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UNIVERSITY OF SOUTHAMPTON

**THE CONTESTED SUBJECT:
CHILD PROTECTION ASSESSMENT BEFORE
BIRTH**

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**Doctor of Philosophy
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ABSTRACT

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THE CONTESTED SUBJECT: CHILD PROTECTION ASSESSMENT BEFORE BIRTH

by Diane Hart

Government guidance states that the duty of social workers to safeguard children begins before birth. However, the theoretical, practical and ethical dilemmas faced by practitioners undertaking pre-birth assessments have received little attention. This study attempts to illuminate both the surface performance and the underlying meaning of the activity with a view to stimulating debate about the nature of best practice. The ontological perspective is essentially interpretative: it is contended that, rather than there being a single truth to be uncovered through the assessment process, social workers are constructing a version of their clients which can only be understood contextually. However, it is also suggested that such constructions should be subject to critical and moral scrutiny. The range of overlapping discourses which contribute to the theoretical context of pre-birth assessment are reviewed, including the contested status of unborn children, constructs of children's needs and fit parents, and the threshold/s for state intervention in family life. The prevailing paradigm is identified as that of the welfare child who must be protected, resulting in the evolution of the contemporary child protection system based on the identification and management of risk. The problematic nature of the paradigm of risk and the evidence base underpinning assessments are examined and the possibility of alternative paradigms raised.

The epistemological approach was also interpretative and primarily qualitative but with a quantitative element. A documentary analysis was selected as the most useful method, but drawing on a range of documents providing different types of data. The study focused on the activity of an inner city local authority during one year. This was contextualised by an analysis of statistical data, the policy and procedural framework and the organisational structure of the study authority. Data from the case files of all babies (31) either unborn or under the age of one year who were subject to an Initial Child Protection Case Conference during 1993-4 year were then collected using a pro forma. Key documents were copied and studied in their entirety. Three levels of textual analysis were applied: a *description* of the families, the operation of the child protection system and the outcome for the babies one year after the Conference; *case studies* illustrating both the range of dilemmas and social work styles, and a *thematic* analysis of the ways in which the assessing social workers constructed the notion of a 'safe baby'.

These levels of analysis are reflected in the presentation of the findings. The population of families who had been the subject of pre-birth assessment was found to be particularly troubled, with mothers experiencing substance use or mental health problems. Many also had a history of difficulty in caring for previous children. There were indications that the child protection system provided an inadequate framework for undertaking pre-birth assessments and the response to referrals was inconsistent. However, only a quarter of the babies where pre-birth or neo-natal assessment had taken place were living with their mother in the community at follow-up, supporting the view that this vulnerable population is particularly in need of an adequate social work response. The case studies confirmed this vulnerability whilst demonstrating the variable nature of social work practice. When this practice was further explored thematically, judgements were found to be based on constructions about the natural mother, the peripheral father and the passive baby. Fundamental issues were raised about an alternative paradigm for practice where the subject status of those involved in the assessment process could more effectively be recognised in the construction of evidence. However, the political framework would need to support such an approach and further debate is needed about the proper role of social workers at this point in a child's life.

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CHAPTER 1: INTRODUCTION

Each child is a new being, a potential prophet, a new spiritual prince, a new spark of light, precipitated into the outer darkness. Who are we to decide that it is hopeless? (Laing 1967, p.26.)

This thesis explores one aspect of social work practice: assessments of parenting undertaken before the child is born. The broad expectation that social workers must intervene where children are being harmed is generally accepted in (post)modern society, although the practical application of this may be contested. Intervention even before a child has been born, however, raises a more complex set of theoretical, ethical and practice issues that have rarely been explored. My interest in the topic is firmly rooted in professional practice, rather than academia, as the management of pre-birth assessments was central to my work at the time of embarking on the study. Before describing the ways in which I attempted to illuminate the topic, it may be useful to the reader to understand how the seeds of the research question were germinated.

A career in social work: from meaning to performance

The search for meaning was central to my choice of a career in social work. Leaving university equipped only with a politics degree and an admiration for the anti-psychiatry movement, I worked as a nursing assistant on a unit for people with acute psychotic illness. Believing that 'madness' was actually a manifestation of normality in an abnormal world did little to prepare me for the reality of caring for people experiencing acute mental distress. Determined to understand and facilitate rather than to label or oppress, I was (understandably) a constant irritant to the experienced staff whose aim was to eliminate symptoms and effect a 'cure'. I was baffled about *how* to help the 'patients' make sense of their experiences and forced to acknowledge my own helplessness. What was needed was a social work course - to expand my knowledge and provide practical tools for engaging in enabling relationships with clients.

My training and early years as a social worker were in the 1970s when social work was emerging from the 'casework' model (Jones 1996, Parton 1996a). A wave of new recruits to the social work profession within the post-Seeborn era were recent graduates, many of us imbued with idealistic notions of anti-materialism and the empowerment of the oppressed.

This, combined with the zeitgeist of peace and love, led us to reject the ‘old fashioned’ paradigm of a practice aimed at changing the internal world of our clients in favour of changing the way in which those clients were treated by the outside world. The focus of the work shifted from individuals/families seen as pathological towards a community approach. In contrast to the current de-politicised approach based on competency rather than critical reflection, this perspective appears refreshing if somewhat naïve. However, it was a challenge to maintain and make sense of this idealistic perspective when out in the ‘real’ world as a practitioner. In my first week as a qualified social worker, I was sent to visit a family thought to be harbouring an absconder from a children’s home and was met with overt hostility and threats of violence. My overwhelming preoccupation was to work out what I should be *doing*. How would I account for myself when I got back to the office? Would more experienced colleagues think I had somehow failed because I had retreated without managing to retrieve the child? Notions of empowerment began to be submerged by the need to develop a persona as a ‘proper’ social worker.

This divide between the theory and practice of social work is a continuing theme in the literature. As Sheppard (1998) writes, theory needs to pass the test of practice validity to be useful and I struggled to find a theoretical model that made sense of day to day experiences. The 1980s presented a further threat to my confidence as a practitioner with its series of child death scandals. The social worker involved with Jasmine Beckford was pilloried both by the media and the Inquiry report because she *should have known* that the child was at risk of being killed (London Borough of Brent 1985). I, along with many other social workers, wondered if we too could have failed to recognise the warning signs and we began to doubt our practice. This was the start of the socio-legal era within childcare social work, well documented by a number of writers (Parton 1991; Otway 1996) and described more fully in Chapter 3, with its increasing emphasis on risk assessment and the strive for certainty.

Society requires social workers to do the right thing, even in circumstances where they do not know what the right thing is, and where several courses of action are seen as equally right (Rojek *et al.* 1988, p.5.)

The child protection discourse emerged to regulate not only the activity of abusive parents but also that of their social workers, with a consequent growth in bureaucracy and managerialism (Howe 1992). The task became to predict and control the behaviour of

vulnerable families, not to understand and share in their experiences. Howe (1996) describes these respective positions as being concerned with the 'surface' or 'depth' of human activity.

It was during the ascendancy of the child protection discourse that I became the manager of a childcare team based within an inner city hospital. The majority of referrals were not, as expected, of sick or injured children but pregnant women where midwives were concerned about their ability to care for the expected baby. Many of these situations were at the 'heavy end' of childcare practice. Referrals were of women who had experienced years of schizophrenic illness or heroin use; who lived on the streets; were terrorised and beaten by partners but unable to leave, or couples whose previous children had been removed following abuse. In many of these situations it seemed irresponsible to wait and see what happened when the baby was born. The potential risks were obvious and serious, and a plan was needed to ensure the baby's safety as soon as s/he was born. Inquiry reports following the deaths of Tyra Henry (London Borough of Lambeth 1987) and Doreen Aston (Lambeth, Lewisham and Southwark Area Review Committee 1989) reinforced the validity of this perspective by suggesting that they may not have died had there been pre-birth planning. The particular vulnerability of infancy is endorsed by studies which show that children are at most risk of fatal or severe assaults in the first year of life, usually inflicted by their carers (d'Orban 1979; Creighton 1995) and is recognised in the high proportion of children within this age range on Child Protection Registers. How much more vulnerable, then, were this population of babies whose parents had such severe difficulties that they caused concern even before the baby was born? As a team, we were driven to develop our practice in order to try to safeguard these babies.

Describing the problem

When I began to practice in this area, there were no formal planning mechanisms for the protection of unborn children but this changed with the publication of *Working Together under the Children Act 1989* (Home Office *et al.* 1991, s.6.42). This directed that child protection procedures should be implemented where there was concern about 'future risk' to an unborn child, including conferencing and registration. This principle has just been reiterated in the updated guidance (Department of Health *et al.* 1999). However, the guidance stops there. Social workers are left to make sense of the task of pre-birth assessment without any further direction. Yet there are clear differences in the assessment and protection of

children before and after birth from theoretical, practical and ethical perspectives. Firstly, in spite of occasional attempts to compel pregnant women to comply with medical advice deemed to be in their baby's interests, an unborn baby is not a 'person' and has no enforceable rights in law. Secondly, the possibility of placing an unborn baby on the child protection register has presented logistical difficulties. What does it actually *mean* to register an unborn child? The child has no name, no gender, no date of birth and no action can be taken to ensure her/his safety. In the absence of further clarification, local authorities have adopted different approaches to their registration of unborn children (Barker 1997). Thirdly, official guidance relating to the investigation of risk to children (Home Office *et al.* 1991; Department of Health *et al.* 1999) is implicitly based on the premise that an incident or allegation has taken place and that the child is accessible to observation/ monitoring. The *Orange Book* (Department of Health 1988) which, until recently, prescribed the detailed content of risk assessment contained a series of questions about the well-being of the child, difficult to apply in a pre-birth context. Finally, there are a series of ethical dilemmas which social workers face when working with expectant parents, who are usually heavily invested in the new baby as the symbol of hope for the future and appalled at the prospect of their fitness to parent being called into question. Any attempt to protect an unborn baby inevitably impacts on the civil liberty of the pregnant mother, provoking feelings of unease amongst social workers. Childcare professionals frequently have to balance the respective rights of parents and children and, although this may be complex, there is clear statutory support for the view that the needs of the child are paramount. There is no such clarity when the child is unborn.

Developing the research question/s

In spite of (or perhaps because of) the above difficulties, I was convinced that pre-birth assessment was an important area of work deserving further exploration. The focus of interest throughout the study has been the social work process rather than the experiences of the families involved, but within this the aims have shifted considerably. Initially, I wanted to explore whether it was *better* to undertake assessments before rather than after birth. Did it protect babies from harm and ensure that effective plans were made? I envisaged that, at the end of the study, I would be able to draw conclusions about cause and effect: whether pre-birth assessment *works* or not, and to make concrete recommendations for practice. This approach stemmed in part from an assumption that the only valid approach to research was a

positivist one (for example, I worried about how it would be possible to establish a control group) and that the proper goal of the researcher was to establish universal laws and objective truth. In discovering more about epistemological and ontological complexity, this goal became not only unrealisable but also unsatisfactory. I no longer believed that there could be objective ‘proof’ that a particular model of practice was the ‘right’ one.

The next set of questions were essentially pragmatic (Trinder 1996, 2000). Rather than attempting to test a particular hypothesis, I planned to undertake a descriptive analysis. The overall aim was to illuminate and explore the practice of pre-birth assessment through an examination of real cases, and specific questions were primarily concerned with *what happens*:

- *which* families are referred for child protection assessments prior to birth;
- *what* does the assessing social worker actually do;
- *what* is the outcome for the baby?

However, a number of other influences then entered the arena. I became increasingly persuaded by the concepts of social constructionism and postmodernism and this compelled a re-examination of fundamental questions about the legitimacy of the assessment task itself. If notions of good-enough parenting are socially constructed, then a social work assessment is nothing more than one of many possible versions, selected in order to ‘make a case’ about parents’ ability to care for their baby. If this is accepted, then the focus of research interest shifts to questions about *how* and *why* the social workers developed their story and persuaded the readership:

- *how* do social workers make judgements about future risk to unborn children;
- *why* is it concluded that some parents are unable to care for the baby?

I perceived these ‘new’ questions to be crucial but could not accept that they were the only ones worth asking, or that there is no such thing as a valid assessment. Whilst acknowledging the epistemological problems, I still wanted to ask questions about whether the actions of the practitioners were effective. In spite of reservations about the theoretical basis on which we intervene to assess risk to unborn children, there are instances when it feels entirely right to do so, and as practitioners we must strive to ‘do a good job’. However selective the stories which are told, they are told by real social workers about real children

and their families, to whom real events happened during the course of the study. Decisions were made about placing children on the child protection register or removing them from the care of their parents. I cannot pretend to be disinterested in these events, however problematic they may be to interpret, and they will almost certainly be the topic of most concern to the families who become caught up in the process. The question of *what happens* cannot therefore be dismissed. The danger lies in assuming that it is the only story which can be told or that there is a simple causal relationship between social work actions and the outcome for the baby.

Related to the above but arising from the data itself, a final challenge to the formulation of the research question/s emerged. This was an increasing awareness of variations in practice: not only in the surface arena of performance (what the social workers did) but in terms of the depth of their professional practice (how they made sense of the task). Whilst complying with procedures, the study social workers appeared to operate from different value bases and to adopt different styles. These were not made explicit but were evident from the way workers recorded interactions with the study families and the assumptions they appeared to hold about safe and unsafe families. Yet another layer of issues presented themselves:

- what is the nature of social work expertise;
- are there alternative paradigms for better practice?

Arriving at a starting point

The dichotomy posed by these different levels within the research topic began to be resolved as the study progressed. Rather than focusing on the surface *or* depth of the assessment process, I began to recognise that these approaches could be reconciled and that all the questions described above should be asked. The reflexive practitioner operates both in the surface world: making appointments, convening child protection conferences, applying for care orders *and* in the sphere of meanings: interacting with families, trying to make sense of their experiences and arriving at judgements about the care they could provide for the baby. Similarly, a reflexive researcher can embark on a spiral of discovery, constantly reflecting on the meaning of new information and formulating new questions.

The aim of the study became to describe and analyse the process of pre-birth assessment on a number of levels:

- The surface world of structure and performance, focusing on questions about *what happens*;
- The submerged world of social work judgement, focusing on *how* and *why* meanings are attributed during the assessment process.

This led to consideration of the nature of social work itself, and the possibility of alternative paradigms for practice, with pre-birth intervention as illustrative.

My perspective is that the social work task is a process: one of *interpretation* rather than *identification* of problematic parenting, and that judgements about good and bad parents are socially constructed. I also believe, however, that some babies cannot be safely cared for by their parents and that it is legitimate for social workers to intervene in order to attempt to protect them from harm. Furthermore, it is possible to explore whether different ways of intervening could be described as ‘good’ practice. In order to do this effectively it has been necessary to move beyond the child protection discourse, which is a relatively narrow one (Corby 1993), and to consider the activity of pre-birth assessment from a moral and political perspective. The search for meaning which informed my early career has been resurrected, but is now also informed by the need to provide the actors with a clear framework within which to operate.

In order to make sense of the phenomenon of pre-birth assessment, it became necessary to enter a reflexive cycle of theorising and re-examination of practice. The following study is essentially empirical but with a theoretical thread running throughout. A belief in the discursive nature of assessment and of social work practice itself informs the nature of the research and the subsequent discussion. Overall, the thesis is an attempt to contribute to the knowledge base about both the surface and depth of pre-birth assessment.

CHAPTER 2: BECOMING A FAMILY

Future subjects: unborn children and expectant parents

Inevitably, social work reflects the values and beliefs of the society in which it functions. Before turning to the literature about childcare practice, it is therefore important to explore the way in which unborn children are conceptualised within western society. If practitioners are charged with a duty to assess whether intervention is needed, the complex meanings associated with life before birth and the rights and responsibilities of the key players must be unravelled. In turn, this requires an examination of the wider theoretical framework about the nature of childhood and parenthood.

‘The child’ is a myth, a fiction, an adult construction. So is ‘childhood’ (Gittins 1998, p.2).

The concept that childhood has always been recognised as a distinct entity has been challenged by Ariès (1973) who suggested that children were considered to be no different from adults until ‘childhood’ was invented in the 17C. Other writers have contested this view, suggesting that notions of childhood may have been different from those today but have always existed, understandable only in their historical and social context (Pollock 1983; Archard 1993). Hendrick (1990) maps the developing constructions of childhood starting with the Romantic child, when children were considered to be innocent, through notions of the sinful (Evangelical) child who needed to be trained. These constructions have continued to evolve alongside socio-political and economic changes. Hendrick suggests that the dominant construction now prevailing is that of the Welfare child, who must be looked after and protected. This would seem to accord with current childcare policy, based on the notion of children as a ‘bundle of needs’ (White 1998) who must be nurtured and moulded by adults if they are to develop. Childhood is seen as a series of universal stages with adulthood as the ultimate goal (Freud 1948; Piaget 1959; Erikson 1963; Fraiberg 1971). Children also have rights, however, enshrined in the *UN Convention on the Rights of the Child*, albeit:

... rights which children themselves have not enunciated and are powerless to enforce (Greer 1990a).

Within this developmental model, children are dependent on adults to determine their needs and protect their rights, prompting criticism for its denial of full subject status to children.

Oakley (1994a) argues that the language of ‘best interests’ in respect of children reinforces their disempowerment and Woodhead (1990) takes issue with the focus on ‘children’s needs’ because he feels it contributes to their construction as dependent and powerless beings.

An alternative paradigm (Jenks 1982; Mayall 1994; Qvortrup *et al.* 1994) takes the constructionist position that there are no universal truths about childhood other than the fact of physical immaturity (James and Prout 1990). Children, instead, can be seen as ‘small people’ (Ribbens 1994), able and entitled to exercise agency and negotiating their own pathway towards adult status. However, this model is of limited value in conceptualising unborn children, who receive little attention in the literature and tend to be subsumed into discussions about their parents. Where they are discussed, elements of the welfarist model may be in evidence but there is a more fundamental question: whether unborn children can claim to exist at all.

The status of unborn children

If the subject status of children is in question, then that of unborn children is even more contested, being inextricably linked with that of the mother. The debate centres on whether an unborn child is a person and, if so, at what point. The *UN Convention on the Rights of the Child* states that:

... the child, by reason of its physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, *before as well as after birth* (Preamble: emphasis added).

This implies that the fact of birth does not mark any significant passage and the status of unborn children is effectively the same as that of any other child. Yet this concept has been fiercely debated, often in the context of women’s right to seek a termination of pregnancy (see Greer 1990b). Indeed, anti-abortionists stress the personhood of unborn children to claim that abortion is murder. In contrast, those who are committed to supporting a ‘woman’s right to choose’ have perhaps wished to deny the unborn baby’s personhood because of the implications for the autonomy of the pregnant woman. Personhood implies the existence of rights but these have little meaning if unenforceable, and any attempt to enforce the rights of an unborn child will inevitably impact on those of the mother (Luker 1984). An additional dimension, however, is the pregnant woman’s own perception: she is

likely to talk about her *baby*. Women who have had a miscarriage describe a sense of bereavement and are insulted by suggestions that their loss cannot be compared with that of a *real* person.

Petchesky Pollack (1987) describes the contribution of visual imagery in reinforcing the concept of the foetus as a separate being. Technology which allows the baby to be seen via an ultrasound scan or photography encourages the perspective of mother and baby as separate individuals and allows the mother to be marginalised. She quotes Katz Rothman:

... the foetus in utero has become a metaphor for 'man' in space, floating free, attached only by the umbilical cord to the spaceship. But where is the mother in this metaphor? She has become empty space (Katz Rothman 1986, p.114).

