

Glasgow Child Protection Committee



Inter-Agency procedural guidance for vulnerable women during pregnancy

August 2008

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1. Introduction

- 1.1 Glasgow Child Protection Committee issued Inter-Agency guidance in respect of Alcohol and Drugs in Pregnancy in November 2002. Since then, significant organisation and structural change including the development of Community Health and Care Partnerships has taken place in Social Work Services and NHS Glasgow and Clyde. In addition there have been a number of research documents and publications that have necessitated the rewriting of the guidance.

Vulnerable parent(s) need to be able to ask for advice and help from appropriate agencies and to work together with them to safeguard their children. An important part of this help needs to involve an inter-agency parental assessment of risk which focuses on parental vulnerability factors and the impact these may have on children.

The early identification of a vulnerable mother will ensure that the mother's needs are assessed, potential risks to her unborn child identified and appropriate services put in place. Early parental assessment informs and significantly contributes to any future Integrated Assessment of the newborn child using Glasgow's Integrated Assessment Framework.

The aim of this guidance is to assist vulnerable parents to acquire the necessary parenting skills and to support both the women and their partners in:

- Putting their children's welfare first. Every child has the right to protection from all forms of abuse, neglect or exploitation.

The legal framework for this procedural guidance is the Children (Scotland) Act 1995. This places a greater emphasis on working in partnership with parents in order to enable them to look after their children, and to use compulsory measures of care only when this is absolutely necessary for the child's welfare.

These procedures are designed to complement single agency Child Protection Procedures and Glasgow's Child Protection Committee Inter-Agency Child Protection Guidance. This guidance provides the operational framework in which key agencies will work together to protect children.

Social Work Services will co-ordinate and manage the operational aspects of these inter-agency procedures.

1.2 Definition

It was recognised there was a need to widen these procedures to include pregnant women who are deemed vulnerable for reasons other than substance misuse. **It should be noted that not every woman who may be in the following categories will require to be referred under these procedures. Initial assessment of the needs of the mother should identify those women who require inter-agency support through this procedure.**

Where a decision is taken that a woman does not require to be referred under these procedures, the reasons must be fully recorded in the appropriate agency client information system.

These procedures refer to women who:

- Have mental health difficulties
- Have learning disabilities / difficulties
- Are involved in drug or alcohol use
- Are subject to domestic abuse
- Are subject to immigration control
- Are homeless
- Have children currently or previously accommodated
- Partners are deemed vulnerable
- Are deemed vulnerable
- Young women who are accommodated who are care leavers
- Vulnerable teenage pregnancy

This list is not exhaustive and it is anticipated this procedural guidance will be used in a wide range of situations where services are concerned about woman who are deemed vulnerable due to a range of circumstances.

1.3 Application of Procedures

A comprehensive inter-agency assessment should be undertaken on all vulnerable pregnant women who have been identified via the liaison process. Their vulnerability may be related to, for example, alcohol or drugs, both prescribed and illegal, domestic violence, mental health or learning disability.

Drug problems can range from occasional recreational use to individuals who have a physical and psychological dependence on drugs that affect their ability to parent children safely. Alcohol problems range from consistently exceeding sensible drinking limits through to more serious

physical/psychological dependence on alcohol. The amounts of alcohol involved will vary from individual to individual and over time.

In respect of mental health this could range from mild to moderate mental health to severe and enduring. Both the degree and effects of the parent's behaviour is particularly relevant to the risk assessment that needs to be undertaken.

Intervention by the authorities in the life of a vulnerable parent is justified:

- If their baby is likely to be in need
- If their baby is likely to be at risk

Each of these is under-pinned by legal definitions and frameworks.

1.4 Children in Need/At Risk

Children living with vulnerable parents can be 'in need', or they can be 'at risk', or they may be both 'in need' and 'at risk'. Multi-agency intervention should be considered if children are thought to be 'in need' even if the assessment indicates that they are not 'at risk'. Proactive intervention in the early stages of a child 'in need' may prevent future care and protection concerns arising.

In view of the nature of the vulnerability and its potential effect on parenting capacity, there will always be a requirement to examine parental vulnerability in the context of child protection policies and procedures and thereby assess risk. However, it is important to look at the wider implications of a child's safety and welfare and assess need. This will necessitate the development of inter-agency support services in order to offer a more 'holistic' form of support for children and their families.

Whenever an assessment of risk is undertaken and it is determined that child protection is not required, an assessment should be undertaken in order to identify whether they require a service as a child in need.

2. Values and Principles Underpinning Inter-Agency Intervention

- 2.1 All agencies involved in providing services to vulnerable women will ensure that the welfare of the child is paramount. This will be achieved by attempting to work in a spirit of partnership with the family wherever possible.
- 2.2 Any intervention by a public authority in the life of a child must be properly justified and should be supported by services from all relevant agencies

working in collaboration. Vulnerable families can often be a cause for concern; however, it should not automatically lead to either child protection registration or compulsory measures of intervention.

- 2.3 In order to promote their inclusion in society, all agencies need to provide a range of treatment and support services to vulnerable families which help parents to cope with their problems and to develop positive lifestyles – linking them to health, accommodation, education and employment opportunities.
- 2.4 In line with the Children (Scotland) Act 1995, babies and children should be cared for in their own families wherever possible. The placement of babies away from their own families, or their prolonged hospitalisation, should be avoided unless this is essential to their health or welfare.

3. Confidentiality

- 3.1 Vulnerable women might be particularly concerned about their support services sharing information with other professionals. They may fear that they will be denied help, disadvantaged, stigmatised or blamed if other professionals or agencies are given any information about them. This may have been their experience in the past. Parents involved in criminality or with drug problems may also fear being subject to investigation by the police or inquiries by child protection agencies about their behaviour.
- 3.2 Unlike drug use where professionals are concerned about any drug taking activities, it is less clear cut for professionals when dealing with parents with alcohol problems simply because alcohol is a legal drug. Professionals are sometimes hesitant about intervening until the situation arises where they have no option. This equally disadvantages clients with alcohol problems.
- 3.3 Professionals need to be mindful that intervention from their agency may be stressful for parents and families even if there is no cause for concern. In most circumstances users of treatment and support agencies can rely on confidentiality as their guiding principle. **But there are exceptions to this.**

If a child may be at risk this will always override a professional or agency requirement to keep information confidential. Professionals have a responsibility to act to make sure that a child whose safety or welfare may be at risk is protected from harm. They should always tell parent this.

3.4 If there are worries about a child's care, development or welfare, professionals in touch with the family must co-operate to enable proper assessment of the child's circumstances, provide any support needed and take action to reduce risk to the child. This will normally require them to **share relevant information**. Guidance from professional bodies emphasises that the child's welfare is the paramount consideration when deciding what they should do in such circumstances.

3.5 **The Scottish Executive, 2000 issued guidance that states –**

“Personal information about children and families given to professionals is confidential and should be disclosed only for the purposes of protecting children. Nevertheless the need to ensure proper protection for children requires that agencies share information promptly and effectively when necessary. Ethical and statutory codes for each agency identify those circumstances in which information held by one professional group may be shared with others to protect the child”

3.6 **The General Medical Council issued guidance in July 1993 that states -**

“Deciding whether or not to disclose information is particularly difficult in cases where the patient cannot be judged capable of giving or withholding consent to disclose. One such situation may arise where a doctor believes a patient may be the victim of abuse or neglect. In such circumstances the patient's interests are paramount and will usually require the doctor to disclose information to an appropriate office of a statutory agency”

3.7 When staff begin working with a vulnerable parent they should explain their policy on confidentiality and information sharing.

If an agency is concerned that a child may be at risk of significant harm, the practitioner should:

“Inform the client of the concern and discuss the reasons for this (except where telling the client that information is being passed on may result in harm to a child). Ask the client for consent to seek help from other services. If this consent is not given and the agency believes that the child is at risk of significant harm, it should as a matter of good practice override the parent's wishes”

4. Inter-Agency Partnership

- 4.1 Key agencies have a collective responsibility to protect children at risk. This demands effective communication and co-ordination of services at both strategic and operational levels.
- 4.2 Not all vulnerable women welcome the intervention of social work services and may seek to avoid contact. Inter disciplinary discussions and planning may assist engagement in such situations
- 4.3 Ensuring that vulnerable pregnant women receive appropriate antenatal care and supports to maximise both their own and their expected baby's health and well being is a task shared by all those involved. Good practice indicates that regular information sharing between agencies is vital. All parents who attend specialist Glasgow clinics will have contact with a range of health and social work services.
- 4.4 The effectiveness of working with vulnerable families can be greatly enhanced by good inter-agency communication and co-operation. In 1998, the Scottish Office published "Protecting Children, A Shared Responsibility". This guidance highlights the need for statutory and voluntary agencies to work together in partnership with parents to protect children.
- 4.5 Vulnerable parents should be assessed in the same way as other parents whose personal difficulties interfere with or lessen their ability to provide good parenting. It is important to look at the vulnerability of both prospective parents from the perspective of the child and the impact it may have on the child's life and development.

5. Vulnerable Parents and Child Protection

5.1 Child Protection

A parental vulnerability is not enough in itself to qualify as "child abuse". However, the effects on children of the parent's vulnerability may be a matter of serious childcare concern, which may result in the seeking of compulsory measures of care and referral to the Reporter. General childcare concerns (for example poor housing conditions, children unkempt, poor parenting skills) may not in themselves, result in child abuse concerns. **Child Protection Procedures and child protection measures, are only required when the component of significant harm, or its likelihood, is present.**

Where child protection concerns are identified with regard to pregnant women these should be addressed at the **Pre-Birth Case Conference.**

5.2 Vulnerability and Protective Factors

The ability of a parent to adequately care for their children may at any given time vary depending on their current circumstances. Risks associated with parental difficulties can be mitigated by other protective factors that include:

Protective Factors

- **Support for the woman from at least one caring adult**
- **Extended family support**
- **Community supports for parent and child**
- **Sufficient income and good physical standards in the home**
- **A consistent caring adult, who will provide for the child's needs and give emotional support**
- **Regular monitoring and help from health and social work professionals, including respite care and accommodation**
- **An alternative, safe and supportive residence for mothers subject to violence and the threat of violence**
- **Good regular ante-natal care**
- **Willingness of parent to engage with professions**
- **Regular attendance by older children at nursery or school**
- **Sympathetic and vigilant teachers**
- **Children belonging to organised out-of-school activities**

5.3 Addiction

“The interests of the child and the mother are inextricably linked. Maternity Services and those who may be helping the parent to tackle their substance misuse must work closely together.”

