Assessment and evaluation for early intervention services.

These are collected ideas on what can be evaluated and monitored during the process of the work of a multidisciplinary infant mental health service, or for that matter any team working with children in the early years such as a children's centre. They are based on the working group held at the Anna Freud Centre and what has been found in the literature. This document will be kept updated. A recent paper provides an overview from a slightly different perspective. Eduardo Szaniecki and Jacqueline Barnes (2015) *Measurement issues: measures of infant mental health.* Child and Adolescent Mental Health, published online 23rd April. It has a comparison table of structured questionnaires and mentions a few observational methods. The CORC website also has a plethora of measures for all age groups http://www.corc.uk.net/resources/measures/.

I have made a division into eight domains (there is a lot of common ground) and in the appendix are some early years assessment measures where either further information is hard to find or they do not seem quite suitable. These have been retained as they might fit a specific bill for a different setting. Feedback and further information would be welcome on all measures. Speaking personally, I see no point in doing any sort of evaluation / assessment unless it helps the caregiver understand their infant, and can be communicated in everyday language.

These are the slightly overlapping areas of assessment considered (by section not page number):

1) parenting skills and actual interactions between parent and infant;
2) the parent's perception of the infant, or of their own parenting;
3) the stresses that the caregiving relationship is under;
4) the quality of the caregiving relationship, including attachment;
5) the child's social and emotional development as well as his or her global development;
6) the state of mind of the parent;
7) some more public health oriented indices which might interest commissioners;
8) and client feedback at end of contact.

Measures need to be appropriate for children under the age of two. They might sometimes duplicate or overlap with those used by heath visitors, community pediatricians or adult mental health services. Any measure should not dominate a session when it is being applied, and should preferably produce clinically useful information that will be understandable by the client and relevant to partner agencies and commissioners. They should also be

moderately less likely to generate fake, or false positive, responses. Evidence shows that collecting outcome measures improves outcomes. There are three different levels to consider here: clinical practice, routine outcome measures and finally those for research and RCT purposes.

A massive list of tools for evaluating home visiting has been published by DOHVE - http://www.mdrc.org/dohve-project-resources and also on http://www.mdrc.org/sites/default/files/img/DOHVE%20TA%20Compendium_Updated.pdf Handy for a quick and extensive overview. Also, CORC have already made some suggestions in this field, and I can send them if you are interested, email me at: robin.balbernie@pipuk.org.uk

Head Start in America has developed a range of evaluation tools for looking at outcomes in the early years. See: http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/family/assessing and explore the links that follow for many examples.

The Social and Emotional Assessment Group that contributed to the recent report from the DoE and WAVE, 'Conception to Age 2 - The Age of Opportunity' (see: http://www.wavetrust.org) listed the principles behind the selection of methods for assessment in the early years. Full report available.

They were:

1. The purpose with all assessments of a child's social and emotional wellbeing should be to establish the level of social and emotional functioning of the infant in addition to the sensitivity/responsiveness of relevant carers in order to guide the family and the practitioner towards the most appropriate support and intervention for the family within the context of a gradient of need.
2. Assessment tools should be practical as well as valid and reliable, based not only on sound research and evaluation but also on a high likelihood of it being implementable as part of a busy practice.
3. All assessment tools need therefore to make sense to parents and carers, and to be seen as supportive rather than judgemental; this requires that such tools be implemented as part of a promotional and partnership model of working.
4. Measures and methods must be usable across the whole spectrum of ability including social disadvantage, disability, culture and language
5. Finally training in any proposed assessments must be easily accessible and not prohibitively time consuming or expensive.

Beyond validity, there may be other questions to answer to see if a parenting assessment tool will be useful, the following are based on ideas from KIPS:

1. Does it document outcomes that match agreed service goals? i.e. Will it make sense to clinicians, parents and commissioners?
2. Is it clinically useful, identifying the parent's individual strengths as well as any areas needing improvement? Are the assessed behaviors potentially changeable and the changes measurable?
3. Will it provide information relevant to quality of parenting?
4. Can the answers / behaviours being measured be easily simulated? This applies to the child as well, as by 15 months a toddler is capable of faking false positive behaviours and affect
5. Is it sensitive enough to note parents' progress, or where further work needs to be done? Is the assessment information useful in planning and promoting services?
6. Is it designed so the information makes sense to a parent and can be used to reinforce a parent's progress and build their confidence?
7. Does it highlight parent-child interaction?
8. Does it provide easy to understand language that can be shared with parents, team members, and other agencies alike?
9. Does the assessment information support reflective practice, promoting both 'mind-mindedness' and reflective supervision?
10. Does it provide information and data that will be helpful in continuous improvement of both the staff and the service?

1) Parenting / interaction assessment tools.