Others have argued that there is almost a sliding scale of personhood depending on the gestational age of the foetus. Terminology can reflect the differing stages of development. Douglas (1991) suggests the term *embryo* for the first 8 weeks of existence and, thereafter, *foetus* until the birth. Only after birth should the proper term be *baby*. The issue of viability i.e. the age at which a baby can survive outside the uterus, may also be described as an important transition towards personhood (Tunkel and Wright 1985). This has influenced legislation on abortion. The fact that babies may be viable at 23 weeks gestation yet also be legally aborted is thought by some to be a moral contradiction. Douglas argues that it is the fact of birth that is significant regardless of gestational age because, before that time, intervention can only be directed at the baby through the mother's body.

Perhaps the personhood debate is unhelpful. Oaks (1994) contrasts the western preoccupation with women's v. foetal rights to the situation in Japan, where abortion is relatively common but the debate is not in evidence. This is not because personhood is denied: the foetus is referred to as a baby and abortion clearly seen as the termination of life. The difference seems to lie in a belief that the spirit of the foetus will be reborn into the family and religious rites are carried out to ensure that the foetus is remembered: a different form of subject status is thus conferred. Other writers also challenge the usefulness of personhood in understanding the significance of abortion. Dworkin (1993) suggests that human life does not have intrinsic moral worth but is given meaning by the woman who creates that life. In this sense, it may be more 'selfish' for a woman to proceed with a pregnancy than to elect to have an abortion: the pregnant woman herself is best placed to

make that decision. Figs (1996) pursues this argument when she states:

Increasingly, women cannot pretend that a 10-week foetus is just a blob. They have to acknowledge that they have killed a very young life.

She argues, nevertheless, that abortion is still morally acceptable because motherhood requires ‘immense sacrifices’ which it is reasonable for women not to wish to make. This is in contrast to the position of those opposing abortion:

For anti-abortionists, a woman’s ‘natural’ role is as wife and mother. She is essentially self-sacrificing (South 1985).

If the subject status of an unborn child is contested, then so is that of the mother.

Himmelweit (1988) develops an alternative approach emphasising the interrelated aspects of mother and baby. She stresses the mother as an active participant in the creation of the baby rather than another being whose body is acting as a temporary ‘container’. Rather than separate individuals with discrete rights, the pregnant woman and her unborn child are interdependent and it is unreasonable to expect a woman to separate her ‘pregnant condition’ from the ‘child she will bear’. For this reason, Oakley (1994b) suggests that the description of a woman being ‘with child’, although now little used, is actually a helpful way of understanding the problem. Instead of the debate concentrating on whether a pregnant woman is ‘one person or two’ (Morris and Nott 1995) perhaps it would be more productive to accept that the pregnant woman is in a category of her own. This thesis contends that an unborn child can most usefully be conceptualised as a *future-subject* and cannot be considered in isolation from the mother. In turn, she has full status as a pregnant woman but can also be thought of as a future-subject: a *mother-to-be*. The position of fathers also needs consideration, and is somewhat different. Although they are also future subjects in the sense of being a *father-to-be*, the link with the unborn child is tenuous rather than inextricable. The respective roles and responsibilities of the key players in relation to unborn children are now considered.

Roles and responsibilities: whose foetus is it?

The complexity of the respective status of mother and child gives rise to conflict about the ownership of the unborn baby. One pregnant woman writes:

Society stretches out its hand to claim your child rather earlier than you would expect. Already, well before it is born, the baby is no longer entirely yours. There is a communal interest in its welfare - and you, being the baby's present place of abode, are no longer a private place ... Along with morning sickness, any pregnant woman can expect intimate queries about her domestic arrangements and a recommended pharmacopoeia of vitamin and mineral supplements and the hands of strangers patting her stomach (Thomas 1996).

The extent to which the mother and father are empowered to make decisions about an unborn baby reflects their respective claims to ownership. This may arise in relation to a woman's decision to seek an abortion, where the rights of the father are uncertain. There have been instances where men have attempted to prevent their partners from terminating a pregnancy but these have been unsuccessful (Furedi 1997). It seems that the role of fathers is particularly undefined during pregnancy (White and Woollett 1991) and they may not be considered to be a parent in any meaningful sense until the baby is born. However, they continue to play a crucial role in conferring 'legitimacy' on a baby and the issue of paternity continues to be of significance (Smart 1987). Even where neither parent intends the father to take an active role in the baby's life, the state still wishes to know who the father *is* in order to exact a financial contribution to the child's upbringing. When a pregnancy is announced, there is often a tacit question as to men's ownership of the baby: 'is it mine?' or 'whose is it?'

Developments in reproductive technology have further increased the complexity of defining parenthood and the 'ownership' of babies:

Motherhood as a unified biological process will be effectively deconstructed: in place of 'mother', there will be ovarian mothers who supply eggs, uterine mothers who give birth to children and, presumably, social mothers who raise them (Stanworth 1987, p.10).

AID, egg or embryo donation and surrogacy have challenged our notion of 'natural' parents. Until recently, motherhood was not contested in the same way as fatherhood but this is beginning to be eroded now that a baby may be born to a surrogate mother with no genetic relationship to the child. A gay couple who wished to become parents arranged for a woman to provide donor eggs which were then fertilised with their sperm and implanted in the body of a surrogate mother. She has now given birth to twins in the US and it has been agreed that they will carry birth certificates naming both men as the parents: not mother and father but parent 1 and parent 2. One of the men is reported as saying:

I have known these babies from when they were a vial of sperm and a petrie dish of eggs, becoming embryos and the scan picture of a little dot. And here they are, live babies being born. Our babies (*The Mail on Sunday*, 12 December 1999, p.4).

Such technological advances had been suggested by Firestone (1970) as a means of liberating women but, now that the prospect of separating the biological from other forms of mothering has become a reality, others see it not as a utopian solution but another means of oppressing and regulating women. The futuristic vision of a society where some women are used purely to produce children as envisioned in Margaret Atwood's novel *The Handmaid's Tale* (1985) is a chilling prospect. Stanworth (1987) suggests that the technologies are not intrinsically good or bad: the important issue is the exercise of power in their application. The Warnock Committee was established in an attempt to address some of these dilemmas and made recommendations (Warnock 1985) leading to the *Human Fertilisation and Embryology Act 1990*. This established regulations for fertility treatment and the subsequent handling of any resulting embryos. Some have suggested that this legislation emphasises the interests of the foetus and men at the expense of women and is driven by a fear of encouraging autonomous motherhood (Smart 1987; De Gama 1993). The argument is supported by the fact that fertility treatment may be denied to women without a male partner (Millns 1995) and the outcry in the media about the possibility of 'virgin births' as a result of artificial insemination. Furthermore, sperm cannot legally be used after the death of a man without his written consent. Wynn Davies (1996) in describing the case of a woman who was refused leave to be inseminated with her late husband's sperm, suggests the reason:

... the decision to bring what will be a fatherless child into the world is such a serious one that rigorous safeguards must be applied.

Yet women who were effectively dead have been maintained on life support systems in order that their unborn babies could be delivered (Stanworth 1987). One father who did not wish his partner to be treated in this way said:

Any shred of humanity was taken away from her. She was not treated as a person, she was treated as a human incubator (Varley 1996).

Free agent or human incubator?

The model of individual rights raises a number of complex ethical questions in relation to

unborn children and their mothers. Stanworth (1987) and Rose (1987) suggest that reproductive technology may operate as a form of eugenics, particularly with increasing knowledge about genetics. Parents with a family history of ill health may be offered genetic screening even before conception and pregnant women undergo an increasingly complex battery of tests to establish the well-being of the baby. The natural desire to have a healthy baby may be distorted into becoming 'a duty, aimed at the welfare of the gene pool' (Stanworth 1987) where pressure is exerted to persuade parents not to have children who are not 'perfect'. Both refer to the fact that most obstetricians will not perform an amniocentesis unless the woman agrees in advance to terminate the pregnancy in the event of a significant abnormality being detected.

... Pregnant Woman is no longer Woman but is a means, albeit to whom certain duties are owed, to an end. That end is the production of a healthy child who must be protected against her mother if necessary (Morris and Nott 1995, p.58).

The desire within society to regulate women's bodies has been noted by a number of writers (Smart 1992, 1995; Bridgeman and Millns 1995). They are described as unruly, dangerous or 'incredible' (Scutt 1992) and in need of control by outside agencies. A Cartesian divide between mind and body is attributed to women so that they are not considered to be fully rational in the exercise of their sexuality or reproduction. This may be particularly so during pregnancy because a woman has become what Corea (1988) describes as a 'mother machine' rather than a free agent:

The 'Mother machine' produces her commodity, the product of her labour, and a commodity which is increasingly subject to forms of quality control (Millns 1995, p.80).

Perhaps it is this question of quality control that is crucial. The combined effect of perceiving the foetus as a person with rights and the technological advances which allow access to the foetus has been to increase the pressure on pregnant women to put the needs of the foetus above their own. Where a foetus has health problems, it is increasingly possible to start intervention before birth with the use of surgery or medication (Ho 1988). The pregnant woman is expected to produce the perfect child and, in order to do so, to follow the advice of the medical profession. The reality is that most women will, in fact, make sacrifices in order to produce a healthy baby but there will be times when they may not be able to attain these standards. Oakley (1994b) suggests that women *know* that they should

stop smoking when they are pregnant but are facing a particularly stressful time that increases their desire to smoke. Their inability to comply with the advice therefore makes them feel guilty and compounds their stress:

The organisation of much obstetric care is based on the assumption that a pregnant or parturient woman has no other responsibilities or interests which conflict with her function of producing a baby. What happens when they do not? They may be the subject of disapproval or there may be an attempt to force compliance (p.22).

There must also be concern as to the limits of a mother's responsibility. A journalist describing a study which suggested that 'children born from unwanted pregnancies have an increased risk of developing schizophrenia' goes on to muse that, although it might be possible for pregnant women to control aspects of the foetal environment such as nutrition:

Ensuring that their thoughts are always positive ones may be slightly more difficult (Dillner 1996).

It is clear that women are expected to live out their pregnancy in such a way as to prioritise the health of the baby: to behave as *future-mothers*, but at what point does their failure to do so constitute 'foetal abuse' warranting intervention? Terry (1989) and Diduck (1993) both refer to the work of foetal rights advocate, Margery Shaw, who compiled a list of a pregnant woman's 'prenatal duties': potential grounds for intervention or litigation if she failed to perform them. These ranged from: antenatal screening to detect foetal abnormalities; eating 'properly'; not smoking or using drugs/alcohol, through to issues which, it could be argued, are beyond the woman's control: not residing in high altitudes, avoiding workplace toxins or infection diseases. Shaw (1980) is quoted by Terry as stating that 'a decision to carry a defective foetus to term would be an example of foetal abuse' which relates back to the eugenics argument above.

Legal intervention

The role of the law in relation to unborn children is controversial. There are differences in standpoint between the US and Canada, where such action is increasingly sanctioned, and the UK, where it is generally accepted that the foetus has no legal status. Several writers (Terry 1989; De Gama 1993; Diduck 1993) describe instances where the law has been invoked. This may take the form of forcing a woman to accept medical intervention. For

example, Morris and Nott (1995) outline the Canadian case of *Re AC* (1988), a terminally ill woman forced to undergo a caesarean section against her wishes at 26 weeks gestation in the hope of preserving the baby's life. Both mother and child died shortly afterward. The court clearly accepted that the foetus had rights, appointing counsel to provide separate legal representation, and it was stated in the judgement that: 'a physician treating a pregnant woman in effect has two patients, the mother and the foetus' and 'a viable unborn child is literally captive within the mother's body'. Even where the woman's body is not invaded, she may be constrained in other ways. In Washington during 1988 a woman was jailed for forgery and detained for the duration of her pregnancy, not because of the offence alone but because she was using cocaine and the baby was thought to be in need of protection (Madden 1993).

Case law in the UK has been more cautious in its approach to the unborn child. In 1988 an attempt was made to make an unborn baby a ward of court (*Re F*: All E.R.193) because of the mother's drug use, mental disturbance and propensity to go missing, but was unsuccessful. In 1992, however, this principle was breached (*Re S*: All E.R.671). A woman had been in labour for some time and the medical opinion was that the baby could not be born naturally: the lives of both woman and child were at stake. Both parents refused their consent to a caesarean delivery on religious grounds and were clearly of sound mind but the High Court overruled them. The case was controversial, although the family did not appeal (Dyer 1994), and the Ethics Committee of the Royal College of Obstetricians and Gynaecologists stated their view that a mentally competent woman has the right to refuse such treatment even where it results in her death or that of the baby. The issue may be more complex when it is deemed that a woman is *not* mentally competent. This may result from a mental illness but may also be seen as a function of pregnancy: the irrational or unruly woman described earlier. Dyer (1996) describes two cases where it was said that, although not suffering from a mental disorder, 'the pain and emotional stress of labour had prevented the women from weighing up all the considerations and making a choice'. More recently, a woman who rejected medical advice to have a caesarean delivery was admitted to hospital under the *Mental Health Act 1983* and the operation performed against her wishes (Dyer 1997). She did subsequently appeal and the action was deemed unlawful.

Alternatively, there may be no intervention before birth but subsequent prosecution because of a woman's behaviour during the pregnancy. For example:

In September of 1986, 27 year old Pamela Rae Stewart was charged with contributing to her infant son's death because she took drugs and had sex during pregnancy. Her doctor had suggested to her that these actions would put the foetus at risk (Terry 1989, p.13).

This was in the US and there have been subsequent similar cases, including charges of attempted murder where a baby was born with foetal alcohol syndrome (Usborne 1996). Where the criminal law is not invoked, civil action may still be taken against a mother. Terry describes a case where a child whose teeth had been discoloured by the mother's use of antibiotics during pregnancy was given permission to sue her for damages. Alternatively, a baby may be removed from the mother's care via the civil law following birth because of behaviour during the pregnancy. Diduck (1993) describes a situation where a mother initially refused medical advice to have a caesarean delivery but subsequently capitulated and gave birth to a healthy baby. Nevertheless, the baby was removed:

... if the 'Mother' would not risk her own physical well-being for her 'Child', she must be a bad mother, and therefore the best interests of her child dictated that he or she be taken from her (p.462).

Similarly, care proceedings in the UK may well take into consideration behaviour during pregnancy. King (1987) outlines such a case concerning a baby born with drug withdrawal following the mother's failure to comply with treatment. This was considered to be sufficient grounds to make an application to remove the baby, regardless of the mother's subsequent conduct towards the baby following the birth. Although it occurred prior to the *Children Act 1989*, the principle was established.

Undoubtedly, women in the UK come under considerable pressure to promote the health of their unborn babies in line with medical advice. Although they are less likely than women in the US or Canada to find themselves in court, they may experience powerful disapproval. Although 'women's right to choose' is widely accepted, the consequence appears to be the ascription of a moral duty:

... a woman who has decided to allow a pregnancy to proceed to term would usually be seen as having accepted some obligation to act in the best interests of the foetus (*Community Care*. 14 May 1998, p.15).

The role of professionals in the UK is not to act as the 'uterus police' (Kroll 1997) by bringing prosecutions against women who have 'abused' their unborn baby. There is,

perhaps, more recognition that pregnant women are subjected to many pressures and cannot always attain the ideal. Nevertheless, there is still a clear expectation that they should act in the best interests of the unborn baby, in line with the welfarist paradigm.

Fitness to parent

The 1948 *Universal Declaration of Human Rights* (Article 16) refers to the fact that: 'Men and women of full age ... have the right to marry and found a family', but what does this mean in practice? Some writers suggest that parenting should not, in fact, be looked upon as a right and that those wishing to care for children should be licensed, as with any other potentially harmful activity, whether the children in question are to be naturally conceived or not (La Follette 1980; Westman 1994). Archard (1993) differentiates between the bearing and rearing of children and suggests that judgements can and should be made as to whether parents are 'fit' to embark on either activity:

Why shouldn't the state, or society as a whole, decide whether a child should be born and, if it is, to which parents it should be allocated? (p.39)

Such ideas have not been universally accepted, perhaps because of unease about their illiberal nature, but also because of the impracticality of preventing people from bearing children. The most notable exception to this is where women with learning difficulties have been the subject of legal intervention to achieve forcible sterilisation 'in their own interests' (Mason and McCall-Smith 1994, Chapter 4). Apart from such cases, the prevailing paradigm is that nothing can (or should) be done to enforce childlessness. This is effectively summarised by Brazier *et al.* (1998):

We accept that people have a *prima facie* right to procreative or reproductive autonomy, and we are certainly opposed to any notion of a state-controlled licensing system which prevents people from making their own procreative choices, through, for example, limits on numbers of children or enforced contraception or sterilisation. We agree that a consequence of this may be that some children are put in grave hazard by the circumstances of their conception and birth. However, we do not regard procreative ability as an absolute right, especially since it can come into conflict with the rights of others. Procreation is not just a matter of individual freedom. It entails bringing about the life of another human, whose welfare and autonomy deserve the highest attention from the state, because of the total dependency of children on others. In view of this, we believe that *when regulation is practicable* and when it does not entail major

state intrusion into the lives or bodily integrity of individuals, it may be ethically justifiable (pp.37-38: emphasis added).

The threshold for regulation is therefore different for those who require assistance to become parents in that this provides the *opportunity* for the state to exert its authority. The *Human Fertilisation and Embryology Act 1990* determines the circumstances in which fertility treatment can be offered, including the requirement that treatment centres have arrangements in place to satisfy themselves that any child born as a result will be adequately cared for:

A woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for a father) and of any other child who may be affected by the birth (s.13.5).

It is left to the discretion of individual clinics as to how they exercise this responsibility. Decisions will often be led by medical staff although authority in disputed cases rests with the Human Fertility and Embryology Authority and, ultimately, the courts. The medico-legal discourse could be said to dominate but this does not mean that judgements are not essentially moral (Millns 1995). Warnock (1987) acknowledges this:

We are surreptitiously making moral judgements. It is not wrong to do this: indeed, such judgements must lie somewhere behind all social policy.

Social workers are not routinely involved in such decisions, despite the fact that assessments of parenting are commonly seen as their province. Both Warnock and Blythe (1993), writing in relation to surrogacy, expressed a view that social workers could make a useful contribution but this role has not developed in practice.

Although fertility treatment requires some scrutiny of parents' capacity to care for the child who may be born as result, this is not a particularly in-depth process. For example, there is no access to police records to establish whether prospective parents have a record of abusive behaviour towards children. However, there is a parallel situation where prospective parents *are* subject to scrutiny: where they wish to acquire a child through adoption. In this instance, assessments are more rigorous and firmly within the arena of social work. In fact, many have argued that it is too difficult to be approved to adopt a child and media reports express outrage that couples are rejected for flimsy reasons, such as being 'too fat, too old or too white' (*The Guardian* 2. 19 February 1997, pp.8-9). The process involves medical, local

authority and police checks, the taking up of references and several interviews with both prospective parents, together and individually. The assessment is prescriptive and comprehensive and the standard format includes detailed information about the applicants' personal history, marital relationship and motivation to adopt. The expectation is that, to take on someone else's child, applicants must be prepared to disclose a wealth of personal and psychological information before being considered suitable. This has led to some criticism that social workers are 'unnecessarily intrusive, and extremely unrealistic in their judgements of what a parent should be' (*The Independent Review*. 16 October 1999, pp.1-2). The question as to what a parent should be and how far this is reflected in reality are now explored.

