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# ***SAFEGUARDING THE UNBORN BABY***

**Safeguarding Children and Young People  
North East England  
Regional Inter-agency Procedures**

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Additionally, there is a special note of appreciation to Martin A. Calder, MA, CQSW, who has very kindly given permission for the use of his article *Unborn Children: A Framework for Assessment and Intervention* in 'Assessment in Child Care: Using and Developing Frameworks for Practice' (Eds Calder M.C. and Hackett S. 2003) Russell House Publishing.

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## **PREFACE**

### **Status of the Document**

The procedure in this document applies to all staff of agencies represented on the Area Child Protection Committees (ACPCs) and Local Safeguarding Children Boards (LSCBs) in the North East of England. Staff of these agencies should:

- Comply with the procedures contained in this document, unless there are exceptional reasons, which should be recorded.
- Take account of the rest of the contents.

ACPCs/LSCBs and their constituent agencies should ensure that any other inter-agency or internal procedures/guidance/protocols are consistent with this document.

### **Principles**

- All children and young people should be safe and able to develop to their full potential.
- The needs of the child or young person are paramount and should underpin all work to safeguard children.
- All children and young people deserve the opportunity to achieve their full potential.
- All children and young people have the right to be safeguarded from harm and exploitation whatever their:
  - Race, religion, nationality, first language or ethnicity
  - Gender or sexuality
  - Age
  - Health, physical or learning disability
  - Location or placement
  - Criminal behaviour, where this applies
  - Political or immigration status.
- Responsibility for the protection of children and young people must be shared because they are safeguarded only when all relevant agencies and individuals accept responsibility and co-operate with one another.
- Statements or allegations about abuse or neglect, made by children and young people, must always be taken seriously.
- The wishes and feelings of children and young people, which are vital elements in assessing risk and formulating protection plans, must always be sought and given weight, according to the level of understanding of the child or young person.
- No child or young person should be allowed to feel responsible for actions taken by professionals, nor for the outcomes.
- During enquiries, the involvement and support of those who have parental responsibility for, or regular care of a child or young person, should be encouraged and facilitated, unless doing so compromises that enquiry or the immediate or long term welfare of the child or young person.

“The basic requirement that children are kept safe is universal and cuts across cultural boundaries. Every child living in this country is entitled to be given the protection of the law, regardless of his or her background. Cultural heritage is important to many people, but it cannot take precedence over standards of childcare embodied in law. Every organisation concerned with the welfare and protection of children should have mechanisms in place to ensure equal access to services of the same quality, and that each child, irrespective of colour or background, should be treated as an individual requiring appropriate care.”

### **Victoria Climbié Inquiry Report 2003**

## **1. LEGISLATION - MAIN ACTS**

### **1.1 Children Act 1989 Section 17**

A child is defined as 'in need' by Section 17 of the Children Act (1989) if:

- he or she is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services or
- his/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services or
- s/he is disabled.

### **1.2 Children Act 1989 Section 47**

Where a local authority has reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

'Harm' is defined as ill treatment, which includes sexual abuse, physical abuse and forms of ill-treatment which are not physical, for example:

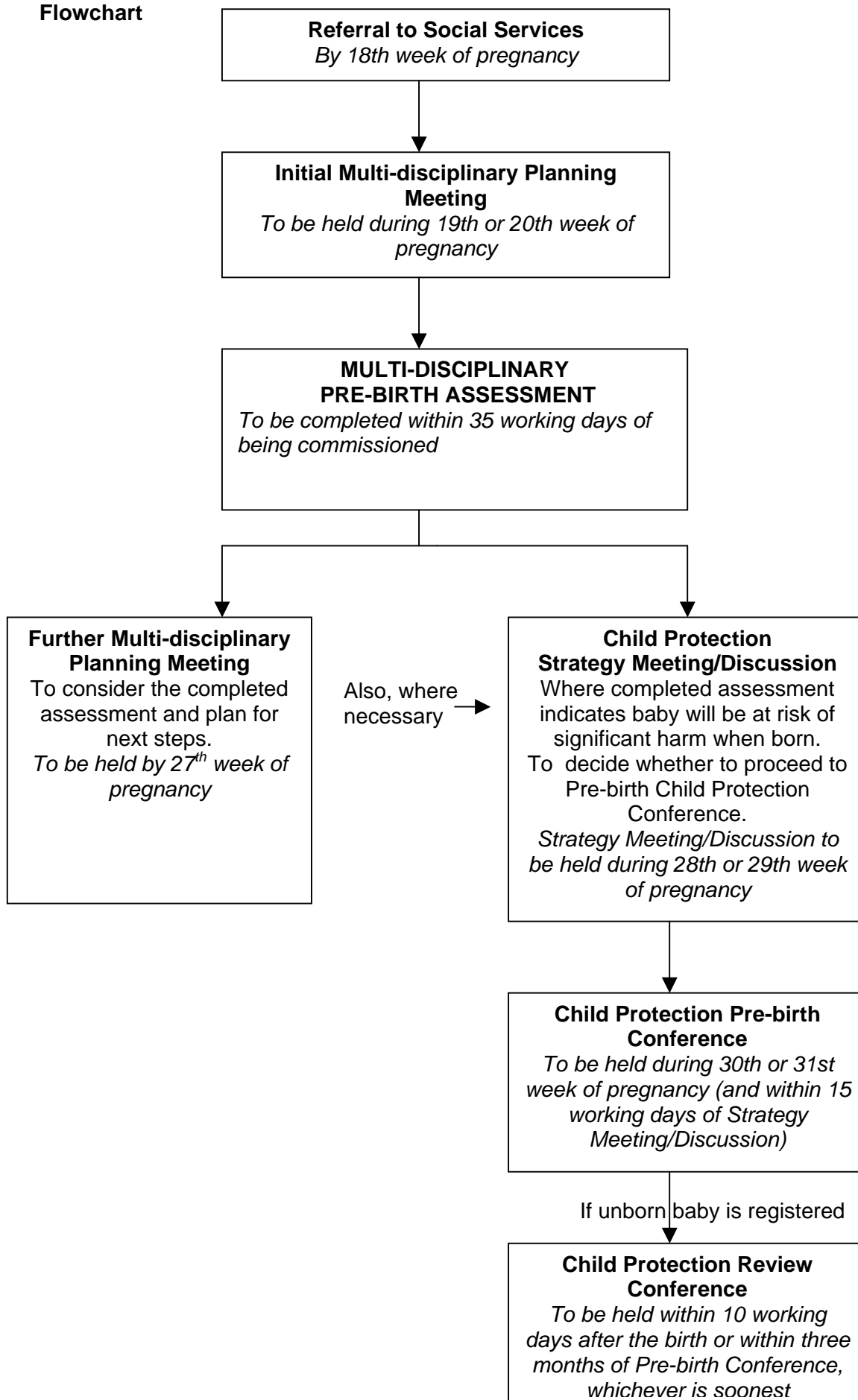
- emotional abuse or
- impairment of health (physical or mental) or
- impairment of development (physical, intellectual, emotional, social or behavioural)

This may include seeing or hearing the ill treatment of another (s120 Adoption and Children Act 2002).

