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Strategic
Briefing

Pre-birth assessment

Dartington

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About this briefing

The number of care order applications reached record levels in England and Wales in 2017 (FRG, 2018) and remain at a high level. This is turn means that the number of care order applications concerning infants (children under one year) has also increased and within that age range there has been a rise in the number of care order applications in relation to newborns (infants aged under one week)[1] (Broadhurst et al., 2018; Alrouh et al., 2019). There is, at the same time, increasing, and overdue, attention, informed by research (Broadhurst et al., 2017), being paid to parents who experience sequential care proceedings which result in the removal of their children.

We know that infants are particularly vulnerable to significant harm and are over-represented in cases subject to serious case reviews (Sidebotham et al., 2016). There is also research demonstrating the longer-term harm to infants who are not given adequate protection within a timeframe that is consistent with their developmental needs (Ward et al., 2012). We also know that the perinatal period is a crucial time for human development and provides a good opportunity to harness the desire of parents to be good parents to their expected child (House of Commons, 2019). Finally, we know that pre-birth assessment practice varies widely across England and Wales and there is no national guidance on good pre-birth assessment practice (Lushey et al., 2017; Broadhurst et al., 2018).

This briefing is for senior managers, strategic leads and commissioners in child and family social care, and commissioners and safeguarding leads from health services and midwifery, who have oversight of, or leadership responsibilities for, pre-birth assessment activities. Its purpose is to encourage a review of local practices, procedures and protocols in relation to pre-birth assessment and to support change and development in policies and practices where this is necessary.

1 In Wales the definition of newborn is an infant under 2 weeks old.

The key sources for this briefing are:

- The findings from the Nuffield Foundation funded research *Vulnerable birth mothers and recurrent care proceedings: Final main report* (Broadhurst et al., 2017) and the Nuffield Family Justice Observatory funded *Born into Care* (Broadhurst et al., 2018). Both of these were carried out at The Centre for Child and Family Justice Research at Lancaster University.
- Findings from research into pre-birth assessment practice (Lushey et al., 2017; Mason et al, 2019).
- Models of assessment or approaches to pre-birth assessment practice (Barlow et al., 2014; Harnett et al., 2018; Slade, 2006).
- Practice experience shared during a series of four Research in Practice Knowledge Exchange workshops on pre-birth assessment in 2019, facilitated by Claire Mason and Mary Ryan. In all, 40 Local authorities were represented and 73 practitioners attended, the majority of whom were social workers.

The briefing highlights the challenges currently facing practitioners and families when there are child protection concerns about the expected baby because of past or current parental behaviour. It considers legal and human rights as well as practice issues. The briefing does not propose a particular model of pre-birth assessment and intervention, but it does suggest some key principles that should apply.

Pre -birth assessments should:

- start as early as possible
- involve evidence-informed, supportive and intensive interventions as part of a dynamic assessment of capacity to change
- use trauma-informed and relationship-based practice
- focus on parental capacity to change as well as potential parenting capacity
- pay attention to ways of supporting the development of a positive relationship between the parents and their unborn baby
- lead to a clear plan that has been shared with parents before the birth.

The context

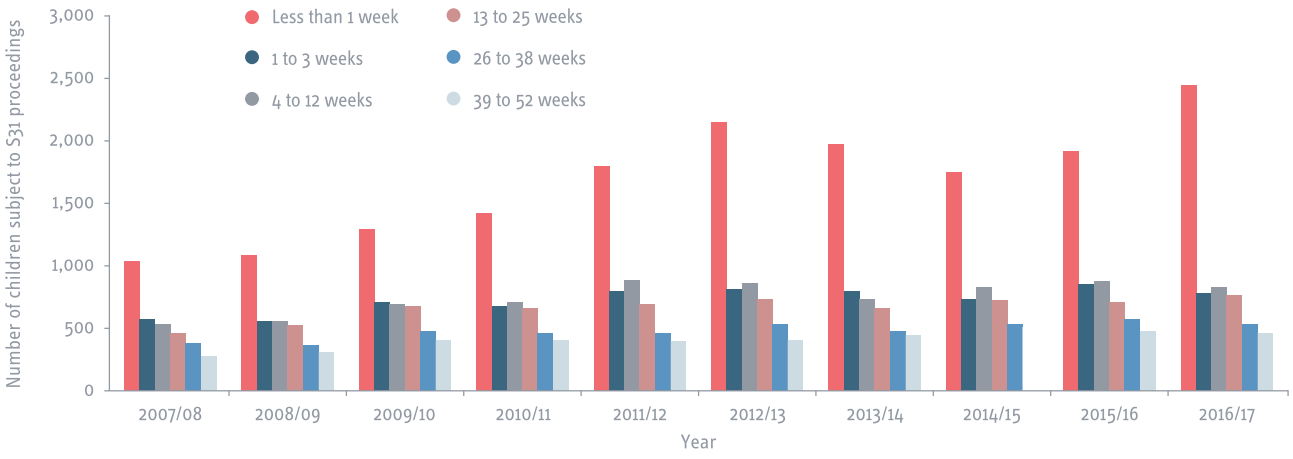
Newborns in care proceedings in England

Born into care used CAFCASS data on care proceedings between 2007/8 to 2016/17 to provide the first analysis of newborns and infants in care proceedings in England. It establishes the volume and proportion of newborns involved in proceedings and the incidence rates over time. Newborns refers to infants under one week old in England and under two weeks in Wales[2]. The full report is available at:

www.nuffieldfjo.org.uk/resource/born-into-care-newborns-in-care-proceedings-in-england-final-report-october-2018

Research and other data on children involved in proceedings, or children looked after, usually has a category of 'infants' which covers children under one[3]. This study broke down the under one year category for infants subject to applications for care orders to understand more clearly the number of newborns involved in care proceedings. This has shown that, while the proportion of care proceedings involving infants has remained similar over the years (around 27%), the proportion of newborns within that group has risen from 32% in 2007/8 to 42% in 2016/17. If the age band 1 to 3 weeks is added to the newborns then, by 2016/17, over 50% of applications in relation to infants concerned babies less than one month old.