(Hidden Harm, Next Steps Supporting Children- Working with Parents, Scottish Executive, 2006)

In the case of addiction, parents may require support to enable them to reduce their physical and emotional dependence on alcohol and/or drugs, to enable them to prepare for the birth of their child. The research suggests that where a parent is in effective treatment this is a protective factor for children. Community Addiction Teams (CATs) offer a wide variety of treatment and support. This includes prescribing, support within the community and access to residential rehabilitation of which residential detox can be a part.

Although parental addiction does not affect every family to the same degree, substance use can lead to a chaotic lifestyle which impacts on children in a number of ways including:

- Lack of stability in the household
- Lack of basic necessities (food, heat, and safe environment)
- Domestic violence
- Association with drug/criminal culture

However we know parental addiction can impact on the child adversely. Therefore, both mother and baby would benefit from a comprehensive inter-agency assessment to manage their future support needs and ensure that the child is protected.

This assessment needs to identify indicators of risk alongside protective factors that are in place.

Protective Factors

- **Non drug-using adult (usually parent) in the home**
- **Parent in effective treatment or receiving support to address drug/ alcohol problem**
- **Stable home environment**

Maternity services are now seeing older women with alcohol problems having babies. Often these women tend to be in poor physical health, which has consequences for the baby.

Pregnant women with alcohol and/or drug problems may adversely affect the physical and developmental health of the foetus leading to a range of problems, including low birth weight and/or premature birth, Foetal alcohol effect/syndrome and congenital abnormalities. A newborn baby may also develop withdrawal symptoms and require treatment. However, it should be noted that the babies of mothers with alcohol and/or drug problems might be ill for reasons unconnected with their maternal alcohol and/or drugs problem. If the newborn baby is ill, it may strain the mother's already compromised parenting skills.

The legal nature of alcohol use may mean, however, that it is less visible to services than drug use because the purchase and consumption of alcohol does not (by and large) attract attention. The legality of alcohol may also lead to a more inconsistent approach by services. Alcohol use often receives less attention than drugs although the problems can be just as serious. It can be more difficult to assess the impact of parental alcohol use on children.

5.4 Domestic Abuse

Whilst all women are vulnerable to domestic abuse, being pregnant has been acknowledged as a particular risk factor. Many women report that the

onset of physical violence occurred during pregnancy, or where it is already a feature that it increases in frequency and severity during this time. Very often the abdomen becomes the focus of physical assaults during pregnancy, and some babies may be miscarried, stillborn or born disabled as a result.

Domestic abuse can compromise both the abused woman's and the perpetrator's ability to parent. A perpetrator is clearly not providing good parenting when he physically attacks his pregnant partner. Living with a violent man has considerable impacts on a woman's whole life, and for some woman, the physical and psychological effects of living with a violent partner may make mothering very difficult to achieve. Women who are subject to domestic abuse could be deemed vulnerable, as could the unborn child.

The demands of living from day to day and keeping herself and her children safe can result in a woman feeling overwhelmed, finding it difficult to cope with every day tasks. Concealing injury and trying to care for her children can be both physically and emotionally overwhelming. Mothers living with domestic abuse will frequently have their ability to parent reduced due to the time and energy they must devote to dealing with their own psychological and physical trauma and in ensuring the safety of their children.

Assessment needs to identify indicators of risk alongside protective factors that are in place.

Protective Factors

- **An alternative, safe and supportive residence for mothers subject to violence and the threat of violence**
- **Extended family support**

5.5 Learning Disability

A person with a learning disability has a significant impairment of intellectual and social functioning with all three of the following noted facets:

- Reduced ability to cope independently
- A condition which started before adulthood (before the age of 18) with a lasting effect on the individual's functioning
- A global impairment with an I.Q. of below 70 with reduced ability to understand new or complex information or learn new skills

People with a learning disability are a diverse group and support needs will vary from individual to individual. Two factors to consider when working with someone who has a learning disability is that they may require additional support with communication and may need more support and time to learn new skills. Professionals need to be mindful of this when undertaking an assessment.

Planning support to someone with a learning disability tends to be longer term from the outset, reflecting the nature of his or her disability. This is especially significant when supporting an individual to parent and should be borne in mind during the assessment and care planning process.

Ensuring effective communication is crucial when working with someone with a learning disability. A specialist Speech and Language profile can be completed via the local Area Learning Disability Team to determine an individual's current level of understanding and offer guidance on effective communication.

As with all service users, it is essential that all information conveyed to someone with a learning disability be produced in a format that the person can understand. Repetition of some information may be required to allow learning to be assimilated. Additional time may therefore be required to impart information to an adult with a learning disability to ensure understanding.

Having a learning disability does not preclude effective parenting and this should be borne in mind by professionals. Child protection procedures and child protection measures should be implemented when the parents' needs adversely affect their capacity to safely parent their children.

Terminology

There has been much debate over the most appropriate language to use in reference to this particular group of people, i.e. whether to use 'learning disability' or 'learning difficulty'. These terms are often confused. The Glasgow Learning Disability Partnership brings together services provided by social work and primary health care and the adopted term used by this partnership is "learning disability". This reflects the interpretation that 'learning disability' is a term used to refer to global impairment and 'learning difficulty' refers to specific difficulties such as dyslexia. However, it is recognised and respected that the People First organisation has consulted with individuals themselves and that 'learning difficulty' was selected by them as the preferred term to be used when referring to individuals.

As this protocol is primarily aimed at those working with individuals, it has been decided to use the term most commonly recognised by organisations,

which is 'learning disabilities'. The term is not meant to disrespect, disempower or cause offence to the individuals concerned.

Protective Factors

- **Early intervention and improved joint working between agencies**
- **Information in a format which is easy for people with learning difficulties to access**
- **Assessment and support from professionals with a knowledge and understanding of the needs of individuals with a learning disability**
- **Commitment of long term support with both life and parenting skills**
- **Advocacy style support from another parent**

5.6 Looked After and Accommodated Young Women (LAAC)

Young women who have been or are currently LAAC may require additional supports when it comes to caring for a baby of their own. It is important for these young people that they are identified as soon as possible and immediately linked into the relevant services. This will enable the risks, needs and strengths to be identified.

Any risk assessment must link with the young woman's care plan or pathway plan and consideration whether to allocate to separate workers to undertake the risk assessment should be considered in situations of conflict.

Protective Factors

- **Stable, supportive living accommodation**
- **The presence of an alternative or supplementary caring adult who can respond to the development needs of babies**

5.7 Mental Health

Pregnancy itself can result in a woman suffering some form of mental health problem when there has been no previous illness, i.e. post-natal depression

Section 328 of the Mental Health (Care and Treatment) (Scotland) Act, 2003 provides that "mental disorder" means any mental illness, personality disorder or learning disability however caused or manifested.

In the case of mental health, parents may require intensive support around the birth of the baby to sustain stability. Mental health can vary from mild to moderate to severe and enduring and the impact of this has to be considered when assessing the ability to parent and the timing of supports both during the pregnancy and after the birth of the baby. Assessment is undertaken by using the Integrated Care Pathway for Peri-Natal mental health. Residential support for the mother and the baby may be required after the birth however this should be assessed and discussed prior to the baby's birth to offer the best service possible i.e. the peri-natal unit (Southern General Hospital) may be an appropriate resource.

The majority of parents who suffer mental ill health are able to care for and safeguard their children. However families may require specific support to enable them to prepare and care for their baby. Adult care services must always consider the welfare and safety of any children within the family unit. Close liaison must take place between adult and children and family services to ensure adequate support and the assessment of need for any children affected by parental mental illness. Support requires to be offered towards the management of mental health disorders that could include medication, psychiatric supports

Inconsistencies in parenting abilities may be the result of lack of compliance with medical regimes and if parents are stabilised on medication this may enable them to continue to parent. However, some parents have poor parenting skills regardless of their vulnerability. It should not be assumed that if their mental health is stable or their drugs problem is controlled that they will immediately become 'good enough' parents.

Child protection procedures should be considered when:

- The parents' needs adversely affect their capacity to safely parent the child/ children
- There are poor support networks or no alternative care within the extended family to prevent emotional abuse (including emotional support for the child) neglect or other incidents of abuse

This assessment needs to identify indicators of risk alongside protective factors that are in place.

Protective Factors

- **Supportive adult in the family home**
- **Parent in effective treatment or receiving support to address mental health difficulties**

6. Glasgow Maternity Services

6.1 There are currently three maternity units in Glasgow. However, in the near future there will be two units based in the Princess Royal and Southern General Hospital.

Current Maternity Units

- Princess Royal Maternity Hospital
- Southern General Hospital
- Queen Mothers Maternity Hospital

They all provide routine and specialist services on a geographical basis through hospital and community based clinics.

