



**WORKING WITH VULNERABLE UNBORN
BABIES AND THEIR FAMILIES
MULTI AGENCY PRACTICE GUIDANCE**

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Author	Aberdeen City CPC Operational Subcommittee
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1. Introduction

“All children and young people have the right to be cared for, protected from harm and abuse, and to grow up in a safe environment in which their rights are respected and their needs met. A large number of children in Scotland, however, are born into, and live within, families that can be considered vulnerable.” (A Pathway of Care for Vulnerable Families 0-3, Scot Govt, 2011.)

This multi-agency guidance has been produced by the Aberdeen City Child Protection Committee and reflects the *Getting It Right for Every Child* (GIRFEC) National Practice Model approach to delivering services to children, young people and their families. It recognises that early intervention is critical if we want to ensure that problems in vulnerable families do not become more damaging and difficult to address at a later stage.

The ethos of the National Practice Model has recognised that the majority of children and families are supported effectively within their own family networks, through the universal services of health and education and therefore are not required to come to the attention of statutory agencies. Where single agencies identify that some targeted support may be required, this intervention can be proportionate to identified need and should be pursued in conjunction with the views of the child and family themselves. Where there are felt to be child care and protection concerns which might place a child at risk of significant harm, specialist intervention will be required from Children’s Social Work. For this to be most effective, appropriate supports should be identified and then implemented within a timely manner. Intervention across the public sectors will strive to be collaborative at all times, and emphasis will be on working in partnership with children, parents and their wider family network, to ensure that the wellbeing of a child remains paramount.

Learning from Significant Case Reviews has demonstrated that there is a need to consider all the issues which can impact on a parent’s capacity to adequately parent and care for their child. These issues include substance misuse, domestic violence, mental health concerns and parental learning difficulties. Other factors such as parental experience of childhood neglect and abuse can also impact on our capacity to parent children.

Babies by nature of their age are amongst the most vulnerable children in our society, and concerns for their wellbeing may well begin pre-birth, during pregnancy. Some unborn babies and their families need additional support, guidance and in some instances measures of intervention are required to keep unborn babies safe from harm; these are the children who are the subject of this guidance.

This guidance should be read in conjunction with the National Guidance for Child Protection in Scotland 2014

- Link - The National Child Protection Guidance (2014) - <http://www.scotland.gov.uk/Resource/0045/00450733.pdf>

and the National Risk Framework to support the assessment of Children and Young People, 2012.

- Link to National Risk Assessment 2012 - <http://www.gov.scot/Resource/0040/00408604.pdf>

It applies to professionals working across all agencies, whether working with children or with adults.

This guidance is a live document and will be reviewed bi-annually by Aberdeen City's Child Protection Committee.

2. Purpose

The aim of this guidance is to help any staff working with children and adults within Aberdeen City to:

- Recognise and understand the impact on a child or unborn child of problematic substance misuse, mental health, learning disability, domestic violence and parental experience of childhood abuse or neglect, on parenting
- Share information appropriately. Remember that a child's needs are paramount. If at any point, child protection concerns arise, do not delay in sharing concerns with social work or police colleagues, in line with Child Protection guidelines. All professionals and service providers have a duty to take action to make sure that a child or unborn child whose safety or welfare may be at risk, is protected from harm, even if the child is not the service user.
- Identify unborn children who may be in need of additional support and those in need of protection within both universal and specialist services
- contribute to effective pre-birth assessment and planning to maximise collaboration with parents, early intervention and effective reduction of risk and vulnerability to children

3. Principles

The rights of the child are paramount. The rights of parents, carers and pregnant women for support in fulfilling their parental roles and responsibilities do not override the rights of a child to be protected.

For the most part, the law allows parents to bring up their children according to their own values and beliefs. This means that parents have the right to make decisions about their child or young person's upbringing without interference unless a parent's action or inaction causes harm or places their child at risk of harm.

Children are usually best brought up within their own families and support should be provided to enable this where possible. Professional activity should build on the strengths and signs of safety within families and community.

The Children and Young People (Scotland) Act 2014 legislates that every child from birth to the age of 18 has a Named Person. The named person is a role designated within the universal services of health or education, in most cases, the health visitor for pre-school children, being replaced by the Head Teacher, for primary school aged children and for secondary aged children, a member of staff responsible for pupil support. The named person will be the first point of contact for children, their families and relevant agencies where there are any wellbeing concerns about a child that they cannot themselves help with.

Whilst there is no named person allocated until birth, a midwife is the key health contact during pregnancy. If any wellbeing needs are indicated during pregnancy, the midwife will advise the prospective named person (health visitor or family nurse practitioner) as soon as is reasonably practical (named persons usually initiate contact with expectant mothers between 32 and 36 weeks gestation.)

As such, the midwife and subsequently the named person may well be the most appropriate first point of contact to seek more information from or to share information with when there are concerns raised about an unborn child's wellbeing and in order to determine what that unborn child/child may need, pre or post birth.

4. Context

There is significant public concern about children who are affected by problems that impact on parenting capacity. There have also been a number of high profile cases where children have been directly harmed, sometimes fatally, by parents or those with responsibilities for their care.