Number of infants in care proceedings per infant age band (2007/08 to 2016/17)

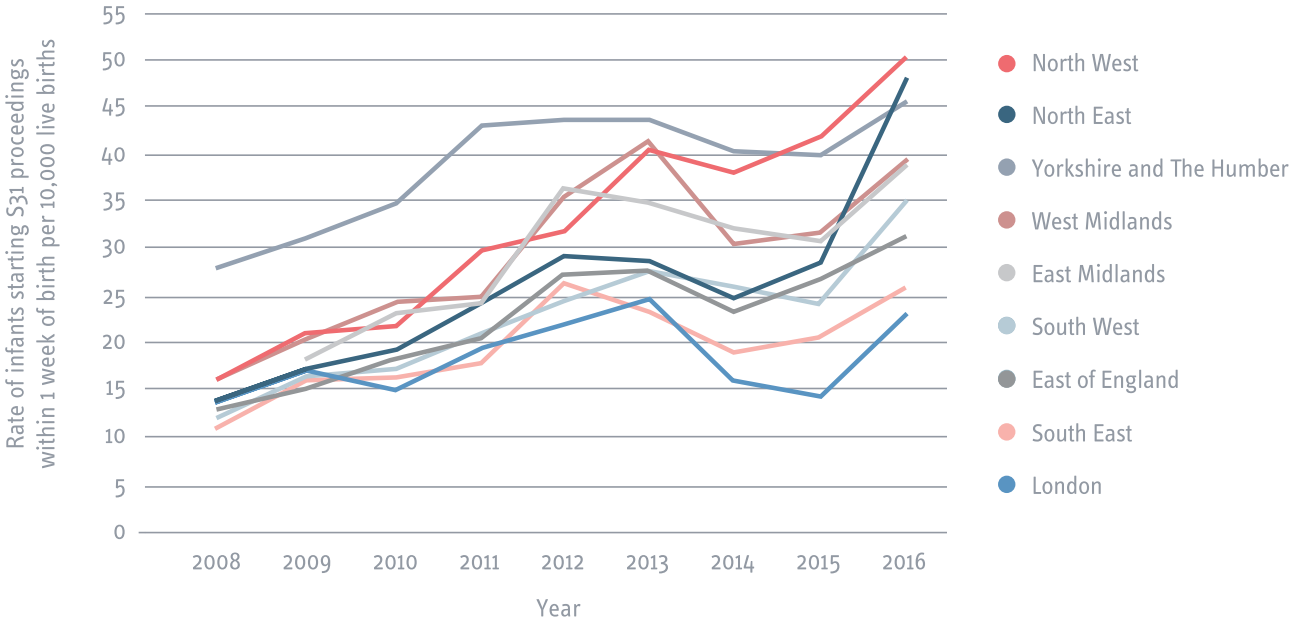


2 The data given in the remainder of this section reflects the position in England. The data for Wales is different, but the message is the same. For Welsh data see Alrouh et al., 2019.

3 See for example the Department for Education *Annual reports* on children looked after: **www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2018-to-2019**

In addition, the incidence rate of newborns becoming involved in care proceedings in England has risen from 15 per 10,000 to 35 per 10,000 over the ten years. There are, however, marked regional differences in incidence rates, as demonstrated in the chart below.

Incidence rates: Regional variation (2008 to 2016)



Earlier research by Lancaster University (Broadhurst et al., 2017) with women who have experienced recurrent care proceedings in respect to their children found that, after an initial set of proceedings, proceedings in relation to subsequent children tended to start early on, often just after birth. It is therefore not surprising that *Born into care* shows that, on average, 47% of newborns subject to proceedings were children born to mothers who had had previous children removed within the time period of the study. What is perhaps more surprising is that 53% of newborns were not, apparently, 'subsequent' children, in that the mother had not been involved in care proceedings in the five years prior to the set of proceedings captured by the study.

These findings raise many questions about the reasons for the rises in numbers and the regional variations they reveal. As with the overall rise in the number of proceedings, there are likely to be a range of contributory factors behind the rise in the numbers of care proceedings for newborns and behind the wide regional variations in the use of proceedings. *The Care Crisis Review* (FRG, 2018) noted that many overlapping factors were contributing to the rise in proceedings, including:

- Reduction in family support and other more intensive services as a result of austerity.
- Increases in poverty and deprivation impacting on families.
- A focus on risk, leading to a culture of risk aversion across children's social care and the family justice system.
- Differences in professional practice reflecting different approaches and practice cultures in children and family social care, and designated family justice areas.

There is also a possibility that increasing understanding about the importance for development of the first two years of life may be leading to earlier intervention in relation to infants.

Building understanding about the local picture in relation to newborns and younger infants becoming subject to proceedings is an important part of ensuring there is effective pre-birth assessment practice in your local area.

Questions for reflection

- How many care proceedings in your area involve newborns or infants in the first weeks of life?
- How does that compare with your statistical neighbours?
- Why might your area have lower or higher incidence rates?

Pre-birth assessment practice: Background

It is important to remember that pre-birth assessment and intervention activity is likely to be happening in relation to many more expected babies than the numbers revealed by the *Born into care* study, which only reflects the numbers of babies who are subject to proceedings. There will be many other cases where pre-birth assessments lead to a plan for supporting the family and newborn baby in other ways, including early intervention services or the limited use of s.20 or s.76 voluntary provision of accommodation.

Newborns are extremely vulnerable, so anxiety about ensuring their protection is understandable (Ward & Brown, 2012). We know, for example, that 41% (120 of 293) of the children who were the subjects of serious case reviews over the period 2011-2014 were

under one at the time of their death or incident of serious harm and that nearly a half of these infants were under three months old (Sidebotham et al., 2016). The vital importance of the perinatal and early years period for child development has also been widely recognised:

> *The foundations for virtually every aspect of human development - physical, intellectual and emotional - are laid in early childhood. What happens during these early years, starting in the womb, has lifelong effects on many aspects of health and wellbeing - from obesity, heart disease and mental health, to educational achievement and economic status.* (Marmot, 2010)

Since the Marmot Review (2010) there has been a more specific focus on the first 1000 days - from conception to the age of two - resulting in specific recommendations to government, local authorities and health services to refocus on this important time and ensure there is sufficient investment into services and support for families (House of Commons, 2019).

Although care proceedings can only begin once a baby is born, the threshold of 'likely significant harm' for the making of a care order means that proceedings can start immediately following birth on the basis of the likelihood of significant harm in the future. As a result, there is a recognition in statutory guidance that children's services may begin the process of assessment and safeguarding before the baby is born. The two key pieces of statutory guidance (DfE, 2014, and HM Government, 2018) mention the possibility of pre-birth activity but give no detail about practice. So, for example, *Working Together* states:

> *'If concerns relate to an unborn child, consideration should be given as to whether to hold a child protection conference prior to the child's birth.'*

The statutory guidance in *Court Orders and Pre-Proceedings* is similarly lacking in detailed guidance, stating only:

> *'Where the local authority is considering bringing proceedings after birth, the pre-proceedings process provides an effective framework for social work with the parents before the birth of the child, ensuring fairness by enabling parents to get free, non-means-tested legal advice relating to:*
>
> - *Pre-birth assessments.*
> - *Agreeing arrangements for support of the parents before and after the birth.*
> - *Agreeing arrangements after the baby's discharge from hospital, if required.*
> - *Assessment of parental care following the birth.'*

There is subsequently a reference to making sure that in such cases the formal pre-proceedings letter to parents is sent as early as possible, which the guidance suggests is 'at or before 24 weeks'. The timing of pre-birth assessment is an important issue which is covered in more detail later in this briefing.