The (gendered) nature of parenting

The above discussion has focused on unborn children and expectant or aspiring parents but needs to be seen in the context of broader expectations about parenting. The literature overwhelmingly accepts that contemporary western children are the responsibility of their parents although society as a whole remains a stakeholder in the process (Dingwall *et al.* 1983). Can we be clear about the expectations which ensue from the role? The *Children Act 1989* defines parental responsibility as 'all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property'. This does not constitute a clear job description but nevertheless there are notions of the 'right' way to exercise parental responsibility. Commentators such as Etzioni (1993), described as new communitarians, argue that there is a 'parenting deficit' in current western society caused by the exodus of fathers from the family and by mothers working outside the home. He interprets this as parents choosing to put consumerism above the interests of their children. Initiatives of the New Labour government appear to echo this moral perspective. For example, the *Crime and Disorder Act 1998* makes it clear that parents will be held to account for the behaviour of their children and may be the subject of 'parenting orders' to direct the way they exercise parental responsibility.

It was argued earlier that childhood was a social construct. Inevitably, so is parenthood. A widely quoted extract from the advice to parents offered in the 1920s by John Broadus Watson illustrates the shifting ground of the 'good' parent:

Never hug and kiss them. Never let them sit in your lap. If you must, kiss them once on the forehead when you say goodnight. Shake hands with them in the morning (Watson 1928).

Present-day parents who stated an intention to care for their children in this way would be likely to attract attention for emotional abuse. The expectations of how parents should behave is inextricably linked with beliefs about the nature and needs of children. Where children are thought to be intrinsically innocent, parents should be protectors; where they are thought to be intrinsically sinful, parents must be their disciplinarians. However, the term 'parenting' is difficult to unpick. Is it a joint enterprise or is it the total of the input of each individual parent? It is unclear whether it has to be undertaken by a biological parent or can be done equally successfully by someone else, given the increasingly complex structure of families (Stainton Rogers and Stainton Rogers 1992; White and Woollett 1992; Bernardes 1997). Sometimes the term parenting clearly means the activity of mothers, at other times it refers to that of fathers, but often it is not clear what it means. For example, an article entitled *Maternal Depression and Child Development* (Cummings and Davies 1993) refers throughout to depressed *parents*, although it is clear that the studies described relate to *mothers*. The terms are perceived as interchangeable. Busfield (1987) writes:

... the significance of parenthood is not the same for the two genders, a point which the recently fashionable term 'parenting' ignores and even hides (p.66).

Hill and Tisdall (1997) suggest that all societies differentiate between male and female roles in respect of childcare. The literature supports the view that, either explicitly or implicitly, the task of parenting is, in fact, largely the responsibility of mothers. When a child is unborn, it is inevitable that the focus will be on the mother but there is evidence that the gendered nature of parenting persists throughout childhood.

Motherhood and mothering

Assumptions are made about women's natural wish to mother and that this is how they acquire adult status:

That women should have babies and provide childcare is generally regarded as the norm in our society. It is 'what women do'. It is regarded as natural: the expression of maternal instinct to want to care for children which all 'normal' women are deemed to possess (Richardson 1993, p.ix).

Phoenix *et al.* (1991) deconstruct discourses of motherhood and argue that there is a narrow set of normative assumptions about 'good' mothers, defining them in terms of their role as caregivers to children rather than as women:

It is not surprising, then, that conceptualisations of motherhood and of good mothering merely reflect ideas about children. What children are thought to need for development is generalised to define good mothering (Woollett and Phoenix 1991, p.40).

The recent outcry in the media about both teenage and post-menopausal mothers reflects the fact that there is more to the idea of a 'good' mother than her ability to give birth to and care for a child. They should be the right age and have a stable partnership with a man; they should stay at home and yet be available to work if society requires them to; they should instinctively know what is best for their children but accept expert advice or 'parenting' education (Urwin 1985). How else does a 'good' mother manifest herself?

Maternal self-sacrifice

The theme of mothers sacrificing their own needs in order to meet those of their child is pervasive in theoretical texts, child rearing manuals and popular fiction and drama. Kaplan (1992) describes this as the 'angel in the house' ideology of mothering.

To be a 'good mother' demands unceasing selfless devotion to the child under all and any circumstances, requiring the mother to put the child's interests above her own (Wetherell 1995, p.231).

Some writers suggest that this does not present a difficulty: 'Fun for him is fun for you' (Leach 1977). This assumption about self-sacrifice has been questioned not only on the basis that it is oppressive to women but also an abnormal model of behaviour. In any other relationship, complete self-denial would be considered to be pathological and not beneficial to either participant (Wetherell 1995). However, the dominant discourse calls for maternal 'sensitivity' and 'child-centredness' and is thought by many to be an essential prerequisite for secure attachment (Ainsworth *et al.* 1978). Woollett and Phoenix (1991) suggest that child-centredness may be a middle class construct that ignores the complexity of influences on the child, not least the child's own agency. The theory is also questioned by Walkerdine and Lucey (1989) for ignoring the underlying political issues and by Mayall (1996) who suggests that there is a much more complex two-way mediation between mother and child than is generally recognised.

The other side of this idealised vision of saintly motherhood is the blaming of mothers: 'A mother's place is in the wrong (Stainton Rogers and Stainton Rogers 1992).' In addition to the 'angel in the house', Kaplan (1992) identifies the paradigms of the over-indulgent mother, who is really meeting her own needs, or the evil, devouring mother. The child development model lends itself to 'mother blaming' in that the quality of childcare is seen as a causal factor in later development. Richardson (1993) describes how the growth of psychoanalytic theory in the 40s and 50s led to a change in a mother's 'job description':

It is the mother who is responsible for the child's intellectual growth, emotional adjustment, and chances of future happiness in relationships ... It is increasingly her fault if things go wrong (p.42).

Critics of Bowlby's (1956) work suggest that the concept of maternal deprivation also resulted in the view that mothers were damaging their children if they did not make themselves constantly available (Rutter 1981). The real-life problems of caring for children were largely ignored and mothers who were unable to devote themselves wholeheartedly to their children, or who did not delight in doing so, were likely to feel considerable guilt:

I'm sure I didn't play with Shirley enough. Play with her with bricks and puzzles and things ... I think other mothers enjoy it! Perhaps that's said to ease my guilty conscience (Urwin 1985, p.192).

The reality of mothering

I've had the kids ... and when I had them it was like a nightmare, really. Somebody said: 'Motherhood is the best kept secret in the world.' They're right, because no one really owns up to what it's like. All this rubbish that's written about it (McCrindle and Rowbotham 1979, p.377).

The above ideas about natural mothering have been the subject of extensive criticism by feminist writers as being oppressive to women, who should not be defined simply in terms of their role as mothers:

... by depicting motherhood as natural, a patriarchal ideology of mothering locks woman into biological reproduction, and denies them identities and selfhood outside mothering (Glenn 1994, p.9).

They have attempted to deconstruct the role and to draw a distinction between the biological fact of motherhood and the socially constructed tasks of mothering. Early feminist writers

suggested that these functions should be untangled and that there was no reason why women should take on the responsibility for childcare. Ways in which women could seek liberation were suggested: either by freeing women from motherhood itself; removing the pressure to have children or developing different means of reproduction (Firestone 1970; Badinter 1981); or by changing the context of mothering; making fathers do their share (Chodorow 1978) and providing child care and flexible employment (Oakley 1976).

This proved difficult for those feminists who, in spite of the difficulties, valued their role as mothers and did not necessarily want to be liberated from childcare. Perhaps in reaction to this, some writers suggested that motherhood was, in fact, affirming and accorded women special status and power (Rich 1976). Others have rejected both positions. They want to be 'good' mothers but also 'good' feminists and describe their personal attempts to reconcile the contradictions involved in the loss of autonomy which results from caring for dependent children (Gieve 1987; Freely 1995; Segal 1995).

Seventies feminism may have been wrong to present motherhood as all hell, but its not all heaven either (Coward 1995).

There has been increasing interest in studies which describe the experiences of mothers, allowing them to attribute their own meanings to the role (Boulton 1983; Ribbens 1994). Glenn *et al.* (1994) present the diversity of mothering concealed behind the dominant ideal of a white, middle class woman having the care of her children as her sole mission. Alternative stories of the reality of mothering for poor or black women are told, where childcare is likely to be shared within the extended family or community whilst mothers go to work, and child-centredness is not seen as desirable or viable.

An emerging theme when mothers are allowed to speak for themselves is that of ambivalence:

I felt cut to the quick by my child. He knew me at my very worst. He elicited from me both my greatest love and generosity and my darkest anger and frustration (Gieve 1987, p.43).

There is a taboo in Western society about expressing maternal ambivalence (Hollway and Featherstone 1997), which perhaps contributes to abuse. In reporting the trial of Suzanne Oatley for the infanticide of her 11 day old baby, *The Independent* (1 September 1995, p.3)

quoted her as saying: ‘ Perhaps we should have him adopted. I wish it was just the two of us again’, but this plea had not been responded to. As Parker (1997) says, ‘Maternal ambivalence is curiously hard to believe in (p.17)’. She suggests, however, that ambivalence is purposeful in allowing a mother to see herself and the child as subjects, with separate needs. Benjamin (1995) also expresses the view that it is actually beneficial for a child to have an autonomous mother rather than one who suppresses her own needs in deference to the child. Featherstone (1997a) argues that there is a need to develop a theory that balances the needs of mothers and children.

Writers have attempted to deconstruct the term *mothering*. Bernardes (1997) questions whether men can ‘mother’ children (Schaffer 1977). Katz Rothman (1994) clearly supports the view that they can, describing mothering as ‘an activity, a project’ which need not be gender based. She quotes Rudick’s vision of a world where there will be ‘mothers of both sexes’. Mothering is thus equated with childcare but this prompts questions about the nature of fathering and fatherhood. Smart (1991) has undertaken a study of custody disputes following divorce and found that mothers were primarily involved in ‘caring for’ the children but this tended to be invisible when determining custody. Instead, the assertion by fathers that they ‘cared about’ their children was privileged, suggesting that the parenting behaviour of mothers and fathers is judged according to different criteria.

Fatherhood and fathering

The language used in respect of mothers and fathers supports this difference. There is no parallel discourse in relation to fatherhood being ‘natural’ and the father of an unborn child has no clearly defined role. Similarly, there is no difficulty in acknowledging that fathers may have negative feelings towards their children. The opposite view may be expressed: that men do not want to be saddled with the responsibility of fatherhood and will avoid it if they can. This has been particularly evident in recent reports of teenage fathers, with the Government stating its intention to pursue them ‘vigorously’ to support their child whereas young fathers themselves may indicate that they *want* to care for their children and to ‘stand by’ the mother (Freely 1999).

Whereas *mothering* is generally used to describe the activity of caring for children, *fathering* is used to describe the biological fact of producing a child. For example, Clarke (1997)

describes a survey which asked men about children they had ‘fathered’, effectively separating the relationship with the child from the fact of paternity. A survey that asked women about children they had ‘mothered’ would carry a different connotation. The fact that paternity may be contested, whereas maternity is (usually) obvious, contributes to this separation. The law confirms this potential for doubt by conferring parental responsibility automatically on mothers, but on fathers only in specified circumstances.

This more tenuous and contested relationship continues in terms of the role fathers are expected to play in children’s lives. The clearest aspect of the role is that of breadwinner, in spite of demographic changes which challenge the traditional roles of working fathers and home-based mothers. Being a good provider is no longer likely to be perceived, however, as tantamount to being a good father:

... children need and deserve active, involved fathers throughout their childhood and adolescence (Doherty *et al.* 1998, p.279).

They describe the ‘distant breadwinner’ father as being a phenomenon of the 19C, replaced by the ‘genial dad’ but with the emerging expectation in the late 20C that fathers should be ‘equal co-parents’. Although some writers suggest that mothers and fathers can, or should, take equal responsibility for childcare (Stoppard 1984), there is little to indicate that this is actually the case. Lewis and O’Brien (1987) suggest that an ideology has developed of the ‘new’ father, involved in both childcare and housework, but that ‘the evidence for the existence of such a man is much less convincing’.

Quantity and quality

Since the 1980s, there has been an increasing interest in the role of fathers, whether in terms of their impact on child development (Lamb 1997), the experience of fatherhood (McKee and O’Brien 1982; Moss 1995), or suggestions that the role needs to change (Campbell 1996). The emerging picture is of fathers as the secondary parent in western society, either by force of circumstances or choice. Studies of the extent to which fathers were involved in the day to day lives of their children (Grossman *et al.* 1988; Burghes *et al.* 1997) found an immense variation in the quantity of time they spent interacting with their children, but it was still less than mothers even where parents had equal work commitments. The nature of their involvement was also different, with fathers engaging in episodic play with their children rather than messy and repetitive care tasks (White and Woollett 1992). This pattern

of involvement was reported even where fathers were the primary carer for the child, suggesting that parental roles are not straightforwardly interchangeable. Although there may be advantages in spending time with children, Grossman *et al.* (1988) say that the quality of interaction is not dependent on the quantity but rather on the psychological characteristics of the father *and the mother*. They describe mothers as having a gate-keeping role in the father's relationship with the child, not only in how far they allow him to be involved but also in modelling 'good' parenting. Other writers also comment on this expectation that the mother will be the expert on the children (Backett 1987; Doherty *et al.* 1998). Mothers are seen as the parent who is responsible for the children, with fathers 'helping out' if they undertake childcare tasks. The nature of the parental relationship is therefore crucial in the negotiation of fatherhood. It may be that mothers have an investment in retaining the central role for themselves if they perceive fathers to be less competent as carers, or wish to retain the expert status conferred by motherhood.

Luxury or necessity

The question of whether children need fathers is not taken for granted in the way that it is for mothers. Studies of fathers' relationships with their children have demonstrated that they can provide infants with a secure attachment, even where they spend much less time with them than mothers (Lamb 1997). The increasing expectation that fathers will attend the delivery and develop a relationship with their baby as soon as s/he is born have been thought to contribute to the closeness. White and Woollett (1991) question the evidence for this, suggesting that it is probably the fathers who are already more involved who opt to attend the delivery. They do report that fathers were very absorbed in their new-born infants, holding and touching them extensively and this, in turn, affected the way that mothers related to the baby. Perhaps it is a positive relationship with the mother that indirectly improves the outcome for children rather than the direct relationship between the father and child. Whilst it is difficult to research the impact of a father's presence, studies examining the impact of paternal absence have been inconclusive. It may depend on factors such as the quality of the interaction with each parent or the age and gender of the child (Burghes *et al.* 1997). Fathers are much more vulnerable than mothers to the possibility of marginalisation. They have to overcome the hurdles of proven paternity, reduced contact because of work/ societal expectations, the mediating role of mothers and the risk of separation through family breakdown. They also have to contend with a degree of scepticism about their worth:

No doubt the ideal father is better than none but many fathers are so far from ideal that their non-existence might be a positive advantage to children (Russell 1929: quoted in Richards 1987, p.29).

Having explored notions of family life, we will now consider those situations where the state exercises its authority to intervene, particularly the areas which are the province of social work.

CHAPTER 3: SAFEGUARDING THE CHILDREN

The previous chapter focused on constructions of unborn children and the job description of parents-to-be. The prevailing story was of needy babies, self-sacrificing mothers and (more or less) supportive fathers. An additional body of literature concerns the regulatory role of the state in family life, from the threshold for deciding that intervention is needed to the nature of that intervention. Social workers have been given the task of policing this boundary (Foucault 1977; Donzelot 1979; Parton 1985, 1991, 1996a) and their regulatory function is perhaps particularly evident within childcare. Although there are ongoing attempts to 're-focus', childcare practice is dominated by the child protection system, within which pre-birth assessment is formally located. This chapter examines the system and its underlying paradigm of risk. A range of operational difficulties are described, including the contested nature of thresholds, the problematic notion of 'good' outcomes for children, the gendered nature of child protection intervention, and the validity of partnership working. A crucial question when assessing the safety of children is the nature of the 'evidence' and critiques of a modernist approach are described, including the proposal of uncertainty as a more suitable paradigm. Finally, the limited literature on pre-birth intervention is presented. The dilemma throughout for practitioners is how to keep unborn children in mind within this broader agenda.

Child protection: discourse and process

The evolution of the current child protection system has been extensively described (Frost and Stein 1989; Corby 1993; Otway 1996; Parton 1985, 1991, 1996b; Parton *et al.* 1997). To summarise Parton's argument, it began with the identification of the 'battered child syndrome' by Kempe *et al.* (1962) in the mid 20C. The perception was of child abuse as a 'disease', diagnosable within the medical model. Abusers were seen as pathological individuals who needed treatment by skilled professionals within the new human sciences, the 'psy' complex. As a result, the assessment process was rendered unproblematic: by engaging in a benign relationship with clients, social workers could uncover the true nature of their problems and arrive at solutions. However, in the 1980s this welfarist model was seen to be failing. Children continued to be killed by their caregivers in spite of social work involvement or, conversely, were subjected to unnecessary intervention.

A paradigm of risk

This marked the start of an era of ‘high modernity’ (Howe 1994) with its approach to child abuse as a phenomenon that could be predicted and prevented. Blom Cooper expressed this position in his Inquiry report following the death of Jasmine Beckford when he talked about the need to establish ‘predictive techniques of dangerousness’ (London Borough of Brent 1985). The view that this is an achievable goal has had a lasting impact on public expectations of social work: the implication being that if only all the facts had been considered, it would have been obvious that a child was at risk of being killed by her/his carers.

The positivist view of child abuse assumes that it can be predicted using researched criteria (e.g. premature babies are more likely to be abused). This only works if we assume that child abuse exists as a discrete, identifiable phenomenon and that most of these factors reside in the parent’s personalities. Further it follows that high risk cases can be predicted if a number of predisposing factors are met (Frost and Stein 1989, p. 54).

This perspective prompted a series of attempts to identify ‘risk factors’ by studying incidences of child abuse, particularly fatal abuse, and listing the common characteristics of the families. A causal link between these factors and abuse was assumed. Checklists (Greenland 1987; Browne and Saqi 1988) or risk assessment schedules (Nasuti and Pecora 1993; English and Pecora 1994) could then be produced to guide professionals in deciding which families were ‘dangerous’ (Dale *et al.* 1986). Factors thought to be relevant included *parental characteristics*, e.g. young mothers, *characteristics relating to the child*, e.g. prematurity and low birth weight, or the *family situation* e.g. poverty (see Corby 1993).

However, an additional element of risk was identified by many of the Inquiries into child deaths (e.g. London Borough of Brent 1985; London Borough of Lambeth 1987; Lambeth, Lewisham and Southwark Area Review Committee 1989). In a study of Part 8 reports, James (1994) found that 26 of the 30 families were known to Social Services (para.3.1). This suggested that dangerousness lay not only in families: individual or collective failures within professional practice were thought to have contributed to child fatalities. Deficiencies highlighted were poor inter-agency communication, lack of training and supervision (Department of Health 1991), or poor quality assessments and a failure to gather an adequate history (Munro 1998a). A further dimension to the concept of professional dangerousness

was the perceived over-intervention of social workers in the Cleveland and Orkney child sexual abuse cases. Alongside a failure to protect children, they were now also accused of actively causing harm to innocent families (McGee and Westcott 1996).

There is a need to protect families from hysterical and malignant social workers (*Daily Mail*. 7 July 1988, quoted in Franklin and Lavery 1989).