Key themes have been identified from findings of inquiries and reviews conducted into child death and abuse cases in recent years. These findings have impacted on child protection policy and in the shaping of new legislation,

significantly, the Children and Young People (Scotland) Act, 2014 which provides the framework for intervention with children and their families.

The following environmental factors have been noted as relevant in inquiries and reviews:

- The presence of violent men, particularly the cohabitee of the natural parent
- Parental conflict and or domestic abuse
- Mental health problems
- Substance misuse (drugs and/or alcohol)
- Young parents
- Social isolation
- Criminal convictions
- Adults who themselves have come from abusive backgrounds or whom themselves were looked after as children
- Learning difficulties
- Long term involvement with specialist agencies, including adult services
- High levels of involvement with health
- Withdrawal from contact with universal services, notably sustained non-attendance at school and health appointments

While individual risk factors may be significant there is no clear causal relationship between these factors and child death or serious injury. It is more likely that it is the coexistence of several risk factors that increases risk of significant harm to children.

Agencies involved with children who have either died, or have suffered serious injury by their parents or carers, have identified:

- Working in partnership with parents is vital whilst remaining astute to the needs of the child being paramount
- The need for clarity about what information can and should be shared when child protection thresholds have not been met
- The importance of assessing the parenting skills of fathers and significant males, rather than focusing solely on mothers
- The impact of mental health difficulties on the care of children can be varied, and in some cases, will require comprehensive multi-agency assessment
- Professionals may require to undertake a comprehensive assessment of the impact of learning difficulties and complex health issues on parental capacity to care for and protect their children
- All professionals should be aware of the link between domestic abuse and the risk of harm to children and be alert to the risk that violent males pose to vulnerable women and children. Professionals need to find out who is living

in households with children as well as who may come into extended contact with children

- Professionals should assess the risks posed by significant parental drug and alcohol misuse, particularly to unborn children and very young babies. Police may hold information in relation to drug and alcohol misuse that can be used in assessing the risks to children
- Police may hold important information relating to criminal convictions or suspected criminal activity which should be included in assessing the risks adults pose to children
- Professionals may wish to obtain as much information about parents own childhoods as they can in order to support parents to identify potential sources of strength, as well as to help them explore what aspects of their own experience they would wish to bring to future parenting
- The most vulnerable children can often be those on the margins of child protection processes. Often a trusting relationship between these families and allocated professionals is lacking. This highlights the importance of all professionals being able to identify when care afforded to children is impacting negatively on wellbeing

5. What is Parenting Capacity?

Parenting capacity is defined as "the ability of parents or caregivers to ensure that the child's developmental needs are being appropriately and adequately responded to, and to [be able to] adapt to [the child's] changing needs over time". This includes providing for the child's basic physical needs, ensuring their safety, "ensuring the child's emotional needs are met and giving the child a sense of being specially valued, promoting the child's intellectual development through encouragement and stimulation, demonstrating and modelling appropriate behaviour and control of emotions, and providing a sufficiently stable family environment." (Department of Health, Dept for Education and Employment, and Home Office (2000) Framework for the Assessment of Children in Need and Their Families.)

5.1 What Impacts on Parenting Capacity?

A number of factors impact on parenting capacity, including structural and environmental stressors and it is acknowledged that parenting under stress is often very difficult. We also recognise that a major stress on many parents stems from poverty and the drain on personal resources in coping with poverty can seriously undermine an individual's capacity to meet their children's needs. It will be important to consider the impact of social deprivation on the unborn child and to signpost families to other potential avenues of support in relation to financial struggles, such as Citizens Advice Bureau. This can be particularly challenging when working with families who have no recourse to public funds.

In line with all other cases, here professionals must consider the wellbeing of the unborn child/children and where care and protection concerns are evident, multi-agency support will be required to minimise risk of harm to baby.

The risk factors outlined above (4 – Context) can all impact on parenting capacity. For more detailed consideration of the impact of problematic substance misuse on parenting capacity please refer to the CPC Practitioner's Toolkit to Getting our Priorities Right. Mental health difficulties in adulthood are common and very often treatable. It is also recognised that the perinatal period is one where women can be more susceptible to poor mental health and therefore time limited additional support from specialised health services may well be required.

It is recognised that the presence of some or a number of these risk factors can cause parents to:

- behave in inconsistent and unexpected ways
- have difficulty in organising their lives
- have difficulty controlling emotions
- experience feelings of depression and despair
- become isolated from sources of family and community supports
- become insensitive to their children's needs
- be unresponsive to their cues

For some parents, often where there are multiple risk factors coexisting, a focussed and comprehensive parenting assessment will be required to enhance professional understanding of the impact of parental capacity on the changing needs of a new-born child. Such cases are likely to be referred to Children's Social Work, with a social worker having the role of lead professional whilst this intervention is undertaken.

Please see Part 4 in National Guidance for Child Protection in Scotland 2014 for further information on risk indicators.