Some examples:

1. The CARE index (created by Patricia Crittenden) was developed for use with high-risk populations. This covers 0 to age 2 or 3 and assesses mother-infant interaction by using about 5 minutes of videoed play. It codes sensitivity in a free play situation. See http://www.patcrittenden.com/include/care_index.htm The coding system is comprised of seven scales: three parent descriptors (sensitive, controlling, unresponsive) and four infant descriptors (cooperative, difficult, compulsive and passive), each one having two points allocated, giving a total scale score of 14 for the parent and child each. Seven aspects of maternal interactive behavior are evaluated, including facial and vocal expression, position and body contact, expressions of affection, pacing of turns, control and choice of activity. The training is expensive and lasts about 13 days. Apparently reliability is difficult (and more expensive) to achieve. But this does give a good, fine-grained, assessment of parental sensitivity and baby's responses, and also can pick up frightening / frightened behavior. What is called

"false positive affect" in the baby is a form of dissociative behavior, indicating a high-risk situation. Other measures may not detect this.

2. The Keys to Interactive Parenting Scale (generally known as KIPS). See: http://www.comfortconsults.com/ This is video based and gives a way of evaluating 12 different aspects of parenting behavior from analyzing about 15 minutes of interaction. Can be used from age 2 months on. (I can send a description and a recent study.) The scores on 12 scales may be recorded and provide a quick profile for evaluating changes. On-line training ($150) and back up, and so good value. Re-accreditation necessary on a yearly basis and the cost of annual recertification is $60. KIPS produces clinically useful information that can be fed back to caregiver, and can pinpoint clearly defined strengths and thus be used as a basis for video feedback. In America this tool is recommended by The National Child Traumatic Stress Network http://www.nctsn.org/content/keys-interactive-parenting-scale and the Californian Evidence-Based Clearinghouse for Child Welfare http://www.cebc4cw.org/assessment-tool/keys-to-interactive-parenting-scale/ This measure concentrates rather more on actual parenting behavior and does not specifically look for markers for problems or disorganized attachment in the child. One scale is for sensitivity, and here the use of slow motion helps identify moments of mutual interactive regulation – 'serve and return' dialogues; this is separated from the capacity to appreciate and respond to the child's emotions. The scores can be used to show changes during treatment, with one caveat. There is one problem with quoting the total score on KIPS if not all dimensions have been rated, i.e. when there are some "Not Observed" dimensions. If there are missing dimensions the total should be pro-rated before being recorded, i.e. (current total / no. of dimensions scored) x 12 = pro-rated total score. This give a better picture of change, and quoting the individual dimensions refines this down further if needed.
3. The Parent-Infant Relational Assessment Tool (known as PIRAT) has recently been developed by the Parent Infant project at the Anna Freud Centre and further revised by Carol Broughton. This is an excellent observational measure designed to assess the dyadic quality of parent-infant interactions in a variety of settings. PIRAT provides global ratings of parent-infant and infant-parent interactions (affects and behavior), including ratings of optimal parenting behavior and risks. Assessment of the level of concern focuses on three major themes: degree of observed dyadic attunement; frequency of behaviours indicating relational disturbance; and severity of observed relational disturbance. It is adapted for infants and toddlers up to age two, and is applied to 'live' or videotaped observations of ten minutes of free play. Training is at the Anna Freud Centre. This takes four days. Information on the

measure and the training at: http://www.annafreud.org/courses.php/47/parent-infant-relational-assessment-tool-pirat-training-for-health-professionals This is based on clinical practice and has been revised and piloted in the field, I have some more details.

4. The Brigance Parent-Child Interactions Scale. This is seen as a measurement of both resilience and psychosocial risk, and identifies both positive and problematic parent child interactions as well as being an indicator of possible delays in development. It is recommended to be used at age 6 months and again at 15 months (or when parents' concerns indicate a lack of awareness as to what is age-appropriate behavior). There is a separate pro-forma for parents' use, which taps perceptions and feelings, or for someone observing the interactions. The parent version can be downloaded from http://www.pedstest.com/Portals/0/TheBook/BPCISinEnglish.pdf and the publisher's website is http://www.curriculumassociates.com/products/detail.aspx?title=BrigEC-Screens3
5. Structured observation is perhaps as good a way as any for noting and comparing significant aspects of caregiver-infant interactions; and this can be used to give 'snapshots' at different points of time. I have an example of a useful format that has been adapted from the IMH service at the Merrill Palmer Institute at Detroit University, which is good for picking up positive interactions. (Could back up PIRGAS, see below.)
6. The Parent-Infant Interaction Observation Scale (PIIOS) developed by Jane Barlow and P. O. Svanberg, that again uses video to analyze parent-infant interaction. Description available. This is designed specifically for health visitors and other front line staff to quickly pick up at-risk families. It is not a tool for outcome evaluation as it is focused on early identification of at-risk interactions only. The training takes 3 days. Well thought out and useful for practitioners.
7. The Emotional Availability Scales provide a method of assessing interaction inn order to gauge the emotional availability of the parent to child and child to the parent. This makes it clinically useful for a psychodynamic approach as it may pick up "ghosts". It is a global measure of overall interactional style in each partner and requires clinical judgement and an awareness of contextual factors. This is video based again. There is extensive research to show that caregiver's emotional availability is highly associated with the infant's later attachment behaviour. Distance training is available http://www.emotionalavailability.com/ea-distance-training-and-certification/ Training is expensive, but cheaper than CARE Index.
8. There is the new 'Parenting Interactions with Children: Checklist of Observations Linked to Outcomes' measure, (or PICCOLO) – an

