

Title

Assessing Parental Capacity when there are Concerns about an Unborn Child: Pre-Birth Assessment Guidance and Practice in England.

Authors

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Assessment where there are concerns that an unborn child is likely to suffer significant harm is one of the most difficult tasks that social workers undertake; the legal and ethical context makes the process of assessment and intervention during this period complex. This paper explores pre-birth assessment guidance and practice in England. Local safeguarding guidance in 147 English localities was accessed and analysed, and interviews were conducted with 22 practitioners involved in pre-birth assessments. The findings showed that while most local safeguarding guidance was more detailed and explicit than the national guidance, legal and ethical issues were rarely addressed. Interview data showed that, in general, guidance to support social work assessments during the pre-birth period was insufficient, and that few practitioners used standardised tools to aid assessment. Some practitioners regarded pre-birth assessments as less urgent than cases involving infants/older children, thereby increasing delays in decision-making. It is concluded that existing guidance and practice with regard to pre-birth assessment are inadequate.

Key practitioner messages

- Existing guidance regarding pre-birth assessment are inadequate with regards to providing practitioners with the necessary information about the assessment process or tools with which to undertake the assessment.
- Practitioners undertaking pre-birth assessment should be provided with better training regarding the assessment process.
- There is a need for practitioners undertaking pre-birth assessment to use standardised tools alongside professional judgement.

Introduction

There is a wealth of evidence to show that some health behaviours and social problems can have a significant impact on the long-term development of the baby when they occur during pregnancy. For example, it is well established that alcohol (Riley et al., 2011) and some drugs (Ostrea et al., 2004) can cross the placenta and be harmful for the foetus in terms of causing perinatal mortality (including miscarriage), stillbirth, premature delivery, low birthweight, impairment of normal foetal brain development, neonatal abstinence syndrome and foetal alcohol syndrome. Research has also highlighted the adverse effect of intimate partner violence during pregnancy, which can result in miscarriage, stillbirth, premature birth, low birthweight, foetal brain injury and bone fractures (Boy and Salihu, 2004; Guaderrama de Moseson, 2004; Pallitto et al., 2005).

The Children Act 1989 provides the legislative framework in England and Wales by which the state can intervene to safeguard and promote the welfare of children. It does not provide for legal proceedings to protect a child before birth, although statutory guidance (HM Government, 2013) does make reference to taking formal steps to protect an unborn child. English law provides limited recognition of the foetus, and an unborn child generally does not have legal rights until personhood is achieved at birth. There are, however, a few exceptions: a pregnancy cannot be terminated after 24 weeks' gestation (Abortion Act 1967) and under the Infant Life (Preservation) Act 1929 it is a crime to kill an unborn but viable foetus (Knight, 1998). In addition to this, where a pregnant woman is suffering serious mental health problems, professionals can take action under the Mental Incapacity Act 2005, but the primary objective has to be to protect the mother's health, rather than that of the unborn baby. At a national level, the Department for Education publishes statutory guidance on interagency working to safeguard and promote the welfare of children (including unborn children) (see HM Government, 2013). Within this context, a key role of each local safeguarding children board (LSCB) is to develop and provide procedures for all agencies and individuals working with children within their locality. No woman, regardless of mental capacity, is legally required to engage with statutory services to safeguard her unborn child.

The legal and ethical context makes the process of assessment and intervention during the pre-birth period complex (Hodson, 2011), and research suggests that this can result in: social workers delaying pre-birth assessments until the latter stages of pregnancy or sometimes after the birth of the child (Calder, 2003; Hart, 2010; Hodson, 2011; Office for Standards in Education, Children's Services and Skills (Ofsted), 2011), and insufficient support for parents during pregnancy (Ofsted, 2011; Ward et al., 2012). Delayed assessments mean that time frames are often subsequently compressed (i.e. particularly if assessment is not commenced until the third trimester), and the time available for parents to effect change can then be limited or parents have too little time to make sustained changes and demonstrate capacity to care for their child (Ward et al., 2012). A recent overview of Serious Case Reviews following the death or serious injury of a child reported that, in a number of cases, expectant parents with substantial difficulties were in fact given little support during pregnancy or beyond (Ofsted, 2011).

Overall, this body of research suggests that the ethical, practical and legal context makes pre-birth assessment a complex task, and this paper describes the results of a study that was undertaken to assess the adequacy of the guidance at a national level and the perspectives of social workers and health practitioners with regard to the assessment process.