5.2 How does Parenting Capacity Impact on Children/Unborn children?

It is evident that the wellbeing of children is at the heart of the Getting it Right for Every Child approach. This approach is the key thread running through policy and practice affecting children, young people and their families in Scotland. At its heart is the National Practice Model, which provides the foundation for identifying concerns, assessing needs and initial risks and making plans for children in **ALL** situations. The GIRFEC approach stresses the importance of understanding risk and needs within a framework of the child's whole world and wellbeing. It acknowledges eight areas of wellbeing in which children need to progress in order to do well now and in the future - SHANARRI. The eight indicators are the basic requirements for all children to grow, to develop and to reach their full potential making up what is referred to as the wellbeing wheel. This and other tools such as the My World Triangle,

and the Resilience/Vulnerability Matrix should be used by practitioners when assessing the needs of children and young people.

As stated in the National Risk Framework, 2012, at all times in a child's life, there are identified needs and when such needs go unmet, are partially met, or inappropriately met, risks may arise. To optimise the protection of children **ALL** agencies should collaborate and undertake the tasks of assessment and analysis of family circumstances together.

The impact of parental problems may mean that a child is either

- in need of services/ support to help ensure that the outcomes above are achieved or
- in need of protection where there are concerns about the child or unborn child being at risk of significant harm.

Definition of a Child in Need:

The statutory definition of a 'child in need' contained within the Children (Scotland) Act 1995, is wide. For the purposes of Part 2 of the same legislation, i.e. promotion of children's welfare by local authorities, and therefore eligible for services, a child in need is defined as follows:

- (a) being in need of care and attention because—
- (i) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development unless there are provided for him, under or by virtue of this Part, services by a local authority;
 - (ii) his health or development is likely significantly to be impaired, or further impaired, unless such services are so provided;
 - (iii) he is disabled; or
 - (iv) he is affected adversely by the disability of any other person in his family;

(S93(4) Children (Scotland) Act, 1995)

Definition of a Child at Risk of Significant Harm:

Where a child is deemed "to suffer significant harm" or "to suffer unnecessarily and be impaired seriously in his/hers health and/or development. (Children (Scotland) Act, 1995)

The critical issue in considering the potential impact on a child/unborn child of an adult's actions or inactions is whether these issues are placing, or could place, the child at risk of significant harm which would require intervention by statutory child protection agencies or which would require compulsory measures of supervision to be agreed by the Children's Hearing.

Harm need not have taken place; it is sufficient for a risk assessment to have identified a likelihood or risk of significant harm.

There is no statutory definition of 'significant harm.' To reach a threshold which warrants a Court Order authorising compulsory assessment (Child Assessment Order) or a child's removal from home (Child Protection Order), the child must be suffering or likely to suffer harm which is serious and not of a minor, transient or superficial nature. It may be physical or emotional and will include developmental harm. Since the aim of the legislation is to protect the child's welfare, harm will always be considered to be significant when it is clearly more serious than the potential trauma removal from home will almost inevitably cause a child. (Norrie K, McK., (1995) p197).

The key message for practice is that in assessing the impact of parental problems on a child or unborn child, an ecological approach needs to be taken where child development is seen in context.

The impact of adversity due to parental problems on a child will depend:

- on the child's resilience and vulnerability. Resilience can be defined as normal development under difficult conditions. Vulnerability is 'those characteristics of the child, their family circle and wider community which might threaten or challenge healthy development'
- on the parent/carers ability to make use of support
- on the protective factors around for the child/family

Children's resilience i.e. the capacity to prevent, minimise or overcome the damaging effects of adversity and trauma can be built, promoted or increased in a variety of ways within a variety of relationships.

6. Identification of Concern

Adult Services: Professionals working with adults in relation to any of the risk factors noted in section 4, will want to consider the needs of and the potential risk to any child/unborn child, closely linked with their adult service users.

When considering if the unborn child may upon birth be deemed a child in need, or may be at risk of significant harm, you will want to consider:

- Is the adult you are working with already a parent?
- Does the adult already care for children or are they closely linked to children? If so, do you or do others have any concern about risk the adult may pose to the unborn child or to children?
- Can your service provide additional services that would benefit the service user?
- Do you know what other services are involved and what their role is?

- Do you need help from another service? If so, what outcome would you expect?
- Is the unborn baby at immediate risk of harm? If so, do not delay in contacting Police Scotland.
- Is the unborn baby likely to be at risk of immediate harm upon birth? If so, share your concerns with the midwife, lead professional or contact Police Scotland.
- Are any other professionals expressing concern about risk the adult may pose to the unborn child or any other children?
- Is your service user an expectant father whose risk factor will impact on his ability to provide care for the child and support for the mother?
- Have you shared your concerns/concerns of others with other involved professionals?
- Do you need to discuss with your manager or other relevant professional?

Remember that whilst it is considered best practice to be open and honest with service users regarding any disclosure of their personal information, where there are child protection concerns, consent is not required, nor should seeking it result in any delay to sharing of information where this is felt necessary. Unless you are aware of there being a different lead professional already identified, the midwife, as key professional for the unborn baby, is likely to be your most significant contact.

7. Addressing the Needs of the Adult and Child Together: Inter-agency Information Sharing

The key to good multi-agency working is information sharing. Information sharing will be central to any multi-agency meeting. Successful exchange of information supports both the identification of potential support for adults and children/unborn children as well as clarifying what legal measures may require to be taken to support and protect children.