The lack of detailed pre-proceedings guidance was noted as something that needed attention in the *Care Crisis Review* (FRG, 2018) and is one of the matters being considered by the President of the Family Division's Public Law Working Group. The consultation paper from this group recommended more detailed guidance on pre-proceedings generally, including cases where the process is taking place pre-birth[4].

Pre-birth assessment practice – some messages from research and practice

The sources for this section of the briefing are:

- Lushey C, Barlow J, Rayns G and Ward H (2017) *Assessing Parental Capacity when there are Concerns about an Unborn Child: Pre-Birth Assessment Guidance and Practice in England*. This article is based on a review of pre-birth assessment guidance and practice in England. Local safeguarding guidance in 147 English localities was accessed and analysed, and interviews were conducted with 22 practitioners involved in pre-birth assessments. The findings showed that, while most local safeguarding guidance was more detailed and explicit than the national guidance, legal and ethical issues were rarely addressed. Interview data showed that, in general, guidance to support social work assessments during the pre-birth period was insufficient, and that few practitioners used standardised tools (see page 21) to aid assessment. Some practitioners regarded pre-birth assessments as less urgent than cases involving infants/older children, thereby increasing delays in decision-making.
- Mason C, Robertson L and Broadhurst K (2019) *Pre-Birth Assessment and Infant Removal at Birth: Experiences and challenges*. A literature review. Nuffield Family Justice Observatory. A rapid evidence review to identify key messages from research on the views and experiences of women and professionals in relation to pre-birth assessment and removal at birth. Women who had had previous children removed felt stigmatised and fearful of being judged negatively and lacked trust in social workers. Engagement was more likely when a strong relationship with professionals existed, underpinned by a non-judgemental and respectful attitude, and an empathetic and supportive approach.
- McElhinney H, Taylor B & Sinclair M (2019) *Decision Making by Health and Social Care Professionals to Protect an Unborn Baby: Systematic Narrative Review*. Child Care in Practice. This is a systematic narrative review of child protection decision-making among health and social care professionals in relation to

4 See **Consultation on Children Cases in the Family Court** (2019): **www.judiciary.uk/publications/consultation-children-cases-in-the-family-court-interim-proposals-for-reform**

an unborn baby. The review identifies evidence about the importance of both and health and social care professionals adopting a respectful, empathetic, non-judgemental approach to pregnant women where there are child protection concerns to assist engaging the women in the assessment process.

- A survey of practitioners carried out by the Nuffield Family Justice Observatory in 2018.[5]
- The practice experience of participants in the Research in Practice Knowledge Exchange workshops in 2019.

There is a considerable measure of convergence of messages from these sources. Where a message emanates from one source only, this is indicated in the text.

Wide variations in practice

Given the lack of detailed national practice guidance, local authorities and their safeguarding partners have developed their own procedures, protocols and guidance in relation to pre-birth assessment, resulting in a lack of consistency and wide variations in practice across England and Wales. Some local guidance is very brief; longer guidance may be focused more on process than on practice. Very few areas include practice guidance on what should happen if a removal at birth is planned.

There are also variations in whether or not specialist interventions, or indeed any interventions, are offered during the pre-natal period or whether the process is more of a static assessment of potential future risk.

There is a lack in many areas of a consistent use of standardised tools to measure change over time, although there is evidence of some use of standardised tools at some point in the process. Where tools are used, there is much variation as to which are used.

There is wide variation in the recommended time to start a pre-birth assessment. Guidance in some areas is that pre-birth assessments should start at the beginning of the second trimester of pregnancy (at 12 weeks) whereas in other areas it is recommended that the process does not start until 20 or 24 weeks. This later timeframe reflects the limited guidance provided in *Court Orders and Pre-Proceedings* (DfE, 2014).

Concern about timing

The issue of timing is one which causes general concern. Policies and procedures which recommend starting the process of assessment at 16, 20 or 24 weeks are often based on the view that work on pre-birth assessment should not start until the foetus is viable and/or the time has passed for the mother to opt for a termination of the pregnancy.

5 The survey was distributed via Research in Practice and received 83 responses, 40 of which were sufficiently complete to analyse.

Discussions and survey responses also indicate that other reasons behind starting at this late stage include capacity issues in relation to staff numbers and pressure of work.

All the evidence from research into the experiences of mothers and the research into parental capacity to change would suggest that this approach is short-sighted and unfair to parents and the unborn child.

Delays in initiating pre-birth assessments mean:

- The already tight timescale of 40 weeks is further reduced to ten or fewer weeks, which is insufficient time to carry out a good quality, intervention-informed assessment.
- Reduced opportunities for parents to demonstrate their capacity to change if the child protection concerns are based on their history of parenting or other aspects of their behaviour.
- It is harder to develop the relationship with the parents that helps to ensure they are engaged in the process.
- It is harder to ensure that the wider family can be involved sufficiently early on in the process.

In some areas where procedures did recommend starting the process at 12 weeks this did not happen on a regular basis, either because referrals from other agencies were received late or because pressure of work meant that pre-birth cases were regarded as low priority by children's services managers.

One participant in the Knowledge Enquiry workshops raised an issue that had also been identified as problematic in another case which was the subject of a reported judgment in care proceedings (A Council v M [2014] EWFC B158 - summarised in Ryan, 2019). In both cases midwives had made a referral to children's social care in relation to a pregnant woman at around 10 or 11 weeks. The response was that the referral was too early, and should be made again after 12 weeks, but in both cases this did not happen and the second referral was not made until much closer to the birth of the child – thereby allowing little time for a proper assessment or for the parents to demonstrate capacity to change.

Communication between agencies

Research findings and practice feedback indicate that in some areas there are long-standing problems of communication and working between children's social care and health professionals - including midwives, hospital managers and staff, and adult mental health and substance misuse treatment services. This can impact on the timing of referrals and also on the extent to which health professionals are involved in the assessment process and planning for what should happen at birth, particularly if the plan is for the removal of the baby.

Professional perspectives

Midwives place very high importance on being 'women-centred' and this professional perspective can feel compromised by child protection concerns, leading to a sense of role conflict, particularly in cases where there is removal at birth. Midwives' important role within the context of child protection and removal at birth is not always acknowledged by practice guidance, or by other professionals.

Social workers also experience tensions between balancing responsibilities to the unborn child and the parents. In addition, social workers express the need for greater access to specialist knowledge about child development, and the need for better access to specialised tools and measures.

Engagement of parents

Research has identified a lack of evidence-informed guidance on the importance of empathetic, relationship-based practice during the pre-birth assessment period. There is, for example, little reference to the importance of building a relationship with the parents and taking account of their concerns, while keeping the needs of the foetus and likely needs of any newborn baby in mind.

