CONTEMPORARY UNBORN RISK TEMPLATE (CURT)

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The assessment is used to address the following concerns:

- Is the pregnant mother's current lifestyle putting the development of the unborn child at risk?
- Will the baby be safe in the care of these parents/carers once born?
- Is there a realistic prospect of these parents/carers being able to provide adequate care throughout childhood?

The purpose of pre-birth assessments is to allow social workers and the professional network to:

- identify sources of harm to the unborn child and predict future harm
- enable work with parents that helps them reflect on the pregnancy and how the child's birth will affect them
- identify support parents may need to help strengthen parenting capacity to meet the child's needs once born
- plan for the child's care and make decisions on interventions to keep the child safe in the present as well as long-term decisions on the child's future care.

ASSESSMENT STRUCTURE

Name and Expected Date of Delivery: e.g. Unborn Baby ……EDD: 01.01.11

Concealed pregnancy or late presentation to antenatal services. A late presentation is where a woman books for antenatal care after 18th week of pregnancy, whereas a concealed pregnancy is where a woman has not booked for antenatal care prior to attending in either labour or immediately after the birth of the baby. Concealment or late presentation to antenatal services may be as a result of sexual abuse or domestic abuse, a deliberate act to avoid services, act of denial or in some very rare cases the woman may be unaware that she is pregnant. The reason for the late presentation or concealment is key to determining the risk to the unborn baby and the need for additional support from children's agencies

Family Structure/Composition: Names, addresses, dob, relationships with extended family members. If possible, this should include a genogram.

- Non-disclosure of birth father. It is rare for an expectant mother not to disclose the name of the birth father. Where this occurs, this should be regarded as a possible cause for concern and agencies should seek to understand the reasons why a disclosure isn't being made. Consideration must be given to any vulnerability, including capacity to consent and whether the non-disclosure is an indicator of sexual abuse or other forms of harm.
- When a pregnant woman and her family go missing, all involved agencies should seek to clarify her location and re-engage her with services. Midwifery and other health services must action unborn baby regional and/or out of area alerts. Children's Social Care and the police should be informed immediately where there are significant concerns about the unborn baby or where the unborn baby is already an open case to Children's Social Care
- Assessing unknown male partners: Be clear as to who exactly lives in the household and their relationship and involvement with the mother and individual children. Insist on knowing the identity and carry out background checks accordingly. Involve and interview the new male partner as part of the assessment. Ensure that information on 'new men' accessing families is shared between agencies and assessments undertaken when necessary. The background information should include appropriate checks with other agencies and the subject of the checks should be interviewed by the allocated social worker. Information should also be obtained on other adults having substantial contact with the children, including occasional carers such as baby-sitters.

Reason for Assessment:

Sources of Information: Include dates of visits to family members and who was seen. Names of professionals who were consulted along with dates, as well as any records that have been consulted.

Decision on the timing for the assessment to start:

The earlier in the pregnancy the assessment starts, the more reliable is the woman's presentation, the more likely there is to be a supportive rather than a protective outcome, and the concerns that relate specifically to the pregnancy – such as substance use or domestic abuse, consequences of continued use of prescribed medications to manage mental health etc. – can be addressed.

The Importance of Early Intervention

Research highlights that:

- Early environment and the first three years of life play a significant role in shaping cognitive, social, and emotional development and that the most important aspect of this environment is the child's relationship with their caregivers.
- Pregnancy and the early years should be central to safeguarding practice both as the foundation for children's development and as the optimal window for prevention and early intervention.
- Parents' own early experiences can shape their parenting and that early relationship patterns are developed in interaction with primary carers, internalised and re- enacted within later relationships including those with partners, children, and professionals.
- Most of the brain cells responsible for regulating behaviour, thinking and emotions are unconnected at birth. Their connecting pathways are formed within the first two years of life.
- The processes of brain maturation are ''use dependent'' and there are windows of opportunity for developing critical processes such as attachment, self-regulation, and language. If these windows are missed, then catching up is a much harder process.

- Exposure to chronic stress in early years also decreases the capacity of developing brains to regulate rage, anxiety, impulsivity, and aggression. Therefore, it is more effective to protect children from damage than to undo the neurological and psychological effects of early abuse and neglect. (Howe 2005)

Timely intervention in pregnancy can therefore help:

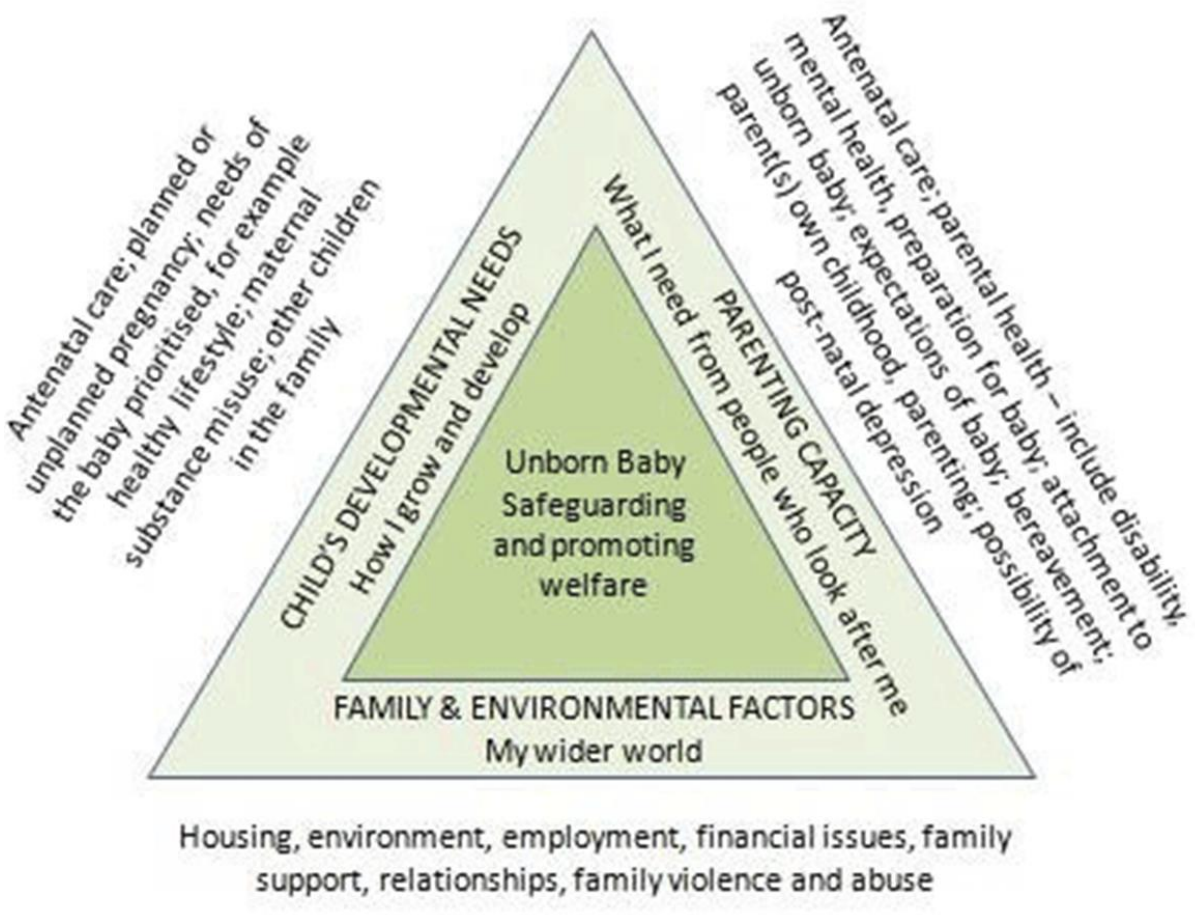
- Ensure that vulnerable parents are offered support at that stage of their parenting rather than when difficulties have arisen
- Establish a working relationship with parents before the baby is born
- Assist parents with any of the problems that are impacting on their parenting

Details of professionals involved with contact details, roles, and responsibilities:

Not registered with a GP. Pregnant women who are not registered with a General Practitioner should be encouraged to do so as soon as possible. If the woman experiences any difficulty registering with a GP, then she should be advised to contact Primary Care Services to request a GP be 'allocated' to her. Requests must be made in writing. The process of being allocated a GP normally takes about one week.

Conceptual framework for approaching pre-birth assessments

The assessment triangle can be easily adapted to make it more specific for structuring pre-birth assessments.



Which of the following are workers concerned about at the onset of the assessment?

Pre-birth harms

Risk of	**From**
Injury/miscarriage/stillbirth Preterm delivery/in utero growth retardation Neurological damage – Incl. subtle changes to behavioural and emotional pathways Disorders of Embryological development Blood borne virus infection	Domestic violence Self-harm/suicidal attempts Fabricated or induced injury Drugs/smoking / 'legal highs' Alcohol Self-neglect – nutritional – medical non-compliance – No antenatal care Risk-taking behaviour

	STIs – gonorrhea, syphilis, HIV, herpes, Chlamydia, Hep B/ C

Risk of Harm post-birth

Sibling on CP plan/previously removed

Maternal Self-neglect

- risk of extension to neglect of baby/children
- late booking/neglect of antenatal care

Nutritional, basic hygiene, exercise (DVT risk)

Domestic Violence

Parental mental health issue or learning disability

Parental drug or alcohol issue

Very young/LAC or Care Leaver/CSE risk mother

Concern about bonding

Concealed pregnancy

Lack of engagement with antenatal care/late booking

Antenatal diagnosis of foetal abnormality

<u>Will this risk arise:</u>

before the baby is born.

at or immediately following the birth?

whilst still a baby (up to 1-year-old)?

as a toddler? or pre-school? or as an older child?

If there is a risk that the child's needs may not be appropriately met …

Ante-Natal Care: Medical and Obstetric History

Pregnancy can create special circumstances/influences for both parents, which need to be accommodated and understood by all professionals who come into contact with these families. Pregnancy will have a major impact on some people's lives and will affect both behaviour and relationships. Pregnant women's' health and their responses to external factors often change in pregnancy - and the physiological, emotional and social influences that both cause and are affected by these changes can have a direct impact on their behaviour, health and how they manage in key relationships.

This section should be completed by an appropriate health professional. The central question is whether there is anything in the medical and obstetric history that seems likely to have a significant negative impact on the child.

The booking interview is a time of collection of information and an opportunity for the midwife and mother to plan her care in pregnancy. It is an ideal time for the midwife to assess health and social needs of families and to consider packages of care and support suitable for individual needs. The interview is usually in the woman's home or at the GP's surgery. It is at this interview that the midwife is able to assist women in their choices for childbirth and ensure they are informed of all the options available to them.

Missed appointments. Where the pregnant women consistently miss appointments agencies should seek to ascertain the reasons for this and take appropriate steps to address any issues. In instances where the pregnant women is a teenager or may have a learning disability 'was not brought' should be considered as they may be reliant on their parent/carer to bring them for appointments. In all cases consideration should be given to any additional assessment or support that may be required; this could include initiating an early help assessment or where there are concerns about complex/serious needs or child protection concerns, a referral must be made to Children's Social Care. If it appears that the family has moved

and there is no forwarding address, the process for families who move area or go missing should be followed.

Antenatal appointments are arranged to suit the individual clinical needs of the mothers and the initial choices may change if complications of pregnancy arise. A collaborative approach between all health professionals is encouraged with direct midwife referral to obstetrician being available at all times.

Questions should consider:

Partner support

Whether this was a planned or unplanned pregnancy

Feelings of mother about being pregnant

Feelings of partner / putative father about the pregnancy

Any issues about dietary intake

Any issues about medicines or drugs taken before or during pregnancy

Alcohol consumption

Smoking

Previous obstetric history

Current health status of other children

Miscarriages and terminations

Chronic or acute medical conditions or surgical history

Psychiatric history – especially depression and self-harming

Housing/Finance

Workers should clarify whether the parent retains the records as 'patient-held' and whether the professionals retain copies for their records in the event the parents destroy or refuse to share their records in the event of disagreement about the way forward.

Parents' feelings towards the current pregnancy and the new baby will need exploring throughout the pregnancy:

Is the pregnancy wanted or not?
Is the pregnancy planned or unplanned?
Is this pregnancy the result of sexual assault?
Is domestic abuse an issue in the parents' relationship?
Is the perception of the unborn baby different/abnormal?
Are they trying to replace any previous children?
Have they sought appropriate ante-natal care?
Are they aware of the unborn babies needs and able to prioritise them? Do they have realistic plans in relation to the birth and their care of the baby?

Similarly, there needs to be some consideration to the parents understanding of the expectant baby's needs and their ability to meet them:

What are the social and cultural expectations of the family?
What are the ethnic expectations of the family role and interventions?
What are the family roles for women, children, men, and elders?
What is the response to ethnic history?
What is the impact of any racism?
What is the impact of class and social position?
Is the family integrated/marginalised/powerful/powerless?
What belief systems and values influence role expectations, define and set limits of acceptable behaviour?
What are the key support structures?
Which are the key relationships within the immediate and extended family?
What life cycle stage are the family at/ what are the risks and challenges?
What solutions are used to manage family conflict?
How have the parents both individually and together responded to their expected baby?

