RISK ASSESSMENT
PRE-BIRTH: A PRACTICE MODEL

Initial Pilot
This model is to be read in conjunction with the accompanying guidance and anyone interested in using the model is also required to attend the NSPCC training course developed to underpin this model.
# CONTENTS

1. **BACKGROUND**  
   1.1 Process  
   1.2 Rationale for Practice Guidance  
   1.3 Structure and Approach of this Practice Model  
   1.4 Aims of Pre-birth Risk Assessment  
   1.5 Legal and Ethical Context  

2. **REFERRAL TO CHILDREN’S SOCIAL CARE**  
   2.1 Who should refer pregnant women?  
   2.2 Reasons for referral  
   2.3 Timing of referral  

3. **UNDERPINNING PRINCIPLES OF THE MODEL**  
   3.1 Principles  
   3.2 Structured Professional Judgment and Capacity to Change  
   3.3 Engaging Parents, Partnership and Multidisciplinary Working  

4. **PRE-BIRTH ASSESSMENT: CHILDREN’S SOCIAL CARE**  
   4.1 Introduction  
   4.2 Initial Referral  
   4.2.1 Circumstances for pre-birth assessment  
   4.2.2 Timing of pre-birth assessment  
   4.3 STAGE ONE: CORE CROSS-SECTIONAL ASSESSMENT  
   4.3.1 Cross-Sectional Assessment  
   4.3.2 Core Data Gathering  
   4.4 Stage 2: Case Conceptualisation  
   4.4.1 Introduction  
   4.4.2 Case Conceptualisation  
   4.4.3 Static and Dynamic Risk Factors  
   4.4.4 Themes and Patterns  
   4.4.5 Data mapping tools  
   4.4.6 Visual organisation of data  
   4.4.7 Critical appraisal of data  
   4.4.8 The Discrepancy Matrix  

5
4.4.9 Deciding on a theoretical hypothesis 48
4.5 Stage Three – Capacity to Change and goal setting 48
   4.5.1 Introduction 48
   4.5.2 Goal Attainment Scaling 50
   4.5.3 Achieving Goals 54
4.6 Stage Four – Intervention 55
   4.6.1 Introduction 55
   4.6.2 Part A: Evidence-based techniques 55
   4.6.3 Part B: Evidence-based programmes 59
4.7 Stage 5 – Capacity to Change 66
4.8 Stage 6 – Pre-Birth Decision-Making 69
   4.8.1 Introduction 69
   4.8.2 Assessment of Risk and Resilience 69
   4.8.3 Risk classification 72

5. CONCLUSION 75

REFERENCES 76

ANNEX 1: DOMAINS OF ASSESSMENT 81
1. BACKGROUND

This model has been designed by the NSPCC, working in partnership with Warwick University and the University of Loughborough and should be read in conjunction with the accompanying set of guidance and tools, following model specific training.

PRACTICE APPLICATION:

You are the first social workers in the UK to be using this model and we are really keen to understand from you whether this has proved to be helpful to you in carrying out your pre-birth assessments. In order for us to know whether the model works, it is really important that you follow the process in this model and use the tools and measures included. We will be gathering your thoughts and feedback during the period that you have been asked to test this model. Your views will then inform a further period of review and amendments to the model so that we ensure it works to support high quality and robust pre-birth assessment practice.

Pre-birth risk assessments raise complex theoretical, ethical and practice issues. Whilst there is an increasing body of scientific evidence about the risk and protective factors during pregnancy that are associated with later maltreatment of the child, this evidence has not yet been fully harnessed and built into standard practice. There is a significant lack of guidance and evaluated models to support professionals in undertaking pre-birth assessments, which has led to inconsistent practice and limited understanding of the need for these assessments. Recent research shows that almost a half (45%) of Serious Case Reviews in England involve a child under one, and a substantial proportion of such cases involve babies of 3 months or younger (DfE 2010). Inquiries into a number of child deaths or serious injuries have suggested that such babies may not have died or been seriously injured if a protection plan had been formulated prior to the birth.

The Ofsted report Ages of concern: learning lessons from serious case reviews highlights key lessons learnt from reviews of serious incidents involving either babies under one year old or children over 14. Of the 482 SCRs evaluated between 2007 and 2011, which involved 602 children, 35% were babies less than one year old, and highlighted that in too many cases for babies less than one year old, there were shortcomings in timeliness and quality of pre-birth assessment.

This model is designed to build an evidence base to show what should be included to support those completing pre-birth risk assessments and can be used for first time and existing expectant parents.
1.1 PROCESS

The Flow chart below shows the overall process that is to be followed in this model:

**Flow chart**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Process</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral</td>
<td>Decision to undertake Pre-birth Assessment</td>
<td>By 16 weeks</td>
</tr>
<tr>
<td>Stage One</td>
<td>Cross Sectional Assessment</td>
<td>45 days following referral</td>
</tr>
<tr>
<td></td>
<td>Complete domains data and TI measures</td>
<td>Within 3 / 4 month period</td>
</tr>
<tr>
<td>Stage Two</td>
<td>Case Conceptualisation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Risk and Resilience Table</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mapping tools</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Static and dynamic factors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hypothesis</td>
<td></td>
</tr>
<tr>
<td>Stage Three</td>
<td>Goal Setting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agree goals for intervention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>GAS</td>
<td></td>
</tr>
<tr>
<td>Stage Four</td>
<td>Intervention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Time limited</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proven evidence base</td>
<td></td>
</tr>
<tr>
<td>Stage Five</td>
<td>Assess Change</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Re-administer measures (T2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Goal Attainment Scale</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Direct observations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agency reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complete C2C Scale</td>
<td></td>
</tr>
<tr>
<td>Stage Six</td>
<td>Analysis and DecisionMaking</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Risk and Resilience Table</td>
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<td>Decision prior to birth</td>
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1.2 RATIONALE FOR PRACTICE GUIDANCE

**PRACTICE APPLICATION:**

The DH Assessment Framework 2000 (HM Government 2013) provides the current guidance with regard to undertaking assessments, but it contains little specific information to inform assessment during the pre-birth period. In addition, the recommended AF assessment tools/measures are not sufficiently specific to address the needs of workers assessing the extent to which adverse parental behaviours pose a risk of significant harm to the foetus. The list does not include tools/measures that have been validated for use during pregnancy or that address prenatal attachment or are particularly helpful for those that are first time parents. This practice model and accompanying guidance describes a Pre-birth Model of Risk Assessment (PBA) that is aimed at addressing these gaps in the current guidance by building upon the AF triangle and populating the assessment dimensions for an unborn baby – see Box 4.3.1 Pre-birth Assessment Framework on page 31.

Pre-birth risk assessments are not routinely undertaken during pregnancy and usually reflect a high degree of concern about the potential risk of significant harm to an unborn child. Pregnancy and the first year of life are extremely important, not only because of the complete physical and emotional dependency that a foetus/infant has on their parent, but also because these are key developmental stages, and lay the foundations for later life. Recent research has highlighted two ways in which the developing brain and organs of the foetus (see for example, http://www.beginbeforebirth.org), and infant (see for example, http://developingchild.harvard.edu/resources/multimedia/videos/three_core_concepts/brain_architecture/), can be affected.

Firstly, research shows that significant foetal programming occurs during pregnancy, in which the development of the unborn child is influenced by the intra-uterine environment, and in particular exposure to a range of toxic substances, such as smoking, alcohol, and drugs. For example, research shows that exposure to alcohol during pregnancy can result in a spectrum of disorders ranging from Fetal Alcohol Syndrome (FAS) through to Alcohol-Related Birth Defects (ARBD) (Sokol, Aney-Black, Nordstrom 2003), and that such problems affect around 6% and 16% of children and youth respectively in the child care system (Lang et al 2013). Recent research has also highlighted the adverse influence of chronic maternal stress during pregnancy (http://www.beginbeforebirth.org), and shows that prenatal stress may account for around 18% of the risk of emotional and behavioural problems in children (Talge et al 2007), and around 17% of cognitive problems (Bergman et al 2007).

Secondly, research has also highlighted the family/environment and parental factors that place an infant at risk of harm following birth, including for example, domestic violence and abuse, and substance/alcohol dependency (McGovern, 2012). This research suggests that the impact of such parental adversity during the first and second years of life is increased as a result of the rapid neurological development taking place during this time, and also because this is a key period in terms of the infants developing capacity for trust and secure attachments. Specifically, the research shows that up to 80% of abused children have a ‘disorganised’ pattern...
of attachment (Van Ijzendoorn, Schuegel, Bakermans-Kranenburg 1999), and that this is strongly associated with significant later psychopathology (Green and Goldwyn 2002; Madigan et al 2006). Disorganised attachment occurs as a direct consequence of a range of ‘atypical’ or ‘anomalous’ parent-infant interactions, which are strongly associated with the above types of adversity (Lyons-Ruth 2005).

Recent research shows that adversity during pregnancy or the postnatal period in terms of some of the factors described above, influence foetal/infant development via ‘epigenetic’ changes in which the adverse factors leave a ‘chemical signature’ on the child’s genes, which determines whether and how the geneses are turned on or off (www.developingchild.harvard.edu).

Pregnancy is as such an optimal time to support parents to promote their baby’s development (i.e. in terms of promoting parental behaviours that do not increase the risk of adverse programming during pregnancy), but also to assess and work with parents whose behaviours during pregnancy place the infant at significant risk of harm following birth. Pregnancy represents a significant “window of opportunity”, in which pregnant women can be helped to change their lifestyle, behaviours and relationships, in a way that promotes the wellbeing of their baby.

1.3 STRUCTURE AND APPROACH OF THIS PRACTICE MODEL

This pre-birth model is underpinned by the latest empirical evidence about development during pregnancy and the postnatal period in terms of the factors that have a significant impact on the long-term wellbeing of the foetus and infant. The model uses this evidence to develop a timeframe for conducting pre-birth assessment that is consistent with the developmental needs of the infant, and in particular the onset of ‘preferential attachment’ at around 7 months of age, which is the point at which an infant begins to demonstrate their preference for key caregivers, and at which they become distressed when they caregiver is not accessible.

The model involves the use of Structured Professional Judgment in which professional judgment is supported with a range of evidence-based standardised tools and methods of working with parents.

The model builds on the Assessment Framework by populating the assessment “triangle” with guidance about the dimensions that should be considered within each of the three domains when undertaking a pre-birth assessment. This includes a set of standardised tools/measures that can be used alongside clinical judgment as part of assessment during the perinatal period.

The model involves locating the standard cross-sectional assessment (that is, an assessment at a particular point in time) with a dynamic assessment of capacity to change in which pregnant parents are provided with evidence-based support to enable them to achieve the necessary change to ensure the safety of the infant.
The model includes a decision-making tool that is based on Jones and colleagues (2006) model of risk assessment, and that has been modified to include risk factors that are pertinent to the pre-birth period. It also includes a template that enables the practitioner to collate the data collected as part of the assessment process to assess the overall level of risk of significant harm.

1.4 AIMS OF PRE-BIRTH RISK ASSESSMENT

A range of risk factors can pose a threat to a) the development of the foetus during pregnancy; b) the safety of the newborn infant.

Assessment during the pre-birth period should be aimed at the identification of risk factors that:

a) pose an existing risk to foetal development, and that can be the focus of supportive intervention that is aimed at the reduction or elimination of the risk behaviours during pregnancy;

b) may pose a future risk to the newborn infant, and which should i) inform decisions about the legal steps that should be initiated (i.e. pre proceedings) to protect the newborn baby; ii) be the focus of targeted and evidence-based intervention to reduce or eliminate the identified risk factors, prior to the birth of the infant.

c) with a view to mitigating these risk factors

1.5 LEGAL AND ETHICAL CONTEXT

PRACTICE APPLICATION:

We know that research shows that pregnancy and childbirth can offer an important opportunity to engage parents, whose lifestyles and behaviours represent a source of significant risk to their unborn baby (Marmot 2010). Identification of these parents during early pregnancy is important to allow for robust assessment and early intervention. If we conduct timely pre-birth assessments of the parent’s circumstances this can offer important information to enable appropriate support to be provided, and to reduce the potential risk to the baby. However, a number of legal, ethical and moral issues make assessment during this period complex, these include the woman’s rights over her own body, the issue of foetal viability, and both the parents’ and the baby’s right to family life.

The guidance regarding the implementation of safeguarding prior to the child’s birth is complex. In England the Children Act 1989 provides the legislative framework through which the state can intervene to safeguard and promote the welfare of children. Although the act does not provide for legal proceedings to protect a child before birth the statutory Guidance, Working
Together to Safeguard Children (Department for Education, 2013), makes reference to taking formal steps to protect an unborn child:

Following section 47 enquiries, an initial child protection conference brings together family members (and the child where appropriate) with the supporters, advocates and professionals most involved with the child and family, to make decisions about the child's future safety, health and development. If concerns relate to an unborn child, consideration should be given as to whether to hold a child protection conference before the birth of the child (HM Government, 2013, p.40).

English (and Welsh) law provides only very limited recognition for the foetus. Formal protective action such as care proceedings can only be taken after birth. A woman has control over her own body, subject to the restrictions on termination of pregnancy in the Abortion Act 1967.

A pregnant woman (except one who lacks mental capacity) can refuse medical treatment, even if doing so will put her unborn child at risk of harm. Where a woman lacks capacity to make decisions, including decisions about medical treatment during pregnancy/at birth, the Mental Capacity Act 2006 makes provision for the court to decide whether treatment can be imposed. Such decisions are rare. The fact that a woman is a compulsory patient under the Mental Health Act 2007 does not automatically mean that she is unable to make decisions about her own pregnancy. Any medical or social work professional with concerns about the mother's capacity to take decisions should seek legal advice within their agency.

Although there have recently been a number of high profile cases in which a woman has been considered so mentally ill or incapable as to be unable to make decisions and the LA have applied for and been granted the right to have her made subject to a caesarean in order to protect her and her the unborn child, on the whole, during pregnancy a woman has the right to refuse to engage with statutory interventions to safeguard the welfare of her unborn child, and it is not until the birth that this right is superseded by the child's rights to life and to be protected from significant harm.

During pregnancy therefore a woman has the right to refuse to engage with statutory interventions to safeguard the welfare of her unborn child, and it is not until the birth that this right is superseded by the child's rights to life and to be protected from significant harm.

While legal proceedings for supervision or removal cannot be instigated until after the baby has been born, social workers can make plans for such actions during pregnancy. The pre-proceedings process for care proceedings (DCSF 2008; DfE 2014) provides a framework for working with parents before the birth where a baby is thought likely to suffer significant harm at birth.). The Pre-proceedings process involves the local authority sending a letter to parents, informing them of the local authority's concerns. The letter entitles parents to (free) legal aid so they can obtain legal advice, and have a solicitor with them at a meeting to discuss the local authority's concerns. This advice can help parents to understand the local authority's concerns and encourage them to co-operate with pre-birth assessment and planning the child's care at
birth. Recent research found that this process was valued by everyone involved as a fairer way of working with parents; it resulted in the avoidance of care proceedings through improvements in parenting or agreements for caregiving to be delivered by others (Masson 2013; Broadhurst et al Forthcoming).

The revised Public Law Outline (PLO) process, which involves a 26-week timescale emphasises the importance of rigorous assessment before proceedings are started (Munby 2013). Effective engagement of parents is important to achieving this, and this pre-birth assessment model should be used in conjunction with local guidance about the application of the revised PLO process. Under the new PLO, assessments can only take place during proceedings where the court decides that they are necessary for decisions in the case.
2. REFERRAL TO CHILDREN’S SOCIAL CARE

2.1 WHO SHOULD REFER PREGNANT WOMEN?

A range of practitioners who have contact with expectant parents are ideally placed to identify parents whose unborn child may be at risk of abuse and neglect. This includes midwives, health visitors, drug and alcohol workers, mental health workers, police officers, adult learning disability workers, residential workers, leaving care workers, probation officers, nurses, and general practitioners.

All pregnant women are offered antenatal care, which includes a booking interview at around 10–12 weeks gestation. During this interview the midwife will enquire into past or present severe mental illness including schizophrenia, bipolar disorder, psychosis in the postnatal period and severe depression; previous treatment by a psychiatrist/specialist mental health team, including inpatient care; and family history of perinatal mental illness (NICE, 2010). It is advised that the environment in which antenatal appointments take place should enable women to discuss sensitive issues such as domestic violence/abuse, sexual abuse, psychiatric illness and drug use. In addition, throughout the antenatal period, healthcare professionals are instructed to remain alert to factors, symptoms or conditions that may affect the health of the mother and baby, such as domestic violence/abuse.

The antenatal booking interview therefore provides an ideal opportunity to screen for factors that would suggest that the foetus is being adversely affected due to maternal behaviours (i.e. substance use) or that may place the infant at risk of harm following the birth.

All practitioners who have contact with expectant parents should be aware of the factors and circumstances that might affect the welfare of an unborn baby and know how to make the necessary referrals to Children’s Social Care.

2.2 REASONS FOR REFERRAL

Referrals to Children’s Social Care should be considered where there are concerns that the unborn child is likely to suffer significant harm or is at risk of abuse and neglect, due to the following circumstances:

- Alcohol and/or substance use
- Domestic violence/abuse
- Mental ill health issues
- Learning disabilities
The presence of one of these factors does not automatically require referral but suggests that referral may warrant consideration. For example, the research shows that families suffering from one single difficulty (e.g., mental illness) with adequate support can successfully parent their children and safeguard them from harm. However, the presence of two or more of these problems increases the risk of significant harm, particularly the ‘toxic trio’: problem drug and/or alcohol use, mental illness and domestic violence/abuse (McGovern, 2012).

Factors that require immediate referral to Children’s Social Care comprise the following:

- A parent or other adult in the household has been convicted of an offence against a child, or is believed by child protection professionals to have abused a child
- Previous children have been removed because they have suffered or been deemed likely to suffer significant harm
- A child in the household is the subject of a child protection plan.
- A child under the age of 16 is pregnant
- Other circumstances that may require consideration are:
  - A parent has a history of social care involvement because of abuse and neglect during their own childhood
  - A parent spent time in care during their own childhood
  - A parent is a looked after child
  - There are concerns about the mother’s ability to protect

It is vital that concern for the welfare of an unborn child is raised early to ensure that there is time to undertake a comprehensive pre-birth assessment, and to provide early intervention to enable parents to make the changes required within the child’s timeframe, or where this is not possible, to make plans for the baby’s protection.