Methodology

In order to identify issues in current practice, the research team undertook a documentary analysis of the guidance issued by all 147 LSCBs in England to update that undertaken by Hodson (2011) and conducted interviews with 22 practitioners from nine localities all of whom were involved in pre-birth assessments, to examine their perspectives about the

assessment process. An online survey was also sent to all LSCBs in the UK. While the data provided useful indications of issues that merited further exploration in interviews, the response rate (less than 20%) was too low to provide a reliable database for robust quantitative analysis, and the findings have not therefore been further reported here. Ethical approval was obtained from Loughborough University's Ethics Approvals (Human Participants) Sub-Committee, and written informed consent was obtained prior to interviews.

LSCB Guidance

The safeguarding procedures were obtained from each LSCB website in England. In order to update the analysis undertaken by Hodson (2011), the research team used the data collection tool that she had developed to assist in her data collection. The tool was based on information contained in Working Together to Safeguard Children (HM Government, 2010, ch. 5):

'Name of Safeguarding Board:

Edition or date of procedures:

1. Is pre-birth assessment addressed in the procedures? Yes/No

2. If YES, how much space is allocated to it?

a). Number of pages in procedures.

b). Number of pages allocated to pre-birth assessment.

3. Paragraph 5.14 (Chapter 5 individual circumstances) of Working Together states, "The procedures and timescales set out in this chapter should also be followed when there are concerns about the welfare of an unborn child".

a). Is this reflected in these procedures and if so how?

4. How far does the guidance reflect paragraph 5.140 of Working Together? Yes/No

5. Is distinction made between pre-birth and post-birth assessment? Yes/No

6. Is the lack of legal status of a foetus addressed? Yes/No

7. Is there any guidance regarding a pregnant woman's right to autonomy over her own body? Yes/No

8. Is there any guidance regarding the timescale for intervention pre-birth? Yes/No'

(Hodson, 2011, p. 271)

The data were entered into SPSS and analysed using descriptive analysis to summarise and present the data obtained.

Interviews with Practitioners

Nine LSCB locality areas were deemed by the research team to have developed and implemented pre-birth assessment models and/or practice that involved innovative or newly improved pre-birth assessment guidance or policies, or newly established multidisciplinary pre-birth teams. This assessment was made on the basis of information contained in the LSCB documents, which indicated that there had been changes made to practice. Sites were recruited initially by contacting LSCB chairs in order to obtain permission for their LSCB area to participate in the research. Following this, key personnel from relevant services (e.g. children's social services, midwifery) were contacted to seek permission to interview their staff (e.g. social workers, midwives). Once permission was obtained and contacts provided, emails were sent to practitioners inviting them to take part in an interview. All those able to participate within the timescale were interviewed.

Twenty-two practitioners from these authorities were interviewed and this included: two midwives with specific responsibilities for safeguarding children; nine social workers; two psychiatrists (one from mental health and another from a drug treatment service); five practitioners from health-related fields (including health practitioners and workers from drug treatment centres and mental health services – anonymised to ensure confidentiality); and four family support workers (the latter were interviewed collectively).

Semi-structured interviews were conducted using an interview schedule designed for the purpose of this research, over the telephone and took approximately one hour. The interviews focused on pre-birth assessment guidance, referrals, engaging parents, multidisciplinary working, timescales, content of pre-birth assessments (e.g. questions, other standardised tools used), interventions and outcomes.

Interviews were recorded, transcribed and exported into the NVivo software package and thematic analysis was undertaken to identify patterns through a rigorous process of data familiarisation, data coding and theme development. A deductive approach was undertaken whereby data coding and theme development were directed by existing ideas. As such, the research team had a theory/hypothesis based on existing research evidence and collected interview data to test this hypothesis through deducting conclusions from the data gathered. This analysis allowed the team to test their hypothesis with data specifically gathered to either confirm or refute the team's original hypothesis (Snieder and Lerner, 2009).