The response to these perceived failings was to issue Government guidance telling practitioners how to assess, (*Orange Book*: Department of Health 1988) and manage, (*Working Together*: Department of Health and Social Security *et al.* 1988) child protection concerns. This marked the origin of a discourse of child protection, based on the need to prescribe the activity of families *and* practitioners, replacing the more uni-dimensional discourse of child abuse. The emergent system was based on the premise that children can be protected if practitioners collect and share standardised information, follow procedures and are rigorously managed.

The *Children Act 1989* which consolidated these changes was an attempt to balance the paternalistic and parental rights perspectives described by Fox Harding (1991) whereby parents are supported in caring for their children but children are also protected from poor parental care (see Packman and Jordan 1991). The *Act* gave social workers primary responsibility for both these functions, but the service is not universal and the first task is therefore to undertake an assessment. The difficulties which have arisen in attempting to operate the system are now considered.

The threshold debate

Whilst assessment may appear a reasonably straightforward task, the difficulty lies in the operational thresholds. The initial threshold as to whether a child is 'in need' and therefore entitled to services, is contested but of more significance here is the child protection threshold. This requires a level of consensus not only about what is harmful to children but when that harm is significant enough to override parents' right to privacy. As early as 1994 concern was being expressed about the way in which the thresholds for intervention were being operated (Audit Commission 1994; Department of Health 1994a). Research was commissioned by the Department of Health to explore the operation of the child protection system and an overview report published: *Messages from Research* (Department of Health

1995a). Although there was some acknowledgement of the complexity of the task, it concluded that practitioners were getting it wrong: ‘too much of the work undertaken comes under the banner of child protection’. This view was based particularly on the study by Gibbons *et al.* (1995a) which showed that 6 out of every 7 children initially considered within the child protection system were filtered out without being placed on the child protection register and only 4% were removed from their parents. The analogy of minnows being caught in a net was used to suggest that a more appropriate response in most cases would have been to offer support. Since the report was published, there has been continuing controversy about how to adopt a more supportive approach without missing those children who *do* need protecting. A key question is where responsibility lies for re-drawing the thresholds: society in general, central government, local ACPCs or practitioners (Parton 1996c).

Contested outcomes

It would be reasonable to expect a system designed to protect children to have clear measures for demonstrating success. However, the literature on the outcomes of child protection intervention is equivocal. The topic was first tackled by Parker *et al.* (1991) in an attempt to evaluate outcomes of children in ‘care’. However, they acknowledged the difficulty of applying their model in a family context where a *good* outcome for one member may be at the expense of others:

However carefully they are chosen most outcomes cannot simply be classified as ‘successes’ or ‘failures’ (p.33).

Messages from Research (p.41) suggests that the following criteria must be considered when evaluating the outcome of intervention:

- effects of abuse on children;
- extent to which children are protected;
- effects of abuse enquiries on families.

It goes on to describe other possible criteria, including the ‘gains and losses for other family members’; the prevention of ‘scandalous events’; respect for ‘children’s and families rights’; money ‘well spent’ and standards maintained. This suggests that it is not just the protection of children that matters but the *way* in which they have been protected, and that practitioners also have a stake.

Studies have considered different aspects of these outcomes. A review of the literature on the effects of abuse is offered by Corby (1993), ranging from emotional and psychological problems; relationship difficulties; developmental and intellectual impairment; mental illness; delinquency; drug abuse; violence; depression; low self-esteem etc. The literature tends to differentiate between the effects of sexual or physical abuse and neglect. Corby urges caution in causally linking abuse and outcome, however. Some children appear to be traumatised by relatively minor abuse, whilst others demonstrate surprising resilience (see Gilligan 1997). Gibbons *et al.* (1995b) concluded from their follow-up study of children who had suffered physical abuse that its significance was as an indicator of a punitive parenting style rather than being necessarily harmful in itself. Hagell and The Bridge Child Care Development Service (1998) present a somewhat bleaker picture, pointing out that an estimated 100-120 children are fatally abused each year, over $\frac{1}{3}$ of whom will be infants under the age of 1 year.

The second question as to whether children are protected by the system is a difficult one to answer if a social constructionist perspective is accepted. Once in the system, families are more likely to have their actions construed as abusive. The studies in *Messages from Research* indicate a re-abuse rate of between $\frac{1}{4}$ and $\frac{1}{3}$, albeit of a less serious nature. Gibbons (1997) concludes:

... the only safe verdict on the question of whether or not current protective procedures safeguard children identified as at risk is 'not proven' (p.82).

The evidence for the final measure suggested by *Messages* is also bleak. The studies indicate that families were initially shocked, fearful and angry about the abuse investigation, although this was not always maintained. Investigation could also have a detrimental effect on family functioning, possibly making the situation worse rather than better for the child. Gibbons *et al.* (1995a) attempted to categorise the outcomes for children who had been the subject of case conferences. These ranged from 'good' (where the child is safe at home) or, where this is not achievable and the child is removed from home, 'least bad':

... the child should be safe in a family setting, either her or his own or, if that would not be safe, in an alternative family. Second, there should be clear plans for the child's future so s/he does not become 'lost in care'. Third, links with his or her immediate and extended family should be preserved where this is at all possible. Fourth, appropriate help should be mobilised to compensate for any developmental delays or problems the child may experience as a result of

maltreatment (pp.101-102).

A complex equation of different outcomes is therefore calculated to decide whether the child's welfare is being promoted, of which the prevention of abuse is only one. Indeed, a level of abuse may be considered acceptable if outweighed by other gains for the child. Given this complexity, it is little wonder that social workers are torn between optimism and caution.

The gendered nature of practice

The previous chapter indicated that the notion of equal co-parenting does not reflect the reality of family life, yet there is little recognition of the importance of gender within official guidance. The language is of *parents*, although Milner (1993) suggests that when the term is used throughout the *Orange Book*, it clearly means *mothers*. Nigel Parton (1990) acknowledges that his early work was gender-blind and that the term *parenting* needs to be disaggregated, as indeed does the notion of *family*, and he criticises *Messages from Research* for paying insufficient attention to this (Parton 1999). In fact, there is evidence of a gendered approach within the child protection process. This is manifested both in assumptions about dangerousness and in the focus of intervention.

A gender-blind approach to assessment is not being advocated: the problem lies in basing practice on assumption rather than evidence. For example, Wattam's (1992) study showed that the presence of a male in the household was thought to be risky, as did Gibbons *et al.*'s (1995a) but the reasoning was not made explicit. The literature does indicate differences in the harm inflicted by men and women on children. Of particular interest for this study is the gendered nature of the fatal abuse of babies. Marks and Kumar (1993) studied babies under the age of 1 year who had died at the hands of their parents. They found that mothers who kill their baby are more likely to do so on the first day of life and in a disturbed state. They also use less violent means. Once these instances were excluded, the majority of perpetrators were fathers, and they were likely to have killed the child through an act of violence.

Most studies focus on the type of abuse perpetrated by men and women. There is little dispute that sexual abuse is predominantly committed by men (Campbell 1988; Hearn 1990),

physical abuse is thought to be perpetrated equally by the genders whilst women are said to predominate in terms of emotional abuse and neglect (Greenland 1987). However:

If it was possible to control for who spends the most time with the child, this level of men's abuse would be higher, given that their participation in childcare is so low (Christine Parton 1990, p.43).

This highlights the fact that the issue of responsibility for abuse may not be straightforward. Where mothers are abusive, the stress caused by the men in their lives may be seen as a contributory factor (Lacharité *et al.* 1996; McGee 1997). Alternatively, women are more likely to be considered neglectful because it is their job to provide childcare or they may be blamed for failing to protect children from male violence (Dale *et al.* 1986). The opposing suggestion that both women and children need to be protected from patriarchal violence also fails to reflect the true complexity. Christine Parton (1990) points out that a mother's failure to protect a child from male violence must be considered in the context of women's relative powerlessness both in family life and society as a whole but that the role of women cannot be ignored. Featherstone (1997b), whilst acknowledging the imbalance in power, makes a plea for studying the roles and responsibilities of *both* parents:

... the understandable anxiety on the part of feminists to avoid mother-blaming has resulted in an equally problematic tendency to assume that women carry no responsibility (p.173).

The differing levels of risk posed by men and women are not straightforwardly reflected in practice. Farmer and Owen (1998) describe the differential treatment of mothers and fathers at each stage of the process in respect of 44 children placed on the child protection register. At the point of referral, those relating to lone mothers or emotional abuse and neglect (i.e. those perceived as indicating difficulties in mothering) were most likely to be filtered out without services. This was the case even where women were actively requesting help: rather than women being seen as 'allies in the protection of their children, they were often treated with suspicion'. Where allegations related to a male partner, mothers were often overlooked during the investigation with little recognition of their need for support. This marginalisation of mothers changed, however, when it came to the child protection conference. Mothers usually attended, often without their partner, but found the experience punitive:

Women felt that they were blamed and that their moral fitness as parents was being judged (p.549).

This was regardless of the alleged perpetrator: mothers were seen as the best source of information and as carrying ultimate responsibility for the welfare of the child. Men, in contrast, were allowed to opt out. Decisions about whether to place the child on the child protection register also appeared to be affected by gender: maternal physical abuse being more likely to lead to registration. Following the conference, the focus of attention rapidly fixated on the mother regardless of the nature or circumstances of the abuse. Typically, mothers were offered 'support' rather than intervention being directed at the abuser/ abusive behaviour. The authors concluded:

Indeed, in a child protection system developed and then driven by child deaths, most of which were committed by men, it is a paradox that attempts at regulation are unrelentingly directed at women (p.556).

The role of male violence within the family was frequently ignored, both in terms of the risk to the children and the power imbalance within the family. Women were held responsible for protecting the children even where there was evidence that they could not protect themselves.

O' Hagan (1997) suggests that men are *actively* excluded throughout the child protection process. It is mothers who are interviewed, even where the father or partner is present in the room: the social worker may not ask his identity and he is allowed to read or watch television. Men are not only physically absent at the case conference but omitted from the case conference report. They are even absent from care proceedings, where their parenting ability may receive little mention in the written evidence. Where children are placed in foster care, the pattern of contact is likely to be between the mother and child, excluding the father. These differences are not lost on parents. Brazil and Steward (1992) report that they were well aware of the focus on mothers:

A woman whose partner had physically abused her child resented the fact that the focus was on her. Another said: 'Social workers never involved my husband, they should have talked to him, brought him in'.

Interestingly, this punitive response to mothers is not reflected by the criminal justice

system, which appears to treat them more leniently. In their study of parents who killed their children, Wilczynski and Morris (1993) found that there was a clear disparity according to gender, particularly where the child had been under the age of a year. The offence of infanticide can *only* be committed by mothers and refers to the killing of their own child under the age of 1 year and is considered to be a lesser offence than murder. In general, women were more likely to have the charges reduced to manslaughter on the grounds of diminished responsibility and to be disposed of through hospital or probation orders. Men were more likely to be convicted of murder and to receive a prison sentence.

The overriding message is that, where children are considered to be safe, women are 'left to get on with it': where they are thought to be at risk, women are held to be responsible whilst men fade into the background. Why do men and women receive such different treatment? Wilczynski and Morris (1993) suggest that:

Women are assumed to be inherently passive, gentle, and tolerant: and mothers are assumed to be nurturing, caring and altruistic. It is an easy step, therefore, to assume that a 'normal' woman could surely not have acted in such a way. She must have been 'mad' to kill her own child (p.36).

Similarly, the rationale for charging a mother with infanticide is that 'the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation'. The dominant perspective is of the 'natural' mother, described earlier, who could not possibly want to harm her child, in spite of evidence that the reality of mothering is often stressful and unsatisfactory (Graham 1980; Boulton 1983). Featherstone (1999) suggests that, not only is maternal ambivalence difficult to express, it is difficult for professionals to hear. This may have serious implications for their ability to protect children. She describes the case of Rikki Neave, who died at the hands of his mother:

For some time Ruth had asked social workers to take Rikki away and had expressed her belief that she would harm him if this was not done. Clearly, listening to Ruth and taking seriously what she was saying could have ensured quite a different outcome in this case (p.50).

Farmer and Owen (1998) note a historical reluctance to make male violence visible unless there are concerted attempts to bring it to public attention. The impact of working with

'dangerous' men is often not fully acknowledged and the admission of fear not encouraged within the social work profession, particularly, as O'Hagan (1997) points out, amongst male workers. It is no surprise that social workers may take every opportunity to avoid men altogether or to steer clear of any action likely to provoke a confrontation, preferring to direct their energies towards the (less threatening) women. He also suggests that there may be underlying hostility to men amongst some social workers, seeing them as the cause of women's problems and feeling that the family would be better off without them. Perhaps the most compelling explanation, however, is the persistent belief that caring for children is women's work:

As women are seen to be responsible for the care and control of their children, when something goes wrong the mother is blamed for inadequacy and negligence. This means that the term parenting, although an attempt at gender neutrality, is nothing but an empty gesture (Milner 1993, p.52).

O' Hagan (1997) stresses the importance of working with men, despite the temptation not to. He notes the fact that men exert a significant influence on the quality of childcare even where the mother is ostensibly a single parent. If no attempt is made to engage the men in a child's life, this will have an adverse impact on the ability to protect her/him and will place an unfair burden on the mother. Finally, leaving out men may alleviate them of responsibility but will also deny them access to help:

... techniques for working with fathers will not be developed; and their hopes and wishes will not be identified and articulated (Milner 1993, pp.60-61).

The problem of partnership

A further difficulty within the child protection process is that of the relationship between assessor and assessed. Alongside the increasing proceduralisation of practice, there has been an exhortation to work in partnership with families. This principle was enshrined in the *Children Act 1989*, although there was initially little to guide practitioners in its implementation other than the directive to invite parents to attend case conferences. This was the point at which the study social workers were operating. Additional guidance has since been issued (Department of Health 1995b), differentiating between the levels of *providing information, involvement, participation* and *partnership*. It was acknowledged that true partnership was not always possible in child protection work but should be the goal.

As a minimum, social workers must provide adequate information and be willing to ‘listen without pre-judging’. The degree to which family members should be involved was left to the discretion of practitioners with the proviso that ‘efforts to work in partnership must not put the child at risk’.

Healy (1998) suggests that participation is actually an inappropriate goal within childcare work, based on a simplistic notion of paternalism *or* partnership. It is linked with ideals of social justice and equality that fail to recognise the complexity of the task. Social workers must make professional judgements and a more appropriate goal would be to ensure clarity about the basis of these judgements rather than suggesting that parents can participate in their formulation. Thoburn *et al.* (1995) undertook a study in which they interviewed families and social workers involved in case conferences to establish the extent to which partnership working had succeeded. It was certainly not damaging to the outcome for the children: conversely, where families were not engaged, this had a detrimental effect on planning. However, they found that only 16% of families felt that they had been fully involved. Interestingly, families were less concerned with *what* had been done than the *way* in which it had been done. They were very aware of being patronised and wanted to feel, not only that the work was ‘competent and well-planned’ but that the social worker ‘cared about them as people’. Brazil and Steward’s (1992) study confirms the importance of the individual practitioner’s approach. One mother said:

The second social worker had much more belief in us, and I was aware of her trying to work towards the children’s names coming off the register.

A similar study undertaken by Bell (1996) confirmed that parents would rather be involved in case conferences than not, but did not necessarily feel that they had been able to influence the decisions. The benefit in many instances was, instead, that they were able to ‘learn about how the diagnosis of abuse has been constructed’.

Challenging the system

This question about the origin of social work judgements is key and is linked to a number of critiques of the system. It is useful to return to the paradigm on which the system is based, namely that risk can be effectively assessed and managed.

Are risk factors valid?

The validity of risk factors as a basis for assessment has been questioned on a number of grounds. Dingwall (1989) suggests that they are doomed to fail as accurate predictors. Firstly because of the *definitional fallacy*: the fact that there is no operational definition of abuse. Many writers have attempted to define the point at which children need protection, whether in terms of good enough parenting (Adcock and White 1985) significant harm (Adcock *et al.* 1991) or child abuse (Swann 1993), but have been unable to arrive at agreed criteria. This is demonstrated by studies where practitioners were presented with hypothetical vignettes or criteria but displayed little consensus about the boundary when parenting behaviour becomes abusive (e.g. O'Toole *et al.* 1983; Meddin 1985; Shapira and Benbenishty 1993). Secondly, Dingwall identifies the *statistical fallacy*: any attempt to use a checklist in practice will inevitably result in a number of false negatives and positives. Corby (1996) contends that risk factors not only have questionable validity as predictors but it is impossible to know how they could be weighted. Wattam (1997) points out that those who developed checklists were not comparing like with like: for example, there may be very different phenomena associated with sexual abuse and neglect. She also criticises much of the literature for being tautological – based not on the total population of abused children but those who have been reported as such. She concludes:

No single factor or combination of factors can reliably predict who will harm or injure which children in any particular case (p.117).

It can also be questioned whether analyses of child deaths provide sound evidence about risk. Fatal abuse may, in fact, be atypical of abuse generally (Gelles 1991; Kelly and Milner 1996). Moreover, it is not a single phenomenon: studies by d'Orban (1979) and Wilczynski (1995) confirm a spectrum of differing motives and circumstances amongst parents who kill their children. For example, the psychotic mother quoted in Falkov (1996) who drowned her child 'before the mafia got to her' is not easily compared with the father who systematically beat his child for not being able to spell. If this is the case, it must be of concern that child deaths have been so influential in shaping child protection policy and that their prevention is proposed by some writers as the *raison d'être* for the child protection system (see Pritchard 1992; Lindsey and Trocmé 1994; MacDonald 1995).

There is a danger that the categorisation of 'risky' parents could lead to the over-

investigation of disadvantaged groups, regardless of the actual risk they pose. Booth and Booth (1994; 1996a; 1996b) are particularly concerned for parents with learning difficulties, where there may be an erroneous 'presumption of incompetence'. However, the following could equally be applied to other parents likely to come to attention:

The consequence of coming under professional scrutiny is that they are put in a position of not knowing how they will be judged, and of striving to meet standards that are never made explicit and often vary from one practitioner to another (1996b).

The role of race and culture in leading to assumptions about risk has also been highlighted (Singh 1999). The *Children Act 1989* requires social workers to give 'due consideration' to the race, religion, culture and language of the families with which they work, but this can be interpreted in many ways.

Although many professionals are aware that it is essential to take account of race and culture, and in particular to be culturally sensitive in their practice, they are often at a loss to translate this into practical terms (Dutt and Phillips 2000, p.38).

Banks (2001) describes the double bind whereby social workers are so keen to demonstrate their non-racism that they fall into the trap of operating on the basis of racial bias. Macdonald (1991) describes the ways in which racism in social work practice may be manifested, from ignoring the needs of black families to discriminatory intervention. Children may be left unprotected because assumptions are made about the norms of an ethnic or cultural group, e.g. physical punishment, and practitioners fail to act. The latter has been identified as *cultural relativism* (Dingwall *et al.* 1983) and was a feature in the case of Tyra Henry. Her African-Caribbean grandmother was left with the responsibility of caring for and protecting Tyra because of assumptions about cultural patterns of childcare (London Borough of Lambeth 1987). Conversely, if the task of assessment is based on a white Eurocentric model of family life, the appearance, behaviour or language of minority ethnic parents may be misunderstood and interpreted negatively. It has been suggested that this may account for the disproportionate number of black children in public care (Barn 1993). Dutt and Phillips (2000) offer guidance to practitioners in the difficult task of conducting a culturally sensitive assessment. They contend that all children have the same fundamental care needs but highlight areas of potential difference within black families that need to be recognised and explored before drawing conclusions.