### 2.3 TIMING OF REFERRAL

Where there are concerns about risk of significant harm to the foetus, a referral to Children’s Social Care should be made as soon as possible. Referrals made later than 16 weeks gestation limit the amount of time available to undertake a pre-birth assessment and provide early support to parents. The timeframe for an assessment is 45 days, which means that several weeks of pregnancy can elapse before the assessment is completed. Pregnant women using substances or experiencing domestic violence/abuse have an increased risk of premature delivery. Late referral therefore also increases the likelihood of the assessment not being completed prior to the birth of the child.

Under the new Public Law Outline courts will be required to complete care proceedings within six months of application. If court proceedings are considered to be necessary, late referral will reduce the amount of time available to offer parents opportunities to demonstrate to the courts that they can make sufficient changes to ensure the safety of their children.
Late assessments also have the potential to cause further distress, and may also impact on the developing attachment between the parents and their unborn child during the second and third trimesters; uncertainties may lead parents to distance themselves from feelings of attachment to their unborn child as an emotional defense mechanism (Ward et al., 2012; Corner, 1997).

Early referral and timely response therefore provides sufficient time for a full and thorough assessment to identify issues that might cause harm to an unborn and new-born baby, provide early support to enable parents to make necessary changes and provide adequate time to make plans for the baby’s protection, where this is necessary.
3: UNDERPINNING PRINCIPLES OF THE MODEL

3.1 PRINCIPLES

This pre-birth assessment model is underpinned by a number of principles concerning both the content and conduct of such an assessment. In terms of its conduct the model is premised on the following principles:

- The importance of including evidence in the process of gathering data for the cross sectional assessment and the assessment of capacity to change using standardized tools as part of a model of structured professional judgment;
- The importance of engagement, partnership and multidisciplinary working.

With regard to content, the model is underpinned by recent research about key aspects of intervening during the perinatal period, including:

- Working with the past in the present
- Promoting affect regulation
- Developing reflective function and the attachment to the unborn baby
- Self-efficacy

Working Effectively During the Prenatal Period

The research suggests that effective working during the perinatal period should involve addressing the ways in which the pregnant woman's life experiences are affecting her pregnancy and her potential ability to look after her newborn baby, and that this should involve ‘working with the past in the present’. Research from the fields of infant mental health and developmental psychology also points to the importance of increasing the ability of the mother-to-be both to regulate emotional states, and also extend her capacity for reflective functioning (see below), both of which have been found to be of central importance for the wellbeing of the infant during pregnancy and the postnatal period.

Working with the past in the present

Attachment theory has demonstrated the way in which early experiences with caretakers are internalised in the form of 'internal working models' that then inform the way an individual feels about him/herself and their relations with other people. Such working models play a significant
role in the infant/toddler’s evolving sense of self, and their capacity for later relationships. For example, ‘disorganised attachment’ is a frequent outcome of neglectful, abusive or traumatic parenting in the early years, leading to a range of later developmental and psychological problems (see for example, Shemmings and Sheemings 2011 for an overview). Perhaps most importantly, such patterns of relating are established early in life and occur at an unconscious level. It is the unconscious nature of these patterns that contributes to them being re-enacted in later relationships, including relationships with children, and other adults (including partners and professionals such as social workers). Box 1.2 provides two examples of the significant ways in which interactions with children in the present can evoke painful childhood memories that then become the basis for future abusive parenting.

**BOX 1.2: CLINICAL VIGNETTE**

‘a) Mary is angry, demands a lot of attention from the therapists and ignores her baby. The therapists try to calm her down and ask her to tell them what has happened. She describes how her baby’s fingers had clung to her hair at home, and how it caused a strong reaction in her “I lost my temper and I remembered how my mother dragged me by the hair with my feet 10cm from the ground. I left the baby crying and I went to the balcony for a cigarette to calm my nerves...”

b) Linda always feeds her baby with unheated milk. During lunch we discuss the memories that the mothers have of food when they were little children. Linda finds a connection between the cold bottle and her childhood experience. She remembers how her own mother and baby-sitter forced her to eat and drink food and liquids so hot that her mouth was burned over and over again.’ (Belt and Punamaki 2007)

Working with the past in the present, involves taking account of the ‘transference’, which refers to ‘the process of a person re-creating her or his patterns of emotional experience in the context of the present therapeutic relationship’ (Flaskas 2007). Flaskas has written widely about the way in which an understanding of what is happening in terms of the transference between client and worker not only enables ‘empathic connection’ but also enables the worker to use ‘difficulties in therapeutic engagement and impasse to further, rather than hinder, the therapeutic process (Flaskas 2007).

A parent who engages in behaviours that are harmful for the foetus or the newborn baby will often have experienced early parenting that is inconsistent, neglectful or abusive. They will have developed one of a limited number of potential internal working models of self, and self in relation to others, which was established during early childhood, and which has continued with them into adult life and relationships.

Working with the past in the present involves the social worker:

a) exploring with the pregnant women and her partner, their own experiences of being parented;
b) reflecting on the way in which such experiences have shaped their feelings about themselves and ability to relate to others, and specifically the extent to which this has resulted in distorted perceptions/constructions about the foetus/baby;

c) reflecting on what feelings the interactions with the family produce in the social worker.

**Promoting Affect Regulation**

Affect regulation refers to the ability to regulate emotional states. Many of the parents who are referred for assessment during pregnancy will be experiencing problems with affect regulation. For example, Personality Disorder involves an inability to regulate emotional states that may have its origins in the individual’s early experiences of being parented and in particular in a disorganised attachment (Fonagy et al 1996; 2000). Such individuals experience a range of dysregulated emotional states (e.g. severe anger, shame, and anxiety), that are triggered very easily and that result in a range of erratic behaviours, some of which may be aggressive either in terms of themselves (i.e. self-harm; suicidal ideation), or others (violent outburst). They may also use substances to help them to manage the dysregulated emotional states that they are experiencing.

In section 3.3 of this document we recommend a range of methods of working that will help to promote the pregnant woman’s capacity for affect regulation.

**Promoting Reflective Function in Pregnancy**

Reflective function (RF) refers to the capacity to understand another person’s behaviours in terms of their internal states such as their intentions, beliefs, etc. It is now thought that an inability for reflective function is a central part of the pathology of individuals with personality disorders (Fonagy et al 2003), and that a key part of therapeutic work should involve attempts to increase reflective function in clients, particularly in the field of child protection.

RF in pregnancy is defined as the mother’s imagined relationship with her baby (Patterson et al., 2005). Women who are described as ‘Balanced’, for example, can provide ‘richly detailed, coherent stories about their experiences of their pregnancies and their positive and negative thoughts and feelings about their foetuses’. Women who are ‘Disengaged’, however, appear to be uninterested in the fetus or their relationship with it, and demonstrate ‘few thoughts about the babies’ future traits and behaviours or themselves as mothers’; Women described as ‘Distorted’ tend to be ‘tangential or express intrusive thoughts about their own experiences as children, often viewing their foetuses primarily as an extension of themselves or their partners’ (Levendosky et al 2011, p. 514).

The importance of such representations is that they are stable over time such that women with distorted or disengaged prenatal representations still have them at 1 year post-partum (Theran et al., 2005), and they predict observed parenting behaviours and child attachment at age 1 (Levendosky et al 2011). Women who are experiencing domestic violence (Huth-Bocks et al 2004) or who are substance dependent (Pajulo et al 2012), have significantly more negative representations of their infants and themselves as mothers.
Walker (2008) suggests relationship-based work should involve the use of questions such as: 'Why do you think you behaved in this way?'; 'Why do you think your partner was violent to you?' and 'Why do you think your social worker is worried about you?' in order to invite clients to 'explore the possible meaning of another person's behaviour'. The responses to such questions are important because 'a parent who is able to recognise that a child is crying because she is upset, hungry or frightened is more likely to respond benignly than one who is feeling that the child's crying is intentional and that she is persecuting or attacking them'. Walker goes on to suggest that assessing reflective function enables social workers to both make a more accurate assessment of risk and to better understand 'an individual's potential vulnerability in terms of their capacity to communicate and relate'.

The type of question that can be used to promote the mothers RF specifically in relation to her unborn baby during the second and third trimester of pregnancy could include: “I wonder whether being pregnant is how you thought it would be, or whether there are things you hadn't expected.” and “I wonder what you (and your partner) think your baby will be like as a person?”. The social worker might encourage the mother to stroke her tummy and to talk to her baby, and to imagine what her baby might be like and might be feeling. A number of resources are now available including an app for parents that can be downloaded onto the pregnant woman’s phone (android only) and that shows pregnant women talking and singing to their babies. http://www.your-baby.org.uk/baby-states/download-getting-know-your-baby-app

**PRACTICE APPLICATION:**

In essence you need to consider during your assessment:

- How and why the manner in which expectant parents were cared for and nurtured as children impacts on their current ability to parent their expected child (ie working with the past in the present – The “Ghosts in the Nursery” (Fraiberg et al., 1975) and Complex Families (Thoburn, 2009) to understand more about the impact of childhood trauma on parenting)

- How expectant parents manage their emotions, particularly negative or explosive bursts of feelings and how this impacts on their ability to parent in a calm and consistent manner – there is a mountain of research that shows that responsive, nurturing and predictable caregiving by parents, particularly the primary carer, in the first year of life lays the foundation for optimum development into adulthood (http://www.eif.org.uk/our-work/)

- How attachment patterns are likely to develop with their baby, including expectant parents’ ability to form attachment during pregnancy and to think about their unborn baby as someone who will become a unique individual, with their own life trajectory. Reflective functioning means that a parent tries to understand their child’s behaviour in terms of feelings, thoughts, desires and intentions ie feelings underlie behaviours, both for themselves and for their children. Often the fear of removal of their child at birth drives deviant behaviours by expectant parents and it is important that you seek to build open, honest and trusting relationships with expectant parents – see section on partnership and collaborative working.
• Self-efficacy theory (Bandura 1991) is concerned with how people develop a belief in their own ability to succeed and the goal setting process aims to support expectant parents to achieve small goals, as part of a process of achieving an overall bigger aim.

3.2 STRUCTURED PROFESSIONAL JUDGMENT AND CAPACITY TO CHANGE

Unaided professional judgment in relation to the assessment of risk of harm, is now widely recognised to be flawed (Arad-Davidson and Benbenishty 2008; DePanfilis and Girvin 2005; Munro 1999; Pfister and Böhm 2008). There is increasing recognition within the field of child protection of the need for a 'third generation approach' toward assessment, which involves the use of empirically validated, structured decision-making (Douglas et al. 1999) and structured professional judgment (Hart 1998a; Hart 1998b), in which evidence-based standardised tools are used alongside professional judgment. 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.

PRACTICE APPLICATION

As part of this model, you are required to use a number of standardised measures in your discussions with parents. The information gathered through the use of these measures is to be included in your thinking about the family and forms part of your assessment, alongside your interview data and observations during visits. The measures in this model are suitable for use during pregnancy and should inform your professional judgment about the risk and protective factors that are apparent in each family.

Some of the tools are core and should be used in all cases, and some are optional depending on the concerns and circumstances within each unique family and you will need to use your judgment about which tools are suitable and when they should be used. For example, some measures are only to be used with existing parents expecting another child where there are concerns about their existing parenting and are not suitable for first time expectant parents; other measures are only to be used if there is a concern about substance misuse and would not be suitable if this was not an issue in the family. You should discuss and agree the measures to be used in supervision sessions with your manager/professional mentor. In effect this means that you will need to plan and prepare for visits, and that you will need to consider which measure you want to use during each visit and ensure that you take a copy of the measure with you for completion. You will also need to be able to explain to parents why you are using each measure and what they are designed to achieve, so it is important that you familiarise yourself with them at an early stage. An explanation of each measure and how to score them is included in the accompanying pre-birth guidance pack.
It has recently been suggested that although cross-sectional assessment of families provides important information about family functioning at one point in time, this is often of limited usefulness, particularly when the results are equivocal (Harnett 2007), and that what is actually needed at such times is an assessment of a family’s capacity to change, including an evaluation of the parent’s motivation and capacity to acquire parenting skills.

Capacity to Change (C2C) is related to, but not the same as, ‘readiness’ to change. An examination of the individual, family and caseworker characteristics associated with problem recognition and intentions to change found that ‘readiness for change may depend on the nature of presenting problems and the contexts within which these problems occur’.

Capacity to change is also distinct from ‘parenting capacity’ or ‘parenting capability’, which focuses explicitly on assessing the parents’ ability to parent the child, rather than their capacity to change by improving their parenting skills and overcoming adverse behaviour patterns and environmental factors that place their child at risk of significant harm.

**PRACTICE APPLICATION:**

A more detailed explanation of the Capacity to Change (C2C Harnett 2007) is included in Stage 4.5.

It is based on a four step process:

**Step 1:** Complete a cross sectional assessment of the family’s current functioning using a range of standardised tools (Time 1), and collate these with other data obtained from interviews, observations and other agency reports.

**Step 2:** Define and agree measurable goals with the family that address their unique situation specifying what needs to change.

**Step 3:** Provide an effective (i.e. evidence-based) intervention that is designed to support the family to bring about the change required – this has to be relevant to address the concerns identified in the cross sectional assessment (see section 4.6 for details of a number of evidence based methods of intervention and promising practice that support parents during the pre-birth period).

**Step 4:** Following the provision of the intervention, the final step is to re-administer the standardised tools that were used previously (Time 2). You will then have a measurement of change that has been obtained using standardised tools, and which should be considered alongside the extent to which the goals agreed with the family have been achieved, and alongside information that has been gathered during observations and other discussions with the family, and the reports from other agencies also working with the family. This step will also involve you in considering the factors that have either supported or hindered the parent from achieving the necessary change.
3.3 ENGAGING PARENTS, PARTNERSHIP AND MULTIDISCIPLINARY WORKING

a) Engaging Parents

In this section we describe a range of evidence-based methods of working that you should use to develop a working alliance and engage with families during the pre-birth assessment process. These skills or ‘techniques’ of working with families have been identified as being effective in helping to support engagement and also to assist individuals/parents to change and are used to underpin a partnership model of working with families.

A basic premise of this model of pre-birth assessment is that its success depends on your ability to establish a trusting relationship with the pregnant woman and her partner (where appropriate). Establishing such a relationship is challenging not only because of the potentially adversarial nature of the process of pre-birth assessment, but also because the early life experiences of many of the women who are referred for pre-birth assessment will have been seriously suboptimal, and a majority will have ‘unresolved’ trauma or a disorganised attachment. Toth (2002) (see Box 3.5) describes this in her work with maltreating mothers of preschool children.

**BOX 3.5: WORKING THERAPEUTICALLY**

‘Maltreating mothers, who often have childhood histories of disturbed parent-child relationships and frequent negative experiences with social services systems, often expect rejection, abandonment, criticism and ridicule. Through empathy, respect, concern, and unfailing positive regard, therapists help maltreating mothers to overcome these negative expectations and provide a holding environment for the mother and pre-schooler in which new experiences of self in relationship to others and to the preschooler may be internalised (Toth et al., 2002, p.891).

In addition to establishing a ‘therapeutic relationship’, core methods of working with the family during pregnancy (and the postnatal period where appropriate) should involve promoting the woman’s capacity to:

1. Regulate her emotional states – this will enable her to begin to be able to regulate the high states of arousal she will experience in response to her newborn baby and also to regulate her infant’s own emotional states. It will also reduce the stress to which the foetus may be exposed;

2. Develop her capacity for reflective function (see below) and space to think about the baby without distortion or misattribution – this will enable the mother to be to begin to develop a relationship with the baby;

3. Develop an attachment to the baby – the prenatal attachment to the infant will increase the woman’s ability to take the necessary actions to look after the baby and keep him/her safe (e.g. changing diet; ceasing smoking/alcohol/substances; reducing other risks such as...
violence from a partner); and an understanding about both the emotional and physical needs of the infant and to plan how she can meet these;

4. Develop an understanding about the ways in which her own experiences have impacted on her, and the specific ‘triggers’ that may affect her ability to parent

**Motivational Interviewing**

Interventions underpinned by cognitive-behavioural models of change are amongst the most widely evidence-based models of intervention now available and Motivational Interviewing (MI) is underpinned by this approach. MI conceptualises behavior change as compromising a number of stages along a continuum of ‘motivational readiness’ that includes pre-contemplation, contemplation, preparation, action, maintenance and relapse add (Prochaska and DiClemente, 1982, 1983). MI involves practitioners using empathic and reflective listening to create a supportive, non-judgmental, directive environment that is aimed at enabling the practitioner to work with the client to explore their motivations, readiness and confidence for change, as well as their ambivalence about such change. It involves a range of MI skills and techniques that are underpinned by four basic principles: expressing, developing discrepancy, rolling with resistance and supporting self-efficacy.

UK based trainings ranging from 1 hour (one-line and introductory) to 2–3 days (intermediate/advanced) is available (http://www.motivationalinterview.org/quick_links/mitraining.html).

**Adopting a Mentalising Stance**

You can help expectant parents become aware of and learn to reflect on their underlying mental states (thoughts, feelings, intentions, beliefs, desires) and also reflect on the mental states of their babies, which is essential to the development of secure attachment by adopting a mentalising stance.

Mentalising means understanding and considering the way in which mental states (our own as well as those of others) connect with our feelings and behaviour.