observational measure of developmental parenting which looks very useful both for assessment and intervention. Unfortunately training is not available in the UK yet, although a training dvd and users guide are available from Brookes Publishing (www.brookespublishing.com) that suggests that a team could self-train. This uses a short period of video to rate parenting behavior on four scales: affection, responsiveness, encouragement and teaching. (See: https://www.youtube.com/watch?v=0mDIMAMLLAc) Unfortunately it begins at age one year, although some aspects cold still be applied earlier and in a way it could also triangulate with KIPS as the same activities are being graded through slightly different lenses. It does not take long to train in and produces clinically salient information. It is meant to be an easier training than KIPS. This has been tested for validity (see IMHJ, 34 (4) 2013) and is psychometrically sound. It has been identified as best practice in Michigan and I have some papers describing its use if anyone is interested. See: http://www.cpdusu.org/projects/piccolo/ and http://products.brookespublishing.com/Parenting-Interactions-with-Children-Checklist-of-Observations-Linked-to-Outcomes-PICCOLO-Tool-P677.aspx

2) The parent's perception either of the infant or of their own parenting.

This will invariably be a subjective snapshot if only done once with a single measure, with the risk that reporting is influenced by mood or events. Also all these are open to falsifying by a parent who fears to be judged as they are frightened of the consequences. Remember, there are studies showing that parental self-report has a fairly low correlation with actual behavior.

1. The Post-partum Bonding Questionnaire (copy available) was devised to screen for problems in the mother-baby relationship. This has four subscales: impaired bonding; rejection and pathological anger; infant-focused anxiety and; incipient abuse. This can be self-scored online, see: http://www.mothersmatter.co.nz/PBQ.htm However, as with so many of parent reporting measures this would be easy to fake in order to produce a false positive. The negatives are not very subtle!
2. The Maternal Object Relations Scale, adapted for babies (original was for age 2-4) as "My Baby" (copy available) would be useful in some situations; but again, very high risk and wary parents could easily produce false positives. Those whom I have spoken to who have used this do not think it suitable for PIP purposes; but they may be wrong! See:

http://oro.open.ac.uk/37587/1/__APPLETON_jmo2_transfer_research_Warwick_1477-7525-11-49.pdf

3. The Working Model of the Child Interview, WMCI, developed by Zeanah and Benoit is widely used in America, and does produce clinically salient information. This takes several days to train in and involves a structured interview that is videoed and assessed. It can produce a clinical opinion on the caregiver's internal representations of the infant. Narrative accounts are classified as balanced, insecure-disengaged or insecure-distorted. It has been shown that responses on the WMCI provide data that indicate the likelihood of attachment security or not in the child. There is a pre-natal version. This is slightly time consuming but useful. See: http://sundspsykologerna.se/files/C.H-Zeanah-et-al-Working-Model-of-the-Child-Interview.1986-1993.pdf It can be applied for a one-off (or forensic) assessment, and can be used with both birth and foster parents as a window into how their perceptions of the same child can lead to quite different behaviours. Training is available in the UK.
4. The newly developed Tool to measure Parenting Self-Efficacy (TOPSE) is currently being used to evaluate parenting programmes in several regions of the UK. Some details available. See: http://www.topse.org.uk There is a version designed for parents with learning disabilities too. I would be interested to hear how helpful this is if anyone decides to take it up.
5. The Adult-Adolescent Parenting Inventory (AAPI-2) is a questionnaire used to assess parenting attitudes and child rearing practices of adolescents and adults. The purpose of the inventory is to determine the degree to which respondents agree or disagree with parenting behaviours and attitudes known to contribute to child abuse and neglect. https://www.assessingparenting.com/assessment/aapi As far as I can see so far this has to be assessed on line. (I have a copy). Responses to the questions are used to assess expectations of children, empathy with children's needs, use of physical punishment, role-responsibilities and children's power and independence. See: http://www.nurturingparenting.com/images/cmsfiles/aapi-2_summary_descriptionaapidescription.pdf for another description.
6. A Parenting Self-Efficacy measure might possibly be useful. There are several to choose form. See: http://www.copmi.net.au/research/evidence-evaluation/parents-carers-families/family-competence.html There is a maternal Self-Efficacy Scale developed to examine maternal depression, infant difficulty and maternal competence. Feedback invited.
7. A well validated and useful looking measure from Australia is the Karitane Parenting Confidence Scale. This was originally developed in a residential setting and revolves around perceived parental self-