Practitioners in research and in the Knowledge Exchange workshops expressed concern about:

- Judgemental attitudes and practice (across all professions) towards women who had had previous children removed and towards young women who had been in care.
- The language used by professionals being unclear and impenetrable, making it harder for families to understand the concerns.
- An over-reliance and/or over-focus on the parents' previous history of parenting and insufficient attention paid to the present and future, and to their capacity to change.
- Professional discomfort about a plan to remove a baby at birth leading to reluctance to discuss this with parents and, as a result, a lack of clarity in the parent's mind about what was going to happen and when.
- Changes of social worker during the pre-birth assessment process because of staff shortages or changes arising from the transfer to a different team if the decision is made to go ahead with proceedings, which reduces the possibilities of parents being able to establish a trusting relationship with practitioners.
- The challenge of working with cultural diversity in the pre-birth period and in getting access to interpreters when necessary.

Views and experiences of parents

There is a lack of research looking at the experiences of parents going through a pre-birth assessment process, although two evidence reviews have recently identified some key messages (Mason et al., 2019; McElhinney et al., 2019). These include:

- Women subject to pre-birth assessments frequently feel stigmatised and judged by the child protection and family justice system.
- The above feelings and fear of their baby being removed, combined with a lack of trust in professionals all contribute to women's reluctance to engage with professionals.
- Despite this anxiety, or sometimes because of it, some women actively seek professional involvement from early on, in order to maximise their chances of keeping the baby.
- Parents felt that assessments which started late or delays in the process meant they had less chance to show they could, or had, changed, and delay caused them great anxiety.
- Engagement was more likely when a strong relationship with professionals existed, underpinned by a non-judgmental and respectful attitude, and an empathetic and supportive approach.
- Continuity of care - from midwives, health visitors and social workers - helped to support the building of relationships between mothers and professionals.
- Poor communication between professionals and parents can result in parents being unclear about the process, the plans and the reasons for the concerns.
- Removal at birth is acutely traumatic, causing intense loss and grief, which is complicated by guilt, stigma and shame. It has a profound and enduring psychological impact on the mother. Despite this, mothers reported a lack of emotional support around removal at birth, a lack of empathy and a lack of preparation.
- A subsequent pregnancy after a child has been removed is often haunted by a previous removal and this mix of very difficult and conflicting emotions often manifest in very high levels of anxiety.
- For women who give birth in prison, all the above problems are compounded by particular problems in relation to poor communication and inadequate planning.
- There is a lack of focus on fathers during pre-birth and removal at birth processes. Similarly, what little research there is largely focuses on the impact on mothers.

The comments below are from mothers who gave interviews to the Lancaster study on recurrent care (Broadhurst et al., 2017):

If I felt down or something I couldn't go to my doctor because I'm too scared that social services would... They'll put it oh, she's feeling low again on her pregnancy and she ain't going to be able to cope. It makes you feel as though you can't trust anyone.

I think social services, when they deal with young mothers that have gone through a lot, I think in some cases they need to take the time and give the benefit of the doubt. You don't just say, okay because you've got a history of doing this, I'm not going to give you a chance. Everyone deserves a chance, everyone deserves a second chance... then you've got someone like me who has got a bit of a paper trail and won't even be given an inch, let alone a mile... The problem with social services is they do everything at the last minute. So I think that they need to kind of give people a chance.

It broke... it killed me, it literally... still, to this day, I sleep with her baby-grow sometimes. I've still got all of her clothes; it did kill me. What killed me, it wouldn't have hurt me that much if they'd come in and took her straight away, you know, and if I wasn't that interested and not fighting or anything like that, it was the matter of fact that... that I thought I was going to take her home and have a good chance; I had everything at the property, I bought everything, so I told my social worker, I told my solicitor to come round to the property, that I've got everything for (child); and, no, they just took her. They granted foster parents to come in the hospital the day after to have a meeting with me and then to take (child) from me.

Resources

Participants in some areas felt there was a lack of resources and, in particular, a lack of intensive provision to provide support for parents - including a lack of support for parents who had lost children through care proceedings. Findings from the survey of pre-birth practice and comments from participants at the workshops indicated that many specialist pre-birth assessment teams had been disbanded as a result of budget cuts.

Others commented that a lack of social workers impacted on the ability to carry out pre-birth work or that the high turnover of social work staff and the wide use of agency staff impacted on consistency of approach and on embedding change.

In some areas, pressure on hospitals for space led to hospitals refusing to keep mothers and babies on the ward until a placement had been found for both of them or for the baby only.

This refusal was either absolute or dependent on whether the local authority would pay for the hospital space. This was reported to be a contributory factor in the need for urgent applications to court for interim care orders. In other areas there was no problem with hospitals agreeing to keep mothers and babies in these circumstances.

Resources, as well as local culture, also affected the number of residential placements available for mothers or parents and babies. The FJO survey and participant feedback at the workshops indicated very wide variations in what was available in local areas. In some areas there was an assumption that a residential or mother and baby foster placement would be found in order to assess parenting capacity once the baby had been born and before removal would be sought, but in many more areas it was reported that such placements were either non-existent or in very short supply.

Responding to the challenges

A number of participants gave information about the ways in which their local authorities or agencies were responding to the challenges listed above, including:

- Overall, the experience of participants in the workshops indicated an increasing number of local authorities starting the pre-birth assessment at 12 weeks.
- Provision of a pregnancy liaison service responsible for booking mothers into early help services where appropriate.
- Having clear pre-birth pathways on the electronic systems within children's services.
- Making use of a parent/baby assessment centre to test capacity to parent before making any application to court for an order to authorise the removal of the baby.
- Consistent use of Family Group Conferences (FGCs) in the pre-birth period.
- Specialist multi-disciplinary teams working with parents in pregnancy.
- Ensuring early referrals for pregnant care leavers and a dedicated pathway with named social workers, midwives and early help staff.
- Ensuring that women who had had children previously removed through care proceedings were referred back into the long-term social work team that dealt with their case previously, rather than being referred into the assessment or MASH teams.
- Ensuring multi-agency access to information from any previous court hearings where parents had had children previously removed.
- Safeguarding midwives developing a trauma-informed approach to separation at birth.

Questions for reflection

- Do you have a protocol for pre-birth assessment in your area?
- Does it involve key partners in health and adult services?
- What is the recommended start time for pre-birth assessment in your area?
- What is the average length of a pre-birth assessment in your area?
- Do you have a sufficient range of intensive services to support parents to achieve change in this period?
- Do you have protocols or processes for removal at, or shortly after, birth?
- Do you have clear systems in place to resolve problems such as hospitals discharging mothers and babies because of a lack of beds, despite the lack of adequate safeguards in place?
- Do you have any residential or foster placements for parents and new babies in your area?
- Have you explored potential sources of funding from Public Health, Big Lottery or any other source to support parents in the perinatal period, linked to initiatives arising from the 'First 1000 Days' campaign?
- Are there opportunities in your area for midwives and social workers to have time for reflection and de-briefing after removing a baby at birth?
- Are you satisfied that professionals in your area have opportunities to hear from parents directly about their experiences of pre- birth assessment and about removal at birth?
- Are you satisfied that communication with parents is as timely, clear and honest as it should be?