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## 2. INTER-AGENCY PROCEDURES

### 2.1 Flowchart



## **2. INTER-AGENCY PROCEDURES**

### **2.1 Flowchart**

See previous page.

### **2.2 Referral to Social Services**

Where a practitioner anticipates that prospective parents may require support services to care for their baby or that the baby may be at risk of significant harm, a referral is to be made to Social Services. (Where Social Services are already working with the family the Team Manager/Social Worker should ensure that this referral is made).

Wherever possible, the referrer should share their concerns with the prospective parent(s) and seek to obtain agreement to refer to Social Services, unless this action may place the unborn child at risk, for example, through termination of the pregnancy or the parent(s) possibly making their whereabouts unknown.

The referral should be followed up in writing within 48 hours. Social Services should acknowledge receipt of the referral and decide on the next course of action within one working day, also give feedback to the referrer.

### **2.3 Timing of Referral to Social Services**

Referrals to Social Services about unborn babies should be made by the 18<sup>th</sup> week of the pregnancy, unless it has not been possible to meet this timescale, for example, because the pregnancy has been concealed.

Referring to Social Services by the 18<sup>th</sup> week:

- Provides sufficient time for a full and informed assessment.
- Avoids initial approaches to parents in the latter stages of pregnancy, as this is already an emotionally charged time.
- Enables parents to have more time to contribute their own ideas and solutions to concerns and increases the likelihood of a positive outcome.
- Enables the provision of support services so as to facilitate optimum home circumstances prior to the birth.
- Provides sufficient time to make adequate plans for the baby's protection, where this is necessary.

### **2.4 Multi-disciplinary Pre-birth Assessment**

A multi-disciplinary pre-birth assessment must always be undertaken where the following circumstances apply.

- Where previous children in the family have been removed because they have suffered harm or been at risk of significant harm.
- Where a person who has been convicted of an offence against a child, or is believed by child protection professionals to have abused a child, has joined a family.
- Where concerns exist regarding the mother's ability to protect.
- Where there are acute professional concerns regarding parenting capacity, particularly where the parents have either severe mental health problems or learning disabilities.
- Where alcohol or substance abuse is thought to be affecting the health of the expected baby, and is one concern amongst others.

- Where the expectant parent(s) are very young and a dual assessment of their own needs as well as their ability to meet the baby's needs is required.
- Where the child is believed to be at risk of significant harm due to domestic violence.

The above list is based on the work of Calder (2003) with the addition of the last bullet point.

## **2.5 Initial Multi-disciplinary Planning Meeting**

An initial multi-disciplinary planning meeting must be held to plan the pre-birth assessment.

The meeting should be convened by Social Services and arranged at a time when relevant professionals can attend. It should be held during the 19th or 20th week of pregnancy.

Agencies/professionals who should be invited to, and who should attend, the meeting include:

- Social Services Team Manager and Social Worker
- Identified Midwife
- The likely Health Visitor
- The family GP (Calder 2003 proposes that it may be more realistic for the Health Visitor to collate any relevant health information and bring it to the meeting).
- A representative of any local family centre or equivalent, where appropriate.
- Any other professional involved with the family.

It is essential that information held by the Police and by the Named Nurse for Child Protection (or equivalent) is obtained.

The meeting should specify what type of multi-disciplinary pre-birth assessment is to be undertaken (see 2.6 below).

A date must be set for a Further Multi-disciplinary Planning Meeting to receive the completed multi-disciplinary pre-birth assessment report (see 2.7 below).

## **2.6 Undertaking the Multi-disciplinary Assessment**

**A model (Calder 2003) of a multi-disciplinary pre-birth assessment is given in Section 3. The use of Calder's model is highly recommended.**

Parents should throughout be involved in planning as far as possible.

The assessment is to be completed within core assessment timescales of 35 working days from being commissioned.

## **2.7 Further Multi-disciplinary Planning Meeting**

The completed multi-disciplinary pre-birth assessment report should be considered at the Further Multi-disciplinary Planning Meeting. This meeting should be held by the end of the 27<sup>th</sup> week of the pregnancy.

The report should include conclusions and recommendations in relation to support of the baby and family. It should also, where necessary, include recommendations about intervention to protect the baby when born.

The Further Multi-disciplinary Planning Meeting is to consider the assessment report and make plans about next steps in relation to support and any necessary intervention to protect.

## **2.8 Child Protection Strategy Meeting/Discussion**

If the conclusions of the pre-birth assessment are that the baby, when born, is likely to be at risk of significant harm, a child protection Strategy Meeting or Strategy Discussion must take place. This must include Child Protection Police and the Named Nurse for Child Protection.

The Strategy Meeting/Discussion is to be held during the 28th or 29th week of pregnancy.

If the Strategy Meeting/Discussion concludes that it is likely that an inter-agency protection plan is required to safeguard the baby when born, arrangements are to be made for a Pre-birth Child Protection Conference to take place. This applies whether or not Social Services intend to take legal proceedings in respect of the child.

## **2.9 Pre-birth Child Protection Conference**

A Pre-birth Child Protection Conference is an Initial Child Protection Conference concerning an unborn child. It carries the same status and conveys the same purpose as an Initial Child Protection Conference.

This Conference is to be held during the 30th or 31st week of pregnancy and within 15 working days of the Strategy Meeting/Discussion.

It is essential that midwifery services are represented at the Conference.

A report from the Social Worker, which should include an outline of the pre-birth assessment process, the conclusions and recommendations for future action, is to be made available to the Conference.