6.2 Women's Reproductive Health Service (WRHS)

The Women's Reproductive Health Service (WRHS) provides specialist care for vulnerable women as outlined in Section 2. It is the only specialist service in the city dealing with alcohol and/or drug problems. Referral to this service can be made by any agency or by women themselves. The in-patient service is based at the Princess Royal Maternity Hospital (PRMH), but provides a Greater Glasgow wide multidisciplinary service through the Ante Natal Clinic teams located within:

- South East Community Health Care Partnership
- South Community Health Care Partnership
- West Community Health Care Partnership
- North Community Health Care Partnership
- South West Community Health Care Partnership
- Princes Royal Maternity Hospital (City Centre Clinic)
- Hospital Based Clinics (Southern General / Queen Mothers)

Within Glasgow, the Women's Reproductive Health Services (WRHS) should see the majority of women with complex social problems. Where a woman presents at her GP for antenatal care, consideration is given to referring to the WRHS clinic for ongoing antenatal care. In addition, if a woman presents at the Southern General or Queen Mothers' maternity hospitals, the hospital **should** consider referring the woman to the WRHS clinic for specialist assessment and support.

Women referred to WRHS should be seen at their local clinic (as outlined in Sect 6.2). Multi-disciplinary care including inter-agency assessment is available across all sites. Women can access referral to WRHS by any referral route, including self-referral. Women already booked into

mainstream maternity services can be offered referral to WRHS by any member of staff involved if a concern arises. This includes staff from adult services and children and families staff. (See p. 22 flowchart)

6.3 Hospital Social Work

A number of specific circumstances are dealt with by the hospital based Social Work Service, for example where there is a concern in respect of social problems only identified at time of birth or a woman is admitted to hospital unbooked. Where appropriate, the hospital based PTL will liaise with the relevant CHCP PTL and Operations Manager.

Hospital-based Ante Natal Clinic teams or in-patient wards should alert the hospital-based social work unit of any concerns that arise about individual women.

7. Inter-Agency Clinics and Liaison Meetings

7.1 The Ante Natal Clinic Team

The clinic team led by an obstetrician will be responsible for the ante natal care of the mother. The clinic team will initially assess the mother's health and well-being and where a mother is considered vulnerable will refer the woman to the Inter-Agency Liaison Meeting for comprehensive assessment using the single shared referral form (Appendix 1 & 1A). Clinic team members will normally take part in any case discussions/conferences about the family.

The **Clinic team** will generally include:

- Obstetrician, Named Midwife, Health Visitor
- Paediatric and obstetric nursing
- A member of staff from the local PACT team and/or hospital team
- A member of staff from the community addiction team

The clinic team should ask questions about children and child care arrangements at each clinic appointment. All vulnerable parents should regularly be asked about their parenting and childcare practices.

A member of the ante natal clinic team (usually the midwife) should ask all pregnant women relevant questions regarding their personal, family, social and medical needs as part of the Public Health Assessment Tool.

7.2 The fortnightly Inter-Agency Liaison Meeting

All hospital and WRHS community based ante-natal clinics will hold multi-agency **Liaison Meetings** on a **fortnightly** basis to review those women referred to the Liaison meeting, to discuss new referrals and to identify women who may be vulnerable and in need of additional support and review their progress.

The community-based inter-agency liaison meetings will be chaired by the Practice Team Leader, (PACT or designated C&F PTL) in the local CHCP and by the designated hospital Practice Team Leader in the hospital-based liaison meeting.

Social Work Services will provide the co-ordination and administration of these arrangements and it will be the responsibility of social work and health managers hosting liaison meetings to ensure appropriate representation at the meetings.

The Liaison Meeting should comprise of all those individuals and professionals who can make a contribution to the assessment of risk and to the inter-agency action plan. The Liaison group should include:

- Senior Addiction Worker (even if they are not known to the service)
- Allocated Health Visitor and/or Link Health Visitor
- Named Midwife
- Administrative support
- Other workers as deemed relevant by the Chair, for example mental health/learning disability practitioners/criminal justice staff
- Representative from Parents Support Project
- Obstetrician/Paediatrician (for information only)

This meeting will have the responsibility for co-ordinating work and information sharing, facilitating the assessment process and making recommendations to Operations Managers as to progress.

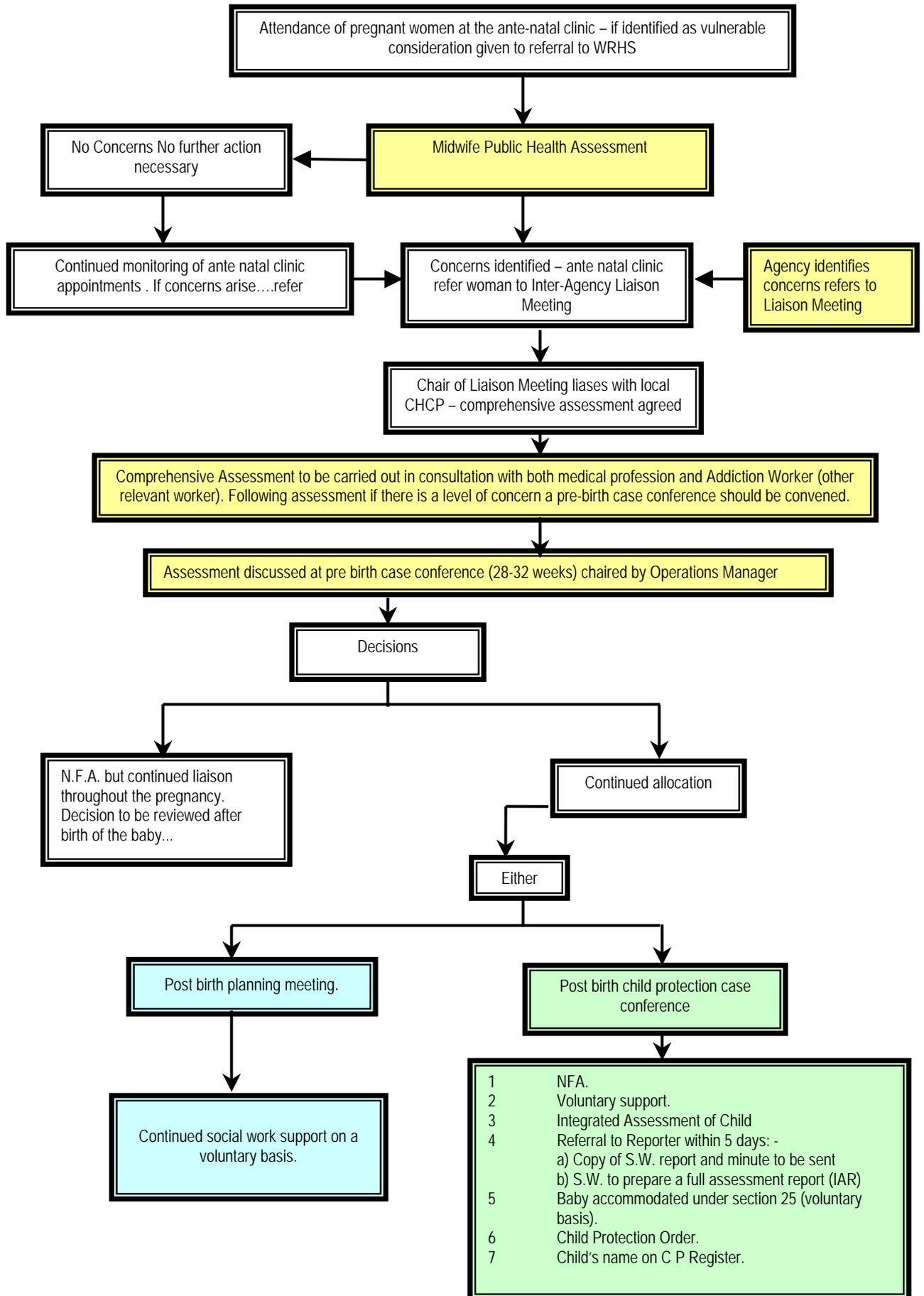
The chair will also have the responsibility of feeding back information/decisions to any relevant person.

The assigned CHCP worker responsible for completing the pre-birth comprehensive assessment will receive a copy of the Liaison Meeting minute detailing any agreed action or issues of concern relating to their client.

7.3 The Link Health Visitor:

- Will identify the health visitor who will be responsible for supporting the family after the birth of the baby.
- Will ensure information is communicated between the Health Visitor and Liaison Meeting.

Referral Pathway



8. Process of Assessment

8.1 General Comment

There is a need for a co-ordinated assessment of need/risk and effective communications amongst all related agencies working across both statutory and voluntary sector agencies. It is therefore important that the pre-birth risk assessment is an ongoing evaluation that is reviewed every time a new piece of information is received.

All professionals who come in to contact with vulnerable families have a responsibility to ensure that pregnant women in these circumstances are identified as early as possible and are given appropriate support. Early identification and the right kind of support, for both parents and children, can often mean that children can remain with their parents. However, there are some circumstances, for example serious and chaotic drug use, when the risks to children are so severe that staying with their parents cannot be an option.

Assessment in pregnancy cannot be seen in isolation. Significant adults who will have a parenting role and other children in the family should be seen and be an integral part of the assessment. The pre-birth assessment will significantly contribute to the decision to undertake an integrated assessment following the birth of the child, or in relation to other children in the household. The information gathered during the pre-birth assessment will significantly inform the IAF process.

8.2 Initial Assessment - To Decide If A Referral to the Liaison Meeting Is Necessary

When vulnerability concerns are identified by the Ante Natal Clinic team or another professional working with the woman, an initial assessment will require to be undertaken.

This initial assessment can take the form of:

1. **Midwifery Services** – Midwifery services have developed Special Needs In Pregnancy (SNIPs) ante natal and post natal referral pathways (Appendix 2). The pathways support the identification of vulnerable women and introduce the concept of traffic lights:
 - **Green** – healthy women with no risk factors identified. These women would not require referral to the Liaison Meeting
 - **Amber** - women with potential risk identified requiring further assessment. These women would not automatically be

referred to the Liaison Meeting. However, consideration should be given following initial assessment.

- **Red** - women with significant medical/obstetric risks identified or women with complex social needs. All women assessed within this category should be automatically referred to the Liaison Meeting.