The 'myth' of assessment?

If the simplistic application of checklists cannot provide a reliable indication of whether a particular child is safe or not, what is the alternative? An assessment is required, but Waterhouse and Carnie (1992) comment on the difficulty facing workers:

Social workers need a defined moral and social context in which to fit their professional opinions. This in turn would enable social workers to focus on the probability and severity of adverse affects without also having to assume responsibility for deciding what is acceptable behaviour between children and their parents or care givers (p.60).

In the absence of this defined context, judgements about 'good-enough parents' must still be made. Are they based on theoretical teachings, research evidence, practice wisdom or, more alarmingly, unconscious personal and societal values?

It cannot be assumed that, if the right information about the family is collected, judgements will be unproblematic because, as Munro (1998a) points out, 'Facts on their own are silent'. This hints at a conspicuous weakness in the guidance to social workers: how to *make sense* of information in order to reach a judgement. The task of child protection assessment can be described as one of interpretation rather than identification, with the social worker as an active player. Campbell's study (1991) supports the view that the interpretative process is important because, in terms of objective criteria:

There are few simply identifiable differences between the children and families who are on the Child Abuse Register and those who are not (p.271).

A number of recent studies have analysed this process of risk assessment, from receiving a referral, framing it as child protection, deciding to investigate, holding a case conference, placing a child's name on the child protection register and taking legal steps to remove a child (see Gibbons *et al.* 1995a). Marked inconsistencies have been uncovered, with evidence that social workers select and privilege certain information in order to, as Wattam (1992) describes it, 'make the case'. Her study found that the social work response to sexual abuse referrals was influenced by the factors of motive, corroboration, specificity of allegation and categorisation. For example, if an estranged partner made the allegation, assumptions were made that they may be maliciously motivated. Thorpe's (1994) study in Australia suggested a similar construction and he identified a race and gender bias in

assessments, with Aboriginal and female single parents being treated more punitively. Scott's study (1998) concluded that we are all more inclined to 'seek evidence which fits our pre-existing schema and belief systems' than to entertain multiple hypotheses. Dingwall *et al.* (1983), in their important study of children presenting to A&E departments, found that assessments were influenced by the 'rule of optimism'. The components of the rule were the ascription of a moral character to the parents (they did not intend to harm the child); cultural relativism (parental actions were understandable given their culture/class); natural love (all parents love their child as a fact of nature). The consequence of the rule was that workers were inhibited from reading evidence which was inconsistent with these assumptions. They would only intervene if parents were discredited in some way and could therefore be perceived as deviant or 'incurable', setting themselves outside the liberal order. The central issue was, therefore, not the condition of the child but the culpability of the parents.

This is confirmed by studies of the decision-making at case conferences (Hallett and Stevenson 1980; Waterhouse and Carnie 1992; Farmer and Owen 1995; Fisher *et al.* 1995; Hallett 1995). From a study of 40 conferences, Higginson (1990) reports:

Information was ignored or distorted to support stereotypes of whether parents were the type of person likely to abuse children. There was a strong link between abuse and parents exhibiting deviancy against 'community values' (e.g. alcoholism, drug addiction, violence and criminality).

It is of concern that in all the above studies, neither the degree of harm nor the views of the child appear to be at the forefront of decision-making (Wattam 1996). Instead, assessment is driven in part by the values and assumptions of the social worker.

It could be argued that these 'subjective' assessments are indicative of bad practice *per se*. They are certainly at odds with the modernist vision described earlier of social workers performing their task in a standardised way, based on objectively proven evidence. Instead, confirming information is presented for endorsement while conflicting information is suppressed (Stenson 1993). Social workers undertaking an assessment can thus be described as constructing the client and their problems.

In gathering a body of knowledge about a client or a client family, a worker, using professional language, develops a version of who the client is and how the client is functioning in his or her life and relationships; the social worker then offers a set of explanations that attach meaning to the knowledge. The

assessment, because of its professional nature, is generally accorded the status of truth and influences the beliefs that begin to develop about the client among all the helpers with whom the assessment is shared (Pozatek 1994, p.401).

An alternative reading of this phenomenon, however, is not that it is evidence of bad practice but that the modernist vision is flawed. Social constructionism has received some official recognition:

... child maltreatment is not the same sort of phenomenon as whooping cough: it cannot be diagnosed with scientific measuring instruments. It is more like pornography, a socially constructed phenomenon which reflects values and opinions of particular cultures at particular times (Gibbons *et al.* 1995a, p.12).

However, Wattam (1996) suggests that the official position is contradictory and unhelpful. Although *Messages from Research* pays lip service to the notion of child abuse as socially constructed, it goes on to treat this as unproblematic. Individual researchers use terms such as 'the allegations were not substantiated', or 'sexually abused children were living with the non-abusing parent'. They do not appear to recognise that one version of events may have been privileged over another in reaching these conclusions. Wattam writes in response:

... what we do not have is official agreement on what constitutes child abuse in our time and our culture (1997, p.110).

Instead of there being a single truth which social workers can uncover, there are multiple stories to be told. The strive towards objectivity is therefore doomed to failure and Parton's (1998) view that the paradigm of risk is fatally flawed becomes credible.

An alternative paradigm of uncertainty

The belief that social workers can effectively assess and manage risk if they follow procedures is open to challenge. Parton (1991, 1996a) describes the basis of this approach as *legalism*, with its emphasis on proving that abuse has occurred. Given the fact that only a small proportion of cases will end up in the legal system, it can be questioned whether the 'distorting mirrors of the law' are helpful in the consideration of child welfare issues (King 1991). White (1998) agrees that the system is based on a forensic approach but contends that this is not associated with the demise of the 'psy' complex. Instead, a hybrid discourse of *psycho-legalism* has developed, but with professionals other than social workers providing the insights. Within this discourse of risk management is an assumption of certainty: abuse

can be both proved and predicted. A consequence is to impose a burden on practitioners who are assumed to have failed if a child is harmed.

Where the key concern is risk, the focus becomes not making the *right* decision but making a *defensible* decision, where the processes and procedures have been followed and where the range of misery and need coming the way of the child welfare agency can be prioritised and contained (Parton 1998, p.21).

The imperative for social workers becomes to give a 'good account' of their work (Pithouse 1987). This is likely to be at the expense of the relationship between the social worker and the family. Howe describes the phenomenon as the *bureaucratisation* of social work (1992), emphasising the performance as opposed to the performer:

The social worker's practices are more likely to be task orientated and performance related, quantifiable and measurable, product-minded and subject to quality controls. Procedure manuals and lists of competences define more and more what social workers should do and how they must do it (Howe 1994, p.529).

Pozatek (1994) and Parton (1998) offer the counter proposal that social work is essentially ambiguous and should be characterised by notions of uncertainty rather than risk. This would allow for more consideration of the values underlying the child protection enterprise and the need to establish a relationship between worker and the family. The implications of these conflicting paradigms for the process of pre-birth assessment are now explored.

Protecting unborn children

If all practitioners are grappling with the contested nature of evidence, those undertaking assessments before birth face the additional complication of working with contested subjects: both present (pregnant women and male partners) and future (unborn babies and parents-to-be). Brazier *et al.*'s (1998) acknowledgement that reproductive autonomy may result in children being born into hazardous situations was described earlier (see p.18). Where there is concern before or at birth that this could be the case, there may be a request to assess *future* parenting ability. Little has been written about this topic and practitioners are left to find their own way through an ethical and legal minefield.

The first, and fundamental, question is which parents provoke this response. In a time of

optimism about predictive tools, attempts were made to screen for vulnerable families in order to offer preventative programmes of support to the new parents. Screening could be on the basis of demographic factors e.g.

... the age of the mother, whether a termination had been requested, whether she was married, and any physical problems before or during the birth. Large families and step-parents were other 'danger' areas (Hills 1980).

Other programmes selected their target population on the basis of mother-child interaction following the birth where there was thought to be 'bonding failure' (Ounsted *et al.* 1982). Typically, the families (or, in reality, mothers) then received additional intervention through home visiting with a view to reducing the risk of harm to the child and promoting a better parent-child relationship. Some studies reported beneficial results, e.g. Olds *et al.* (1986) claimed that the level of abuse was reduced, mothers were more positive about their babies and there were less visits to A&E. However, those reviewing the evidence judge it to be inconclusive (Barth *et al.* 1986; Barth 1991). As Cox (1997) points out, it is often impossible to establish which types of abuse the programmes were attempting to prevent, or whether the goal was to reduce incidence or severity. Gough (1993, 1994) writes that even successful schemes can only claim modest benefits and these may be outweighed by the negative impact of labelling or the undermining of coping ability. Initiatives tended to be multi-disciplinary and to rely heavily on the involvement of health visitors or midwives. In this sense they reflect the medical model, often the dominant discourse at this point in a child's life, but the simplistic analogy of doctors screening for child abuse as they might screen for cystic fibrosis is challenged by Montgomery (1982).

However, this thesis is not concerned with such general initiatives but with the 'heavy end' of pre-birth work: cases that have entered the child protection system. The need for such intervention was highlighted by two Inquiries following child fatalities in the 1980s, both of which proposed that a pre-birth plan might have prevented the death:

We think that the seeds of the tragedy had been sown before Tyra was born - not in an abstract or fatalistic sense but in that avoidable errors had by then been made which left the new-born baby exposed to known risk (London Borough of Lambeth 1987, p.19).

Similarly, the workers involved with Doreen Aston did not make a plan before her birth and

then became so preoccupied with crisis management that they failed to recognise the dangers (Lambeth, Lewisham and Southwark Area review Committee 1989). These cases led to the following guidance being included in *Working Together under the Children Act 1989*:

On occasions there will be sufficient concern about the future risk to an unborn child to warrant the implementation of child protection procedures and the calling of a child protection conference to consider the need for registration and the need for a protection plan. Such a conference should have the same status and be conducted in the same manner as an initial child protection conference (Home Office *et al.* 1991, s.6.42).

The updated version (Department of Health *et al.* 1999) endorses the guidance and confirms that such action falls within s.47 of the *Children Act 1989* i.e. the duty to safeguard children. It is striking that both versions treat this directive as unproblematic and, indeed, suggest that practice should be the *same* as it is for other children. This is to deny the complexity of assessing a child who has only future-status and is inextricably linked with her/his mother. It also denies the complexity of working with women and men who are future rather than current parents.

The evidence is that social workers have struggled with the task. For example, in 1992 the London Borough of Lambeth did convene a pre-birth meeting to consider the needs of Mia Gibelli and made decisions that, with hindsight, might have protected her. They did not accord these decisions the formal status of a protection plan, however, and instead allowed Mia to go home with her mother who drowned her whilst severely depressed (Cervi 1993). An inconsistency of approach is also reflected in the differing rates of registration of unborn children between local authorities, with some never registering a single child (Barker 1997). He proposes that these do not stem from differences in the needs of the babies but from 'the policies and practices of the child protection agencies and workers in these authorities'. This will be considered in greater detail in Chapter 5.

The reasons for this inconsistency can only be speculated upon. Practitioners may find it impossible to focus on the unborn child, given that the baby is off-stage. As has been seen earlier, the unborn child does not have subject or legal status and workers may therefore feel that there is nothing to be *done*. The entangled subject status of the pregnant mother also raises an ethical dilemma – any attempt to safeguard the baby inevitably impinges on the autonomy of the mother. As a result, Barker expresses some unease about the timing of

intervention:

If the pregnancy is in the early stages, the mother of the child may seek to have the pregnancy terminated, the experience of the child protection intervention and the worries about its future impact being a factor increasing the likelihood of termination (1997, p.225).

This unease is reflected in the comments of Baroness Warnock (1987):

It is intolerable for social workers to say dogmatically to a couple that when their baby is born he will be taken into care on the grounds that they are not fit to bring him up.

Yet this may be the reality in a number of cases. Although applications by local authorities in respect of unborn children have been unsuccessful (see *Social Work Today*, 21 January 1988, p.3) decisions have been taken to seek an order as soon as the child is born. Following an outcry in the media about such a case one commentator said:

Is the general public really saying that if we move to protect a newly-born child in circumstances in which three children have already died, we are acting wrongly? (*Community Care*, 26 November 1987, p.30).

Tredinnick and Fairburn (1980a, 1980b) undertook a national survey to establish the incidence and circumstances surrounding such decisions and received reports of '160 examples of disqualification from parenthood (1980b)'. Most children had older siblings who had been maltreated but 16 were the first-born. Social workers had found these experiences extraordinarily stressful. One factor was that 'there was no body of experience on which to draw', but:

The radical intervention almost as soon as a mother has given birth – mankind's most primal act – was another, viewed by many with awe and dismay even though they mostly concluded that the action had been right (1980a, p.498).

Respondents described a range of reactions: that they were 'stealing children', or 'harsh', and an uncertainty about whether to tell parents of the decision. They were also acutely aware of the disruption of 'bonding', and concerned about the insensitivity of the legal process in such situations.

A case study highlights some of the dilemmas, albeit arising in Switzerland. Unger-Koeppel

(1996) describes a family with a history of neglect and physical abuse and a reluctance to accept help in further pregnancies. As the writer says: 'We are not allowed to interfere with the fertility of the mother' but: 'what has to be done, when a mother who has severely battered is expecting the next child?'

Corner (1997) undertook a survey of NSPCC practitioners and interviewed the professionals and parents involved in one pre-birth assessment. Despite making the erroneous assumption that such assessments only take place when there is previous evidence of child abuse, his study is the most comprehensive to date in attempting to unravel some of the practice issues. His findings support those of Tredinnick and Fairburn (1980a; 1980b) in that the assessment raised strong feelings amongst practitioners, who referred to the possible removal of a baby at birth as 'against the laws of nature' or 'like playing god'. Corner suggests a number of differences between pre-birth and other child protection assessments in terms of parental attitudes, professional anxiety and working relationships within the network. He offers a model for pre-birth assessment based on the following information: birth parents' relationship and lifestyle; view and understanding of the past abuse; acceptance of responsibility for the abuse; attitude to previous children and the effects of the abuse upon them; view of past professional intervention; what has changed since previous child was abused, including support network; are the unborn child's needs given priority; impact of the baby on parental relationship and plans; parents' relationship with professionals. He advises that the assessment be undertaken openly, in a spirit of partnership, and early in the pregnancy. The family who were the subject of Corner's study kept their child and were able to provide adequate care, which may have led to an over optimistic stance:

Undertaking a pre-birth assessment during early pregnancy provides the parents with an opportunity to show the child protection network that they have changed (p.36).

This begs the question as to what would happen if they hadn't changed, and is in direct contradiction of Barker's (1997) position regarding early assessment as a possible pressure towards termination. However, Corner does usefully acknowledge that pre-birth assessment is not the same as the investigation of abuse, despite the formal guidance.

Conclusion

How does the assessment of unborn children fit within the child protection process? It has been suggested that the evidence base for all assessment is contested and, inevitably, subjective. This is compounded when there is no child to consider and, thus, no specific allegation to investigate. Crucial evidence will not be available until after the birth and all that may be left is the moral character of the parents. However, even this is complex because they are, more accurately, parents-to-be. The task of the social worker is therefore to gather and analyse information about them in the present and to speculate about how it will impact on their behaviour in the future. Predictions about future behaviour are inevitably uncertain, but in this case there is an additional level of complexity: the cast of two is going to be joined by an unpredictable third actor, the unborn child, who will inevitably change the dynamic. In writing about the assessments of prospective adopters, Ryburn (1991) suggests that different social workers confronting the same couples will reach different conclusions about their suitability as parents, and that claims to objective assessment in these circumstances are a myth.

Similarly, other problems of the system are accentuated. The threshold for intervention is undefined and the notion of outcome has a different meaning, since the baby is not yet accessible to social work intervention. In a sense the first 'outcome' is for the child to be born: only then can other measures come into play. The already gendered nature of practice is magnified where the child is unborn, with the actions of the mother perceived as key, whilst the father has no direct involvement with the child and can be ignored. The parameters of partnership need to be re-defined as the social worker has no real authority and must negotiate a relationship on the basis of future rather than present identities. Given these complexities, some guidance to social workers is called for. It must be recognised, however, that no amount of procedural direction will provide definitive answers: for those undertaking pre-birth assessment, the need to acknowledge and work with uncertainty would seem to be inescapable.

CHAPTER 4: AN EVOLVING METHODOLOGY

Different research methods are not simply different *ways of doing*, they also represent different *ways of seeing* and *ways of thinking* (Sidell 1993, p.108).

Developing a research strategy

When determining which research questions can legitimately be asked, beliefs about the nature of social work are crucial. Alternative conceptualisations were described in the previous chapter: social work as a technical performance ‘whereby it is assumed the world can be ever more subject to prediction and calculation’; or as an intuitive process involving practitioners and clients in a struggle to understand each other in human terms, ‘much better characterised in terms of indeterminacy, uncertainty and ambiguity’ (Parton 1999, p.10). These perspectives could be seen as mutually exclusive, requiring a researcher to choose whether to focus on questions about the performance of social work or on the meaning underlying the performance.

However, the experience of the practitioner poses a different set of dilemmas. A childcare social worker operating within the statutory sector does not have the luxury of choice: the current child protection system is based firmly within a managerialist and technocratic paradigm and social workers must find ways of making sense of their practice within this. Moreover, procedures are not necessarily a ‘bad’ thing. Whilst recognising that judgements about whether a baby will be safe with her/his parents are essentially moral, a clear framework for action should at least render the process clear and open to challenge. The aim of this study is therefore to explore both the performance *and* meaning of the practice of pre-birth assessment. The ontological perspective is essentially interpretative. It is contended that, rather than there being a single truth to be uncovered through the assessment process, social workers are constructing a version of their clients that can only be understood contextually. However, it is also suggested that such constructions should be subject to critical and moral scrutiny. To return to the research questions, the study aims to increase our understanding of:

- the surface world of the structure and performance of pre-birth assessment, asking questions about *what happens*;
- the submerged world of social work judgement, focusing on *how* and *why* meanings

are attributed during the assessment process.

Having formulated the questions, the researcher must then choose an appropriate methodology. This process will also be based on beliefs: about the validity of different approaches in general and their applicability to the specific topic being considered. Again, it could be suggested that the above questions arise from different ontological perspectives and therefore require different epistemological approaches. A study aiming to tell the reader *what happens* indicates an acceptance of the uncontested nature of facts: a belief in the real world where events are explicable and certain. Conversely, a study which acknowledges that meanings are mediated by both practitioners and researchers is based on a belief in multiple versions of reality.

Traditions in social work research

Before turning to the choices made within this study, differing approaches to social work research are considered. Trinder (1996, 2000) identifies three main strands: empirical and evidence-based; pragmatism; and critical/standpoint. Each of these traditions reflects not only different ways of researching but different beliefs about the questions that can legitimately be asked. The most frequently asked question and, consequently, the topic of most studies, is how far social work is effective in achieving positive change. The aim is to incorporate this research-generated knowledge into practice: to ensure that it is 'evidence based'. The title of a series of publications by Barnardo's perhaps sums up this perspective: *What Works?* (Roberts 1998).

What works?