Findings

Documentary Data

An analysis of the guidance issued by English LSCBs revealed that in 2012–13 all 147 (100%) made reference to pre-birth assessments in their procedures, and 134 out of 139 (96%)

provided guidance additional to that contained in the statutory document Working Together to Safeguard Children (HM Government, 2013). [Those LSCBs that did not refer to paragraphs 5.16 or 5.149 in the statutory document were excluded of which there were eight.] For example, they provided referral procedures, advice on when to undertake a pre-birth assessment and the type of information that required collating. An example of the typical guidance provided with regard to the purpose of pre-birth assessment is given below:

‘The purpose of the pre-birth initial assessment is to allow:

- Thorough assessment which will give practitioners a clear understanding of parental history, their family and community support networks and their ability to prepare for and adapt to the needs of the child;
- Support for the parents so that (where possible) they can provide safe care for their baby; and
- Early identification of other family members who might be able to support or provide primary care.’ (LSCB No. 1)

One-third (48/147: 33%) of English LSCBs acknowledged the lack of legal status of a foetus (see also Hodson, 2011) and 36 out of 147 LSCBs (24%) made reference to a pregnant woman's right to autonomy over her own body. The quotation below provides an example of the typical guidance provided to address the complexities surrounding the legal status of an unborn child and a woman's rights over her body:

‘An unborn child has no legal standing. Law cannot force an expectant mother, to have any medical intervention at birth unless she is deemed to lack capacity. It is only possible to make appropriate contingency plans and to ensure that the woman/girl is fully aware of the consequences of her actions. In such circumstances, legal advice should be sought.’ (LSCBNo. 2).

The level of detail with regards to timescales varied. Some LSCBs set out the timescale for each stage of the referral and assessment process (in some instances using flow charts), whereas others referred to timescales for undertaking and/or completing the assessment or child protection conferences (including reviews).

Interview Data

The interview data produced four themes, which are as follows: adequacy of the guidance, complexities of assessment, timing of assessment and use of standardised tools. These themes and subthemes are summarised in Table 1.

Table 1. Themes and subthemes

Themes	Subthemes
Adequacy of the guidance	Guidance insufficiently specific Reliance on advice from colleagues Desire for more guidance
Complexities of assessment	Barriers to engagement Short timescale Need for a non-judgemental attitude and honesty
Timing of assessment	Deferral and delays Perceptions about urgency Possibility of miscarriage Benefit of timescales
Use of standardised tools	Limited use of standardised tools Difficulty identifying appropriate tools to use Available tools and framework not specific to the pre-birth period

Adequacy of the Guidance

In some localities, the guidance available was not specific to the pre-birth assessment period, whereas in others safeguarding procedures included a section on assessments during the pre-birth period:

‘Interviewer: Do you have any specific [pre-birth assessment] guidance?’

Interviewee: No, no there is nothing specific, there is the guidance in the Child Protection Procedures, which talks about the importance in doing a timely pre-birth assessment... it doesn't say much about first babies...’ (Social worker)

In the absence of comprehensive guidance, some practitioners relied on advice from colleagues with experience of undertaking assessments in the pre-birth period or examined older pre-birth assessments to identify the type of information that had been collated:

‘There is nothing specific that I have seen... that tells you what to kind of look for... and obviously when I was new and things like that and when I had not done one it was speaking to colleagues who had done one, having a look at their assessment, speaking to them [social workers] that have done them really. There is like I say the guidance but in terms of guiding it is more just prompts like questions to ask so what things have they got for the baby, for instance under [the dimension of] basic care.’ (Social worker)

Most social workers who were interviewed would have welcomed additional guidance:

‘I think it is an area that needs developing... I think sometimes if you're not somebody who has knowledge of what research tools are out there and don't research or haven't got access to that then it can feel a little bit like swimming through treacle really. Where do you start, what things do I need to take account of?’

How do I even structure the assessment? So there is information there but I think it is not information that is very visible.’ (Social worker)

Complexities Surrounding Assessment of Risk to the Unborn Child

Despite the legal complexities surrounding professional interventions to safeguard an unborn child, the interviewees reported that most expectant parents participated in a pre-birth assessment. Interviewees nevertheless described a number of barriers to engagement including the stigma associated with social work involvement, previous negative experiences of social care intervention, the misconception that the outcome of the assessment has already been decided (i.e. forgone conclusion) and impaired capacity due to substance misuse or mental ill health:

‘Because what tends to happen is that, when people hear that “you're going to have a pre-birth assessment” or “you're going to have a parenting assessment”, lots of times that fear is that it is already seen that “my child is going to be taken away”, that is, lots of times, people's impression that they quote “well you have already made a decision”.’ (Social worker)

The short timescales for pre-birth assessment, in addition to the time needed to develop the type of relationship necessary to overcome reluctance to participate, were perceived to leave little time available to undertake further work:

