

An Evidence-Based, Pre-Birth Assessment Pathway for Vulnerable Pregnant Women

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Abstract

The developmental needs of infants during the first year of life have been emphasised by recent research from a variety of sources highlighting the crucial role that early parent–infant interaction plays. Infants identified as being at significant risk of maltreatment need adequate protection within a time frame consistent with their developmental needs. This briefing paper describes a new care pathway established within a UK-based social care team, which aims to provide early identification, intensive support, timely assessment and decision making for a group of highly vulnerable, pregnant women, their partners and their infants. The pathway of care is described and a case study is presented to illustrate this care pathway. A mother is referred at eighteen weeks of pregnancy and supported post birth for six months. The combination of supporting structured professional judgement by the inclusion of standardised tools and training in a programme specifically developed for high-risk families suggests that this pre-birth risk-assessment process warrants further evaluation.

Keywords: Pre-birth assessment, Parents Under Pressure, Early identification, standardised tools

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Background

Infants under one account for up to 11 per cent of child protection registrations in the UK (DfE, 2012), with neglect (49 per cent) and emotional abuse (22 per cent) accounting for over two-thirds of these. Infants also

face four times the average risk of child homicide (Bunting, 2011), the risk being greatest in the first three months and the perpetrators being the parents in most cases (Bunting, 2011). Over the past few years, there has been a 63.3 per cent increase in children under the age of one with a Child Protection Plan (Brooks, 2010), primarily as a result of some of the recent high-profile cases.

Abuse and neglect during the first few years of life have a disproportionate effect on the child's later development primarily because of their impact on the infant's rapidly developing brain (e.g. Schore, 2001) and their attachment system (Fonagy et al., 1991; Sroufe, 1996). For example, infants whose emotional and physical needs are largely neglected show poor developmental outcomes across all domains of functioning in early childhood (Widom et al., 2012). Infants exposed to 'frightened and frightening' parenting (known as Fr-behaviour; Main and Hesse, 1990) are at increased risk of a 'disorganised' attachment which is strongly associated with a range of later problems including severe psychopathology (Lyons-Ruth et al., 2006; Green and Goldwyn, 2002).

In light of the adverse impact of physical abuse and neglect, it is vital that child protection systems respond in a timely manner to ensure infants are given the care and protection required to ensure optimal development. In the UK, infants identified as being at risk of abuse or neglect receive a core assessment under section 47 of the 1989 Children Act in which the local authority is required to make enquiries, to ascertain whether action to safeguard and promote the welfare of the child is required. Section 32 of the act deals with the time frame for finalising proceedings. Concerns that the time frame was often prolonged, to the detriment of the children involved in Care and Supervision proceedings, led to changes to this section of the 1989 Children Act and the specification of a twenty-six-week time limit to finalise cases. The *Public Law Outline: Guide to Case Management in Public Law Proceedings* (2008, 2 FLR 668, available online at www.familylaw.co.uk/system/uploads/attachments/0000/2168/public_law_outline.pdf) that provides guidelines for case management in public law proceedings, was revised in light of the legislative changes and a pilot scheme is currently underway in selected courts to evaluate the implementation of the new court processes aimed at supporting the proposed twenty-six-week time limit for proceedings.

A recent prospective study of infants who had received a core assessment or became 'looked after' before their first birthday found that two-thirds had been identified as 'at risk' before their birth. Of these, 43 per cent were still living with parents who had shown little change and were assessed as being at medium or high risk of abuse, at three years of age (Ward et al., 2010, 2012). The assessment at age three found that over half of the children were showing serious developmental problems (poor speech) and significant behavioural difficulties (aggression), and many of the placements of children who had been removed were approaching breakdown. Further, the long-term well-being of 60 per cent of the permanently separated children had been

doubly jeopardised by late separation from an abusive birth family followed by the disruption of a close attachment with an interim carer when they entered a permanent placement (Ward *et al.*, 2010, 2012).

This evidence points to a need for practitioners to work more effectively when a section 47 assessment is indicated and within timescales that are consistent with the developmental and attachment processes of infants. However, this must be balanced against the practical limitations of arriving at an accurate, conclusive decision in all cases within a pre-determined time frame. There may well be times when, after twenty-six weeks, parents have demonstrated some capacity to change and deserve more time, with appropriate support to further improve their parenting (see Family Justice Review Panel, 2011). What may be more important than finalising court proceedings is demonstrating to the court that the assessment team has been proactive in assessing capacity to change over the twenty-six-week period in order to justify an extension of the assessment period.