## **2.10 Pre-birth Conference: Protection and Support Planning**

If it is decided to place the unborn baby's name on the Child Protection Register, the protection plan is to make explicit the actions to be undertaken, and by whom, immediately following the baby's birth. This is to ensure the baby's protection until the Review Conference is held. Points to be included in the protection plan are:

- Identification of the Core Group members, including Key Worker, Co-worker, Midwifery Services, Health Visitor, Parent(s) and others as necessary.
- Specifications regarding any continuing assessment in terms of what has to be done and by whom.
- Support services required, including the period mother is in hospital.
- That if concerns arise at a Core Group meeting, the Core Group should consider the need for an immediate return to a Child Protection Conference.
- Contingency arrangements if the protection plan is not succeeding.
- That legal advice should be sought where necessary.
- The Hospital to have contact details of the Key Worker/Team Manager.
- The Hospital to inform Social Services when the baby is born.
- The expectation that the parent(s) will follow medical advice regarding discharge of the baby.
- Specific action required to ensure the protection of the child in the period between birth and the Review Conference, including the time the baby is in hospital.
- The name of any identified person who should not have contact with the baby.

- A statement to say whether the baby should go home with parent(s) or not.
- Where the plan is that the baby should not go home with the parent(s) the action to be taken should there be any attempt to remove the baby from the hospital, including consideration of Police Protection or Emergency Protection Order.
- Where the baby is not to go home with the parent(s), the contact arrangements and whether this is to be supervised and by whom.
- Where appropriate, details of alternative carers.
- That a copy of the protection plan and Conference minutes are to be sent to the Named Midwife for Child Protection and the Team Manager of the Social Services Emergency Duty Team (or equivalent).
- That if the baby is transferred or placed in a different hospital, a copy of the protection plan is to be sent immediately to the new venue.

The Pre-birth Conference must set a date for the Child Protection Review Conference, (see 2.11 below). Note that where, exceptionally, the Pre-birth Conference decides to wait longer than 10 working days after the birth, as given below, there should be a statement in the Minutes of the Pre-birth Conference as to why this was agreed.

Where a Pre Birth Child Protection Conference is held and the child's name is not placed on the Child Protection Register, but it is considered that the child will be in need, the Conference should make recommendations in respect of support for the baby and family.

## **2.11 Child Protection Review Conference**

The Child Protection Review Conference should be held within 10 working days after the birth of the baby, or within three months of the Pre-birth Conference, whichever is the soonest.

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### **3. INFORMATION FOR GOOD PRACTICE**

#### **3.1 Pre-Birth Assessment (Calder 2003)**

The following is a model of good practice and is highly recommended. It is reproduced with the kind permission of the author Martin Calder. The full text is found in *Unborn Children: A Framework for Assessment and Intervention* by Martin C. Calder in 'Assessment in Child Care: Using and Developing Frameworks for Practice' (Eds Calder M.C. and Hackett S. 2003) Russell House Publishing.

Calder gives a process for undertaking a thorough multi-disciplinary assessment, the multiple possible components which may be appropriate to a wide range of presenting circumstances and a matrix to determine the level of projected risk once the baby has been born.

The following is based on Calder's work.

#### **3.2 Possible Professional Issues**

Professional issues which may need acknowledging and addressing with professionals at the outset of any pre-birth risk assessment include:

- The perceived and actual consequences of making a wrong decision in high-profile, high concern cases.
- The consequences for professionals of deciding for removal at birth - possibly lengthy and demanding legal proceedings.
- Feeling bound by the conclusions or views of previous professionals and any variation now may be perceived as disloyal.
- The number of factors for consideration in the assessment that are rarely part of the professionals direct experience.
- The emotive nature of such work, particularly when coupled with a strong view about removing children at birth.

#### **3.3 Planning**

Calder recommends that planning is on a multi-disciplinary basis.

The task of the Initial Multi-disciplinary Planning Meeting is to collate all the relevant family and agency history and determine the form of the assessment.

Parents and relevant family members should be involved in planning as far as possible.

#### **3.4 Components of the Pre-birth Assessment**

The following components should be considered for each assessment and they could usefully be used as an agenda for planning.

- Definition of the problem - what is the purpose and scope of the assessment?
- Ante-natal, medical and obstetric history
- Full social history
- Current family structure, extended family and potential support
- The parental relationship and family support
- Family functioning and strengths
- Previous abuse or convictions, including any previous assessments, with any increased acceptance of responsibility or major changes
- Family attitudes towards previous action / professional involvement, and ability to

engage them in the current intervention process (note that it is important to engage *both* parents in the assessment process).

- Assessment of non-abusing parent's ability to protect
- Understanding of expected baby's needs and ability to meet them
- Future plans
- Alcohol using parents and anticipated health problems
- Drug using parents and anticipated health problems
- Measuring the family's potential for, and motivation to, change
- Determining the way forward: the risk factors

The professionals and the family should construct a written agreement which sets out clearly the agreed tasks, roles, responsibilities and time-scales. It should identify the need for any specific assessment, e.g. psychiatric or psychological (processing it if resources permit) and appoint a co-ordinating professional (usually the social worker). For further details on these issues, the reader is referred to Calder and Horwath (1999).

### **3.4.1 Definition of the problem**

It is essential that professionals and the family address the concerns at an early stage to ensure there is no confusion about why a particular assessment package has been constructed. Workers have a duty to set out clearly for the parents a statement of their concerns, the process and content of the assessment and what the expected child needs to be protected from. They also need to be advised about the potential consequences of non co-operation. This allows the parents to clarify the outcome needed and decide whether they can make the necessary changes in a time-scale commensurate with the expected child's needs. In some cases, this will only become clear as the assessment itself unfolds, but workers should punctuate the work with feedback to accommodate this. It is sometimes useful to assess a parent's motivation to address the concerns at the outset of the assessment and re-gauge these at the end of the formal assessment to see if any change has been noticed.

### **3.4.2 Ante-natal care: medical and obstetric history**

Pregnancy itself creates special circumstances/influences on both parents, which need to be accommodated by the workers. For example, pregnancy has a major impact upon their present lives, affecting both their behaviours as well as their relationships. Pregnant women's health and responses to external factors change during pregnancy. The physiological, emotional and social influences effecting and affected by this change will determine, to some extent, how representative their behaviours are, their state of health and the functioning of key relationships.