‘It takes quite a while [to overcome some parents’ reluctance to engage with social workers] and by the time, usually, you have got that good rapport with them and they understand you're “not out to get them” as they put it and things like that, it is the end of assessment so by the time you have got that, you have established that relationship and they are becoming more open and honest with you because they know that you're there to support them, then it is usually... the seven weeks is kind of up.’ (Social worker)

Social workers reported that parents were more likely to engage if the practitioner was non-judgemental; if the purpose of the assessment was explained in a clear manner, in particular in terms of it being an opportunity to identify strengths as well as areas that may be problematic; and if they were honest about what the potential outcomes of the pre-birth assessment might be:

‘Making sure that you're open and honest with them at every stage of that [pre-birth assessment] process. That is why I will bring out the assessment so they can see what I am writing about; that it is not negatives saying what is mum doing wrong, what dad [is doing wrong], which I think they think it will be. It is more about pulling their strengths out as well.’ (Social worker)

Timing of pre-Birth Assessments and Decision-Making

The professionals interviewed in the current study sometimes viewed pre-birth assessments as less urgent than cases involving infants or older children:

‘The difficulty though, is the pressure of work. I think pre-birth assessments aren't always at the top of people's lists of priorities because if you have got 20 cases on your case load and you have got 19 born children, it is going to be very difficult to really concentrate on doing a pre-birth [assessment].’ (Social worker)

‘We found that, when social workers sometimes get busy or in the past when they've got busy, the pre-birth [assessment] will be left.’ (Midwife)

Some interviewees indicated that pre-birth assessments were deferred until the chances of a miscarriage had decreased and the foetus was deemed viable, or delayed because the pregnancy had been concealed, resulting in late referral to children's social care and delayed assessments. A number of the local authorities participating in this study had introduced set timescales for early referrals and pre-birth assessments. These were deemed important to ensure that enough time was available to undertake a thorough assessment; provide early support to parents to prevent maltreatment in utero and post-birth; prevent delay and drift – reducing the likelihood of a rushed assessment and rash decision making towards the end of pregnancy; and to collect and analyse sufficient information to enable social workers to make a decision as to whether the child would be safe if they were to remain with their parents following birth:

‘We're now allocating cases roughly around the 16 week gestation. That allows our team to be involved with the family for slightly longer and to try and implement any changes or any recommendations before the baby is born. Whereas if you were allocated at 25 weeks, by the time you've agreed a plan, whether it's [care] proceedings or child protection [plan], mum's not far off from delivery.’ (Social worker)

Pre-Birth Assessment Models and Tools

Two of the sites were utilising standardised tools for the purpose of pre-birth assessment. One of these sites had specialist multidisciplinary teams who undertook the pre-birth assessment work and the other was using such measures as part of a standardised programme that they were piloting:

‘Well we have got the [standardised assessment] tools – what we call our tool kit so we have got tools in there, like, we have got the attachment style interview, which some of us are trained in, we have obviously got the antenatal attachment scales, paternal attachment scales and the DASH (Domestic Abuse Stalking and Harassment and Honour Based Violence) risk assessment, and the assessment for looking at alcohol and drugs [Alcohol Use Disorders Identification Test Audit] and so yes there are quite a few things we can draw on.’ (Social worker, emphasis added)

However, in most of the sites, interviewees completed pre-birth assessments only by speaking to and observing the parents, and gathering information from other sources (e.g. midwives, police) without making use of standardised assessment tools. Difficulty in identifying and accessing standardised tools for use during the pre-birth period appeared to be one of the reasons for not making use of them:

'I kind of had a few problems to start with, sort of accessing them and just really trying to kind of think about different measures that were free because obviously with costs of things and in the end it was just luck really...It was kind of a bit of a struggle trying to find stuff, but it is just knowing where to look and how to find it...so it was a bit of a mission yes.' (Health practitioner)

In some authorities, the age-related core assessment records, designed to support the implementation of earlier national Guidance (Department of Health et al., 2000), had been replaced with a single generic assessment tool to be used for children of all ages. An unintended consequence of this attempt at simplification had been to heighten the potential for social workers to overlook important information and to rely entirely on their own efforts to adopt a 'pre-birth angle':

'It is exactly the same as the core assessment, with pre-birth...our pre-birth assessments so it is exactly the same format. So if it was a ten-year-old child it would be the same as a pre-birth but obviously it is the information that we put in, we have just got to look at it from the pre-birth angle.' (Social worker)

Discussion

The results obtained from the analysis of LSCB guidance documents and interview data confirm and extend those of Hodson (2011). Perhaps most importantly, both sets of data indicate the lack of detailed guidance for pre-birth assessment. The documentary analysis of LSCB guidance showed little evidence of legal and ethical issues, and interviewees described an absence of pre-birth assessment frameworks and tools, and in some cases had to rely on the advice of colleagues.