Taking account of the legal framework

Any approach to pre-birth assessment needs to take the principles of the *Children Act 1989*, the *Human Rights Act 1998* (HRA) and the rights of the child as set out in the United Nations Convention on the *Rights of the Child* (UNCRC) into account. Although the Children Act and the UNCRC only apply to children once they are born, the recognition in the Act of the potential to protect children from likely significant harm means there is a recognition in statutory guidance that pre-birth assessment and child protection activity can take place (though, as above, the guidance is short on detail).

Before the birth the key legal principles will be those contained in the *Human Rights Act* 1998 relating to the parents' right to a fair trial and their right and the right of their baby to have a private and family life without interference[6]. The principles of the *Children Act* are, however, very relevant in informing the plans that are made by the local authority in partnership with the parents before the birth. These are the principles of involving the parents and the wider family in decision-making and, if the removal of the child seems likely, then beginning the investigation of potential placements with family members.

If removal at, or shortly after, birth is regarded as necessary, or if the local authority considers that care proceedings should be initiated after the birth, whether or not removal is planned, then a good understanding of the law and the interpretation of the law through the judgments of the higher courts is also crucial (see Ryan, 2019, for a summary of the legal framework and lessons from case law).

Key messages relating to Article 6 and 8 of the HRA indicate the importance of:

- Proper advance planning.
- Making sure parents, and their legal representative (if they have one), are clear about the intended course of action.
- Making sure that other professionals, particularly midwives and hospital staff, are equally clear.
- Paying particular attention to women who are in prison and who may wish to seek a place on a prison Mother and Baby Unit (Joint Committee on Human Rights, 2019).

6 Articles 6 and 8 *Human Rights Act 1998*

Other messages from case law confirm that:

- s.20 (or s.76 in Wales) voluntary accommodation can theoretically be used if separation is needed, providing the parents understand their legal position, genuinely agree to devolving their parental responsibility, and are clear that they can ask for the return of the child at any time. This arrangement may be suitable for a short period of time until care proceedings can be commenced.
- Applications for EPOs should be used sparingly and only when there is a genuine emergency. The principle of proportionality arising from Article 8 is important to consider. Even if an emergency application is justified, is the actual removal of the child at that particular time a proportionate response?
- There is much case law on interim care orders. Key messages are that the removal of the baby can be proportionate if its safety, including emotional safety and psychological welfare, demands immediate separation.

If care proceedings are started following a pre-birth assessment the court will be considering the evidence that the local authority are bringing in relation to the likelihood of significant harm, which will require clarity about the *nature* of the likely harm and evidence about *why* it is likely and why it is *significant*. In relation to final orders in proceedings, case law is clear that adoption is appropriate only when nothing else will do.

The *Born into care* analysis of orders made at the end of the proceedings in England over a six-year period, from 2010/11 to 2015/16, indicates that there has been some change over years in relation to the proportions of infants subject to different types of order - but these changes are not major. In relation to the figures for babies under three weeks old when proceedings begin there had been:

- a rise in the proportion made the subject of a Special Guardianship Order (from 18% to 24%)
- a drop in the proportion made the subject of a placement order (from 43% to 41%)
- a rise in the number of children made subject to a supervision order on its own (from 13% to 16%)
- a fall in the proportion of babies made subject to a care order (from 19% to 14%).

It is important to note that the relative proportions for each order rise and fall over the whole period and, in relation to care orders, a proportion of 19% was unusually high compared to all the following years. The main message from this is that just under a half of babies aged under three weeks are placed for adoption at the end of care proceedings. Other research using CAFCASS data for this period indicated that there are wide regional variations in the types of orders made at the end of proceedings (Harwin and Alrouh, 2018) but, as this study does not break down the ages of the children, it is not possible to tell whether these regional variations apply to such an extent to the orders made in relation to babies under the age of three weeks.

Participants at the Knowledge Exchange workshops identified another area of inconsistency - in the approach of different courts to applications for interim care orders at the start of proceedings immediately post-birth. Participants from some areas said that the pressure of time on the courts locally meant that all applications for interim care orders (ICOs) were sorted out between the parties outside of court and that it was very rare to have a hearing, whereas in other areas contested interim hearings were not uncommon. The absence of a hearing in cases where applications for ICOs are contested is a worrying development.

Developing improved pre-birth assessment practice

There are some messages from research which have particular relevance for pre-birth assessment practice. Theories around capacity to change and reflective functioning are also relevant:

- Developmental psychology, which gives us an understanding about infant developmental needs and provides strong evidence that a good caregiving environment during the perinatal period is critical for the healthy development of infants (see Marmot, 2010; Barlow & Rayns 2014 and 2015; House of Commons, 2019).
- Epidemiological research in relation to risk and protective factors relevant to foetal and infant development (see Barlow & Rayns, 2014 and 2015). This research has improved our understanding about the impact of such things as smoking, drinking and drug misuse on the development of the foetus and the longer-term impact on outcomes (see Research in Practice briefings by Mukherjee, 2017, on Foetal Alcohol Spectrum Disorder and Taylor, 2013, on parental substance misuse):

  www.researchinpractice.org.uk/children/publications/2017/july/fetal-alcohol-spectrum-disorders-fasd-identifying-and-responding-in-practice-with-families-frontline-briefing-2017

www.researchinpractice.org.uk/children/publications/2013/november/the-impact-of-parental-substance-misuse-on-child-development-frontline-briefing-2013

In addition, there is now also better understanding of the impact on longer-term outcomes of pregnant women experiencing stress, anxiety or domestic abuse.

- Neuroscientific research, which is providing new insights into how early emotional transactions impact on the development of brain systems involved in affect (the experience of feeling emotion) and self-regulation (the ability to appropriately control emotions). Understanding of the impact of trauma on early brain development is in its early stages and its application to direct work with children and families is a matter of some controversy (see Brown & Ward, 2013; Wastell & White, 2012; Pitts-Taylor, 2016; Woolgar & Simmonds, 2019).

- Growing understanding and application of the concepts of 'mentalisation' and 'reflective functioning' in assessing and supporting the relationship between parents and their unborn child (see Fonagy, 1991 and 2002; Slade, 2006 and 2008; Barlow and Rayns, 2014; Shemmings et al., 2016).

- Research into parental capacity to change and effective ways of supporting change (see Harnett, 2007; Bowyer et al., 2013).

Basic assessment frameworks

The standard model for assessment in children's social care is the *Framework for the Assessment of Children in Need and their Families*. The assessment triangle does not specifically cover the factors to be considered in a pre-birth assessment (DH, 2000). Small scale research projects carried out both before and after the implementation of the *Assessment Framework* suggested models for pre-birth assessment (Corner, 1997; Calder, 2013; Hart, 2010). These models have many similarities and recommend collecting information about:

- antenatal and obstetric issues
- previous child neglect and abuse, and child protection involvement
- the parents' view of the expected baby
- drug and alcohol use
- family structure and functioning, including the parental relationship
- preparation for the new baby
- the likely impact of a new-born child on the parents.