The question is the central concern of those working within the empirical tradition, adopting the positivist premise that there is an objective reality to be captured through experimental research. The most notable advocate of this position in the UK is Sheldon (1988, 1998) who continues to express his frustration that social work practice is based on opinion rather than empirical evidence (see also MacDonald *et al.* 1992). Critics have expressed scepticism about the usefulness of an empirical approach to the evaluation of practice, both on ethical and epistemological grounds (Smith 1987; Lishman 1988; Gough 1993). There are serious ethical dilemmas in controlling, for experimental purposes, access to services. Moreover, human subjects are not easily manipulated through scientific experimentation. Many

variables are too complex to identify or control, giving rise to challenges about validity.

... research which is exclusively concerned with outcomes rather than processes suffers from the serious limitation that it is impossible to tell what the outcomes were outcomes of (Smith 1987, p.406).

Thus firm claims about cause and effect cannot be justified, and results are often embarrassingly inconclusive in their failure to demonstrate any positive difference in outcome between those who receive services and those who do not. Trinder (1996) claims that an empirical approach fails to capture the complexity of human relationships: 'The client's life becomes a response to a technique'. Furthermore, the attribution of 'effectiveness' is dependent on there being consensus about the purpose of social work intervention. Stevens (1999) challenges this through his contention that the term 'outcome' is multi-faceted, with each stakeholder having a different objective:

Political motivations may for example be linked to the need to save money or make decisions about the best use of resources. Practitioners may want to know the safest approach to child protection so that they can protect themselves from the negative consequences of a child death. Families would probably want to know that the interventions they undergo have a good chance of resolving their problems (p.27).

Outcomes may therefore best be understood as a mixture of gains and losses, not lending themselves to uni-causal explanations or simple categorisation into good or bad. However, the need to evaluate the impact of social work intervention is still valid – the issue becomes how this can be achieved. Everitt and Hardiker (1996) propose the proper goal of evaluation as being to 'judge merit' rather than to establish cause and effect. They challenge the positivist paradigm for its suppression of moral debate about practice and the assumption that evidence is value-free.

What is happening?

Guba (1990) identified a post-positivist approach, still based on the assumption that there is a real world to be discovered but recognising the impossibility of achieving total objectivity. Researchers must therefore do the best they can whilst subjecting their work to critical scrutiny. This is echoed in the second tradition described by Trinder (1996) as being essentially pragmatic, glossing over epistemological dilemmas. Studies undertaken within this paradigm are concerned with *what* is happening in social work (but not *why*). The focus

is still largely evaluative but with more consideration of social work processes alongside outcomes, in recognition that the experiences of those involved are an important consideration as well as the end result. For example, the feedback from families who had experienced child protection investigations informed the development of ideas about 'partnership' work, although the outcome of protecting the child may be achieved without it (Thoburn *et al.* 1995). Methodologies are likely to draw on non-experimental quantitative methods such as surveys, but supported by limited and structured qualitative data. Trinder comments that, although affording a 'passing glance to plurality and social constructionism', pragmatism is based on 'a vision of an ordered and understandable world'. *Messages from Research* is said to fall within this paradigm and is criticised for its a-political and anti-intellectual stance (Parton 1996c; Wattam 1996).

Critical theory

Critiques of realism pose a challenge to those wishing to research or understand social work processes, both in terms of the questions that can legitimately be asked and the need for new methodologies. Instead of a focus on social work activity as rooted in universal (and therefore generalisable) truths, interest shifts to its contingent nature and the ways in which subjects are constructed and rendered manageable. The strive towards objectivity is abandoned, not only as unrealisable but invalid. Advocates of critical, or standpoint, theory believe that research is not a neutral fact-finding activity but based on power relationships, particularly those connected with gender. Studies therefore focus on giving a voice to the oppressed subject, who is considered to have a 'better understanding' of the world (Trinder 2000). The difficulty with this approach lies in the contradiction between rejecting modernist notions whilst claiming that it is possible to possess privileged knowledge.

Reading the texts

Trinder (2000) suggests that a way forward may be to adopt a postmodern feminist approach which acknowledges the importance of the voice of the subject, advocated by critical theorists, but also attempts to analyse how subjects are discursively created. Thereby the way in which claims to truth are constructed becomes the legitimate focus of study alongside, or instead of, the claim itself. Within postmodernist theory the role of language is deemed to be crucial: nothing can be said to exist independently from the text, and texts are dependent on the meaning ascribed to them by the (notional) reader (Burman and Parker 1993). A universalist approach is rejected in favour of the pluralistic notion of 'regimes of

truth'. This stance can be seen as a development of the interpretivist methodologies suggested by Lincoln and Guba (1985) and Hammersley (1989).

The task is at once to avow the importance of interpretation in understanding human life and to show that this process, rather than being antithetical to the project of generating valid knowledge, is in fact perfectly compatible with it (Freeman 1993, p.16).

A consequence of this perspective is that the researcher can no longer pretend neutrality but becomes another actor in the process, actively interpreting and ascribing meanings to the accounts of the research participants and, in turn, offering their own account. Researchers applying postmodernist concepts must strive to develop ethical methodologies, avoiding the relativist trap that all accounts are equally valid. This is perhaps particularly significant for those undertaking social work research because of the use to which their findings may be put:

A philosophy of social work which risks relegating compassion, respect, and dignity to the status of a discursive construction, it could be argued, is in the end unethical (Merrick 1996, p. 42).

The application of such methodologies is explored in Chapter 6.

Devising a methodology

The difficulty of keeping an unborn child in mind within practice is mirrored in the difficulty of researching the topic. The challenge for this study was to devise a methodology that could explore both the surface and depth of the practice. Mason (1996) supports the usefulness of integrating methods, not in the sense of triangulation whereby the expectation is that different methods will provide the same result and thereby demonstrate reliability, but in the sense that they will illuminate different aspects of the topic (Sidell 1993; Stevens 1999). This study combines the pragmatic and social constructionist traditions in order to develop a conceptual framework which increases our understanding on a number of levels, albeit within a single methodology. Mason (1996) also suggests that the divide between quantitative and qualitative epistemologies is misleading: they can be combined provided they are incorporated within a coherent ontological perspective (see also Smith and Cantley 1988). That position is adopted here, presenting an element of quantitative data within a

primarily qualitative study. As the study developed, so did the methodology, influenced by exposure to the literature and themes emerging from the data. New ideas were also generated by, and tested against, the 'reality' of continuing practice as the manager of a team engaged in pre-birth assessment. Although documentary data was used throughout, a process of progressive re-focussing took place, reflecting the shifting interest between the surface and depth of the topic (Buist 1988). A more detailed account of the data sources, types and levels of analysis is provided later in the chapter but firstly, the decision to undertake a documentary study is explained.

Why a documentary analysis?

A documentary analysis was chosen as the method that would provide the clearest insights into both the performance and meaning of pre-birth assessment. Social work records have been noted as a particularly rich source of data. In her study of record-keeping within child guidance clinics, Prince (1996) found that social workers described it as an 'insignificant, boring chore'. However, on closer analysis, records 'functioned not only as an index of power but also as a bearer of meanings, codes, resources and emotions (p.180)'. They were the means by which clients could be categorised and controlled. Clients described the stigma of 'having a file' and were anxious about the content of records, rarely asking to read them. Once records were shared and clients encouraged to make their own contribution, the power relationship altered. Reports to case conferences were particularly powerful:

A written report, even if given to the client to read beforehand, does, in a curious way, set the agenda, and chairs of case conferences seem powerless to prevent the social worker's written report dominating the proceedings (p.184).

Records thus allow a valuable insight into the invisible practice of constructing the case. A social worker will record 'evidence' of risk, framed in a way that is acceptable within the norms of the agency. The extent to which both the writer and subject of the record are fulfilling their ascribed roles as 'good' social workers or parents is thus exposed to scrutiny. Thorpe and Bilson (1998) endorse the view that a documentary analysis has particular benefits in their study of child protection records:

The writers are aware of criticisms (for example, Pithouse 1987) of files as factual statements of the work carried out by social workers. However, the content of files provide justifications of the work carried out, and the values and beliefs which can be read from the text give an important insight into the way

that workers socially construct the world of child protection (p.375).

Alternative methods were considered but rejected for a variety of reasons. The use of an experimental approach to demonstrate that a particular practice ‘works’ was described earlier. It would have been inappropriate for this topic. Apart from the fact that it does not accord with a constructionist perspective, there would have been ethical and practical difficulties. It may be theoretically possible to establish a study and control population within a matched cohort of expectant parents and to examine their parenting capacity and subsequent child rearing. However, it would not be morally defensible to manipulate the variables by, for example, withholding intervention from a vulnerable family. In any event, variables such as parental separation would not be accessible to such manipulation.

Another possibility would have been an ethnographic study to gather contemporaneous data as practice unfolded. This would have necessitated intense observation over a period of many months and then periodic follow-up to establish outcome. It would inevitably have been limited to a handful of cases which may or may not have been representative, providing rich, in-depth data but without allowing for an overview. In addition, the presence of the researcher could have resulted in participants ‘making their case’ with the researcher in mind whereas a study of documents draws on material not constructed for the purpose of research.

Finally, it would have been possible to gather data directly from those involved, either through interviews, written questionnaires or focus groups. Again, this was discarded. The assessment of risk to unborn or young babies is highly emotive, and all those involved have their own agenda. Parents are usually distressed that their fitness to parent is being questioned, and fearful of the baby being removed: professionals are burdened by the importance of the decisions and fearful of ‘getting it wrong.’ To ask the participants for their opinions whilst engaged in an assessment could interfere with their task: to ask them afterwards would establish only their retrospective construction of events, influenced by the *outcome* of the assessment. A parent who has had a child removed shortly after birth is unlikely to feel that the *process* of assessment was a reasonable one.

Had the focus of the research been to learn more about the families, the use of a documentary analysis would have had limitations. The views of families are not usually directly expressed in case files, only appearing as mediated by the practitioners.

Furthermore, as in many child protection studies, the selected population had already been defined as those presenting a risk, prompting the charge of tautology. There were, perhaps, similar children who had not come to the attention of social services or had been referred but subsequently screened out without a case conference. This would have been an insurmountable problem if the aim were to establish a comprehensive profile of 'risky' families. Again, the aim of the study in looking at professional practice means that the reason these particular children were selected for assessment forms part of the data.

The usefulness of a documentary study thus depends on the research question. Garfinkel (1967) proposes that the 'shortcomings' found within clinic records are understandable if their purpose is to provide accounts relevant to the organisation. He identified the concept of the 'entitled reader' who is capable of reading the hints contained in the record because they understand the contextual requirements. Omissions in the records are illuminating rather than problematic to a researcher interested in the functioning of the organisation. Scott (1990) develops this argument and suggests that texts must be studied as 'socially situated objects' requiring an analysis of the selective point of view through which they were constructed. Where the research topic is an aspect of professional practice, documentary analysis may be the most useful method.

Administrative records are used in their own right, rather than *faute de mieux*, for research on the policy process itself and in evaluation research. In this case records and documents, albeit incomplete accounts, are part of the reality being studied, rather than being regarded as a poor substitute for data that would ideally be obtained in other ways (Hakim 1993, p.134).

Jupp and Norris (1993) describe three traditions within documentary analysis, broadly based on positivist, interpretative or critical theories. *Positivist* studies of documents assume that their content exists regardless of context and that they can be researched in an objective and systematic fashion: an assumption rejected within the other models. Those seeking to *interpret* documents consider the meanings attributed to them by both author and audience, and do not believe that the content can be understood without this contextual framework. *Critical theorists* accept this premise but are more interested in the power relationships concealed in the text. They developed the approach of discourse analysis through which these could be understood and challenged.

Problems attributed specifically to documentary data have been described (Platt 1981; Scott

1990; Hakim 1983, 1993). Documents must be assessed for their authenticity, credibility and representativeness. There can be little control of the data because it is not generated by the research activity and it may be difficult to determine whether records are missing. There will also be inconsistencies between those who have written the records. Perhaps most importantly, caution must be exercised in the inferences drawn from the data. The researcher must recognise that their personal perspective cannot be excluded and adopt a reflexive stance. This is particularly important for the insider researcher and will be considered in greater depth when describing the ethical implications of the study.

Conducting the study

Having explored the rationale behind the methodology, a detailed description of the way in which the study was conducted now follows.

Sources of data

A range of documents providing different types of data and offering opportunity for different levels of analysis were selected for study. There were two main sources of data:

- documents providing information about the context in which the practice of pre-birth assessment took place;
- social work case files from an inner city social services department during one year.

Contextual information

Firstly, the routinely generated statistics of child protection activity, both nationally and locally, were collated. Information on children who are placed on local authority child protection registers is forwarded to the Department of Health on an annual basis and forms the subject of a statistical report (Department of Health 1994b). Within the study authority, additional quantitative data was available on the children who were the subject of child protection conferences and not registered. The source of this data was the database held by the Child Protection Unit and their annual management report containing the statistics and a discussion of trends.

Secondly, although the outline of the child protection system is established by national guidance, each local authority is expected to devise its own mechanisms for implementation.

The child protection procedures within the study department were therefore an essential source of data in understanding individual instances of practice. The structure and working practices of the department were also examined, partly drawing on organisational charts but primarily based on personal knowledge. Again, these provide part of the backdrop to the action and assist in the process of contextualising the practice.

Case files

Social work case files contain a range of documents serving a variety of purposes. Some documents are structured into standard formats, with prescribed headings. Others are unstructured and allow the practitioner to select the content and format. A file where a child has been the subject of a child protection conference will include the following:

- Structured documents
 - *Referral Form* providing demographic data about the family and the reason for referral;
 - *Report to Conference* written by the assessing social worker, offering an opinion about the risk to the child and making recommendations for action;
 - *Case Conference Minutes*, formally recording not only the decisions but the preceding discussion.
- Unstructured documents
 - case notes of contact with the family and other professionals, including accounts of interviews;
 - notes of the social workers' judgements and plans, and records of supervision with managers;
 - correspondence between practitioners and the family/other agencies.

There were therefore different types of data contained within each file. Some information was factual (dates of birth; ages; household composition), but most was open to interpretation and deconstruction (the characteristics of the assessed families; the information deemed to be evidence of risk). The material was also designed for different purposes and audiences. *Reports to Case Conference* and *Case Conference Minutes* are written for a wider audience of other professionals and the family. They are the means by which practitioners provide an authoritative account of their assessment activity and conclusions. In addition to their content, the prescribed format of these structured documents provides an indication of the standard components of an assessment. Social

workers' case notes are primarily for their own use and to provide an accountable version of their work for other practitioners and managers. Correspondence is used for a variety of formal and informal purposes.

Study population

All children either unborn or under the age of 1 year who were the subject of an initial or pre-birth child protection case conference within the study department in the year 1 April 1993 to 31 March 1994 were identified. This was done through a search of the database of all child protection conferences held by the Child Protection Unit. Where information was ambiguous, for example conflicting information regarding a child's date of birth, a manual search was undertaken of case conference minutes and the index held within individual teams/centres. The study department did not have a centralised index at that time.

The reasons for the selection of the population were:

- these categorisations by age and conference date correspond with those used by the Department of Health in their annual statistical reports and therefore allow comparison with national data;
- the choice of year was based on the assumption that the *Children Act 1989* and its corresponding guidance (Home Office *et al.* 1991) would by then have been integrated into practice;
- the Registration category of Grave Concern was no longer being used, allowing for a clearer definition of risk;
- the children would be of sufficient age at the time of the study to allow for some consideration of outcome.

The decision to include children under the age of 1 year in addition to the unborn, who are the main focus of interest, was to gain information about the range of practice. Some babies were the subject of assessment and conference before birth: others were not. By studying the whole population it was intended to uncover whether differences in response stemmed from the characteristics of the families or the constructions of practitioners. Albeit tentatively, this allowed an element of evaluation: for example, whether an infant was harmed by a 'risky' parent who could/should have been identified before birth.

Collecting data from the case files

Designing the method

It was agreed that the authority's Child Protection Co-ordinator would act as the agency consultant. This was invaluable, not only in the advice she could offer, but in her representation of the research proposal to senior managers within the department. Unconditional access to social work records was agreed and administrative time provided in order to help to locate them.

Drawing on themes suggested by the literature and from personal experience as a practitioner/ manager within this field, a data collection sheet was devised for use on case records. The data sheet was designed, as far as possible, to follow the chronological sequence of the files, starting with referral information, progressing through the assessment process, to the case conference decisions and the subsequent outcome for the baby. It was discussed with the Child Protection Co-ordinator who made helpful suggestions as to how it could be amended. The focus at that stage (in early 1996) was to describe events and actions: e.g. what the social worker did and what happened to the babies. A front sheet was devised to collect demographic data about family composition, ages, genders and ethnicity. The age or gestation of the study baby (and any siblings) at the time of the Initial Child Protection Conference and the decisions regarding registration were also recorded here. This was followed by 14 headings to guide the collection of information:

- Who made the referral?
- What were the identified concerns?
- Nature of the assessment? (i.e. the process)
- Profile of parents?
- Which other professionals were involved?
- Partnership with parents?
- Who did the social worker consult?
- What meetings were held?
- What decisions did they take?
- If registered, what was the protection plan?
- If not registered, services offered?
- Were plans implemented?

- Career of the case?
- Comments?

The source of the data within the records was also noted. The data sheet was then tested on two cases, each outside the period of the study, by the researcher and one of the Child Protection Officers working separately. The resulting data were compared and found to be comprehensive and broadly consistent. A shared observation was that social workers appeared to be working to a different agenda from the one they would apply to other parenting assessments. This was both in comparison with the other main type of assessment where future rather than actual parenting is under scrutiny, i.e. prospective foster carers/ adopters, and standard child protection investigations following an allegation of harm. Pre-birth assessments tended to focus on identifiable problems exhibited by parents e.g. details of drug use, rather than issues of parenting *per se*. This suggested the evidential *content* of assessments as an additional important topic.

Pilot study

The data sheet was piloted on 5 cases from the year following that identified for the main study, i.e. 1 April 1994 to 31 March 1995. The cases were selected to provide a range of the following factors: social work team undertaking the assessment, the baby's age at conference and the nature of the child protection concerns. The aim of the pilot was to test feasibility: to examine the quality of the data and, therefore, to establish how far an understanding of the process of pre-birth risk assessment could be gained from case records. The pilot study also served to further develop the data sheet. The whole file was examined in order to identify additional themes that had not been considered. This was, in fact, the case. For example, the differential treatment of mothers and fathers became evident. The pilot study therefore prompted the possibility of further levels of analysis: not only an exploration of what happens but questions of how and why came into focus. The data sheet was therefore revised to enable this information to be collected systematically. Several of the existing questions were broken down into sub-sections to allow for more complex data to be recorded. For example, 'Nature of the assessment?' was broken down into the following: network checks; contact with mother; contact with father; contact with extended family. Two new sections were added to the revised data collection sheet:

- *Background* i.e. previous involvement with Social Services/ other agencies. Some of the families studied within the pilot had considerable history with the department or other

social care agencies, which appeared to influence the response to the referral.

- *Content of the assessments* i.e. the information selected and recorded by social workers as evidence of parenting capacity. This section was subdivided into content relating to mothers/ fathers/ other factors deemed to be relevant, and enabled a further analysis of the way a safe or unsafe parent is constructed.

The strategy of always recording the source of data within the record was abandoned as it had not yielded particularly useful information. The final version of the data collection instrument is contained in the *Appendix*.

