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# Research on the number of children in Wales placed into care from parents with learning disability and the reasons behind their removal

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Research on the number of children in Wales placed into care from parents with learning disability and the reasons behind their removal

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Views expressed in this report are those of the researcher and not necessarily those of the Welsh Government

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## Glossary

Acronym / key word	Definition
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
In utero	Before the child's birth (whilst in the uterus)
IQ	Intelligence Quotient, derived from standardised tests designed to assess human intelligence
PAM(S)	Parenting Assessment Manual (assessments) developed by McGaw et al (1999)
PLO	Public Law Outline, which sets out the duties local authorities have when thinking about taking a case to court to ask for a Care Order or Supervision Order, for example to formally outline concerns about a child

## Executive Summary

The Institute of Public Care at Oxford Brookes University has undertaken this mixed method study for Welsh Government. The study includes a combination of:

- Rapid research and practice review.
- Quantitative research methods including an analysis of all-Wales data relating to children who have received a Care and Support Plan and/or who have become looked after from 2010 to 2018.
- Qualitative research methods including collection and analysis of data from a sample of children's case files, interviews with parents and interviews with professional stakeholders in five local authority areas across Wales.

It provides indicative evidence in relation to the following three key research questions:

### **1. To what extent are parents with a learning disability in Wales involved or over-represented within Children's Social Care Services?**

There is insufficient reliable information about the number and proportion of children of parents with learning disability involved with Children's Social Care Services and/or coming into care upon which to base an opinion about the extent to which they are involved or over-represented in this population. One of the main reasons for this is the absence of a sufficiently clear national definition and guidance for Children's Social Care Services in how to identify and record such a disability (for the purposes of estimating a true proportion). However, accurate recording is further complicated by a range of other factors that may be present including parental reluctance to disclose a disability or differential causes of parental difficulties in processing or responding to information, for example a parent's own history of trauma, abuse, neglect or mental health problems.

### **2. What are the factors driving patterns of involvement of parents with learning disability with Children's Social Care Services?**

Learning disability is rarely the only concern and reason for parents being referred to Children's Social Care Services and for children to be taken into care. It is difficult to disentangle a main factor in what are usually relatively complex cases, but other commonly presenting factors include: parental or family characteristics (that can also present risks) including parental substance misuse, domestic abuse, and/or parental mental health problems; poor home conditions; or parental vulnerability to abusive adults in the community. In many cases, the child of concern to services already has older siblings or half siblings in care.

However, it is clear that professional cultures and systems that encourage 'fast-tracking' of new parents into Children's Social Care Services or through court systems naturally place some parents at a disadvantage in terms of the time they will have to prove themselves as effective parents. Similarly, social work assessments that are not well-

rounded and/or specialist assessments that are undertaken late or in inexperienced hands also have the potential to limit parental ability to benefit from services that are well-tailored to their needs at the very least.

Apart from well-tailored support services, supportive key (including social) workers and extended family members are clear resilience factors in addition to the parent's own internal resilience and motivation to parent.

### **3. What evidence is there of good practice along a journey of Children's Services intervention and broader support to parents with learning disability?**

Although there are pockets of good practice, with some parents with learning disability supported effectively to care for their children, there is still much room for improvement; including in:

- identifying and effectively exploring the impact of learning disability on parents' capacity to parent in a timely way;
- providing parents with good quality and accessible information about what to expect from Children's Social Care Services;
- ongoing effective communication between social workers and parents;
- the provision of support to parents who are vulnerable in their own right (including in part but not only because of their degree of learning disability);
- the availability of advocacy;
- the availability of support sufficiently early, including to take into account the particular needs of parents with learning disability who are expecting a baby; and,
- ensuring that the support offered to parents with learning disability is sufficiently well-tailored to their needs.

The study findings suggest that more could be done to improve the national understanding of parental experience in this area as well as actual support services across Wales. Seven recommendations are made. These can be found in full in section 8 of the full report but are summarised, as follows:

1. Develop an improved national definition of learning disability to assist local authorities in identifying parents with a learning disability and recording these instances accurately for statistical purposes.
2. Require the national or local development and provision of easy read, accessible information about being a parent and / or being involved with Children's Social Care Services and the family court.



3. Develop national guidance and consider mandatory training for social workers on:
  - how to identify parent learning disability / difficulty in a timely and effective way;
  - how to communicate effectively with parents who have a learning disability or difficulty;
  - when advocacy should be provided; and
  - best practice in conducting assessments where a parent has a learning disability.

Consider including other (early help) professionals in the guidance to facilitate earlier and more effective screening and support for parents with learning disability.

4. Encourage the development of effective protocols between Adults and Children's Social Care Services to help improve joint working and support between these services.
5. Encourage and incentivise the provision of early support to parents who may have a learning disability / difficulty and who are known to be vulnerable, for example because of adverse childhood experiences.
6. Promote more consistent provision of well-tailored support services to meet the needs of parents with learning disability / difficulty, whether support is provided in the parent's own home or in a parent and baby placement.
7. Promote more consistent provision of support for adults with learning disability / difficulty immediately after a child has been removed from their care with a view to helping them to address the issues that have had an impact on their ability to parent effectively and / or to care effectively for themselves.

# 1. Introduction

## 1.1 Rationale for the commissioned research project

Welsh Government is committed to improving outcomes for looked after children and identifying early preventative action to help reduce the number of children taken into care.

As part of the Government's 2018 work programme, the Improving Outcomes for Children Ministerial Advisory Group identified a paucity of information about the extent to which children with parents who have a learning disability are involved in care proceedings and about the reasons why they may be involved in care proceedings.

Therefore, Welsh Government commissioned the Institute of Public Care (IPC) at Oxford Brookes University to carry out pioneering research to:

- **Establish the extent to which parents with a learning disability in Wales are involved with or in receipt of Children's Social Care Services**, including parents of children involved in care proceedings or who are removed from their parents' direct care.
- **Gain a multi-perspective understanding of the factors driving patterns of involvement** of parents with a learning disability with Children's Social Care Services.
- **Understand effective and less effective practice** in order to support an improvement agenda in this area.

It was anticipated that the findings and recommendations from the project would inform the ongoing development programme of the Improving Outcomes for Children Ministerial Advisory Group and the Learning Disability Advisory Group Transformation Programme which are aiming to strengthen learning disability services more broadly across Wales.

Since the research was commissioned, the First Minister for Wales has highlighted the overall increasing numbers of looked after children in Wales as a priority area for action. To tackle this issue, the First Minister has proposed the introduction of targets to reduce the overall number of children taken into care across a range of measures, including specifically to reduce the number of children in care who have parents with a learning disability.

As a priority area for the Welsh Government, it is therefore hoped that the research findings will help to inform an emerging evidence base in Wales about the proportion of children in care who have parents with a learning disability and their support needs. There is also a commitment to using the research findings and recommendations to inform future policy and ensure robust data collection measures are put in place.

## 1.2 Existing policy and research in this area

It is widely acknowledged that more women with a learning disability are becoming mothers and that this is the result of changes in social care policy and practice from the 1980's onwards towards service provision and decisions based on 'ordinary life' principles (Malouf et al, 2017; Hewitt et al, 2016; and The Kings Fund, 1980).

However, it has proved difficult to obtain accurate estimates of the number of active parents with learning disabilities in the overall UK populations (Stewart, 2017). In part, this is a definitional issue, although there is increasing consensus about what definition(s) should be used to describe learning disability. Welsh Government uses one such commonly recognised definition for the purposes of collecting statistical information in relation to parental learning disability in the context of children with a Care and Support Plan:

*“An impairment of intellectual function that significantly affects their development and leads to difficulties in understanding and using information, learning new skills and managing to live independently”*

This and other similar definitions used in current policy and practice guidance documentation encompass people with a broad range of disabilities not limited strictly, for example, to an IQ of below 70 (thought to only affect approximately two per cent of the population).

It has been suggested in the past by some UK-based researchers (for example Booth, 2005) that children of parents with a learning difficulty are more likely to come into care compared with other children in need. Other researchers have estimated that between 40 and 60 per cent of all parents with a learning difficulty or disability have children removed from their care due to being assessed as unable to provide an adequate standard of parenting (for example, Wilson et al, 2013). Others have further suggested that children of parents with learning disability may be over-represented in the child protection system (Cox, Kroese and Evans, 2015), usually because of neglect rather than other more 'deliberate' forms of abuse (McConnell et al, 2000 and McConnell and Strike, 2002). It is difficult to generalise about the current population of parents with learning disability in Wales based on these research findings, as they are relatively dated and/or reference samples that are relatively small or of a particular type (for example, interviews with solicitors or non-UK samples).

Historical and more recent hypotheses about the factors behind a possible over-representation of parents with learning disability in cohorts of children involved with Social Care Services have included:

- **That a key predictor of neglect is the degree to which the mother's resources, knowledge, skills and experience are sufficient to meet the needs of their child** (Cleaver et al, 2007). The complex and enduring nature of neglect makes it a

challenging issue for practice on a number of levels – conceptual, practical and organisational (Daniel et al, 2011; Gardner, 2016; Horwath, 2013; Tanner and Turney, 2003).

- **Other factors that are often present particularly when children are removed from parents with a learning disability**, such as mental health/physical health problems; substance abuse; isolation; domestic abuse; and the targeting of mothers with learning disability by other adults looking to sexually abuse children (Cleaver et al, 2007).
- **Factors that might be described as discriminatory such as social and professional disapproval of pregnancy in women with learning disabilities** (Malouf, 2017); what have been described as ‘over-zealous’ approaches to the assessment of risks including a presumption of parental incompetence (Social Services Inspectorate, 1999); under-investment in the right kind of supports tailored for parents with learning disabilities (McGregor et al, 2017); and/or a suggestion that learning disabled parents have to meet stricter criteria than other parents to demonstrate their ability to parent (Tarleton, 2006).
- **Insufficiently sensitive communication and/or assessment practice by professionals** including occasions where the learning disability only comes to light during care proceedings; or where unsuitable, non-adapted tools to assess parenting capacity are applied (Stewart, 2017).
- **Organisational or whole system barriers**, such as the separation of adults and children’s disability teams and concurrent high thresholds for adults’ teams; the pressure since the Public Law Outline (PLO) was introduced to identify a plan for permanency in tight timescales; variations in court decisions regarding parents with learning disabilities and their children; and budgetary pressures affecting the provision of early help (although Wales has made a strong commitment to prevention enshrined in the Social Services and Wellbeing (Wales) Act 2014).
- **The statutory legal framework** naturally predicated on protecting the welfare of the child and achieving permanency for children as a priority, although the Social Services and Wellbeing (Wales) Act 2014 also requires councils to support the upbringing of children by their parents where possible. Councils also need to apply good process to their decision making, as governed by the family courts and it is notable in this respect that the President of the Family Division of Courts for England and Wales has in 2018 endorsed the up-dated Good Practice Guidance on Working Together with Parents with a Learning Disability (2016).
- **Reported high levels of mis-trust between authorities and parents with learning disabilities**, and difficulties for these parents sometimes in demonstrating accepted indicators of commitment to raising their children, for example by remembering to attend appointments or by demonstrating an understanding of the purpose of appointments (Research in Practice, 2018).