Although there was also a lack of detailed information in the LSCB guidance about the rights of the foetus in law and the rights of a woman over her body in the national guidance (HM Government, 2013), and the team speculated that one of the consequences of this may be a delay in the initiation and implementation of pre-birth assessment, the interview data suggest that the main causes of late pre-birth assessments are barriers to engagement with the assessment process and short timescales within which to develop a relationship. The interview data also highlighted the low priority given to pre-birth assessment relative to the assessment of children already born, and deferrals due to the risk of miscarriage. The findings also identified a perception that waiting until late pregnancy to undertake a pre-birth assessment is reasonable because, although plans can be made during pregnancy, actions such as instigating legal proceedings for removal or supervision cannot be undertaken until after the birth. These findings are consistent with previous research

(Hodson, 2011; Ward et al., 2012), and may be underpinned by a misconception that a mother's wellbeing and experiences during pregnancy will not impact significantly on the development of the foetus and a lack of understanding about the long-term consequences of an adverse in-utero environment for the unborn baby (Brown and Ward, 2013; Ward et al., 2010).

Assessments are complex and depend to some extent on the knowledge and skills of individual practitioners (Turney et al., 2011). Although the use of standardised tools alongside professional observation and understanding can improve the quality of assessment (Baynes, 2013; Turney et al., 2011), it was rare for such tools to be used by practitioners taking part in this study. Practitioners referred to difficulties in identifying and accessing appropriate tools, but insufficient knowledge of and training in the use of standardised assessment tools is also likely to be a significant factor. Hodson (2011) reported that social workers concentrated on areas that were essentially 'easier' to measure (e.g. environmental factors, attendance at antenatal appointments or compliance with drug treatment programmes) and that social workers are not supported to measure other areas such as maternal and paternal attachment that could help make decisions.

Absence of the use of standardised measures and a structured framework for core assessments in the pre-birth period, in some localities taking part in this research and others (see also Hodson, 2011), could increase the likelihood of variation in what social workers deem relevant information to support decisions concerning whether a baby can be sufficiently cared for at home or requires taking into care. The core and initial assessments were combined following the Munro review of child protection which reported that social workers found that they were too prescriptive and lengthy and thought that they devalued professional expertise (Department for Education, 2011). However, a recent study has revealed that some workers found that 'the boxes [in the core assessment] were a helpful reminder of what needs to be looked at' and 'that there is a potential for things to be missed' in the absence of prompts (Munro and Lushey, 2012, p. 8). Furthermore, preliminary evaluation of a standardised pre-birth assessment pathway found such a pathway to be a useful method of evidencing the capacity to change of pregnant, vulnerable women (Barlow et al., 2016), including providing the necessary evidence to make decisions about the safety of the unborn/newborn baby.

Pregnancy and childbirth can offer a unique window of opportunity for parental change. Ward et al.'s (2012) longitudinal study of infants suffering significant harm found that most of the parents who had succeeded in overcoming adverse behaviours had begun to make changes during pregnancy and all except one had overcome their difficulties before the baby was six months old. Parents who had not managed to effect major change during pregnancy, but had made some progress around the birth of their child were generally not able to sustain such changes. This illustrates the importance of early pre-birth assessments to help social workers to make decisions about parental capacity to change, and highlights the need for timely support and intervention to help parents make changes before the birth of their child.

Two guidelines for pre-birth assessment have been developed to date (Calder, 2003; Corner, 1997), but these have not been widely adopted and may now be in need of updating. The findings from this study suggest the need for a set of guidelines that provides detailed guidance regarding the specific roles of different practitioners, legal and ethical issues, timelines, pre-birth assessment framework and standardised tools, and possible methods of working with parents to bring about change.

Conclusion

The findings of this research highlight the need for better guidance and training with regard to pre-birth assessment, particularly in terms of what to assess and when, and the use of standardised assessment tools alongside professional judgement. This could help to address some of the problems identified by interviewees in addition to standardising practice and improving outcomes for families.

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