Good practice dictates that information sharing should in the main be carried out with the knowledge and consent of service users. However it is acknowledged that there are times when seeking or gaining consent is not deemed to be appropriate or necessary. Where a child is at risk of significant harm, or where there are concerns that this might be the case, information should be shared without any delay.

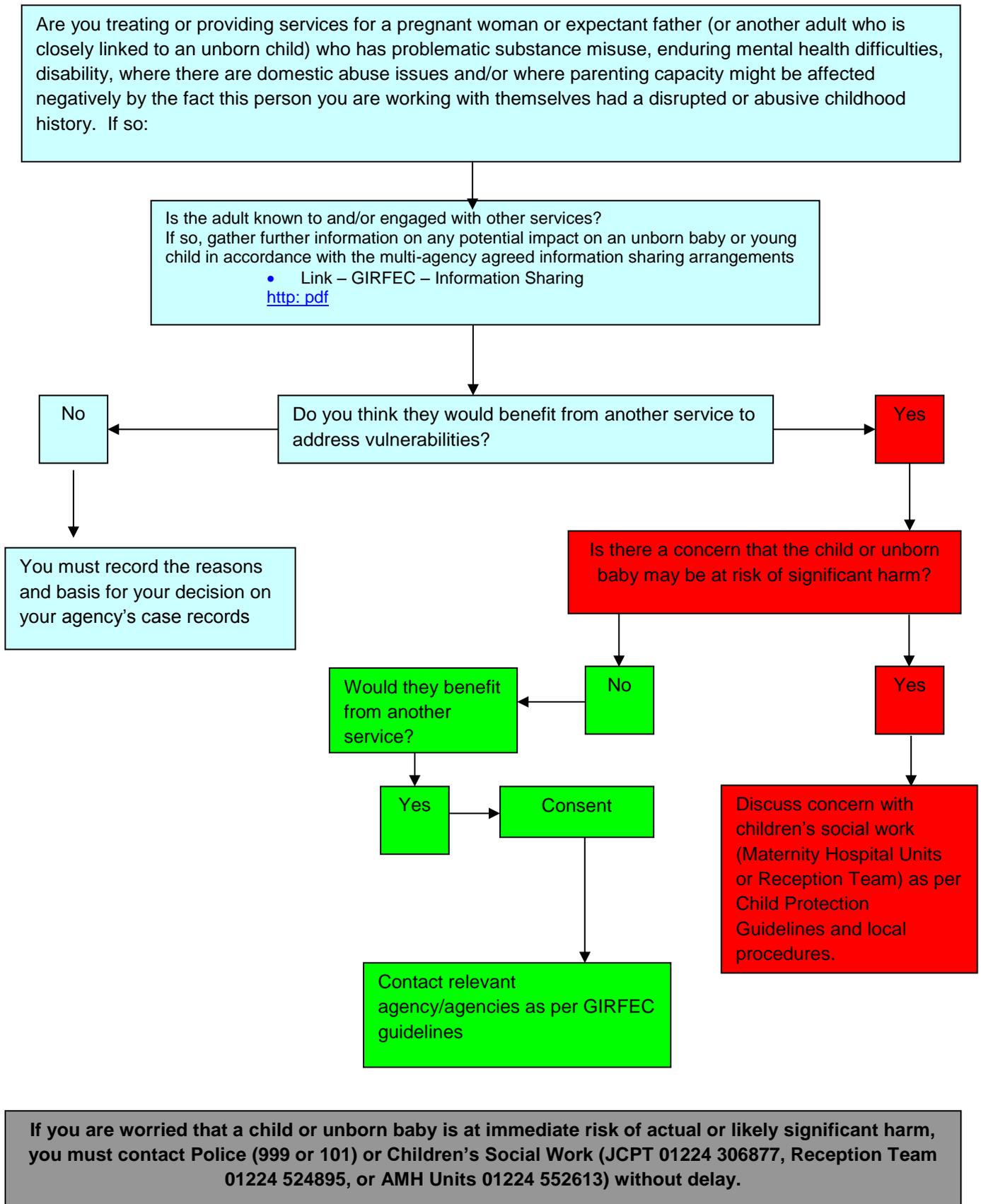
In other situations, the terms of the Children and Young People (Scotland) Act 2014 provides a wide definition and threshold for information sharing. It states that information ought to be provided if the likely benefit to the wellbeing of the

child or young person outweighs any likely adverse effect. In short, the purpose of legislation surrounding information sharing is not to prevent information sharing, but to ensure that such sharing is appropriate, proportionate and timely.

The agreed multi agency information sharing arrangements can be found at

- [Practitioner's Guide to Information Sharing, Confidentiality and Consent](#) Grampian GIRFEC Group 2014

7.1 Referral Consideration Flowchart



7.2 Referral to Specialist Agencies

Midwifery colleagues or GPs should identify as early as possible in pregnancy the possible spectrum of vulnerability and risk speaking with other involved professionals where appropriate, proportionate, and necessary. This will include pre-referral discussion, or referral to children's social work, as appropriate in line with National Practice Model approach. Pre-referral discussion will allow a sharing of knowledge, in order to clarify whether there is a need to refer to children's social work. It is expected that parents will be informed by the midwife about any such referral/pre-referral discussion but in certain circumstance, for example, where there is felt to be a risk that the family will disengage from services, this may not be appropriate.