The midwife will complete the MPHA (Midwife's Public Health Assessment) for all women, but where a woman is deemed to be vulnerable (red), a Referral should be made to the appropriate Liaison Meeting for support and potential comprehensive assessment. The single shared referral form should be sent to the PTL chairing the Liaison Meeting (Appendix 1 & 1A – adapted for use by health). The PTL should complete the reply slip and return to the referring midwife.

Where a young mother is identified as vulnerable, the midwife should link with the Link Midwife for Teenage Pregnancy (Appendix 3) and discuss the needs of the young person and how best they can be managed.

Assessment is not a static process. If at any time during the antenatal period the clinic team become concerned regarding deterioration in an individual woman's circumstances, they can refer the woman to the Liaison Meeting.

The Ante Natal Clinic team should inform the Liaison Meeting of the progress of the pregnancy, the needs of the parent(s) and potential risks for the unborn child and any other children within the family.

2. **Social Work (CP 12 - Appendix 4)** - Where the woman is known to Social Work Services, an initial single agency assessment (CP12) will be undertaken by the assigned worker (this may be an adult care worker). This assessment will include a recommendation as to whether or not a woman should be referred to the appropriate Inter-Agency Liaison Meeting and the reasons for this. When referring a woman to the Inter-Agency Liaison meeting, a copy of the CP12 should be forwarded to the PTL chair.

Where the CP12 concludes that the pregnant woman does not require to be referred to the Inter-Agency Liaison Group, the assessment requires to be signed off by the worker and responsible PTL and a copy of the report retained in the woman's case file.

The CP12 should form the basis of any subsequent assessments (including IAF) and should provide all workers with key information with

regard to the needs of the woman, child care/protection concerns, partner and family supports.

As a matter of routine, consideration should also be given to whether the woman's partner is deemed also to be vulnerable (i.e. alcohol and/or drug problem/mental health issue or learning disability) and an assessment made as to whether their presentation confirms the information given.

Enquiries should also be made as to whether domestic abuse is an issue and an assessment made as to whether their presentation confirms this.

From the outset, professionals should discuss their concerns with the parents and discuss the potential need to refer to the Inter-Agency Liaison Meeting.

8.3 Inter-Agency Liaison Meeting

Once a woman is identified as vulnerable and requiring support she will be referred to the Liaison Meeting. Any agency (or the woman herself) can make this referral.

Once a referral is received by the Liaison Meeting, the following will occur:

- The need for a comprehensive assessment (Appendix 5 CP13) will be agreed. Where the woman does not have an assigned worker within Social Work Services, the PTL chairing the group will liaise with the relevant CHCP to ensure the assessment is assigned promptly.
- For all women referred to the Liaison Meeting, a provisional Pre-Birth Case Conference date will be scheduled with the relevant Operations Manager. However, following comprehensive assessment it may not be necessary to proceed with this. Putting a provisional date in the diary ensures that workers are clear of assessment timescales and confusion is avoided.
- When identified, the worker responsible for completing the comprehensive assessment will be given the date their assessment is due to be submitted to the Liaison Meeting. This will be approximately two weeks prior to the Pre-Birth Case Conference and the worker may be asked to attend the Liaison Meeting to discuss their assessment.
- The Liaison Meeting will make a recommendation to the relevant Operations Manager as to whether there is a need for the scheduled Pre-Birth Case Conference. Ultimately the decision is that of the Operations Manager responsible for the case.

- An appropriate member of the Liaison Meeting will attend the Pre-Birth Case Conference and report on behalf of the Liaison Meeting.
- If the decision is to progress to Child Protection Case Conference post-birth, the Liaison Meeting will continue to monitor the progress until this the conference takes place. The allocated social worker will complete a CP1 for the conference.

9. Comprehensive Assessment (Appendix 5 – CP13)

- 9.1 Where the Liaison Meeting decides a Comprehensive Assessment is required it will normally be co-ordinated by a social worker and must include input from other relevant identified workers, for example addiction worker or an adult services worker. The assessment will help to identify whether further support or intervention is necessary and will be based upon information provided by professionals and agencies with knowledge of the family and direct engagement with the family themselves. The assessment will assist in the preparation of the inter-agency action plan and form the basis of discussion and planning at the Pre-Birth Case Conference and any future IAF processes.
- 9.2 Home visits are an important part of comprehensive assessment in order to ensure that appropriate preparations are in place for the new baby.
- 9.3 Where there are other children living in the family home, all agencies making home visits should observe, assess and record the conditions that children are or will be living in. They should also record who was in the home, especially children and how they presented. They should note how the child interacts with their parents.
- 9.4 In keeping with the principle of working in partnership with families, parents should be informed of the Interagency Child Protection Procedures and of the purpose of any case discussions/conferences. This should be undertaken by the worker completing the comprehensive assessment early on in their involvement, so that parents are aware of the expectations of them and are fully prepared for case discussions. When proceeding to Pre-Birth Case Conference, women and their partners should have the opportunity to read the assessment report prior to the Pre-Birth Case Conference. If this is not possible, staff should advise the woman and her partner of the details of their assessment prior to the Pre-Birth Case Conference taking place.
- 9.5 The contribution that the parents themselves and other family members can make to the assessment and inter-agency action plan should not be underestimated. Parents should be encouraged to participate in Ante Natal Clinic discussions and throughout the assessment process.

9.6 Following the completion of the CP13 where the recommendation is not to proceed to Pre-Birth Case Conference, the following action is required:

- The reasons for this should be fully recorded and the provisional conference date cancelled.
- The Operations Manager should countersign the CP13 agreeing that a Pre-Birth Case Conference is not necessary.
- A copy of the CP13 should be retained in the woman's case file in an order that care professionals can access if necessary.
- A copy should be given to paediatrics when a case file has been opened following the birth of the child. This information will assist paediatricians in their overall assessment of the child.

10. Inter-Agency Pre-Birth Case Conference

10.1 When the decision is to proceed to Pre-Birth Case Conference, this should take place between 28 and 32 weeks recognising that some women, particularly those with substance misuse issues, have premature births.

10.2 The Pre-Birth Case Conference is a multi agency forum and invitations should be issued to any agencies that are currently involved or that may become involved with the family (Appendix 6). Prospective parents should be invited to attend the meeting. The guiding principle should be that parents are treated as partners in the process and should not be excluded from meetings unless there are very strong grounds to do so (for example child's interests, staff safety, possible police investigation). This is at the discretion of the Operations Manager. It is noted that occasionally families will choose not to attend meetings.

10.3 The Pre-Birth Case Conference will consider the available information and make decisions about the level of intervention and agree the elements of any inter-agency action plan to be provided for the remainder of the pregnancy and immediately following the birth. The meeting will consider the potential risk to the baby and whether a Child Protection Case Conference will be necessary after the child is born. **In all cases where the Pre-Birth Case Conference has identified concerns, a Post Birth Child Protection Case Conference must be convened.**

10.4 Social Work Services will provide the co-ordination and administration of these arrangements, and Operations Managers will chair the Pre-Birth Case Conference.

10.5 Assessment reports and minutes of meetings will be distributed by Social Work Services on the basis that each agency should have access to information essential to its role. The principle of openness with families, subject to appropriate safeguards, will be applied. Within 24 hours, a letter will be circulated to all invitees detailing the decisions taken at the conference. Minutes of case conferences will be completed and circulated within agreed timescales. The key areas of concern and the decisions taken should be clearly recorded. The inter-agency action plan will identify the needs and risks to the unborn baby, define outcomes for the child and their family, set out agreed tasks and allocate responsibilities.

11. Inter-Agency Post Birth Procedures

- 11.1 **Child Protection** - When the child is born and there are concerns the child is at risk of significant harm, the Child Protection Procedures and Guidelines should be followed and a Child Protection Case Conference held within five working days of the child's birth. Good practice would be that the child should not be discharged home prior to the case conference. Where an emergency arises and there are immediate concerns for the safety of the baby, the midwife should immediately contact hospital social work services to alert them to the situation and where there is an immediate risk to the child the police should be contacted.
- 11.2 **Post Birth Planning Meeting (Appendix 7)** - Where the level of concern does not necessitate a post birth Child Protection Case Conference, best practice would be to convene a post birth planning meeting chaired by the relevant PTL within 10 working days of the child's birth. In some instances the baby will be discharged home prior to the planning meeting taking place. A decision of the planning meeting may be to proceed with an integrated assessment of the newborn child's needs and any potential risks.
- 11.3 Assessment is an ongoing process and the days following the birth can be a vulnerable time for both parent and child. It is therefore important to maintain liaison and collaboration between the key agencies in the post-birth period. Consideration should be given to the following:
- In the case of drug-using mothers there is an additional risk in some cases posed by the potential for the baby to have prolonged symptoms of withdrawal. This is particularly prevalent for women using Benzodiazepines as there is a potential for the baby to have delayed withdrawals. In some instances the baby may be discharged still in receipt of prescribed medication, and in such

instances additional medical and social work support should be provided.

- Babies should not remain in hospital longer than the time needed to complete any treatment or medical care that could not be provided safely in the community. Equally, babies should not be discharged from hospital to circumstances in which there will be a high level of risk or an inadequate level of support
- Hospital staff should always liaise with the Social Work Services CHCP team to discuss the discharge plan for the baby when there has been concern about the mother or her partner. Other services involved with the family should also be notified in order that they can provide appropriate support.

11.4 Inter-Agency Action Plans

All agencies have a shared responsibility to contribute to integrated assessment processes, arrange appropriate packages of support and contribute to Action Plans for vulnerable families.

Where there is a significant concern it is important that all intensive community based options are considered as an alternative to the baby being accommodated.

11.5 Specialist Residential Units that enable Mother and Baby to stay together

The admission of new babies to care placements, which cannot also accommodate the parent(s), may have a detrimental effect upon the bonding process, and should be avoided where possible.

