The assessment and decision-making process often relied on subjective as well as objective criteria and most practitioners acknowledged that there was some element of judgement involved. In particular, the relative importance of emotional availability and warmth versus physical care was not always as clear-cut as might be expected. Hostile and critical treatment of children was unequivocally seen as detrimental and an indication of poor or risky parenting, but some respondents cited cases where there was a warm and emotionally supportive parent–child relationship but also elements of physical neglect and high risk in the parenting style adopted. Emotional responsiveness and warmth were therefore necessary but not sufficient criteria for good enough parenting.

The impact of diversity: time for a broader view?

Practitioners had experienced and were able to articulate the impact that perceived shared and different identities with their clients had on individual consultations and practice in general. Emphasis was placed on valuing and acknowledging difference and not making judgements, particularly about cultures and parenting styles.

Perceived similarities, especially of ethnicity and culture, could assist in building relationships but also create conflicts between practitioners’ personal beliefs and experiences and those of the families they worked with. Perceived social class similarities could lead to greater expectations regarding what families could and should do to reduce disadvantage.

The sense of shared identity was broad, especially in the area of ethnicity, where the concept of ‘non-whiteness’ was perceived by black and minority ethnic practitioners to assist in working with some families and help relay messages around potentially damaging or risky parenting practices. It remains to be seen how well BME practitioners such as these feel supported in cross-cultural practice given that most information on cultural competence appears to work implicitly from the perspective of the white practitioner and the BME family. With the great ethnic diversity among practitioners in the family support field, it may be timely to explore the greater complexity of cultural competence and shared identities in practice, and review how well professional training and support address these issues.

Perceived differences were felt most notably in the areas of ethnicity and socio-economic class. Practitioners felt it was important to identify and reflect on diversity issues but often had no formal way, such as supervision, frameworks or tools, to help them to make sense of the impact of diversity on parenting and the family, and incorporate this into assessments. Some practitioners therefore felt a lack of confidence or uncertainty around cultural and ethnic differences, in particular in relation to physical punishment and discipline. The importance of adequate supervision and peer support was emphasised by practitioners.

The need for better co-ordination for professional development and training

Training and information ‘gaps’ were identified across a number of areas, particularly culture and ethnicity, disability and special needs, and also in the quality and ‘level’ of training aimed at professionals. Training occurred in a largely ad hoc manner, with participants taking the lead in identifying training needs and locating suitable courses, especially in the case of health visitors.

Paediatricians and teachers had received the least training in parenting styles and assessment. They were also least likely to use tools and other structured ways of formally or informally assessing parenting support need. This reflected the primary focus of their roles and the time and opportunities (for example, home visiting) required to take advantage of such activities and other services available to them, such as extended schools’ parental and family services. Despite the practical barriers to using more structured means of assessing support need, the majority of teachers and paediatricians expressed an interest in learning more about parenting support and assessment in general. This highlights the need to continue to support and develop the teaching workforce as the role in family support expands through the growth of extended schools; and to consider how paediatric training might incorporate more work on family support and parenting. With the newly established National Academy of Parenting Practitioners in the UK there is hope that training in parenting support will become more widespread and accessible to a wider range of professionals such as these.

Use of the Common Assessment Framework (CAF) and other assessment tools

Health visitors reported using the greatest number of structured assessment tools for assessment, such as the Framework for the Assessment of Children in Need and their Families. Although not used by all health visitors, this gave a useful holistic guide to exploring and making sense of parenting capacity, along with the child’s developmental

needs and family and environmental factors.

There was uneven use of the CAF reported. It was used by most health visitors, family support workers and some teachers but much less by paediatricians. Some paediatricians had undertaken training, received CAF forms with referrals or referred to the Framework, but few reported actually completing CAF forms. The CAF was being used alongside other assessment tools and many respondents reported using it only as a method of referring families on to other agencies for support rather than as a universal tool for the assessment of parenting, linked to a referral. Therefore the Framework was used as a mechanism to obtain help rather than as part of an assessment and support process.

The benefits of using the CAF were acknowledged; however, concerns were highlighted about the increased workload that it could create and how the fragmented and inconsistent use of the Framework led to challenges and frustration in multiagency working. There appears to be a need for better support around the use of the CAF for some groups of professionals such as paediatricians and teachers.

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Appendix:

Topic guide for interviews

Introduction

- To start with could you tell me about your background and training? When did you qualify?
- Where have you worked? Which families have you worked with?
- What would you say is a 'typical' family registered in the centre/school/clinic?

Making assessments

- How often would you meet with parents on a one-to-one basis? What are the main reasons for meeting with parents? Where do meetings usually take place?
- Would you say that you offer parents family support as part of your role?
- Do/would you refer parents on to other agencies for support? Which agencies?
- What factors/criteria do you feel play a role in your assessments of parenting? Are these factors used universally by all professions or specific to your profession?
- What information do you need to gather/know/observe to make assessments of parents' support needs? What contextual information do you use in making assessments – for example, housing, income, social/emotional support?
- What kinds of formal and informal support do you offer to families? How is this decided? Appropriateness for different kinds of families?

Personal beliefs concerning assessment-making

- How comfortable and confident do you feel about making assessments of parents and parenting?
- Would you say that you draw on your own personal experiences when working with parents? How? Can you give examples?
- Do differences/similarities between you and the families have an impact on how you work with parents and the outcome? [For example, ethnicity, parental status, gender, class, age, disability] Can you give specific examples?
- Are there any types of families or circumstances that pose difficulties? Why? Could you give examples? What is the impact on the services received by these families? How could this be improved?
- What role does instinct and gut reaction play in your family support work? Could you give an example?

Concepts underpinning assessment

- How would you describe 'good enough' parenting'? Could you give specific examples? Would you say this is universal across all families?
- How would you describe 'risky' parenting? Could you give specific examples? Would you say this is universal across all families?

Policy and professional context of assessments

- How easy is it to access information regarding policy and practice developments? What information do you regularly receive?
- Which parenting information sources do you most use to inform your work with parents?

- Which assessment tools do you use in your family support work? How helpful are these?
- Have you received training in assessing parents' support needs? How was this taught? Was the training adequate? Are there any skills/information/training gaps?

Finally, do you have any other comments on anything discussed?

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The Family and Parenting Institute (FPI) is an independent charity and centre of expertise on families in the UK. FPI research what matters to families and parents, using findings to influence policy-makers and foster public debate on how to improve the services families use and the environment in which children grow up.

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