However, many pressure and support groups alongside some researchers believe that, if provided with earlier personalised support, fewer learning disabled parents would become involved with the child protection system and fewer children would be placed in care. Certainly, the Good Practice Guidance on Working with Parents with a Learning Disability (Department of Health, 2016) adopted by Family Courts and governing social work decision making recognises that many parents with learning disabilities can be good parents, particularly where they are provided with positive support. This guidance, supported by a body of research, proposes five key features of good practice in working with parents with learning disability:

- 1. Accessible information and (clear) communication** including: use of ordinary words, avoiding jargon, and writing 'big'. Giving information in small amounts, breaking down complex information or tasks into small amounts.
- 2. Clear and coordinated referral and assessment procedures, eligibility criteria and pathways.**
- 3. Support designed to meet the needs of parents** with learning disabilities and their children including, for example: mostly home-based parenting support, reinforced regularly and/or parenting programmes that are flexible enough to meet the needs of parents with learning disabilities.
- 4. The provision of long-term support where necessary**, although some researchers have also emphasised the need for early intervention including pre-birth where appropriate.
- 5. Access to independent advocacy** for example for and at important meetings.

### **1.3 The content of this report**

This report includes:

- A summary of the research methodology
- Key research findings organised by the key questions for this study
- Study conclusions and recommendations
- A list of references and appendices

## **2. Research Methodology**

### **2.1 Introduction**

The research methods applied to deliver this research project include a combination of:

- Rapid research and practice review.
- Quantitative research methods including an analysis of all-Wales data relating to children who have received a Care and Support Plan and/or who have become looked after from 2010 to 2018.
- Qualitative research methods including collection and analysis of data from a sample of children's case files, interviews with parents and interviews with professional stakeholders in five local authority areas across Wales.

### **2.2 Stage One Activities**

By way of introduction to the research project, researchers at IPC wrote to all Heads of Children's Services across Wales to inform them about and request their participation in the research study. The initial contact with Heads of Service was then followed up by a series of focused interviews with relevant staff within 12 of the 22 local authorities about:

- How learning disability is defined and applied locally with reference to parents and parenting.
- How data is recorded, in particular for the purpose of completing statistical returns about Children's Services to Welsh Government.
- What assessment tools are used currently in relation to parents with learning disability.
- What, if any, specific supports are available locally for parents with a learning disability.

An analysis of the regularly collected and published (fully anonymized) national data sets was subsequently undertaken with particular reference to children with a Care and Support Plan and/or who become looked after who have a parent with learning disability.

Researchers were also keen to explore other national data sets that could help to identify the extent to which parents with learning disability may be either under or over-represented in the overall cohort of children subject to a Care and Support Plan or looked after. With this in mind, researchers:

- Explored a range of potential sources of data relating to the whole or particular populations of parents, particularly new parents, with learning disability.
- Contacted a range of national stakeholders to explore their perceptions of the availability of such further trend data, for example relating to the prevalence of

parents with learning disability in populations of families who receive forms of early help support.

## **2.3 Stage Two Activities**

During the early stages of the research programme, all local authorities across Wales were invited to participate in a more in-depth study involving: case file analysis, interviews with parents, and interviews with professional stakeholders. Five local authorities agreed to participate, representing a variety of local authority type (urban and rural, smaller and larger) and geographical location.

### **Case File Analysis**

Participating local authorities were asked to provide a list of the 20 most recently closed children's cases involving parents with a learning disability. In all cases, a list of fewer than 20 (between 13 and 17) was provided.

The children's case files were examined by researchers with significant experience of both delivering and leading Children's Social Care Services and also of research projects of this nature. The data on electronic case files was interrogated with reference to the key research questions and existing research studies in this field to identify, for example:

- The characteristics, histories and family circumstances of parents with learning disabilities prior to child protection procedures or care procedures. These characteristics are outlined in Appendix 1 to this report.
- The characteristics of the key child(ren) involved in child protection / care proceedings. These characteristics are also outlined in Appendix 1.
- The nature of the overall safeguarding concerns and/or reasons for support being provided.
- Whether and to what extent the parent or family received early help.
- Factors influencing the statutory decision-making processes.
- The extent to which there was evidence that practice with parents with a learning disability was appropriate with reference, for example, to the quality of information given; the quality of communication; the duration and extent to which the support offer was tailored to the needs of the parent; the extent of access to advocacy.
- The extent to which 'fit for purpose' tools and approaches were applied to undertaking assessments including of risk by both social workers and other assessors.
- The extent to which a parents' learning disability was reflected in and influenced the development, implementation and review of the Care and Support Plan.
- The extent to which the care pathway (including assessment and support elements in particular) included any liaison with adult learning disability teams and the quality of any coproduced support.

- The impact of support put in place for families.
- Desired and known outcomes achieved for the children involved including statutory or court decision(s).

A total of 70 case files were analysed including between 13 and 17 per local authority area. The data was captured in an anonymised format within a spreadsheet that was subsequently analysed with reference to the key questions for the research.

Whilst the information on the case files was largely sufficient to answer the research questions, there were some issues with access to particular types of information in some cases, particularly court-related documentation. Additionally, it was impossible for researchers to verify the extent to which the list of cases in each of the local samples included an element of pre-selection (rather than simply, for example, the 15-20 most recently closed cases). However, the overall sample certainly appeared to researchers to include a range of families, presentations and outcomes.

Finally, there are known limitations to case file analysis that also apply here, in particular that, although there is a significant amount of case recording on children's social care files, not everything relating to practice, assessment and decision making can be and is recorded.

### **Parent interviews**

In each of the five local authority areas, researchers also sought to undertake interviews with parents with known learning disability who had a recent experience of Children's Social Care Services, for example because their child(ren) had been subject of a Care and Support Plan or had become looked after. Up to 15 face-to-face interviews with parents were proposed but only eight could be undertaken. Interviews were conducted only with parents who had a demonstrable capacity to consent to such an interview and who did indeed give their informed consent to participate in this way. Consent to participate was brokered initially, as appropriate, through workers (other than the child's social worker) and / or support groups who were well known to the individual parents concerned. A judgement about parental capacity to consent and support for parental participation was delivered carefully by researchers with reference to national guidance on working with / interviewing parents with learning disability and a suite of easy read / view support documents that were co-produced with an organisation with significant expertise and experience in developing such tools.

All interviews were audio-recorded and were analysed thematically with reference to the key questions for the research.

The interviewees were not sought to be representative of the whole population of parents involved with Children's Social Care Services, rather illustrative of some experiences of parents with these services.



Almost all the parents with learning disability who were interviewed for this evaluation were in fact living with their children. One parent was expecting their three children to be returned home to them shortly after a period in care, with support from Children's Social Care Services. Another parent's only child had been removed from their care at age six months.

- Parent interviewees were aged between 19 and 30 years when they were awaiting their first child.
- Six participants are mothers and two are fathers.
- The parents have between one and seven natural children in total.

A summary of the questions asked of parent participants is reproduced at Appendix 2.

### **Professional stakeholder interviews**

Over a two-day period, and with the support of the five local areas involved, researchers sought to interview as many relevant professionals as possible including 'a range of people who work with or manage people who work with families and/or support parents with a learning disability'. These interviews were undertaken mostly on a one to one basis (face to face and over the telephone) but, in some cases, a conversation was facilitated on site with a group of professionals including:

- Social workers and team managers from Children's Social Care Services' teams.
- Other key professionals or children's services managers embedded in local authorities, for example professionals with a responsibility for quality assurance or the overall management of child protection services, Independent Reviewing Officer (IRO) managers.
- Professionals or managers based in other parts of the council or other relevant organisations, for example Legal, Housing, Health, Adults' Services including Disability and/or Substance Misuse Services), and the Voluntary and Community Sector.

A summary of the questions asked of professional interviewees is reproduced at Appendix 3.

A total of 46 professionals participated in these interviews.

The interviews can be said to be representative of most if not all of the sector involved in supporting parents with learning disability or difficulty, although early help support was not as well-represented as the statutory (social care) sector.

## 2.4 Ethics

A full ethics committee submission was made to the Oxford Brookes Research Ethics Committee in August 2018. The submission was approved (FREC Reference 2018–12) prior to the deeper dive element of the research being commenced at end January 2019. Key elements of the approach to this research study approved by Welsh Government and the Ethics Committee included:

- With respect to reviewing the children’s case file for the deeper dive element of the research, the project did not seek the consent of parents to participate, relying instead on the public interest in the findings of national significance (GDPR Article 6 (1), Article 9(2), Article 12 (notice) and Article 35 (Privacy Impact Assessment) and also the UK Data Protection Bill (draft) Article 89(1) (the appropriate safeguards) and Schedule 1 (Part 2) (Processing of Health and Social Care Records); Schedule 3 Paras 10 and 11 (re: abused children)). In relation to children who had become looked after or who had been taken into care, the research team additionally relied on the consent from the Head of Children’s Services locally (the corporate parent) to review the children’s case files. In all circumstances, it was considered that the privacy of the subjects of the case files would not be compromised significantly and that they would not suffer serious harm by this limited disclosure, as a very limited number of experienced Disclosure and Barring Service (DBS) - checked researchers would be involved and the names / other personal material that could identify subjects would not be recorded at any stage. No patient health records or confidential patient information was accessed during this activity or at any times during the study. The substantial main benefit of this approach and rationale for relying on the public interest in the findings was considered to be the achievement of a far more representative sample of cases for inclusion in the study than could realistically be achieved by retrospectively requesting consent from the families involved.
- Significant attention to exploring parental capacity and obtaining informed consent to participate at every stage of their involvement in the research project including with the support of easy-read / view materials about the research (Information Sheets and Consent Forms) and trusted brokers of the interviews who could explore and confirm capacity and consent to participate directly with the participants themselves before involving any researchers directly.