In some circumstances consideration should be given during the assessment to accessing specialist residential services. These services can offer support regarding mental health difficulties or addiction etc.

11.6 Referral to Scottish Children's Reporter Administration (SCRA)

An overarching principle of the Children (Scotland) Act 1995 is that the level of intervention in the lives of families should be the minimum necessary to safeguard and promote the welfare of children. The referral of children to the Reporter should only take place when there is reason to believe that compulsory measures are needed to ensure the safety and welfare of the child.

11.7 Children requiring to be accommodated by the Local Authority

If the mother and her partner are not willing to allow suitable relatives to care for the child and the child needs to be accommodated, the mother and her partner should be asked to agree to the accommodation.

If they are not prepared to agree to this and the comprehensive assessment indicates that the baby will be at risk of significant harm then a Child Protection Order should be applied for.

12. Difficulties in Maintaining Contact

- 12.1 It can be very difficult either to establish or maintain regular contact with people who have complex needs or are vulnerable. Planned appointments or visits may not be kept and parents may not respond to letters or calls. Assessment should include both planned and unplanned home visits. It should include observation of any children in the household and of their interaction with their parents, information about daily routines and sleeping arrangements.
- 12.2 A number of inquiry reports have highlighted situations in which professionals failed to identify children suffering neglect and poor parenting resulting in significant harm. This occurred when parents refused entry to the family home and professionals did not persist until they obtained access to the child.
- 12.3 All agency staff should persist in their efforts to establish and maintain contact with the family, ensuring that they see the child. It is essential that professionals adopt an assertive follow up approach to ensure that the child is seen and are satisfied that the child is not at risk of significant harm.
- 12.4 Some families can appear to be “co-operating” although this is at times on a superficial level, i.e. services are getting in to the house but there is no up-to-date analysis of the family situation or evidence of outcome being achieved.
- 12.5 All inquiry reports have identified communication as a major concern. The O’Brien Inquiry in to the circumstances surrounding the death of Caleb Ness identified that there were a number of agencies involved with the family. Agencies did not communicate effectively with each other and there was no ongoing assessment of the child and his circumstances.

12.6 Even though professionals obtain access to a household, the child/ren in the family may not be seen. Staff should record every unsuccessful attempt to see the child/ren. It is essential that every child in the family is seen and assessed. One child's situation may be different from the others. When professional staff with responsibility for a child's welfare repeatedly fail to gain access to the children the Social Worker, their Practice Team Leader or the Operations Manager should be notified immediately. Consideration should be given to the need to apply for a Child Assessment Order, requiring parents to make the child available to professionals. If there is any concern that a child may be in immediate danger, consideration should be given to either contacting the Police or applying for a Child Protection Order.

12.7 **Working with parents who do not want Agencies involved**

Agencies in touch with families where there are worries about children's safety or welfare, should try to help the parent(s) understand agencies concerns about a child's welfare, and to motivate them to want to make changes necessary to promote and safeguard their child's welfare. They should discuss with the parent(s) the need for support from child protection agencies such as Social Work Services or SCRA. Referral to these agencies should generally be made with the parent(s) consent and knowledge unless it is felt that this will have an adverse consequence for the children's safety. Where the parent does not accept help or agree to a referral being made but worries about the child persist, the practitioner should initiate referral to Social Work Services without delay (see section 3).



Appendix 1

Shared Referral Form

1a. Referral Details

Name of Referrer	Agency	Designation	Postal Address (include postcode)	Email	Phone	Fax

1b. Designated Contact Person (if different from 1a)

Name of Referrer	Agency	Designation	Postal Address (include postcode)	Email	Phone	Fax

2. Referral To

Date of Referral	Time of Referral (AM or PM)	Name of Worker Spoken To	Designation	Is the Parent/Carer Aware of This Referral? Yes/No?	Is the Young Person Aware of This Referral? Yes/No?
Area/Hospital Social Work Team		Responsible Local Authority	Phone	Is This A Re-Referral From Your Service? Yes/No	If Yes, Please Enter Date(s) of Previous Referral(s)

3. Subject Of Referral

Child's Name	Other Name Known By	D.O.B. DDMMYY	Age	Gender (M/F)	Home Address (include postcode)	Ethnicity	Religion
1							
2							
3							

Preferred Language	Interpreter Required (specify)

Child Affected by Disability

Description	Communication Assistance Required (Specify)

4. Family Details

Mother's Name	D.O.B. (if known)	Other Name Known By	Current Address (if different from child)

Father's Name	D.O.B. (if known)	Other Name Known By	Current Address (if different from child)

4. Family Details (cont'd)

Family Address (include postcode)	Phone	Is Child Currently Resident At This Address? Yes/No	If No, State Address (include postcode)

Principal Carer's Details (if different from Mother/Father)

Name	D.O.B. (if known)	Relationship To Child	Address (including postcode)	Type Of Residence (if not at home)

Other Adults in Household

Any Other Significant Adult(s) (if known, please include contact details)

Name	D.O.B. (if known)	Relationship To Child	Name	D.O.B. (if known)	Address	Phone	Relationship To Child

Siblings not subject to referral

Child's Name	Other Name Known By	D.O.B. DD MM YY	Age	Gender	If In Relation To Unborn Baby or Mother Is Pregnant – Estimated Date of Birth

5. Summary Of Concerns

For all other referrals please complete the following:

If applicable please complete

Suspicion/risk of (factors relating to the child)	
Absconding	
Child Safety	
Education	
Emotional Care/Development	
Health – Illness/Disability	
Outwith Parental Control	
Physical Care/Neglect	
Self harm	
Sexual Exploitation	
Offender Behaviour	
Substance Misuse	
Other (please specify below)	

Suspicion/risk of (factors relating to parents/carers)	
Alcohol Abuse	
Asylum Seekers/Refugees	
Domestic Abuse	
Drug Abuse	
Housing/Accommodation	
Learning Disability	
Mental Illness	
Parenting	
Physical Illness	
Poverty/Financial	
Other (please specify below)	

Suspicion/risk of	
Physical Injury	
Emotional Abuse	
Physical Neglect	
Non-Organic Failure to Thrive	
Sexual Abuse	

6. Reason for Referral/Request for Services: (please record reason for concern and how this impacts on child. If applicable, please indicate alleged abuser. Indicate what action, if any, you have taken prior to the referral).

7. Agreed Actions (Actions agreed during phone referral)

8. Agency Involvement

Health	GP's Name	Address	Phone	Email
Health Visitor/School	Name of Health Visitor/School Nurse	Address	Phone	Email
Education (Nursery / School)	Name of School and Contact Person	Address	Phone	Email
Any Other Agencies (if known)	Name of Agency and Contact Person	Address	Phone	Email

Signature of Referrer _____ Please print name _____

Date _____

Signature of Line Manager (if applicable) _____ Please print name _____



during pregnancy

Glasgow Child Protection Committee
**Notification of concerns about
a child to Social Work Services**

Acknowledgement Notification of concerns about a child to Social Work Services
Social Work Services use only (Return to Referrer within 5 working days)

Insert Social Work Services Address

Family Name:

SWID No.

Date of Referral:

Request Treated As:

Outcome of Referral/request for Services:

Any other comments:

Practice Team Leader Signature:

Date:

Additional Information for Midwifery Services (2007)

Under Section 3

“Subject of referral” please insert “unborn child”

Child name please insert “unborn child”

Child age please insert “0” under age

Under Section 5

In addition to summary of concern outlined in section 5 please consider:-

Negative attitude towards birth

History / evidence of homelessness

Resistant of Professional intervention

Social isolation

Physical disability that may affect care of child

Previous child(ren) not living at home (insert details if known)

Previous child(ren) on Child Protection Register / Child Protection concerns
(insert details if known)