Ante-natal care is usually provided on a shared care basis by Midwives, General Practitioners and Hospital Consultants. Care begins as soon as pregnancy is confirmed and continues until a minimum of 10 days post-partum up to a maximum of 28 days post-partum. The named midwife (geographically attached to a GP) will provide women with choices about the place of birth and the type of care they would like to receive. A booking interview is carried out at around 8-12 weeks of pregnancy, either in the women's home or in the GP's surgery according to the women's wishes.

During the booking interview the midwife is collecting information, which will build into a full medical and social history (now held on computer). When all the data is assimilated, the midwife is then able to assist the woman in making informed choices about the care she receives and advises on the suitability of her choices. The midwife will discuss with the woman the pattern of care, which is thought to most suit her needs. A holistic approach, taking into account the woman's social history will be provided. The information collected usually includes:

- Name
- Age/ DOB
- Address
- Next of Kin
- Marital status
- Partner support
- Family support
- Family structure
- Occupation
- Ethnic origin
- Planned/unplanned pregnancy
- Feeling about being pregnant
- Dietary intake
- Medicines or D=drugs taken before and during pregnancy
- Alcohol/cigarette consumption
- Previous Obstetric history including:
  - Number of children, DOB of children, names, current health status
  - Miscarriages and terminations of pregnancy
- Information regarding chronic and acute medical conditions, surgical history and psychiatric history i.e. previous depression, suicide attempts.

Post-natal care will be provided either completely in the home in the case of home births or, where the birth occurs in hospital or the GP unit, the initial post-natal care will be on the post-natal ward. Hospital stays are getting shorter with many women going home 6 hours after the birth and 12-48 hours being the routine lengths of stay. Post-natal care is then transferred to the named community midwife who will then visit regularly according to need. The Health Visitor attached to the women's GP will have been notified during the pregnancy, some do an ante-natal visit, others write to mothers in the first week of life and arrange a primary visit at around the tenth day of life. Midwives will often transfer the care of mother and baby over to the Health Visitor following the tenth day visit. Midwives can however continue to provide care up to 28 days post delivery.

### **3.4.3 Full social history**

*'Anyone wanting to promote changes in clients must first obtain a comprehensive understanding of the total context in which the behaviours occur'* (Lazarus, 1976, p25).

A detailed social history is essential and should not differ from a social history taken in any other situation. The social history is designed to collect information which will help understand the parents developmental experiences which may be contributing to the identified concerns; whether any contemporary factors might have increased the concerns or risks; as well as being an excellent mechanism for engaging the parents via a routine, non-threatening process (see Calder et al, 2001 for a review). Workers can use this component to evaluate their ability and willingness to recount events.

There are no boundaries to a social history, although most embrace their family of origin; the quality of their parenting; their early life experiences; social, educational, medical, marital, occupational, criminal (and sexual) history. For detailed guidance on this, the reader is referred to Calder (1999; 2001). We should consider complications during the pregnancy and birth; developmental issues, including their milestones; peer and sibling relationships; school performance; family relationships; drug and alcohol abuse; general impulsivity; anger levels; self-esteem; social skills and competence; and past psychiatric history.

#### **3.4.4 Current family structure, extended family and potential support**

It is essential that we establish full details of the immediate and extended family, including dates of birth, full names and addresses, so that full checks can be done on relevant criminal and child protection history. There are very real advantages to using eco-maps and genograms for this purpose, and further guidance on adapting them to different cultures can be found in Congress (1994) and Hardy and Laszloffy (1995).

#### **3.4.5 The parental relationship**

The parental relationship is crucial and needs to include information on how they met, why they stay together, how their relationship has developed and changed, what the good and bad parts of their relationship are, the number of children each has had previously, domestic violence, etc. The workers need to focus on the parental relationship and their individual physical, intellectual and emotional abilities/ control; as well as the affect of a baby on the parental relationship. Workers need to establish which parent is likely to provide the main care for the expected baby. Changes in the parental relationship in the context of previous abuse, family violence, drug or alcohol use, and environmental factors such as housing and unemployment need to be understood as either superficial or fundamental. Workers need to consider the relevance of problems in any previous relationships and the impact this may have on their current relationships. Workers need to explore the previous family unit within which any previous abuse occurred and consider the positives and the negatives about the new relationship and any changes that remain outstanding. Workers should explore who they are now, their current lifestyle and what has happened since the removal of their previous children.

#### **3.4.6 Family functioning and strengths**

It is important to look at the current family functioning, particularly lifestyle, roles and responsibilities, and how they envisage adapting to the arrival of a newborn baby. This should include the stability and quality of family life, the extent of agreement on raising children, family rules, the identification, management and resolution of conflict, whether they support or undermine each other, particularly around colluding with each other to deny the problems, and their strengths and capabilities.

Working with family strengths is proving to be an excellent mechanism to foster working relationships without excluding the need to focus on risk. It is a more acceptable way of looking at how to manage risks. It recommends that we focus on individuals by focusing on their capacity, talents, competencies, possibilities, visions, values and hopes. It is not enough to assume that strengths exist in the absence of any identified weaknesses. The most heavily weighted factors when judging a family's strengths are their level of co-operation, aspects of their parenting, and aspects of their social system. A major consideration as part of strengthening families is promoting their abilities to use their existing strengths in a way that produces positive changes in family functioning. For a detailed discussion of the strengths perspective, the reader is referred to Calder (1999b) and Saleebey (1992, 1996).

#### **3.4.7 Previous abuse or convictions**

It is imperative that workers research written and verbal accounts of past events: gain descriptions from those involved, and collect and codify reports/statements. They need to allow for the probability that previous records will be extensive as well as held in numerous places (e.g. court section; police; archives; family centres, etc), as well as the reality that many are incomplete or disorganised. If possible, workers should try and speak to the workers at the time of the previous abuse to assist them in their preparation.