efficacy which has been found to be principally associated with the following three areas: 1) *Parental competence* - evidence in this area was considered to be strong, with many studies indicating that high PPSE is related to competent and positive parenting practices, strategies, and behaviours. 2) *Parental psychological functioning* - high PPSE is associated with lower rates of parental depression and higher satisfaction in the parenting role, and to a lesser extent with lower stress and better coping; and 3) *Child adjustment* - low PPSE was found to be associated with child behaviour problems and socio-emotional maladjustment, and to a more limited extent with academic under-achievement and child maltreatment. Also, PPSE has been identified as a mediator of the effects of several historically recognised correlates of parenting quality, including maternal depression, stress, and child temperament. Taken together, the accumulated body of research suggests that PPSE is an important resiliency or protective factor and is a predictor and possible mediator of parenting competence and child outcomes. For the manual and details of the self-report form see: http://preventchildabusenj.org/newsletters/hf_weekly/kpcs_manual.pdf

3) Stresses on the caregiving relationship.

1. These can be noted using a simple check list (available from PIP UK or me; see appendix 2c of 'Conception to age 2') which then gives a quick profile of the difficulties a family faces, enables intervention to be put in on the basis of risk (before maltreatment may have occurred), makes clear other targets for intervention besides direct clinical work and provides both an anonymous description for comparison and data for commissioners and partner agencies. These are risks in the ecology of parents' lives that will have a deleterious impact on the caregiving relationship. It cannot be assumed that such a list will invariably identify all children at risk; also, there is a socio-economic bias and, of course, a child might be maltreated with no obvious family risks being visible. This can be integral to a 'request for service' form, ensuring that referrals carry a range of appropriate information. It also can be used to demonstrate how early intervention work is usually highly complex, needing to deal with a wide range of factors where families are struggling with multiple adverse circumstances. It makes clear that there are no quick fixes.
2. In the Zero to Three DC:0-3 there is another index of risk, their 'Psychosocial & Environmental Stressor Checklist', that has sections covering: challenges to a child's primary support group; changes in the

social environment; education/child care challenges; housing challenges; economic challenges; occupational challenges; health-care access challenges; health f a child; legal/criminal justice challenges; and other (which includes abduction!). Copy available on http://www.zerotothree.org/child-development/early-childhood-mental-health/dc0-3r-forms.html

3. Perhaps the Parenting Daily Hassle Scale would come into this section. This is also a measure that, with a bit of imagination, can be used to evaluate the effects of intervention for both group and individual work. It aims to assess the frequency and intensity and impact of twenty everyday experiences with children that can be stressful to parents. Copy from DoH and https://www.cafcass.gov.uk/media/215160/parenting_daily_hassles_scale.pdf

4) The quality of the caregiving relationship / attachment.

Pritchett, et al. (2010) have overviewed measures of family relationships / functioning. (Copy available.) They have split the measures in terms of 6 different aspects of family functioning: parent-child relationships; parental practices and discipline; parental beliefs; marital quality; global family functioning, and situation-specific measures. They are not limiting to infancy. Also there is a very useful review by Michelle Sleed from the AFC, which I have a copy of.

Another handy online list (all ages and not all measures relevant here) and review is available from The National Child Traumatic Stress network http://www.nctsn.org/resources/online-research/measures-review

1. The Parent Infant Relationship Global Assessment Scale (PIR-GAS). The PIR-GAS is a research-based rating instrument covering the full range of parent/infant relationships used to describe the strengths of a relationship as well as to capture the severity of a disorder. (http://www.zerotothree.org/child-development/early-childhood-mental-health/dc0-3r-forms.html) A clinical interview with the parent coupled with observed behavior patterns allows the clinician to place the relationship into one of nine categories, ranging from well adapted (scoring 100-91) to grossly impaired (10 and under). There is a risk that caregivers might act out positive behaviours while being observed, but the rating can be changed with new information. Relationship difficulties are assessed based on the intensity, frequency, and duration of maladaptive interactions and a score below 40 marks a