This paper describes the development of a new care pathway in a UK-based social care team, aimed at early identification, intensive support, and timely assessment and decision making for vulnerable and high-risk pregnant women. It includes a systematic method of assessing capacity to change, which involves the use of an evidence-based model of assessment and treatment that includes the repeated administration of standardised measures of family functioning and monitoring of goal attainment, consistent with recommendations of best practice (Barlow *et al.*, 2012; Harnett, 2007).

Treatment model

The treatment model adopted in the new care pathway is Parents under Pressure (PuP), a home-based intervention with a focus on developing a safe and nurturing relationship between carer and infant. Managing parental dysregulated affect and impulsive behaviour, in relation both to parenting and to other lifestyle issues such as substance abuse, are addressed through the use of mindfulness exercises and a focus on recognising and managing negative emotional states.

The PuP programme is underpinned by the Integrated Theoretical Framework (Dawe and Harnett, 2013), which is a dynamic model of assessing key areas of child and family functioning to identify clear, objective and collaborative goals for change. An intervention is then provided that is aimed at supporting the family to achieve these goals, resulting in an iterative model of goal attainment and identification of new goals. The Integrated Theoretical Framework also involves a focus on assessing current developmental outcomes with the aim of ensuring that an infant has in place the necessary support to ensure optimal outcome across all domains of functioning: physical, social, emotional and cognitive, whilst respecting the parent's spiritual/cultural values. Assessment of the quality of the care-giving relationship

provides critical information about maternal sensitivity, and the capacity of the parents to provide sensitive and responsive parenting and to structure the environment with predictable routines and consequences to help the child organise their behaviour and emotions. Assessment also focuses on the parent’s capacity to show genuine warmth and nurturance that allows the infant to feel loved, and to present opportunities and scaffolding to promote cognitive development.

A key component of the Integrated Theoretical Framework is an explicit recognition that a parent’s ability to provide an optimal care-giving environment is dependent on the availability of internal and external resources. This includes the parent’s capacity for understanding and managing their own emotional state in the context of parenting a young infant, and the emotional and practical support of others to cope with the demands of parenting. Thus, the assessment addresses the current developmental outcomes of the child including the parent’s values and expectations of the child, the quality of the care-giving relationship, parenting skills, parental capacity for emotion regulation and management of emotions, mood disorders and substance abuse, and social contextual factors such as financial disadvantage, social isolation and drug/crime involvement (see Figure 1). The assessment leads to the setting of individualised therapeutic goals tailored to address the needs of an individual family and support in attaining the set goals. The PuP programme has been evaluated in a series of single case studies in which change in key measures of family functioning and abuse potential were assessed in women leaving prison (Frye and Dawe, 2008), families with a

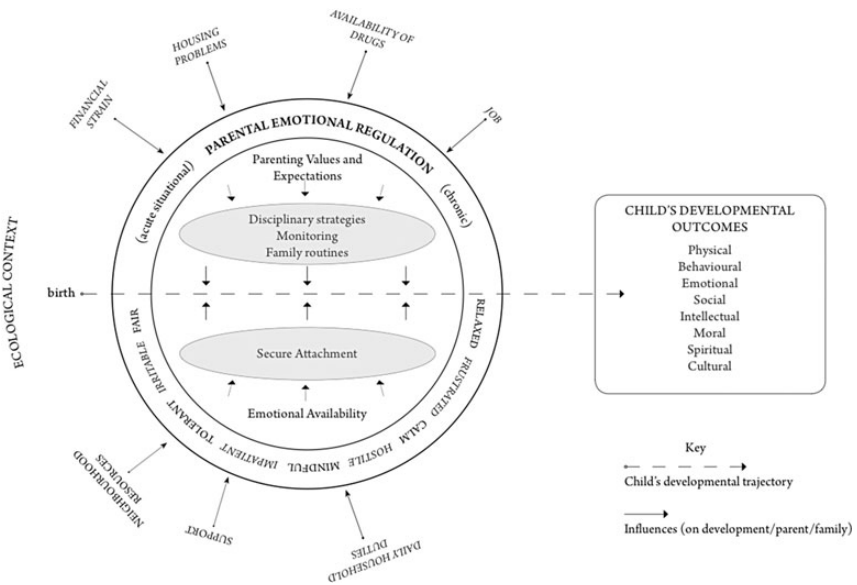


Figure 1. The Integrated Framework (Harnett and Dawe, 2012)