Where pregnant mothers already have children in their care, the involved midwife should make contact with lead professional if known, or children's social work to share their knowledge and to clarify whether there is a need to refer to children's social work in respect of the unborn baby or in respect of older children.

7.3 Role of Children's Social Work with Vulnerable Unborn Babies

When eligibility criteria for children's social work involvement has been met, contact should be made with Children's Social Work, Aberdeen Maternity Hospital, where an initial assessment will be carried out to consider care and protection concerns raised. Usually, an initial meeting will take place with parents/close family members, in order to reach consensus about any potential impact on the unborn child of the concerns raised. Collaboration and joint working with allocated midwife or where appropriate, named person (health visitor) or lead professional where appointed will take place.

Agreement will be reached regarding what supports might be helpful to the unborn baby/parents and with consent from parents, signposting or referring to other agencies can take place, in conjunction to discussion with midwife/named person.

For a number of families, initial social work assessment will be all that is required, and case responsibility will thereafter revert to the midwife/named person.

Following initial assessment, where child care and protection concerns for the unborn baby prevail, children's social work will take the role of lead professional. Intervention is aimed at minimising wellbeing concerns and reducing risk to baby, whilst coordinating the information which will inform the comprehensive assessment. Within Aberdeen City, this assessment is called an Unborn Child's Assessment and Plan.

For families who do not already have an allocated children's social worker, and where there are no other children at home, this is likely to be from within Aberdeen Maternity Hospital social work units but given the importance placed on families not having to repeat their stories unnecessarily, case allocation will take into account existing professional relationships.

Where further intensive, practical support is required, additional intervention from the Pre-birth team, based at Deeside, Aberdeen may be sought to augment the care-plan. This will be referred internally via Children's Social Work colleagues.

Comprehensive Assessments benefit from a collaborative approach, involving key professionals from all involved agencies working closely together, with the family at the centre of discussions. Hence, regular multi agency meetings (MAMs) will be held throughout vulnerable pregnancies, allowing family and professionals to share thought and agree the planning deemed necessary to improve wellbeing and reduce risk to baby prior to and post birth. Where parents are not in agreement with the plans formulated in respect of their unborn baby, this will be recorded, alongside the reasons for professionals remaining involved.

It is important that specialist services, such as children's social work, focus attention on children and unborn children where care and protection is required. It is only in these cases that statutory intervention is justified and supported by legislation. As such, if information or assessment indicates that risk has reduced below this threshold, case responsibility should revert back to the midwife, or named person, as appropriate at the earliest opportunity.

Within the mid-trimester period of pregnancy (around 24 weeks gestation) a multi-agency review meeting (known within Aberdeen City as the Mid Trim Review - MTR) will take place. This meeting like other multi agency meetings (MAMs), will share information to shape planning and will determine what support eg, social work, health (universal, substance misuse service, perinatal mental health, CAMHS), education, 3rd sector, will be required for the duration of the pregnancy and beyond. Confirmation as to who will be the lead professional will be agreed. Family strength as well as perceived vulnerability and risk which might impact on the baby will be shared at this meeting. Consensus will then be reached on whether welfare concerns are likely to remain post birth, ie, whether the unborn baby is likely to become a 'child in need' post birth, or whether child protection measures are required. In both cases, children's social work will likely remain the lead professional. Where child protection measures are required, the lead professional will update the unborn Child's Assessment and Plan, recommending that a pre-birth child protection case conference (PB CPCC) is convened.

In Aberdeen City, this decision will be taken by a Children's Services Manager and if agreed, a CPCC will be convened by 28 weeks of pregnancy or within 21 days of notification of the child protection concern. It is therefore important that all professionals who hold knowledge about the strength, vulnerability and potential for risk within the unborn baby's family are able to share their views with the family, at this MTR meeting. If any professionals or key family members cannot be present, then their views must be taken into consideration.

8. Providing Services to Children and Adults

A key principle is that where an adult's circumstances or problems are impacting on a child's needs then this requires inter-agency collaboration between adults and children's services to ensure effective service responses. This will help ensure optimal outcomes for children

Agencies providing services for adults should hold current information about the range of universal and specialist services for children and families and ensure that this is available to parents. In many cases this will involve offering support to help families

access and use these services. Their assessment should lead to specific actions to support positive parenting, reduce risks identified and enhance the life and well-being of the child or children. These actions may be undertaken by the agency dealing with the adult or may involve asking for support from another service.

8.1 Providing Services to Children: Child in Need

Where initial assessment shows that parents have the capacity to provide safe care for their children but need support to meet their children's needs and promote their well-being then agencies will work together to identify needs of children/unborn children and to shape the planning and intervention from all involved agencies. Each Local Authority in the Pan-Grampian area has their own procedures for assessment and planning under GIRFEC National Practice Model approach. Within Aberdeen City, this assessment is the Child/Unborn Child's Assessment and Plan.