To what extent are the parents developing a sense of attachment to their expected baby?
How do the parents build relationships and whose responsibility to they feel it is?
What understanding do the parents have of their expected baby's basic needs?
Do the expectant parents have the capacity to provide 'good enough parenting' to the expected baby?

Midwives will usually monitor for gestational diabetes in pregnant women.

Women who have had a traumatic birth, miscarriage stillbirth or neonatal death should be offered the opportunity to talk about their experience. This should extend also to the partner.

Assessment of the parent(s) and the potential risk to the child

This section will usually be completed by the Social Worker – but they will need to draw on help from a range of other professionals regarding some aspects of it.

Mental Health Problems

At a woman's first contact with primary care or her booking visit, and during the early postnatal period, consider asking the following depression identification questions as part of a general discussion about a woman's mental health and wellbeing:

During the past month, have you often been bothered by feeling down, depressed, or hopeless?
During the past month, have you often been bothered by having little interest or pleasure in doing things?
Also consider asking about anxiety using the 2-item Generalized Anxiety Disorder scale (GAD-2):
Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious or on edge?
Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?

Perinatal risk Indicators for referral to mental health services

Perinatal Red Flags and Risk Indicators

- Recent significant changes in mental state or emergence of new symptoms.
- New thoughts or acts of violent self-harm
- New and persistent expressions of incompetency as a mother or estrangement from the infant.

Perinatal risk indicators (Antenatal and postnatally period)

- Women with a history of bipolar disorder, schizophrenia, severe depression, other psychotic disorder, or previous inpatient/crisis care should be referred to the perinatal team; this group is at increased risk of severe postpartum episodes.
- Women with a family history of a first degree relative with bipolar disorder or puerperal psychosis should be referred even if presenting with mild symptoms of mental disorder
- Antenatal presentation can be a predictor for post-natal episode of mental ill health; discuss all antenatal referrals with perinatal team.
- High risk period for is 1-10 days post-natal but the threshold should be lower for women up to 10 weeks postnatally
- Women who are presenting with uncharacteristic symptoms and marked changes to normal functioning. This can include symptoms of confusion and general perplexity.
- If partner, family, friends report significant change in presentation and acting out of character.
- Older professional women with depression who appear to be functioning at high level • Women who present with anxiety/panic attacks or unusual or overvalued ideas (ideas that seem out of context or extreme)

Consider asking the following depression identification questions as part of a general discussion about a woman's mental health and wellbeing (The Whooley Questions):

- During the past month, have you often been bothered by feeling down, depressed, or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things?

Also consider asking about anxiety using the 2-item GAD scale (GAD-2):

- During the past month, have you been feeling nervous, anxious or on edge? (Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3)
- During the past month have you not been able to stop or control worrying? (Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3) If a woman responds positively to either of the depression identification questions above or scores 3 or more on the anxiety GAD-2 scale, is at risk of developing a mental health problem, or there is clinical concern, consider: • using the PHQ-9 scale for further assessment (as below)
- using the GAD-7 scale for further assessment
- Referring the woman to her GP or, if a severe mental health problem is suspected, to a mental health professional

If there is a risk of self-harm or suicide

assess whether the woman has adequate social support and is aware of sources of help

arrange help appropriate to the level of risk
inform all relevant healthcare professionals (including the GP and those identified in the care plan
advise the woman, and her partner, family, or carer, to seek further help if the situation deteriorates

Assessing parental mental health

<u>Attachment and relationship</u>

Is the child's attachment damaged due to inconsistent parenting?

Is there consistent emotional warmth from adult caregivers?

Is there appropriate parental response in accordance with the child's age and stage?

Is parental incapacity affecting the child taking on too much responsibility?

Are the child's emotional needs consistently met (including security, stability, and affection)?

Living conditions

Are the child's physical needs being consistently met?

What is the child's living conditions like?

Is the physical environment provided for the child good enough?

Financial circumstances

Is there enough money to allow for adequate parenting/the child's needs to be met?

Social and environmental circumstances

Does the parent's behaviour impact negatively on the child's treatment in the community (e.g. bullied, excluded, ostracized)?

Is the child or young person and their family able to access resources in the community?

Who looks after this child when the parent/carer is not able to care for them appropriately and/or in treatment/on medication?

What are the outcomes for this child? What is the long-term impact for each child of being exposed to parental mental health problems in the home?

How does exposure to parental mental health problems impact on the child's overall well-being and all areas of child development?

What is the evidence on which you base your assessment and analysis?

When a woman with severe mental illness decides to stop psychotropic medication in pregnancy and the postnatal period, discuss with her:

her reasons for doing so
the possibility of restarting the medication, switching to other medication, having a psychological intervention, or increasing the level of monitoring and support.

Ensure she knows about any risks to herself, the fetus or baby when stopping medication.

When a woman with depression or an anxiety disorder decides to stop taking psychotropic medication in pregnancy and the postnatal period, discuss with her:

her reasons for doing so

the possibility of having a psychological intervention, restarting the medication if the depression or anxiety disorder is or has been severe and there has been a previous good response to treatment or switching to other medication.

If a woman has taken psychotropic medication during pregnancy, a full neonatal assessment of the newborn baby should be carried out, bearing in mind:

the variation in the onset of adverse effects of psychotropic medication

the need for further monitoring

the need to inform relevant healthcare professionals and the woman and her partner, family or carer of any further monitoring, particularly if the woman has been discharged early.

Encourage women with a mental health problem to breastfeed unless their medication contra-indicates.

Substance misuse as a risk factor

Both recreational and prescription drugs can affect the foetus in many different ways. This section refers to psychostimulants and mood-alerting drugs.

There is no evidence that recreational or street drugs are safe at any time during pregnancy. All can potentially affect the baby and cause harm. Drug use can damage the health of a pregnant woman both directly and indirectly, can cause complications during pregnancy and can damage the foetus. Drug use in pregnancy has been associated with premature birth, low birth weight, placental abruption, neonatal abstinence syndrome (NAS), admission to a Neonatal Intensive Care Unit (NICU), and an increased risk of still birth and neonatal death. Drug use in pregnancy is closely linked to poverty and deprivation, which can have a negative impact on health outcomes for the mother and child, and which are therefore factors that contribute to health inequalities.

Pregnancy can act as a strong incentive for a woman to make a positive change in behaviour and lifestyle. It is important that this is both recognised and supported by early years and health practitioners who work with pregnant women.

It is important for practitioners, whether health professionals or other early years practitioners, to contextualise drug use within what may be a multiple and complex risks issue. It is important to consider a woman's whole experience and the social factors that may have an impact – not just drug use in isolation. For this, a holistic and person-centred approach is advisable, linking women to the tailored pregnancy support they need, as well as providing information regarding the potential harm of continued use and unmodified behaviour.

For women using drugs, specialist support should be provided in addition to antenatal care, for example through an alcohol and drugs liaison nurse.

Practitioners have a responsibility to support women and see that they are provided with services that can help them protect their babies.

Factors affecting outcome in children pre-natally exposed to alcohol

- genetic and/or physical vulnerability: suggesting that some individuals may have more tendency to be affected by exposure than others.
- drug type and drug action

- type of exposure: dose, duration during gestation and timing (daily or binge use)
- maternal health, access to health services and prenatal care
- pregnancy complications (e.g. prematurity)
- status variables: (such as postnatal care-giving factors, the immediate family environment, and the general social environment i.e. socio-economic status), as well as the developmental process itself and the many factors that are known to affect it i.e. particular behaviours of family members, the caregiver's style, and specific and significant events, such as the loss of a parent, which affect the developing child.
- availability of services: prevention, education, and treatment

<u>Substance and Alcohol Misuse questions</u>

- What type of substances is the prospective parent/s dependent upon?
- What is the route/amount/duration/pattern of the substance misuse?
- The consequences for the baby of the mother's substance misuse during pregnancy e.g. withdrawal symptoms, and for the parenting of any other children in the household.
- The history of parental substance misuse, current dependency.
- Any evidence of being incapacitated/comatose or paranoid/overtly psychotic?
- Is the prospective parent engaged with drug and alcohol services?
- Motivation to engage with drug and alcohol services?
- What is the prospective parent/s understanding of the potential effects of their substance misuse on the unborn and new born child?
- Can parental substance misuse be managed compatibly with the demands of a new-born child?
- What has been the impact of parental substance misuse been on other children/sibling within the household?
- patterns of substance misuse

- whether it can be managed compatibly with caring for a new born child
- whether parents are willing to attend treatment
- any dual diagnosis (substance misuse coupled with mental health problems)
- the consequences for the unborn baby of continued misuse of substances or withdrawal during pregnancy

More detail could be indicated and would include:

<u>Parenting and attachment relationship</u>

Is the child's attachment damaged due to inconsistent parenting?

Is there consistent emotional warmth from adult caregivers?

Is there a level of unpredictability of the caregivers and inconsistencies in parenting, and how do these affect the child?

Is there appropriate parental response in accordance with the child's age and stage?

Is parental incapacity affecting the child taking on too much responsibility?

Are there any caregivers that do not use substances?

Is there evidence of praise and encouragement?

<u>Living conditions</u>

Are the child's physical needs being consistently met?

What is the child's living conditions like?

Is the physical environment provided for the child good enough?

If drugs are kept in the home, is it possible that children can access them?

Financial circumstances Is there enough money to allow for adequate parenting/the child's needs to be met?

<u>Potential for harm</u>

Is the child placed in physical danger?

Are the child's emotional needs consistently met (including security, stability, and affection)?

Social and environmental circumstances

Does the parent's behaviour impact negatively on the child's treatment in the community (e.g. bullied, excluded, ostracized)?

Is the child or young person and their family able to access resources in the community?

How are alcohol and/or drugs sourced?

What impact has this on the child?

Who looks after this child when the parents are incapacitated, seeking treatment, sourcing alcohol/drugs?

Culture of the family and how alcohol misuse affects family life, E.g. unknown adults coming into the family home, children and young people being taken to potentially risky environments.

Is the child in contact with unknown/potentially risky adults at any time?

Is the child (or children) left home alone at any time while adults source alcohol/drugs?

What are the outcomes for this child?

What are the consequences and long-term impact for each child of being exposed to parental substance misuse in the home?

How does exposure to parental substance misuse impact on the child's overall well-being and all areas of child development?

What is the evidence on which you base your assessment and analysis?

Appendix 1 provides workers with a summary of the effects of various substances throughout the pregnancy.

Domestic abuse as a risk factor

Around 30% of domestic abuse starts during pregnancy; around 9% of women being abused during pregnancy or after giving birth

Associated with a wide range of compromised physical outcomes: late prenatal care; miscarriage, preterm and stillbirth; foetal injury (bruising, broken and fractured bones, stab wounds)

- Maternal depression and PTSD
- Significantly more negative representations of their infants and themselves
- Babies were more likely to be insecurely attached

Workers do need to examine as many of the questions indicated:

Domestic abuse and other violent behaviours

The nature of violent incidents
Their frequency and severity
Information on what triggers violent incidents.
The non-abusing/nonviolent parent's recognition of the potential risks as a result of the history of or current domestic abuse/ violent behaviour
Domestic abuse incidents in the pregnancy
Parent/s may exhibit aggressive behaviour
There may be pregnancy complications that could lead to e.g. pre-term delivery with the result of a baby that will require a higher level of care
Potential characteristics which may make the expectant child harder to care for.

Is the pregnancy one of the few times when the mother has been permitted to go to the doctor?

Is this an early or late presentation?

Have they ever attended with injuries requiring hospitalization before?

Is she allowed to attend by herself?

Has the mother been screened for domestic violence using a screening tool?

Was the pregnancy planned or wanted? If not, it escalates the chance of domestic violence in the pregnancy. Women with intended pregnancies reported less abuse at each period. Violence was four times higher among women whose partners did not want the pregnancy

Does the mother wish to seek a termination or is she under pressure to secure one from her perpetrator?

Is there any concern that she may be at risk of being given foods or medicines that could induce a termination?

Are there religious considerations if the couple are unmarried or have no plans to remain together post-birth?

Or is the pregnancy a period of respite from the violence as the perpetrator has secured short-term control through the pregnancy

Do we know the identity of the expectant father and whether it differs from the perpetrator?

Is there knowledge of similar situations arising in either parents' previous relationships? Do we know when that started and/or escalated?

Has the mother been coping by using drugs and/or alcohol?

What factors may be known to be present and counterbalance or mitigate against any harm inducements

Did the violence predate the pregnancy confirmation?

Has it continued to date?

Is there any motivation known or suspected for the violence?

- Jealousy toward the unborn child
- Anger toward the unborn child
- Pregnancy specific violence, not directed to the child
- 'Business as usual'.

In relation to the timing of abuse, can the mother identify whether it occurred only during the 12 months before the pregnancy, during the pregnancy or during both time periods.

Is the violence targeted at multiple injury sites (such as head, limbs, and neck) or targeted specifically to their abdomen? Or does it change? Or is it predictable? Where there has been a direct non-accidental injury to the abdomen of the pregnant woman complications may include:

Infection

Hemorrhage and placental abruption

Miscarriage

Premature rupture of the membranes

Fatal injury

Preterm delivery

Stillbirth

Is there any evidence of gynecological problems, complications in pregnancy and childbirth, depression, anxiety, chronic somatic disorders, sexually transmitted diseases (STDs) and HIV infections and eating disorders?