In assessing the previous abuse, workers should consider the following factors:

- The category and level of abuse. Workers also need to consider the ages and the gender of children previously removed, and whether there is a predicted pattern of continuing abuse against either a particular sex or age band.
- What happened? Why did it happen? What else was happening? Workers need to acknowledge the 'filter' that time places on past events, and this requires that they consider carefully the context and significance. Even where the factual information uncovered is thorough, they need to contextualise the decision-making to allow them to accurately translate the significance of past events for the purposes of predicting future risk.
- The parents' explanation for, and view of, the abuse (then and now), testing the congruence of individual accounts and that of professionals. Incongruity should be fed back to parents to enable them to move on and provide alternative explanations/ change their story. It may be that we do not know who perpetrated the previous abuse, so we need to explore who might have done it.
- The ages of the parent(s) at the time may be relevant now. For example, they may have been very immature as 15-year old parents when the last abuse occurred and they are now wanting to be assessed as more mature and responsible 25 or 30 year old adults.
- The acceptance of responsibility for the abuse (has there been a criminal or civil court finding of responsibility?). Where do the parents now place responsibility for what happened in the past? Workers are often left with the task of finding explanations and establish responsibility for the abuse years on from the events themselves. If no-one admits / accepts responsibility for past abuse, then our conclusion is that future children are not safe. If there is no believable acceptance of responsibility for or explanation of the abuse forthcoming, it is essential that a way forward be identified. For example, workers should actively facilitate parents to again address responsibility for the abuse; find realistic, congruent and 'felt' explanations; and address the need for change from their current position. See Calder (1999) for a review of denial and engagement strategies. Some families may never accept any responsibility for the previous abuse, but they may have changed their attitudes towards working with professionals to look at the future risks and safety of the expected child. Workers may often have to consider whether the plans for the future, regardless of the past, can adequately protect the expected child.
- The parents' concern/understanding for the abused child. What understanding do they have of the impact of their past abuse on the child/ren - then, now and possibly in the future? If workers can elicit this information from the child themselves, then it can be a powerful tool to use to get them to look at issues around victim empathy.
- Any previous assessments, with outcome and recommendations. If the couple accept some responsibility for the abuse; offer a believable explanation; recognise the impact of the abuse on past children; work can concentrate on why children were abused in the past; what has changed since, that would indicate future children would be safe; what needs to change for future children to be safe; and to evaluate likelihood of this change-within what time-scale for the children. Workers need to be aware that it is unrealistic to predict future risk with the mathematical accuracy applied to the solution of a mathematical problem. This is particularly true when looking at the chances of a particular risk materialising. In many cases it is usually difficult to do more than place these chances within a fairly broad band, such as 'negligible', 'very high', or 'about 50/50'- and even then it may be hard to avoid an appreciable amount of speculation. However, it is usually easier to predict the likelihood of a risk materialising in the future if that risk has actually materialised in the past, than if it is, as yet, a purely hypothetical risk. However, the seriousness of the harm already done is not a predictor that future harm will be more or less serious, only that the likelihood of it is increased, unless relevant interventions can be made that will lessen that risk (Calder, 1999c). Workers do need to be cautious

about making decisions for children if they hold either incomplete or biased information.

In this section, it is important to consider the seriousness of the previous abuse, and how the parents either individually or together have cared for previous children. This may be their own birth children or children they have been responsible for. The abuse of previous children is not a bar to caring for future children, although the parents attitude towards that abuse and their attitude towards the child is a factor where there would need to be significant and fundamental change.

### **3.4.8 Family attitudes towards previous action/professional involvement, and ability to engage current intervention**

*Note. It is important to engage both parents in the assessment process.*

Much of the success of the assessment depends on the relationship between the workers and the family, and what their understanding is of the assessment task. However, in many of the cases where a pre-birth risk assessment is commissioned, individual professionals and their agencies will have taken decisions / actions that have affected families fundamentally, i.e. the removal of their children. This can lead to acute difficulties for the current workers, particularly if both sides have become entrenched in their positions. Workers can sometimes feel bound by the assessments and decisions they have inherited - as any change may be construed as disloyal.

It is important that professionals remain loyal to one another (co-working is essential) if families are hostile or resistant. It is always worth pointing out to the parents that there will be a need for a similar assessment to be undertaken whenever they present with a pregnancy or join with a new partner with children.

Professionals should try to avoid expressions of over-concern, avoid moralistic judgements, avoid criticising the client, avoid making false promises, avoid displays of impatience, avoid ridiculing the client, avoid blaming the client for their failures, avoid dogmatic utterances, and respect their right to express different values and preferences from your own (Ivanoff et al, 1994) - if they want to engage the parent.

Working in partnership is not about sharing power, but about working together towards a common goal. Parents should be allowed to have a reasonable level of understanding about the assessment process; give their views as well as receiving and debating the views of the professionals; and having a time limit to ensure they are clear where the goalposts are- as any failure to do so will lead to them opting-out of the process (plus distancing them from the experience/decision) - until the next pregnancy (Calder, 1995).

There is a need to engage partners (usually men) in the assessment to maximise the accuracy when predicting future risk (see Calder, forthcoming). It is useless to have undertaken a parenting assessment of the mother in isolation when the principal risk is believed to be the (male) partner. Workers may sometimes struggle to engage men in assessments (see O'Hagan 1997 for a review) where they do not hold any parental responsibility for the foetus and are not able to have any say in decisions affecting them pre-birth.

### **3.4.9 Assessment of non-abusing parent's ability to protect**

We need to establish whether they are new partners (in which case we need to examine who they are-their own personal history; how they view what has happened in the past-how critical/uncritical; realistic/unrealistic are they?), or long-standing partners, party to the old abuse (in which case we need to explore what has changed regarding their understanding

/view of past abuse; their acceptance of responsibility for a failure to protect or collusion with the abuse; their view of past children and the effects the abuse has had on them; what has changed, and for whom, particularly when changes may have occurred only because there were no children living within the family; what sort of change it is - temporary or permanent/fundamental or superficial ; and what the potential for change is in the light of previously expressed concerns?).

Smith (1994) has provided us with a useful preliminary framework for assessing non-abusing parents' capacity to protect, strengths, weaknesses and areas for change, which includes:

- Position regarding the abuse or conviction- immediate and now? What information do they have, and who was this provided by? Can other information (police, medical, judicial) be provided to assist the mother move from her disbelieving position?
- Feelings towards the child- anger, sympathy? Who do they blame, and why?
- Did they have a role in the investigation of the previous abuse? Was it helpful or a hindrance? To whom, and in what way?
- Position regarding responsibility for the abuse- is easier if the perpetrator has taken full responsibility, but the message has to be that this is where the full responsibility rests in all circumstances.
- Perceived options- do they have sufficient resources to provide their own solutions? Can they co-operate with the statutory agencies? A task centred approach with a clearly defined outcome is important.
- Relationship history - do they have to choose their child or their partner? Are they highly dependent on male partners? Do they have a history of violent and abusive relationships?
- Other vulnerabilities- physical disabilities, including hearing and visual impairments, chronic physical illness, psychiatric illness, or any condition which isolates them from independent help.
- Recognition of future risk situations and their ability to manage them safely for the child.