Main study

31 babies met the criteria for inclusion in the study. Records were located with the help of administrative staff in the respective social work centres and the Child Protection Unit. Some cases had remained the responsibility of a single team and/or centre whereas others had been transferred, when practice differed as to whether the team passed on the whole file, part of the file, or copied the sections deemed to be relevant. It was therefore necessary to visit every setting where work had been undertaken on a case to ensure that the total record was studied. Most of the data collection took place in the second half of 1996 but was then suspended for the period of 15 months due to the demands on the researcher of working as a full-time practitioner/manager. The final data were collected in early 1998. The majority of files were complete and many ran to several volumes. Three records were incomplete in that volumes were missing, and others appeared to have gaps, but some data were available on all cases. The Child Protection Unit retains a separate record of all *Reports to Conference* and *Case Conference Minutes* and these were therefore usually available even where case files were lost.

Each case file was examined to establish its structure and content. Information preceding the referral of the study baby was read and summarised by the researcher. This was in order to establish a profile of the parents but also to provide information about the characteristics associated with a decision to assess. Similarly, those sections of the record relating to events occurring more than one year after the initial/ pre-birth case conference were examined to provide additional contextual information for the researcher. The detailed data collection, however, focused on the intervening period and a numbered data sheet was systematically completed for each case under the ascribed headings. Some information was recorded in

note form but other sections of the text, where the social worker was engaged in constructing the subjects, were transcribed verbatim. In addition, *Reports to Case Conferences*, *Case Conference Minutes* and case notes regarding unborn children were photocopied in their entirety. This was to prevent the foreclosure of themes that may not yet have been recognised, and provided continued access to raw data during the analysis stage.

Data analysis

The case files overall were a rich source of data: factual accounts allowed for a description of *activity and events* but the *values, attitudes and assumptions* from which social workers construct their case were also apparent. From the structured documents, *Referral Forms* enabled an analysis of the characteristics of the families identified by practitioners as being risky. *Reports to Case Conference* and *Conference Minutes* provided information about departmental expectations of risk assessment. They were also the means whereby the social worker told the story not only to managers and professional colleagues but to the family concerned, providing the main vehicle for the construction of good and bad parents and the social worker as an objective assessor worthy of respect.

The unstructured documents also provided a variety of data. The content of the social workers' case notes was inconsistent, with some recording very little and others providing long and detailed descriptions and justifications of their work. Correspondence gave an indication of the way the case was constructed to other agencies or family members. Of particular interest were the letters to parents by the social workers. These served not only a practical function, arranging appointments etc., but to explain the purpose of the social worker's involvement, to express concerns and to confirm plans. They were clearly more than a tool for factual communication, and sometimes appeared to have been used for evidential purposes, putting on record the attempts to work with the family.

Following the data collection, the completed data sheets and the photocopied sections of the files were read through in their entirety in order to develop a model for categorising and analysing the data. This was considered against the background of the contextual data described above. The headings within the data sheet served to structure the initial analysis of the data but did not correspond directly with the themes which began to emerge. For example, information about the profile of the parents was contained within the *front sheet*

and the sections on *background, reason for referral* and *content of the assessment*.

Preliminary themes were identified and the data re-examined to assess whether these themes were robust and ‘made sense’. Where information did not ‘fit’ into this schema, it was recorded separately in order to allow for any new themes to be identified.

A progressive re-focussing

In order to explore different aspects of the topic, the data was subjected to three levels of analysis:

- *descriptive*
- *narrative*
- *thematic*

Phase 1: Descriptive analysis

The first phase of the study focused on a description of assessment before birth as an activity, reflecting the pragmatic approach described by Trinder (1996, 2000) and thus accepting aspects of a realist paradigm, but a reality that is multi-faceted and inseparable from context. Both quantitative and qualitative methods were applied. Having set the scene through a description of the contextual documents described earlier, the data from the case files were analysed in order to provide a ‘factual’ account of the phenomenon of pre-birth intervention.

This included some consideration of outcome, not only in describing what happened, but introducing an element of evaluation. The difficulty in both defining a ‘good’ outcome and making firm claims about the factors contributing to that outcome were explored earlier. As Mason (1996) suggests, the perspective that neither practice nor research can ever be objective but are mediated through a process of interpretation precludes claims about universal cause and effect. However, this does not mean that intervention cannot be subjected to critical scrutiny (Everitt and Hardiker 1996). As Stevens (1999) says:

Clearly there will be some sort of link between an intervention ... and salient features of the subsequent situation. The question is how to establish the nature of this relationship, the meanings of the subjective experience and the extent to which regularities can be established across numbers of individual cases (p.30).

Childcare practice is driven by the desire to improve outcomes for vulnerable children and

debate must engage with the relationship between intervention and outcome. The researcher's employing authority, understandably, wished to know what the practical applications of the study might be. An attempt was made, therefore, to explore the relationship between the operation of the system and the well-being of the baby. This highlighted another element of the equation, however. It became clear that the social workers had interpreted the procedural mandate differently, or had adopted very different styles whilst following the same procedural path. Thus a simplistic explanation of 'good' practice was not possible and further levels of analysis, taking into account the ways in which the key players interpreted their roles, were needed in order to understand.

Phase 2: Narrative analysis

Having described the activity, the next step was to begin to look beneath the surface. The approach taken marks a shift from the pragmatic approach to one located within the social constructionist paradigm, with its rejection of universality and a recognition of the multiplicity of truths. This process began with a narrative analysis of 3 cases compiled from textual data extracted from the case files and supported by the information available on the data collection instrument.

The categorisation of data into themes allows a conceptual framework to be developed but, as Featherstone (2000) points out, this is at the expense of the individual narrative. There are benefits in also considering the 'whole' story. The aim of the thesis, described earlier, is to explore the performance and meaning of pre-birth assessment. A case study approach allows a synthesis of these differing aspects of the topic. It describes what happened but also introduces questions about why and how the social work construction of a (real) safe baby was developed. The term case study in this context is not used in the traditional sense of a story with the family as its subject: rather it is the social worker who holds centre stage. The story has a beginning, middle and end, and each of the players within the family is ascribed a moral character.

Phase 3: Thematic analysis

The final level of analysis moved from specific cases to the study population as a whole, looking thematically at the way social workers constructed judgements about which babies were safe and which were not. Analysis was primarily qualitative but with an element of numerical analysis of recurring themes. Both the social workers' approach and the nature of

the evidence they presented were considered in an attempt to deconstruct underlying theories, values and assumptions. This allowed links to be made with themes evidenced in the literature, where similar accounts are given as to what constitutes a good mother or father. In this sense the distinction drawn by Trinder (2000) between narrative and discourse analysis is useful in that the latter encourages a study of the *range* of texts which position the actors. This level of analysis allows the question of outcome to be revisited, but with the dimension of social work practice added to those of the family characteristics and the externally imposed 'system'.

Ethical considerations

A documentary analysis raises less obvious ethical problems than a survey or ethnographic approach, in that it is non-intrusive, but it would be wrong to assume that it is entirely unproblematic. Additionally, as a manager within the department, it was extremely easy to negotiate access to records. It was therefore essential not to abuse this position of trust, both in terms of respect for colleagues and the necessity to live with any mistakes after the completion of the project.

Informed consent

The main source of data in this study is a retrospective study of social work records, raising the issue of who the 'subjects' of the research are: the babies, parents, practitioners contributing to the record or the employing local authority. This dictates whose consent should be sought. In fact, inevitably within a local authority, permission to undertake research was negotiated primarily with managers: the social workers whose practice was to be exposed were not consulted. A particular issue with documentary analysis is that the record has not been created for the purpose of research. This has an advantage for the researcher in that it offers an opportunity to study the contemporaneous text, but it is likely to make participants feel particularly powerless. Had social workers known that their records would be scrutinised, they may have chosen to write differently. A letter was circulated within the department explaining the purpose and method of the study. It was essential to explain that the research was designed to establish general themes rather than to judge the practice of individuals. In the climate of performance monitoring and inspection, this required a degree of trust but the openness and enthusiasm of practitioners in making

their records available was impressive.

Although the focus of the study was the social work process, did this mean that the family/child did not need to be involved at all? They would be aware that a record existed for administrative and legal reasons but this cannot be assumed to include access for research purposes. On the other hand, to seek their consent could have been a damaging and intrusive exercise designed more to protect the sensibilities of the researcher than to empower the family (Gallagher *et al.* 1995). A compromise solution was to include an explanatory note in the record should the family seek access to it, inviting them to contact the researcher for more information.

Confidentiality and anonymity

There was a need to respect the confidentiality of both the study families and the practitioners. Each study case was assigned a number and the families are referred to within the findings either by this number or by a fictitious name. Other minor details have also been altered to prevent their identification. The position of the social workers is perhaps more complex. They were unlikely to feel able to question the actions of a manager, albeit acting in the role of researcher. It was necessary to be scrupulous about drawing a boundary between the two roles and to resist any temptation to comment on specific information gleaned through the research in a management capacity. The only exception to this, agreed with the Child Protection Co-ordinator, would have been if dangerous practice were uncovered. Individual social workers were told of this agreement, and were also reassured that anonymity would be maintained: no social workers or families would be identified. However, in an organisation, it must be acknowledged that colleagues will often recognise the individuals involved even where names are concealed. Within the study department, staff turnover is high and there has been major re-structuring. Most of the assessing social workers have now left and cases have been transferred between teams, which has perhaps been helpful in terms of making information less identifiable.

Validity and generalisability

Trinder (2000) highlights the difficulty in establishing the validity of postmodern research methods. Where multiple versions of reality are possible, are all versions equally valid or

are some more valid than others? It could be argued that this is the case with any research undertaken within an interpretative perspective: there is no 'test' as to the truth of an interpretation. This is particularly problematic in an analysis of records undertaken by a single researcher, whose interpretation is therefore uncontested. It would have been possible to check back with participants that the interpretations were 'accurate' (respondent validation), but this would be problematic where social workers felt defensive about their practice and/or were informed by hindsight. Instead, it was decided to involve the Child Protection Unit: specialist advisers outside of the management structure. In addition to the help described above in devising the data collection instrument, Unit staff agreed to a meeting to discuss a report prepared following the pilot study. They confirmed that the findings at that stage 'rang true'. As Trinder suggests, perhaps this is the best we can hope for. Mason (1996), however, questions all versions of respondent or peer validation because they imply a position of epistemological privilege whereby some readings of the data are placed above scrutiny. She suggests instead that:

Validity of method and of interpretation therefore must be demonstrated through a careful retracing and reconstruction of the route by which you think you reached them, and there are no easy answers or shortcuts in this process (p.152).

The researcher attempted to adopt this rigorous approach at all stages of the study. At the point of data collection, it was essential to ensure that consistent information was collected, and to record even that which appeared insignificant or contradictory. Sections of the case file were copied in their entirety to allow for the possibility of new themes emerging during the analysis. All the data were read through before establishing preliminary themes. These were then interrogated in an attempt to uncover the researcher's own values and assumptions, both on a personal and professional level, reflecting the process described by Featherstone (2000). She describes the need for the reflexive researcher to constantly 'think against' her/himself in order not to privilege the meanings which are important to the researcher at the expense of other possible readings. Any data which had not appeared to make sense initially or which seemed insignificant was then revisited in order to establish whether any new themes could be identified.

The fact that the study of case records took place only in one local authority may also give rise to doubts about the generalisability, or transferability, of the findings. The national data does allow for a comparison of the incidence of child protection registration but not for an

analysis of qualitative differences in practice between local authorities. It is possible to say that some authorities place far more unborn children on the child protection register than others but not to illuminate their reasons for doing so. However, this study does not claim that the activity of pre-birth assessment in the study authority is statistically representative. Rather the aim is to explore the multi-faceted issues and dilemmas raised for practitioners who are striving to make sense of the task. In this sense, it is possible to suggest that the findings may have theoretical resonance both for other settings undertaking pre-birth assessment and for those who wish to reflect on paradigms for practice in a broader sense. This is distinct from any claim that there is a particular formula for undertaking pre-birth assessment which should be universally adopted or that findings would be replicated in other settings.

Insider and practitioner-research

The researcher faced the challenge not only of conducting research within the employing authority (insider research) but also of being involved with the client group as a social work manager. The role of practitioner-researcher presents both opportunities and challenges. There are the advantages of being able to identify topics of relevance to service users and practitioners (Robson 2002), to understand and access suitable sources of data (Fuller and Petch 1995) and to be able to feed back into the 'real world of social work' (Humphreys and Metcalfe 2000). Where a researcher can 'speak the language' (Thoburn 2000), there is an increased chance of the findings being credible with practitioners and of some use. The challenges, however, relate not only to the pragmatic difficulties of insufficient time and research expertise, but to a more fundamental question: whether the practitioner-researcher can generate valid knowledge given their standpoint or, as Fuller and Petch describe it, 'see the wood from the trees'. They argue that it is possible, but that ways must be found of standing back from taken-for-granted social work practices in order to establish a separate identity as researcher. This is particularly complex when the practitioner-researcher is researching within their own setting and must thus confront:

...the ideological and logistical dilemmas of assessing practice which may have been directly delivered by the practitioner, certainly the agency (p.18).

Such was the case within this study, where the researcher had been involved in a decision-

making capacity with some of the families. In a sense, the researcher's own practice was therefore 'on the line'. It was of some concern whether these cases could be viewed from a different perspective or whether the research would serve to confirm existing beliefs and understandings. The challenge was to differentiate between the world of practice, where pragmatic decisions must be taken on the basis of imperfect information, and the world of research, where all things are possible. Whilst it is *always* the case that the interpretations of the researcher are shaped by personal values and assumptions, the practitioner-researcher's version of events must therefore be subjected to particularly close scrutiny. This topic will be re-visited in the concluding discussion, where an attempt will be made to explore the dilemmas raised by this example of practitioner-research and to submit the resulting version of events to critical examination.

The findings of the study will now be presented reflecting the three levels of analysis described above. Firstly, the activity of the pre-birth assessments and the context in which they took place are described; secondly three case studies are presented and finally, the meanings beneath the surface of the activity are explored.

CHAPTER 5: DESCRIBING THE ACTIVITY

Setting the scene

Social work activity, including assessment, takes place in a legislative, political and organisational framework which a reader needs to be aware of in order to understand. Before turning to a description of the study cases, an analysis of this framework is presented based on the documentary sources described earlier (see pp.59-60). Although this information is primarily descriptive, interpretations are offered as to the impact of the context on the assessment process.

Procedural and organisational context

It is essential to consider the ‘blueprint’ for intervention at this point in a child’s life: what it is that practitioners are expected to *do*. The state’s responsibility to safeguard children who are suffering or likely to suffer significant harm is enshrined in the *Children Act 1989* (s.47.1). National guidance then provides the framework for the implementation of this responsibility. At the time of the study, this was *Working Together under the Children Act 1989* (Home Office *et al.* 1991), reflecting the bureaucratisation and managerialism commented upon when reviewing the literature: the implication being that the operation of procedures will protect children. It also demonstrates a forensic approach to decision making, with social service departments and the police sharing an ‘investigative’ role in cases of suspected child abuse. For the first time, unborn children were included in the guidance. This was discussed in detail in Chapter 3 where it was suggested that pre-birth assessment is portrayed as unproblematic and essentially the ‘same’ as other child protection work. Reference is made to the occasions where there is ‘sufficient concern about the future risk to an unborn child to warrant the implementation of child protection procedures’ (s.6.42) but there is no attempt to specify what those occasions might be or to describe how unborn children *can* be protected.

The study department responded to the new guidance by issuing detailed child protection procedures (228 pages) compliant with both the forensic and managed approach. For example, the previous factor of the *Quality of the Relationship with Worker* was discarded as

irrelevant. The procedures took as their starting point the premise that abuse had occurred or was suspected and prescribed both the conduct and content of investigations. However, the study authority did attempt to be more specific than the national guidance in describing the circumstances when a pre-birth case conference should be convened:

A pre-birth conference is called when there is serious concern about the future welfare of a yet unborn child. Such conferences are normally held where:

- There have been child protection issues in relation to previous children or,
- Serious concerns have arisen during the pregnancy. These concerns may relate to parents' mental health problems, learning difficulties, drug or substance misuse or social situations which indicate that the child is likely to be at risk of significant harm in the first few days of life.

The procedures confirmed that pre-birth conferences were effectively the same as other initial conferences but, perhaps recognising that there may be difficulties with this, continued:

By definition pre-birth conferences may lack crucial information that will only become available upon birth. The conference may therefore wish to fulfil all the functions of an initial conference, but stop short of a final decision upon registration adjourning to a date upon the birth in order that relevant information may be considered and a final decision made.

These local procedures did, therefore, recognise the problems inherent in applying the child protection system before birth and provided additional guidance but this focused on the operation of the system, leaving practitioners to decide what constituted *evidence* of risk before birth from procedures designed for a different purpose. Many of the usual investigative tasks such as medical examination, interviewing the child, observing parent/child interaction are inapplicable but this was not acknowledged. Indeed the procedures stated:

No investigation or initial assessment is complete without a social worker seeing the child in question.

In spite of the procedures, pre-birth assessment remained a marginal activity within the study authority. Child protection work was undertaken by social workers based across 5 settings: 3 centres serving their surrounding geographical area and 2 teams in the local hospitals. Although it was not dictated by the procedures, there seems to have been an expectation that

pre-birth assessments were the province of the hospital teams. However, they too were given little direction and differed in their approach. Hospital A took a more proactive stance, with guidelines for hospital staff about which cases to refer. The work was also more ‘managed’ via a centralised referral and allocation system, whereas hospital B had social workers attached to the maternity service who negotiated their own work.

A statistical analysis

An analysis was also undertaken of the statistical data described earlier regarding child protection conferences both nationally and within the study authority. The annual report of national data (Department of Health 1994b) contains an account of the profile of children on child protection registers, national trends and local variations. It is therefore possible to study the extent to which unborn children and babies under the age of 1 year are placed on the register, to compare these with other age groups and to map activity across authorities.

During the year 1 April 1993 - 31 March 1994, 45,800 children in England were the subject of initial child protection conferences, of which 28,500 were registered: a registration rate of 62%. Together with the children who were already on the register, this provided a total number of 34,900 (31.7 children per 10,000 population): a 7% increase from the previous year. In terms of age, the highest *rate* of registrations was for children under the age of 1 year. Although statistics are provided of the total number of unborn children who were registered, they are subsumed into the ‘all children’ category without explanation. The data are summarised in *Table 5a*, reproducing exactly the way in which information about unborn children is presented in the report.

Table 5a. Numbers and rates of registration during year 1 April 1993 to 31 March 1994 by age in England (*extracted from Department of Health Table 1.1*).

	<i>All ages²</i>	<i>Under 1</i>	<i>1-4</i>	<i>5-9</i>	<i>10-15</i>	<i>16 and over</i>
Numbers	28,500	4,000	8,300	8,000	7,500	500
Rates ¹	26	62	32	26	21	5

^{1.} Rates are per 10,000 population in each age group; not applicable to unborn children

^{2.} The ‘all ages’ total includes 295 unborn children

There were thus 295 registrations of unborn children, constituting 1.4% of the total number of new registrations. However, these were not evenly distributed across local authorities, with some appearing to register relatively large numbers and others none at all. This is

illustrated in *Tables 5b* and *5c* by the registration statistics from two Department of Health Regions. It can be seen that, although both of these Regions conform to the national average for registrations of unborn children, there are significant discrepancies within this total when the activity of each authority is examined.

Table 5b. Registrations of unborn children by local authority during year ending 31 March 1994 in the North of England Region (*extracted from Table 2.12*).