Is there evidence of physical and psychosomatic disorders, behavioural problems, post-traumatic stress?

How does this potential compromise to her parenting capacity correspond with elevated needs/risks to the expectant baby?

What do professionals fear may inhibit disclosure from the mother?

- Shame and/or embarrassment
- Fear of the abuser and retribution
- Belief the abuse is normal and common among couples
- Fear of judgmental attitudes
- Belief or hope he will change (when the baby comes)
- Her partner is present

- The abuse is her responsibility, no-one else can help

Does the mother have a preferred means of delivery?

Does this include the perpetrator?

Is he pushing for a shared birth? Or having it away from a hospital?

Are there options locally for choice of delivery site?

The risk to unborn babies of women involved in street prostitution

What are their reasons for working?

When are they usually out on the streets - at all hours and in all weathers?

Do they have a history that includes trauma of previous childhood abuse, mental and physical health problems and are vulnerable to the vagaries of the men who solicit them for sex, drug dealers, local people, and the police?

Do they have regular customers who they have developed relationships with?

Do they provide gifts, drugs, and meals, providing accommodation etc.?

Are they vulnerable themselves and if so, in what way?

Do the women work on the streets only or do they also work in a number of other locations, including saunas, private houses and as escorts?

Have the women ever been subject to stigmatization; verbal, physical and sexual abuse; violence; and robbery by the very men who pay to have sex with them.

Are they consuming drugs? Alcohol? If so, list them.

Have they ever over-dosed?

Do they have any health problems as a result of the drug use?

Are they involved in any treatment programme – now or in the past?

How much are they spending on drugs a day/week?

How much does the women charge for her services? Are pimps involved?

Is there any history of control or conflict/domestic violence in the work environment/relationships?

Have they suffered verbal abuse, bullying, intimidation, and physical abuse in their work?

Is such stigmatization and consequent abuse impact on them when they are a parent as well as potentially being experienced by their children and other family members.

The main factors that will influence a woman's ability to safeguard and promote the well-being of her child are:

- The level and combination/s of her drug/alcohol use, and any resulting chaos.
- The number of children she has, their ages, individual needs, and level of understanding.
- The level of support she gets from a non-drug using or stable partner, and any family members and friends.
- The insight she has about how her lifestyle may have a negative impact on her child, and therefore what measures that she takes to protect him or her.

<u>The mother</u>

Is the mother's ability to provide basic care for her child impaired by her drug or alcohol use, or mental health problems?

Is she able to provide the physical necessities for her child, such as food, adequate accommodation, heat, light, and appropriate clothing?

If the child has any special educational needs or is disabled, how does the mother respond/cope?

Is she able to ensure her child is safe at all times?

When she is out working the streets or using drugs/alcohol, where is her child?

Is s/he being cared for by a responsible person?

Does s/he witness any drug taking or other illegal activity?

Is the child at risk from anyone she brings to the flat, including “punters”, drug dealers or people involved in other crimes such as handling stolen goods?

Does her child ever witness sexual activity or other inappropriate sexual images?

Is her child ever left alone?

How does street working affect her as an individual?

How does it affect her ability to parent her child?

Does she use (or use more) drugs/alcohol to cope with what her work entails?

- Is she out late and therefore not functioning well in the mornings or sleeps in? If so, how does this show, physically and/or emotionally?
- Is the mother able to give her child emotional warmth?
- How consistent is she in her parenting of her child?
- Does it change depending on her drug/alcohol use?

Does her lifestyle affect her emotionally?

- Is she able to be emotionally warm and affectionate with her child?
- What is the interaction between her and her child?

Does the mother have a partner?

Is he the child’s father? How does he react to her working, and how does this impact on the child?

Does the mother provide age and capacity appropriate stimulation to her child?

- Are there toys or games in the house?

Does the mother provide age and capacity appropriate guidance to the child?

- Does she provide the child with appropriate boundaries? If so, does she stick by them?
- Does she give her child conflicting guidance (for example, to not lie or steal and then does exactly that herself – witnessed by her child)?

Does the mother provide the child with stability? If so, in what areas are positive and what, if any, areas need improvement?

What other agencies are involved with the mother and how does she engage with them?

- Does she attend necessary appointments for herself or her child (health, criminal justice services, support to exit street work etc.)?

As well as her weaknesses, what are her strengths?

<u>Additional issues related to pregnancy</u>

How does she feel about being pregnant?

Who is the father? Does he know and if so, what is his opinion and is she influenced by him? What does she want to do about the pregnancy?

Bring up the baby, adoption, other permanence options, or termination?

Does she need support with decision-making and appointments? If termination or adoption is an option, is post-termination or post-adoption support available?

Has she had other children removed/or who are being raised by family members?

If she is keeping the baby:

- Is she still working the streets while pregnant?
- Are there any other health issues for the baby, for example is the mother a heavy smoker, malnourished, has infections or blood borne viruses, is a victim of violence, or has mental health problems?

- What is the input/relationship/support of the baby's father – negative, positive, or ambivalent?
- Seek advice from specialist midwifery services; referral for assessment and treatment; monitor attendance and compliance
- Discuss possible child in need/child protection issues with relevant partner agencies, including voluntary sector agencies, and implement procedures as appropriate (see local safeguarding children board procedures).
- Drug/alcohol treatment may be required for the baby when born to reduce neo-natal withdrawals.

Once she has had the baby:

- How is she managing to care for and bond with her new baby?
- What is her compliance with drug treatment, progress with other areas of her life such as stable accommodation, coping with a reduction in income, and making friends/getting support from non-drug using social networks?
- Monitor through child in need/child protection processes as appropriate.
- How are any other children reacting to their new sibling, especially in light of their family circumstances?
- If she has previously had a child adopted or brought up by a family member, what affect does this have on her now in her relationship with her new-born baby?

Does the woman want to exit prostitution?

Is there a plan in place to achieve this?

Learning disabilities

Do both parents present with a learning disability?

What do we know about the severity of their diagnosis?

What are the known or anticipated stressors e.g. having a disabled child, domestic violence, poor physical or mental health, substance misuse, social isolation, poor housing, poverty, and a history of growing up in care?

What kind of support might they need to develop sufficient understanding, resources, skills, and experience to meet the needs of their child?

Do they understand the baby's needs?

Is there concern that they may struggle to adjust their parenting to keep up with the changing needs of the baby as they develop?

What needs have been identified for the parents in their own right?

Are there services available to match the identified needs?

What professional concerns about the capacity of the pregnant woman and her partner to self-care and/or to care for the baby exist?

Risk in teenage pregnancy

Particular care should be taken when assessing risks where the prospective parents are themselves children i.e., under the age of 18 years and in particular if they are themselves Children Looked After. Attention should be given to evaluating the quality and quantity of support that will be available within the extended family, the needs of the parent(s) and how these will be met, the context and circumstances in which the baby was conceived, and the wishes and feelings of the child (or children) who are to become parents.

If the perspective parent is a Child Looked After, then attention should be paid to their long-term plan and how assessing for independence should incorporate the thinking of 'independence with responsibility for a child'.

Pregnancy may present physical risks as teenagers are still growing and developing, and pregnancy places additional demand on the body. It may also present psychological risks to their mental health and wellbeing. The responsibility of care and parenthood may pose a heavy burden of unwanted responsibility and young women may be unable to cope. In addition to health risks, there are a variety of circumstantial and

environmental risks to both mother and baby that may affect the opportunities and future outcomes available to both mother and child. Financial concerns and a potential drop-off in further education may reduce the economic opportunities of young women facing parenthood, thus increasing the risk of poverty.

What risks are associated with teenage pregnancy?

- Negative short, medium, and long-term health and mental health outcomes for young mothers
- Young mothers being less likely to complete their education, pursue positive post-school destinations (in employment or education), or to have qualifications in adulthood
- Teenage mothers being more likely to be in receipt of income-based benefits or in low paid work; so, poverty is strongly associated with teenage parenthood
- Teenage mothers being more likely to be lone parents, and are more likely to experience family conflict

Teenage mothers living in deprivation tend to remain in poverty. Both mothers and fathers in this group are less likely to continue in education beyond age 16, to have any qualifications or to be in employment aged 33. Birth weight is lower and infant mortality 60% higher among babies born to teenage mothers than those born to older mothers. However, a Scottish study closely linked higher rates of infant mortality and low birth weight to higher rates of smoking during pregnancy among teenage mothers. Teenage mothers experience poorer mental health in the first three years after giving birth than do older mothers, are less likely to breastfeed, and the children themselves are more likely to become teenage parents.

The negative outcomes which babies and children born to teenage mothers, could face include

- Babies tend to have lower than average birth weight
- Infant mortality rates are higher than for babies of older women

- Lower rates of breastfeeding, which means babies are less likely to benefit from the associated positive health outcomes
- Greater risk of living in a lone parent household, with greater risk of poverty, poorer quality housing and poorer nutrition

Identifying those at risk

It's important to link with other professionals who may know more about the family and their circumstances, e.g. carers, GPs, social workers, the police, and voluntary sector agencies.
The following factors place teenage women at increased likelihood of becoming pregnant:

- being the child of a teenage mother
- young people in or leaving care
- homeless young people
- school excludes, truants and young people underperforming at school
- young people living in deprived neighbourhoods
- Young people suffering abuse.

Disliking school and violence in school and the home are also identified as factors linked to teenage pregnancy

Another major predictor is being in or recently having left care

What vulnerabilities does the young person present with?

- live in unstable families that are unlikely to be able to offer support
- may have become pregnant as a result of child sexual exploitation
- are under the age of 13
- are concealing the pregnancy from their family and/or are concerned about their parent's reaction to the pregnancy
- have specific issues that make them more vulnerable, for example mental health difficulties.

Protective factors

Teenage mothers who do better are aided by:

- support from family
- having a positive partner relationship
- developing a career or having employment they liked

Wider contextual considerations for assessment

Family of origin

Both parent's culture of origin.
Parental criminal/ ante-social behaviour
The extent of any parental alcohol and substance misuse and its consequences for them and their family.
Presence and degree of any parental conflict including physical violence.
What caused this violence?
Who was it directed towards?
What were the consequences of that violence then and now?
What did their parents enjoy doing together?
Extent of parental separations and family bereavements?
Family interests and activities?
Allocation of roles and responsibilities?
Family demonstration of feelings?

Childhood

The nature and quality of family relationships and the type and adequacy of role modelling.

What was it like to be a child in their family home?
Who was special to them and who cared for them the most?
What was their place in the family?
Were they abused or neglected, if so, who by, for how long?
What was the emotional and behavioural consequence for them?
Had there been any referrals to professional agencies?

Any periods of time in local authority care?

School

Mainstream or special schooling?

Subject to any statement of special educational needs?
Any academic difficulties, behaviour, or attainment issues?
School achievements, aptitude, abilities, and qualifications?
Existence of any attendance issues?
Reasons for any changes in schooling, moves or exclusions etc?
Any other significant events?

Occupational/social/recreational history

Degree of success in establishing adult relationships, social, intimate, employment and the degree of satisfaction with these?

Employment history, evidence of any dismissal and extent to which this may indicate social incompetence, problems with authority or substance misuse?
Types of jobs, performance, satisfaction and level of responsibility and dependability.
Types of leisure activities/hobbies/clubs etc and extent to which these reflect their social skills and self-image?

Criminal history

Number of previous offences? (one of the best predictors of future abuse is the number of previous offences)

Are the offences against people or property, social rule violations e.g. drink driving?
What is the frequency, circumstances, and motivation of the offending behaviour?
When did they become known to the Police/other criminal agencies? What were the circumstances?
Details of previous disposals and the responses to these?
Are they entrenched in their behaviour and what does this mean for the expectant baby?
Is their evidence of escalation in criminal behaviour?

What were their modus operandi and antecedent conditions or behaviours?
Details of victim; ages, offences, and consequences for the adult/child?

Current Family Structure and Sources of Support

What is the family's culture now and that of their origin?
How the parents met?
Why they stay together?
How their relationship has developed and changed?
The positive and negative attributes that exist within the relationship?
Individual parents physical/emotional/intellectual abilities?
Previous parental experiences i.e. number of children?
Extent of disputes and violence in previous relationships?
Extent of abuse substance misuse in previous relationship?
Potential impact of previous problematic adult relationships on couple?
Parents hopes, aspirations, strengths, and talents?
Parents range of support networks?
Extent to which parents engage with professional agencies?
Parent's ability to use family strengths to produce positive change.

Attitudes to Previous Interventions

Do the parent(s) understand and give a clear explanation of the circumstances in which the abuse occurred?
Do they accept responsibility for their role in the abuse?
Do they blame others?
Do they blame the child?
Do they acknowledge the seriousness of the abuse?
Did they accept any treatment/counselling?
What was their response to previous interventions? E.g. genuinely attempting about that child now
What has changed for each parent since the child was abused or removed?

Parents' feelings towards the current pregnancy and the new baby

Is the pregnancy wanted or not?
Is the pregnancy planned or unplanned?