Calder et al (2001) have significantly extended the assessment components to include: position regarding the child's disclosure; feelings towards the child post-disclosure; their role in the disclosing process; their role in the sexual abuse; their knowledge of the abuse taking place; their position regarding responsibility for the abuse (what are they responsible for?); the mother's distress to the disclosure/consequences; their definition of the risks compared to the professionals, the abuser and their extended family/community; their perceived options; the relationship and co-operation with the agency (throughout the process); their expression of feelings; openness regarding the sexual abuse; knowledge of sexual offending behaviour- generally and specific to their partner; knowledge of effects of child sexual abuse on the victims- generally and specifically to their child/ ren (empathy); position regarding self-protection work: what do their children know now? Their ability to identify indicators in both the offender and the child/ ren; the mother's relationship with her child/ ren; her present attitude and relationship with the abuser; general parenting; social history: including their family background, health and medical history, including lifestyle stress (alcohol and drug use); interpersonal relationships (positive and negative, e.g. domestic violence); anger, aggression and assertiveness; self-esteem and self-concept; social skills and competence; and social support networks. Sexual history, including any history of sexual abuse, and denial around the current issues. Outcomes will look at safe care: strategies for managing risk (short- and long-term); contact; desire for reunification, with reasons; their understanding about treatment programmes; and any agreed priorities for change. Extra-familial sexual abuse will be covered separately.

Workers need to bear in mind that the uncertain nature of the assessment, particularly around the mother's ability both to protect as well as respond to her expected child needs to be explored and understood. Despite this, they do need to determine at the end of the assessment whether the non-abusing parent is capable of making the transition to becoming a protective parent. If not, then the baby should not remain in the care of the parents.

#### **3.4.10 Understanding of expected baby's needs and ability to meet them**

It is probable that this section will be completed by a family centre or similar resource.

It is important to consider how the parents, individually and together, feel and respond towards their expected baby. The parents' developing sense of attachment to their expected baby is a useful measure of the quality of the likely attachment between the parents and the child at birth.

It is important to look at how individuals build relationships and whose responsibility they feel it is. It is worth noting that many parents may be unable to articulate a response to such questions, but this does not always mean that they are unable to form strong bonds with their children.

There is a need to look at their understanding of the child's anticipated basic needs and whether they will be able to meet them in a time-scale commensurate with their developmental level. The baseline is establishing whether the parenting will be 'good-enough' to meet the baby's needs.

#### **3.4.11 Future plans**

Workers have to consider the future family and should include answering questions about:

- How realistic are the parents' plans for the future?
- Have they considered the impact of a future child on their relationship/lifestyle?
- Do they consider that such an impact might be 'negative'?
- Is it safe for the child to be placed with these parents?

Workers do have to allow for the fact that many pregnant women have a restricted or unrealistic view of their relationship with their unborn child during pregnancy and of their anticipated relationship with the child once born.

If no-one admits or accepts responsibility for past abuse, then the conclusion should be that future children are not safe, whatever other strengths have been identified.

#### **3.4.12 Drug using parents and anticipated health problems**

The parents should be advised either to attend the local community drugs team or get their GP to review their drug regime, taking into account the past history of the user, their motivation and their current situation as well as the demands of the pregnancy. Treatment options can then be discussed with them and include maintenance, partial reduction or complete withdrawal during pregnancy. It may not be desirable for the woman to withdraw completely from drugs before the birth because the additional stress that she may experience during pregnancy may precipitate a crisis in an already chaotic lifestyle, which may result in harm to the baby. In addition, a parent in a withdrawal crisis may be unable to look after a child adequately, as it can impair people's capacity to tolerate stress and anxiety.

The woman needs to be encouraged to book at the ante-natal clinic as early as possible in the pregnancy to ensure they receive advice on general health issues and counselling (SCODA, 1989). However, pregnant drug users are often reluctant to come forward to ante-natal care or to admit to their drug use, because of the fear that the expected child may be taken away at birth. As a result, many do not access ante-natal care until late in pregnancy or when they are in labour. However, it is worth noting that pregnancy can act as an incentive to cease or stabilise drug use, e.g. by prescribing methadone.

Professionals need to assess carefully the mother's and/or partners understanding of the potential effects of their substance abuse on the expected child. This always has to include factors such as social supports, parenting skills, the parent-child relationship and family resources (Azzi-Lessing and Olsen, 1996). The parents need to have some idea about the criteria by which professionals will begin to be concerned about the foetus, e.g. failed ante-natal appointments, continued use of street drugs (Kearney and Aldridge, 1989). Given the potential vulnerability of children pre-natally exposed to alcohol or drugs, and/or the challenging behaviours exhibited by children born to substance abusing mothers, the parenting skills of the primary caregiver (usually the mother) become more important.

Further explanatory information on the issues of drug use in pregnancy, also embracing how to assess risk can be found in Bays (1993) who explores the impact of addiction on the child and Coleman and Cassell (1995) who explore the direct / indirect effects of drugs and alcohol, both on the individual as well as family life. (Coleman and Cassell, 1995). The reader is referred to the Local Government drug forum/SCODA policy guidelines (1997) for detailed information on the issues relating to drug-using parents.

#### **3.4.13 Alcohol using parents and anticipated health problems**

The first twelve weeks of pregnancy is when the embryo is developing and the potential teratogenic effects are likeliest. The teratogenic model explains negative consequences of prenatal exposure in terms of direct damage to the foetus caused by exposure in gestation. This model assumes that both physical defects and behaviour problems observed neonatally and during later childhood are the direct result of exposure to a teratogen, which leads to observable deficits in cognitive, emotional and behavioural outcomes (Wilson, 1977). It is popularly assumed that prenatal exposure to alcohol is always associated with negative outcomes. This assumption rests on the idea that these psychoactive substances are teratogens (that is they are chemicals that cause damage to the developing foetus leading to physical birth effects).