### 3. **Research Question One: To what extent are parents with a learning disability in Wales involved with Children's Social Care Services?**

#### **Key messages:**

- There is insufficient reliable information about the number and proportion of children of parents with learning disability involved with Children's Social Care Services and/or coming into care upon which to base an opinion about the extent to which they are over-represented in this population.
- One of the main reasons for this is the absence of a sufficiently clear national definition and guidance for Children's Social Care Services in how to identify and record such a disability (for the purposes of statistical returns).
- However, accurate recording is further complicated by a range of other factors that may be present including: parental reluctance to disclose a disability; or differential causes of parental difficulties in processing or responding to information, for example not (only) an underlying learning disability but also a parent's own history of trauma, abuse or neglect or mental health problems.

Published statistical returns from local authorities in Wales to Welsh Government (Stats Wales, 2019) suggest that the proportion of parents with learning disability amongst children on the Child Protection Register has been reducing slightly from between eight and nine per cent across 2010 - 2016 to five per cent at March 2018. The published national data sets also suggest that the proportion of parents with learning disability amongst children with a Care and Support Plan more broadly (seven per cent at March 2018) or children who become looked after (11 per cent at March 2018) have remained more or less the same since 2010.

Of course, these trends differ from local authority to local authority and there have been some 'outlier' authorities in particular in the years 2010 – 2013. However, by March 2017, most of these local authorities were in line with the national average percentages.

It is impossible to establish whether and to what extent these proportions of children of parents with a learning disability reported to be involved with Children's Social Care Services are over or under representative of those within the overall population. This is because there is no known data set in Wales that establishes the proportion of parents with learning disability within the overall population of parents or, perhaps more meaningfully, the population of parents with new-born babies. Equally, there are no known national data sets identifying the proportion of parents with learning disability engaged with early help services such as targeted community health provision, Flying Start, Families First, or Team around the Family populations.

There is also another problem with the available national data, namely that it is described by performance officers and other local authority representatives interviewed for this research as being fundamentally unreliable for the purposes of estimating proportions of parents with learning disability in the key statutory populations of children. This is in part because the reason for collecting the data may be subtly different or even mixed including not only for statistical returns but also to identify factors that will need to be considered to develop an effective Care and Support Plan. There are also inconsistencies in how, at what stage of the journey through care and support, and by whom parental learning disability is recorded. Local authority representatives recognise that the national definition of learning disability utilised to identify this factor for statistical returns naturally encourages a degree of interpretation based on how an impairment affects a person's functioning rather than the impairment itself. Some sector leaders also make the point that even more parents possibly than those reported to Welsh Government for the purposes of statistical returns may find it difficult to either:

- process information presented to them in relation to the care and support or child protection system; or
- understand and act upon educational messages from social workers or family support staff relating to their parenting.

The reasons for this may be linked with an underlying learning difficulty (or mild form of learning disability) and/or other factors such as substance misuse, domestic abuse or mental health problems. In the view of sector leaders interviewed at the start of this project, it is often difficult in practice to be clear which is a significant or the most significant factor.

The case file analysis and interviews undertaken for this study reinforce this overall view and further suggest that:

- **A parent's learning disability or difficulty may be difficult to establish** even across a significant journey of care and support relating to their child. This is described by professional interviewees as sometimes resulting from a parent wishing to hide their disability or difficulty (out of fear of the consequences). Alternatively, it could be that some parental responses to people and situations are either adapted to earlier (childhood) trauma or abuse or driven by their mental health needs or substance misuse, making it difficult to ascertain what is the cause of difficulties in processing or responding to information or situations.

*When do learning difficulties become disabling? What is the cause of the learning disability or difficulty? Emotional issues or neglect may impact as well as core cognitive functioning. In practice, the needs and principles of how to work with the parent apply to both (sector leader)*

The case file cohort for this study included only 53 per cent of parents whose learning disability / difficulty was known at the point of referral to Children's Social Care Services. Many professionals interviewed for the study thought that it is rare for a parent's learning disability to be identified at referral except where the parent is already known to either Adult or Children's Social Care Services. Where referrals to Children's Social Care Services are made by other organisations, professionals suggested that a communication or cognitive difficulty may sometimes be alluded to (for example, that the parent is 'struggling') but often not spelled out:

*It seems to be hard for people to talk about (social worker)*

- **Parents with very mild learning disability or a learning difficulty are frequently identified as having a learning disability for the purposes of returns to Welsh Government** (as well of course as those with moderate to severe learning disability). Identification may rely on a range of informal approaches (including talking with the parent and/or broader intelligence-gathering with other agencies) as well as more formal methods such as a cognitive assessment. In the case file sample, only four per cent of the main parents identified as having a learning disability were thought, from all the available information, to have a significant learning disability. 36 per cent were thought to have a moderate learning disability, 41 per cent a mild learning disability and 19 per cent a learning difficulty.
- **The level, impact or implications of the parental learning disability or difficulty is not always well explored or explored sufficiently early in the intervention 'window'** for this information to become useful in driving the nature and delivery methods of support.

*If you leave it late, people have to address things quickly, it's speeded up (social worker)*

Many of the parents in the case file cohort who were thought at referral to Children's Social Care Services to have a form of learning disability were not the subject of significant further exploration as to the form of disability / difficulty or impact of the disability on their functioning. In 12/70 or 17 per cent of cases, the disability or difficulty was neither identified at referral nor arguably ever clearly identified. In almost all of these cases, the parent(s)' learning needs appeared to be masked to some extent by their other needs, particularly their alcohol or drug misuse and/or their mental health problems, sometimes thought to be linked with their own experience of an abusive childhood.

Professional interviewees agreed that identification of parental learning disability is often made quite late in the statutory process, if at all, including where parents refuse to be assessed or are reluctant or too frightened to share information; or because of

a professional culture that expects specialist assessments to be commissioned or undertaken only at the point where proceedings are anticipated or commenced.

- **Many, if not all agencies including many Adult Social Care Services apply much tighter definitions of learning disability** than Children's Social Care Services including for receiving an assessment or support service on the basis of learning disability.

In only 15/70 (21 per cent) of cases in the case file cohort was a member of the Adult (Learning Disability) Team involved at all in the assessment of parent and family needs. The proportion of cases where the Learning Disability Team had been involved in this way varied significantly from area to area from: zero per cent in two local authority areas to 19, 31, and 62 per cent in the other three areas. There was evidence in some other cases that the child's social worker had made a referral to the Learning Disability Team, but that the referral had been refused, including often on the basis that the parent had an IQ of above 70 (in some instances above 65).

Professional and sector leader interviews reinforce this finding, with many suggesting that the threshold for Adult Social Care Services becoming involved in either an assessment or in providing support remains very high even after the reforms of the Social Services and Wellbeing (Wales) Act 2014.

*Adult teams don't contribute, they see it as a Children's Services issue. Also, their model doesn't fit our needs – they are focused on advocacy for the adult member, not the whole family/the child's needs (team manager)*

*For an Adult Services assessment, the parent would have to come into the office and it's a test of under 70 IQ. Most of our parents would have learning difficulties, not a learning disability with reference to this definition (team manager)*

Only one area participating in the deeper dive elements of the study was beginning to perceive a shift in how these thresholds were determined locally:

*Our adult teams are moving to a functional compared with an IQ-based diagnosis, based on how a difficulty or disability affects an individual's functioning (team manager)*

#### **4. Research Question Two: What are the factors driving patterns of involvement of parents with learning disability with Children's Social Care Services?**

##### **Key messages:**

- The evidence from this study suggests that parent learning disability is rarely a factor driving patterns of involvement with Children's Social Care Services in isolation. Other factors also commonly present include parental mental health problems, substance misuse, domestic abuse, older children having been removed, and parent vulnerability to physical, financial and sexual exploitation or abuse.
- The case file analysis element to this study provides indicative evidence that decision making by Children's Social Care Services is appropriate but that some families with parents with learning disability may be 'fast tracked' into these services without a preceding plan of early help and/or into PLO or court proceedings. Similarly, some families' assessments may be rushed and/or specialist assessments undertaken too late to inform support service delivery.
- In this context, the current timescales required for decisions about children in court may be too short for parents with learning disability to 'prove' their parenting competence.

##### **4.1. Findings from statistical returns relating to all children with a Care and Support Plan**

Recently published (Stats Wales, 2019) statistical returns from local authorities to Welsh Government suggest that the proportion of children with a Care and Support Plan, on the Child Protection Register or Looked After reported to have a parent with learning disability is significantly lower than the proportion of these children with other specific parental features including: substance misuse, mental health and domestic abuse.

These proportions are explored in Table 1 below:

**Table 1: Parental factors identified in different types of statutory child populations across Wales at March 2018**

<b>Type of Child Plan / Outcome</b>	<b>Learning Disability</b>	<b>Substance Misuse</b>	<b>Domestic Abuse</b>	<b>Mental Ill-Health</b>	<b>Physical Ill-Health</b>
Children with all types of Care and Support Plan	7%	28%	26%	32%	11%
Children on the Child Protection Register	5%	37%	42%	42%	10%
Children who are Looked After	11%	36%	29%	37%	12%

Source: Stats Wales 2019

#### **4.2. Findings from the case file analysis and interviews**

The case file analysis undertaken for this study reinforces the finding from statistical analyses (above). Whilst the findings are indicative rather than conclusive, they suggest that the referral patterns of children with parents who have a learning disability are very rarely driven by parental learning disability or learning disability in isolation. Very often, the key drivers for referral were noted to include: domestic abuse; older children having been removed from their parents' care; parental drug or alcohol abuse; significant parental mental health issues; concerns about a parent's social isolation / vulnerability; or housing conditions. Where families in the cohort were referred pre-birth or before the child's first birthday, the expressed concerns were predominantly that the mother was isolated and vulnerable to sexual, financial and / or physical exploitation in the community or from their chosen partner.