**Special Needs in Pregnancy (SNIPs)
Antenatal Criteria**

**Midwife Led Care
With Additional Needs
Identified**

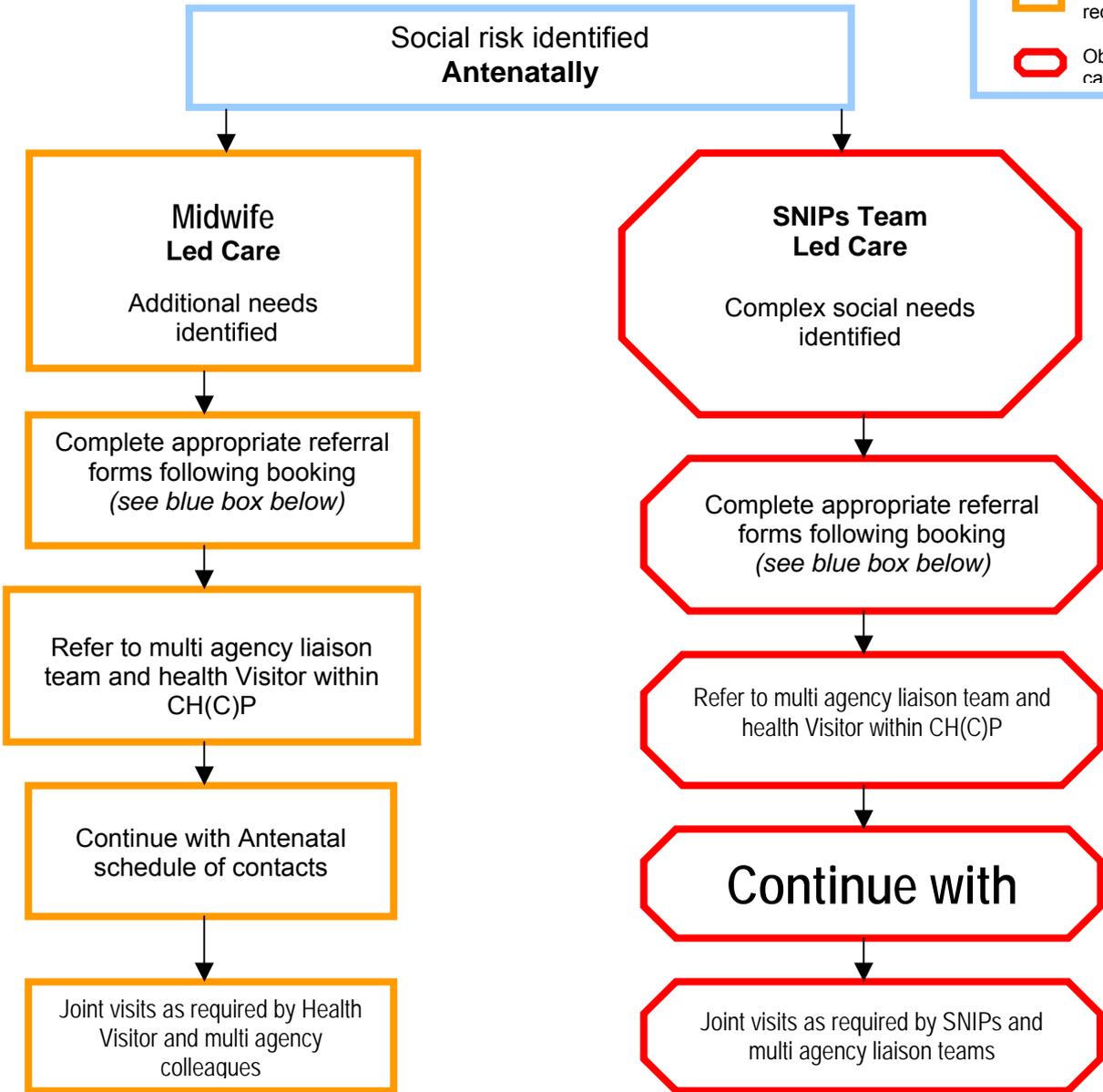
- Asylum Seeker/Refugee
- Gender Based Violence
- Would benefit from Social Work Support
- Women who are resistant to professional intervention
- Learning difficulties that could impact on parenting
- Domestic violence with child protection issues
- Homeless without other significant factors
- Living in supported accommodation
- Young mothers without other significant factors. To include:
 - Those living in supported accommodation
 - Those of educational age but not in education
 - Lacking social support from family/socially isolated
 - Experiencing mental ill health
 - Those with learning disabilities
 - Accommodated by local authority
 - Linked into leaving care services
 - Presenting with concealed pregnancy

**SNIPs Team Led Care
Complex Needs Identified**

- Substance misuse within the last 12 months
- Alcohol misuse within the past 12 months
- Woman and/or partner in criminal justice system
- HIV positive
- Child protection issues/concerns for this baby or any previous children whether or not currently with parents
- Significant mental health issues (refer to SGH Perinatal Mental Health Service) such as:
 - Previous history of bipolar disorder, schizophrenia or other psychotic illness, or previous admission to hospital for treatment of mental illness
 - Family member with history of bipolar disorder (mother/father/brother/sister)
 - Current mental health problem for example depression, anxiety disorder, psychotic symptoms, or there are current thoughts of suicide or self harm
- Complex homeless
 - Unaccompanied homeless minors seeking asylum/refugee
 - Illegal immigrants
- Asylum seeker or refugee with additional above factors
- Complex young mums or anyone under 16 years. To include:
 - Linked into leaving care services with complex needs
 - Those with identified or potential child protection concern
 - Receiving considerable social work support for complex needs
 - Concealed pregnancy with more complex needs
 - Pregnancy conceived under difficult circumstances and/or resulting from rape
 - Disengaged from mainstream maternity services
 - In the youth criminal justice system



**Special Needs in Pregnancy (SNIPS)
Antenatal Pathway**

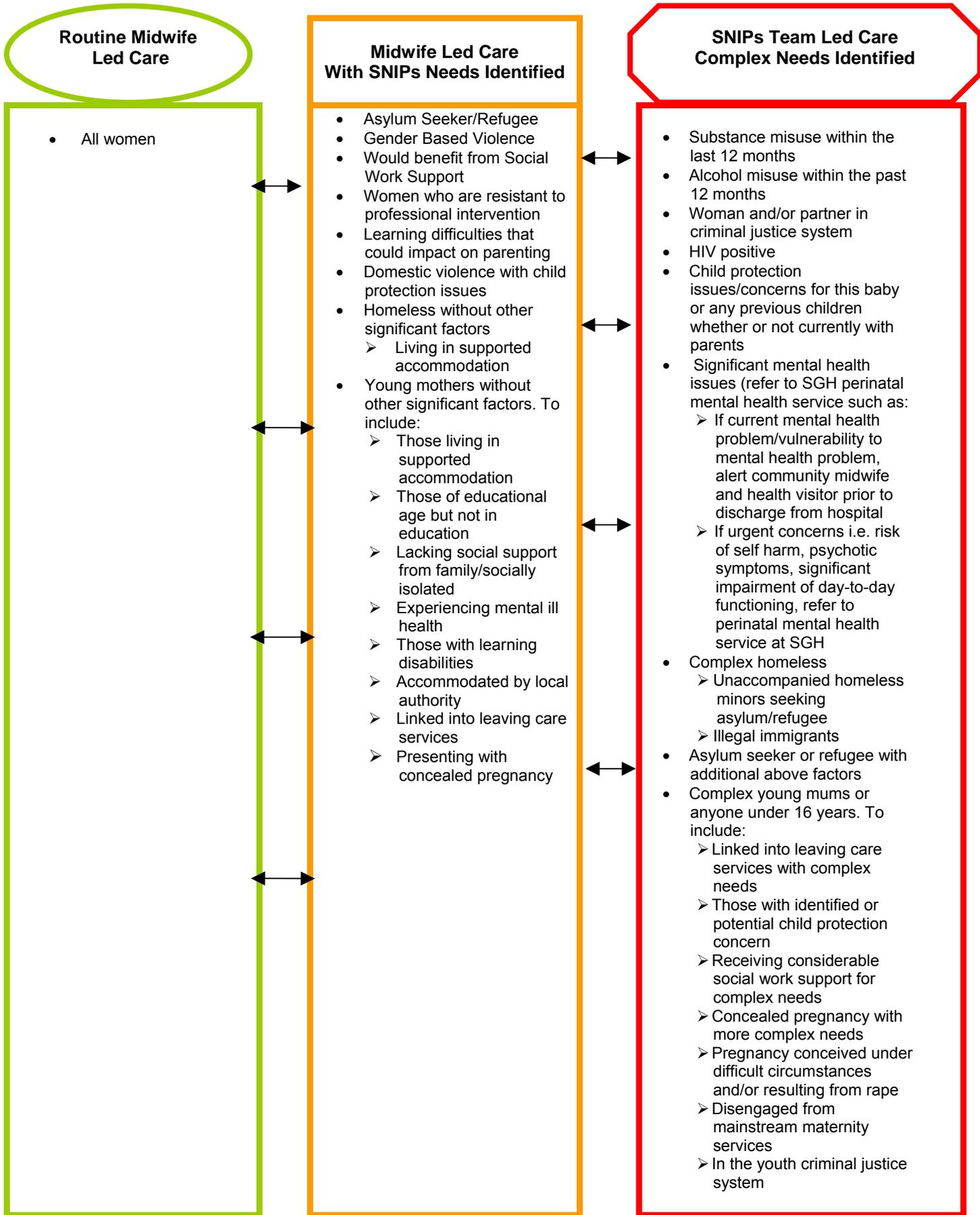


Referral Forms (such as)

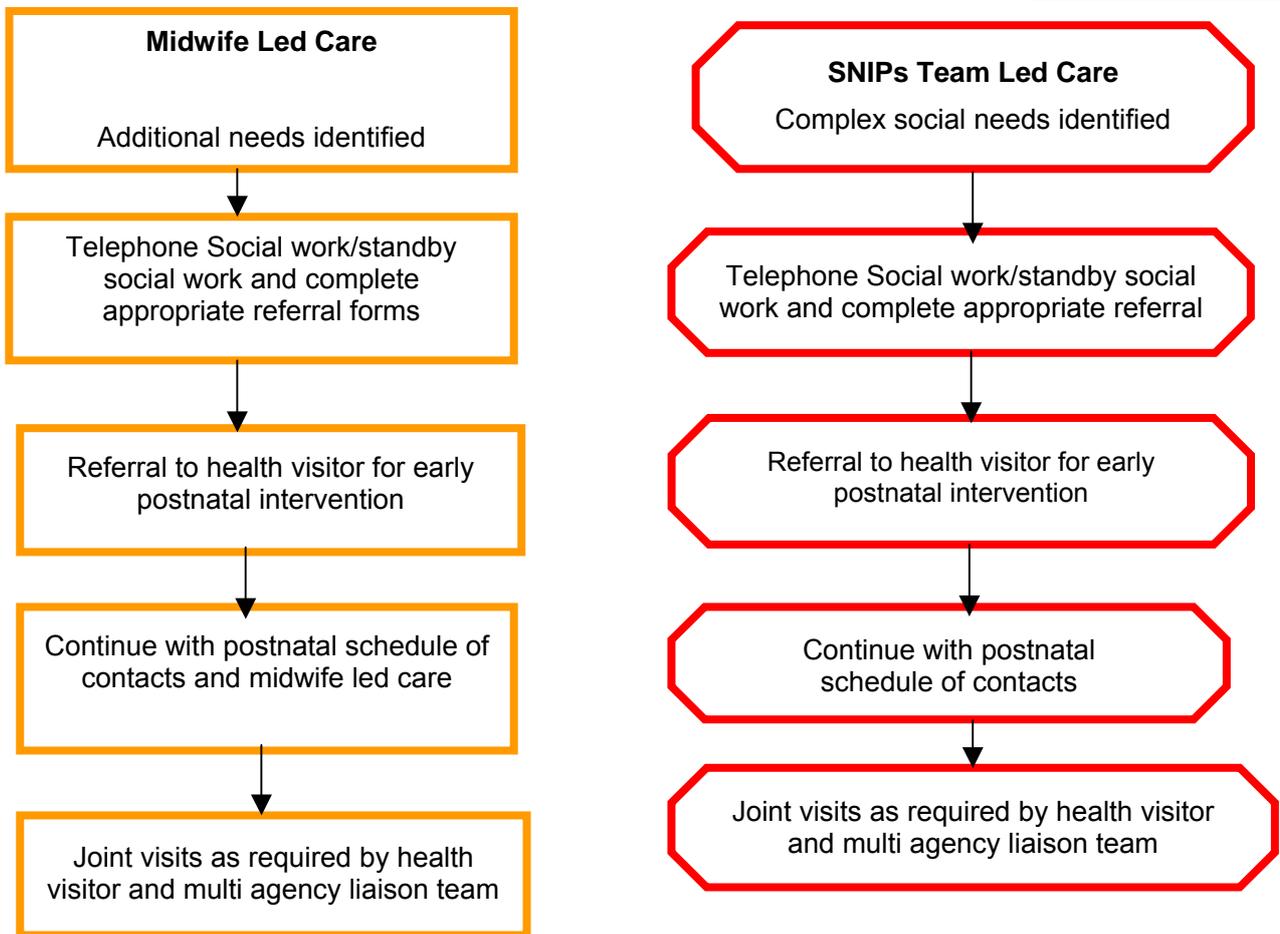
- “Notification of concerns about a child to Social Work Services”