When a pregnant woman drinks alcohol it crosses the placental barrier, into the babies blood stream and then to the developing brain. Ideally pre-conceptual care and advice should be sought when attempting to conceive. The advice is to follow the guidelines for safe drinking in pregnancy. The risk to the foetus increases as the mother's alcohol consumption increases but it is not clear whether there is a safe limit for alcohol intake in pregnancy below which there is no risk. It is likely that there may be critical stages in the development of the embryo when it is especially vulnerable to alcohol. The latest guidelines from the Royal College of Obstetricians and Gynaecologists is:

- No adverse effects on pregnancy outcome have been proven with a consumption of less than 120 grams of alcohol (around 15 units) per week.
- Consumption of 120 grams (15 units) or more per week has been associated with a reduction in birth weight.
- Consumption of more than 160 grams (20 units) per week is associated with intellectual impairment in children.

Based on our current knowledge, it is difficult to identify accurately the risk of exposure in any given individual (Coles, 1995). Most women spontaneously reduce alcohol during

pregnancy and since the problems exposed with alcohol exposure have become better known, many women have avoided drinking all together. However, Rosett and Weiner (1984) estimated that 5%-10% of pregnant women drank at levels high enough to place their foetuses at risk. Fortunately, foetal alcohol syndrome (FAS) does not occur that frequently. However, it is estimated that FAS has an incidence of 0.3-1 per 1000 live births (Abel and Sokol, 1991).

*See Appendix 1 'Possible Outcomes of Alcohol Use in Pregnancy'*

#### **3.4.14 Measuring the family's potential for, and motivation to, change**

Workers need to estimate the prospects of change: such as a lessening of acute risk factors, or issues such as compliance, the likely response to intervention, and the means through which change might be achieved. The process of expected change always has to be placed in a short time-scale, because of the expected baby's pressing needs for parenting.

There are a number of useful tools for looking at the prognosis for change and the parent's motivation for achieving change. Tony Morrison (1991) produced an excellent continuum of motivation, which shows clearly whether the parents' motivation for change is only because of external pressures (e.g. threatened or actual legal intervention, known as external forces) or because they themselves recognise the need for change to ensure the expected child is safe (known as internal forces). The greater the internal force, the better the future prognosis, and vice-versa.

It is important to assess their motivation to sustain any work that has been identified. Questions such as the following may help workers:

*See Appendix 2 'A continuum of Motivation'*

#### **3.4.15 Determining the way forward**

The following framework allows workers to analyse the future risks and possible protective factors when reaching decisions on the way forward with the case.

The use of this framework should help in giving a considered, proactive and needs led response. The aim of the assessment is to accurately identify the level of anticipated risk and look at whether this risk is manageable or not. The goal is to try and enhance the prospect of maintaining the baby with their parents, either through an inter-agency child protection plan or a detailed package of support. A good plan should ensure that everyone is clear about what will happen when the baby is born and for the pre-birth risk assessment conclusions to be reviewed once the baby has been born and the actual observation of parenting can be started.

When the assessment identifies a risk of significant harm a Pre-birth Child Protection Conference should be convened.

**RISK ESTIMATION: A FRAMEWORK FOR PRACTICE (ADAPTED FROM CORNER nd)**

<b>ELEVATED RISK</b>	<b>LOWERED RISK (INC. PROTECTIVE FACTORS)</b>
<p><b>Abusing Parent</b></p> <ul style="list-style-type: none"> <li>• Negative childhood experiences, inc. abuse in childhood; denial of past abuse.</li> <li>• violence/abuse of others.</li> <li>• abuse and/or neglect of previous child.</li> <li>• parental separation from previous children.</li> <li>• no clear explanation.</li> <li>• no full understanding of abuse situation.</li> <li>• no acceptance of responsibility for the abuse.</li> <li>• antenatal/post-natal neglect.</li> <li>• age: very young/immature.</li> <li>• mental disorders or illness.</li> <li>• learning difficulties.</li> <li>• non-compliance.</li> <li>• lack of interest or concern for the child.</li> </ul>	<ul style="list-style-type: none"> <li>• positive childhood.</li> <li>• recognition and change in previous violent pattern.</li> <li>• acknowledges seriousness and responsibility without deflection of blame onto others.</li> <li>• full understanding and clear explanation of the circumstances in which the abuse occurred.</li> <li>• maturity.</li> <li>• willingness and demonstrated capacity and ability for change.</li> <li>• presence of another safe non-abusing parent.</li> <li>• compliance with professionals.</li> <li>• abuse of previous child accepted and addressed in treatment (past/present).</li> <li>• expresses concern and interest about the effects of the abuse on the child.</li> </ul>
<p><b>Non-abusing Parent</b></p> <ul style="list-style-type: none"> <li>• no acceptance of responsibility for the abuse by their partner.</li> <li>• blaming others or the child.</li> </ul>	<ul style="list-style-type: none"> <li>• accepts the risk posed by their partner and expresses a willingness to protect.</li> <li>• accepts the seriousness of the risk and the consequences of failing to protect.</li> <li>• willingness to resolve problems and concerns.</li> </ul>
<p><b>Family Issues (marital partnership and wider family)</b></p> <ul style="list-style-type: none"> <li>• relationship disharmony/ instability.</li> <li>• poor impulse control.</li> <li>• mental health problems.</li> <li>• violent or deviant network, involving kin, friends and associates (include drugs, paedophile or criminal networks).</li> <li>• lack of support for primary carer / unsupportive of each other.</li> <li>• not working together.</li> <li>• no commitment to equality in parenting.</li> <li>• isolated environment.</li> <li>• ostracised by the community.</li> <li>• no relative or friends available.</li> <li>• family violence (e.g. spouse).</li> <li>• frequent relationship breakdown/ multiple relationships.</li> <li>• drug or alcohol abuse.</li> </ul>	<ul style="list-style-type: none"> <li>• supportive spouse/partner.</li> <li>• supportive of each other.</li> <li>• stable, non-violent.</li> <li>• protective and supportive extended family.</li> <li>• optimistic outlook.</li> <li>• previous efforts to address the problem, e.g. attendance at relate, have secured positive and significant changes (e.g. no violence, drugs, etc).</li> <li>• supportive community.</li> <li>• optimistic outlook by family and friends.</li> <li>• equality in relationship.</li> <li>• commitment to equality in parenting.</li> </ul>