Is this pregnancy the result of sexual assault?
Is domestic abuse an issue in the parents' relationship?
Is the perception of the unborn baby different/abnormal?
Are they trying to replace any previous children?
Have they sought appropriate ante-natal care?
Are they aware of the unborn babies needs and able to prioritise them? Do they have realistic plans in relation to the birth and their care of the baby?

Previous Abuse and Acceptance of Responsibility

The circumstances of the abuse: e.g. was the perpetrator in the household?

Was the non-abusing parent present?
What relationship/contact does the mother have with the perpetrator
How did the abuse come to light? E.g. did the non-abusing parent disclose or conceal?
Did the child tell? Did professionals suspect?
Did the non-abusing parent believe the child? Did they need help and support to do this?
What are current attitudes towards the abuse? Do the parents blame the child/see it as her/his fault?
Has the perpetrator accepted full responsibility for the abuse? How is this demonstrated? What treatment did he/she have?
Who else in the family/community network could help protect the new baby?
How did the parent(s) relate to professionals? What is their current attitude?

Non-Abusing Parents Ability to Protect

How critical or uncritical are they regarding their partner's abusive behaviour?
To what extent were they party to or aware of their partner's abusive behaviour?
What has changed regarding their understanding of past abuse?
To what extent to they accept responsibility for failure to protect or collusion with the abuse?

What is the non-abusing parent's position regarding the abuse/ conviction both at the time and now?
What information do they have regarding the abuse and who provided it?
Can additional information be provided to move the parent from any disbelieving position?
What feelings do they have to the child? E.g. anger, sympathy, blame?
To what extent does the non-abusing partner accept that their partner was responsible for the abuse?
To what extent can the non-abusing partner work with Children's Social Care and other agencies?
Could/can they choose their unborn child over abusing partner?
To what extent is the non-abusing partner dependent on the abuser?
How vulnerable is the non-abusing partner?
Do they have a history of violent or abusive relationships?
Does the non-abusive partner have other vulnerabilities i.e. disability, ill health, or other condition that isolates them from help?
To what extent do they recognise the existence of future risk to the unborn child
What is their ability to manage this?
What level of knowledge do they have re the impact sexual offending behaviour in general and specific to partner?

<u>Understanding of expectant baby's needs and ability to meet them</u>

What are the social and cultural expectations of the family?
What are the ethnic expectations of the family role and interventions?
What are the family roles for women, children, men, and elders?
What is the response to ethnic history?
What is the impact of any racism?
What is the impact of class and social position?
Is the family integrated/marginalised/powerful/powerless?
What belief systems and values influence role expectations, define and set limits of acceptable behaviour?
What are the key support structures?
Which are the key relationships within the immediate and extended family?
What life cycle stage are the family at/ what are the risks and challenges?

What solutions are used to manage family conflict?
How have the parents both individually and together responded to their expected baby?
To what extent are the parents developing a sense of attachment to their expected baby?
How do the parents build relationships and whose responsibility to they feel it is?
What understanding do the parents have of their expected baby's basic needs?
Do the expectant parents have the capacity to provide 'good enough parenting' to the expected baby?

<u>Parent's potential for and motivation for change</u>

Can the parent's make the required changes in the timeframe for the child?

Is there a history of successfully making changes?

Were they sustained?

Are the services to help the parents if they so wish available/accessible?

Are there elements of previous professional involvement that means they are resigned to the outcome and so disengage?

Overall Risk Assessment Analysis and Conclusions (with) Recommended Actions with Timescales

The collection of information needs to be organized, carefully considered, and then applied to an evidence-informed framework of indicators of risk as well as protective factors. Ideally the following areas should inform that process:

Concerns identified

Strengths or mitigating factors identified

Is there a risk of significant harm for this baby? It is crucial to clarify the nature of any risk - of what? From whom? In what

circumstances? etc. - and to be clear how effective any strengths or mitigating factors are likely to be

Will this risk arise:

- Before the baby is born.
- At or immediately following the birth?
- Whilst still a baby (up to 1 year old)?
- As a toddler? or pre-school? or as an older child?
- If there is a risk that the child's needs may not be appropriately met. e. What changes should ideally be made to optimise well-being of child? If there is a risk of significant harm to the child.

What changes must be made to ensure safety and an acceptable level of care for child? E.g. How motivated are the parents to make changes?

How capable are the parents to make changes?

What is the potential for success and history of making change as assessed by professionals?

This new risk estimation framework tries to offer a useful template for workers to locate the information they have collected. Workers should identify which are present as a starting point and then examine the balance of risks and strengths across the three areas of unborn, parent and wider considerations. Judgements then need to be made about the balance as well as the mix of risks and protective factors to draw some preliminary conclusions. It may also identify where there are gaps and time permitting, those need to be covered.

The strengths of this structure are that it is generic and therefore all-embracing but it requires the support from other additional tools when the balance of risks and strengths is unclear or professionals are stuck.

Indicators of risk and protective factors to inform analysis

	RISK FACTORS	PROTECTIVE FACTORS
UNBORN CHILD	Unwanted/concealed pregnancy Pregnancy as a result of rape Complex medical needs/special needs such as disability or substance withdrawal Unrealistic expectations of baby Poor engagement and/or cooperation with ante-natal services Low birth weight Premature birth Stressful gender issue Foetal abnormalities	Wanted pregnancy Healthy pregnancy and good foetal development Realistic expectations of baby Good engagement and co-operation with agencies Attends all necessary adult as well as child health appointments
PARENTS	Childhood experience of neglect and abuse Lack of positive parenting role models e.g. care leaver Lack of awareness of child's needs Lack of preparation for the child's birth Abuse or neglect of previous children Siblings removed Presence of mental health, substance misuse, learning difficulties that could	Positive childhood experiences Good parenting role models Good awareness of child's needs Good preparation for birth Absence of any parental issues that could impact on their ability to parent Previous positive experiences of being a parent

	impact on their ability to parent Very young or immature parent Poor contact with professionals Inability to work with professionals Unattached to unborn baby Exhibits inappropriate parenting plans No plans Inability to prioritize baby's needs Perceptions different /abnormal Denial of past abuse Violence/abuse of others Post-natal depression Past antenatal or postnatal neglect No commitment to parenting Lack of self-care skills Low reflective function Communication difficulties No recourse to public funds Asylum seekers	Good contact with professionals Realistic expectations and understanding about potential issues Significant changes to health behaviours demonstrated and sustained (e.g. stopped smoking or drinking) Early signs of bonding to the child Improvements in reflective function Evidence of understanding about the impact of early life experiences Ability to reflect and work on relevant issues Evidence of establishing daily routines and making the home safe and secure for the child Commitment to providing for all the child's basic needs – food, clothes, warmth, personal hygiene, comfort, safety, stimulation, age-appropriate activities etc.

FAMILY, HOUSEHOLD OR ENVIRONMENTAL	Poor adult relationships, domestic abuse, and violence Relationship disharmony/instability Frequent changes of partner/multiple relationships Inappropriate associates Homeless or unstable housing Poor home conditions Frequent moves of house Significant debt/unemployment Lack of family or community support Criminal activity /anti-social behaviour Inappropriate social networks – such as violent or deviant Unsupportive of each other Pets – uncontrolled and/or potentially dangerous Mistreated animals	Good adult relationships Stable home in good condition Stable finances and employment Well supported by family and wider community Support for the expectant mother of at least one caring adult An alternative, safe, and supportive residence for expectant mothers subject to violence and threat of violence Safe storage of drugs, safe storage, and disposal of injecting equipment Ability to manage associates who are part of a history of substance misuse Contingency plans in place in the event that parents unable to provide adequate supervision e.g. a named responsible adult

I am including a couple of examples of supplementary specific frameworks that may offer some further guidance to workers.

Unborn babies of children in care or care leavers

RED	✓	AMBER	✓	GREEN	✓
There has been a previous unexplained death of a child whilst in the care of either parent		History of low mood or anxiety or low level substance / alcohol use (either parents)		All children in care or care leavers who are parents to be should be supported to engage with early intervention / preventative services through universal services.	
A parent or other adult in the household, or regular visitor, has been identified as posing a risk to children					
A sibling to the unborn / baby is the subject of a child protection plan or is or has been looked after (voluntarily or via a court order)		Previous parental childhood experiences / experience of poor parenting /sexual abuse			
The parent is a child in care (under age of 18yrs)		Previous concealed pregnancy			
Domestic abuse is known to have occurred or there are concerns about the current parental relationship (control, coercion, emotional abuse etc)		Unstable housing, risk of eviction or temporary housing situation			
The degree of parental mental illness/ impairment, learning disability, physical disability, substance misuse is likely to have a significant impact on the baby's safety, care or development		Concern about lack of support network and / or isolation from family / friends / community.			
There are concerns about parental maturity and ability to self care and look after a child.		Stresses related to finances, work or lack of work, benefits			
The parent to be is under 13 years old		Disengagement or poor engagement with SW / LCW			
Any other concern exists that the baby may be likely to suffer significant harm including a parent previously suspected of fabricated or inducing illness in a child					
Parent not registered with GP with no intention of this					

RED	✓	AMBER	✓	GREEN	✓
WHAT DO YOU NEED TO DO NOW?					
If one or more ticks then an automatic referral to social care needs to be made and a discussion with the midwife is needed	**TOTAL**	If one or two ticks then a discussion with the midwife is needed referencing the reason for concern as a minimum. If a more than two ticks present then a referral to CSC is needed	**TOTAL**	Discussion with midwife as a minimum.	

Specific risk measures where substance misuse is the presenting concern

Baby	Parent	Environment
Prematurity Equipment dependency (e.g. oxygen) Medically fragile status Irritability/hyperactivity/ poor sleeping Lethargic (increases risk for neglect) Feeding difficulties Special medication needs	Denial of drug/alcohol use in spite of indication of use Parent's belief that drugs/alcohol are not a problem for her/him in spite of indication to the contrary Non-compliance with substance misuse treatment programme Entrance into drug/alcohol treatment within the third semester No prenatal care Non-compliance with prenatal care Unwanted pregnancy Parental history of abuse during childhood Unrealistic expectations/perceptions of the child's behaviour Severe intellectual limitations/ developmental disability	Unstable living situation (homeless) Safety or health hazards in the home Lack of preparations for infant History of family violence Presence of known drug user in the household Siblings with untreated health problems Siblings without current immunizations Siblings with untreated developmental delays or school problems

	Prior removal of a sibling from the parent's custody Previous allegation of child abuse/neglect Serious medical problems History of mental health problems History of violent behaviour Hostility towards the child Rejection of the child Abandonment of baby in hospital Denial of infant's problems/ symptoms Refusal to cooperate with health care team Lack of responsiveness to infant's needs Poor skills in providing care of the infant	

In many ways there are boundaries to the analysis. For parents who present with their first pregnancy the prediction of harm is a best guesstimate: the proof of the pudding only comes post-birth. The initial decision will clearly be how safe is the baby remaining with the parent/s post-birth whilst a further assessment is undertaken about seeing whether the hypothetical has become the reality. It matters therefore that the issue around what happens after the birth is attended to in some detail and should include:

Birth and discharge planning considerations

How long the baby will stay in hospital
Level of Supervision required.
How long the hospital will keep the mother on the ward
The arrangements for the immediate protection of the baby if it is considered that there are serious risks posed to the e.g. parental substance misuse
The plan should include the risk of potential abduction of the baby from the hospital particularly where the plan is to remove the baby at birth
The plan for contact between mother, father, partner, extended family, and the baby whilst in hospital. Consideration to be given to the supervision of contact - for example whether contact supervisors need to be employed
Consideration of any risks to the baby in relation to breastfeeding e.g. HIV status of the mother; medication being taken by the mother which is contraindicated in relation to breastfeeding
To plan for the baby upon discharge, where alternative care has been agreed, e.g. discharge to extended family members; mother and baby foster placement; foster care and supported accommodation
The Social Worker may need to seek a legal order to protect and safeguard the new born baby and there will need to be a discussion with the hospital to agree the child remaining on the ward until this has been resolved in the court.
The court order may not be immediately available; however, the social worker and the hospital must agree the best plan in the safety and interest of the new born baby. (A paper copy of the legal document

If may not be available to the social worker. The social worker must have identification document and follow the discharge from hospital process in the tools section of this document). The discharge from hospital process should be followed swiftly and should not delay progressing care for the baby).

Contingency plans should also be in place in the event of a sudden change in circumstances

The Children's Emergency Duty Team (Out of Hours Service) should have all discharge information as soon as it is agreed. A written discharge plan will be agreed between the hospital and the social worker and uploaded onto the child's file.

Post-birth assessment

What to look for when assessing parenting capacity

One needs to consider parent–child interaction and parental readiness to change, parents' understanding of concerns and parents' intention and commitment to change. As a practitioner, it is important that you establish the actual evidence to answer these questions.

Where there is cause for concern about what is happening to a child, it is important to gather information about how parenting tasks are being carried out by each parent/carer in terms of:

- their response to a child and his or her behaviour or circumstances
- the manner in which they are responding to the child's needs (see appendix 2 for guidance on age-focused developmental expectations)
- the areas where they are experiencing difficulties in meeting needs
- the effect this child has on them as individuals and parents/carers
- the quality of the parent–child relationship
- their understanding of the child's needs and development
- their understanding of concerns about the child's safety and/or well-being; their comprehension of parenting tasks

- the relevance of the parenting tasks to the child's developmental needs; the impact of any difficulties they may be experiencing themselves on their ability to carry out parental tasks and responsibilities
- the impact of past experiences on their current parenting capacity
- their ability to face and accept their difficulties
- their ability to use support and access help
- their capacity for adaptation and commitment to change in their parenting response.