8.2 Child in Need and At Risk of Significant Harm

When children/unborn children are deemed to be 'in need' it is most common for agencies to work together, alongside the family, until such a time as it is felt appropriate for universal services to resume the named person role without support from other agencies. Where the needs of a child/unborn child are more complex, a multi-agency response will often be considered. A Lead Professional, usually a social worker from Children's Social Work, will be identified from amongst the practitioners involved and their role will be to take forward the coordination of the activity supporting that child. Unlike a Named Person, which flows directly and automatically from the function of the universal services of health and education, the Lead Professional should be the practitioner best placed to coordinate multi-agency activity supporting the child/unborn child and their family.

It is important that planning around the child is coordinated. The Child/Unborn Child's Plan is the single or multi-agency action plan agreed by involved services, preferably in conjunction with the parents/family. The assessment and plan should lead to specific actions to support positive parenting/reduce identified risks and should be reviewed in line with the National Practice Model approach.

Where there are concerns about significant harm to a child/unborn baby, then planning may come via an Interagency Referral Discussion (IRD) or from a direct referral to children's social work from Police colleagues. Where these risks merit it, formal child protection measures will be instigated, at times, leading to the convening of an initial Child Protection Case Conference or a pre-birth Child Protection Case Conference. These processes are led by the statutory child protection agencies from the outset, but will still have multi-agency input in terms of information sharing at the IRD stage and beyond.

Community midwives may additionally require to complete NHS paperwork (NHS Protection Plan &/or Midwifery Alert) to record and share information within the National Health Service, where there are deemed to be risks to an unborn child, whether the risks have been shared within is a multi-agency child protection plan from CPCC, or via GIRFEC assessment.

8.3 The Multi-Agency Pre-Birth Child Protection Plan

This plan will include protective factors as well as recognising and mitigating against risk and should also include detail of:

- Management of parental non-cooperation
- Who should hospital contact when mother admitted /baby delivered
- What happens if the baby is born out with office hours
- What level of contact should parent/s have with baby, and how should this be supported if there are plans to accommodate baby following discharge from hospital
- Arrangements for initial legal proceedings if required
- What the parents' views regarding the multi-agency child protection plan are

For further information on the IRD, Child Protection Case Conference processes and legal interventions refer to National Guidance for Child Protection in Scotland, 2014, and child protection materials and documentation on the CPC web pages.

9. Pregnancy (and the Early Years)

The Importance of Early Intervention

Research highlights that:

- Early environment and the first three years of life play a significant role in shaping cognitive, social and emotional development and that the most important aspect of this environment is the child's relationship with their caregivers.
- Pregnancy and the early years should be central to safeguarding practice both as the foundation for children's development and as the optimal window for prevention and early intervention.
- Parents' own early experiences can shape their parenting and that early relationship patterns are developed in interaction with primary carers, internalised and re-enacted within later relationships including those with partners, children and professionals.
- Most of the brain cells responsible for regulating behaviour, thinking and emotions are unconnected at birth. Their connecting pathways are formed within the first two years of life.
- The processes of brain maturation are "use dependent" and there are windows of opportunity for developing critical processes such as attachment, self regulation and language. If these windows are missed then catching up is a much harder process.
- Exposure to chronic stress in early years also decreases the capacity of developing brains to regulate rage, anxiety, impulsivity and aggression. Therefore it is more effective to protect children from damage than to undo the neurological and psychological effects of early abuse and neglect.(Howe 2005)

Timely intervention in pregnancy can therefore help:

- Ensure that vulnerable parents are offered support at that stage of their parenting rather than when difficulties have arisen
- Establish a working relationship with parents before the baby is born
- Assist parents with any of the problems that are impacting on their parenting

9.1 Relinquished Babies

A small number of parents advise during pregnancy that they do not wish to parent their baby, and that they would wish to relinquish the care of their child to either a known person, or to the care of the local authority, in order that their baby can be placed for adoption. Often it is a health professional who is first to hear of this situation and it is vital that a referral to children's social work is made at the very earliest convenience. This will allow specialist social work intervention with the parent/s and key family members at the earliest opportunity.

Intervention here will aim to ensure that parents are allowed to explore their wishes and to progress child centred planning for their child, with all the information and support necessary to make an informed decision. An early referral will also allow for planning to commence exploring post-birth care options, including direct placement from hospital with prospective adopters.

9.2 Concealed Pregnancy and Late Bookings

Some expectant mothers deliver their babies without having booked in their pregnancy, or having only very recently commenced ante-natal care. This can be due to lack of knowledge that they were pregnant, or due to avoidance, denial or in some cases, due to fear of professional intervention. Health professionals are usually best placed to gather information in order that a referral to specialist services can take place at the earliest opportunity, where there may be child care or protection concerns for unborn or newly born baby.

10. Advice on Drugs, Alcohol and Psychiatric Medication in Pregnancy

All professionals who are working with children/unborn children, young people and/or with their families affected by problematic alcohol and/or drug use should familiarise themselves with Getting our Priorities Right, the updated good practice guidance written on behalf of Scottish Government, 2013, by practitioners, for practitioners. Getting our Priorities Right, provides both child and adult service practitioners working with these vulnerable families, an overview of the supporting evidence base regarding problematic alcohol or drug use. See also the CPC Practitioner's Toolkit to GOPR on the child protection webpages.