<b>ELEVATED RISK</b>	<b>LOWERED RISK (INC. PROTECTIVE FACTORS)</b>
<p><b>Expected Child</b></p> <ul style="list-style-type: none"> <li>• special or expected needs.</li> <li>• perceived as different.</li> <li>• stressful gender issues.</li> </ul>	<ul style="list-style-type: none"> <li>• easy baby.</li> <li>• acceptance of difference.</li> </ul>
<p><b>Parent-baby Relationships</b></p> <ul style="list-style-type: none"> <li>• unrealistic expectations.</li> <li>• concerning perception of baby's needs.</li> <li>• inability to prioritise baby's needs above own.</li> <li>• foetal abuse or neglect, including alcohol or drug abuse.</li> <li>• no ante-natal care.</li> <li>• concealed pregnancy.</li> <li>• unwanted pregnancy/ identified disability (non-acceptance)..</li> <li>• unattached to foetus.</li> <li>• gender issues which cause stress.</li> <li>• differences between parents towards unborn child.</li> <li>• rigid views of parenting.</li> </ul>	<ul style="list-style-type: none"> <li>• realistic expectations.</li> <li>• perception of unborn child normal.</li> <li>• appropriate preparation.</li> <li>• understanding or awareness of baby's needs.</li> <li>• unborn baby's needs prioritised.</li> <li>• co-operation with antenatal care.</li> <li>• sought early medical care.</li> <li>• appropriate and regular ante-natal care.</li> <li>• accepted / planned pregnancy.</li> <li>• attachment to unborn foetus.</li> <li>• treatment of addiction.</li> <li>• acceptance of difference -gender /disability.</li> <li>• parents agree about parenting.</li> </ul>
<p><b>Social</b></p> <ul style="list-style-type: none"> <li>• poverty</li> <li>• inadequate housing.</li> <li>• no support network.</li> <li>• delinquent area.</li> </ul>	
<p><b>Future Plans</b></p> <ul style="list-style-type: none"> <li>• unrealistic plans</li> <li>• no plans</li> <li>• exhibit inappropriate parenting plans.</li> <li>• uncertainty or resistance to change.</li> <li>• no recognition of changes needed in lifestyle.</li> <li>• no recognition of a problem or a need to change.</li> <li>• refuse to co-operate.</li> <li>• disinterested and resistant.</li> <li>• only one parent co-operating.</li> </ul>	<ul style="list-style-type: none"> <li>• realistic plans</li> <li>• exhibit appropriate parenting expectations and plans.</li> <li>• appropriate expectation of change.</li> <li>• willingness to consider changes in lifestyle.</li> <li>• clear about changes and affect on relationship.</li> <li>• willingness and ability to work in partnership.</li> <li>• willingness to resolve problems and concerns.</li> <li>• parents co-operating equally.</li> </ul>

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## APPENDIX 1: POSSIBLE OUTCOMES OF ALCOHOL USE IN PREGNANCY

There is a wide range of possible outcomes of alcohol use in pregnancy and table 1 lists some of the factors that are believed to contribute to the impact of alcohol on the foetus and the child. It is important to remember that alcohol may have different effects on both mother and child because of their biochemical actions.

Factors affecting outcome in children pre-natally exposed to alcohol (Coles, 1995, p10)

- genetic and/or physical vulnerability: suggesting that some individuals may have more tendency to be affected by exposure than others.
- drug type and drug action (see table 2 below)
- type of exposure: dose, duration during gestation and timing (daily or binge use)
- maternal health, access to health services and prenatal care
- pregnancy complications (e.g. prematurity)
- status variables: (such as postnatal care-giving factors, the immediate family environment, and the general social environment i.e. socio-economic status), as well as the developmental process itself and the many factors that are known to affect it i.e. particular behaviours of family members, the caregiver's style, and specific and significant events, such as the loss of a parent, which affect the developing child.
- availability of services: prevention, education and treatment

Problems noted through alcohol use in pregnancy (Coles, 1995, p11)

- Foetal wastage
- Facial dysmorphism
- Persistent growth retardation
- Central nervous system damage/intellectual deficits
- Cardiac abnormalities
- Neonatal withdrawal
- Failure to thrive
- Vision and hearing problems
- Long-term effects

The impact of alcohol consumption during pregnancy on the physical development of children is well established. Intrauterine growth retardation has been found in alcohol exposed infants, due to poor maternal nutrition, the direct effects of alcohol on the foetus, and alcohol's interference with foetal nutritional intake. Alcohol exposed children are often exposed with failure to thrive and growth retardation is often sustained throughout childhood. Neuro-behavioural outcomes include irritability, poorer habituation and orientation, increased tremors, poorer arousal, disturbances of sleep, poorer motor tone and development, and diminished spontaneous movement (Harden, 1998).

A spectrum of specific patterns of physical sequelae exists in children chronically exposed to alcohol in utero, ranging from foetal alcohol effects (FAE) to the more severe foetal alcohol syndrome (FAS). The three primary features of FAS are pre- and postnatal growth retardation, central nervous syndrome dysfunction and facial dysmorphology (Coles, 1993). Other features of FAS include intra-oral deformities, vision and hearing deficits, cardiac problems, hypotonia, poor co-ordination and skeletal malformations. Neuro-behavioural outcome have been documented such as feeding difficulties, sleep irregularities and hyperactivity (Weiner and Morse, 1988). In contrast, children with FAE usually do not have all three types of physical health impairment and often do not display these difficulties throughout childhood.

Children with FAS display severe cognitive impairments, such as mild to moderate mental retardation, with accompanying language and perceptual difficulties (Rosett and Weiner, 1984). Children without the full-blown syndrome also have lower intelligence, language and academic achievement scores. Factors that impede academic functioning have also been noted with these children, including difficulties in reasoning, problem solving, memory, and auditory and visual-motor processing (Coles, 1993).

In the neonatal period, sudden infant death syndrome (SIDS) is approximately five times higher than average among all groups of substance abusers (Regan et al, 1987).

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## **APPENDIX 2: A CONTINUUM OF MOTIVATION**

Adapted from Morrison, 1991, p34).

### ***Internal motivators***

I want to change.  
I don't like things as they are.  
I am asking for your help.  
I have resources to help solve this.  
I think you can help me.  
I think things can get better.  
I have other support, which I will use to encourage me.  
I accept that I am doing something wrong.  
I accept what you say needs to change.  
I accept that others are right (family, friends, community, agencies).  
You defining the problem clearly helps.  
I understand what change will involve.  
I accept that if I do not change, you will take my children away.  
I can change if you do this for me.  
I'll do whatever you say.  
I agree to do this so the family can be reconstituted.  
It's your job to solve my problem.  
You are my problem.  
I am right and you are wrong.  
I don't have any problems.

### ***External motivators***

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