disordered relationship. Three aspects of the parent/infant relationship are evaluated in order to classify a disordered relationship: the behavioral quality of interactions, affective tone, and psychological involvement. A bit subjective, but does focus the mind on relationships, and how these have changed. This is best combined with a structured observation form, for example one from the Merrill Palmer Institute or even the Relationship Problem Checklist from Zero to Three. For all its faults is widely used in America and Australia, and is central to Zero to Three's DC:0-3. (https://www.google.co.uk/#q=dsm+0-3) It should be discussed in supervision; and could be used on a team level, perhaps applied to video material. This is the only measure that specifically can be used to evaluate a change in the quality of the caregiving relationship, which might well be an obvious target that is useful for local services, delivery partners and commissioners. It is best applied to video of interaction, in which case could be combined with KIPS.

2. John Condon and team in Australia have developed a questionnaire to assess attachment for both mothers and fathers in both the pre- and post-natal period. These are available from: http://dspace.flinders.edu.au/xmlui/handle/2328/35290

N.B. This is a gap in available measures, so I would be grateful for any further ideas or information on how the quality of the caregiving relationship / attachment can be assessed. However, looking at the interaction though different lenses as in (1) may be as good as it gets.

5) The child's development, global as well as social and emotional.

1. The two Ages and Stages Questionnaires are useful here, and widely used in infant mental health / early intervention services in America and elsewhere. http://agesandstages.com They can be parent completed alone, but are far better done by a practitioner with the parent (after a few meetings) as all the questions can open up aspects of the child's behavior and the parent's anxieties. They do not take very long to complete, and parents like having a copy and this can be shared with other agencies. Make sure you have the latest versions. See: http://www.mdrc.org/sites/default/files/img/DOHVE%20ASQ-3%20and%20ASQ-SE%20Issue%20Brief_Cleared.pdf The ASQ-3 begins at age 2 months and covers communication, gross and fine motor skills, problem-solving and personal-social skills. The scoring and how this relates to a developmental norm are both clear. This is useful if there is a suspicion that the infant may have a developmental

delay, showing up the need for a further referral, and there are allowances made for prematurity.

2. The ASQ:SE2 (second edition) complements the ASQ-3 and focuses on social and emotional development and produces a score which can be compared to their benchmark cut-off score for each age. It can first be used at age two months; and the time taken increases a bit with age as the child can do more things. Many questions link to behaviours one would expect to see if the attachment system is activated. No training needed to administer either of these – but for the ASQ you are often stuck for a clear bottle and a Cheerio! Comes with clear and useful handouts appropriate for each age.
3. Similar but more comprehensive is the SWYC, Survey of Well-being of Young Children, with the great advantage of being free. See: http://www.theswyc.org from where all forms, information and details of scoring can be downloaded. It was written to be simple to answer, short and easy to read. Every form includes sections on developmental milestones, behavioural and emotional development and family risk factors. At an appropriate age a section for screening for Autistic Spectrum is included. It covers from age two months to sixty months. A revised version addresses postnatal depression as a major issue in the development and well-being of young children
4. The Attachment Screening Questionnaire (ASA) developed by The Anna Freud Centre looks at the behaviours of the child in situations where normally the attachment system would be activated; e.g. when frightened or in distress. It carries a series of descriptors coupled to a five point Likart Scale. This looks very useful but I have no further information.
5. The Brief Infant-Toddler Social and Emotional Assessment (BITSEA) that screens for social, emotional and behavioral problems and delays in overall competence. See: http://www.cup.ualberta.ca/wp-content/uploads/2012/06/FINAL_BITSEA_Jun_2012.pdf This spans age 12 to 35 months and seems to be widely used in America, and has been well validated. It takes about ten minutes to complete. Paper on this at: http://jpepsy.oxfordjournals.org/content/29/2/143.full.pdf Also http://www.cup.ualberta.ca/wp-content/uploads/2012/06/FINAL_BITSEA_Jun_2012.pdf
6. The Alarm Distress Baby Scale can be used to assess social withdrawal in children under the age of three. For full information and a download of the scale (after registering) see: http://www.adbb.net/gb-intro.html

6) The state of mind / mental health of the parent(s).