parent on methadone (Dawe and Harnett, 2013) and families referred to child protection (Harnett and Dawe, 2008). These case series found that up to one-third of families made clinically significant change (Jacobson and Truax, 1991) on key outcome measures. The programme was subject to a small randomised controlled trial (RCT) (Dawe and Harnett, 2007) where families on methadone maintenance receiving PuP showed significant improvements on measures of family functioning and a decrease in child abuse potential at six months compared to standard care and those receiving a brief parenting intervention. Notably, these studies were undertaken in Australia and thus the transportability of this intervention to a UK context, in addition to a focus on a younger age group, needs to be evaluated (Dawe and Harnett, 2013), and an RCT is currently underway with substance dependent parents of children under two years of age.

The OxPUP team

The OxPUP team is based in Oxford, UK, and consists of social workers and family support workers, all of whom have received specialist training for practitioners in Infant Mental Health. In preparation for the new care pathway, practitioners attended PuP training and clinical supervision in the PuP model, and became accredited PuP therapists following completion of competency-based assessment that required (i) completion of standardised tools at assessment and post treatment for three families, the results of which were entered into a purpose-built database that scores and provides feedback to practitioners to assist interpretation of the scores, and (ii) completion of a detailed case study to demonstrate understanding of the PuP treatment model and Integrated Theoretical Framework underlying the programme (see www.pupprogram.net.au).

The 'OxPUP' new care pathway

The pathway involves three components: referral; assessment that provides a framework for developing an individualised intervention; and assessment/decision making as described below.

Referral to the social care team

This is made by midwifery staff at a city teaching hospital antenatal clinic at eighteen weeks' gestation. Women who meet at least one of a range of criteria including experiencing domestic abuse, drug or alcohol problems or who are care leavers and who are aged fourteen to thirty-five and are between eighteen and twenty-eight weeks pregnant are referred to the hospital social work

team by midwives. These criteria are checked using standardised risk-assessment questions that are delivered as part of the antenatal visit.

Each alternate family referred by the midwife to the hospital social work team who meets the entry criteria receives OxPUP until capacity within the Community Parenting team has been reached; the remaining families receive standard care. Once a referral has been received by the lead social worker, an appointment is made to discuss the new pathway and what is involved with the woman and her partner.

Pre-birth assessment and development of an individualised intervention (eighteen to twenty-two weeks)

The pre-birth assessment is guided by the Integrated Theoretical Framework when women are referred at between eighteen and twenty-two weeks of pregnancy and again at between thirty-two and thirty-four weeks of pregnancy. At this point in time, there is a focus on the mother's state of mind and well-being, including the wider social context in which she lives. In addition to the clinical interview, the parent's state of mind is assessed using the Depression Anxiety and Stress Scale (DASS; Lovibond and Lovibond, 1995), alcohol consumption is assessed using the Alcohol Use Disorders Identification Test Audit-C (Meneses-Gaya et al., 2010), support is assessed using the Social Support Scale (Zimet et al., 1988) and, where appropriate, the Domestic Abuse Stalking Harassment Risk Identification and Assessment and Management model (DASH, 2009) is also used. Parenting attitudes are assessed using the Brief Child Abuse Potential Inventory (Ondersma et al., 2005) and parental capacity for reflective functioning is assessed using the Parent Development Interview (Slade et al., 2003).

Following birth

Mothers are further assessed post birth (two months), using additional measures including an objective assessment of parent–infant interaction (CARE-Index; Crittenden, 2001) and the home environment (HOME Inventory; Bradley et al., 2003), followed by a final assessment at exit or at six months. In addition to the standardised tools described above, developmental outcome is assessed by liaison with child health services, which includes monitoring of physical well-being (weight and height). The quality of the care-giving relationship is informed by the constructs of emotional availability as described by Biringen (2000), although practitioners were not formally trained in this observational method. Mother–infant foster placements are used where appropriate. A final decision about the need for permanent removal is made in conjunction with the courts by the time the infant is six

months of age. During this period, links are also made as appropriate with other services such as Children's Centres and the Complex Needs team.

The research

A pilot study is underway, following approval from the Social Care Research Ethics Committee. The study compares outcomes for women who received the new care pathway with those who received standard care using data from participant case notes and interviews with key stakeholders including OxPUP recipients. The research aims to answer the following questions:

- Is the new care pathway that identifies and supports mothers to demonstrate capacity to change associated with timelier decision making?
- What are the perspectives of a range of stakeholders (e.g. social workers, judiciary, families) with regard to the acceptability and usefulness of this pathway?
- Can the new care pathway be embedded with existing services for child protection, and what additional processes are required to enable this to take place?