“Mentalising simply implies a focus on mental states in oneself or in others, particularly in explanations of behaviour. That mental states influence behaviour is beyond question. Beliefs, wishes, feelings and thoughts, whether inside or outside our awareness, determine what we do.” (Bateman & Fonagy, 2006)

It is difficult to mentalise (or be reflective) in the face of intense negative thoughts or feelings and in highly charged complex relationships, expectant mothers will find it hard to think about their baby if they are feeling stressed themselves. She may be wrapped up in dealing with on-going crises and her behavioural responses may be impulse based, rather than “thinking” based. You can help her to adopt a “thinking” approach by modelling a mentalising stance and trying to understand her behaviour.
Taking an “intentional” or reflective stance as opposed to a “physical” stance means:

- Instead of trying to control behaviour, trying to make sense of it
- Instead of trying to stop behaviour, trying to understand its causes
- Think of the behaviour as a communication
- Instead of assuming, wondering and enquiring

*Mentalising is not just a skill. It is an attitude and a “way-of-being”. Be curious about people.*

“Being a good mentaliser does not mean that you will always be able to accurately read one’s own or another’s inner states, but rather you approach developing relationships with an expectation that one’s own thinking and feeling may be enlightened, enriched and changed by learning about the mental states of other people. In this respect, mentalising is more like an inquiring, respectful attitude than a skill; that suggests awareness of the limits of your knowledge of others, and reflects the view that understanding the feelings of others is important for maintaining healthy and mutually rewarding relationships”. (Fearon, Target, Sargent, Williams, McGregor, Bleiberg and Fonagy, 2006)

**PRACTICE APPLICATION:**

We all mentalise a lot of the time – although it is harder to do when we are anxious or fearful. It means that you are thinking about what others are thinking and feeling, recognising that they have different thoughts and feelings to you, and that these thoughts or feelings are underpinning their behaviour.

When people don’t mentalise, you may find that their conversation is difficult to follow – you may find that the conversation is confusing and lurches from one thought to another, with no clear link; or you struggle to follow the line of conversation. You may find that whatever you say is not helping and sometimes is making the situation worse. This makes it harder for you to “think” rather than just react.

Some techniques to support this working this way include:

- settling the conversation – “let’s slow this down and think about....”
- stopping and rewinding – “let me stop you there and go back to...”
- interrupting with a prompt – “I am getting confused......”
- adding another perspective – “I wonder what it is like for your baby when you...”
- practicing naïve curiosity – “this may sound daft, but I am wondering whether.....”
Fathers

Historically, the role of the father (and other male members of the family) has been absent from pre-birth assessments. Ofsted’s (2011) review of serious case reviews described fathers and partners as ‘ignored’, ‘invisible’ and ‘the ghost in the equation’. This raises concerns, particularly as the father may pose a risk to the unborn child, or alternatively prove to be an important protective factor in their life. The involvement of fathers and other significant males in pre-birth assessments is an important part of the assessment process and provides the opportunity to identify their present and future role in the child’s life, and was highlighted by the National Service Framework for Children:

“Involvement of prospective and new fathers in a child’s life is extremely important for maximising the life-long well-being and outcomes of the child (regardless of whether the father is resident or not). Pregnancy and birth are the first major opportunities to engage fathers in appropriate care and upbringing of their children.” [Standard 11, 5.6, p.11]

However it is important to acknowledge that a father does not have legally recognised rights until the birth and that the identity of the father may be unknown or unclear. The father may be a source of support for the mother or a potential risk.

There is minimal research on the inclusion of males in pre-birth assessments, but social workers interviewed as part of Hodson’s (2011) study reported that although they generally attempted to obtain father’s views, their level of involvement varied, and the threat of violence and aggression was a real concern with social workers reporting being anxious about the potential for violence within the home and also being concerned that their involvement might increase the risk of violence to the woman.

**PRACTICE APPLICATION:**

Where the couple reside separately you should continue to include the father in the assessment process, and although information about the pregnant woman cannot be shared with the baby’s father without her consent, his ability to parent safely should be solicited and attempts should be made to work proactively with him as part of the assessment process provided that this does not put the mother at risk.

**b) Partnership working**

Working with resistant, aggressive or challenging parents is often part of child protection practice and expectant parents are likely to be highly anxious or hostile about being the subject of a pre-birth assessment process.
Although parents have the right to refuse to engage with statutory interventions to safeguard the welfare of their unborn child, it is important that you encourage them to participate in an assessment pre-birth, in order to explore their needs and provide early support to help them overcome their difficulties, and reduce the risk of harm to the baby. Parents who have had previous involvement with Children’s Social Care and/or older children taken into care may be particularly difficult to engage. They may feel as though they will ‘not be given a chance’ or that Children’s Social Care will ‘snatch their baby away’ (Corner, 1997). It is important that you clearly explain the pre-birth assessment process; advise them of professionals’ concerns about their parenting, discuss the measures that it may be possible for them to take to address these concerns, and explain what support will be available. You should openly acknowledge the potential for the child to be removed at birth and ensure that parents are kept fully informed of the decision-making process. Research evidence suggests that parents prefer social workers who are honest and upfront and not afraid of breaking bad news (Corner, 1997; Munro et al., 2008; Ward et al., 2012). And parents will need to understand what will happen if they are not able to make the necessary changes in time for the arrival of their newborn.

Both the assessment process and delivery of evidence-based methods of supporting parents to change should be undertaken as part of this model of partnership working. A partnership model of working not only enables practitioners undertaking assessment during the pre-birth period to work ‘alongside’ the family to achieve the required change, but also provides them with the necessary skills to negotiate the statutory and legal requirements that the social worker may be required to implement in a manner that will increase the potential for the family to remain engaged and co-operate with the process.

The Family Partnership Model is underpinned by a cognitive, goal-oriented, relational approach to working with families. It also recognises the significance of the individuals’ past experiences in terms of current functioning, and can be used alongside the other aspects of relationship-based working that are described below. This model defines the key processes involved in helping the relationship, alongside the practitioner skills and qualities needed to facilitate this. The Family Partnership approach involves working collaboratively with parents to negotiate short-term goals which parents are then helped to achieve. The use of such an approach can provide an indication of parental capacity for change, in addition to addressing issues such as ‘false compliance’ (Crispin Day, Personal Communication; Harnett and Day 2008).

Effective partnership working is characterised by: i) working closely together with active participation and involvement; ii) sharing decision-making power; iii) recognition of complementary expertise and roles; iv) sharing and agreeing aims and process of helping; v) negotiation of disagreement; vi) mutual trust and respect, and openness and honesty; and vii) clear communication.

The Family Partnership Model defines the core ‘internal qualities’ required by practitioners in order to work effectively in partnership. These include respect, genuineness, empathy,
humility, quiet enthusiasm, personal integrity, attunement and technical knowledge (including an understanding of the processes of helping).

Training in the use of this model of assessment and working can be obtained from the Child and Parent Centre for Support: http://www.cpcs.org.uk/index.php?page=family-partnership-training

PRACTICE APPLICATION:

Remember that the aim of the assessment is to address the question “how safe is it for this baby to be born to and cared for by these parents? The working alliance formed with parents is based on the need to address this question and it is important to hold the unborn baby in mind at all stages – developing a partnership with parents is not the end in itself. A robust working alliance is based on openness by all parties, mutual trust, joint goal setting, a willingness by both parties to listen and reflect; and a focus on both risks and strengths that are contained within the family. You will need to clarify for parents what the concerns are and, where concerns are found, to specify what changes need to be evidenced prior to birth. Parents may refuse to co-operate with the assessment and your role would then be to keep the family informed about their rights and about what action the professionals intend to take. Where neither parent is willing or able to engage with the assessment process, you should utilise information from other sources, either until such time as engagement with the family becomes possible or until legal proceedings are instigated if this is the course of action taken.

c) Multi-agency/disciplinary working

Safeguarding children, including those unborn, is the responsibility of everyone. Practitioners who should ideally be involved in the pre-birth assessment process include ‘all those involved with/working with the family’ (Corner, 1997) and this includes but is not limited to:

- Social workers
- Midwives
- Family support workers
- Health visitors
- Workers from mental health services, drug and alcohol teams, domestic violence services, probation teams, adult learning services, youth offending teams, and children centres.
- Police officers
- Nurses
- General practitioners
- Teachers
- Leaving care workers
- Housing officers
- Social workers from other local authorities

Attending appointments made by other practitioners or visiting parents with other practitioners such as mental health workers should be considered where appropriate because it can help facilitate parents’ involvement in the pre-birth assessment. Holding regular multi-agency/disciplinary meetings can benefit the pre-birth assessment process by providing a forum to discuss potential referrals to Children’s Social Care, and on-going pre-birth assessment cases. Routine multi-agency/disciplinary meetings provide opportunities to make shared decisions, exchange information in a timely manner (although urgent information should not be saved until meetings but shared early through another means of communication where necessary), explore support options for parents, and open up speedier communication and fulfilment of actions.
4. PRE-BIRTH ASSESSMENT: CHILDREN’S SOCIAL CARE

4.1 INTRODUCTION

This section sets out the process that you will follow in order to complete a pre-birth assessment.

Table 4.1: below depicts the key stages of the pre-birth model from initial referral through to decision-making (i.e. Stage 6).

Each of the stages of this assessment process is fully described in the text that follows.

Table 4.1: Pre-birth Model Key Stages

<table>
<thead>
<tr>
<th>Stage</th>
<th>Process</th>
<th>Factors/ Measures</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial referral</td>
<td>Decision to undertake pre-birth assessment</td>
<td>See section 2.3</td>
<td>By 16 weeks gestation</td>
</tr>
<tr>
<td>Stage 1</td>
<td>Core cross-sectional assessment</td>
<td>Standardised tools – see table 4.3.3</td>
<td>45 working days</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Case conceptualisation</td>
<td>The Discrepancy Matrix and the resilience matrix – see boxes 4.4.8 and 4.4.6. Use the risk and resilience table (box 4.4.1) to consider those not suitable for C2C assessment.</td>
<td>20–22 weeks</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Goal Setting</td>
<td>Goal Attainment Scaling (GAS) – see figure 4.5.1 and table 4.5.1</td>
<td></td>
</tr>
<tr>
<td>Stage 4</td>
<td>Intervention</td>
<td>See Section 4.6</td>
<td>20 – 36 weeks</td>
</tr>
<tr>
<td></td>
<td>• Time-limited</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Evidence-based</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage 5</td>
<td>Assess capacity to change</td>
<td>Standardised tools – as above GAS – as above Reporting template – see capacity to change table</td>
<td>36 weeks gestation</td>
</tr>
<tr>
<td></td>
<td>• Re-administer stage 1 measures</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Monitor achievement of goals</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Direct observation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Multiagency reports</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.2 INITIAL REFERRAL

4.2.1 Circumstances for pre-birth assessment

A pre-birth risk assessment should be considered when the following situations pertain (Wallbridge 2012, Calder 2013):

- Previous children have been removed from the family because they have suffered harm and/or there has been a previous suspicious death of a child
- Existing children are currently subject to a child protection plan or there have been previous child protection concerns
- A person posing a risk to children (previously known as a schedule one offender) has joined a family and especially when a parent or other adult in the household is a person identified as presenting a risk, or potential risk to children
- Concerns regarding the mother’s ability to keep the baby safe
- Concerns that the mother is actively hostile or rejecting of the baby during the pregnancy
- Acute professional concerns regarding parenting capacity, particularly where the parents have either severe mental health problems (e.g. psychosis or personality disorder) or learning disabilities
- Alcohol or substance misuse is thought to be affecting the health of the expected baby, or the woman is experiencing domestic abuse
- Adolescent pregnancy requiring a dual assessment of the adolescent’s needs as well as their ability to meet the baby’s needs
- The expectant mother/father has experienced abusive parenting, spent time in care or is a care leaver; concerns about the impact of earlier life trauma on his/her parenting
- Other maternal risk factors (e.g. denial or concealment of pregnancy, avoidance of antenatal care, non-cooperation with necessary services, non-compliance with treatment with potentially detrimental effects on the unborn child, including frequent moves e.g. area to area or hospital to hospital)
- Concerns that the expectant mother/father is at risk from honour based violence or the infant may be subject to FGM.

4.2.2 Timing of pre-birth assessment

Historically pre-birth assessments have been a low priority but late intervention reduces opportunities to undertake robust assessments, and to work with parents to help them make sustainable changes and reduce the risk of harm to their unborn baby (Calder, 2000). Starting the pre-birth assessment process early allows sufficient time for thorough assessments and for support to be provided during pregnancy, which may help parents develop their parenting capacity and show evidence of change. It also improves the chances of the parent continuing
to parent their baby and avoids stress being caused to the parents close to the birth. The need to adjust timescales where there is an increased likelihood of premature birth must also be considered. Early assessment also offers additional time to assess family members as potential carers.

Once the referral to Children's Social Care has been made the processes for initiating assessment are the same as for any child in need or child protection referral. The assessment should be undertaken in a timely manner (see Legal requirements above), and families should be made aware of the outcome as soon as it is known (i.e. not have to wait until the assessment deadline).

The assessment should start immediately upon receipt of the referral (and before 16 weeks gestation) to ensure that there is sufficient time to undertake a full and thorough assessment, provide services to enable parents to make necessary changes, and to ensure that there is adequate time to make plans for the baby’s protection where this is necessary.

A pre-birth assessment could commence at any time from confirmation of the pregnancy. Ideally, all cases should be allocated by 16 weeks pregnancy. Where the process is begun later than this, there is less time for the parents to demonstrate their capacity to change.

The threat of removal of a baby at birth may influence a mother’s decision as to whether or not to keep her baby or terminate her pregnancy. Parents should be supported to access services to help them to make this decision. As a social worker you cannot be involved in the making of this decision; as it is the parent’s decision to make.

4.3 STAGE ONE: CORE CROSS-SECTIONAL ASSESSMENT

4.3.1 Cross-Sectional Assessment

The pre-birth assessment should begin with information gathering; this should include speaking to the family to gather a social history and collating information from external agencies/practitioners. Standardised and validated assessment tools should be administered to screen and assess the risk of harm to the unborn child. If the parents refuse to engage, the pre-birth assessment must proceed through the gathering of information from external agencies/practitioners.

The assessment framework (HM Government, 2013) specifies a range of dimensions in the three interrelated domains of parenting capacity, family and environmental factors that should be explored during the course of a core assessment. However the dimensions shown in the current version of the Assessment Framework (HM Government 2013, p. 20) are not specific to the pre-birth period. This pre-birth assessment model is therefore based on a revised version of the assessment framework, modified to focus explicitly on factors that are relevant to this period – the mother’s medical and social history; the developing foetus/baby; family and environmental context.
During the pre-birth period, the assessment of parenting capacity in relation to the unborn child (as opposed to any existing children) can be assessed using a range of outcomes that are associated with later parenting practices including for example, the developing relationship with the baby and their willingness to put the needs of the foetus/baby before their own (i.e. reduction of harmful behaviours).

Box 4.3.1 below shows the revised pre-birth assessment framework developed to be used as part of the pre-birth assessment model.

**BOX 4.3.1: PRE-BIRTH ASSESSMENT FRAMEWORK**

**Baby’s Development Needs**
- Foetal Development (e.g. impact of smoking, substance dependency, stress, poor parental nutrition, HIV or Hepatitis C, Planned/unplanned pregnancy)
- Pregnancy history and antenatal care
- Birth planning and preparation
- Feeding plans
- Maternal relationship with foetus

**Parenting Capacity**
- Maternal and paternal prenatal attachment styles
- Attitude towards pregnancy
- History of previous pregnancies
- Understanding of foetal and infant development
- Previous experience of parenting
- Impact of current domestic abuse/substance misuse or mental ill-health on future parenting
- Ability to manage stress and regulate emotions
- Couple relationship
- Capacity for reflective parenting style
- Family planning
- Capacity to change adverse behaviours and to learn new skills

**Family and Environment**
- Home environment and preparation for birth
- Attitude to professional involvement
- Employment and child care plans
- Financial problems
- Criminal history
- History of childhood exposure to domestic abuse parental substance misuse, parental mental ill-health
- Experience of childhood sexual abuse or unresolved trauma
Parents should not find the measures onerous or difficult to complete. You should explain clearly to them that the measures are used to capture evidence about strengths and difficulties in families as well as being used to demonstrate change. Attempts by parents to shut out professionals and/or an unwillingness to complete the assessment measures or collaborate in goal setting may be a cause for concern. It may be that parents indicate a willingness to complete some measures and not others; however, it needs to be explained that as part of this process you will be using a range of measures that cover many areas and that you would expect all those you bring to be completed in order to ensure you gather a range of information that allows the family to demonstrate both their strengths and difficulties across a number of areas.

Table 4.3.2 describes a number of brief screening tools that can be used at the beginning of the process to identify those factors that might either individually or in combination with others place the infant at risk of harm, and that might then be more formally assessed during the cross sectional assessment.

**PRACTICE APPLICATION:**

It is important at the start of any assessment to be clear about the domains that need to be included, and as it is possible that referrers do not always know about the range of risks or concerns that exist in a family, we have included some key measures that may help you to "screen" for key issues.

The tools listed below contain brief measures about domestic violence/abuse, substance use, mental ill health and post-traumatic stress disorder (PTSD). It is important to note that the measures do not lead to medical or definitive diagnosis of conditions, but may indicate a need for more specialist intervention during the assessment period.

These screening measures may not always establish the existence of concerns; for example, domestic violence/abuse may remain hidden if parents do not disclose, but the message from you at the beginning of the assessment should be that you are prepared to raise the issues and that you may want to explore this further when your working relationship has developed.
Table 4.3.2: Screening Tools

<table>
<thead>
<tr>
<th>Role</th>
<th>Domain</th>
<th>Standardised assessment tool</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening Tools</td>
<td>Domestic Abuse</td>
<td>DOMESTIC VIOLENCE SCREEN (DAW, n.d.) 4 items</td>
<td>Start of assessment</td>
</tr>
<tr>
<td></td>
<td>Substance use</td>
<td>SUBSTANCE USE RISK PROFILE-PREGNANCY SCALE (Yonkers et al., 2011) 16 items</td>
<td>Start of assessment</td>
</tr>
<tr>
<td></td>
<td>PTSD</td>
<td>PRIMARY CARE PTSD SCREEN (PC-PTSD) (Prins et al., 2003) 4 items</td>
<td>Start of assessment</td>
</tr>
<tr>
<td></td>
<td>Mental health</td>
<td>ADDICTION SEVERITY INDEX (ASI) – PSYCHIATRIC STATUS SECTION (University of Pennsylvania/Veterans Administration Center for Studies of Addiction/McLellan, 1990)</td>
<td>Start of Assessment</td>
</tr>
</tbody>
</table>

We have also compiled a range of standardised tools/measures that can be used as part of this model of pre-birth assessment. Table 4.3.3 below describes the measures that have been identified for each of the key domains, and when they can be used. Most of these tools can be used at both the beginning of an assessment (Time One (T1)) and then again after parents have been supported to overcome identified problems (Time Two (T2)) as part of the process of assessing capacity to change.