1. The Adult Well-being Scale appears to have a wide use and is regarded as helpful. (Copy available.) Available from the department of Health. You can download this from lots of other sources, e.g. http://www.falkirk.gov.uk/services/specialist/girfec/iaf/pdf/doh/FamilyPackQuestionnairesScales.pdf Not sure if this might not merge infant mental health work into compensating for a lack of adult mental health provision, but this would not apply in a combined perinatal service. The advantage of this, compared with the HADS, is that it also probes for irritability as well as anxiety and depression.
2. The Depression, Anxiety and Stress Scale. http://serene.me.uk/tests/dass-42.pdf No real idea about this, feedback welcome.
3. The Generalized Anxiety Disorder assessment, GAD-7, is widely used. May identify those with real anxiety problems along with the neurotic who like to think they have a problem. Could easily give false positives. See: http://sfaetc.ucsf.edu/docs/gad-7-print.pdf Again the risk of an early intervention team being seen as an adult service. Both caveats also apply to all these measures of course.
4. The Patient Health Questionnaire (PHQ-9) that is designed to pick up depressive symptomology. http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf
5. OXPIP have devised (or found, no reference yet) a risk assessment for suicide covering intentions, plans, actions and prevention. Only used when a hint of risk has been previously picked up. This is not given to a parent but the questions are used as prompts. Copy available.
6. The Hospital Anxiety and Depression Scale (HADS, for a copy see: http://www.sandbachgps.nhs.uk/uploaded_files/files/ashfields/HADS.pdf) This carries 7 questions each for anxiety and depression and takes about 5 minutes at the most to complete. It is meant to enable early identification of both. Might be easy to fake positives if you really wanted to, but apparently this rarely happens, and it is widely used and makes sense to parents. Has the advantage of combining two issues and has been recommended. (I have a copy.)
7. The Kessler – 10 Questionnaire is also widely used to measure psychological distress. It is a ten item questionnaire designed to give a global measure of distress based upon questions about the anxiety and depression symptoms the individual has experienced in the previous four week. See: http://amhocn.org/static/files/assets/bee05b2a/Kessler_-10.pdf

7) Possible public health measures, some initial ideas:

1. Increased of family connections or some sort of involvement with their local community.
2. Return to work or education as a result of improved parental self-confidence or well-being.
3. Better / safer / more child-oriented home environment.
4. Fewer infant / child medical emergencies or brushes with A&E.
5. Fewer child injuries (accidental or not).
6. A reduction in maltreatment (all forms of abuse and neglect), and so less children involved with child protection services.
7. An improvement in school readiness down the line.
8. Reduction of domestic violence, or less children exposed.
9. Less closely spaced pregnancies.
10. Reduction in youth crime – eventually!
11. Improvement in employment for parents.
12. Less closely spaced pregnancies.
13. Reduction in obesity (which has been linked to poor attachment).

The question is how can these be recorded without some sort of tracking and follow-up system, which might be complicated and relatively expensive for a small organization to implement? But could be a gift for a postgraduate student looking for a project.

8) Parent feedback at end of contact.

1) PIP UK has developed a parent-completed evaluation form that can be scored as well as having space for free format comments. Copy available on request.
2) The Family and provider/Teacher Relationship Quality measures have been validated and are very thorough; these could easily be adapted to an infant mental health team's needs, or any other form of early intervention including (especially) children's centres. There is a long and short version of the Parent measure, with accompanying scoring sheets. See for further details the website: http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/family/relationship/measuring-relationship-quality.html

Conclusions so far.

There is currently no completely satisfactory single assessment tool for a clinical situation involving children under age two, with all those listed having disadvantages of one sort or another. Although perhaps some of the ones I could not get full information on might be useful, and so please get back to me if you have more information.

It was decided that the measures that would initially be recommended to new PIPs, to ensure consistency, would be: KIPS, PIRGAS (with great reservations and in conjunction with a structured observation); both the Ages and Stages Questionnaires when useful, with ASQ:SE2 at least giving some idea of whether or not the infant is on course in terms of social and emotional development and the standard ASQ available for screening for developmental delay / difficulties and the need for a further specialist referral. All, except the PIR-GAS, have the advantage of being shareable with the parent.

In terms of the parental states of mind the GAD-7 and PHQ-9 can be used, or else the HADS which has the advantage of assessing both anxiety and depression with one measure and so takes up less time for both parent and clinician. This measure was suggested by the panel.

The risk factor checklist provides anonymous records of the difficulties impacting the caregiver-baby relationship that some families contend with. In terms of evaluation and feedback to other services and commissioners, this can be used to give an anonymous profile of the families worked with. It also is a rough indicator of both complexity and other, more distal, targets for intervention. (Psychological work may not begin until certain practical issues, such as safety, have been resolved.) Plus, it would be important to include a parent evaluation at end of service contact (PIP UK has an example). More measures may be developed in the future; but for now each PIP could also explore other ways of assessing their work as well and share information as services develop.

Appendix.

(These are some measures to not loose sight of, ones I picked up when searching that did not seem quite the ticket for a PIP at first, but may be useful for other services.)