Although the above models do encourage consideration of such things as the impact of drug and alcohol use during pregnancy on the development of the foetus, the impact of many other factors, for example parental stress on foetal development, was not fully understood when these models were devised. In addition, these models of assessment are all focused on providing a picture of family functioning and parenting capacity at a particular point in time.

Dynamic approach to assessment and capacity to change

More recently researchers and practitioners have been advocating the importance of a focus on parental capacity to change alongside parenting capacity (Harnett, 2007; Bowyer et al, 2013; Platt & Riches, 2017; Barlow, 2013; Barlow & Rayns, 2014 and 2015; Harnett, 2017). This has established the importance of a dynamic approach to assessment and intervention which involves:

- assessment
- case conceptualisation/formulation identifying the needs and risks and proposing ways to meet these and improve parenting capacity
- evidence-informed interventions linked to the formulation
- ongoing review of progress, making use of standardised tools to measure progress towards the goals over time
- clear timescales
- working in partnership with the family, with openness and honesty, throughout.

Further reading

Research in Practice resources on capacity to change are co-authored by Paul Harnett and Sharon Dawe and support the use of their dynamic approach:

www.rip.org.uk/resources/publications/frontline-resources/assessing-parents-capacity-to-change-frontline-briefing-2013

www.researchinpractice.org.uk/children/content-pages/videos/assessing-parental-capacity-to-change-2015

Relationship-based, empathetic and trauma-informed

Other findings from the research referred to above, and other studies, emphasise the importance of an approach to pre-birth assessment and intervention that:

- is empathetic to parents
- is relationship-based, promoting good relationships between the family and the professionals
- takes account of parents' views, wishes and goals

- is trauma-informed, recognising that many parents caught up in the child protection system may well be suffering from complex trauma due their experiences in childhood and beyond
- promotes attachment and reflective functioning
- is, where necessary, therapeutic.

Reflective functioning

There is growing recognition of the importance of a parent's capacity for reflective functioning in the development of positive attachment relationships and in good developmental outcomes for children. The concept of reflective functioning, the ability of an individual to imagine mental states in self and others (and, thus, to understand the meaning of their own and others' behaviour) was originally developed by Peter Fonagy and colleagues. Their research, plus that of others, has demonstrated that, when a mother has the capacity for reflective functioning this strengthens the parent/child relationship, helps the child to understand and regulate his/her behaviour and supports the child's cognitive development (Fonagy et al., 1991; Schechter et al., 2006; Barlow & Rayns, 2014; Shemmings et al., 2016).

These findings have led researchers and clinicians to use this research to develop reflective parenting interventions, including in the pre-birth period (Slade et al., 2006 and 2008). The Parenting Interviews developed by Arietta Slade to measure reflective functioning are referred to in more detail in the section below on standardised measures.

Another specific intervention to measure and to support reflective functioning in parents is *Video Interaction Guidance* and this can also be used in the pre-natal period as well as once the baby is born (Kennedy et al., 2017).

Research has found that factors likely to reduce reflective functioning are:

- unwanted pregnancy
- unresolved trauma or loss
- chronic depression
- experiencing domestic abuse
- misusing drugs or alcohol.

Use of standardised measures

It is acknowledged that unaided professional judgement in relation to the assessment of risk of harm is insufficient and that there is a need for a different approach to assessment in which evidence-based standardised tools are used alongside professional judgement. This is referred to as structured judgement. A number of standardised methods of assessment have been developed to aid such decision-making, and these have the potential to improve the classification of risk of harm by providing practitioners with tools to assess specific dimensions of functioning as part of cross-sectional assessment.

A range of assessment resources make suggestions about the sorts of standardised tools that can be helpful in informing assessments or measuring change (Bowyer, 2013; Research in Practice, 2015; Barlow & Rayns, 2015; Harnett, 2007; Harnett et al., 2018).

The dynamic risk assessment model described in Barlow et al. 2014 and in the Research in Practice webinar by Jane Barlow and Gwynne Rayns (Barlow & Rayns, 2015) included a considerable number of standardised tools. This model was tested in a small number of local authorities and the feedback on the use of the tools included positive comments about how they had aided conversations with parents, and how they had helped practitioners to focus on current circumstances and capacity to change, rather than just on past history. Feedback also indicated that they had helped practitioners to develop their thinking and improved the depth and confidence of their analysis. The number of standardised tools had also led to the feedback that pressure of time can make it difficult to administer them and there were concerns over the skill levels needed to analyse and/or score them.

As noted earlier, feedback from participants at the Knowledge Exchange workshops suggests that use of standardised tools as part of the assessment process varies from area to area, as do the particular tools used. Participants acknowledged the potential of tools to aid structured decision-making. During the workshops a number of different standardised tools were reviewed by participants and feedback was that the use of tools was helpful, particularly to prompt discussions with parents. Some participants were wary of the more 'tick-box' and scoring type of assessment, while others felt that those had some merit. Arietta Slade, from the Yale Child Study Centre, is one of the key clinicians working in the area of reflective functioning. In a recent webinar for Research in Practice, Slade introduces the Pregnancy Interview and the Father Pregnancy Interview, a semi-structured clinical interview administered late in the second or during the third trimester. This has been developed to assess a mother's or father's capacity to reflect on her/his emotional experience of pregnancy and the quality of her/his representation of her/his relationship with the unborn child. The webinar aims to explore how the Pregnancy Interviews may be integrated into local pre-birth assessment practice.

In the course of her webinar Arietta Slade stresses very strongly that the Pregnancy Interview should *not* be used to as a tool to predict outcomes. It is a part of the story only and its purpose is to help assess a parent's capacity for reflective functioning, their readiness to parent and areas of strengths and vulnerability that should pave the way to pre and post-natal interventions:

www.researchinpractice.org.uk/children/content-pages/videos/pregnancy-interview

The Pregnancy Interviews were one of the tools considered by participants at the Knowledge Exchange workshops and they were extremely positive about them. They thought they helped to prompt the practitioner to ask

certain questions and to have a wide-ranging conversation with parents. They also thought the focus on emotional readiness for the child, as well as practical readiness, was important. Some participants felt the interviews should be used in every pre-birth assessment.

Engaging the resources of the wider family and friendship network

There has been a renewed focus in recent years on the need to involve the wider family and friendship network at the earliest opportunity when there are child protection concerns, and a recognition that not enough is done to ensure this happens (FRG, 2018; Trowler, 2018; Family Justice Board, 2019). A key principle of the *Children Act 1989* is that children should be supported so they can grow up safely within their own families and the legislation is clear that, if children cannot stay with their parents, then the wider family is the first place to look for somewhere secure for the child to grow up. Working with the family to complete ecomaps and genograms to help identify support networks is essential.