**PRACTICE APPLICATION:**

The list of measures below is to be used during the cross sectional assessment (Time 1) – then repeated later if a capacity to change assessment is also to be completed (Time 2). Initially this list may look daunting but remember that there are core and optional measures depending on the domains that you consider are relevant for the family with whom you are working. You should be able to explain why you are choosing the measures that you do/do not use. For example, if you have used the screening tool for substance misuse, and this gives no indication that this is a concern about this within this particular family, you may choose not to complete the parent behaviours measures addressing substance misuse.

Copies of each of these measures are available in the accompanying guidance, which also includes detailed guidance about what they are designed to achieve, how they should be administered and what the findings mean.

The list of parenting attitudes measures are to be used only with existing parents and are not suitable for first time parents.
The Pictorial Representation of Attachment Measure (PRAM) and the Needs Jigsaw are visual measures which are suitable for parents who have learning difficulties.

The questions in all the measures can be asked by you, where parents struggle to read written information and/or you may decide that you prefer to use the measures as part of an interview discussion. You must not: a) amend the order in which the questions are administered; b) miss questions; or c) change the wording of questions, because this will make them invalid as a standardised measure.

Table 4.3.3 Standardised Outcome Measures

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
<th>Standardised assessment tool</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family and environmental risk factors</td>
<td>Social Support</td>
<td>THE MULTIDIMENSIONAL SCALE OF PERCEIVED SOCIAL SUPPORT (Zimet et al., 1988)</td>
<td>T1 and T2</td>
</tr>
<tr>
<td></td>
<td>(core)</td>
<td>Part A: 12 items and Part B: 4 items.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Domestic Violence/abuse</td>
<td>CONFLICT TACTICS SCALE (Straus, 1979; 1996)</td>
<td>T1 and T2</td>
</tr>
<tr>
<td></td>
<td>(optional)</td>
<td>39 items</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family functioning</td>
<td>THE NORTH CAROLINA FAMILY ASSESSMENT SCALE – G (NCFAS – G) (National Family Preservation Network, 2014)</td>
<td>T1 and T2</td>
</tr>
<tr>
<td></td>
<td>(core for existing parents and applicable sections for first time parents)</td>
<td>39 items</td>
<td></td>
</tr>
<tr>
<td>Domain</td>
<td>Description</td>
<td>Standardised assessment tool</td>
<td>Time</td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Parent Mental Health</td>
<td>Psychiatric status</td>
<td>ADDICTION SEVERITY INDEX (ASI) – PSYCHIATRIC STATUS SECTION (University of Pennsylvania/Veterans Administration Center for Studies of Addiction/McLellan, 1990)</td>
<td>T1 and T2</td>
</tr>
<tr>
<td></td>
<td>(optional)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Depression, anxiety and stress.</td>
<td>DEPRESSION, ANXIETY AND STRESS SCALE (DASS) (Lovibond and Lovibond, 1995)</td>
<td>T1 and T2</td>
</tr>
<tr>
<td></td>
<td>(core)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adult attachment style</td>
<td>THE RELATIONSHIPS QUESTIONNAIRE (Bartholomew and Horowitz, 1991).</td>
<td>T1</td>
</tr>
<tr>
<td></td>
<td>(core)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emotional regulation</td>
<td>EMOTION REGULATION QUESTIONNAIRE (ERQ) Gross &amp; John 2003</td>
<td>T1 and T2</td>
</tr>
<tr>
<td></td>
<td>(core)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent behaviours</td>
<td>Addiction severity</td>
<td>ADDICTION SEVERITY INDEX (ASI): – DRUG AND ALCOHOL SECTION (University of Pennsylvania/Veterans Administration Center for Studies of Addiction/McLellan, 1990)</td>
<td>T1 and T2</td>
</tr>
<tr>
<td></td>
<td>(optional)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alcohol consumption</td>
<td>ALCOHOL USE DISORDERS IDENTIFICATION TEST AUDIT-C (Babor and Grant 1989)</td>
<td>T1 and T2</td>
</tr>
<tr>
<td></td>
<td>(optional)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domain</td>
<td>Description</td>
<td>Standardised assessment tool</td>
<td>Time</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quality of a mother’s representation of her relationship with her unborn child. (core during third trimester only)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PREGNANCY INTERVIEW – REVISED (Slade, 2011)</td>
<td>During third trimester of pregnancy – see intervention section</td>
</tr>
<tr>
<td>Parenting Attitudes/Problems</td>
<td>Parenting and child rearing attitudes (core for existing parents)</td>
<td>ADULT-adolescent PARENTING INVENTORY (AAPI-2) (Bavolek &amp; Keene, 1999) Form A – 40 items</td>
<td>T1 and T2</td>
</tr>
<tr>
<td></td>
<td>Parent-child stress (core for existing parents)</td>
<td>PARENTING STRESS INDEX – SHORT FORM (PSI) (Abidin, 2012) 21 items PARENTING DAILY HASSLES SCALE (Crnic and Booth, 1991) 20 items</td>
<td>T1 and T2</td>
</tr>
<tr>
<td></td>
<td>Child abuse potential (core for existing parents)</td>
<td>BRIEF CHILD ABUSE POTENTIAL (CAP) INVENTORY FORM VI (Milner, 2012) 24 items</td>
<td>T1 and T2</td>
</tr>
<tr>
<td></td>
<td>Understanding child’s needs (optional for parents with learning difficulties)</td>
<td>THE NEEDS JIGSAW (APS Marketing &amp; Consultancy, 2007)</td>
<td>T1 and T2</td>
</tr>
</tbody>
</table>
4.3.2 Core Data Gathering

The definition of the problem and background information should be the first stage of the assessment process and should build on the presenting concern, including the referral information and first contact with the family. This should include information about the following:

- Expected date of birth
- Who is concerned and why?
- Are there times when the concerns are not evident? If so, why?
- What is the purpose of the assessment?
- What are the parent’s views of the need for assessment?
- What does each parent think they need to do to achieve the outcome they want?
- What outcome do they want/think will happen?
- Have there been times when there have been previous concerns and parents have overcome them – What were they? How did they achieve change?

The family structure and history should involve the development of a genogram and chronology, alongside the use of parent interviews and social work and other (e.g. police, school) records, to develop information regarding:

- Current and past relationships
- Parent’s cultural origins
- Birth family structures
- Extent to which their own parents were involved in criminal activities
- Childhood experiences of parental substance misuse or domestic abuse
- Childhood sexual abuse and other traumas etc.
- History of being in LA care or having contact with social care agencies.
- Stability of accommodation or changes in family circumstances
- Significant family events (e.g. death of significant person)
- Information regarding concerns or removal of other children in the family

Related to this an assessment of the current home and family circumstances and also the family support systems should be undertaken to assess preparations for the new baby and the need for adaptations, stability of the home environment and socio-economic deprivation. The North Carolina Family Assessment Scale (NCFAS-G) is a reliable and valid practice-based instrument that assists practitioners in identifying areas for intervention, covering a wide range of domains (e.g. environment, parental capability, family interaction, family safety, child wellbeing, social community life, self-sufficiency, family health) and which has
been shown to be accurate in predicting out of home placements (Kirk, Kim, Griffith 2005). It should be noted, however, that only some of the domains can be used with first-time parents (e.g. Environment; Self-Sufficiency; Family Safety – 3 items; Social/Community Life). The Ecomap can be completed to identify wider family members and community contacts and the Multidimensional Scale of Perceived Social Support can be used to assess their perceptions about the support available from family, friends and significant others.

The assessment of current and previous pregnancies should include data obtained from an interview with the birth mother in addition to the collation of data from medical and midwifery records. It should include information about earlier pregnancies (e.g. miscarriages and terminations) and maternal health (e.g. depression/suicide attempts); the conception (e.g. planned/unplanned; concealment; trauma related to conception) preparation for the birth (e.g. attendance at clinics and appointments; plans for birth, feeding, contraception). In terms of the current pregnancy the interview with the couple should explore the mothers experiences and include her emotional experiences of pregnancy (e.g. anxiety and depression), both parents developing attachment to the infant (e.g. using the Maternal and Paternal Attachment Scales or the pictorial representation of attachment measure (PRAM) for parents with learning difficulties), and their representations about the baby (e.g. using the Pregnancy Interview, which should be administered in the third trimester of pregnancy (Trimester 3: 27–40) weeks and can be coded externally to explore the extent to which the mother has disengaged or distorted representations of the baby – see intervention section.

Assessment of the mother and father's preparation for becoming parents should include the collation of information about expectations regarding the impact of a baby in their lives, preparation for changes to lifestyle, how to include the new baby into their existing family, strategies for coping with crying and sleepless nights, and other parental stressors.

Assessment of the health and development of the unborn baby should include information from the midwifery records about the growth and developmental stage of pregnancy, any pregnancy complications, and the potential impact of maternal health behaviours including her diet, smoking, substance use, and exposure to violence.

The couple relationship should be explored alongside their views about the unborn baby. This should include a variety of aspects such as duration; how they met, shared interests/differences, what they value about the other person, how they make decisions and resolve difficulties/disagreements, hostility, and earlier relationships. Evidence of hostility should explore the format that takes (e.g. triggers; dynamics in terms of escalation, violence; frequency, severity, bi-directional nature of violence; whether it is limited to the family; recognition of risk to foetus and so on. We have included two standardised measures – The Conflicts Tactics Scales and the Relationship Questionnaire. The former measures a total of 39 behaviors divided into five categories: 'physical assault', ‘injury’, ‘psychological aggression’, ‘sexual coercion’, and ‘negotiation’. The Relationship Questionnaire comprises four items that correspond to the four types of adult attachment style (e.g. Dismissing-Avoidant: D. I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me), and that can be used to help
you to better understand the relationship problems of the mother and her partner, both to each other, to other professionals and to the unborn baby.

A number of the assessment domains relate specifically to the parents and include their **medical history and current health; mental health and substance use; criminal history; learning disability.**

In terms of **mental health,** the evidence strongly suggests that in both pregnancy and the postnatal period chronic maternal mental health common problems such as depression and anxiety, through to more complex problems such as personality disorder, substance dependency, and psychosis), have a significant impact in terms of both programming of the foetal nervous system and impacting on the parent-infant relationship.

Two aspects that are now recognised to be particularly important in relation to all of these mental health problems is their impact on:

- the parents ability to regulate their emotional states (e.g. manage anger and frustration, engage in thoughtful planned activity rather than impulsive behaviours, and their ability to cope with crisis/stress/unexpected events)
- the parents ability for reflective function and to engage with their unborn/newborn baby without distortion (i.e. inappropriate projections such as ‘the baby is evil’) and their ability to think about the baby’s behaviour in terms of their internal states.

In addition to information that is collected from the parents, medical records and psychiatric assessment we have included standardised measures that can help assess the parents level of depression, anxiety and stress (Depression, Anxiety and Stress Scale), their parenting stress (Parenting Stress Index), their ability to regulate their emotional states (Emotion Regulation Questionnaire) and their reflective function (Pregnancy Interview).

**Parental alcohol/substance misuse/dependency** should be assessed using information from any agencies with whom the parent may be involved. The nature and extent of their current dependency can be assessed using two standardised tools – The Alcohol Use Disorders Identification Test – C, and the Addiction Severity Index. Discussion about substance dependency should address the couple’s recognition of the impact of the alcohol/substance use on the unborn baby and their willingness to engage with relevant agencies to manage their addiction.

Both parents **criminal history** should be examined using police, social work and probation records. This should include information about the number and nature of previous offences (e.g. social rule violations versus offences against people/property), motivation for the offending behavior (e.g. is it entrenched? What does it mean for the unborn baby?), details about the victims (e.g. age, offence, relationship to offender), and evidence of any escalation in offending behavior.

**Parental learning disability** should include specialist assessment of their abilities (e.g. level of difficulty such as preventable accidents to either parent, unexplained patterns of injuries/incidences, delays in seeking help, failure to follow appropriate and accessible advice, evidence
of absence of appropriate supervision of existing children, and/or signs of neglect). Ability to learn and learning styles should also be examined (e.g. how does each parent acquire new skills? What recent examples are there?), the existence of reliable support networks (see section above on Family Support), their own experiences of being parented and ability to reflect on their own childhood experiences. Protective factors should also be identified (e.g. sociability, responsiveness to others, readiness to take on responsibility and develop partnerships with support agencies/networks, involvement with external community, stability and family support etc).

Standardised tools that can be used the support the assessment of parents with learning disability include the Needs Jigsaw. The Needs Jigsaw can be used to both assess parents understanding about the needs of children and also as a tool to teach them about children's needs.

Parental expectations in relation to childrearing and parenting styles should include information about parenting existing children (e.g. how are these children developing? Have there been concerns expressed about their development including evidence of emotional and behavioural, or attachment problems? Do they attend nursery/school?). There are, of course, cultural variations in parenting practices. For example, it has been suggested that the valuing of interdependence in Japanese culture means that Japanese babies share beds with parents, grandparents or siblings until they are fifteen years of age. This contrasts quite starkly with the practices of European/American parents who it is suggested value independence, thereby adopting independent sleeping arrangements from the first few days and weeks of an infant's life (Gross, 1996). However, many of these cultures can change over time, and children's basic needs for love and attachment are the same irrespective of cultural differences. For example, recent research on attachment has pointed to the importance of 'sensitive' and 'responsive' parenting that is neither overstimulating nor understimulating in terms of meeting the needs of all infants, irrespective of race or culture (Carlson and Harwood, 2003).

For families who already have children and where there are concerns about their care, you should explore parental understanding and attitudes with regard to the concerns raised or previous removal of other children (e.g. are they able to recognise and accept their responsibility for the problems? Talk about what they struggled with? What have they tried to implement? What they have learnt along the way? Do they show concern and understanding for child removed? What strategies/interventions were implemented? What was the outcome?).

This pre-birth model of assessment includes a number of standardised tools that can be used to assess pregnant parents views about parenting or their existing parenting practices (e.g. Adult-Adolescent Parenting Inventory), their parenting ability (e.g. Parenting Daily Hassles Scale), stress related to parenting (Parenting Stress Index), and potential for abuse (e.g. Child Abuse Potential).
The final domain assesses the parent’s attitude toward professionals and their receptivity and motivation to change. You should use your professional skills to assess whether parents are reluctant to agree that change is necessary or unwilling to accept support, and this should include explorations about the basis for this; willingness to engage with the social worker and other specialist services (e.g. DV/substance dependency services) or avoidance of contact with professionals, or false compliance, their ability to build partnerships or create divisions among professionals, and their participation in goal setting including their ability and attitude toward change.

4.4 STAGE 2: CASE CONCEPTUALISATION

4.4.1 Introduction

This stage involves evaluating and making sense of the needs of the unborn baby in the context of the prospective family environment. Information gathering is an important part of an assessment process, as is the way in which you make sense of the data.

PRACTICE APPLICATION:

It is important that you have a clear understanding of the empirical factors that denote risk and resilience at this life stage in order to start making sense of the data. Table 4.1 below shows a modified version of the Jones, Hindley and Ramchandani (2006) Factors Association with Future Harm table. This table has been modified to include factors that have been shown to be important predictors of the parent’s later relationship with the infant, in addition to risk factors with regard to existing children.

It may be that when you map your information and weigh up how the expectant parents have engaged in the assessment process that you consider that you have sufficient evidence to make a decision about “how safe is this baby to be born into this family” at this stage. However, often families have a range of risk and resilience factors, and when there is uncertainty about the decision then further assessment which targets the capacity of the parents to change their behaviour is required. Information about this assessment process is detailed in the next section.

For some families at this stage, the decision will be clear and further assessment of their capacity to change and intervention to support their development may not be required.
### Table 4.4.1: Risk and Resilience Factors (modified for pre-birth)

<table>
<thead>
<tr>
<th>Factors</th>
<th>Future significant harm more likely (e.g. Risk)</th>
<th>Rating Yes/No/NA</th>
<th>Protective factors evident post intervention</th>
<th>Rating Yes/No/NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current and previous pregnancies</td>
<td>• Unwanted/unplanned pregnancy&lt;br&gt;• Concealed pregnancy&lt;br&gt;• Non-attendance at appointments&lt;br&gt;• No preparation</td>
<td></td>
<td>• Preparation for parenthood&lt;br&gt;• Realistic expectations and understanding about potential issues</td>
<td></td>
</tr>
<tr>
<td>Preparation for parenthood</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and development of unborn baby</td>
<td>• Poor health behaviours (e.g. smoking; alcohol; substances)&lt;br&gt;• Foetal abnormalities</td>
<td></td>
<td>• Significant changes to health behaviours demonstrated and sustained (e.g. stopped smoking/drinking etc)</td>
<td></td>
</tr>
<tr>
<td>Parental attachment to unborn baby</td>
<td>• Little attachment to unborn baby&lt;br&gt;• Poor parental representations&lt;br&gt;• Low reflective function</td>
<td></td>
<td>• Early signs of bonding to infant&lt;br&gt;• Improvements in representations and reflective function</td>
<td></td>
</tr>
<tr>
<td>Parental Experiences</td>
<td>• Parent experienced maltreatment/trauma as a child&lt;br&gt;• Little experience of good parenting (e.g. Care leaver)</td>
<td></td>
<td>• Evidence of understanding about the impact of early life experiences&lt;br&gt;• Ability to reflect and work on relevant issues</td>
<td></td>
</tr>
<tr>
<td>Parental Health</td>
<td>• Personality Disorder&lt;br&gt;• Paranoid Psychosis&lt;br&gt;• Learning Disability plus mental illness&lt;br&gt;• Denial of problems&lt;br&gt;• Lack of compliance</td>
<td></td>
<td>• Engagement with relevant mental health services&lt;br&gt;• Acceptance of support/intervention</td>
<td></td>
</tr>
<tr>
<td>Parenting and parent/child interaction</td>
<td>• Abuse/suspected abuse of other children (e.g. neglect; growth failure; physical abuse such as burns; fabricated induced illness)&lt;br&gt;• Existing children experiencing problems (e.g. attachment / EBD)</td>
<td></td>
<td>• Acceptance of role in earlier abuse&lt;br&gt;• Appropriate feelings of guilt expressed&lt;br&gt;• Motivation to parent differently&lt;br&gt;• Demonstrated ability to benefit from support to improve existing parenting</td>
<td></td>
</tr>
</tbody>
</table>
### Factors

<table>
<thead>
<tr>
<th>Factors</th>
<th>Future significant harm more likely (e.g. Risk)</th>
<th>Rating</th>
<th>Protective factors evident post intervention</th>
<th>Rating</th>
</tr>
</thead>
</table>
| Partner         | • No partner support  
• Interparental conflict violence                                                                                |        | • Developed supportive relationship with partner  
• Couple developed conflict resolution skills  
• Discontinuation of violent relationships |        |
| Family          | • Family stress  
• Poor home environment  
• Power problems (poor negotiation; autonomy and affect expression)                                             |        | • Moved away from family  
• Made necessary changes to home or financial circumstances                                                       |
| Professional    | • Refusal to engage with social worker and/or other professionals                                              |        | • Ability to sustain a working relationship with social worker  
• Ability to benefit from intervention/services being offered                                                          |
| Social Setting  | • Social isolation  
• Lack of social support  
• Violent, unsupportive neighbourhood                                                                               |        | • Moved to a new home  
• Developed new contacts/support with local family centre                                                               |
| Macro setting   | • Cultural/social setting that supports violence                                                               |        | • Removal to new setting                                                                                         |

### 4.4.2 Case Conceptualisation

'Case conceptualisation' or 'case formulation' are terms that are used to refer to the process of organising assessment data gathered through the use of assessment tools, direct observations and other records to formulate a hypothesis or plan for future intervention. It helps to guide decision making: **moving the case from assessment to intervention.**

The tools used during the cross sectional assessment support diagnosis of the strengths and problem areas within a family. Case conceptualisation is a process that leads to integration of the data and identification of an understanding of the impact of these problems, which in turn leads to decisions about effective intervention.
A hypothesis should be developed which explains the underlying dynamics of the presenting problem in order to formulate an appropriate intervention plan (i.e. clarification of what the issues are and what needs to be in place to effect change).