Referrals

Over the study period, a total of twenty-six cases have been referred to the OxPUP team; risk factors for these women have included the following: mental health issues/previous child/ren removed/offending/drugs and or alcohol misuse/partner in prison care leaver/neglect/adoption breakdown/homelessness/physical abuse/sexual abuse. Most ($n = 20$) cases exhibited between four and seven risk factors, with only one case exhibiting one risk factor.

The following case study has been chosen to illustrate the potential of this pathway because this was an early case where the mother and her partner were clearly engaged with the process from pre-birth and thereby provided an opportunity to describe the full working of the new pre-birth assessment model. Key identifying features have been removed.

A case study

Jessica was referred to the team when she was eighteen weeks pregnant after multiple pregnancies. Her previous history included termination, miscarriages and children removed from her care who have since been adopted. Jessica had a history of relationships involving domestic abuse but was in a new relationship thought to be free of abuse and was keen to receive help

to enable her to keep this child. PuP assessment procedures and intervention were used to explore the family history from childhood onwards and to examine the events that led to the removal of her previous children. The assessment, goal setting and intervention delivered was as follows.

Parental values, expectations and parenting skills (assessed pre-birth and again at two months)

In the pre-birth assessment, Jessica had many doubts about her parenting capacity. She was unclear about establishing routines, expressed considerable regret about her previous attempts at parenting and reported that her own troubled childhood had left her with no understanding of how to be a good parent. These concerns led to the identification of goals that would provide Jessica with knowledge about parenting of young infants (bath time and bedtime routines) and an understanding of how she could provide sensitive and responsive parenting. In the post-birth period, Jessica was helped to recognise the responsiveness that was evident in the infant to her mother's presence.

Parent's state of mind

Jessica initially presented as low in mood and quite tearful. She struggled to manage her emotions and responded to daily hassles with great distress. She demonstrated very low self-esteem and reported, even with the steadfast support and positive input from a loving partner, feeling worthless and guilty for the mistakes of her past. Her low mood was maintained by a profoundly negative view of herself as undeserving. Goals focused on both the immediate coping strategies to reduce anxiety by using relaxation and mindfulness techniques in addition to learning to share emotions and talk more openly with her partner about her concerns.

Pregnancy, birth and early development

The pregnancy proceeded without difficulties leading to a full-term delivery of a healthy infant. The overarching goal of the practitioner was to support the mother in her ability to provide sensitive and responsive care-giving for her infant.

Quality of the parent–infant relationship (assessed at two months)

An assessment of the quality of the care-giving relationship was informed by Biringen's work on emotional availability (Biringen, 2000; Biringen and

Easterbrooks 2012; Biringen *et al.*, 2012). Jessica had considerable difficulties in the early weeks of her infant's life as she was easily agitated, believing that she was not able to meet her baby's needs. Her parenting style showed limited sensitivity to her infant and she was intrusive at times, trying to pre-empt her baby's cries by rushing to change, feed or cuddle her, and ultimately failing to understand her baby's states and cues. When the baby would not settle quickly, Jessica would respond by becoming distressed and voicing beliefs that she was unable to be a good-enough mother. These observations led to a series of collaborative goals, which were supported by the case worker and aimed at helping Jessica develop confidence in her ability to parent. Support using video feedback and in-vivo modelling was given as Jessica was helped to learn about her baby's cues and to respond in a relaxed, non-intrusive and sensitive manner.

Quality of mother's relationship with baby's father

The parents were living together and the father was in full-time employment. He was involved in the PuP intervention, with many sessions structured around his working times. Both partners engaged in discussion around relationship issues. These involved helping both partners to express their concerns about their ability to parent and their desire to provide a stable home environment for their baby. This included setting goals around shared parenting roles that were flexible and responsive to their own needs as well as those of the infant.

Wider social context

Jessica and her partner were socially isolated, with no contact with their families of origin. Jessica made some explicit goals around accessing services that could help her with her parenting.