Physical care and wellbeing

Is there any reason to be concerned about the child's physical care and wellbeing in terms of?

Nutrition and feeding?

Physical warmth?

Physical Health?

Mental and emotional health?

Safety and Protection?

Cleanliness?

Possessions and personal space?

Pets and animals?

Visitors to household?

Parents emotional involvement with the child?

If any of these may be issues, explore them in more detail as follows:

Nutrition and Feeding

Regularly fed? Enough food? Appropriate food? Patiently handled during feeding. And/or not punished for not eating? Encouraged to eat? Encouraged to develop appropriate skills? Flexible routines? Parent aware of child being over or under weight? Parent seeking help regarding

nutrition/feeding problems? Evidence that child is thriving. Or any reason to suspect that child is not thriving?

Is there anything about 'nutrition and feeding' that seems likely to have a significant negative impact on the child? If so, what is it and what is the impact?

Physical warmth

Appropriately dressed for the weather. Bedroom appropriately heated? House in general is appropriately heated?

Is there anything about 'warmth' that seems likely to have a significant negative impact on the child? If so, what is it, and what is the impact?

Physical Health (includes dental)

Physical health needs are anticipated by parent?

And get an appropriate and timely response?

Expert advice is sought appropriately regarding non-emergencies?

Expert advice is sought appropriately regarding emergencies?

Expert advice is acted on?

Any special needs of child are understood and appropriately acted on?

Parent ignores or does not recognize needs for diagnosis and/or treatment of physical health needs?

Parent acts in a way that increases likelihood of poor physical health (This may include not taking known appropriate prevention measures and/or not acting on advice in this respect).

Is there appropriate and active management of any head lice?

Is there anything about 'physical health' that seems likely to have a significant negative impact on the child? If so, what is it, and what is the impact?

Mental and emotional health

Parent ignores or does not recognize need for diagnosis and/or treatment of mental and emotional health needs.

Parent refuses to allow or provide or facilitate diagnosis and/or treatment of mental and emotional health needs.

Parent acts in a way that increases likelihood of poor mental and emotional health?

Is there anything about 'mental and emotional health' that seems likely to have a significant negative impact on the child? If so, what is it, and what is the impact?

Safety and protection

Child is not left alone inappropriately.

All babysitters are over 14? And known to child?

And are adults or young people without obvious problems that may affect ability to care for child?

Safe physical boundaries? (e.g. not allowed/able to wander from home, and /or parents have clear idea of limits of play areas).

Safety equipment in use? (e.g. stairgate regarding under 5s, fireguard etc.).

Windows and doors cannot be opened by child if unsafe for them to do so?

Appropriate safety measures in place?

Dangerous household substances kept safely? (e.g. bleach, cleaners, or insecticide etc.).

Dangerous personal items kept safely? (e.g. medication, needles, drugs etc.). Dangerous household equipment kept safely? (e.g. cookers, electrical appliances, knives, lighters etc.).

Effective supervision in potentially dangerous situations - in and out of home? Child not expected/allowed to do inappropriate dangerous tasks (e.g. cooking, lighting fires, supervising very young siblings etc.).

Any history of fire-setting? (Inside or outside the home?

By any member of household?)

Is the garden (area immediately around home) safe? (In terms of dangerous objects, boundaries, balconies, stairwells etc.)

Is there anything about 'safety and protection' that seems likely to have a significant negative impact on the child? If so, what is it, and what is the impact?

Cleanliness

General hygiene in home is reasonable?

Animal faeces (etc.) are under control? And out of reach of child?

Old food is cleared away?

Rubbish is safely disposed of.

Child has clean clothing available.

Child does not smell. And especially is not teased or rejected by peers because they smell?

Bedding is clean and dry? Food is stored hygienically.

Toilets are not fouled.

There are facilities for washing and bathing? And they are used regularly?

Does house have an unclean smell?

Is there anything about 'cleanliness' that seems likely to have a significant negative impact on the child? If so, what is it, and what is the impact?

Possessions and personal space

Child has own clothing.

Child plays with appropriate toys and possess toys of own?

Child has personal space (e.g. bedroom) - including personal privacy?

Child has appropriate personal possessions.

Is there anything about 'possessions and personal space' that seems likely to have a significant negative impact on the child? If so, what is it, and what is the impact?

Animals and pets

Are the pets appropriately cared for?

Are pet's needs prioritized over those of child?

Are pets safe in terms of harm to child? (e.g. biting, poisoning, smothering etc.)

Is significant proportion of family income being spent on pets?

To the detriment of the child?

Is denial to access to, or ill-treatment of, a pet used to control or punish the child?

Are animals avoidably harmed by any member of the household?

Do parents ensure child learns to behave appropriately with pets, and take appropriate responsibly for them?

Is there anything about 'pets and animals' that seems likely to have a significant negative impact on the child?

If so, what is it, and what is the impact?

Visitors to the household

'Visitors' may be of concern if they are 'strangers' - i.e. adults or young people who have no significant relationship with the child - or are unrelated adults or young people who live or spend significant time at the child's home. Using this definition:

Is the child's home often frequented by 'visitors' - i.e. adults or young people who have no significant relationship with them?

Is the child effectively left in the care of 'visitors'?

Does the presence of the 'visitors' disrupt the child's normal routines, or result in inappropriate routines?

Do 'visitors' needs take precedence over the child's needs?

Do 'visitors' stay overnight?

Are 'visitors' genuinely friends of a parent, or are they exploiting or abusing a parent?

Is there anything about 'visitors' that seems likely to have a significant negative impact on the child?

If so, what is it, and what is the impact?

<u>Parent's emotional involvement with child</u>

Child not comforted when distressed?

Parent expects comfort form child when parent distressed?

Child is denigrated.

Child is not rewarded/praised for effort to achieve?

Or no pride taken by parent in child's achievements of efforts?

Or parent emphasizes and/or punishes failure?

Parent has limited physical and emotional contact with the child?

Affection is not shown and expressed?

Parents have negative attitude toward child.

Parents lack emotional maturity. (e.g. do they genuinely care for/support each other and can they articulate this?)

Sense of belonging and togetherness and security in the family? (i.e. sense of parent's commitment to the child and to protect the child?)

Child is free to express themselves

Is there anything about 'emotional involvement' that seems likely to have a significant negative impact on the child? If so, what is it, and what is the impact?

Also consider the way in which the parent interacts with the child in the following terms:

Style of Interaction Indicators

Controlling overt hostility

Physically abrupt

Physically rough

Angry

Impatient

Controlling

Covert hostility

Ignores child's mood and wishes

Demonstrates pseudo-sensitivity

Child's wishes not seen as important or are devaluated by parent

Unresponsive

Parent distant and emotionally unavailable

Parent disinterested in child

Sensitive

Parent is alert to child and child's needs, and attuned to them

Inept - all of the above

Parent unable to maintain coherent pattern of sensitively, or sustain over time

Also consider the attachment of parent and child.

<u>Routines</u>

Routines are age appropriate regarding meals, bedtimes, access to television, school attendance, homework?

Routines are consistent and consistently applied?

Is there anything about 'routines' that seems likely to have a significant negative impact in the child? If so, what it is and what is the impact?

Controls

Child is locked or shut in rooms or cupboard etc.?

Child is subject to punishment or sanctions that cause damage or pain?

Parent not able to instigate/ maintain appropriate controls and/or maintain structure/routines and/or ensure safety and protection

Is there anything about 'controls' that seems likely to have a significant negative impact in the child? If so, what it is and what is the impact?

Parent's expectations of child

Age appropriate?

Ability appropriate?

Poor awareness of child's needs?

Poor awareness of child's developmental progress?

Unrealistic?

Significant inconsistent?

Child inappropriately expected or allowed to act as carer for parent or sibling?

Is there anything about 'parents' expectations' that seems likely to have a significant negative impact in the child? If so, what it is and what is the impact?

<u>Domestic Violence</u>

Does the child experience domestic violence as part of family life? ('Experience' means being aware of, not just being actually involved in it or seeing it. Violence includes assault, verbal abuse, and threats).

Is there anything about 'domestic violence' that seems likely to have a significant negative impact in the child? If so, what it is and what is the impact?

Parent's behaviour

Parent not able to instigate and maintain basic routines?

Parent's behaviour is chaotic and/or unpredictable and/or inconsistent?

Parent allows multiple carers especially if they do not have a relationship with the child?

Parent allows age/gender inappropriate carers?

Parent leaves child unattended?

Parent provides reactive rather than proactive care?

Parent treats animal better than child?

Parent acquires possessions for themselves, but markedly less so for child.

Parent provides better living conditions for themselves then for child. (e.g. bedrooms).

Parent does not help child to know right from wrong.

Parent involves child in criminal/drug related/anti-social behaviour?

Parent does not appropriately attempt to address child's inappropriate behaviour? This includes committing offences, causing damage, being abusive and/or threatening, not attending school etc. Parents allows, or does not discourage, or fails to prevent bullying by siblings.

Is there anything about 'parents behaviour' that seems likely to have a significant negative impact in the child? If so, what it is and what is the impact?

Appendix 3 offers some sample worksheets to support staff both in the pre-birth and post-birth assessments and can also be used as educational as well as assessment orientated.

NOTES

Appendix 1: Drugs and their effects on the developing baby

All women should be given information on the effects of smoking, alcohol use and drug use in pregnancy. Ideally, information should be given well before conception so that the woman has an opportunity to modify her drug use before she becomes pregnant.

The general answer to a question like 'I took some x before I found out I was pregnant. Is it likely to harm the baby?' is almost certainly 'no'. However, outcomes depend on the drug used, the amount taken, over what time period, how it was taken, at what stage in pregnancy, and many other factors such as diet and social circumstances. One unfortunate aspect of over-emphasising the likelihood of adverse effects is that it may persuade some concerned women to inappropriately consider termination. Others may suddenly stop their dependent drug use (which could be dangerous to the foetus) or avoid engaging with professionals because of exaggerated concerns.

Drug use is associated with increased rates of obstetric and paediatric mortality and morbidity and can affect pregnancy in a number of ways. During the 1st trimester, when foetal organs are actually forming, teratogenic (malformation) effects are the main concern. This is a time when the woman may not even know she is pregnant. During the 2nd and 3rd trimester the main concern is about growth and functional development. Impaired placental function and foetal growth can result in a low birth weight baby. Chaotic drug use can increase the risk of pre-term labour and result in early delivery. The risk of Sudden Infant Death Syndrome (SIDS) is increased and Neonatal Abstinence Syndrome is common in the babies of women who are dependent on certain drugs.

Many women with alcohol / drug related problems feel worried and guilty about the effects of their drug use on the baby and may appear reluctant to discuss these issues as a result. Professionals need to give parents license to voice concerns, fears, and questions that they are reluctant to bring up spontaneously. Very often parents will be relieved when a professional raises the subject and encourages them to share their concerns. Allowing them to voice anxieties about poor outcome and their ambivalence about

their current situation, including their substance use, treatment and so on can be therapeutic. Parents often complain that they are not 'told enough' and professionals comment that parents are 'ill prepared' or 'ill informed'.

Effects of tobacco

The significant risks associated with maternal use of tobacco are particularly well established. There are many harmful substances contained in cigarettes. Nicotine, carbon monoxide and cyanide are thought to have the greatest adverse effects, reducing blood flow and oxygen to the foetus. Maternal smoking in the first 12 weeks of pregnancy (until the end of the 1st trimester) is responsible for up to 25% of all low birth weight babies. Smoking tobacco causes a reduction in birth weight greater than that from heroin and is a major risk factor in Sudden Infant Death Syndrome. Although there is no convincing evidence that smoking cigarettes causes congenital birth defects, many other pregnancy complications are associated with smoking (Johnstone 1998). These include:

- miscarriage
- pre-term (premature) delivery
- stillbirth
- intrauterine growth restriction (IUGR) or 'small for dates'
- low birth weight
- placental abruption
- reduction in breast milk production
- sudden Infant Death Syndrome (SIDS or 'cot death').

Babies born to heavy smokers may also exhibit minor signs of withdrawal, including 'jitteriness' in the perinatal period. Children of smokers also suffer more respiratory infections in childhood and adolescence.

Effects of alcohol

Alcohol use during pregnancy may potentially affect foetal brain development at any gestation. At all points along the continuum from occasional light drinking to regular heavy drinking there is conflicting evidence as to the possibility of damaging effects on the foetus.