In order to do this the data needs to be mapped in a way that supports the process of “making sense” of the information, including identification of the patterns and themes in terms of what is known about a family and also information that is missing or not known at the end of the cross sectional assessment.

Case formulation involves three stages:

1. Learning about the issues (map your assessment data)
2. Organising the information into patterns or themes
3. Explaining these patterns or themes using a theoretical framework

When all these stages are complete there is a clear picture of what you believe to be the issues that have led to the concerns (etiology) and what factors are maintaining or perpetuating the problem (sustaining factors).

Understanding the etiology and sustaining factors leads to effective intervention planning to address, reduce or resolve the issues. Once the themes are organised it is possible to plan targets for change.

4.4.3 Static and Dynamic Risk Factors

Empirically supported risk factors fall into 2 groups – static and dynamic.

Static risk factors are those that don't change (e.g. date of birth, history of care, record of offending, past admitted/corroborated abusive behaviours, legal history, marital history etc). They are useful for identifying baseline risk.

Dynamic risk factors are amenable to change (e.g. level of substance use, level of family violence, parenting style). Identification of dynamic risk factors helps target opportunities for change and identification of appropriate intervention and levels of support, whereas static factors highlight unchangeable features.
4.4.4 Themes and Patterns

This stage involves the identification of patterns and themes that thread throughout the interactions with parents during the assessment. These can be picked up during interviews, through ways in which the parents explain their feelings or thinking; or by the way they behave or explain their behaviour and how they describe the way they have experienced life events. Some examples of common negative threads include: families feeling victimised, feeling at a loss to control or change their situation, feeling they can't cope, feeling despair or hopelessness, feeling fearful, avoiding intimacy or relationships, inability to consider perspective of others or be reflective, concern about failure or lack of trust, deferring to others etc. Some examples of common positive threads include: feelings of hope, ability to think about others, taking...
responsibility and control over things, being able to change or improve, being able to explore, try new skills or have a go at something, being open minded, expressing feelings and praising others, feeling happy or able to talk about being uncertain etc.

4.4.5 Data mapping tools
You will use the data mapping tools to help you to a) visually organise and b) think critically about the data that has been gathered.

4.4.6 Visual organisation of data
The resilience matrix can be used during or at the end of the data gathering process to help practitioners to organise the material that has been collated to produce a visual map.

The matrix supports the integration of information about the unborn baby or child, the family and environment and leads you to focus on the impact of these factors on the vulnerability of the baby/child.

The focus of the work is to reduce the vulnerabilities and increase the protective factors; strengthen the factors that promote resilience and mitigate the impact of adverse factors as plotted on the matrix.

4.4.7 Critical appraisal of data

You will use “The Discrepancy Matrix” tool (Morrison 2009) to assist you and your supervisors to evaluate the quality of the information that has been gathered during an assessment. There are five kinds of ‘discrepancy’ in relation to data that emerges during an assessment, these are:

- Informational – contradictory information from different professionals about a family
- Interpretative – different professionals draw different conclusions from the same information
- Interactive – parent’s intentions are contradicted by the reality of their actions
- Incongruent – the way a parent talks about their child is inconsistent, contradictory or incoherent
- Instinctual – the worker’s intuition suggests a concern that cannot be identified

You can use the discrepancy matrix to identify the above discrepancies, and also to identify where information about a family is missing or unknown. You should use it not only as part of your assessment to judge the status and quality of information gathered, but also to good purpose in supervision, group supervision and multi-disciplinary fora. In the latter situation professionals can often become polarised in their views of a family and perceived levels of risk (this is particularly pertinent in cases of neglect). Where this occurs the use of such a matrix invites people to consider the status of the information, for instance, whether people are holding assumptions about the family formed at an early stage in work without reassessing the updated information. The added value of a tool that encourages people to be more objective is that it can also serve to distance or address the professional tensions.

The green arrows show the process of gathering evidence that moves information into the area of strong ground; the red arrows are reflective of information that is known and not considered to be relevant or necessary for this assessment.

4.4.8 The Discrepancy Matrix
4.4.9 Deciding on a theoretical hypothesis

A theoretical hypothesis simply means having a testable proposition which seeks to identify the best way of understanding the family’s situation and how to move forward.

Shemmings (2008) describes the ‘hypothesis’ process in terms of the practitioner:

• Having a view or idea about what is happening
• Knowing what this view is and why they hold it
• Putting their view on one side
• Interrogating that view – Why do I think that? What is my evidence? How can I test my view? Might there be other ways of seeing this situation? How might others describe and explain what is going on?
• Reviewing their view: Does this still make sense? Do I need to change my view?

Having identified a perspective about what the problems are in the family and what needs to change, practitioners can then intervene appropriately to moderate these factors and consider the need for a capacity to change assessment (C2C Harnett 2007).

4.5 STAGE THREE – CAPACITY TO CHANGE AND GOAL SETTING

4.5.1 Introduction

PRACTICE APPLICATION:

This section is applicable for parents for whom there exists both risk and protective factors and is designed to increase your certainty about the decision you make.

It involves taking the information obtained during the cross-sectional assessment, using this to identify and agree defined goals with the family, provide an intervention to help support them achieve the goals and then complete the standardised measures again to obtain Time 2 scores to see what, if any, change has occurred.
Capacity to Change Assessment:

BOX 4.5.1: PROCEDURE FOR ASSESSING PARENTS’ CAPACITY FOR CHANGE IN CHILD PROTECTION CASES

1. A cross-sectional assessment of the parents’ current functioning, including the use of a range of standardised psychological tests to supplement other sources of information and to include an assessment of parent-child interactions.
2. Specification of operationally defined targets for change that should include the unique problems facing individual families and using standardised procedures such as Goal Attainment Scaling — GAS.
3. Implementation of an intervention with proven efficacy for the client group that addresses multiple domains of family functioning, is delivered in the home using individualised goals and is tailored to address the specific problems of individual families and the achievement of identified targets for change.
4. Objective measurement of progress over time including standardised tests administered pre and post the intervention; direct observation of changes in parent-child interaction; and evaluation of the parents’ willingness to engage and cooperate with the intervention and the extent to which targets were achieved. (Harnett 2007)

Parents may need to make a number of changes in order to ensure their unborn baby (and/or existing children) are safe. These may be associated with the need to change behaviours or factors in their own lives that increase the risk to their children, or they may need to improve the parenting provided to existing children.

Social work assessment of what needs to change should draw on the range of data collated during the cross-sectional assessment process and includes:

- Assessment data from the standardised measures
- Assessment data from multi-agency records
- Direct observations of family interactions and behaviours AND
- The theoretical hypothesis and case conceptualisation work which captures the thinking about what needs to change in order for the unborn baby to be parented safely and securely and make satisfactory developmental progress
- Data regarding the child’s wishes and feelings where other siblings exist
4.5.2 Goal Attainment Scaling

Goal Attainment Scaling (GAS) enables you to operationalise specific and clinically meaningful goals that are unique to each family and to define, observe, and monitor these over time (Harnett 2007). GAS can also involve the use of a numeric scale that enables you to quantify the amount of change achieved for each goal, although the calculation of a figure to represent the overall change (i.e. across all goals) is not recommended.

Instead goals are scored using the method below:

If the individual/family achieves the expected level, they score 0

If they achieve a more than expected outcome this is scored at:

+1 (a little more) or
+2 (a lot more)

If they achieve a less than expected outcome this is scored at:

−1 (a little less) or
−2 (a lot less)
Goal setting can help parents focus on particular aspects of their behaviour that they need to change – it reduces ambiguity and confusion for both the family and professionals and supports focused visits/contacts, as well as promoting planned, thoughtful, reflective working practice prior to the beginning of the intervention/treatment and throughout the period of professional involvement. A baseline rating is undertaken before the intervention and rated again at the end of the three/four months of work.

Goal setting supports engagement in monitoring change at various levels including:

- Multi-disciplinary working – as team members meet together to discuss the outcomes and goals to be achieved

- Service user involvement – goals are more likely to be achieved if families are involved in setting and agreeing them. It is important that the goal setting process is collaborative and based on what you and the family consider are achievable as well as meaningfully addresses the concerns. Goals that are unachievable are not appropriate since the family will be set up to fail and are unlikely to engage in this process. A more formal process of setting and agreeing goals with families supports transparent working and information sharing enabling families to be clear about the change that is required.

An overall objective is agreed with the family and then “staged goals” are set as steps towards these objectives, with between 3–5 goals being agreed per family. These need to be measurable and capable of being assessed using direct observation (i.e. not based on practitioner’s perceptions about the client’s internal states, that is, the way they are perceived to think or feel – the change must be considered in relation to behaviour). An overall objective may be that existing parents need to improve their parenting. However, this is not an appropriate goal as it is too big and unstructured for parents to demonstrate. Research supports the use of smaller, more achievable goals that are shaped by an overall target based on case conceptualisation. A larger goal needs to be broken down into small steps that can be measured. A balance needs to be found between setting goals that are realistic and achievable, but are not so undemanding that no real change can be demonstrated or achieved within a timescale that is appropriate for the child.

The wording of goals is important and we encourage the use of language suggested by parents so that agreed goals are understood and unambiguous so that parents are clear about what is expected of them.
Table 4.5.1 illustrates a GAS and defines three operationalised goals.

Table 4.5.1: Goal Attainment Scaling

<table>
<thead>
<tr>
<th>Level of expected outcome</th>
<th>Goal 1</th>
<th>Goal 2</th>
<th>Goal 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reduc</td>
<td>Antena</td>
<td>To prepare sleeping space for baby’s arrival</td>
</tr>
<tr>
<td></td>
<td>tion in</td>
<td>tional</td>
<td></td>
</tr>
<tr>
<td></td>
<td>substance use</td>
<td>preparation</td>
<td></td>
</tr>
<tr>
<td>Date of review</td>
<td>4 months</td>
<td>3 months</td>
<td>3 months</td>
</tr>
<tr>
<td>Much more than expected (+2)</td>
<td>X amount reduction of intake for at least 4 months and maintenance of the reduced level.</td>
<td>Pulled together a range of material, read it all, including Baby Steps materials and developed detailed birth plan in line with reading</td>
<td>Space prepared for baby to sleep in own cot or baby basket. Bedding, clothing and nappies in place. Cot in place and ready.</td>
</tr>
<tr>
<td>More than expected (+1)</td>
<td>X amount reduction of intake for at least 2 months and maintenance of the reduced level.</td>
<td>Pulled together some additional resources, read some of it, can discuss birth plan. Accessed Baby Steps materials for 10 mins per week.</td>
<td>Space prepared for baby to sleep in own cot or basket, some preparation re bedding, clothes or nappies but not all in place. Cot still to be obtained.</td>
</tr>
<tr>
<td>No change (0)</td>
<td>Consumption on-going at usual level, although stated intention to reduce.</td>
<td>Read some of the leaflets given by midwife, given little thought to birth plan, accessed Baby Steps only on one occasion</td>
<td>Little preparation made, some items bought. Some effort made to clear space for sleeping but not completed. Cot available, but not in situ.</td>
</tr>
<tr>
<td>Less than Expected (-1)</td>
<td>Consumption on-going at usual levels, with one episode of binge drinking.</td>
<td>Still holding on to the leaflets with intention of reading, not really talking about birth planning, not accessed Baby Steps information</td>
<td>Little effort made to secure cot or baby equipment. No space cleared for sleeping, but some emergency items in place (e.g. nappies).</td>
</tr>
<tr>
<td>Much less than expected (-2)</td>
<td>Consumption on-going with more than one episode of binge drinking and use of other illegal substances.</td>
<td>Discarded or lost all information, not willing to talk about birth planning, not looked at Baby Steps materials.</td>
<td>No sign of any items in place or intention to provide – leaving all until needed.</td>
</tr>
</tbody>
</table>

Harnett (2007) writes regarding GAS:

“...The goals set should be manageable as well as meaningful. Goals that require substantial behavior change may be overwhelming for the parents, effectively setting the family up for..."
Agreement on the meaningfulness and manageability of targets can be facilitated by asking each party to rate each goal on a five-point scale of meaningfulness and manageability...and discussing any discrepancies until consensus is reached. The three most manageable goals rated as at least 'Quite meaningful' by all parties are targeted in the capacity-to-change procedure.”

The following is an example of a five-point rating scale:

Point 1 – Highly meaningful
2 – Very meaningful
3 – Quite meaningful
4 – Not very meaningful
5 – Unmeaningful

It is possible to ‘weight’ goals for difficulty and importance – see below:

<table>
<thead>
<tr>
<th>Importance</th>
<th>Difficulty</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = not at all (important)</td>
<td>0 = not at all (difficult)</td>
</tr>
<tr>
<td>1 = a little (important)</td>
<td>1 = a little (difficult)</td>
</tr>
<tr>
<td>2 = moderately (important)</td>
<td>2 = moderately (difficult)</td>
</tr>
<tr>
<td>3 = very (important)</td>
<td>3 = very (difficult)</td>
</tr>
</tbody>
</table>

In effect, if the goal is ‘not at all’ important it will not be selected and if ‘not at all difficult’, may already be achieved, so the discussion with families should lead to agreement regarding the 3 – 5 goals which are important to achieve with some acknowledgement regarding the degree of difficulty required in order to achieve the changes necessary.

Engagement in Goal Attainment Scaling

Specific factors are known to be associated with levels of engagement including:

- A family’s particular circumstances
- Parents perceptions of their situation
- The intervention identified and its relevance to the identified concerns
- Factors relating to the workers and their ability to engage the family

These factors interact to produce different levels of engagement with families. Assessment of engagement needs to be an on-going feature of the work with families during this process. This requires regular monitoring of progress towards goals and a process for reviewing progression within the agreed timescale, at frequent intervals, often on a fortnightly basis. This will also include a review of barriers to engagement (which may be influenced by internal or external factors) as most parents will feel ambivalent about making changes and will need support to achieve the progress required. Discussions with parents on goal attainment should be based on regular feedback with families during the period agreed.
Practitioners need to be aware that compliance with interventions in itself does not constitute readiness to change or evidence of genuine capacity to change, nor does it demonstrate evidence of actual change. Compliance can be seen as an example of a parents stated intention to change, but is not necessarily linked to actual achievements.

4.5.3 Achieving Goals

Families will follow different action plans to achieve a similar goal since the way progress is achieved needs to work for each unique family; there is no single way to achieve a goal. Goals are not intended to prescribe behaviour by parents, but rather set agreed targets that they can work towards in their own way.

Of course vulnerable families often suffer crises or the work can bring additional disclosures that may mean that goals need to be reviewed or new goals discussed and agreed, although the overall objective will remain consistent. Setting goals can bring structure during periods of crisis and chaos.

Achieving longer term change is not always possible in the capacity to change process – remember that this process is designed to measure short term capacity to change in a given timescale in order to reduce uncertainty and support decision making. Longer term change may require on-going supportive intervention for a lengthy period, and it is therefore important to consider linking families to sustainable community based resources. Achieving change is a complex process influenced by internal and external factors and may not be achieved within the child’s timeframe when difficulties are entrenched. Professionals need to be aware of and prepared to discuss and manage failure by families to achieve the goals set. Goals that have been set, understood and agreed with the family and the multi-agency network have been identified as manageable targets and where not achieved may provide evidence of a family’s inability to change as needed.

There is evidence that goal attainment scaling has positive therapeutic value in encouraging families to set and reach their goals; often when families recognise that they have been able to work towards and achieve a target, this can be an important factor in the process of change, leading to an increase in self-efficacy and hope. Reaching a goal is a significant milestone for some families and should be recognised as such (e.g. through use of certificates of achievement) and may support a desire to achieve another or bigger goal.
4.6 STAGE FOUR – INTERVENTION

4.6.1 Introduction

This section describes a number of evidence-based methods of working with pregnant women to enable them to a) achieve the change that has been identified as necessary using a range of sources of data; and b) address the explicit and unique goals that have been established in Stage 3.