Treatment progress and outcome

Developmental outcome and quality of care-giving relationship

Jessica was encouraged to take her time when responding to her baby, to listen to her baby's cries and to think about what her baby might be trying to tell her (PuP program: Module 6: Connecting with Your Baby or Child). Jessica was helped to develop an awareness that she was fearful of her infant's expressions of discomfort and that, in trying to pre-empt this distress, she was failing to listen to her baby's cues. Further to this, she needed to be helped to see that she was a good mother and to recognise all the things that she was doing well (Module 3: View of Self as Parent/Module 6:

Connecting with Your Baby or Child). These modules were key components of the work which was addressed either explicitly through the use of the Parent Workbook or implicitly by comment and praise offered by the team. Jessica was also supported to attend a drop-in session at the health centre so her baby could be weighed and other milestone achievements measured. This reassured her that the baby was healthy and responding well to the care she was receiving (Module 5: Health Check Your Kids).

Parental values, expectations and parenting skills

Jessica was supported in her desire to develop routines around bath times and bedtimes. She was also supported in her attendance at health and children's centres until she was confident to manage this herself. She was then able to access a breastfeeding clinic and, in so doing, developed confidence in her ability to make decisions around day-to-day care of her baby (Module 5: Health Check Your Kids/Module 3: View of Self as Parent).

Parental functioning (including capacity to regulate emotions) and relationship

Jessica developed an awareness of her own emotional state, in particular her anxiety, and was able to develop routines such as long baths and listening to music to help her calm herself. The couple were also able to discuss shared care of the baby and the father began to play an active role in caring for the baby on his return from work, giving Jessica some time to herself. This helped both partners to feel as though they were working together in a supportive manner for their baby while also providing an opportunity for Jessica to engage in self-care (Module 4: How to Manage Emotions Under Pressure/Module 11: Relationships).

Wider social context

In the early stages of the intervention, Jessica needed to be supported to attend the children's centre but, as her confidence grew, she was able to attend alone. Acknowledging financial limitations, the family identified affordable recreational activities and they began to go swimming and walking in the local park at weekends. Jessica also attended a mothers' group where she was able to meet and make new friends. These friendships were extended to beyond the structure of the children's centres, with Jessica meeting up with new friends and their babies in other social settings (Module 9: Extending Support Networks/Module 10: Life Skills).

This infant was supported via a Child Protection Plan which was reduced to a Child in Need Plan when she was thirteen weeks of age. The case was further

reviewed and, as the situation remained positive, the case was transferred out of social care and into a community-based support plan.

Discussion

The OxPUP care pathway has been fully established and the team are currently working to capacity. Those involved in delivering the service are enthusiastic about its potential and early indications suggest that the programme is a useful method of evidencing the capacity to change in pregnant, vulnerable women. There is a sense that working in this way is challenging but also very satisfying.

The comprehensive information gathered through the assessment and as part of the delivery of the intervention provided the opportunity for more effective and timely decision making in the current case study. The team were trained in the administration of standardised measures which were entered and scored on a purpose-built database. Further, interpretative feedback including information on norms, clinical cut-offs and suggestions for treatment was provided.

Core assessment was started at eighteen weeks in the current case and the OxPUP team offered between six and nineteen social work contacts plus twice-weekly PuP visits. The value of professional experience coupled with the ability to integrate complex information from multiple sources, including standardised measures of family functioning, appear to be a powerful and promising way of working. Notably, no additional assessments were required for this case as part of care proceedings. Importantly, the team was working within the twenty-six-week time frame for care proceedings. The model of intensive and comprehensive assessment with a view to ascertaining parenting capacity within a short window of time, clear goal setting and monitoring of goal attainment, and use of well-validated, standardised measures provided evidence of the current family's capacity to change.

This case study provides an example of the incorporation of an intensive, home-based parenting programme developed for vulnerable high-risk families with contemporary social work practice in the pre-birth assessment phase. The case study illustrates how access to an online database that allows for automatic scoring of valid standardised measures of family functioning can facilitate goal setting, treatment planning and the assessment of capacity to change. The feedback report generated by the automated system provided a comparison of the parent's scores with normative data allowing for interpretation and treatment planning. This represents state-of-the-art social work, where practice is truly informed by evidence (Gray *et al.*, 2012). Additional assessment of key constructs associated with the quality of care-giving was also undertaken (Slade *et al.*, 2003). Combined with the information from standardised measures, this allowed for the formulation of clear goals in collaboration with the mother and supported by the team.

The current case study provides a description of a pathway of care as an example of structured professional judgement integrated into a pre-birth risk-assessment process. However, further evaluation of OxPuP is now being undertaken, and will provide information as to whether this pathway provides for more timely decision making, is cost-effective and can be implemented as part of wider social work practice. It will then be possible to review the feasibility of wider adoption of this model.

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