Very heavy drinking in pregnancy (including heavy 'binge' drinking) results in a small number of babies being born with foetal Alcohol Syndrome (FAS). In Scotland, there are an estimated 38 babies born per year with FAS. Foetal Alcohol Syndrome is characterised by:

- foetal growth restriction (with subsequent low birth weight, reduced head circumference and brain size)
- Central nervous system problems, including cognitive dysfunction (learning difficulties) and neurological abnormalities
- A cluster of characteristic facial abnormalities e.g. short palpebral fissures (eye openings), thin upper lip, flattened midface, and indistinct philtrum
- Failure to thrive (the child remains below the 10th centile)

Studies that report alcohol consumption related to FAS have found high levels of drinking (>42 units per week). Patterns of consumption also seem to be important. Frequent high dose ('binge') drinking, to the point of intoxication, is thought to be a greater risk to the foetus than steady moderate drinking. Many other confounding factors, however, may be important. These include general physical health, nutrition, age, parity, smoking and other drug use as well as social deprivation. A wide range of other alcohol-related birth defects (ARBD) appear to occur with heavy drinking. These 'foetal alcohol effects' include more subtle problems identified on behavioural, cognitive, psychological and educational tests.

<u>Cannabis (e.g. marijuana or 'hash')</u>

Despite its widespread use, information on the effects of cannabis in pregnancy is generally poor. A review of cannabis by the World Health Organisation (1997) concluded that there was no good evidence that cannabis itself has a direct effect on pregnancy or the developing baby.

Cannabis, however, is normally mixed together with tobacco and smoked in a 'joint'. Tobacco causes a reduction in birth weight, increased risk of sudden infant death syndrome (SIDS or 'cot death') and many other pregnancy complications.

Benzodiazepines (e.g. diazepam & temazepam)

There is no conclusive evidence that benzodiazepine use by the mother causes adverse effects on the developing foetus. Most studies, however, have studied low dose use, whereas many drug users in Lothian report high dose intake. There have been some reports of facial abnormalities (i.e. cleft lip and palate) following prolonged high dose benzodiazepine use in early pregnancy but these findings have not been reliably reproduced. Benzodiazepines are associated with withdrawal symptoms in the new-born baby that can be severe and prolonged. Because of concerns about the possible increased risk of cleft palate, reduced growth and brain development and long-term outcomes for the baby, dependent women are normally advised to gradually reduce their benzodiazepine use during pregnancy.

Opioids (e.g. heroin, methadone, dihydrocodeine)

Evidence on the effects of opioids is fairly limited, particularly on the long-term effects on the child. Opioids are associated with an increased risk of:

- low birth weight
- intrauterine growth restriction (IUGR) or 'small for dates'
- pre-term delivery (associated with foetal withdrawal in-utero, poor diet, and maternal health)
- Sudden Infant Death Syndrome ('SIDS' or 'cot death').

There is no convincing evidence that opioids cause any significant or permanent neurological damage or increased risk of congenital abnormalities. Abrupt withdrawal of opiates (i.e. 'cold turkey') has been associated with miscarriage in the 1st trimester and stillbirth and pre-term labour in the 3rd trimester. Sudden opiate withdrawal is therefore considered potentially dangerous to the foetus, although the risks of

withdrawal have probably been exaggerated in the past and can be minimised by appropriate drug therapy for the mother. Most studies that report these findings relate to women with a history of injecting opiate use (primarily 'heroin') and chaotic illicit drug use. See section on 'Management of problem drug use' for further information on drug reduction and detoxification during pregnancy.

Neonatal Abstinence Syndrome

NAS or 'neonatal withdrawal') is well documented in babies born to opiate dependent women and is the most commonly reported effect of opiate use in pregnancy.

Cocaine and 'Crack'

Cocaine is a powerful vasoconstrictor (restricting blood flow and oxygen to the foetus) and this effect is reported to increase the risk of:

- placental abruption (placental separation with haemorrhage and foetal hypoxia)
- intrauterine growth restriction (including reduced brain growth)
- underdevelopment of organs and/or limbs
- foetal death in-utero (miscarriage and stillbirth)
- low birth weight babies
- pre-term (premature) delivery.

Adverse effects have been largely reported in heavy crack/cocaine users, rather than with 'recreational' or occasional users. Cocaine 'binges' can potentially cause foetal brain infarcts due to sudden reduced blood flow. Mothers-to-be should be advised not to use cocaine or 'crack' in pregnancy if they possibly can.

High dose cocaine use in the mother can result in the new-born showing signs of intoxication at birth that include: 'jitteriness', irritability, hypertonia, poor feeding and an abnormal sleep pattern. Neonatal Abstinence Syndrome (NAS) has not been reliably reported.

Dependent crack/cocaine users should be managed by the consultant obstetrician and referred to a specialist drug agency for help (see 'services' list).

Amphetamines (e.g. 'speed' or 'whizz')

There is no conclusive evidence that amphetamine use directly affects pregnancy outcomes. However, amphetamine sulphate is a powerful CNS stimulant and heavy users tend to have poor health (due to poor nutrition, weight loss, anaemia, and mental health problems). Like cocaine, amphetamines cause vasoconstriction and hypertension, which may result in foetal hypoxia. Withdrawal symptoms in the new-born baby have not been reliably reported with amphetamine use. As with other drugs, in the absence of good data, advice should be to avoid or at least reduce intake during pregnancy.

Ecstasy ('E')

There is no conclusive evidence that ecstasy use directly affects pregnancy outcomes, however information in the literature is very scarce. Heavy users of ecstasy may have poor physical and mental health (e.g. depression) and this may affect outcome. Ecstasy use by the mother does not appear to cause withdrawal symptoms in the new-born baby.

Hallucinogens (e.g. LSD (lysergic acid diethylamide or 'acid') and 'Magic Mushrooms')

There is little evidence regarding the effects of hallucinogens in pregnancy. There is no evidence of congenital malformations and no conclusive evidence of other increased risks in pregnancy.

Solvents & volatile substances (e.g. 'glue' and butane gas)

There is little evidence regarding the effects of solvent and volatile substance use in pregnancy. However, inhaled solvents may reduce oxygen supply to the foetus and Neonatal Abstinence Syndrome has been reported in heavy users. A number of young people in Scotland die each year from the effects of volatile substances (usually as a result of arrhythmia) and

women who continue to use volatile substances in pregnancy run the risk of sudden death.

Neonatal Abstinence Syndrome (NAS)

A group of drug withdrawal symptoms referred to as Neonatal Abstinence Syndrome (NAS) can occur in infants born to mothers dependent on certain drugs. NAS occurs because, at birth, the infant is cut off from the maternal drug supply to which it has been exposed in utero. NAS is the most commonly reported adverse effect of dependent drug use in pregnancy. In Lothian, approximately 40 babies present with NAS each year and this number is likely to increase with the increasing prevalence of substance misuse.

The classes of drugs that are known to cause NAS include the opioids, benzodiazepines, alcohol, and barbiturates. Classical symptoms of NAS have not been consistently reported with solvents, hallucinogens, cannabis, and most stimulants. NAS symptoms are generally non-specific to the class of drug and differ from drug withdrawal symptoms seen in adults.

NAS is well described in babies born to opiate dependent women. The majority of infants born to dependent mothers (60-90%) will show varying symptoms of NAS.

NAS is characterised by central nervous system irritability, gastrointestinal dysfunction, and autonomic hyperactivity. The following signs and symptoms have been reported in babies born to opiate and benzodiazepine dependent women (including polydrug users) and describe the more severe range of symptoms that a baby may display:

- irritability (marked tremor, easily startled, increased reflexes and excessive crying)
- hyperactivity (excessive body movements, face scratching)
- hypertonicity (increased muscle tone and rigidity)
- a fairly continuous high-pitched cry
- inability to settle or sleep after feeds

excessive sucking (including fist sucking)

increased appetite

poor feeding ability (hungry but difficulty in sucking, swallowing and successfully completing a feed)

regurgitation and vomiting

frequent loose stools or diarrhoea (which cause peri-anal excoriation)

poor weight gain or weight loss

repetitive sneezing, yawning, hiccoughs, nasal stuffiness

tachypnoea (rapid shallow breathing)

respiratory depression

increased pulse and heart rate

temperature instability, fever (>37.5 C), sweating and dehydration

mottling (discolouration of skin)

excoriation (skin abrasions) from excessive movement (usually seen around the buttocks, back of the head, shoulders, and heels)

seizures (fits)

Seizures occur rarely (in approximately 5% of infants) and may manifest up to 30 days after birth (mean age of onset is 10 days). The onset, duration, and severity of NAS symptoms vary greatly and depend on many factors, including the:

type of drugs used

duration of mother's dependency

timing and amount of the mother's last dose

metabolism and elimination of the drug by the infant, as well as the

gestational age of the infant.

Data on possible dose related effects of methadone are inconclusive. Some studies show no correlation between maternal methadone dose and the development or severity of NAS. Others have found a weak positive correlation. Little data exists on the dose related effects of maternal benzodiazepine use. Symptoms normally present within the first 24 - 72 hours of birth (in approximately 75% of cases). Methadone withdrawal in the neonate can present later than heroin withdrawal. Methadone withdrawal symptoms can also last longer and be more severe. The onset of benzodiazepine withdrawal in neonates can also be delayed (due to slow metabolism in the neonate) presenting at 5-10 days of age (Coghlan et al 1999).

Acute symptoms of NAS may persist for several weeks and irritability can last for some months (particularly from benzodiazepines). Pharmacological treatment is required for some infants with acute symptoms (approximately 25% - 40%). Most studies show that babies who require treatment develop symptoms within 72 hours of birth, including babies born to methadone dependent women.

Withdrawal symptoms in pre-term infants tend to occur later than full-term infants and are generally milder and require less treatment. This is thought to be due to a number of different factors, including: their reduced total drug exposure in utero, the developmental immaturity of their central nervous system, the different metabolism of pre-term infants, and reduced ability to communicate the distress of withdrawal. Some babies may present with symptoms of NAS with no reported history of maternal drug use. If NAS is suspected, then the neonatal paediatrician can confirm the diagnosis by toxicology and will discuss the results sensitively with the parents.

Parents who have an infant with NAS experience the same range of emotions as any other parent of a new-born baby who is poorly. Anxiety, helplessness, fear, and grief are commonly reported feelings. In addition, they often feel guilty and ‘to blame’ for their baby’s condition and will require considerable support, reassurance, and encouragement. Caring for a baby with NAS can be very stressful and parents will require a lot of

patience. Involving the parents in all the decisions and choices about their infants care and keeping them fully informed of the baby's progress is important. Ideally, parents will have been given clear and accurate information about NAS in the antenatal period so that they are well prepared.

Antenatal screening for problem drinking

The T-ACE questions are listed below.

> T (tolerance) How many drinks does it take to make you feel high? Answer: '3 or more drinks' scores 2 points
>
> A (annoyance) Have people annoyed you by criticising your drinking? Answer: 'Yes' scores 1 point
>
> C (cut down) Have you ever felt you ought to cut down your drinking? Answer: 'Yes' scores 1 point
>
> E (eye-opener) Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? Answer: 'Yes' scores 1 point

A total score of greater than or equal to two points is considered positive.

Sudden Infant Death Syndrome (SIDS)

Maternal tobacco use, as well as drug and alcohol misuse are associated with an increased risk of Sudden Infant Death Syndrome ('SIDS' or 'cot death'). All parents who use these drugs should be given advice about how to reduce the risk of cot death. The leaflet 'Reducing the risk of cot death' (produced by the Scottish Executive 2000) is included in the hospital 'discharge pack'.

Risk of relapse

In the postnatal period, increased drug and alcohol use is common. For women who have managed to reduce their intake during pregnancy or even come off drugs or alcohol, the risk of relapse to former levels of drug taking is high. There are a number of reasons for this, including:

- feeling that it's now OK to use again

- relief at having a ‘normal’ baby
- wanting to celebrate!
- the stress of caring for a new born baby (perhaps with NAS)
- ‘baby blues’ or postnatal depression
- poor support from partner or family
- anxieties about motherhood

It is important for professionals to acknowledge that relapse is common. Re-assessment of substance use and careful drug management is essential at this time, along with support to remain stable and to prevent relapse.

Ensuring the woman is engaged with a specialist drug and alcohol agency that can provide a relapse prevention service may be an important part of the postnatal care plan.