You can use the interventions below to explore with existing parents their experience and thinking about infant development or with first time parents to gain an understanding of their knowledge and expectations of parenting. We have included a few interventions that can be used with expectant parents and/or parents with infants. However, the focus of this model is on the pre-birth period and we have not explored in any great detail age-specific parenting interventions.

We have identified a range of evidence-based or promising interventions. These are manualised programmes that can be delivered to parents during pregnancy and/or the postnatal period to facilitate the changes that are being sought as part of the assessment of capacity to change. The latter should be delivered in their entirety and with integrity to the training manual and should be delivered as part of a partnership model of working with families.

PRACTICE APPLICATION:

It is important that you include an intervention that is relevant and designed to meet the identified needs of the family as evidenced in the cross-sectional assessment. The interventions below have been included because they promote positive parenting; however, it is likely that they will need to be delivered alongside other interventions that may be necessary to address adverse adult focused behaviour, such as for example, domestic violence/abuse.

All practitioners involved in the delivery of this model of pre-birth assessment, should be receiving regular supervision to help them address issues as they arise, and to ensure that they are delivering the model of working with fidelity to the manual.

4.6.2 Part A: Evidence-based techniques

You can use the skills and techniques below directly as part of your intervention with the family – most of these skills can be developed relatively easily and there is a lot of information freely available on websites.
Promoting affect regulation

You can help pregnant women (and fathers) to deal with their emotional dysregulation by teaching techniques that can be used to help to increase ability for emotional regulation, including mindfulness and urge-surfing: people who have experienced abuse or neglect in their own childhoods find it difficult to control their emotions – they may lash out when they are frustrated or angry, or they may become disproportionately discouraged by minor setbacks or mild criticism and the techniques suggested below help people to manage their emotional responses.

Mindfulness

Mindfulness skills aim to help parents let go of their preoccupation with the worries of everyday life, at least for short periods of time, and helps them to focus on the “here and now”. This meditative technique of refocussing the mind on the present moment and letting go of negative thoughts can, at times, help a person to shift from a severely negative mood state or feeling of anxiety, to one that is less overwhelming.

Mindfulness is one of the third generation CBT approaches that has emerged over the past decade and involves both ‘transformative present moment awareness’ and ‘bare acceptance’ of cognitions, as opposed to the earlier focus of CBT on transforming such thoughts (Shonin et al 2013). It helps parents pay attention to their thoughts, feelings and body sensations so that they are more aware of them and better able to manage them. For example, it teaches you to recognise when you are becoming angry or stressed and provides a technique for focusing on this sensation so therefore assisting to regulate emotion.

Mindfulness exercises can be completed in a few minutes in the home or there are also a range of mindfulness approaches that have been developed and delivered as group-based, eight-week programs including Mindfulness Based Stress Reduction (MBSR); Mindfulness Based Cognitive Therapy (MBCT); and Mindfulness-Based Relapse Prevention (MBRP) (ibid). A review of the effectiveness of such interventions found that MBSR improves mental health and MBCT prevents depressive relapse (Fjord et al 2011) and a review of this type of Buddhist-Derived Intervention (BDI) found improvements in negative affect, substance use; anger and hostility; relaxation capacity; and self-esteem/optimism (ibid).

https://oxfordmindfulness.org/train/

Urge Surfing

Urge surfing has been developed specifically to help individuals recovering from alcohol and/or substance dependency and can be used as part of the Mindfulness approaches described above. This approach is underpinned by teaching clients that most urges are temporary (i.e. they typically last no more than 30 minutes), that the above type of ‘mindfulness’ strategy can be used to observe and reflect on, and to accept the urge until it passes (see http://www.
Developing the Relationship with the Unborn Baby

A number of techniques have been developed to help parents to begin to bond with their unborn baby. Some of these utilise media (e.g. an app for parents of newborn babies that includes video clips of pregnant parents relating to their unborn baby by stroking their tummy and talking and singing to the baby [www.your-baby.org.uk](http://www.your-baby.org.uk)). Others involve the practitioner encouraging the parent to think about the baby and what he or she will be like using question prompts (e.g. Have you thought about what your baby will be like? Have you noticed if your baby moves when you play music? Do you think your baby might like particular sorts of music? etc).

The Pregnancy Interview

This semi-structured interview (Slade, 2011) will assist you to ascertain the mother’s feelings about her pregnancy, about her baby and about herself as an expectant mother. You should use this during the third trimester of pregnancy usually when the mother has experienced foetal movement and is able to ‘imagine’ her baby.

The interview helps you to explore how the mother views her baby and parents who are emotionally connected to their baby will ‘wonder’ about them and be less likely to attribute negative intentions to behaviour, for example; “this baby is kicking me because it wants to hurt me.”

This interview may be formally coded to identify which of the following patterns is prevalent:

- **Balanced**: Women who are described as ‘Balanced’, for example, can provide ‘richly detailed, coherent stories about their experiences of their pregnancies and their positive and negative thoughts and feelings about their foetuses’.
- **Disengaged**: Women who are ‘Disengaged’ appear to be uninterested in the fetus per se or their relationship with it, and demonstrate ‘few thoughts about the babies’ future traits and behaviours or themselves as mothers’;
- **Distorted**: Women described as ‘Distorted’ tend to be ‘tangential or express intrusive thoughts about their own experiences as children, often viewing their foetuses primarily as an extension of themselves or their partners’ (Levendosky et al 2011, p. 514).

Practitioners should use the interview in the following way:

1. To get a sense of which of the above patterns appears to predominate;
2. To use some of the tools described in Part B below to develop the woman’s understanding about the importance of relating to her baby.
**Coping with Crying (NSPCC)**

The Coping with Crying Programme is an education and awareness programme for new parents. It centres around a short film, which aims to help parents to cope with crying by keeping calm and soothing their baby. It also raises awareness of the risks of inflicting head injuries on babies.

The film was originally only used in hospitals prior to discharge after the birth of a baby but is now being piloted during the pregnancy and aims to increase awareness of the dangers of shaking a baby and help parents to deal with frustration caused by crying to reduce rates of non-accidental head injury. Most babies have a peak of crying at around two months old.

You should show the film to parents as part of your discussions about their ability to manage stressful situations; it can be used for both first-time and existing parents and can help to focus parents on their thinking regarding their coping strategies for dealing with the stress of a crying baby. Professor Barr's work in the US suggests that new parents generally know little about the early patterns of baby crying and that this knowledge in itself is empowering (Barr et al 2009 The Period of Purple Crying). Showing this DVD and having a discussion about expectations of patterns of crying may help some parents to cope because they can recognise the crying as a normal developmental pattern that will change and reduce in time. A copy of this DVD is available in the guidance pack of materials.


**Understanding Baby Communication**

It is important that you explore with expectant parents their knowledge of child development and one aspect of this is to help them to understand that baby's behaviour is a way of communicating with their parents. Young babies move through a range of different “states” and they move from wake to sleep states many times during the day. Every baby does this in their own way and encouraging parents to think about this as a pattern and as a means of communicating will help them to understand that they need to mentalise, that is to ‘wonder’, what their baby is trying to say to them.

A reflective parent will be able to link the behavior with what the baby may be feeling or experiencing. However, parents who have received little sensitive care themselves may not be reflective and may interpret their baby's crying as a rejection or manipulation. Parents who are not reflective and have little knowledge of infant development may attribute adult thinking to their baby, for example; “she cries to wind me up”.

This table explains the different states that babies move through – additional information about infant development and communication can be obtained from [www.your-baby.org.uk](http://www.your-baby.org.uk) and [www.brazelton.co.uk/](http://www.brazelton.co.uk/)
Infant wake/sleep states

<table>
<thead>
<tr>
<th>State</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deep sleep</td>
<td>Breathing steady and regular, eyes closed, lies fairly still and is more difficult to rouse</td>
</tr>
<tr>
<td>Light sleep state</td>
<td>Eyes closed or fluttering. May be rapid eye movements under the lids. Easily roused. May makes sucking or smiling movements</td>
</tr>
<tr>
<td>Drowsy-dozing</td>
<td>Pre-awake state. Eyes open but glazed or heavy lidded. Occasionally may startle, but body movements generally smooth. May fall back to sleep or move into alert state</td>
</tr>
<tr>
<td>Quiet alert state</td>
<td>Wide-eyed with a bright face and little body movement – ready for interaction. Be prepared for baby to look away and take some time out. Offer time and space during the interaction for the infant’s response</td>
</tr>
<tr>
<td>Active alert state</td>
<td>Alert but fussy, may cry or may be soothed. Lots of limb movements and may be more sensitive to light and noise. Sometimes babies may show they are over-stimulated through physical signs like hiccupping, yawning, sneezing, squirming and throwing their head back as they move from this state</td>
</tr>
<tr>
<td>Crying</td>
<td>Lots of body activity, grimaces and intense crying. Baby needs calming. Some parents find that babies who have been nursed in the neonatal unit are very sensitive.</td>
</tr>
</tbody>
</table>

4.6.3 Part B: Evidence-based programmes

This section describes a number of evidence-based or ‘promising’ programs that are being used during the pre and postnatal period to support high-risk groups of parents. Each of the programs described involve practitioners undergoing a short period of training and ongoing supervision, most of which are available in the UK, and are not prohibitively expensive. Such training can be provided as part of the preparation of teams of social and family support workers for new methods of service delivery, or as part of continuing professional development. Each of the programmes described requires practitioners to have extensive experience of working with vulnerable families in social work settings.

PUP (Parents under Pressure)

Parents Under Pressure (PUP) is a home-based intervention with a focus on developing a safe and nurturing relationship between carer and infant. The importance of managing parental dysregulated affect and impulsive behaviour, both in relation to parenting and to other lifestyle issues such as substance abuse, are addressed through the use of mindfulness exercises and a focus on recognising and managing negative emotional states. PUP is currently being delivered in the UK in a Children’s Social Care setting where it is being provided by a specialist team of social and family workers during pregnancy and the immediate postnatal period to pregnant
women who are referred because of their midwife's concerns about issues including domestic abuse, substance dependency, mental health problems etc.

The PUP programme is underpinned by the Integrated Theoretical Framework (Dawe & Harnett, 2013) which is a dynamic model of assessing key areas of child and family functioning to identify clear objectives and collaborative goals for change. An intervention is then provided that is aimed at supporting the family to achieve these goals, resulting in an iterative model of goal attainment and identification of new goals. The Integrated Theoretical Framework also involves a focus on assessing current developmental outcomes with the aim of ensuring that an infant has in place the necessary support to ensure optimal outcome across all domains of functioning: physical, social, emotional and cognitive, whilst respecting the parent's spiritual/cultural values. Assessment of the quality of the caregiving relationship provides critical information about maternal sensitivity, and the capacity of the parents to provide sensitive and responsive parenting and to structure the environment with predictable routines and consequences to help the child organise their behaviour and emotions. Assessment also focuses on the parent's capacity to show genuine warmth and nurturance that allows the infant to feel loved, and to present opportunities and scaffolding to promote cognitive development.

A key component of the Integrated Theoretical Framework is an explicit recognition that a parent's ability to provide an optimal caregiving environment is dependent on the availability of internal and external resources. This includes the parent's capacity for understanding and managing their own emotional state in the context of parenting a young infant and the emotional and practical support of others to cope with the demands of parenting. Thus, the assessment addresses the current developmental outcomes of the child including the parent's values and expectations of the child, the quality of the caregiving relationship, parenting skills, parental capacity for emotion regulation and management of emotions, mood disorders and substance abuse, and social contextual factors such as financial disadvantage, social isolation and drug/crime involvement. The assessment leads to the setting of individualised therapeutic goals tailored to address the needs of an individual family and support in attaining the set goals.

The PUP programme has demonstrated efficacy in families with various risk factors, families referred from child protection services (Harnett and Dawe, 2008), parental substance abuse (Dawe & Harnett 2007;2013) women leaving prison (Frye & Dawe, 2008) and is currently undergoing evaluation with substance abusing parents with infants under two and half years of age (Barlow et al, 2013).
Minding the Baby

Minding the Baby (MTB) is an interdisciplinary, relationship-based home visiting programme that begins in the last trimester of pregnancy and continues through to the baby’s second birthday. It is targeted at high-risk pregnant or new mothers. It is delivered by two practitioners (typically a nurse/health visitor and social worker) and is underpinned by the principles of both home visiting and parent-infant psychotherapy. It is targeted at vulnerable parents who have not been able to benefit from other briefer methods of working, and the focus of the intervention is on improving the parental capacity for ‘reflective parenting’ (i.e. the ability of the parent to understand the infant’s behavior in terms of ‘underlying mental states’ (i.e. thoughts, needs, emotions of the baby).

The focus of the work with the mother during the antenatal period depends on the specific needs of the woman but almost always includes strategies aimed at a) helping the mother to make room in her mind for the baby and to begin to relate to the baby; b) preparation for meeting the baby’s concrete physical needs.

During the postnatal period the intervention focuses on addressing the mothers ability to provide reflective parenting and the mothers mental health needs. This almost always involves addressing the parent’s tendencies to ‘distort’ the baby’s cues (i.e. by misattributing things to the baby such as feeling that the baby’s distress is ‘done to annoy the parent’). This is explicitly aimed at reducing aggressive and/or harsh parenting (Slade et al 2005).

Early evidence suggests that this is a promising method of working with parents where there is a significant risk of harm to the infant (Sadler et al 2013) and specifically in reducing numbers of referrals to child protection services. Infants whose parents have been through the programme are more likely to have had all their immunisations and to be securely attached and less likely to have a disorganised attachment at 1 year of age. This programme is currently being evaluated as part of a randomised controlled trial being conducted by the NSPCC in the UK.

Baby Steps

The McMillan (2009) review of UK antenatal education found that the content of most programmes tended to be highly medicalised and missed opportunities to promote positive parenting, build awareness of child development and address the psychological and social impacts of the transition to parenthood. The review also found that often antenatal provision is poor at engaging men or at-risk populations. Baby Steps is a group-based 9-week antenatal education programme that is delivered by health and children’s services practitioners to families experiencing diverse problems during the pre and immediate postnatal period. The programme aims to support men and women to negotiate the emotional and physical transition to parenthood; nurture healthy relationships by encouraging listening and conflict resolution skills; encourage the development of sensitive, reflective relationships with the infant from the antenatal period onwards; promote healthy child development within a network of supportive relationships. The antenatal programme focuses on the following topics:
For example, some sessions focus on partner relationships and techniques for creating a listening culture and active listening. Parents are encouraged to reflect on causes of conflict and how partners deal with it and to try out ways of resolving conflicts effectively. Some of the suggested topics for talk and listen time include:

- Hopes and fears for the new baby
- How will the baby change my life?
- How can we look after one another and our baby?
- How can we manage disagreements?
- What sort of birth are we hoping for?
- What are the priorities in providing for our new baby?
- Are we good at asking for help? Where will we seek help and support?
Family Nurse Partnership

The Family Nurse Partnership is a voluntary home visiting programme for first time young mums aged 19 or under (and dads). A specially trained family nurse visits the young mum regularly, from early in pregnancy until the child is two.

The Family Nurse Partnership programme aims to enable young mums to:

- Have a healthy pregnancy
- Improve their child’s health and development
- Plan their own futures and achieve their aspirations
- The Family Nurse Partnership programme has been shown to be effective in improving health, social and educational outcomes in the short, medium and long term, including improving pregnancy outcomes, reducing child abuse and neglect, improving school readiness, reducing youth crime, improving employment for mothers and reducing subsequent pregnancies and the gaps between them (e.g. Kitzman et al 1997.) There is also evidence of significant cost benefits (http://fnp.nhs.uk).

Other Evidence-Based Interventions

In this section we have included interventions that can be used to address the needs of pregnant women who have other young children about whom there may be concerns. All of the interventions that have been described are explicitly aimed at improving outcomes for children in high-risk populations of parents. Some of the interventions described below can also be used with pregnant women who do not have other children (i.e. prior to the arrival of the infant), including parent-infant psychotherapy and video-interaction guidance.

Parent-Infant Psychotherapy

Parent-infant/toddler psychotherapy focuses primarily on the mother’s ‘representational’ world or the way in which the mother’s current view of her infant is affected by interfering representations from her own history. The aim of therapy being to help the mother to recognise the ‘ghosts in the nursery’ and to link them to her own past and current history, thereby facilitating new paths for growth and development for both mother and infant (Cramer and Stern 1988). One of the basic objectives of current dyadic psychotherapies is to focus on both the representational and interactional and thereby to use the current interaction between parent and child to gain an understanding of the ‘influences of maternal representation on parenting, as maternal representations and distortions are enacted within the context of preschooler-parent interactions’ (Toth et al., 2002, p. 891). The therapy is used to explore the parent’s history and to promote understanding of the links between this and their current parenting, within the context of a corrective emotional experience between parent and therapist.
More recent approaches have combined representational and behavioural techniques (Cohen et al., 1999). For example, ‘Watch, Wait and Wonder’ is an infant/toddler-led parent-infant psychotherapy that involves the mother spending time observing her child’s self-initiated activity, accepting their spontaneous and undirected behaviour, and being physically accessible to the child. The mother then discusses her experiences of the play with the therapist with a view to examining the mother’s internal working models of herself in relation to her child (ibid).

There is a growing body of evidence pointing to the effectiveness of parent-infant psychotherapy (Cohen et al., 2000), particularly in terms of improving attachment security in children of high-risk parents (Barlow et al, forthcoming).

**Circle of Security**

Circle of Security is a 20-week programme that is delivered in groups to around 5–6 parents of young children, where there are concerns about the child’s attachment, or the parents ability to provide parenting that meets the child’s attachment needs. Each session lasts around 75 minutes. The first two weeks has an educational focus and provides parents with an explanation about attachment theory using video examples of their children expressing basic attachment and exploration needs. The remaining 18 weeks focus on individual caregiver/child dyads in which edited video clips of the caregiver and child are used as a springboard to discuss the relationship and attachment patterns. The aim is to help the caregiver improve his or her capacity to read and respond to the child’s cues and miscues (http://circleofsecurity.net).