Example summaries of the main concerns at referral to Children's Social Care Services for children aged under one year made by researchers whilst conducting the case file analysis included:

*Mum has six older children adopted, history of domestic abuse and violent, substance misusing partners. Mum is now 24 weeks pregnant.*

*There have been a number of Police call-outs to the home where pregnant Mum is living with her (hoarding) parents. The call outs relate to Mum's relationship with a man known to be misusing drugs and who has an offending history including*



*domestic abuse and sexual offences. Mum has mental health problems and is known to both the Police and Community Mental Health Services locally. Home conditions are very poor, and the midwife is concerned that Mum has missed antenatal appointments.*

*Police are concerned about domestic abuse at the property, Mum has tried to leave the special care unit with her new born baby who is not ready for discharge. Mum known to have been abused and neglected as a child and exhibits challenging behaviour. Parents thought to be misusing drugs and alcohol. Mum considered vulnerable to sexual exploitation.*

*Mum has been in care herself and has spent time on the streets, homeless, as a care leaver. She is supposed to be living in supported housing but doesn't engage with the workers there. Mum is thought to be at risk of sexual and financial exploitation. Mum has no known support networks and has mental health problems.*

*The Adult Learning Disability Team is concerned that Mum who is 16 weeks pregnant is consuming a lot of alcohol and self-harming (saying she wants to kill herself). She is currently living in her boyfriend's family home.*

*Concerns about poor home conditions, child born very prematurely with physical health needs. Dad has a history of being abused and neglected, has moderate learning disability and challenging behaviours. His first child with another partner was taken into care, concerns relating to him being over-controlling and abusing alcohol, and very squalid home conditions.*

*Concerns Mum has been sectioned under the Mental Health Act whilst pregnant, Mum has Autistic Spectrum Disorder and low mood. Mum discharged to community mental health services and is living with the father of the child.*

*Expectant mother who has moved into the area recently, with a history of anxiety and depression. Seven older children have been removed from Mum's care, one child died, and six others were removed at birth.*

For older children living with their natural parent(s), the recorded reasons for referral were more mixed, including all of the above but in addition, challenging child behaviour or significant child emotional health difficulties affecting their functioning at home and school; and/or specific concerns or allegations of neglect or abuse. Example summaries of the main concerns at referral relating to children aged over one year made by researchers whilst conducting the case file analysis included:

*School concerned that Mum cannot cope with two children, one of whom has learning disability and the other ASD / ADHD. Concerns about escalating issues around domestic abuse in the home (child on parent) and child not attending school / lessons regularly. Concerns about Mum's dependency on a voluntary sector support worker to manage.*

*Mum's partner started smashing the home up. Flat found by Police to be in an awful mess. Mum's partner alleges Mum has assaulted him in front of the child, several assaults previously. Mum's partner has bought crack cocaine and smoked it with the child in the room. Police found crack pipes and paraphernalia in the home. Police have been called several times to the flat in recent weeks.*

*Police concerned these children's father has sexually abused other child family members. This Mum doesn't believe the allegations and may not protect the children.*

*Health visitor concerned about home conditions including chain smoking in the home and Mum and Dad not responsive to advice or support around basic parenting, routines and boundaries and home conditions.*

*Concerns this young child has been physically abused. This in the context of a recent Care and Support Plan because of concerns about neglect and Mum's inability to put in place boundaries and routines and safety for children.*

*Mum expressing concerns with boys' behaviour at home, difficulty in managing challenging behaviour, they are aggressive to Mum.*

*Concerns about unhealthy and unsafe conditions in house, mother finding it difficult to manage three children since her own mother died, missing school, headlice.*

*Child disclosed to school that she is frightened, Dad hits Mum and calls her useless, child gets between, Dad drinks every night.*

Similarly, concerns at the time of the social worker’s early assessment post-referral were rarely just about parental learning disability in isolation, rather a range of concerns including those outlined in Table 2 below:

**Table 2: Case file analysis key concerns about families at assessment for care and support**

<b>Area of Concern</b>	<b>No. and % of cases where this was a key issue</b>	<b>No and % of cases where this issue was unclear</b>	<b>No. and % of cases where this was not a key issue</b>
Parent inability to undertake core parenting tasks	41/70 ( <b>59%</b> )	17/70 (24%)	12/70 (17%)
Parent inability to understand or process information	42/70 ( <b>60%</b> )	20/70 (29%)	8/70 (11%)
Parent vulnerability to abusive adults	36/70 ( <b>51%</b> )	17/70 (24%)	17/70 (24%)
Domestic abuse	30/70 ( <b>43%</b> )	9/70 (13%)	31/70 (44%)
Parental mental health issues	46/70 ( <b>66%</b> )	11/70 (16%)	13/70 (19%)
Parental alcohol or drug misuse	26/70 ( <b>37%</b> )	4/70 (6%)	40/70 (57%)
Child neglect or risk of neglect	58/70 ( <b>83%</b> )	2/70 (3%)	10/70 (14%)
Child physical abuse or risk of physical abuse	23/70 ( <b>33%</b> )	16/70 (23%)	31/70 (44%)
Child sexual abuse or risk of sexual abuse	10/70 ( <b>14%</b> )	16/70 (23%)	44/70 (63%)
Child emotional abuse or risk of emotional abuse	39/70 ( <b>56%</b> )	18/70 (26%)	13/70 (19%)

The most significant parental issue of concern other than an inability to undertake core parenting tasks or understand and process information, mental health problems, existed in combination with domestic abuse in 19/70 (27 per cent) of all cases in the cohort. Parental mental health problems were clear issues in combination with parental drug or alcohol misuse in 20/70 (29 per cent) of all cases in the cohort. In 12/70 (17 per cent) cases, all three (parental mental health, domestic abuse and parental drug or alcohol misuse) issues were present and thought to be an issue at the time of the statutory assessment.

In only 4/32 cases where there were concerns about parent inability to undertake core parenting tasks and/or to understand or process information did these exist in isolation from the three other key parental factors known to increase risks to children (Cleaver et al, 2011) i.e. domestic abuse, drug or alcohol misuse and/or mental health problems.

Although perhaps not overtly driving social worker concerns and initial decisions post-referral, it is worth noting that many of the children in the cases file cohort were **known at the time of the assessment to have older siblings or half siblings in care**. 37 per cent (26/70) of the children in the case file cohort had between one and eight older siblings or half siblings who were already living away from their main carer, many of whom had been taken into care. In an even greater proportion (almost a half) of cases where children were referred to Children's Social Care pre-birth or soon after their birth, other children of the family had been on the Child Protection Register and/or removed from their parent's care.

Other factors external to the parent themselves and that may drive patterns of involvement of parents with learning disability with Children's Social Care Services were also identified by the research.

1. The case file analysis and professional interviews suggest that **some first-time parents with learning disability / difficulty, may be 'fast-tracked' into Children's Social Care** without having previously accessed other forms of targeted early help.

Whilst some of the key drivers for referral (particularly parental vulnerability to abuse combined with learning disability) may explain this fast tracking to a certain extent, it is still noticeable that only 2/15 of the first-time parents in the case file cohort appeared to have received a significant previous plan of targeted early help. Professionals interviewed for this study recognised that this 'fast-tracking' sometimes does happen, albeit for reasons that relate in theory to protecting the interests of the parent (for example to provide them with access to advocacy) or because community-based professionals believe that it should be Children's Social Care Services who 'take on' these cases.

*Health services get nervous and refer families early, then they can be fast-tracked (into social care services and court) (team manager)*

Parent interviewees described in vivid terms the impact of some forms of fast tracking, particularly where this has the potential to disrupt parent/child bonding in the early days and weeks post-birth:

*The difficult part was when Social Services took her into foster care, and I didn't see her from like the Friday 'til the Monday morning (parent)*

*I thought I couldn't get attached to her.. just in case they did take her (parent)*

A relatively large proportion of parents in our interview sample (almost all of whom still care for their child(ren)) described having received targeted early help before being referred to Children's Social Care Services and in many cases this was very well received. They had also often received support from their extended family in the home during pregnancy and in the early weeks and months after their first baby had been born, sometimes as a result of court directions. This support was not without its complications, including for example feeling like the child care had been 'taken over' by extended family. However, half of the parents also experienced Children's Social Care Services being involved either during the pregnancy or soon after their child's birth. One parent at least thought that it would have been better to have had earlier support, in particular to recover from adverse childhood experiences, before becoming a parent.

2. **The way in which assessments are undertaken** (by social workers and others) can also logically drive child and family outcomes to a certain extent. Therefore, it is notable that a majority (51/66 or 77 per cent) of the families in the case file cohort where it was possible to make a judgement were considered by researchers involved with this study to have received a good quality social worker assessment. In a minority (15/66 or 23 per cent) of cases, the assessment was considered to be somewhat to significantly compromised and the main retrospective criticisms include that the assessment or process of assessment:
- Failed to take sufficient time with the family to gather enough information about their circumstances, strengths and needs.
  - Was more judgemental, less balanced than might have been expected (failed to take account of parental strengths as well as needs or concerns).
  - Focused on one aspect of parent need, such as mental health issues, in isolation rather than in the context of broader parent / family needs that might also incorporate a degree of learning disability / difficulty.
  - On balance, placed too great a reliance on information from the past (for example relating to the parent's previous care of a child).

- Was lacking in parent perspectives about their situation, their strengths, and the concerns that had been raised.

Other more specialist assessments were undertaken in a majority (54/70 or 77 per cent) of cases. In most cases, this was a Parenting Assessment Manual (known as PAMS) assessment (in 24/70 cases) or PAMS and cognitive / psychological assessment combined (in 15/70 cases). The PAMS assessments were usually undertaken by a social worker other than the child's allocated worker within the council, or by an independent social worker. In 8/70 or 11 per cent cases, only a cognitive / psychological assessment (sometimes known as a capacity assessment) was undertaken, usually by an independent clinician in relation to one or both parents. In a very small minority of cases, one or both parents were also referred to the Adult (Learning Disability) team within the council for a specialist assessment of their needs. There were no distinct patterns across the local authorities in terms of their use of these different types of assessment. However:

- In a number of instances across all local authority areas, these specialist assessments appeared to be commissioned relatively late in the family intervention for them to be of much use in directing the nature of support, for example within court proceedings or as a result of a court order within care proceedings.
- In some of the local authority areas, a greater proportion of the cases included either a PAMS or a cognitive / psychological assessment (rather than both of these).

Professionals interviewed for this study acknowledged that PAMS is the normal tool used to assess parenting for parents with learning disability. However, this tool is reported to be used rarely before at least the Public Law Outline (PLO) stage, if not commencement of care proceedings. Some interviewees also described feeling pressurised by family courts to undertake PAMS assessments.

There were mixed views among senior sector leaders and professionals about the extent to which a PAMS assessment is useful. Many senior practitioners thought that the usefulness of the tool was only realised fully where complemented by good practitioner skills, particularly in communicating effectively with the family. Others thought that PAMS may not be as helpful where there are other risks or factors to be taken into consideration, such as mental health problems or substance misuse.