Appendix 2

Child Development Checklist 0-5 years

By the end of 3 months	
Social and Emotional	• Begins to develop a social smile • Enjoys playing with other people and may cry when playing stops • Becomes more expressive and communicates more with face and body • Imitates some movements and facial expressions
Movement	• Raises head and chest when lying on stomach • Supports upper body with arms when lying on stomach • Stretches legs out and kicks when lying on stomach or back • Opens and shuts hands • Pushes down on legs when feet are placed on a firm surface • Brings hand to mouth • Takes swipes at dangling objects with hands • Grasps and shakes hand toys
Vision	• Watches faces intently • Follows moving objects • Recognises familiar objects and people at a distance • Starts using hands and eyes in coordination
Hearing and Speech	• Smiles at the sound of your voice • Begins to babble • Begins to imitate some sounds • Turns head toward direction of sound
By the end of 7 months	
Social and Emotional	• Enjoys social play • Interested in mirror images • Responds to other people's expressions of emotion and appears joyful often
Movement	• Rolls both ways (front to back, back to front) • Sits with, and then without, support on hands • Supports whole weight on legs • Reaches with one hand • Transfers object from hand to hand • Uses hand to rake objects
Vision	• Develops full colour vision • Distance vision matures • Ability to track moving objects improves

Language	• Responds to own name • Begins to respond to 'No' • Can tell emotions by tone of voice • Responds to sound by making sounds • Uses voice to express joy and displeasure • Babbles chains of sounds
Cognitive	• Finds partially hidden object • Explores with hands and mouth • Struggles to get objects that are out of reach
By the end of 12 months	
Social and Emotional	• Shy or anxious with strangers • Cries when mother or father leaves • Enjoys imitating people in his/her play • Shows specific preferences for certain people and toys • Tests parental responses to his/her actions during feedings • Tests parental responses to his/her behaviour • May be fearful in some situations • Prefers mother and/or regular caregiver over all others • Repeats sounds or gestures for attention • Finger-feeds him/herself • Extends arm or leg to help when being dressed
Movement	• Reaches sitting position without assistance • Crawls forward on belly • Assumes hands-and-knees position • Creeps on hands and knees • Gets from sitting to crawling or prone (lying on stomach) position • Pulls self up to stand • Walks holding on to furniture • Stands momentarily without support • May walk 2 or 3 steps without support
Hand and Finger Skills	• Uses pincer grasp • Bangs 2 objects together • Puts objects into container • Takes objects out of container • Lets objects go voluntarily • Pokes with index finger

Language	• Pays increasing attention to speech • Responds to simple verbal requests • Responds to 'No' • Uses simple gestures, such as shaking head for 'No' • Babbles with inflection (changes in tone) • Says 'Dada' and 'Mama' • Uses exclamations, such as 'Oh-oh!' • Tries to imitate words
Cognitive	• Explores objects in many different ways (shaking, banging, throwing, dropping) • Finds hidden objects easily • Looks at correct picture when the image is named • Imitates gestures • Begins to use objects correctly (drinking from cup, brushing hair, dialing phone, listening to receiver)
By the end of 2 years	
Movement	• Walks alone • Pulls toys behind while walking • Carries large toy or several toys while walking • Begins to run • Stands on tiptoe • Kicks a ball • Climbs onto and down from furniture unassisted • Walks up and down stairs holding on to support
Hand and Finger Skills	• Scribbles on his or her own • Turns over container to pour out contents • Builds tower of 4 blocks or more • Might use one hand more often than the other
Language	• Points to object or picture when it is named for him/her • Recognises names of familiar people, objects and body parts • Says several single words (by 15 to 18 months) • Uses simple phrases (by 18 to 24 months) • Uses 2- to 4-word sentences • Follows simple instructions • Repeats words overheard in conversation
Cognitive	• Finds objects even when hidden under 2 or 3 covers • Begins to sort by shapes and colours • Begins make-believe play
Social	• Imitates behaviour of others, especially adults and older children • More aware of him/herself as separate from others • More excited about company of other children

Emotional	• Demonstrates increasing independence • Begins to show defiant behaviour • Separation anxiety increases toward mid-year, then fades
By the end of 3 years	
Movement	• Climbs well • Walks up and down stairs, alternating feet (one foot per stair step) • Kicks ball • Runs easily • Pedals tricycle • Bends over easily without falling
Hand and Finger Skills	• Makes up-and-down, side-to-side and circular lines with pencil or crayon • Turns book pages one at a time • Builds a tower of more than 6 blocks • Holds a pencil in writing position • Screws and unscrews jar lids, nuts and bolts • Turns rotating handles
Language	• Follows a 2- or 3-part command • Recognises and identifies almost all common objects and pictures • Understands most sentences • Understands placement in space ('on', 'in', 'under') • Uses 4- to 5-word sentences • Can say name, age and sex • Uses pronouns (I, you, me, we, they) and some plurals (cars, dogs, cats) • Strangers can understand most of his/her words
Cognitive	• Makes mechanical toys work • Matches an object in hand or room to a picture in a book • Plays make-believe with dolls, animals and people • Sorts objects by shape and colour • Completes puzzles with 3 or 4 pieces • Understands concept of 'two'
Social	• Imitates adults and playmates • Spontaneously shows affection for familiar playmates • Can take turns in games • Understands concept of 'mine' and 'his/hers'
Emotional	• Expresses affection openly • Expresses a wide range of emotions • By 3, separates easily from parents • Objects to major changes in routine

By the end of 4 years	
Movement	• Hops and stands on one foot up to 5 seconds • Goes upstairs and downstairs without support • Kicks ball forward • Throws ball overhand • Catches bounced ball most of the time • Moves forward and backward with agility
Hand and Finger Skills	• Copies square shapes • Draws a person with 2 to 4 body parts • Uses scissors • Draws circles and squares • Begins to copy some capital letters
Language	• Has mastered some basic rules of grammar • Speaks in sentences of 5 to 6 words • Speaks clearly enough for strangers to understand • Tells stories
Cognitive	• Correctly names some colours • Understands the concept of counting and may know a few numbers • Tries to solve problems from a single point of view • Begins to have a clearer sense of time • Follows 3-part commands • Recalls parts of a story • Understands the concepts of 'same' and 'different' • Engages in fantasy play
Social	• Interested in new experiences • Cooperates with other children • Plays 'Mom' or 'Dad' • Increasingly inventive in fantasy play • Dresses and undresses • Negotiates solutions to conflicts • More independent
Emotional	• Imagines that many unfamiliar images may be 'monsters' • Views self as a whole person involving body, mind, and feelings • Often cannot tell the difference between fantasy and reality

By the end of 5 years	
Movement	• Stands on one foot for 10 seconds or longer • Hops, somersaults • Swings, climbs • May be able to skip
Hand and Finger Skills	• Copies triangle and other shapes • Draws person with body • Prints some letters • Dresses and undresses without help • Uses fork, spoon and (sometimes) a table knife • Usually cares for own toilet needs
Language	• Recalls part of a story • Speaks sentences of more than 5 words • Uses future tense • Tells longer stories • Says name and address
Cognitive	• Can count 10 or more objects • Correctly names at least 4 colours • Better understands the concept of time • Knows about things used every day in the home (money, food, appliances)
Social	• Wants to please friends • Wants to be like friends • More likely to agree to rules • Likes to sing, dance and act • Shows more independence and may even visit a next-door neighbour by him/herself
Emotional	• Aware of gender • Able to distinguish fantasy from reality • Sometimes demanding, sometimes eagerly cooperative

Source: Centers for Disease Control and Prevention (CDC) (2011), *Developmental Milestones.*

Appendix 3:

Assorted worksheets and materials to use within the assessment

EMOTIONAL NEEDS OF CHILDREN

Responses to Crying

Could you suggest some reasons why babies cry?

How would you respond?

Behaviour of Babies

What sort of behaviour from babies and young children can cause difficulties for parents?

How would you cope with this?

How have you coped in the past?

Would you do things differently now?

Stimulation / Attention / Physical Affection

What kind of play/attention does a new born baby need?

How and when does this change?

How do you know when your baby needs something?

Who will play most with the baby?

What sort of “play” would you do with a young baby?

How does this change?

What sort of play activities do you think parents would do with a toddler?

What have you learnt from previous experience?

How would you do things differently now?

PREGNANCY / PREPARATION FOR BIRTH

SAFETY CHECKLIST

FIRE

How would you protect your child from the risks of fire?

What material are your baby's night-clothes made of?

Where do you keep your matches?

When you have finished a cigarette, what safety precautions do you take?

SUFFOCATING/CHOKING

In what position do you put your baby to sleep?

How do you protect your baby when they are sleeping outside in a pram?

Does your baby have a pillow?

What sort of mattress does your baby have?

Which foods are not safe for your baby to eat?

Where do you keep your plastic bags? What are the dangers of plastic bags?

What do you need to check when buying for Your baby?

When the baby is in the bath, what do you do?

When your baby is having a bottle, how do they feed, by themselves? Do you hold the bottle?

Where does your baby eat? What do you do whilst your baby is eating?

FALLING

How do you protect your child from the danger of falling downstairs?

How do you ensure that your child is safe in the highchair, pram or buggy?

Where do you change the baby's nappy?

Can your baby climb out of the cot?

When sitting your baby in a bouncing chair or cradle where do you place the chair or cradle?

SCALDING / CUTS / ELECTRICITY

How do you make sure that your baby is safe when you are handling boiling water?

When you are drinking a hot drink, where is the baby?

How do you test the temperature of your baby's bath before putting them in?

Where do you keep your ornaments?

Where do you keep your sharp knives?

Thinking about your electrical appliances, where do you put the spare lengths of flex?

What are the dangers with plug sockets, how can you protect your baby?

When you are using your cooker, what safety precautions do you use to protect your baby?

POISONING

Where do you keep your medicines and pills?

Where do you keep your cleaning materials? How do you make sure that your baby cannot reach them?

What sort of paint do you use when decorating at home to ensure that your baby is safe?

Where do you keep your newspapers, paper bags etc? What would be the danger in your baby getting hold of them?

(A) PRE-PREGNANCY

NAME: ..... **DATE:** .....

1	Was the pregnancy planned? How did you find out?	
2.	How did you feel about the pregnancy (e.g. pleased, unhappy, angry, worried)?	
3.	Did these feelings change? If so, when, and how did your feelings change? How do you feel today?	
4.	Did you have any contact with the baby's father during your pregnancy?	
5.	How did the baby's father feel about the pregnancy?	
6.	Did his feelings change? If so, when, and how did his feelings change?	

7.	How was the relationship between you and the baby's father during your pregnancy?	
8.	What effect do you think this had on you?	
9.	Did you have a threatened miscarriage? Did you consider a termination?	
10.	Did anything happened during your pregnancy which particularly upset you?	
11.	Was there anybody who gave you support during your pregnancy?	
12.	When you became pregnant, did you wonder about what the baby would be like?	
13.	Did you have any idea about what the sex of the baby would be? If so, how did you feel about this?	

14.	How did you feel about being a mother (again)? What were your greatest concerns for yourself?	
15.	How and when did you come to decide on a name for the baby? Did you have a name for a boy and a girl?	
16.	What kind of relationship did you think that you would have with the new baby? What are your greatest concerns for your child?	

(B) PREVIOUS PREGNANCIES

1.	Were your previous pregnancies planned?	
2.	How did you feel about them?	
3.	What was (name of previous child/children) like as a baby?	

4.	What did you most enjoy?	
5.	What did you worry about most?	
6.	How did you feel you coped?	
7.	What things change when you have a baby?	
8.	How well do you think you coped with these changes?	
9.	What do you look forward to most?	

(C) CONFINEMENT

1.	Was the baby born early, on time or late? How did you feel about this?	
2.	Where was the baby born?	
3.	How did you describe the labour, the birth and you feelings about it?	
4.	Who was present at the birth?	

5.	How did you feel about the sex of the baby?	
6.	Were you or the baby ill immediately after the birth?	
7.	How soon after the baby was born did you hold him/her? How long for? Can you remember how you held him/her?	
8.	How did you feel about the baby?	
9.	Were you separated from the baby at any time after the birth? If so, give details.	

(D) AFTER THE BIRTH

1.	How long were you and the baby in hospital for, following the birth?	
2.	What was the routine for caring for the baby in hospital?	
3.	Did you have any problems with your health following the birth?	
4.	Did the baby have any health problems following the birth?	
5.	Was there anyone around to offer you support once you came home from hospital?	
6.	Can you describe your first baby in the first few weeks of his/her life? (What kind of baby was he/she)?	
7.	Were you able to get into any routine with the baby (e.g. feeding, sleeping, changing)?	
8.	How were you feeling during these first few weeks?	

Bathing 0-2 months

Name _____ **Sheet Number ____**

Date of Observation						
Time of Observation						
Phase: **B**aseline, **I**ntervention, **F**ollow-up						
1. Makes sure the room is warm, no less than 22^{o} C. Closes doors and windows to prevent draughts						
2. Sets the baby in a safe place						
3. Lays out items needed beside bathing area						
4. Lays out towel on changing mat						
5. Fills bath with cold water first, then hot. Uses 2 inches of water. Mix the water with your hand						
6. Tests temperature with elbow /bathing thermometer						
7. Undresses baby on top of towel						
8. Talks to the baby throughout						
9. Wraps the towel around baby's body while washing hair						
10. Holds baby over the bath with arm across the back, supporting the head with hand						

11. Washes and rinses hair using small amount of baby shampoo (size of 5p)						
12. Dries hair						
13. Unwraps towel, puts one arm behind baby's back so that the head back rest on the bend of arm. Grips the arm furthest away other arm supporting the legs as baby is lowered into bath						
14. While the baby is lying on his back washes his/her front						
15. Leans the baby forward over the other arm, still holding his/her arm to wash the back						
16. Removes baby from bath and lays on towel						
17. Dries baby, paying attention to creases on neck, arms, and top of legs. Dries between toes						
18. Applies cream						
19. Puts on clean nappy & clothes						
20. Sets the baby somewhere safe						
21. Empties bath, rinses it out puts other items away						
22. Puts used nappy in nappy bin						

Bottle Feeding

Name _____ **Sheet Number ____**

	Date of Observation										
	Time of Observation										
	Phase :**B**aseline, **I**ntervention, **F**ollow-up										
1	Puts baby in a safe place										
2	Washes hands										
3	Makes up bottle from previously boiled kettle										
4	Checks temperature of milk by shaking a few drops on wrist										
5	Mother seated comfortably holding baby semi-upright, with head rested on mother's elbow										
6	Puts on bib										
7	Ensures that the bottle is tilted so that the feeding end is full of milk and without air bubbles										
8	Stops half way through the feed to check for wind										
9	Holds the baby either upright against shoulder, or on mother's knee with baby's chin supported, rubs back gently										

10	Gives the remaining milk										
11	If the baby refuses the bottle tries winding again and offers bottle again										
12	Puts baby in a safe place										
13	Discards remaining milk										
14	Rinses out bottle										
15	Talks to baby and maintains eye contact										

Routine

Name _____ Date _____

Write in the latest time that you will have done things by, and the longest time you will go between tasks. Remember all of these must fit around your baby's needs.