Agencies should not advise a pregnant woman to stop using drugs or alcohol without appropriate advice from the GP, midwifery service or substance misuse services. The

immediate withdrawal of such drugs/alcohol could result in premature birth or miscarriage.

On no account should any agency advise a pregnant woman to stop using prescribed psychiatric medication without first seeking advice from the client's GP or psychiatrist. Immediate cessation could result in a relapse of mental health problems increasing risk to a new born.

10.1 Pregnant Women and Alcohol

Alcohol is by far the most popular substance used in Scotland. When a pregnant woman drinks alcohol, so does her baby. The alcohol enters the mother's bloodstream and the alcohol molecules cross the placenta entering the blood supply of the foetus. There is no known safe level of alcohol consumption for the foetus and risk is high in early stages of pregnancy including conception to the first missed period. Alcohol can harm an unborn baby in different ways at different times throughout pregnancy.

There is no way to know how alcohol might affect the unborn baby. One baby may be harmed by alcohol, while another may not. Babies born to mothers who use alcohol may not present at birth as having difficulties but problems may present later.

Babies can be born with a set of mental, physical and neurobehavioral defects that are as a direct result of alcohol consumption during pregnancy. This is called Foetal Alcohol Spectrum Disorder or FASD.

Children and adults with FASD can suffer from learning difficulties, poor impulse control, show poor coordination, and have problems with memory, attention and judgment and exhibit hyperactivity and behavioural problems.

In addition to the specific problems of drug and alcohol exposure, additional complications for the baby include, but are not limited to, the following:

- Prematurity
- Low birth-weight
- Increased risk of loss of pregnancy or stillbirth
- Increased risk of Sudden Infant Death Syndrome

For further detailed information on how substance misuse affects pregnancy and babies contact your nearest NHS specialist pregnancy team or primary care team.

10.2 Pregnant Women: Illicit and Prescribed Drugs

Almost every drug passes from the mother's blood stream through the placenta to the foetus. Drugs that cause drug dependence and addiction in the mother may also cause the foetus to become addicted. At birth, the baby's dependence on the substance continues. However, since the drug is no longer available, the baby's central nervous system becomes over stimulated causing the symptoms of withdrawal this is called Neonatal Abstinence Syndrome (NAS).

Some drugs are more likely to cause NAS than others, but nearly all will have some effect on the baby. Opiates, such as heroin and methadone, cause withdrawal in over half of babies exposed before birth. Cocaine may cause some problems for a new baby but the main risks are due to the toxic effects of the drug itself. Other drugs such as amphetamines, benzodiazepines, nicotine & cannabis can all have negative effects on the unborn and new baby.

Some babies have only mild withdrawal and are cared for in the normal way. Some babies will be exposed to poly-substance misuse (different drugs and alcohol) and it may be difficult to determine how they will present at birth. However, most babies exposed to opiates may be irritable and are often difficult to comfort. The baby may also suffer from dehydration, vomiting and diarrhoea and seizures and these babies will need specific care and medication to treat their withdrawal symptoms. Treatment frequently includes special hospital care and medication with parents providing, where appropriate, the recommended nurturing and handling to help reduce the symptoms of withdrawal.

NAS may resolve slowly however, some babies will require on-going specific care and medication when discharged from hospital.

Some babies may show no signs of NAS when born but following discharge may begin to show symptoms of NAS. This is defined as “delayed onset NAS”

Agencies working with babies affected by substance misuse should be alert to these symptoms as they can be especially difficult for parents as the baby may develop irritability, feeding problems and have difficulties sleeping and settling. Health professionals should be contacted for support and advice if “delayed onset NAS” is suspected.

10.3 Poor Mental Health and pregnancy

Mental health difficulties are common and are very often treatable. Pregnant women experience the whole range of mental disorders, including mood disorders, anxiety disorders, eating disorders, schizophrenia, and personality disorders. Contrary to what is often believed, depression is as common in pregnancy as at any other time in women’s lives.

Women may have an existing mental health difficulty, or may develop symptoms during pregnancy. The disorder will have an impact on the pregnant woman herself, and there is evidence also that it may affect the development of her baby.

There are a wide range of treatments available for mental disorder. Generally it is advisable to avoid non-essential drug treatment at the time of conception, during pregnancy and during breast feeding. There are a few particular drugs that have a very significant impact on the developing baby. However many other medications – including antidepressant and antipsychotic drugs – can be taken during pregnancy and when a woman is breast feeding. In every case it is a question of balancing risks and specialist health professionals will offer guidance accordingly.

There is a period of a few months following birth when women are particularly vulnerable to experiencing severe mental disorder, particularly mood disorders. There are a number of known risk factors, including a past history of bipolar disorder (manic-depression), schizophrenia and depression, or a family history of these disorders. These illnesses require specialist treatment, and can be risky for the mother and the baby. More generally, untreated mental disorder affects the quality of the relationship between a mother and her baby, and this may in turn have a profound impact on the child's later emotional and cognitive development.