1) **Parenting.**

1. Coding Interactive Behaviour (or CIB) is a coding system providing a global measure that looks at parent, child and dyadic affective states and interactive styles. This measure is typically used with adults and children aged between 2 and 36 months. Using pre-recorded video taped material the CIB is broken down into 43 codes that are rated on 5-point Likert scales. There are 21 parent codes, 16 child codes and 5 dyadic codes. All 43 codes can be calculated into subscales, consisting of parental sensitivity, intrusiveness and limit setting, child involvement, withdrawal and compliance and dyadic reciprocity and negative state. Sounds complicated. Could not track content down.
2. The Massie/Campbell Scale of Mother-Infant Attachment Indicators during Stress (ADS) is a one-page guide for practitioners to use in guiding standardized observation of parent and infant (birth up to 18 months) interaction. Specifically designed for rapid use by pediatric and mental health practitioners the scale facilitates early detection of aberrant patterns of parent-infant responsiveness. The scale describes mother-infant bonding through its key parameters: gazing affective sharing vocalizing touching infant clinging maternal holding and physical proximity. It is meant to grade these components for the intensity of the attraction or avoidance between a mother and baby the baby's response; and draws attention to several of the syndromes of psychiatric disturbance that occur in the first two years of life. This tool is said to assist practitioners in making therapeutic interventions early in a child's life to prevent the development of negative parent-child interactions adversely affecting child development. Psychometric studies are limited. Reliability studies, although small-scale have yielded good results. No specific website but see this to purchase: http://www.childdevelopmentmedia.com/assessment-planning/91915p.html

2) **Parents' perceptions.**

1. The Broussard's Neonatal Perception Inventory administered at one month of the baby's age was originally found to predict risk at 41/2 years, although another study failed to replicate this. But this has also been shown to predict risk into adult life. This measures the mother's perception of her infant compared with her view of an average baby. It could be used as a screening tool to assess the relationship between mothers and babies. I have been sent a copy if anyone is interested.
2. I have a copy of the "Me and my baby' rating scale created and used in Belfast, which can be filled in at the beginning and end of every session. Only takes a few minutes. I do not think that this has been validated, and it might possibly intrude in some situations, but does give instant feedback from the parent and also an immediate sense of what they feel they have gained from the session.
3. The Maternal Attitude Scale could be useful. (I have a copy, and see appendix 2d of 'Conception to age 2') But I can find nothing much about this. Available from ChiMat
4. The Mother and Baby Scales are mother completed and, I think, based on the Brazelton Neonatal Behavioral Assessment Scale. Mothers assess their babies at birth and age one month on all items except reflexes. Their results closely followed those of trained Brazelton testers. See: Tiffany Field, et al. (1978) The Mother's Assessment of the Behavior of Her Infant, Infant Behavior and Development, 1, 156-167. Copy of MABS available.

3) **Stress on caregiving relationship**.

1. There is the Parenting Stress Index by Richard Abidin which has a short form taking about ten minutes to administer, and this gives a stress score from 3 scales: parental distress, parent-child dysfunctional interactions and perception of a difficult child. http://www4.parinc.com/Products/Product.aspx?ProductID=PSI-SF But it costs $75 for a set of 25 questionnaires which are not meant to be duplicated. This short version of PSI-$ has 33 questions while the full version has 120. It fails to ask if filling in this form was stressful. Probably a bit cumbersome as a consequence of covering so much. A good bit of clinical assessment and history taking would get the same information but in a less formalized and scored way. I imagine this would be useful for some research purposes.

2. The Department of Health has a publication 'Framework for the Assessment of Children in Need and their Families', but this seems

mostly directed to families with children over the age of two. It contains the following: Strengths and Difficulties Questionnaire; The Parenting Daily Hassle Scale; Home Conditions Scale; Adult Wellbeing Scale; The Recent Life Events Questionnaire; The Family Activity Scale; and The Alcohol Scale. Available on:
http://www.falkirk.gov.uk/services/specialist/girfec/iaf/pdf/doh/FamilyPackQuestionnairesScales.pdf

4) **Quality of relationship.**

1. The Child-Parent Relationship Scale from Robert Pianta seems to focus on slightly older children but could easily be adapted. Would be interested to hear if anyone has done this. (Copy available.) This is a self-report measure that can be completed with a worker.
http://curry.virginia.edu/uploads/resourceLibrary/Mothers_and_Fathers_Perceptions_(Driscoll_Pianta).pdf

2. The original Ainsworth Maternal Sensitivity Scale is still available (I have a copy) and this sets up several dichotomies that, like PIR-GAS have anchoring descriptions for the scales. They are: sensitivity v insensitivity, cooperation v interference with baby's ongoing behavior, physical and psychological availability v ignoring and neglecting, acceptance v rejection of baby's needs. This runs to 22 pages!