Task	**Time or Frequency**
Feeding	At least every _____ hours
Sterilising	By _____ every day
Checking nappy	At least every _____ hour/s
Changing nappy	At least every _____ hour/s
Play	For _____ minutes, _____ per day
Bathing	By _____
Bedtime	By _____ at night
Naps	_____naps _____times per day for_____

Evening Routine

Week beginning _____

Task	Time	Wed	Thur	Fri	Sun	Mon	Tues
Feeding baby	8.00 pm						
Filling in feeding chart	8.30 pm						
Bathing	7.30 pm						
Bedtime (trying to settle baby)	9.30 pm						
Tidying Flat	10.00pm						
Score - Give one point for each task done by the agreed time							
Staff & Mum's initials							

Weekly total _____ Target score _____

No of vouchers _____

Notes:

Home Safety Checklist

Parent _____

Child _____ Child's eye level _____ Child's reach _____

Date _____

Observer _____

Location	**Living Room**	**Kitchen**	**Parent's bedroom**	**Child's bedroom**	**Bathroom**	**Hall**	**Outside**

A. Supervision & Falls	No Yes	No Yes	No Yes	No Yes	No Yes	No Yes	No Yes
Door/ gate left open	1 0	1 0	1 0	1 0	1 0	1 0	1 0
Sharp objects in reach	1 0	1 0	1 0	1 0	1 0	1 0	1 0
Fragile ornaments in reach	1 0	1 0	1 0	1 0	1 0	1 0	1 0
Heavy unstable objects in reach	1 0	1 0	1 0	1 0	1 0	1 0	1 0

Baby unsupervised in walker	1 0	1 0	1 0	1 0	1 0	1 0	1 0
Large toys in cot			1 0	1 0			
Baby left unattended on settee	1 0						
Baby in bouncer on raised surface	1 0	1 0	1 0	1 0	1 0	1 0	1 0
B. Hygiene	No Yes	No Yes	No Yes	No Yes	No Yes	No Yes	No Yes
Soiled nappies in reach	1 0	1 0	1 0	1 0	1 0	1 0	1 0
Spilled food within reach	1 0	1 0	1 0	1 0	1 0	1 0	1 0
Open bins within reach	1 0	1 0	1 0	1 0	1 0	1 0	1 0
C. Choking	No Yes	No Yes	No Yes	No Yes	No Yes	No Yes	No Yes
Dirty Ashtrays in reach	1 0	1 0	1 0	1 0	1 0	1 0	1 0
Small objects in reach	1 0	1 0	1 0	1 0	1 0	1 0	1 0

Toys with removable small parts in reach	1 0	1 0	1 0	1 0	1 0	1 0	1 0

Location	**Living Room**	**Kitchen**	**Parent's bedroom**	**Child's bedroom**	**Bathroom**	**Hall**	**Outside**
D. Ingestion	No Yes	No Yes	No Yes	No Yes	No Yes	No Yes	No Yes
Poisonous cleaning materials in reach	1 0	1 0	1 0	1 0	1 0	1 0	1 0
Cosmetics, shampoos etc. in reach	1 0	1 0	1 0	1 0	1 0	1 0	1 0
Medication in reach	1 0	1 0	1 0	1 0	1 0	1 0	1 0
E. Fire/Burns	No Yes	No Yes	No Yes	No Yes	No Yes	No Yes	No Yes
Lit cigarettes left unattended	1 0	1 0	1 0	1 0	1 0	1 0	1 0
Lighters & matches in reach	1 0	1 0	1 0	1 0	1 0	1 0	1 0
Hot drinks or food in reach	1 0	1 0	1 0	1 0	1 0	1 0	1 0
Ashtrays overflowing	1 0	1 0	1 0	1 0	1 0	1 0	1 0
Fire/heater accessible	1 0						

Grease left in grill pan		1 0					
F. Electric Shocks	No Yes	No Yes	No Yes	No Yes	No Yes	No Yes	No Yes
Cables within reach	1 0	1 0	1 0	1 0	1 0	1 0	1 0
Cables frayed or worn	1 0	1 0	1 0	1 0	1 0	1 0	1 0
Sockets accessible	1 0	1 0	1 0	1 0	1 0	1 0	1 0
G. Suffocation/ Strangulation	No Yes	No Yes	No Yes	No Yes	No Yes	No Yes	No Yes
Pillows for babies under 1 year			1 0	1 0			
Belts, laces or string left within reach	1 0	1 0	1 0	1 0	1 0	1 0	1 0
Plastic bags, or balloons within reach	1 0	1 0	1 0	1 0	1 0	1 0	1 0
Dummy tied on sleeping baby	1 0		1 0	1 0	1 0	1 0	1 0

Circle 0 if the danger is present and 1 if the danger is not. Add up the total score for each area and write it below

Location	**Living Room**	**Kitchen**	**Parent's**	**Child's bedroom**	**Bathroom**	**Hall**	**Outside**

			bedroom				
Total Score							
Maximum Possible score (take off any that don't apply)							

Home Hygiene Questionnaire

Please let us know what you think about the work that has been undertaken with you on home hygiene.

Name _____ Worker _____

1. Since completing the home hygiene check my home is now much cleaner

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

2. I feel better able to identify areas that need to be cleaned

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

3. I felt comfortable when the worker was checking my home

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

4. From now on I will follow the advice given to keep my home clean

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

5. I believe that the programme did NOT help me keep my home clean

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

Home Hygiene Check

Name _____ Sheet Number___

Date of Observation							
Time of Observation							
Phase: **B**aseline, **I**ntervention, **F**ollow-up							
Area	**Task**						
Kitchen	Dishes washed						
	Sink cleaned						
	Cooker wiped						
	Surfaces wiped						
	Floor free of dirt						

	Pedal bin emptied						
Bathroom	Towels are dry/clean & hung up						
	Basin cleaned						
	Toilet seat & handle wiped						
	Bath clean (no tide marks)						
	Floor dry and free from dirt						
Living Room	Room tidied and aired						
	Room dusted						
	Table & high chair wiped						
	Floor clear of food/dirt						
	Toys tidied up						
	Waste bins emptied						
Bedrooms	Room aired						
	Beds made						
	Clothing tidied away						
	Toys tidied away						
	Room dusted						
	Floor vacuumed						
	Dirty washing sorted						

Total steps completed without prompts						
% correct						
Staff Initials						

Definitions for Interaction Checklist

1. **Parent praises child**- any comment directed to the child that expresses approval for something the child does.
2. **Parent talks to child-** verbalisations directed at child, in a gentle or playful tone, this does not include any critical comments.
3. **Parent looks at child**- parent faces the child for at least two seconds.
4. **Parent imitates child vocalisation**- parent repeats, approximates, or expands any noises that the child makes, within 5 seconds.
5. **Parent gives physical affection**- any hugs, kisses, strokes, or tickles.
6. **Reads the baby**- parent appropriately interprets the baby's state, e.g. you're tired, hungry bored etc. or parent gives the baby an appropriate dialogue e.g. 'you're telling me that you want to play'.
7. **Child plays**- child uses toys for intended purpose or plays peek-a-boo.
8. **Child vocalises**- any vocal sound coming from the child except crying, burping, or screaming.
9. **Child looks at parent**- Child faces and looks at parent for at least 2 seconds.
10. **Child positive expression**- Child's mouth turns up at the corners, either open or closed.
11. **Sensitivity Scale**- see attached sheet.

Sensitivity Scale

9 Highly sensitive

Mother responds promptly and appropriately to her baby's signals

7 Sensitive

Mother responds promptly and appropriately to her baby's signals, but sometimes becomes distracted and misses the baby's cues.

5 Inconsistently sensitive

Mother is prompt and responsive to infant cues on some occasions, but either inappropriate or slow at other times

3 Insensitive

Mother is inaccessible or misinterprets the baby's signals. Responses are often delayed or inappropriate, but if the baby's mood and activity match the mother's she shows some sensitivity.

1 Highly Insensitive

Mother is geared almost exclusively to her own wishes. Her response to the infants signal is delayed and inappropriate.

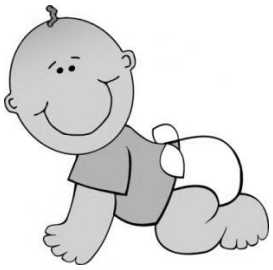
Communicating with Your Baby

You are the most important person in your baby's life. As well as caring for your baby and keeping them safe, you are also your baby's first teacher. By giving lots of time and attention you can help your baby's development and make a strong and healthy relationship.

It's important that you communicate with your baby because:

1. It helps your baby learn to talk
2. It helps your baby's brain development
3. It will make your baby feel safe and loved
4. It will help you to bond with your baby

We would like to do some work with you to help you develop the skills you need to communicate with your baby and help you to learn how your baby communicates with you even before they can speak. We will do this using a video, which will be yours to keep once we have finished this work.



Talking to Your Baby

Your voice is familiar to your baby even before they are born, and your baby will prefer your voice to anyone else's. Although your baby will not be able to understand what you say for a while, they will enjoy hearing your voice. You can tell your baby what you are doing when you are doing things like changing nappies or else sing songs. Your baby won't mind if you're not a great singer!

Talk to your baby, and make a list of the things they do when they hear your voice

_____

_____

_____

_____

Imitating Your Baby

Even before your child uses words, they can talk to you. When your baby makes noises if you copy them it encourages your baby to practice talking. Getting lots of practice helps your baby's language to develop. It also helps your baby learn about taking turns- you talk- your baby talks-you talk. It's nice for your baby to get a response when they are trying to talk, and it's also nice for you. Babies sometimes copy adult faces, for example raising eyebrows or putting out their tongues- try this and see if your baby copies you.

Make a list of the sounds your baby can make now

_____

_____

_____

_____

_____

Look at this list again in a few weeks to see how much your baby's speech has developed

Looking at Your Baby

Even very tiny babies love to look at faces. Your baby particularly likes to look at your face. When your baby is very tiny it's important that your face is close enough so she/he can see you. Looking also shows your baby that you are paying attention.

When your baby has had enough attention, they may look away- it's their way of telling you that they need something different- it might be some quiet time, or it might be something more lively or different. It's important to tune into what your baby is telling you as it will make them feel safe and loved.

Take some time to just look at your baby. Write down some of the feelings you have when you look at them.

_____
_____

Write down how you think your baby feels when they look at you. How might you know?

_____
_____
_____

Praising Your Baby

You can encourage your baby's development by giving lots of praise when they do things like gurgling, smiling, or playing with toys. Although your baby is too young to fully understand what you're saying, they will understand that you are pleased by the tone of your voice and the expression on your face. This encourages them to keep practising new things. As your child grows, it is a good idea to praise all the things you want them to do and make much less fuss about the things you don't want.

Make a list of all the things you can say to praise your baby

_____

_____

_____

_____

_____

_____

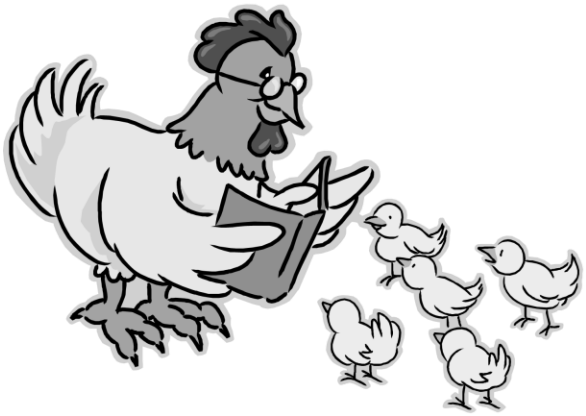
_____

Reading Your Baby

Even though your baby won't be able to use words for a while they can still tell you what they need or want. Your baby does this through:

- Making noises, like cooing or crying
- Facial expressions like smiling or looking surprised
- Gestures like waving their arms and legs

Your baby will give you signals when they want to play or talk to you and may look away when they have had enough. You should watch closely and see what your baby is trying to tell you as this will make your baby feel safe and loved. It can help to imagine that you can hear your baby's voice- watch the video and see if you can guess what your baby is saying to you.



Touching Your Baby

Touch is another way of communicating with your baby, it can let them know that you are there and paying attention. Most babies love cuddles, strokes, kisses, and tickles, or even just holding your finger. Lots of gentle touch helps build the relationship between you and your baby. It can help your baby feel relaxed and secure. Just like any other sort of attention your baby will let you know when they want more and when they've had enough.
Research on babies has found that touch can really help a baby's health, development, and growth.

Make a list of the kind of touch your baby enjoys most

_____
_____
_____

CONTEMPORARY UNBORN RISK TEMPLATE (CURT)

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