Implications for services:

- All women should be asked about possible current symptoms of mental disorder when they first have contact with maternity services. Enquiry should also be made about any past history and family history of mental disorder
- Staff working in maternity services should have good access to specialist mental health services. This may be through local adult mental services (usually accessed by a patient's GP) or by having links directly with specialist perinatal mental health services
- Women who have serious postnatal mental disorder and who require treatment in a psychiatric hospital should have access to a specialist mother-and-baby unit

References:

All Babies Count: Prevention and protection for Vulnerable Babies, NSPCC, 2011
Scottish Intercollegiate Guidelines Network (SIGN)
Postnatal Depression and Puerperal Psychosis, June 2002 (revised 2011)
www.sign.ac.uk

National Institute for Health and Clinical Excellence (NICE)
Antenatal and postnatal mental health; Clinical management and service guidance (NICE clinical guideline 45), February 2007 updated NICE Guideline CG192, 'Antenatal and postnatal mental health', Dec 2014
www.nice.org.uk

Confidential Enquiry into Maternal and Child Health
(triannual report into maternal deaths)
www.cemach.org.uk

10.4 Domestic Violence and Pregnancy

Domestic violence during pregnancy puts a pregnant woman and her unborn child in danger.

For some women, domestic abuse may decrease or cease during pregnancy but for others abuse and physical violence can begin or escalate in pregnancy or following delivery (DOH 1998).

- It is believed that 30% of domestic abuse starts in pregnancy (DOH 1998).

- Women who experience domestic violence are twice as likely to have a miscarriage or stillbirth (CEMD 2001).
- Women who are known to have experienced domestic abuse during pregnancy are at 3 times greater risk of being murdered by their abuser (McFarlane, Campbell, Sharps & Watson 2002)

Where there has been a direct non-accidental injury to the abdomen of the pregnant woman complications may include:

- Infection
- Haemorrhage and placental abruption
- Miscarriage
- Premature rupture of the membranes
- Fatal injury
- Preterm delivery
- Stillbirth

(Scottish Government 2010)

Domestic violence in pregnancy may have long lasting effects and consequences for both mother and child, including the risk of brain injury to the child and infertility for the mother. Other risks which may present include the risk of/ or increased substance misuse and depression and anxiety during the pregnancy (RCN 2008).

Women who are victims of domestic violence should always be given details of how to get confidential and specialist help.

Health care professionals are in a key position to identify and assist women who are victims of domestic violence. Additionally, women are likely to continue to have a relationship with their health care professionals post pregnancy (i.e. at well baby clinics and through their health visitor team). This allows more opportunities for screening and prevention than is available at any other time.

10.5 Pregnant Women and Impact of Parental History of Abuse/Care

Most parents who have themselves been abused or who have spent time being looked after away from their own families as children, provide good enough or very much better than that, care for their children. However, evidence from inquiries and Significant Case Reviews suggests that professionals should be alert to the fact that adults' childhood experiences may impact on their parenting abilities. (Vincent, S.2010)

Parents who were abused or neglected in their own childhoods may well struggle in aspects of their adult lives as a direct result of the lack of care they received and whilst this may impact on parenting capacity, this is by no means automatic. Loss and trauma per se do not predict problematic parenting. Parents who have come to recognize and understand how their experiences have affected them are less likely to continue the cycle. However the more severe the abuse or neglect the more difficult it is to resolve early losses and traumas and the more likely it is that parents will maltreat their own children. (Howe, D 2005)

Unresolved attachment issues triggered by caring for and protecting the dependent and vulnerable child cause fear and distress in the mind of the carer. More than any other type of parent, those with major unresolved childhood losses and traumas show very untypical behaviours when interacting with their infants.

Parents own experiences of adverse parenting can leave them with unresolved tensions that spill over into adulthood care and control conflicts.

Care conflicts can show as:

- excessive reliance on others and fear of abandonment
- distancing themselves from others
- intolerance of a partner or child dependency e.g. unwillingness to prepare antenatally for an infant's dependency needs

Control conflicts in adult life can :

- Be enacted through violence
- Create low frustration tolerance with attempts to assert power over others

10.6 Consultation with Specialist Services

Where necessary to assist in the assessment of the impact of a risk indicator on a child or unborn child, advice and assistance can be sought from adult mental health services, substance misuse services, learning disability services, Children's Social Work and from services offering advice in relation to domestic abuse.

Who to Contact

www.aberdeencity.gov.uk

Please access local contact details via Adult Health and Social Care (Aberdeen City)

In addition the NHS Grampian services including substance misuse services are available via

www.nhsgrampian.org

Links to domestic abuse services Aberdeen City are available via the *call centre* at
Police Scotland

This includes Grampian Women's Aid 01224 593381

National links re domestic abuse are as follows:

Scottish Government Helpline: 0800 027 1234 (24 hours)

<http://www.domesticabuse.co.uk>

Working With Perpetrators of Domestic Abuse :0845 122 8609

Appendix 1 - Diagrammatic flowchart of a referral for an unborn child within Children's Social Work (from the Need to Know More Toolbox, Children's Social Work, link <http://thezone/nmsruntime/saveasdialog.asp?IID=34932&slD=11148>)