3. There is also the Disturbances of Attachment Interview or "DAI" developed by Smyke and Zeanah, (1999). This is a semi-structured interview designed to be administered by clinicians to caregivers. It covers 12 items, namely having a discriminated, preferred adult, seeking comfort when distressed, responding to comfort when offered, social and emotional reciprocity, emotional regulation, checking back after venturing away from the care giver, reticence with unfamiliar adults, willingness to go off with relative strangers, self endangering behavior, excessive clinging, vigilance/hypercompliance and role reversal. Just Google it for a copy. Needs training.

5) **Developmental measures.**

1. AIMS: Developmental Indicators of Emotional Health. See http://www.developingchild.org/descriptionofservices.html This is a way

of assessing attachment, interaction, mastery and social support for children aged 0 to 5 and their families. Begins at age 2 weeks. There are some sample questions on the website which look similar to those in the ASQ: SE. No information on how useful this is yet.

2. The Infant Characteristics Questionnaire comes in three versions: 6 month, 13 month, and 24 month. It evaluates parental perception of infant temperament, focusing on difficult temperament, and so could be used to evaluate whether or not characteristics of the bay are contributing towards problems in the relationship. It works around four scales that combine to give a measurement of infant difficultness. These are: fussy-difficult, unadaptable, dull and unpredictable. See: http://www.psychology.org.nz/cms_show_download.php?id=798

6) **State of mind of parent.**

1. Not sure if this belongs in this section; but one of the best predictors of attachment quality appears to be maternal mind-mindedness. This at least keeps us in the domain of infancy while thinking about the parent. http://www.dur.ac.uk/c.p.fernyhough/papers/Meinsetal2001.pdf A coding manual, based on videoed interaction, has been drawn up by Elizabeth Meins and Charles Fernyhough of Durham University. (I have a copy if anyone is interested.) But this may be too time-consuming for a clinical service as it now stands, and probably needs specialized training.
2. The 14 item self-report Prenatal Reflective Functioning Questionnaire that assesses parental mentalization pre-birth is in the process of being validated; and will lead to a slightly adapted version (mostly involving a change of tense) that can be used in the first year after birth. This looks as if it will be extremely helpful both for screening and assessment. (See: Pajulo, M., et al., (2015) The prenatal reflective functioning questionnaire: exploring factor structure and cohort validity of a new measure in the Finn brain birth cohort. IMHJ, 36 (4) 399-414.) This measure builds upon how differences in the parental capacity to focus on feelings in themselves and the baby affect attachment and socio-emotional development. It assesses three factors from 14 different Likart Scales: opacity of mental states, reflecting on the fetus-baby, and the dynamic nature of mental states. Two scales, one for mothers another for fathers. On a parental cohort of 600 mothers and fathers this measure showed significant promise as a tool for evaluating the need for intervention. It looks very useful, and I have copies of the English translation.
3. The Parental Bonding Inventory is a 25 item self-report questionnaire that assesses the perception that adults have of their level of parental

care and protection/control they received during their first 16 years. There is a separate scale for mothers and fathers. See: https://www.blackdoginstitute.org.au/docs/ParentalBondingInstrument.pdf

4. Not to be lost sight of is the Attachment Style Interview, or ASI, as this can be used to show how the adult (there is an adolescent version too) makes use of current attachment relationships. This is a structured conversational style interview that asks questions about current relationship with partner, family of origin and with two close adults. It then asks about the general style of relating to other adults in terms of self-reliance, desire for company and ease in accessing help etc. This measure is mostly used for assessing potential foster and adoptive parents in order to see what level of support will be most appropriate. See: http://www.attachmentstyleinterview.com Since quality of supporting relationships is the most important protective factor that supports parenting this could be a useful measure.
5. For mothers who have suffered trauma while pregnant the perinatal PTSD Questionnaire is useful. The Perinatal PTSD Questionnaire (PPQ) is a self – report inventory designed to identify symptoms of PTSD that are related to the childbirth experience and the ensuing postnatal period. Copy from: http://www.neonatenurses.com/includes/perinatal_posttraumatic_stress_disorder_questionnaire.pdf And a Google search will also give you papers on this tool.
6. Solomon and George have developed the "'Caregiving Helplessness Questionnaire' which can be found on page 164 of their 'Disorganized Attachment & Caregiving' (2011, The Guilford Press) as well as on http://www.researchgate.net/publication/261436934_Caregiving_helplessness_Development_of_a_questionnaire_to_screen_for_maternal_caregiving_disorganization This has been well validated. It measures the mother's representations of caregiving, and when there is dysregulated helplessness: "Mother and child are trapped in a cycle of mutual abandonment, isolation and aloneness that…constitutes the most frightening human experience" (Solomon and George,2011:138). But unfortunately for infant mental health teams this starts when the child is aged three. It looks very useful.

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