<u>White copy</u> File in core case records with letters	<u>Yellow copy</u> Child protection Unit (CPU)	<u>Pink copy</u> Social Work Department
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- “SGH Perinatal Mental Health Team”
- “Link Midwife for Teenage Pregnancy”

Special Needs in Pregnancy (SNIPs) Postnatal Criteria



Special Needs in Pregnancy (SNIPs) Postnatal Pathway



Referral Forms (such as)

- “Notification of concerns about a child to Social Work Services”

<u>White copy</u> File in core case records with letters	<u>Yellow copy</u> Child protection Unit (CPU)	<u>Pink copy</u> Social Work Department
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- “SGH Perinatal Mental Health Team”
- “Link Midwife for Teenage Pregnancy”

NB. The Child protection Unit (CPU) are available for advice should this be required.



Supports for Young Parents

The Young People's Sexual Health Steering Group, a partnership between Glasgow City Council (GCC) and NHS Greater Glasgow & Clyde (GGC), have created two posts to contribute to the development in the City of a systematic and integrated support for young people who become parents at an early age.

Since July 2007 a dedicated Link Midwife approach for pregnant teenagers has been adopted within the Glasgow Division of NHS GGC. Using a three-tiered model of assessed need, the Link Midwife (Teenage pregnancy) will support community-based midwives to deliver more responsive services to young people up to the age of 19 years. Depending on the level of need and vulnerability, the Link Midwife can offer flexible and tailored supports directly to young women, their families and partners and/or to a range of professionals.

Operational since January 2008, the post of Support & Re-integration Officer has been developed to ensure that school age young women, who are either pregnant or who have had their babies, are afforded social and educational opportunities to maximise their full potential. The post-holder will support young women to continue and/or return to learning both before and after the birth by co-ordinating and brokering packages of individual support from a wide range of services. The post will support young women up to the age of 19 years as long as they remain registered as a school pupil.



Social Work Services Pre-Birth Initial Assessment (CP12)

Client / Service User Details			
Name	Address	DOB	Status (single/married/cohab)

Partner Details			
Name	Address	DOB	Putative Father (yes/no)

Next of Kin		
Name	Address	Relationship

Agencies involved for example Addiction Worker, GP, CPN			
Role	Name	Address	Tel No

Other Children (Full Name)	Hospital Child Born	Correct Gestation (Yes/No)	Delivery (Normal/Section)	Baby's Weight	Date Mother Discharged from Hospital	Date Baby Discharged from Hospital	Was Baby admitted to Special Care

Family Details
 Include Family Composition, Family Circumstances, Present Status

General Health
 Comment on any current issues – drug or alcohol, mental health, self harm, learning disabilities, smoking or others. Also comment on any history of the above issues. Comment on partner's general health, paying attention to the above list.

Agency Involvement
 Outline involvement of all agencies, including non-statutory agencies

1.	Ongoing support will be provided through current plan – no referral to WRHS	Comments

2.	Ongoing work with referral to WRHS for additional support	Comments

Delivery Details					
Proposed Hospital	Midwife	EDD			

Name	Designation	Date	Signature
	Assigned Worker		
	PTL / Team Leader		
	Operations Manager		



Pre-Birth Comprehensive Inter-Agency Assessment (CP13)

To be completed by Assigned Worker for 28 - 32 Week Case Conference

Client Details			
Name	Address	DOB	Status

Clinic Details					
Clinic	Named Midwife	1st Attendance	EDD	UNO	Parity

Partner Details			
Name	Address	DOB	Putative Father (yes/no)

Next of Kin		
Name	Address	Relationship

Other Children - Full Name	Hospital Child Born	Correct Gestation yes/no	Delivery Normal/Section	Baby's Weight	Date Mother Discharged from Hospital	Date Baby Discharged from Hospital	Was Baby admitted to Special Care

Social & Environmental Circumstances

General, support networks, parental history, any periods of accommodation, financial assessment or others

Health

General history in relation to pregnancy, alcohol, drugs, mental health problems, learning disability, HIV, hepatitis or others

Comment on the ability of both parents to meet the child's needs

Consider other children, parenting skills, relevant background factors, parents relationship, domestic abuse

If appropriate, comment on drug / alcohol use, history / mental health issues / learning disability

Include information on both parents

Assessment (including child care concerns / risk factors)

Negative & positive aspects of parenting, relationships, future arrangements for child.

Needs, risks, general future well-being of child, implications for future work with child and family

Action Plan

Actions to be taken (include what is expected of parents)	Person / Agency responsible	Timescale	Expected Outcome

Actions to be taken (include what is expected of parents)	Person / Agency responsible	Timescale	Expected Outcome

If recommending need for Case Conference, give proposed date

Name	Designation	Date	Signature

Guidance Notes

Comprehensive Assessment For Use With Vulnerable Women

Introduction to the assessment framework

Vulnerability does not in itself imply their children require formal child protection measures but it may be of concern and require the intervention of social work services. A multi-agency assessment will identify those situations where a service is necessary to ensure children's needs are adequately met. In a pre-birth assessment of a mother/parents capacity to provide appropriate care to their expected baby the vulnerability of the baby needs to be given priority.

This assessment guidance should assist in information gathering, which leads to an informed assessment, and in turn aids decision-making. The assessment will inform the Pre-Birth Case Conference and subsequent care planning process including IAF.

It is important to evidence your responses and separate fact from opinion. During the assessment it is expected you will be in contact with other relevant agencies. Should clear discrepancies emerge between the information presented by the mother/parents to that presented by other involved parties, these discrepancies should be clearly recorded within the assessment.

Pre-Birth Assessment and Links with Glasgow's Integrated Assessment Framework

This Guidance relates specifically to the assessment of the pregnant woman's needs and her ability to parent as a consequence of her vulnerability. However, the early gathering of information with regard to parenting capacity will inform and significantly contribute to any future Integrated Assessment carried out in relation to the newborn child or other children within the family. Where a decision of either a post birth case conference or a post birth planning meeting, is that an Integrated Assessment should be undertaken with regard to the child, the early information gathered during the mother's assessment will significantly contribute to integrated assessment processes.

This guidance has been written with reference to the Assessment Triangle as outlined in Glasgow's Integrated Assessment Framework, This guidance has taken account of the domain "What I Need From People Who Look After Me", and information gathered during the pre-birth process will inform pre and post birth planning processes including IAF. It will not be possible to comment on all areas of assessment within the domain, as this information may not be available during the pre-birth assessment process.

1. Planning and Preliminary Considerations

Central to the principles of working in partnership is the need to demonstrate openness, to share information, to consult appropriately, to involve parents in the process, and to offer an adequate structure for reparation and complaint.

The process should be open to the scrutiny and influence of the mother/parents without jeopardising the safety and welfare of the child.

In undertaking the assessment it is important to:

- Ensure that the mother/parents and other significant family members know that the child's safety and welfare must be given priority.
- Consider the strengths and potential of the mother/parents and any other significant family members or relationships.
- Be open and honest about your concerns and responsibilities. This includes being clear about your power to intervene.
- Listen to the concerns of the mother/parents and take care to learn about their understanding, fears and wishes before arriving at your own explanations and plans
- Ensure that mother/parents know their responsibilities and rights, including the right to services, and their right to refuse services and any consequence of doing so
- Be sensitive to ethnic, cultural and religious needs.

2. Social and Environmental Circumstances

Clearly adverse material conditions are an important contextual source of stress that can undermine individual psychological resources, couples relationships and parenting behaviour.

A comprehensive assessment should include consideration of the physical environment within the home and the local environment. There are a number of external environmental factors which can affect a family's overall ability to function well such as poor access to resources and amenities, high levels of criminal activity, exposure to negative factors (i.e. alcohol and/or drug problems, harassment and stigmatisation).

The process of assessment should include information in relation to:

- The living conditions of the mother/parents.
- The extent of social and professional contacts (is mother/parents deliberately avoiding help and deliberately alienating themselves).