*The PAMS tool is good, but it's how the practitioner uses it that's important*  
(team manager)

*Courts like PAMS, but it's a bit one size fits all. I wonder why we haven't seen more innovation in this area?* (sector leader)

Whilst it has many recognised positive attributes, a key criticism is that, whilst the PAMS tool was originally designed for use in the early stages of an intervention to inform service delivery, it has increasingly become used to assess whether a child should remain at home with their parent in the context of care proceedings.

Many professional interviewees acknowledged that these kinds of specialist assessment were likely to be experienced by parents as:

- Intrusive, particularly if they don't fully understand the concerns.
- Frightening.
- Exhausting.
- Stressful.

Parents who were interviewed for this research themselves sometimes described experiencing assessments in exactly this way, and that there was a negative impact on them of the experience:

*I stayed in the mother and baby placement then X came to the mother and baby placement, like once a week and assessed me, you know watched me, what I was doing and how I changed, how I bathed, how I played you know, how I communicated and how my daughter reacted to my communication (parent)*

It is notable that many of the children in the case file analysis about whom outcomes were relatively clear (36/68 or 53 per cent) had been supported by a Care and Support Plan to remain living with their parents, either in the parent's own home (46 per cent or 31/68) or with their extended family (7 per cent or 5/68). The Children's Social Care Services' decision making at key stages of the case after the relevant referral appeared to be appropriate in the majority of cases. However, in a small number of cases (7/70 or 10 per cent), the case appeared to escalate either to PLO or to Court or to the removal of the child from the parent(s)' care relatively quickly with reference to all of the circumstances. Many if not all of the children in these cases were under the age of 1 year with no siblings or half siblings in care and no previous Child Protection Plans.

Researchers found no clear examples in the case file cohort of instances where children (and their parents) had been involved unnecessarily with Children's Social Care Services and/or some form of statutory intervention.

Where children were taken into care, the decisions made by the Children's Social Care Services and / or court appeared to be reasonable with reference to all the circumstances at the time they were made.

However, professionals sometimes described how the courts and court system (particularly the timescales required for decision making in most cases) could have a significant effect on the amount of time a parent may have to 'prove' their parenting competence.

## 5. Research Question Three: What evidence is there of good practice along a journey of Children's Services intervention and broader support to parents with learning disability?

### Key messages:

Although some good and effective practice has been identified by this study, it also provides indicative evidence of widespread limitations in practice with parents with learning disability who come into contact with Children's Social Care Services in Wales, including: very limited availability of accessible information for parents about what will happen and why; limitations in social worker / parent communications including some 'arms'-length' practice; limited availability of advocacy in many areas; limited support from Adult Social Care Services and a lack of account taken of a parent's vulnerability in determining eligibility for these services; delays in organising specialist assessments and support; support that is not always well-tailored to the needs of a parent with learning disability / difficulty; and limited support for vulnerable adults in their own right, particularly to promote healthy relationships or after a child has been removed from their care.

Case studies representing both strengths and limitations in practice identified in the case file analysis can be found at **Appendix 4** to this report.

### 5.1 Evidence of Good Practice

In a majority (45/70 or 64 per cent) of cases in our case file cohort, there was **evidence that the social worker had communicated effectively** with the parent with learning disability / difficulty at different stages of the statutory process, including about what would happen and what the parent(s) needed to do and why (although sometimes the parent(s) still had difficulty in understanding what or why).

A key feature of these more effective communications was taking or making sufficient time with the parent to describe in person what were the key issue(s) or area(s) of concern and what would happen.

Parents interviewed for this study valued:

- Social workers who understood why parents might not be completely honest at the start (because they are worried about losing their children).

*I was too scared (parent)*

*She'd ask me a question and (I'd) say why first. But now I understand she'll find out. If I say something to her now she's really good. But it took a bit of time. She's been helpful my social worker, she's been good she has (parent)*



- Feeling that their child's social worker(s) was approachable, supportive and had time for the parent and the child(ren).  
*Because, at the end of the day, if you're gonna give someone a social worker, you want to bond with that social worker. They'd sit on the floor, the toys, .. used to join in and I thought, oh carry on!* (parent)
- Being able to talk openly and in a relaxed way with the worker(s).  
*I can talk to her about anything* (parent)
- Being able to contact the social worker or other worker(s) easily.  
*I only need to message her if I need anything and she's on my doorstep* (parent)
- Communications that are tailored to the parent's needs, for example where a parent doesn't like using the telephone, more face to face.

Professionals interviewed for this study could identify a range of attributes of effective communication methods including: simple phrasing, honest, accessible; repeating information and checking understanding; allowing enough time to communicate; showing / demonstrating what to do, not telling; demonstrating empathy; use of visual materials in support.

*You need to build a relationship, have conversations. Instead of a parent being told what to do, draw out of them what they need to do* (social worker)

Some social workers said that they had been provided with training in effective communication with people with learning disability and that this had been helpful.

There is also indicative evidence from the case file analysis and interviews that:

- **Many parents with learning disability or difficulty are being offered an assessment that incorporates a specialist element** (tailored to their identified or potential needs as a parent with a learning disability or difficulty). Information about these assessments is included in section 4 above.
- **Some parents are receiving and benefitting from advocacy support**, particularly when their children become involved in child protection and/or court processes. In 14/70 or 20 per cent of the case file cohort for this study, this was the case. The extent to which advocacy support is generally offered to and accessed by parents with learning disabilities was reported by professionals interviewed for this study to vary greatly from area to area. In a limited number of areas, it appears to be offered routinely to parents as soon as child protection procedures are commenced:

*We offer it and re-offer it (social worker)*

*Will always refer to advocacy (social worker)*

- **Some parents are benefitting from the involvement of Adult Social Care Services** to support the assessment of their needs and/or to provide support to them in their own right or for their carer(s). The case file analysis provides indicative evidence that in a small minority of local authorities, Adult Social Care Services are frequently, even routinely involved in children's assessments and/or support plans. Professionals in these areas confirm that parents with a learning disability are 'routinely' referred to Adult Social Care Services for support and that co-working is also relatively common.

Where Adult Social Care Services are harnessed in the context of a Children's Social Care-initiated intervention, there is evidence from the case file cohort that this can be very useful, for example: in obtaining support for the parent to communicate effectively during the statutory process; in supporting the children's team to communicate more effectively with the parent; and / or to obtain practical and emotional support for the parent in their own right.

- **Parents with learning disability / difficulties very frequently receive support with parenting** as a result of their child being subject of a Care and Support Plan. In 34/70 (49 per cent) of cases in our case file analysis, the level of family support provided to the family could be described as intensive including, for example, a parent and baby specialist placement and/or an intensive home-based programme of support. In 25/70 (36 per cent) of cases, the type of family support provided to the family was less intensive in nature but nonetheless targeted at some if not all areas of family presenting needs (for example: support with parenting; parent mental health problems; domestic abuse/healthy relationships; parental substance misuse; respite for children with disabilities; access to activities for children). These were often multi-disciplinary packages of support incorporating community health services.

In 11/70 (16 per cent) cases, the support was less obviously targeted towards keeping the family together, mainly because the child had been taken into care early on in the intervention as a result of significant safeguarding concerns, or at the request of the parent(s). In these instances, the support directed towards the parent(s) was usually to enable them to engage positively with supervised contact with their child. In other cases, little or no support had been offered in practice because the parent did not want to engage with the intervention.

The way in which this support is provided seems to vary from area to area, with some local authorities making extensive use of parent and baby placements and others supporting more parents in their homes / the community.

There are examples from the case file analysis of parents responding well or very well to both types of support (community-based and parent and baby placements) and to support of varying duration and intensity, particularly packages that are well-tailored to the needs of the parent with learning disability / difficulty (see below).

Children's Social Care support for parenting is described by many professionals as time-limited in its very nature, including to promote the paramount needs of the child.

The parents interviewed for this study often expressed a desire for the Social Services - driven episode to end and for 'more normal', less monitored home life to begin again. However, professional interviewees acknowledged that parents with learning disabilities may need support on a more ongoing basis, and some described managing this tension for example by stepping families down from Care and Support Plan into targeted early help including Team around the Family arrangements. These early help services may also be under pressure to work with families for a time-limited period. In some instances, professional interviewees thought that it may also be easier and more acceptable to parents for them to access ongoing support in their own right where they are eligible for Adult Social Care Services or support from Children's Disability Teams (if they have a child with a disability), as these often feel less threatening to the parent and are more geared towards delivering medium to long term support.

- **Some support provided to families with a Care and Support Plan is well-tailored to their needs.** In 21/68 or 31 per cent of cases where it was possible to make a judgement about this, the support provided to families in the case file cohort was considered well-tailored to the needs of a parent with learning disability / difficulty. Support was considered by researchers to be well-tailored either where it was provided by a 'specialist' provider (for example a parent and baby placement or community-based parenting support provider specialising in work with parents with learning disability) or where it was provided by a more generic (for example family support) service or team but with reference to good practice attributes such as: utilising pictorial supports and tools; modelling / showing parents what to do rather than telling; regular re-visiting of learning; or tailored reminders about key appointments. In a further 38 per cent (26/68) of cases, the support appeared to be only partially tailored to the needs of a parent with learning disability / difficulty.

Better tailored support was associated in the case file cohort with significantly improved parental engagement with it. In a significant proportion (19/21) of the cohort of cases where parents engaged very well with the support, it was considered either well-tailored or partially well-tailored to their needs. This compares with only 9/20 of

the not well engaged cohort of parents and 19/27 of the partially engaged cohort of parents.

More children in the case file cohort remained living safely with their parent(s), at least in the short term, where there was good social worker support, where the support was tailored to the needs of a parent with learning disability, and/or where there was (helpful) support to care for the child(ren) from the parent(s)' broader family.

Some parent interviewees described returning to their own parents' home in pregnancy, as it was perceived by them to be a protective factor (against losing their child). Many parents described having been worried about impending or actual social services' involvement.

Parents' reported experiences of social workers and social care services were mixed, sometimes for the same parent (with lots of different social workers). Positive experiences for parents interviewed for this study were usually associated with:

- **Having received regular practical help** with the home or with parenting, for example with de-cluttering the house, organising financial support, reading formal letters, or helping with the school run. Some of this support is expressed as for the parent in their own right (rather than in relation to their child), for example from Adult Learning Disability Services.
- **One to one parenting support or advice** with parenting tasks such as routines, healthy eating and setting boundaries that continues for as long as is needed (to establish good routines) and/or that acknowledges how things change as the children get older. This is usually provided by support workers working with the social worker.
- **Visual supports for key parenting tasks**, for example in wall chart format.
- **Accessible playgroup type activities** or nursery care for their children (and accessible information about these activities and/or support to access them).