Recent concerns about delays in identifying relatives and in carrying out assessments of them as potential long-term carers for children have led to a review of research into SGOs (Simmonds et al., 2019). This has confirmed their importance as a permanent placement for children, which provide stability and positive outcomes for children, but has once again highlighted the importance of early identification of relatives, the need for adequate time for assessment and the need for support for special guardians and the children once proceedings come to an end.

There is now new practice guidance on special guardianship orders[7] and this is likely to be updated during 2020 following the publication of the President's Public Law Working Group report. It is also important to remember existing statutory guidance on *Family Friends and Care* (DfE, 2011) which the Care Crisis Review found was all too often ignored (FRG, 2018). The Practice Tool *Assessing and supporting family and friends care* (Hunt, 2020) published by Research in Practice has recently been updated and is a useful resource:

www.researchinpractice.org.uk/children/publications/2020/february/assessing-and-supporting-family-and-friends-care-practice-tool-2020

Family Group Conferences (FGCs) are a specific way of involving family members and are recommended in statutory guidance as a method that should be used to support children and their parents (DfE, 2014). FGCs are not an intervention but are a specific, family-led approach to identifying and harnessing family strengths. Although many local authorities have FGC conveners, either in or out of house, the evidence is still that only a minority of families get offered this approach to planning, including in the pre-birth period.

7 www.judiciary.uk/wp-content/uploads/2019/05/fjc-sg-interim-guidance-pfd-approved-draft-21-may-2019-1.pdf

Questions for reflection

- Does your pre-birth assessment model take account of factors likely to impact on foetal development?
- Is there a focus on reflective functioning in pregnancy?
- Do you have staff skilled in using mentalisation techniques with parents to help assist reflective functioning?
- Do you have staff trained in Video Interaction Guidance)?
- Do you have staff trained in using the Pregnancy Interviews developed by Arietta Slade and colleagues?
- Is your approach trauma-informed?
- Do you combine intensive interventions with assessments?
- Do you encourage a focus on capacity to change?
- Do you include pre and post measuring of progress towards goals?
- Do you have a Family Group Conference service?
- Do you use Family Group Conferences routinely before taking cases to court?
- If you don't use FGCs do you have another mechanism for bringing family members and close friends together to discuss the support they can provide?

Approaches in pre-birth assessment practice

The evidence about effective pre-birth assessment processes and practice is still emerging. There has been some evaluations of models and there are also a number of different approaches that have not been evaluated or are still being tested. This section sets out some examples of approaches that include or incorporate a response to the theories and messages from research outlined in the previous section.

The following examples were given as presentations at the Knowledge Exchange workshops to promote discussion and provide examples of local responses to an identified need for an improved pre-birth assessment offer.

Strengthening Families in Salford is in the process of being evaluated by the University of Essex (report due in 2020) while the approach in Coventry, incorporating the NSPCC model described in Barlow et al. (2014) and elements of the FDAC approach (Harwin et al., 2014 and 2018) was not evaluated.

Strengthening Families, Salford

This is an intensive early help service for parents who have had at least one child removed and taken into care. It was set up in early 2012 because the local authority had identified the problem of the same mothers coming back into care proceedings with new children. The service is located within early help and the team is made up of a team manager, a midwife, two lead practitioners and four parenting practitioners. The team work alongside social work colleagues but are not social workers themselves. The team provides support in three different ways:

- Pre-birth pregnancy support, starting from as early in pregnancy as possible - usually at 12 weeks or even earlier.
- Post-birth family support, supporting parents who are able to keep their children from the time of birth through to the child beginning school.
- Post-proceedings support for parents who have lost first, or subsequent, children through care proceedings.

Cases where parents who have had previous children removed and are newly pregnant are referred into children's social care by midwives and the case is then allocated to the Strengthening Families team. The team adopt an 'assertive outreach' approach and are persistent in keeping in regular contact with parents. They are prepared to work outside of normal working hours and are flexible and creative in their approach to ensure that the support offered is appropriate for the needs of the parents. The ethos of the team is that everyone has capacity to change. Their approach is trauma-informed, strengths-based and relationship-based. The team develop a personalised package of support for each parent. They work with fathers as well as mothers.

During the pre-natal period they work alongside the allocated social worker who has responsibility for carrying out the pre-birth assessment. They focus on providing practical support to parents and delivering pregnancy and parenting programmes - focusing on healthy pregnancies and child development, and on encouraging parents to recognise the impact of their own past adverse experiences on their parenting. There is now a handbook describing the work of the team, which has been developed for other areas that might wish to set up a similar project. This is available from **Sayma.khan@salford.gov.uk**.

Coventry

In Coventry they were also concerned about parents coming back into the system with new children, and were equally concerned about systems and processes that meant that parents who had had previous children removed were receiving very late pre-birth assessments - which gave them little opportunity to demonstrate their capacity to change. They began developing a pre-birth pathway that was informed by the work of Fonagy and the theories of reflective function and mentalisation.

They initially developed a team around the pregnancy but in 2014 also became a site to test the NSPCC pre-birth risk assessment model (Barlow et al., 2014). The approach was intensive and they identified that it required a specialist team, rather than expecting frontline social workers to do it. Specialist workers are able to further develop the relationship with parents, which allows them to build an even greater empathetic understanding. This is essential to fully engaging with them.

In 2015 Coventry worked with academics from Lancaster University and practitioners from the FDAC National Unit to further develop their perinatal support programme. This involved working with parents who had had at least one previous child removed from the start of the second trimester through to the child reaching the age of two. If care proceedings were necessary when the baby was born then the case was heard in the FDAC court in Coventry. The key additional feature of the model from this point was a focus on complex trauma which underlay the difficulties the parents were experiencing in relation to depression, anxiety, substance misuse and engagement with services.

The team identified the importance of working with fathers as well as mothers. The main tools they used were the Depression Anxiety Stress Scales (TASS), the Parent Interview, the Prenatal attachment scales and the Trauma Screening Questionnaire (TSQ). They also used Video Interaction Guidance (ViG) in the prenatal period.

Although Coventry FDAC continues today, the specialist pre-birth element of the service was cut in 2017 due to budgetary pressures. Further information is available from Beverley Barnet-Jones MBE – **bjsocialworks@phoenixhorizonltd.com**.

The following examples are from participants in the Knowledge Exchange workshops who sent these details after the workshops had taken place. These approaches have *not* been evaluated.

Newport City Council and Barnardo's *Baby and Me Project*

The Nuffield FJO *Born into Care* research has identified that the volume of newborn babies make up 30 per cent of the overall population of children involved in care proceedings in Wales. The Newport City Council and Barnardo's *Baby and Me* project is a pre-birth intervention and assessment service created in 2019 for families where the unborn baby is at risk of coming into care at birth. The service offers earlier intervention in order to give parents the best possible opportunity to make changes and keep their family together. In turn, this allows a pre-birth assessment to be completed in a timely manner, enabling evidence-informed decision-making and more effective care planning.