Based on evidence from a one-group pre and post design study, this would appear to be a promising method of working. The results showed that 44% of the pregroup insecure children moved to be secure after the intervention, and that 69% of the disorganised group were organised after the intervention (Hoffman et al 2006).

**Video-Interaction Guidance**

Video Interaction guidance is a ‘behavioural’ approach that involves the use of videotaped interactions of mother and infant being used by the therapist to help the mother to recognise her own positive responses and interactions with her infant, and to elaborate appropriate responsiveness. This approach is based on strengths based principles. Mutual enjoyment and pleasurable interactions are identified and encouraged with a view to building maternal confidence (McDonough 2000). The identification of positive interaction can build on strengths and allow parents to explore areas of difficulty with greater honesty (Jarvis 2011). This approach also involves a ‘reflective conversation’ with the therapist/guider, which helps the parent to move from ‘acting and reacting’ often involving highly emotionally charged interactions between parent and infant and distorted perceptions or misattributions through to ‘awareness of reacting’ and more reflective and flexible thinking as a result of the activation of meta-cognitions in the parent about what they are witnessing on the film, through to ‘symbolic, imaginative and interpretive thinking about self and other’ (Munich 2006, p. 145 in Jarvis p. 218.)
Although evidence from a systematic review (Fukkink 2008) showed that VIG is a highly effective method of changing both parenting attitudes and behaviours and child developmental outcomes with less high risk parents, more recent evidence of its use with maltreating parents showed a significant reduction in the number of children with disorganised attachment in the VIG group (Moss et al., 2011).

The Video Intervention to promote Positive Parenting (VIPP) programme is a structured version of video-interaction guidance, in which the parent/caregiver and infant are videotaped during daily situations at their home such as playing together or bathing the infant. The parent and practitioners then review the tape together and the practitioner discusses selected parts of the video to demonstrate positive interaction sequences. This provides the opportunity to focus on the infant's videotaped signals and expressions, thereby stimulating the parent's observational skills and empathy for his/her child. It also enables positive reinforcement of the parent's moments of sensitive behavior shown on the videotape. Before or after the video feedback the parent receives a brochure on sensitive responding (e.g., about crying and comforting, or about playing together) (http://www.marinusvanijzendoorn.com/video-feedback-intervention-vipp).

VIPP consists of four themes that are explored over the course of the four home visits:

1) the baby’s contact-seeking and explorative behavior
2) the accurate perception of the infant’s (subtle) signals and expressions
3) the relevance of prompt and adequate responding to the infant’s signals
4) affective attunement and sharing of emotions.

By explicitly acknowledging the parent as an expert on his/her own child, the parent is encouraged to participate in the discussion actively. The practitioner also attempts to “speak for the baby” and the parent is invited to take part and to elaborate their understanding of the infant's behavior. The intervention also incudes the delivery of two booster sessions with both parents in which issues of the first four sessions are re-visited and integrated. The session focusing on sensitive discipline, aims to support the parents to use positive methods of limit setting in order to address problems related to the child's growing independence (ibid).

Parenting Programmes

Parent-Child Interaction Therapy (PCIT) is one of the few parenting programmes that has been shown to be effective with maltreating parents (Thomas and Zimmer-Gembeck 2011). The programme focuses on improving the quality of the parent-child relationship and changing parent-child interaction patterns.

*Parents are taught specific skills to establish a nurturing and secure relationship with their child while increasing their child’s prosocial behavior and decreasing negative behavior. This treatment focuses on two basic interactions: Child Directed Interaction (CDI) is similar to play therapy in that parents engage their child in a play situation*
with the goal of strengthening the parent-child relationship; Parent Directed Interaction (PDI) resembles clinical behavior therapy in that parents learn to use specific behavior management techniques as they play with their child’ http://pcit.phhp.ufl.edu

Research with parents of children aged 2.5 – 7 years of age with a history of or at risk of maltreatment found that post intervention mothers were more sensitive, reported less child abuse potential and were less likely to be notified to child welfare services (Thomas and Zimmer-Gembeck 2011).

Promoting change

In the above section we have described a number of evidence-based techniques and programmes that can be used in isolation or combination with pregnant women. For further information about evidence-based methods of working in pregnancy and the early years go to the following website: http://betterstart.dartington.org.uk

4.7 STAGE 5 – CAPACITY TO CHANGE

The final stage of C2C is the re-administration of the standardised tools that were used in Step1. This step may also involve you in compiling additional professional observations regarding the parents’ motivation and engagement and other factors that have either supported or hindered the parent from achieving the necessary change.

This stage creates an opportunity to consider objective measurement of progress over time, in terms of the pre and post assessment of parent’s capability following a period of intervention that was agreed would meet their identified needs. The process clarifies whether the parents have made the necessary change and is based on triangulated data from standardised measures, goal attainment and direct observations.

This data allows you to objectively report on the specific factors that have changed and why, including the extent of changes made and level of engagement with the goals set and intervention.

PRACTICE APPLICATION:

There are two activities for you to complete in this section:

- Use the Capacity to Change template to draw together the changes pre and post intervention
- Use the risk and resilience factors table to consider how any achieved change has made a difference to the existence of risk or protective factors.
The process is as follows:

- Re-administer the same measures you chose to use from the domains table when you obtained the T1 measure to provide you with a T2 score (see capacity to change template below) – the scores show the difference pre and post intervention
- Review the progress made to achieve goals and score the level of change based on the expectations set and agreed with the family
- Include information obtained through interviews with parents and direct observations, particularly of parent-child interactions for existing parents
- Also include other multi-agency reports of progress or concerns

Use the Capacity to Change template provided to undertake Activity 1 below.

<table>
<thead>
<tr>
<th>Activity 1</th>
<th>Sources of information</th>
<th>Framework or guidance</th>
<th>What to think about</th>
</tr>
</thead>
</table>
| Synthesise the data about the family's Capacity to Change | 1. Professional judgment  
2. Standardised measures  
3. Goal Attainment Scaling | Prebirth assessment model; Prebirth guidance | 1. How well did each parent engage with process; were they motivated to achieve change;  
2. Which of the tools showed a need for improvement and was there change after the intervention; was the change achieved sufficiently great to be confident about the safety of the foetus/infant?  
3. How many goals showed some change; no change; worsening? |
### Capacity to Change Template

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Change Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T1</td>
</tr>
</tbody>
</table>

#### Standardised measures
- North Carolina Family Assessment Scale
  - Domain 1
  - Domain 2
  - Domain 3
  - And so on
- Multidimensional Scale of Perceived Social Support
- Depression, Anxiety, Stress Scale
- Emotion Regulation Questionnaire
- Parenting Daily Hassles
- Parenting Stress Index
- Needs Jigsaw
- Reflective Function
- Maternal Attachment Scale
- Paternal Attachment Scale
- Relationship Questionnaire
- Alcohol
- Substance misuse
- Conflict Tactics Scale

#### Goal attainment scale
- Goal 1
- Goal 2
- Goal 3
- Goal 4

#### Key points re direct observations of change
(e.g. High; Medium; Low)
- Motivation
- Engagement with professionals
- Others

#### Key points re reports from other agencies
(e.g. Describe)
- Main areas of strength
- Main areas of concern

Collate the evidence from both qualitative and quantitative data in the template shown above. Both types of data are required to support structured professional judgment and evidence informed decision-making in relation to a parent's capacity to change.
You need to consider what the above data shows regarding:

- What changes have occurred?
- Why these have occurred?
- How important are they in meeting needs of unborn baby?
- Did the family only achieve the changes that required the least or most effort to change?
- Whether there is high, medium, low level of change despite the intervention input?

This clear and transparent process provides the evidence to show whether change has been or has not been achieved following a period of targeted intervention. Collation of the empirical evidence creates greater certainty in the decision making process and provides the basis for analytical report writing.

4.8 STAGE 6 – PRE-BIRTH DECISION-MAKING

4.8.1 Introduction

This section describes a method of decision-making that can be used to assess the overall level of future risk to the infant. It involves synthesising the data that has been collected in Section 4 above in order to assess the overall level of risk posed to the newborn baby. The first section depicts a model of organising the data that has been collected to assess risk; resilience; and capacity to change. The second section depicts a risk classification schema that has preliminary evidence showing its accuracy as a method of predicting future risk.

4.8.2 Assessment of Risk and Resilience

A number of factors have been identified within parents’ histories, their current lifestyles and circumstances, their wider family, neighbourhood and environment, professional responses to their needs and children's characteristics that are associated with recurrent abuse and neglect and the likelihood of future harm to children. Jones, Hindley and Ramchandani (1991, 1998, 2006) have identified these factors by systematically reviewing an extensive body of research.

Table 4.8.1 below shows again the modified version of the list drawn up by Jones, Hindley and Ramchandani (2006) but modified to include additional factors that have been shown to be important predictors of the parent's later relationship with the infant, and which were discussed in Section 4.4 (stage two) above, in addition to risk factors with regard to existing children.
## Table 4.8.1: Risk and Resilience Factors (modified for pre-birth)

<table>
<thead>
<tr>
<th>Factors</th>
<th>Future significant harm more likely (e.g. Risk)</th>
<th>Rating Yes/No/NA</th>
<th>Protective factors evident post intervention</th>
<th>Rating Yes/No/NA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current and previous pregnancies</strong></td>
<td>• Unwanted/unplanned pregnancy</td>
<td></td>
<td>• Preparation for parenthood</td>
<td></td>
</tr>
<tr>
<td><strong>Preparation for parenthood</strong></td>
<td>• Concealed pregnancy</td>
<td></td>
<td>• Realistic expectations and understanding about potential issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Non-attendance at appointments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No preparation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Health and development of unborn baby</strong></td>
<td>• Poor health behaviours (e.g. smoking; alcohol; substances)</td>
<td></td>
<td>• Significant changes to health behaviours demonstrated and sustained (e.g. stopped smoking/drinking etc)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Foetal abnormalities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Parental attachment to unborn baby</strong></td>
<td>• Little attachment to unborn baby</td>
<td></td>
<td>• Early signs of bonding to infant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Poor parental representations</td>
<td></td>
<td>• Improvements in representations and reflective function</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Low reflective function</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Parental Experiences</strong></td>
<td>• Parent experienced maltreatment/trauma as a child</td>
<td></td>
<td>• Evidence of understanding about the impact of early life experiences</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Little experience of good parenting (e.g. Care leaver)</td>
<td></td>
<td>• Ability to reflect and work on relevant issues</td>
<td></td>
</tr>
<tr>
<td><strong>Parental Health</strong></td>
<td>• Personality Disorder</td>
<td></td>
<td>• Engagement with relevant mental health services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Paranoid Psychosis</td>
<td></td>
<td>• Acceptance of support/intervention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Learning Disability plus mental illness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Denial of problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Lack of compliance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Parenting and parent/child interaction</strong></td>
<td>• Abuse/suspected abuse of other children (e.g. neglect; growth failure; physical abuse such as burns; fabricated induced illness)</td>
<td></td>
<td>• Acceptance of role in earlier abuse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Existing children experiencing problems (e.g. attachment / EBD)</td>
<td></td>
<td>• Appropriate feelings of guilt expressed</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Motivation to parent differently</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Demonstrated ability to benefit from support to improve existing parenting</td>
<td></td>
</tr>
<tr>
<td>Factors</td>
<td>Future significant harm more likely (e.g. Risk)</td>
<td>Rating Yes/No/NA</td>
<td>Protective factors evident post intervention</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------------------------</td>
<td>------------------</td>
<td>----------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Partner</td>
<td>• No partner support</td>
<td></td>
<td>• Developed supportive relationship with partner</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Interparental conflict violence</td>
<td></td>
<td>• Couple developed conflict resolution skills</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Discontinuation of violent relationships</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>• Family stress</td>
<td></td>
<td>• Moved away from family</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Poor home environment</td>
<td></td>
<td>• Made necessary changes to home or financial circumstances</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Power problems (poor negotiation; autonomy and affect expression)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>• Refusal to engage with social worker and/or other professionals</td>
<td></td>
<td>• Ability to sustain a working relationship with social worker</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Ability to benefit from intervention/services being offered</td>
<td></td>
</tr>
<tr>
<td>Social Setting</td>
<td>• Social isolation</td>
<td></td>
<td>• Moved to a new home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Lack of social support</td>
<td></td>
<td>• Developed new contacts/support with local family centre</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Violent, unsupportive neighbourood</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Macro setting</td>
<td>• Cultural/social setting that supports violence</td>
<td></td>
<td>• Removal to new setting</td>
<td></td>
</tr>
</tbody>
</table>
Use the blank column of the table in the guidance pack to undertake Activity 2 below:

<table>
<thead>
<tr>
<th>Activity 2</th>
<th>Sources of information</th>
<th>Framework or guidance</th>
<th>What to think about</th>
</tr>
</thead>
<tbody>
<tr>
<td>Synthesise the data about the sources of risk and resilience using a blank template.</td>
<td>Core Assessment Chronologies Case records LAC reports Case conference minutes Capacity to Change Data Goal Attainment Scaling Direct observations Views of other children where relevant</td>
<td>Use table 4.8.1 (page 70) to update the current risk and protective factors evidenced following the assessment of capacity to change, and incorporating the data from activity 1 (page 67) use the risk classification template in box 2 page 73 and traffic light matrix on page 74 to classify the level of risk</td>
<td>What does this information tell us about the risk and protective factors; Is there any missing information? Is all of the data captured by the different sources of information contained in the risk/resilience domains?</td>
</tr>
</tbody>
</table>

4.8.3 Risk classification

Ward et al (2013) used the risk classification scheme shown in Box 2 below to distinguish between those families where the likelihood of children suffering harm in the future appeared to be higher or lower than in others. Their study found that this classification system was a good predictor of the outcome for the child at 3 and 5 years of age (ibid), particularly where children were initially classified as at severe risk of harm.

This classification system requires the social worker to assess three sets of information that has been collected as part of the assessment process:

- Risk factors
- Protective factors
- Capacity to Change

These have already been appraised as part of Activity 2 above.

**PRACTICE APPLICATION**

You need to decide on the level of risk using the classification table below, based on the evidence that you have collated regarding the above three sets of information.
BOX 2: CLASSIFICATION OF RISK

- **severe risk of harm**: Families showing risk factors, no protective factors and no evidence of capacity to change.
- **high risk of harm**: Families showing risk factors and at least one protective factor but no evidence of capacity to change.
- **medium risk of harm**: Families showing risk factors and at least one protective factor including evidence of capacity to change.
- **low risk of harm**: Families showing no or few risk factors (or families whose earlier risk factors had now been addressed), and protective factors including evidence of capacity to change.

The above classification system is intended to guide and structure decision-making with regard to the future risk of harm to the newborn infant prior to birth.

**Severe and High Risk of Harm**

Families in which there has been identified a ‘severe’ or ‘high’ risk of harm will require pre-proceedings to be put in place if it has not already been instigated and that it is appropriate for discussions about the use of protective placements at birth to take place at a further pre-proceedings meeting. While for some families this may ultimately result in immediate removal of the infant following birth, where appropriate it might also involve one of the following:

a) **Mother-infant foster placement** – this can be used to continue assessing and intervening with the family (either by agreement with the parent under Children Act 1989, section 20 or it may be necessary to begin legal proceedings where permission for assessment plans will be required from the court), and could include the following:

- **Assessment of the parent-infant relationship**: A range of standardised methods of assessing the parent-infant relationship are available. This might, for example, include the social worker taking a video-film of a brief (3 minutes) episode of parent-infant interaction, with the instruction to the parent being simply to interact with the infant as they would normally. Where LA funding is available, these videos can be then be coded very cheaply by external coders who will if necessary provide reports that can be used in court (e.g. CARE-Index).

- **Methods of working to support the parent-infant relationship including Video-Interaction Guidance (VIG)**: VIG involves a specially trained practitioner (see above) using brief periods of videotaped interaction between the parent and infant to a) promote more sensitive and attuned interaction by focusing on interactions that are going well; b) the practitioner helping the parent to think about what the infant might be feeling in the interactions and thereby promoting parental RF (see above). VIG training is available in the UK and involves a 2-day training programme in addition to a series of ongoing supervisions (see evidence-based interventions above and http://www.videointeractionguidance.net/train.html).
b) Concurrent Foster Care: This method of fostering this infant can be used whilst continuing to work with and assess the parents’ capacity to achieve the necessary level of change to be sure that the infant is no longer at risk of harm. Concurrent foster care reduces the likelihood of the type of 'double jeopardy' (Ward et al 2013) that can occur where the infant is traumatised as a result of repeated temporary foster placements prior to permanent placement.

Medium Risk of Harm

Families for whom there is a medium risk of harm based on the above classification system should be provided with ongoing support during the postnatal period. This should involve continued use of the existing methods of intervention, but should also include the methods of assessing and improving the parent-infant relationship described above.

Low Risk of Harm

Families for whom there is a low risk of harm based on the above classification system should be provided with ongoing support by their health visitor and staff working within the local Children's Centre.

Use the risk matrix shown below to classify the level of risk demonstrated:

<table>
<thead>
<tr>
<th>Low risks</th>
<th>Medium risks</th>
<th>High risks</th>
<th>Severe risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIN/Child protection plan</td>
<td>Child protection plan</td>
<td>Child protection plan</td>
<td>Legal proceedings</td>
</tr>
<tr>
<td>No risk factors apparent (or previous risk factors fully addressed)</td>
<td>Risk factors apparent (or not all risk factors fully addressed)</td>
<td>Risk factors apparent (and risk factors not being addressed)</td>
<td>Risk factors apparent (and risk factors not being addressed)</td>
</tr>
<tr>
<td>Protective factors apparent</td>
<td>Protective factors apparent</td>
<td>Protective factors apparent</td>
<td>No protective factors apparent</td>
</tr>
<tr>
<td>Parents ABLE to demonstrate sustained capacity for actual change</td>
<td>Parents ABLE to demonstrate sustained capacity for actual change</td>
<td>Parents UNABLE to demonstrate sustained capacity for actual change</td>
<td>Parents UNABLE to demonstrate sustained capacity for actual change</td>
</tr>
<tr>
<td>Very unlikely that abuse will occur/recur</td>
<td>Some possibility that abuse will occur/recur</td>
<td>Strong possibility that abuse will occur/recur</td>
<td>Very strong possibility that abuse will occur/recur</td>
</tr>
</tbody>
</table>

Ward et al. (2012).
Assessing the extent to which an unborn baby may be at risk of harm or neglect following his or her birth is a complex and challenging task, influenced by many factors, including ethical and moral dilemmas. However, the specific vulnerability of these babies makes it of crucial importance that we make decisions in a robust manner, informed by evidence-based assessments and analytic thinking. This pre-birth assessment model seeks to bring some consistency and structure to this decision-making process, provides guidance on what domains should be covered and supports structured professional judgement.