*They helped me to go to a playgroup with her. I hate going to different places and meeting new people, I don't like that at all. So, she's gonna come here and take me up. It's only around the corner, so I'll walk round with her then*  
(parent)

- **Being given what felt like 'a real chance' to parent.**
- **Support to really understand particular risks to the child(ren)**, for example from a violent partner.

*To get me away from the fella I used to live (with). Well, they told me I had to move from there. If it wasn't for them, I'd be still there now, I would have lost her. They opened my eyes they did* (parent)

- **Support for the whole family, for example for Dads as well as Mums** (for example, one father interviewee described having been supported to attend a Dads' Group locally as well as to contribute to the family's routines).

## 5.2. Evidence of Limitations in Current Practice

### Area One: Limitations in the availability of accessible information for parents

There appears, from all the evidence collected for this research, to be a major service limitation currently in terms of the provision of accessible information for parents with learning disability / difficulty about what to expect from the statutory process and why. Only 20/70 or 29 per cent of our case file sample appeared to be provided with such information and, where it was provided, this was always orally rather than through accessible / easy read materials. Almost all professionals interviewed for this study believed that the current availability of accessible information or advice about support services is either limited or very limited. Where provided orally, the key barriers to effective provision of accessible information were considered to be a lack of social worker time, insufficient attention to parental stress and its effects on parental ability to absorb or process information effectively, and insufficient use of visual aids.

*Social workers are too busy to explain (team manager)*

*Social workers say we need to have a legal discussion and parents think it means the children are being taken away. If it's stressful (for parents) it makes understanding a lot more difficult (social worker)*

Professional interviewees believed that information provided in documentary form is driven more by the demands of the statutory processes than the needs of parents with learning disability / difficulty. This information is not generally considered to be user friendly, with the exception of some documents relating to the court process.

### Area Two: Limitations in Social Worker / Parent Communications

The case file analysis provides indicative evidence that **some social worker / parent communications are less than effective** (in 25/70 or 36 per cent of these cases). Features of the less effective communications between social workers and parents identified in the case file analysis included:

- Many or most key communications / conversations held over the telephone (rather than face to face) for example talking through a proposed Safety Plan over the telephone. This often felt like 'arms' length' social work.
- A more overtly judgemental approach taken by the social worker from the start.
- Over-reliance on the parent(s)' legal advisors to explain things to them.

- Focus of conversations on past concerns rather than exploring with the parent their current strengths and the current concerns.
- Expecting parents to respond to written directions or assessments without much explanation (and sometimes not supporting them to access any tailored support as a result).

Parents interviewed for the study sometimes provided examples of less effective communications they had experienced with their child's social worker including: feeling that the social worker was unsupportive, distant, or trying to 'catch them out' in some way; being told that their past experiences (particularly as a child) meant that their parenting would inevitably be impaired; feeling that they were being judged just because of their learning disability; being told not shown; feeling that being honest makes things worse; or feeling that they had been given 'only one chance'.

*She could have done more, you know, to help me, you know, to try and be able to become a parent. She could have shown me what road I had to go down so I could become the parent that they wanted me to become (parent)*

*Social services kept saying to me you be honest with me (will) help .. but that didn't help me. Me being honest made things worse. The way I look at it well if you've been in foster care and you've been diagnosed with this and that, you'd wanna make a better life for your child (parent)*

Most professionals interviewed for the study described the quality including clarity of communication with parents with a learning disability as variable, depending on a number of factors including in particular: the ability of the social worker / other workers to communicate effectively, and the parent's willingness to engage. They could also identify some cultural barriers to effective communication with parents with learning disability or difficulty, including the expectation of social workers that other workers would do the 'showing, not telling' rather than themselves. Whilst some social workers described having been provided with training specifically in communicating with people with learning disability or difficulty, others hadn't received such training and some thought that there was a need for more consistent guidance in this area.

### **Area Three: Limitations in Advocacy Support**

The availability of advocacy support for parents with learning disability / difficulty appears to be limited in some local authority areas in particular. In 80 per cent (56/70) of the cases in our case file sample, parents didn't appear to have received advocacy support. Whilst a small number of parents had been offered but declined such support, there were others whose case files suggested they could have benefited but who clearly hadn't been offered it.

Professionals in some areas described how advocacy support is routinely offered to parents whereas in other areas the perception was that this is not done routinely.

Where advocacy is provided and accepted by the parent(s), it was considered by professional interviewees to be mostly very helpful in terms of providing: practical support (for example to get to meetings); support to understand processes or to contribute to meetings; and broader emotional support for the parent. It was also acknowledged by professionals that this case work can be very time-consuming.

Similarly, whilst in some areas, parents were considered by professional interviewees to be well-supported within statutory processes more broadly, in others they were not thought to be so well supported.

*We have got (much) better at family-focused conferencing and co-producing generally* (social worker)

*Parents can be part of the process but not participating* (team manager)

*We do develop plans, but I don't know how much Mum actually contributes to them* (social worker)

#### **Area Four: Limitations in Support for Parents from Adult Social Care Services**

There is indicative evidence from both the case file analysis and professional interviews that Adult Social Care Services are declining involvement in assessments and/or to support elements of a Children's Social Care-led intervention in a number of local authority areas or individual cases, including where their involvement might be helpful or very helpful.

Professional interviewees in most if not all local authority areas believed that it is very difficult in practice to obtain support from their Adult Learning Disability Team unless the parent has an IQ of less than 70 and/or they already have a (adult) social worker involved with them. Many of these interviewees considered that the criteria is currently set too high and does not take sufficient account of the actual vulnerability and functioning of the parent concerned.

*They say there are no care and support needs but they're very vulnerable (some parents with learning disabilities)* (team manager)

*Often, our referrals are not accepted* (social worker)

*Some parents are crying out for this kind of support but are not given it* (team manager)

*Adult services see parenting as children's services' role, not theirs* (team manager)

The case file analysis suggests a significant variability in the frequency of involvement of Adult Social Care Services in assessments (from no cases to 62 per cent of cases in different local areas).

In some cases, of course, it would not have been appropriate (or desirable from the perspective of the parent) to involve the learning disability service in this way. However, in other cases, researchers noted that involving the service might have been helpful, in particular where the parent was vulnerable within the community (for example because of a combination of learning disability, mental health problems, and their own childhood experiences) rather than just because of their IQ score.

### **Area Five: Limitations in the Tailoring of Support**

In over a third of cases in the case file cohort (39 per cent or 23/68 cases where it was possible to make a judgement about this), the support offered as part of the Care and Support Plan did not appear to be tailored to the needs of a parent with learning disability / difficulty either in terms of the type of support or the way in which it was delivered. Analysis of the family outcomes in these cases suggests that poorly tailored support can have an impact on the extent to which a parent with learning disability / difficulty engages successfully with it. For example, in only a very low proportion of cases where parents didn't engage well with the support (2/20) was this support considered by researchers to be well-tailored to their needs (in a further 7/20 cases, the support was considered partially tailored).

However, the case file analysis also provides indicative evidence that the reasons for support service failure to engage parents successfully (and for children therefore being unable to remain living at home with their parents) are likely to be much more complex. The drivers of failure to engage may also include for example: parents being isolated from any family and community networks; increased risk factors for abuse or neglect (particularly parent vulnerability to abusive adults and domestic abuse); and / or an underlying lack of parental motivation or ambivalence about the parenting task. The limitations of case file analysis means that it is difficult to be clear about the extent to which an apparent ambivalence about parenting is real or rather a manifestation of the parent's lack of understanding about the concerns, mental health problems, lack of positive parenting role models, or merely the parent anticipating losing the child. Certainly, many of the parents interviewed for the study described having been aware at an early stage of the likelihood of losing their child and one described how she thought this prevented her from attaching well to her child:

*I thought I couldn't get attached to her.. just in case they did take her (parent)*



Another parent described having been 'on edge' during the early months after her child was born. Other parents described not having understood (and having been unhappy about) the referrals to children's social care services.

Interviews with professionals suggest that there are pockets only of specialist support services or of excellent practice currently available to support parents with a learning disability within the community although, where they exist, these are highly valued. Moreover, there is an acknowledgement that some more generic parenting support resources just aren't sufficiently consistently tailored to meet parents' needs.

*It looks like parents are being offered a lot (currently) but it is not tailored, hence not meaningful or successful (service manager)*

Other specific gaps are thought to be for specialist parent and baby placements either pre-birth or pre-proceedings.

### **Area Six: Delays in assessing child and family needs or in providing support**

In a number of cases within the case file analysis and across all local authority areas, specialist assessments appeared to be commissioned relatively late in the family intervention, for example within court proceedings or as a result of a court order within care proceedings. These delays limited their potential for directing effective support plans in an acceptable time frame.

In some cases, a referral was made to Children's Social Care Services and an assessment of the unborn child's needs in the context of their parent(s)' circumstances was undertaken 'pre-birth', but the parent was not then offered any support until the baby was born.

Professionals interviewed for this study sometimes acknowledged that these could be unhelpful delays and that it seemed that they were embedded within organisational norms affecting individual workers' responses to individual families.

By contrast, one of the parents interviewed for this study described how having support prenatally had helped her to organise herself in practical terms for the baby's arrival and also to separate from an abusive partner.

*They helped me loads and got clothes and everything. It wasn't a nice house; my ex-partner was like being with a kid. He was making more mess. Never able to clean it. She (the worker) was lovely (parent)*

Another parent (father) described not having received much early support, including during the pregnancy of his partner. He would have liked more support then, including to help him recover from his own (abusive) childhood experiences before becoming a parent.

*Having somebody by me, they would have got me through that .. I could have forgot about my past and then become a first-time parent (parent)*

## **Area Seven: Limitations in the Availability of Support for Vulnerable Adults in their own right**

In particular after children have been removed from the care of a parent with learning disability, this study suggests that it is very likely this parent will be or continue to be very vulnerable including to abusive adults within the community (this was thought to be the case for a large proportion, 20/32, of the parents whose children were removed from their care within our case file sample).