Baby and Me works with prospective parents from 12 weeks gestation onwards, providing a package of support which includes bespoke home visiting, 1:1 support, a Family Group Conference and a six-week group antenatal parenting programme called 'Baby Steps' - an antenatal programme developed by the NSPCC designed to help develop a strong parent-infant attachment and improve the ability of parents to care for and nurture their baby. The team consists of Family Support Workers, a Specialist Health Visitor and a Senior Social Worker.

Baby and Me is a trauma-informed service, which recognises that parents involved with children's services are likely to have experienced prolonged episodes of trauma themselves and which aims to enable parents to explore and reflect upon current and historical issues in order to overcome barriers to successful parenting. The team use a range of strategies and therapeutic approaches to work empathically and engage with parents to optimise family wellbeing, promote protective factors, and empower parents to reach their goals of keeping their family together.

Hampshire

Hampshire Children's Services has combined the learning gained from the Research in Practice Recurrent Care Change Project with their Partner in Practice funding from DfE to recruit four dedicated practitioners to develop a focused offer to those parents, including pregnant mothers who have already experienced the removal of a child within the past 24 months or are risk of a removal. The service works pre and post-birth, and following removal of a child. This is the first time these parents have been supported following the removal of their children.

Central to the work of the practitioners is the support and understanding they offer parents in relation to their own needs and the trauma they have experienced. Supporting parents to stabilise areas of their lives such as substance misuse, housing and mental health is key. Staff have developed strong relationships with colleagues in sexual health and wellbeing services to ensure speedy pathways to services, as well as being able to draw on the skills and interventions of the specialist workers within their multi-disciplinary working hubs.

The service is part of a newly formed intensive support service within which other intensive workers focus on priority cohorts, including children on the edge of care. They are situated in hubs working up to seven days a week to offer support for families when they need it. Feedback from parents on the impact of the support has been positive and there are indications that the service has reduced the occurrence of further pregnancy or further removal of children for some parents.

Enquiries about this work can be sent to **sectorled@hants.gov.uk**.

The following examples have been evaluated and some are in the process of ongoing evaluations in the UK.

Minding the Baby

This is a programme developed by Arietta Slade for young vulnerable first-time mothers, which has been trialled by the NSPCC in the UK and evaluated by a randomised control trial. The results of the final evaluation are due out during 2020. It is a programme which begins in the second trimester of pregnancy and continues until the child is two years old. The aims of the project are to enable mothers to develop a stronger bond with their baby and to prevent a subsequent pregnancy too soon after the birth of the baby.

The model uses mentalisation and intensive relationship-based practice, delivered by a health practitioner and social care practitioner, and makes use of the pregnancy interview. The mother receives weekly visits up to the baby's first birthday and after that the visits are fortnightly, with some flexibility to respond to need. The health visitor and social worker divide the visiting between themselves. There is an emphasis on supervision and clinical oversight from Yale.

In the UK, so far only qualitative findings are available which indicated that the programme was positively received by parents and professionals but also identified key challenges in implementation. Further results from NSPCC evaluation are due later in 2020. For more information visit **https://learning.nspcc.org.uk/research-resources/2017/minding-the-baby-qualitative-findings-implementation**.

Family Nurse Partnership

Family Nurse Partnership (FNP) is a programme that works with first time parents aged 24 or under. Parents enrol in the programme early in their pregnancy and receive visits from a specially trained family nurse on a weekly basis before, and for the first six weeks after, the birth of their child. Visits then continue fortnightly until three months before the child's second birthday, when visits become monthly in preparation for the programme ending. 64 visits in total are scheduled.

The FNP programme has three goals:

1. To improve pregnancy health and behaviours.
2. To improve child health and development by helping parents provide responsible and competent care.
3. To improve economic self-sufficiency by helping parents plan for their own and their baby's future.

FNP is structured - the tools it uses and the nature and number of visits is prescribed, based on years of research, evidence, successful implementation and constant evaluation - but it is also flexible. Within this structure, nurses deliver a highly personalised intervention based around the specific strengths and needs of each client. Family nurses also use specific approaches derived from the world of motivational interviewing, focusing on enhancing a young parent's motivation to change. Family nurses listen, guide and advise using these skills to support parents in making positive changes for themselves and their baby.

FNP is underpinned by three theories:

- Human ecology theory – emphasising the impact of social context and environment on human development.
- Attachment theory – emphasising the importance of the security and safety that comes from a relationship with a primary caregiver to a child's healthy emotional development.
- Self-efficacy theory - nurses use this concept to guide their efforts in supporting positive change, enabling clients to understand why particular actions are important and to develop the confidence necessary to achieve these.

See the Family Nurse Partnership website for more information - **www.fnp.nhs.uk** - and the Early Intervention Foundation guidebook for a full effectiveness analysis - **https://guidebook.eif.org.uk/programme/family-nurse-partnership#about-the-evidence**.

Parents under Pressure (PUP) (see Harnett et al., 2018)

The capacity to change model (Harnett, 2007) was combined with the Parents under Pressure (PuP) programme to test out a perinatal intervention with 'high risk' families. This was evaluated by using a prospective, quasi-experimental study which indicated promising findings for those parents and children allocated to the pre-birth assessment group.

Pregnant women were provided with support from 18 weeks gestation until their baby reached 12 months. The capacity to change model of dynamic risk assessment using standardised tools, professional judgement and intervention alongside assessment was combined with the PuP home-based parenting programme. PuP is a programme for parents with substance misuse problems who are engaged in treatment. Practitioners visit parents at home and the intervention:

- uses praise and reward to encourage good behaviour
- supports parents to develop a good relationship with their child, through recognising their child's feelings and needs and to deal with their own emotions, allowing them to keep calm and focus on being a parent
- helps parents extend their support networks, in order to sustain the positive outcomes achieved beyond the length of the service.

Conclusion

We know from the study into recurrent care (Broadhurst et al., 2017) that parents coming back into the system is not an infrequent occurrence. We also know that, once parents do come back into the system, the likelihood is that proceedings will start shortly after birth (Broadhurst et al., 2017) and we know that the number of newborns becoming subject to care proceedings is rising (Broadhurst et al., 2018).

Other research shows that practice in relation to pre-birth assessment is very varied, frequently starts late in the pregnancy and rarely allows for the testing of capacity to change or for interventions that are building on our growing understanding of the importance of the perinatal period for development or the importance of approaches which incorporate reflective functioning.

There is much activity taking place in relation to the development of improved processes and practice for pre-birth assessment and new evidence is emerging all the time. This is an area of practice that needs concerted attention across England and Wales to ensure best practice on behalf of children and their parents.

Pre -birth assessments should:

- start as early as possible
- involve evidence-informed, supportive and intensive interventions as part of a dynamic assessment of capacity to change
- be undertaken by practitioners confident in trauma-informed and relationship-based practice
- focus on parental capacity to change as well as potential parenting capacity
- pay attention to ways of supporting the development of a positive relationship between the parents and their unborn baby
- lead to a clear plan that has been shared with parents before the birth.

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