2.1 General

- If standards of cleanliness are an issue this should be addressed. It is important, particularly in cases characterised by physical neglect, to explore conditions throughout the house accessing key areas (bedrooms, toilet and kitchen).
- This process of exploring the conditions of the home should allow you to ascertain if their home is used by others i.e. living there or visiting regularly. Suspicions about drugs being supplied from the family home should also be considered.
- Is the condition of the home so poorly maintained that it would pose an immediate threat to a child's welfare (unsafe, filthy or hazardously overcrowded)? Consideration should be given to where drugs (prescribed or otherwise) are normally kept, and how accessible they are to a young child.
- Establishing whether the poor conditions have been a short or long-term problem is also important.
- Will the home environment provide adequate stimulation and safety measures appropriate to each child's age and stage of development
- Do the mother/parents have trouble in managing finances? Do they have debts and to whom for example money lenders or others? Are some of these debts related to their vulnerability? Has "money advice" been given? Has a comprehensive benefit check been undertaken?

2.2 Network of Supports

The quality of social support is important. An individual may have familial and social contacts, but these may not be supportive or alleviate the stress of childcare. There is a need to confirm:

- Level of involvement with specialist services
- If any members of the extended family are aware of the women's, vulnerability and the potential impact this may have on their unborn child
- Have any members of the family been particularly supportive to the woman?
- Are there members of the family who would be deemed vulnerable?
- How involved/supportive family/friends are likely to be following the birth
- Areas of conflict within the extended family

3. Health

The following information should be gathered:

- Brief medical history of the mother and any previous pregnancies
- Details of any hospital admissions and any ongoing treatments
- Present health problems and attendances at clinics
- Any significant past medical history in relation other children

3.1 Pregnancy

Antenatal – The frequency of contact and any significant observations/concerns should be ascertained. It is helpful to establish at what stage in the pregnancy the women registered for antenatal care. The following should be considered:

- The mother's attitude towards the pregnancy – has this remained consistent?
- Is the mother's general health, good or poor? Are there concerns regarding adequate diet and lifestyle?
- What is the partner's attitude to the pregnancy?
- How co-operative is the mother and her partner with medical staff?
- Is the mother experiencing any obstetric problems and/or has she in the past?
- Knowledge of any foetal health problems.
- Are the mother and her partner practically prepared for the baby's arrival?
- How aware are the parents of their vulnerability and how this may impact on their ability to parent.

4. Parenting

Children depend on positive direction and guidance from adults. Parents should be available and responsive to the child's needs, in ways appropriate to his or her age and stage of development.

Parents who have been abused or neglected as children may have low expectations of others and themselves. Low self-esteem may impact on the parent/child interactions and is a risk factor in cases of neglect.

If the mother exhibits signs of immaturity; self-absorption; low self-esteem; lack of empathy; depression; lack of impulse control or irresponsibility, this may place a child at an increased risk of abuse or neglect, an evaluation of

the quality of the relationship between the parent and any older children is essential.

4.1 Older Children

If the mother/father has an older child(ren), it is necessary to assess the parenting history of that child in order to begin to evaluate their ability to parent their latest child. **It is important to keep in mind that the process of assessment may uncover significant concerns in relation to other children which social work and other agencies were not previously aware of.** This should form part of the assessment, irrespective of whether they continue to have care of the older child(ren).

Older children may value the opportunity to talk about their parent(s) vulnerability and what this means to them.

- If they have an older child(ren) but have never had their full-time care, then an assessment of the level of contact, strength of relationship and co-operation with substitute carers needs to be considered.
- An evaluation of any previous accounts of parenting needs to be considered in conjunction with the current circumstances of the mother/parents and what they intend to do differently. In particular if there is a significant difference in lifestyle, living conditions, relationships and attitude to the pregnancy, self-care and co-operation with all the agencies involved.
- The degree to which they acknowledge events in the past will also assist in establishing if sufficient progress has been made.
- Achievement of developmental tasks should be central to the assessment of older children. Neglected and abused children suffer from the omission of parental care, attention and affection: as a consequence, their physical and psychological development, tend to be impaired. Poor developmental attainment may result in behavioural and emotional problems in children.

4.2 Parents' Relationship

The strengths and weaknesses should be explored, in particular the following should be considered:

- Stability of the relationship (periods of separation)
- Quality of the relationship – how supportive, open and inter-dependent is it?
- Do they support or undermine each other?
- Areas of harmony and major disagreement
- Who does what in terms of responsibilities?

- If there are problems – do they both appear to be motivated to change the relationship?
- Do they have any difficulties communicating with each other?
- Do they cope with stress together/separately?

5. Drug History

When a mother/father's alcohol and/or drug problem is seen as a major factor of concern, a comprehensive assessment of the relationship between the pattern of alcohol and/or drug use and the future level of childcare needed is required.

Where the mother or both parents have chaotic or dependent alcohol and/or drug problems, family life will be affected although children may not be at risk of significant harm.

It is important to establish alcohol and/or drug history of both the woman and her partner. In particular:

- What age did she/he first start using alcohol and/or drugs?
- How old was she/he when they first started using alcohol and/or drugs on a regular basis?
- With whom did they start using alcohol and/or drugs?
- Why did she/he start using drugs?

6. Analysis

6.1 General

Family circumstances must be constantly re-evaluated as new information becomes available. It has been identified in a number of inquiry reports, that workers have readily accepted what parents have reported as fact. It is essential that workers check information and constantly re-evaluate what is being presented to them.

Assessments may indicate that there is sufficient evidence to warrant intervention/support, even if legal/compulsory measures of care are not required. It is important for the mother/parents to know by what criteria they are being assessed.

The full circumstances of the mother/partner should be evaluated and considered when reaching a recommendation on future action. The extent and appropriateness of future action should be considered in the context of:

- The danger of mistreatment/ significant harm to the child
- The best interests of the child
- The future well-being of the family
- The no order principle

This section should attempt to identify both protective factors and risks of current parenting, relationships, and future arrangements for the child, needs, risks, and general future welfare of the child. Reference should be made to the implications for future work with the child and family as a consequence of their involvement in the assessment process.

7. Recommendations and Proposed Care Plan

7.1 General

This should include detailed recommendations for future action and resource requirements. It is important to share conclusions and recommendations with the mother/parents when developing the care plan.

Decisions will be based on:

1. Mother/parents acceptance of agency concerns
2. Willingness to co-operate and engage with others to minimise concerns
3. Their capacity for change
4. The level of stability within their current lifestyle
5. Strength/stability of parents relationship
6. Control of their alcohol and/or drug use
7. Impact of their vulnerability (i.e. mental health, learning disability)
8. Co-operation with treatment plan
9. Levels of support from family, friends, professionals, or others
10. Co-operation of all agencies involved in taking forward the action plan

7.2 Recommendations

1. No further action
2. Continued voluntary support in conjunction with other agencies
3. Referral to SCRA
4. Registration of child on the Child Protection Register
5. Emergency measures to remove the child, i.e. child protection order
6. Short term voluntary separation (section 25 Children (Scotland) Act 1995)
7. Separation of the child from the mother/parents with a view to permanency

Invitation Checklist for all Pre and Post Birth Case Discussions and Child Protection Case Conferences

For a thorough assessment of risk to the expected baby the following agencies should be involved in contributing to the comprehensive assessment and invited to:

- The Pre-Birth Case Conference (28 - 32 weeks)
- The Post Birth Child Protection Case Conference.

Invite List:

- Parent(s) and/or any other relevant family member(s) who would be central to the support of the family
- Practice Team Leader, Social Worker, Care manager, social care worker
- Social worker from another discipline if appropriate
- Home Support and Day Care Organiser
- Senior Addiction Worker/PTL
- Relevant hospital based Social Work staff
- GP
- Health Visitor
- Obstetrics - Consultant, Midwifery
- Paediatrics – Consultant Midwifery
- Police (FACU) if considered appropriate
- Parenting Support Team

Note:

1. In order to assist medical/nursing staff to attend a child protection meeting it may be helpful to schedule the meeting either prior to or after the ante natal clinic.
2. A copy of assessment report (CP13) and minute (CP5) should be sent to:
 - All professional staff in attendance
 - All professional staff who were invited and did not attend
 - Parent(s) if attending the whole meeting
 - To social work centre – Principal Officer (Child Protection)



Inter-Agency Post Birth Action Plan

Child Details

Name of Child	DOB	Ethnicity
Home Address	Current Address (if different)	

Parent / Carers Details

Parents / Carers Name	DOBs	Ethnicity
Address		

Meeting Details

Date of Meeting
Present
Apologies
Reason for Meeting

Further Reading / References

Getting our Priorities Right: Good Practice Guidance for working with Children and Families affected by Substance Misuse

<http://www.scotland.gov.uk/Publications/2003/02/16469/18705>

Hidden Harm – Responding to the needs of children of problem drug users, ACMD <http://drugs.homeoffice.gov.uk/publication-search/acmd/hidden-harm>

Scottish Executive's response to Hidden Harm

<http://www.scotland.gov.uk/Resource/Doc/26350/0012816.pdf>

Aberlour Think Tanks http://www.aberlour.org.uk/pdfs/priorities_final.pdf

<http://www.aberlour.org.uk/pdfs/MatterOfSubstanceReport.pdf>

Its Everyone's Job To Make Sure I'm Alright

<http://www.scotland.gov.uk/Publications/2002/11/15820/14009>

Getting It Right For Every Child

<http://www.scotland.gov.uk/Publications/2006/06/22092413/0>

Glasgow's Integrated Assessment Framework.

Inter-Agency Guidance on Working with Hostile & Uncooperative Families. Glasgow Child Protection Committee.

Good Practice Guidelines for Workers Supporting Women Who Are Living With An Abusive Partner. Greater Glasgow Training Consortium.

Finding the Right Support? A review of issues and positive practice in supporting parents with learning difficulties and their children. Tarleton B, Ward L & Howarth J. North Fry Research Centre University of Bristol. 2006.

The Baring Foundation.

<http://www.baringfoundation.org.uk>

Fair for All Disability – Tip Card (Communication advice for working with people with disabilities). RCGP Scotland. NHS July 2007

<http://fairforalldisability.org>

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