However, very few parents in the case file cohort appeared to be offered support in their own right as a vulnerable individual from either the child's social worker or any other worker or service after their child came into care. Interactions with the child's social worker often ended abruptly at the point at which the child came into care or at the end of court proceedings. Two parents interviewed for this study described how it felt to have support ending in this way:

*She doesn't come, I speak to her on the phone. She doesn't come out to see me, no. I've been here eight months now and she haven't come here once. I think that all she wants now is to get the case ended and, you know, get with the adopters and you know (parent)*

*We don't really see Social Services since the court (parent)*

Whilst some professionals identified recent innovations such as the 'Reflect' Programme in theory offering ongoing support to a parent after a child has been removed, it was acknowledged that these are not specifically tailored to parents with learning disability and are only available after a first child has been permanently removed (after the Care Order has been made).

*There should be more support once a child has gone and then they're just dropped (social worker)*

Some professional interviewees also wondered why there wasn't more support for adults and parents with learning disability generally, including before they become pregnant, in particular in relation to healthy relationships.

## 6. Study Conclusions

This study provides indicative evidence that:

- There is insufficient reliable information about the number and proportion of children of parents with learning disability involved with Children's Social Care Services and/or coming into care upon which to base an opinion about the extent to which they are over-represented in this population. One of the main reasons for this is the absence of a sufficiently clear national definition and guidance for Children's Social Care Services in how to identify and record such a disability (for the purposes of estimating a true proportion). However, accurate recording is further complicated by a range of other factors that may be present including parental reluctance to disclose a disability or differential causes of parental difficulties in processing or responding to information, for example a parent's own history of trauma, abuse or neglect or mental health problems.
- Learning disability is rarely the only concern and reason for parents being referred to Children's Social Care Services and for children to be taken into care. It is difficult to disentangle a main factor in what are usually relatively complex cases, but other commonly presenting factors include: parental or family characteristics (that can also present risks) including parental substance misuse, domestic abuse, and/or parental mental health problems; poor home conditions; or parental vulnerability to abusive adults in the community. In many cases, the child of concern to services already has older siblings or half siblings in care.

However, it is clear that professional cultures and systems that encourage 'fast-tracking' of new parents into Children's Social Care Services or through court systems naturally place some parents at a disadvantage in terms of the time they will have to prove themselves as effective parents. Similarly, social work assessments that are not well-rounded and/or specialist assessments that are undertaken late or in inexperienced hands also have the potential to limit parental ability to benefit from services that are well-tailored to their needs at the very least.

Apart from well-tailored support services, supportive key (including social) workers and extended family members are clear resilience factors in addition to the parent's own internal resilience and motivation to parent.

- Although there are pockets of good practice and some parents with learning disability supported effectively to care for their children, there is still much room for improvement including in: identifying and effectively exploring the impact of learning

disability on parents' capacity to parent in a timely way; providing parents with good quality and accessible information about what to expect from Children's Social Care Services; ongoing effective communication between social workers and parents; the provision of support to parents who are vulnerable in their own right (including in part but not only because of their degree of learning disability); the availability of advocacy; the availability of support sufficiently early, including to take into account the particular needs of parents with learning disability who are expecting a baby; and ensuring that the support offered to parents with learning disability is sufficiently well-tailored to their needs.

## **7. Study Limitations**

The methodology section to this report identifies some limitations within the study methodology, in particular in relation to the number of case files we were able to examine across five local authority areas (70 rather than 100) and the extent to which they can be said to be very representative of all recent cases of parents involved with Children's Social Care Services.

More generally, key study limitations are that:

- The quantitative data sourced in relation to Research Question One has significant flaws for the purposes of estimating proportions of parents with learning disability in the key statutory populations of children, as described in Section Three, to the extent that this key question cannot be answered by the study.
- The other, mostly qualitative elements of this study provide indicative rather than conclusive evidence of findings listed in Sections Three to Six above.

## 8. Recommendations

Our seven recommendations for the future development of practice in this area linked with the findings outlined in this report are as follows:

1. Develop an improved national definition of learning disability to assist local authorities in identifying parents with a learning disability and recording these instances accurately for statistical purposes. In addition, Welsh Government and All Wales Heads of Children's Services to work together to develop an easily understandable protocol to assist social workers to interpret the definition and to apply it accurately. Consider how other, for example community health services, may record the number and proportion of parents with learning disability in broader populations, for example of new parents.
2. Require the national or local development and provision of easy read, accessible information about being a parent and / or being involved with Children's Social Care Services and the family court. Information could be provided in the form of more traditional documents as well as websites, apps and video links.
3. Develop national guidance and consider mandatory training for social workers on:
  - how to identify parent learning disability / difficulty (including alongside other presentations for example mental ill-health or substance misuse) in a timely and effective way;
  - how to communicate effectively with parents who have a learning disability or difficulty;
  - when advocacy should be provided; and
  - best practice in conducting assessments where a parent has a learning disability.

Consider including other (early help) professionals in the guidance to facilitate earlier and more effective screening and support for parents with learning disability.

4. Encourage the development of effective protocols between Adults and Children's Social Care Services to help improve joint working and support between these services. These will help in particular to:
  - determine eligibility and access arrangements for vulnerable parents with learning disability to receive support, including when pregnant;
  - clarify roles and ways of joint working when both services become involved;
  - improve communication and the handling of referrals between adults and children's services;
  - enable use of budget flexibilities; and

- promote joint training opportunities.

It is probable that some such protocols already exist in parts of Wales and it would be good to build on effective practice already in place in these areas. Consider incentivising joint budget arrangements.

5. Encourage and incentivise the provision of early support to parents who may have a learning disability / difficulty and who are known to be vulnerable, for example because of adverse childhood experiences. For children referred to Children's Social Care Services pre-birth, this should be in addition to a pre-birth assessment and / or even before the 20 week 'threshold' commonly in place currently.
6. Promote more consistent provision of well-tailored support services to meet the needs of parents with learning disability / difficulty, whether support is provided in the parent's own home or in a parent and baby placement. This could be undertaken for example: by spreading awareness of what 'good' looks like (with support from Social Care Wales); and / or by providing national support for innovation and service development in this area via an injection of national grant funding for local or regional projects.
7. Promote more consistent provision of support for adults with learning disability / difficulty immediately after a child has been removed from their care with a view to helping them to address the issues that have had an impact on their ability to parent effectively and / or to care effectively for themselves.

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## Appendix 1: Child, parent and referral characteristics within the case file analysis cohort

### Key child age, gender, ethnicity and known disability

The age range of the key child of the family at the point of referral to Children's Social Care Services was between under 1 year (including in utero) to 15 years.

- In the majority of cases (37/70 or 53 per cent), the key child of the family was aged under one year. 25/37 of these children aged under 1 year were referred whilst in utero (mother pregnant); 4/37 at birth (whilst still in hospital); and 8/37 as an infant.
- In 50/70 or 71 per cent of cases, the key child was aged between zero and four years.
- In 11/70 or 16 per cent of cases, the key child was aged five to eleven years.
- In 9/70 or 13 per cent of cases, the key child was aged 12 to 15 years.

Of the cases where the child's gender was known (69/70) 55 per cent were male and 45 per cent were female.

67/70 or 96 per cent of the key children's ethnicity was described as White Welsh or British. In 2/70 cases, the child's ethnicity was described as White and Asian and in relation to one further child, White and Black African.

In 42/70 or 60 per cent of cases, either the child had no known learning disability, or it wasn't yet possible to ascertain whether they had a learning disability. In 19/70 or 27 per cent cases, the key child was considered to have a mild to moderate learning disability and in 4/70 or six per cent of cases a severe learning disability. In 5/70 or seven per cent cases, the key child was considered to have a physical disability or physical disability and learning disability.

### Parents and siblings

In almost all (69/70) cases, the main parent was the natural mother. In the other case, the main parent was the natural father. There was evidence of parental learning disability / difficulties across a spectrum including:

- 3/70 (4 per cent) of main parents with what appeared from all the evidence to have **significant learning disability** (including a lack of capacity to make decisions on their own behalf and/or to live independently).

- 25/70 (36 per cent) of parents with what appeared to be a **moderate learning disability** some of whom were eligible for if not already working / in contact with adult disability services.
- 29/70 (41 per cent) of main parents with what appeared to be a **mild learning disability** including with reference to difficulties in: reading and writing, processing and weighing up information, retaining information / remembering things, and responding to instructions; and/or Autistic Spectrum Disorder.
- 13/70 (19 per cent) of main parents with what appeared to be a **learning difficulty** (rather than a learning disability).

In some cases, the degree of learning disability / difficulty was difficult to ascertain with any precision as it was never clearly established on the case file (for example through a current or reference to an earlier capacity assessment or parenting assessment incorporating a parenting capacity element). In many cases, the impact of the learning disability / difficulty was difficult to disentangle from the impact of other parental issues or presentations, most commonly mental health problems.

The age range of the main parent (mostly Mum) at the time of referral was between 17 and 52 years including:

- One main parent whose age was unknown.
- Two main parents who were aged 50 years or over.
- Seven main parents who were aged between 40 and 49 years.
- Twenty-eight main parents who were aged between 30 and 39 years.
- Twenty main parents who were aged between 22 and 29 years.
- Ten main parents who were aged between 18 and 21 years.
- Two main parents who were aged 17 years.

The average age of the main parent at the time of the referral was 30 years.

25/70 (36 per cent) of these main parents were single parents. By contrast, 45/70 (64 per cent) were co-parenting at referral, mostly with the child's natural father but also sometimes with step parents or other family members, such as their own parents (child's grandparents).

Of these 45 co-parents:

- 19/45 had no ascertainable learning disability.
- 20/45 had signs of mild learning disability.
- 6/45 had signs of moderate learning disability.

A proportion of the children thought to have a single main parent also had another natural parent living nearby, this other parent was often but not always in contact with them and their mother.

24/70 (34 per cent) of the key children in the case file sample had siblings or half siblings living with them in the family home including:

- 13/70 (19 per cent) with one sibling living in the family home.
- 7/70 (10 per cent) with two siblings living in the family home.
- 3/70 (four per cent) with four siblings living in the family home.
- One child with five siblings living in the family home.

26/70 (37 per cent) of key children in the case file sample had siblings or half siblings living away from their main (in all cases mother)'s care including a high proportion who had previously been taken into care because of safeguarding concerns:

- 14 children with one sibling living away from their mother's care (mostly looked after, adopted, or living with a family member under a Special Guardianship Order).
- Two children with two siblings living away from their mother's care (both looked after or adopted).
- Four children with three siblings living away from their mother's care (mostly looked after or adopted or with a Special Guardianship Order).
- One child with four siblings living away from their mother's care (adopted or with a Special Guardianship Order or with the other parent).
- One child with five siblings living away from their mother's care (all adopted).
- Two children with six siblings living away from their mother's care (looked after or adopted or deceased).
- Two children with eight siblings living away from their mother's care (looked after or adopted).