The underpinning framework for this model is aimed at promoting a relational approach to risk assessment, emphasising the importance of engaging and working therapeutically with families who are experiencing a range of problems, and who are highly anxious about the potential loss of care of their baby. Frequently, expectant parents ‘engage’ in a process of assessment, not because they want help to address the potential stresses they may face in parenting a new baby, but because they feel they have little choice but to cooperate.

The use of the recommended standardised questionnaires, goal-setting process, and provision of a proven intervention is aimed at ensuring that a more transparent and open assessment process is undertaken in which parents are included in the completion of the assessment tools, are aware of the results of this process, contribute to the definition of the goals that need to be achieved, and are provided with support prior to the birth of their baby.

However, there is a need for balance in risk assessment practice in terms of developing working alliances that support engagement and partnership with parents alongside the need to maintain an analytic stance and focus on the ability to protect and ensure that the needs of the unborn baby remain central to pre-birth work. It is of crucial importance to hold the unborn baby in mind at all times throughout this process and remain aware of the aims of the assessment process, and wider social work role. Highly skilled assessment practice includes both the need to gather evidence and also effectively engage and support parents to achieve change. This model therefore aims to develop the practice balance that needs to be achieved in both supporting parents to demonstrate that they can parent safely, whilst also generating relevant data that would be required for the legal process.

It is also important to recognise that a pre-birth assessment is not the end of the process, but rather the first stage in which further multi agency assessment and or additional support may well continue post-birth when the reality of parenting this baby is fully tested. It is important for children who remain in the care of their parents where there remain some concerns that the assessment process should be on-going to review the actual parenting provided. The remit for conduct of such an assessment is beyond this pre-birth model, but it may be that some of the measures and interventions defined here are appropriate for this purpose.
REFERENCES

Abidin RR. (2012). *Parenting Stress Index™, Fourth Edition Short Form (PSI™-4-SF)*.


References


Thoburn J. (2009). Effective interventions for complex families where there are concerns about, or evidence of, a child suffering significant harm. *Safeguarding briefing paper*. London: Centre for Excellence and Outcomes in Children and Young People’s Services.


**Law**

Children Act (1989)

Human Embryo and Fertilisation Act (1990)

Human Embryo and Fertilisation Act (2008)

Infant Life (Preservation) Act (1929)

Mental Health Act (2007)
# Annex 1: Domains of Assessment

<table>
<thead>
<tr>
<th>Domain</th>
<th>Data Gathering, tools or measures</th>
<th>Core/optional data</th>
<th>T1/T2 measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Expected date of birth</td>
<td>Presenting Concern – referral information and initial contact with family</td>
<td>Core data</td>
<td></td>
</tr>
<tr>
<td>• Who is concerned and why?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What is the purpose of the assessment?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What is the parent’s view of the need for assessment?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What does each parent think they need to do to achieve the outcome they want?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What outcome do they want/think will happen?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Who is treated as a member of the family – complete a genogram for each parent either individually or joint exercise</td>
<td>Genogram</td>
<td>Core data</td>
<td></td>
</tr>
<tr>
<td>• Past or broken relationships.</td>
<td>Parent interviews</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Parent’s cultural origins, their birth family structures, extent to which their parents were involved in criminal activities, childhood experiences of parental substance misuse or domestic abuse.</td>
<td>Social work records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• History of being in LA care, experiencing childhood abuse or having contact with social care agencies.</td>
<td>Police records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Are there gaps in the information provided?</td>
<td>School records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What has already been tried, services already provided</td>
<td>Chronology</td>
<td></td>
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<tr>
<td>• Unresolved conflict in family</td>
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<tr>
<td>• Cultural influences on parenting</td>
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<tr>
<td>• Accommodation – patterns of instability, frequent moves</td>
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<tr>
<td>• Education and employment</td>
<td></td>
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<tr>
<td>Domain</td>
<td>Data Gathering, tools or measures</td>
<td>Core/optional data</td>
<td>T1/T2 measure</td>
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<tr>
<td>• History of earlier pregnancies (e.g. miscarriages or terminations), maternal health (e.g. history of depression or suicide attempts).</td>
<td>Midwifery records&lt;br&gt;Medical records (i.e. general practitioner, substance misuse services)</td>
<td>Core Data&lt;br&gt;Core data</td>
<td></td>
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<tr>
<td>• Single or multiple pregnancy</td>
<td>Parent interviews</td>
<td>Core data</td>
<td></td>
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<tr>
<td>• Attendance at ante-natal education and antenatal clinic</td>
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<tr>
<td>• Care/preparation for birth</td>
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<tr>
<td>• Plans for breast-feeding and contraception</td>
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<tr>
<td>• Pregnancy planned/unplanned, have there been efforts to conceal the pregnancy?</td>
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<tr>
<td>• Circumstances around conception (i.e. traumatic) and plans for birth</td>
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<tr>
<td>• Pregnant women’s health – this will change in response to external factors during pregnancy, therefore her antenatal care and health needs should be kept under constant review.</td>
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<tr>
<td>• Include the father's perspective and his response to his partner's pregnancy needs and involvement in antenatal care</td>
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<tr>
<td>Domain</td>
<td>Data Gathering, tools or measures</td>
<td>Core/optional data</td>
<td>T1/T2 measure</td>
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<td>-----------------------------------------------------------------------</td>
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<tr>
<td>• Growth and developmental stage of pregnancy</td>
<td>Midwifery records</td>
<td>Core data</td>
<td></td>
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<tr>
<td>• Impact of substance misuses – what substance, how much, at what stage of pregnancy consumed</td>
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<tr>
<td>• Impact of domestic violence – small foetus, physical trauma as result of abdominal blows to mother</td>
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<td>• Impact of smoking or poor nutritional intake</td>
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<tr>
<td>• Pregnancy complications</td>
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<tr>
<td>• Parent’s preparation for becoming a parent and their expectation about the impact of an infant in their lives</td>
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<tr>
<td>• How realistic are the future plans for the family?</td>
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<tr>
<td>• What changes do they foresee having to make</td>
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<tr>
<td>• to their lifestyle to accommodate a baby and its needs?</td>
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<tr>
<td>• What are their strategies for coping with crying, sleepless nights and other parental stressors associated with a new baby – for parents who have children this will include their thinking about how to include the new baby into their existing family</td>
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<tr>
<td>• What is their understanding of the development of an attachment relationship with their baby?</td>
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<tr>
<td>• What do they consider are their baby's priority needs?</td>
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<td>• What are their thoughts about what the baby will be like, and their hopes for them</td>
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<tr>
<td>Domain</td>
<td>Data Gathering, tools or measures</td>
<td>Core/optional data</td>
<td>T1/T2 measure</td>
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</tr>
<tr>
<td>Preparation for new baby</td>
<td>Parent interviews</td>
<td>Core data</td>
<td>T1 &amp; T2</td>
</tr>
<tr>
<td>Stability of home environment</td>
<td>THE NORTH CAROLINA FAMILY ASSESSMENT SCALE – G (NCFAS-G) (National Family Preservation Network, 2014)</td>
<td>Core for existing families, specified sections applicable for first time parents</td>
<td></td>
</tr>
<tr>
<td>Adaptations required for new baby</td>
<td></td>
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<tr>
<td>Socio-economic deprivation</td>
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<tr>
<td>Wider family members and community contacts?</td>
<td>Ecomap</td>
<td>Core data</td>
<td>T1 &amp; T2</td>
</tr>
<tr>
<td>What is the nature and quality of family relationships?</td>
<td>Parent interviews</td>
<td></td>
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<tr>
<td>What was it like growing up in this family?</td>
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<tr>
<td>Who was special to each parent?</td>
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<tr>
<td>Were they cared for or abused as children?</td>
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<tr>
<td>Length and stability of relationships?</td>
<td></td>
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<tr>
<td>Number of previous convictions, were the offences against property or people or social rule violations (e.g. drink driving)</td>
<td>Police records</td>
<td>Core data</td>
<td></td>
</tr>
<tr>
<td>Motivation for the offending behaviour, is it entrenched behaviour and what does it mean for the expected baby?</td>
<td>Social work records</td>
<td></td>
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<tr>
<td>Details of the victims – age, offences, relationship to offender</td>
<td>Probation records</td>
<td></td>
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<tr>
<td>Evidence of escalation in offending behaviour</td>
<td></td>
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<tr>
<td>General physical health (e.g. long-term physical conditions or disabilities)</td>
<td>Medical records including those held by general practitioners and Social work records</td>
<td>Core data</td>
<td></td>
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<tr>
<td>Domain</td>
<td>Data Gathering, tools or measures</td>
<td>Core_optional data</td>
<td>T1/T2 measure</td>
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<td>-----------------------------------------------------------------------</td>
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<tr>
<td>Depression, Anxiety and Stress</td>
<td>ADDICTION SEVERITY INDEX (ASI) – PSYCHIATRIC STATUS SECTION (University of Pennsylvania/Veterans Administration Center for Studies of Addiction/McLellan, 1990)</td>
<td>Screen</td>
<td>Screen</td>
</tr>
<tr>
<td>Evidence of psychosis or delusional thinking</td>
<td></td>
<td>Core data</td>
<td>T1 &amp; T2</td>
</tr>
<tr>
<td>History of suicidal behaviour or non-compliance with prescribed medication</td>
<td>DEPRESSION, ANXIETY AND STRESS SCALE (DASS) (Lovibond and Lovibond, 1995)</td>
<td>Core data</td>
<td>T1 &amp; T2</td>
</tr>
<tr>
<td>Evidence of unresolved childhood trauma</td>
<td>Medical records and psychiatric assessments</td>
<td></td>
<td>Screen</td>
</tr>
<tr>
<td>Ability to self-regulate and impulsivity. Dissociative feelings. How do the parents manage stressful situations and level of emotional stability.</td>
<td>PRIMARY CARE PTSD SCREEN (PC-PTSD) (Prins et al., 2003)</td>
<td>Core data</td>
<td>T1 &amp; T2</td>
</tr>
<tr>
<td>How do they cope with crisis and/or chaos/unexpected events</td>
<td>EMOTION REGULATION QUESTIONNAIRE, Gross &amp; John 2003</td>
<td>Core data</td>
<td>T1 &amp; T2</td>
</tr>
<tr>
<td>Ability to manage anger and frustrations</td>
<td>PARENTING STRESS INDEX (PSI) (Abidin, 2012)</td>
<td>Core but only for those who are existing parents</td>
<td>T1 &amp; T2</td>
</tr>
<tr>
<td>Impulsive behaviour vs thoughtful/planned decision making</td>
<td>PARENTING DAILY HASSLES SCALE (Crnic and Booth, 1991)</td>
<td>As above</td>
<td>T1 &amp; T2</td>
</tr>
<tr>
<td>What is the level of stress felt by both parents – what mechanisms increase/decrease stress</td>
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<tr>
<td>Domain</td>
<td>Data Gathering, tools or measures</td>
<td>Core/optional data</td>
<td>T1/T2 measure</td>
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<tr>
<td>• Problematic drug and alcohol use</td>
<td>ALCOHOL USE DISORDERS IDENTIFICATION TEST – C (Babor and Grant 1989) ADDICTION SEVERITY INDEX (ASI) – DRUG AND ALCOHOL SECTION (University of Pennsylvania/Veterans Administration Center for Studies of Addiction/McLellan, 1990) SUBSTANCE USE RISK PROFILE-PREGNANCY SCALE (Yonkers et al., 2011)</td>
<td>Optional dependant on this being an identified issue As above</td>
<td>T1 &amp; T2 Screen</td>
</tr>
<tr>
<td>Domain</td>
<td>Data Gathering, tools or measures</td>
<td>Core/optional data</td>
<td>T1/T2 measure</td>
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<td></td>
<td>Current and past relationships, including strengths and weaknesses, and a history of the patterns of (both) parent relationships.</td>
<td>DOMESTIC VIOLENCE SCREEN (DAW, n.d.)</td>
<td>Screen</td>
</tr>
<tr>
<td></td>
<td>This should be completed for all parents, including those not in a current relationship with the birth father, as he may still play a role in the life of his child, and information about the mother’s ability to form and engage appropriately in a couple relationship is essential information for future relationships that may occur and into which the baby may be born.</td>
<td>CONFLICT TACTICS SCALE (Straus, 1979; 1996)</td>
<td>Optional dependent on DV being an identified issue</td>
</tr>
<tr>
<td></td>
<td>Marital status</td>
<td>THE RELATIONSHIP QUESTIONNAIRE (Bartholomew and Horowitz, 1991).</td>
<td>Core</td>
</tr>
<tr>
<td></td>
<td>Length of relationship</td>
<td>Police and social work records</td>
<td>T1 and T2</td>
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<tr>
<td></td>
<td>Domestic violence</td>
<td></td>
<td>T1</td>
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<td></td>
<td>– how does this manifest itself in the relationship what interventions have been tried</td>
<td></td>
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<td></td>
<td>– how does the hostility start, triggers, dynamics that operate between the couple to escalate or decrease the violence</td>
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<td></td>
<td>– Nature of violent incidents, frequency and severity of incidents</td>
<td></td>
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<td></td>
<td>– extent of psychological and emotional control/physical violence</td>
<td></td>
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<td></td>
<td>– Is the violence bi-directional</td>
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<td></td>
<td>– How safe is the non-violent partner in a family in which there are clear victim/perpetrator roles?</td>
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<td></td>
<td>– Recognition by both partners of the impact of the violent behaviour on foetus/each other</td>
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<td></td>
<td>– Recognition of the risks of the behaviour</td>
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<td></td>
<td>– Is the aggression confined to within the family or not?</td>
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</tbody>
</table>

**Annex 1**
<table>
<thead>
<tr>
<th>Domain</th>
<th>Data Gathering, tools or measures</th>
<th>Core/optional data</th>
<th>T1/T2 measure</th>
</tr>
</thead>
</table>
| • How did they meet, what was the attraction  
• Shared interests/individual differences, what can they say about each other as separate individuals?  
• What do they value about the other person?  
• How do the couple make decisions about things, how do they resolve difficulties or disagreements?  
• What do they consider are each other’s strengths and weaknesses in relation to becoming a parent (or being a parent if there are existing children) – it is important to consider this for each stage  
• What parental roles will they each undertake?  
• Dependencies and other parental vulnerabilities (e.g. disabilities, physical illness and carer responsibility)  
• Maternal and paternal attachment to the infant  
• Quality of mother’s representations of her unborn child; mother’s view of her emotional experience with pregnancy and her expectations and fantasies regarding her future relationship with her child | | | |
| MATERNAL AND PATERNAL ATTACHMENT SCALES (Condon, 1993) OR PICTORIAL REPRESENTATION OF ATTACHMENT MEASURE (PRAM) (van Bakel, 2013) THE PREGNANCY INTERVIEW – REVISED (Slade, 2011) | Core | Core for parents with learning difficulties | T1 & T2  
Use in third trimester |
<table>
<thead>
<tr>
<th>Domain</th>
<th>Data Gathering, tools or measures</th>
<th>Core(optional data)</th>
<th>T1/T2 measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Level of learning difficulty (e.g. preventable accidents to either parent, unexplained patterns of injuries/incidences, delays in seeking help or obtaining help, failure to follow appropriate and accessible advice/information given, absence of appropriate supervision of existing children, signs of neglect of existing children)</td>
<td>Specialist assessment of abilities</td>
<td>Optional for parents with learning difficulties</td>
<td></td>
</tr>
<tr>
<td>• Ability to learn and learning styles (e.g. how does each parent acquire new skills, what is their preferred learning style, is there an example of a new skills acquired recently – what was it and the circumstances around which it was learnt)</td>
<td>THE NEEDS JIGSAW (APS Marketing &amp; Consultancy, 2007)</td>
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<tr>
<td>• The existence of strong support networks see earlier point and ecomap exercise</td>
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<td>• Their own experiences of being parented and ability to be reflective about their childhood experiences</td>
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<tr>
<td>• Protective factors (e.g. sociability, responsiveness to others, readiness to take on responsibility and form partnerships with support networks, involvement with external community, stability and family support)</td>
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<tr>
<td>Domain</td>
<td>Data Gathering, tools or measures</td>
<td>Core/optional data</td>
<td>T1/T2 measure</td>
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<tr>
<td>• Extent of agreement on raising baby, family rules and expectations re child behaviour</td>
<td>BRIEF CHILD ABUSE POTENTIAL (CAP) INVENTORY FORM VI (Milner, 2012)</td>
<td>Core for those who are existing parents</td>
<td>T1 and T2</td>
</tr>
<tr>
<td>• Extent of existing parenting – have they already got children, what are the concerns re their development, history of abuse or neglect, any children previously removed – on what basis and in what circumstances (obtain explanations from parents and official records) – any discrepancies in accounts?</td>
<td>ADULT-ADOLESCENT PARENTING INVENTORY (AAPI-2) – Form A (Bavolek &amp; Keene, 1999)</td>
<td>Core for all</td>
<td>T1 &amp; T2</td>
</tr>
<tr>
<td>• If previous children removed – is there any acceptance of responsibility, any learning or reflection from parents? Desire for reunification</td>
<td>Social Work records</td>
<td></td>
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<tr>
<td>• Parental concern and understanding for the child removed</td>
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<tr>
<td>• Data from any previous assessments, and outcomes, including what, if anything, has changed since this assessment completed</td>
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<tr>
<td>• Data regarding any previous interventions and previous engagement with treatment services</td>
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</table>

BRIEF CHILD ABUSE POTENTIAL (CAP) INVENTORY FORM VI (Milner, 2012)

ADULT-ADOLESCENT PARENTING INVENTORY (AAPI-2) – Form A (Bavolek & Keene, 1999)