## **Referral Sources**

The families had been referred to Children's Social Care Services by a range of agencies, most commonly NHS organisations (in 30/70 or 43 per cent cases). Of these NHS referrals, the most frequently referring services were: Community Midwifery or Nursing (18/70 or 26

per cent of the overall cohort); and Health Visiting (7/70 or 10 per cent of the overall cohort). Other NHS referring services were: Hospital Midwifery or intensive care and General Practice.

**Table 3: Source of and Reason for Referrals**

Source	Frequency
NHS	30
School	10
Police	8
Housing	5
Other local authority	4
Self (parent) referral	3
Adult social care	3
Internal other children's services	3
Anonymous referrer	2
Council transition team (child to adult disability service)	1
Voluntary sector (learning disability support service)	1

## Appendix 2: Summary questions used in interviews with parents

- When you became pregnant:
  - How old were you?
  - Where were you living?
  - Who were you living with?
  - Were there other people who were important to you?
- While you were pregnant:
  - Did you still live in the same place?
  - Did you still live with the same people?
  - Did you still have the same people who were important to you?
  - Did anything else change while you were pregnant?
- What were your feelings about being pregnant?
- What kind of support did you have, if any, while you were pregnant?
- What happened after the baby was born?
- What kind of support did you have, if any, after the baby was born?
- If your child had a social worker, what did you understand was the reason?
- How did the social worker help, if at all? What could they have done better? How easy was it for you to contact the social worker? How easy was it for you to talk honestly with the social worker? Did they understand your needs and concerns?
- What other support did you have, with parenting or with communicating your views, if any?
- How long did the support last? Was it for too long, just the right amount of time, not quite long enough or not long enough at all?
- Did the support help you to care for your child (for example a lot, quite a lot, a bit, not at all)? How could it have been better / even better?
- How are things now?

### **Appendix 3: Summary questions used in interviews with professionals**

- How easy or difficult is it to identify parents with a learning disability (with a view to providing support)?
- To what extent is there accessible information and advice for parents with learning disabilities about support services and how to access them?
- How do parents with learning disability experience being referred to Children's Social Care Services?
- To what extent do parents with learning disability experience clear communication (about what is happening and why and what is required or expected of them and what support they can access) within the statutory process?
- To what extent are parents with learning disability supported to be good enough parents by statutory and/or other services where their children have a care and support plan?
- To what extent are parents with learning disability supported for long enough?
- To what extent is preventative (early help or pre-birth) support accessible to parents with learning disability including before a care and support plan may be indicated?
- To what extent are parents encouraged and supported to participate in the child protection process or other statutory plans?
- To what extent is the parenting capacity of parents with learning disability well assessed?
- To what extent do adult social care or broader council services support the wellbeing of children, parents with learning disability and families?
- To what extent are parents with learning disability involved unnecessarily with social care services or have their children taken into care unnecessarily?
- How can we best promote good practice in working with parents with learning disability?



## Appendix 4: Case Studies

These cases studies representing more positive and more limited practice are derived from the case file analysis element of the study. All real names have been changed to protect the anonymity of participants.

### Case Study: Wendy

Wendy's unborn child was referred to Children's Social Care Services by her midwife referencing concerns that an older child had been removed to the care of a grandparent because of neglect, and both prospective parents' current mental health problems. Wendy was being supported by the Adult Learning Disability Team, including because of difficulties remembering to do things and in understanding other people's needs. Her partner was also thought to have mild learning disability.

The child's social worker clearly took time with Wendy to explain the concerns and to acknowledge Wendy's difficulty in absorbing information. The assessment (including generic and specialist PAMs elements) was strengths-based and led to an informed plan of intensive support, tailored to Wendy's needs (for example for visual prompts, repetition, practical help with specific tasks). The plan included tailored one-to-one parenting support; advocacy; emotional and practical support from the child and adult social workers; and regular respite care for the child with a known foster carer is built in (in part because the child also has special needs).

Easy read and/or pictorial notes were provided for Wendy after key meetings and pictorial forms were also utilised to capture her views about services and plans. She has had access to an advocate throughout.

### Case Study: Stephanie

Stephanie was referred by her midwife into Children's Social Care Services because of missed ante-natal appointments but there were already Police concerns and call-outs to the home because of domestic violence incidents and alleged financial abuse of Mum by her partner. The unborn child's father was also known to abuse drugs and to have an offending history including sexual offences. Mum had mental health problems, was known to the Community Mental Health Team and was self-harming. Stephanie had gone to live with her own parents but the home conditions there were also thought to be very poor.

Stephanie's (mild) learning disability was identified during the social work assessment through interactions with her. Stephanie was engaged effectively by her (unborn) child's social worker and provided with timely access to advocacy and to an intensive, tailored family support package of 12-month duration including:

- a parent and baby placement,
- followed by a placement in semi-supported living and wrap-around tailored parenting support including some specialist (learning disability specific) parenting support services and groups.

Stephanie was also offered support from Adult Social Care Services but declined their involvement.

Mother and child have made good progress and the Care Order (requiring the child to be placed at home) has recently been discharged. However, there are signs from the file that Mum may require some ongoing support with parenting as well as with her own self-care.

### **Case Study: Veronica**

Veronica's son (aged seven years) and sibling were referred by school to Children's Social Care Services because of their challenging behaviour and low mood. Both children are thought to have mild to moderate learning disabilities. Veronica herself is thought to have moderate learning disabilities and is supported by Adult Social Care Services. She also takes medication for her own low mood.

There had been other referrals to Children's Social Care Services and earlier care and support plans, these also relating to concerns about the children's behaviour and about the cleanliness of the home and/or domestic abuse. Veronica had also received earlier support from Flying Start and Home Start services.

Veronica received clear and effective communication from the children's social worker and a sensitive, strengths-based assessment involving the Children's Service and Adult Learning Disability Team combined.

Non-intensive but tailored including practical support was provided within the home. This support focused on building Veronica's confidence and skills in caring for the children as well as household routines, combined with access to appropriate group-based support networks outside of the home (for both Veronica and the children). The support was organised by Children's Social Care, Adult Social Care and community health (mostly Flying Start) services combined. It emphasised continual reinforcement of key aspects of parenting and self-efficacy and support to practice and embed these.

Veronica engaged very well with the support and has more recently initiated some community-based support for herself.

### **Case Study: Penny**

Penny's unborn child was referred to Children's Social Care Services by the Police who were concerned about a man who is a known sex offender visiting the home. Penny had three older children who were taken into care previously because of neglect. Her partner also had older children taken into care previously and is a registered sex offender. Penny has mobility issues and mental health problems. At the time of the referral, she was isolated from her own family with whom there was some degree of ongoing conflict. It was never clear from the case file analysis what form or level of learning disability Penny has, although it was noted that she has difficulties in retaining information and performing some basic parenting tasks.

The prospective parents were visited once prior to the birth of the child, including to undertake an assessment. The social worker attempted then to involve intensive community-based family support services to deliver a pre-birth parenting programme one to one with the prospective parents, but the child was born prematurely so only two sessions were undertaken.

After the child was born, they became subject of an Interim Care Order and spent some time in intensive care before being placed with Penny in a parent and baby placement, and a PAMS assessment was commissioned. It was noted on the file that the parent and baby placement was not an experienced, specialist placement, more a 'normal' foster placement adapted to take in this family. Penny engaged quite well initially with the placement but there were documented difficulties in communication between the foster carer and Mum (the foster carer was described as 'dismissive and condescending' by some other workers). The PAMS assessment concluded after 3 months that Mum hadn't made enough progress in addressing the concerns and was unlikely to be able to meet the needs of the child (with their own special needs) over time.

### **Case Study: Miranda**

Miranda's unborn child was referred to Children's Social Care Services when she was 16 weeks pregnant and aged 19 years, living with her boyfriend's family. The concerns were that she was consuming a lot of alcohol and self-harming, also that an older child had been taken into care previously after a short period of time with Mum in a parent and baby placement. In the proceedings relating to the older child, Miranda had been identified as having significantly impaired intellectual capacity including a lack of capacity for legal instruction. Two referrals were made to Children's Social Care Services before being accepted. The assessment undertaken at a late stage also identified some degree of domestic abuse and alcohol misuse perpetrated by the prospective father. Mum developed a relationship with a new partner very quickly afterwards.

An early application was made to the court for an Interim Care Order and this was followed by a parent and baby placement.

The early and ongoing conversations between the social worker and Miranda were very limited, based mostly around telephone calls, with the social worker emphasising the coordination of activities such as the arrangement of a parent and baby placement and PAMS assessment to be undertaken by an independent consultant alongside it. The PAMS assessment identified that Mum and her partner would need a highly bespoke parenting programme to help them to acknowledge and work on a range of identified issues.

Although the parents engaged in the parent and baby placement, it failed relatively quickly (within four weeks) because of concerns about the physical handling of the baby and the plan moved relatively quickly to finding an alternative permanent home for the baby, before any highly bespoke programme could be put in place.

### **Case Study: Helena**

Helena's unborn baby was referred to Children's Social Care Services by Housing Services who were in the process of repossessing Helena's home because of its extremely poor condition. There were concerns, in this context, for the wellbeing of the unborn child. Helena was relatively young and a first-time mother. She was thought (from previous involvement with Social Care Services and CAMHS as a child) to have learning difficulties combined with ADHD and mental health problems, resulting in difficulties in focusing, planning and self-regulating. She was also thought to be extremely vulnerable, engaging in frequent casual sexual relationships, meeting men on social media, and with very complex emotional needs and responses. The father of the baby was unknown.

The social worker initial and ongoing communications were effective, including clear and accessible information being provided during the assessment period to describe the concerns.

After a pre-birth assessment, the social worker attempted to organise intensive 'edge of care' support for Mum but the baby was very premature, so this did not happen. The baby was removed at Interim Care Order stage (with reference to Mum's significant needs, particularly that she becomes frustrated easily and has a personality disorder) so the support for Helena awaiting the final Care Hearing was in relation to her supervised contact with the baby. This support was well-tailored in that it was delivered by parenting programme-trained support workers, modelling and advising Helena about basic baby care skills and supporting her to implement cleaning routines in the home. However, it

was also limited in that it couldn't support Helena in her own home, with the baby living with her.

Helena attended all contact sessions and child reviews and was open to all social worker visits during this time. However, the capacity assessment undertaken in relation to Helena during this period concluded that she would not be able to parent the baby safely or respond positively to therapy at present.