<i>Local Authority</i>	<i>All children</i>	<i>No of unborn children</i>	<i>% of total registrations within authority</i>	<i>% of total within region</i>
Cheshire	496	-	-	-
Cleveland	620	40	6.5%	71.4%
Cumbria	557	1	0.2%	1.8%
Durham	353	-	-	-
Humberside	713	3	0.4%	5.4%
Lancashire	788	4	0.5%	7.1%
Northumberland	160	-	-	-
North Yorkshire	415	8	1.9%	14.3%
Total	4102	56	1.4%	100%

Table 5c. Registrations of unborn children by local authority during year ending 31 March 1994 in the Central England Region (*extracted from Table 2.12*).

<i>Local Authority</i>	<i>All children</i>	<i>No of unborn children</i>	<i>% of total registrations within authority</i>	<i>% of total within region</i>
Cambridgeshire	307	6	1.9%	10.2%
Derbyshire	592	41	6.9%	69.5%
Hereford and Worcester	257	-	-	-
Leicestershire	443	-	-	-
Lincolnshire	558	-	-	-
Norfolk	284	1	0.3%	1.7%
Nottinghamshire	532	-	-	-
Shropshire	181	-	-	-
Staffordshire	335	-	-	-
Suffolk	326	11	3.4%	18.6%
Warwickshire	142	-	-	-
Total	3957	59	1.5%	100%

Interestingly, only 4 unborn children were registered in the whole of Inner London (13 authorities), representing 0.2% of the total (2260). This figure is considerably lower than the national average in spite of the vulnerability of its population, including as it does a higher proportion of women with substance misuse and mental health problems.

Although detailed instructions are offered by the Department of Health to authorities on collating the statistics, no reference is made to unborn children, ignoring the obvious logistical problems in submitting data on children with no gender or date of birth. Some information relates to the child's age at registration, some to age at the year-end, and it is unclear whether authorities are meant to amend the data when a baby is born. Interestingly, while the statistics are presented, there is no further analysis or discussion in the commentary of the 1.4% of children who were registered before birth. They are subsumed into either the 'under 1' or 'all children' category. It is as if the Department of Health is as baffled as practitioners about what sense can be made of the phenomenon and the reasons for the widespread variation between authorities in the use of the register for unborn children is not addressed. It could be argued that it was due to the fact that formal registration of unborn children had only recently been introduced and authorities were slow to implement it. However, recent statistics indicate that this pattern has continued (Barker 1997).

The published Department of Health statistics for the study authority indicate that they held 164 initial conferences and placed 108 children on the register during 1993-4. Twenty-two children were under the age of 1 year but none were recorded as being unborn. However, this statistic is not reflected in the findings arising from the case files, as will be described later. In discussion with Child Protection Unit staff, it became clear that although a decision may be made at conference to register an unborn child, this is not activated until the child is born, when they are placed on the register without a further conference. It is at this point that the registration will be included in the statistical returns, and they will all therefore be subsumed into the category of registrations under the age of 1 year. It may be the case that other authorities are adopting the same procedure and that the published Department of Health statistics do not accurately reflect the level of activity or concern about unborn children. Furthermore, there is a discrepancy between the published figures and the findings from the study of the numbers of babies under 1 who were registered. Given the discrepancies in the published statistics, it is difficult to establish any patterns or trends in the phenomenon at both a local and national level.

Population, process and outcome

Having set the scene, the assessment activity of the study authority is now described. Firstly, a profile of the families is offered, including their identified problems and parenting history. Secondly, the process of the assessment is described: not in terms of the evidence itself but the way in which the social workers went about the task. Thirdly, there is a description of the operation of the formal child protection ‘system’ and the decisions that resulted. Finally, the outcome for the study babies a year after the initial case conference is explored.

Profile of the families

31 babies under the age of 1 year had been subject to pre-birth or initial conferences in the year selected for study. The age and ethnicity of the parents is detailed in *Tables 5d* and *5e*.

Table 5d: Parental age at birth of baby

<i>Age</i>	<i>Mother</i>	<i>Father</i>
17-20	4	1
21-25	9	4
26-30	10	5
31-35	1	5
36-40	7	1
Over 40	0	1
Not recorded	0	14
Total	31	31

The average age of the mothers was 27 and the fathers 29.

Table 5e: Ethnic origin of parents

<i>Ethnicity</i>	<i>Mother</i>	<i>Father</i>	<i>% of total recorded</i>
White	25	10	71.4%
Black Caribbean	3	4	14.3%
Black African	1	2	6.1%
Bangladeshi	1	1	4.1%
Pakistani	0	1	2.0%
Mixed/ other	0	1	2.0%
Not recorded	1	12	-
Total	31	31	-

When compared with the estimated ethnicity of the study authority's population at the time, shown in *Table 5f*, it can be seen that black parents, particularly those of Caribbean origin, are over-represented in the study population.

Table 5f: Estimated ethnicity of study authority's population in year 1993-1994

<i>Ethnicity</i>	<i>Male¹</i>	<i>Female¹</i>	<i>% of total</i>
White	68,100	75,500	78.8%
Black Caribbean	1,500	1,700	1.8%
Black African	3,300	3,700	3.8%
Black Other	900	1,100	1.1%
Bangladeshi	3,700	3,800	4.1%
Pakistani	500	400	0.5%
Indian	1,600	1,600	1.8%
Chinese	1,500	1,500	1.6%
Other Asian	2,100	2,800	2.7%
Mixed/ other	3,900	3,200	3.9%
Total¹	87,100	95,100	182,200

¹ Rounded to the nearest 100

Sub-groups within the population

It was apparent that within the overall population of 31 there were 2 distinct groups, related to the timing of the referral and the cause for concern:

- 26 babies referred because of concern about *future parenting*. Although the timing varied, all had been referred either during the pregnancy or within 1 week of birth and were causing concern before the baby was discharged from hospital.
- 5 babies referred at a later date following an *incident or injury*. These babies ranged from 6 weeks to 8 months of age and were living with their mothers/ parents in the community.

These distinct points of entry into the system suggest either that the 2 groups somehow constituted different populations, or, conversely, that they were effectively the same but had received a different response, i.e. all posing similar risks but with only a proportion detected before harm had occurred. It is therefore important to consider the characteristics of the families, or, more particularly, mothers since it was overwhelmingly maternal behaviour and history that were perceived as significant by the referrers. These characteristics are summarised in *Table 5g*.

Table 5g: Maternal problems across the total population

<i>Point of entry into the system</i>	<i>Case no.</i>	<i>MI/ LD or substance misuse¹</i>	<i>Previous children apart²</i>	<i>Criminal history³</i>	<i>Homeless⁴</i>	<i>Abusive/ disrupted childhood⁵</i>	<i>Concerns re violence⁶</i>	<i>'Problem' partner⁷</i>
Referred because of concerns about future parenting	1	√	√√√√√	√		√	√	√
	2	√	√√				√	√
	3	√		√	√	√	√	√
	4	√		√			√	
	5	√		√	√		√	√
	6	√		√		√	√	√
	7	√				√	√	√
	8	√	√√		√	√	√	√
	9	√	√√	√	√	√	√	√
	10	√						√
	11	√				√	√	
	12	√	√√√√√	√		√	√	√
	13	√	√	√		√	√	√
	14	√	√√√√			√	√	√
	15	√			√	√	√	√
	16	√		√		√	√	√
	17	√	√√√	√	√	√	√	√
	18	√	√	√	√	√	√	√
	19	√	√	√		√	√	√
	20	√		√	√	√		√
	21	√		√		√	√	√
	22	√						√
	23	√	√√	√		√	√	√
	24	√		√			√	√
	25	√	√√	√			√	√
	26	√					√	
Referred following an incident/ injury	27							√
	28						√	√
	29					√	√	√
	30					√	√	√
	31	√		√			√	√

^{1.} *Significant problems of mental illness, learning difficulty or drug/ alcohol misuse. See table 5h.*

^{2.} *Each child living separately from the birth mother is indicated. See table 5i.*

^{3.} *Known criminal convictions.*

^{4.} *This does not include temporary accommodation but refers to women who had no accommodation.*

^{5.} *Women who had suffered severe abuse, been 'in care' or experienced traumatic family breakdown.*

^{6.} *Usually 'domestic' violence from male partners but several women were reported to be the instigators of violence.*

^{7.} *Partners who were violent, had significant problems with mental illness/ drug use, or were unsupportive/ absent.*

It is evident that some problems occurred consistently throughout the population – notably violence and problematic partners. Violence was mentioned in all but 5 families and only 3 fathers/male partners appeared to be consistently present and supportive. When these factors are excluded, however, it can be seen that those referred because of concern about *future-parenting* were the most troubled: all 26 mothers suffered from serious mental health or learning difficulties, and/or were problem substance users. In contrast, none of the mothers referred following an *incident* had significant mental health problems. However, one mother

from this group (case 31) did have a drug problem and was said to be depressed. Had her problems been apparent during the pregnancy, it is likely that she would have been referred for assessment of her parenting capacity. She could be described as having ‘slipped through the net’ but otherwise the groups appear to have different characteristics.

The *future-mothers* are categorised in *Table 5h* in terms of their most significant problem as defined by the referrer.

Table 5h: Mental health or substance use problems amongst the *future-mothers*

<i>Maternal problem</i>	<i>Instances</i>
Schizophrenia	10
Learning difficulty	4
Opiate/ poly drug use	4
Severe personality disorder	2
Depression / unspecified	2
Problem alcohol use	2
Manic-depressive illness	1
Schizophrenia and opiate use	1
Total	26

The troubled nature of the 26 *future-mothers* is particularly striking when considering their parenting history. 13 were first-time mothers but the remaining 13 had a total of 33 previous children, of whom only 2 were still in their care at the point of referral. The circumstances in which children had become separated from their mothers were not fully documented. In some cases it appeared that families had made their own arrangements but most appeared to have resulted from legal intervention. The data are summarised in *Table 5i*.

Table 5i: Whereabouts of *future-mothers*’ previous children

<i>Child’s situation at point of referral</i>	<i>Instances</i>
Adopted outside family	14
Cared for by relatives	10
Foster care	5
Cared for by birth mother	2
Cot death	1
Living independently	1
Total	33

This history of ‘failed’ parenting was, again, not a feature of the 5 *incident-mothers* who had 4 previous children between them, none of whom had been removed from their care.

It is clear from this profile that mothers referred because of concern about *future-parenting* form a distinct population requiring a response other than a standard child protection investigation. They cause concern because of ‘who they are’, not because something specific has happened to the baby. From this point on, the thesis will focus on these 26 families only, unless otherwise stated. The following section will describe how the families became a cause for concern, the department’s response to the referral and their subsequent progress through the child protection process.

Entering the system: referral

Of the 26 study families, 19 were referred at various stages during the pregnancy and a further 3 within a week of the birth whilst the baby was on the maternity unit. The remaining 4 were already allocated to a social worker before the pregnancy was identified because of childcare concerns (in 1 case the mother was herself a ‘child in need’).

The majority of referrals (20) were made by hospital staff to hospital social workers, indicating the importance of location and working relationships in establishing early intervention. Within this, midwives were particularly active in referring (16), reflecting their access to aspects of an expectant mother’s personal and parenting history: women being more likely to divulge problems such as opiate use to a health professional than a social worker. It is interesting that in all 4 ‘open’ cases, hospital staff independently recognised that there was a problem and referred them again to the hospital team. Practice within the hospitals varied. Staff in hospital A seemed to feel confident about referring women to the social work team and used a form designed for the purpose. Most of their referrals were made at the point when midwives were ‘booking’ the mother for antenatal care, although this varied from 6 weeks to 32 weeks. In hospital B there were fewer referrals overall, they were made at a later stage in the pregnancy - between 16 and 36 weeks, and 3 were not received until after the baby’s birth.

The referrals were all prompted by the core criteria of maternal mental health, learning difficulty or substance use problems, often combined with the removal of previous children. As outlined on p.74, these are the criteria described in the department’s child protection procedures for convening a pre-birth conference, which suggests that there is a consensus about the mothers requiring intervention at this time although it is impossible to be certain

how this consensus evolved. Information about partners may have been an additional cause for concerns e.g. 'Alcoholic, very violent partner - now left (permanently?)', but was never the sole reason for referral. There appeared to be no consistent consideration of the parenting ability of prospective fathers.

The assessment process

Engaging the families

Following referral, responses ranged from a tentative 'wait and see' approach to proactive assessment. Interestingly, the 4 families where there was already an allocated social worker also received a patchy response and it is difficult to trace a discrete pre-birth assessment in the records. The expected baby tended to get lost amongst the more pressing demands of the case.

The approach to parents who are suspected of harming their child is usually a relatively clear process, with social workers displaying some sense of urgency and making their investigative role explicit. This was not the case here. Although some workers tried hard to engage a reluctant and frightened woman, others delayed for several weeks before making contact and did not persevere if appointments were failed, placing the onus on the family to arrange contact. The tentative nature of the contact was also echoed in a lack of clear explanation of the assessment process. Although there were instances where a social worker made concerns explicit and planned a series of structured interviews with parents, these were the minority. It is likely that some parents had little idea that their ability to care for the baby was being assessed or on what basis.

Mothers and fathers

Assessments of future parenting were *always* focused on the mother. Fathers were, at best, of secondary importance and commonly left out altogether. In only 9 of the 26 cases was the baby's father involved. Apart from one father who actively resisted contact, this seemed to be a choice made by the assessing social worker. A variety of strategies were used to justify the non-involvement of the other 16 fathers, even where they had parental responsibility. In some cases, their very identity as the father of the child, and therefore their claim to be involved, appeared to be at stake:

- *Not the 'real' father.* Paternity was actively contested in 2 cases and this was used to legitimise the fact that the partner/ father could not participate, even where he was going to be present in the child's life.
- *Not sure who he is.* In a further 5 cases, there was no attempt to elicit the father's identity. Either the mother was considered to be too disturbed to be able to give a clear account (2) or her comment that she was not in contact with the father was accepted (3), although there may then be mention of him, for example, attending the delivery or visiting the ward.

Alternatively, the identity of a father may have been acknowledged but no contact initiated by the social worker. The reasons appeared to be as follows:

- *Too dangerous.* In 4 cases a decision was taken not to involve fathers because of the threat of violence. It was made clear to the mother that she must separate from the father in order to reassure practitioners that her baby would be safe: there was therefore no need for the social worker to work with him. However, the reality of these separations is debatable and it is concerning that these violent men, who perhaps posed the greatest risk to their babies, were not assessed.
- *Not important.* The reasons for not inviting the final 5 fathers to participate were not made explicit. In 2 cases, their relationship with the mother appeared to be at an end but the remaining 3 fathers were still 'around'. Perhaps there was an implicit expectation that an interested father would put *himself* forward for assessment and that, if he did not, he was not a key player.

Extended family

Members of the extended family were often involved - in fact more so than the fathers. Maternal family, particularly grandparents, were the most engaged with few attempts to speak to paternal families. Where a mother was mentally ill, extended family seemed to play their most active role, being used to provide background information in the absence of her coherent account. They were also involved in planning for the future where it was deemed that the mother could not care for the baby. It is unclear how far mothers had consented to this participation. As with fathers, there was a sense in which the relative/s took control by putting themselves forward as an interested party rather than waiting for an invitation to participate.

Professional opinions

All social workers recognised the importance of gathering information from other professionals. However the usual checklist of agencies to be consulted during a child protection investigation (e.g. health visitor, day nursery) are not necessarily relevant for pre-birth assessments and social workers seemed to have some difficulty in identifying alternatives. This was particularly evident for centre-based workers, who were less familiar with professional roles within the hospital context. They rarely contacted midwives, for example, who were an important source of information for hospital social workers. Where parents had a mental health or substance use problem, the assessing social worker often sought a specialist opinion but professionals working with adults tended to be reluctant to comment on parenting ability. It was the social worker who was routinely required to submit a report to the case conference. Only where there were legal proceedings was separate documentary evidence by 'experts' requested. Pre-birth assessment was therefore not only an uncertain task but one undertaken in isolation and it is perhaps for this reason that the social worker often recommended admission to a residential unit.

Residential placements

A major component of 20 cases was the plan to refer a family for a residential assessment, including the drug-using mother who had 'slipped through the net'. Usually this was for the mother and baby alone, even where the father was heavily involved: in only 2 cases was there an active attempt to include a father in the placement. However, many of the mothers had not expressed any commitment to the plan. The suggestion was usually put to them by the social worker with evidence of overt or covert tactics of persuasion being employed. One mother repeatedly said that she did not want to go into a residential unit but the social worker proceeded to make an application and arrange a visit whilst another family described the plan as 'blackmail'.

The purpose of residential assessment was not always explicit in the files. Ostensibly it was usually for a period of further assessment but, on examination, appears to have been prompted by a need for containment where the risks were perceived to be greatest. Psychotic illness appeared to be considered as the single most 'risky' factor and a residential placement was planned as somewhere the mother and baby could go straight from the maternity hospital. They were also considered for substance users, usually when their use was seen to be out of control. The decision to pursue such a placement was not necessarily

taken in a spirit of optimism:

Early indication on the ward indicated an inability to meet the baby's basic needs without very considerable support and guidance. Dr P (*psychiatrist*) had indicated a very poor prognosis for change.

The placements varied in their programmes but all seemed to have in common the fact that they would provide a safe setting in which to assess the mother's care of her baby and to offer input with 'parenting skills'.

If it is assumed that the purpose of the placement was to establish whether the mother would be able to care for her baby independently, then a range of outcomes could supply this information. Firstly, whether the assessment was completed. Of the 15 placements achieved, 9 broke down - some almost immediately - usually leading to the baby being placed with alternative carers. Placement breakdown was thus interpreted as evidence that a mother could *not* care for her baby. The other 6 residential assessments were completed as planned, raising the second aspect of the evidence: the judgements of residential staff. Little is recorded about this, which is not to denigrate the quality of the work done within the placements. Useful information was provided about matters such as the handling of the baby over a 24 hour period, the behaviour of visitors, drug and alcohol intake: all of which would have been difficult to ascertain in the community, but the information was rarely collated in a formal report.

Where a placement broke down *or* was completed and provided positive evidence of parenting ability, social workers had a clear direction for planning. They had more difficulty in responding to situations where the placement was maintained but provided a negative picture of parenting. Instead of concluding that a mother could not care for the baby, they tended to suggest yet another period of assessment and 2 mothers were given more and more time in other residential settings *until* they failed. The overwhelming impression was that residential placements were offered as an alternative to removing a 'high risk' baby at birth rather than to provide specific information: as a safe place for the mother to succeed or fail without disastrous consequences.

Operating the system

As stated earlier, the department's child protection procedures offer no separate guidance on the child protection process where the baby is unborn. The 'normal' investigatory machinery entails a strategy discussion with the police, followed by, if it is agreed that there are grounds for concern, a medical examination of the child and interviews with family members. Yet the findings indicate a level of uncertainty in applying these procedures, particularly at the planning stage. As the baby became more 'real' in the later stages of pregnancy or at birth, the procedures appeared to fit more easily. It was not that social workers were following an *alternative* procedural route but they conveyed a sense of unease and a need to modify, or 'water down', the stark nature of the child protection system.

Strategy meetings

The usual child protection strategy meetings were not convened: perhaps they were deemed inappropriate given that there was no allegation and, indeed, as yet no baby. A range of other meetings, with no identified status, were used to fill the gap. These were referred to as planning, network or professionals meetings. In some cases they seemed to serve a useful function, planning the assessment in the same way as a strategy meeting would plan an investigation, albeit without the contribution of the police, and culminating in a well-informed initial conference. In other cases they appeared to be used inappropriately, combining and confusing the functions of strategy meeting and initial conference whilst excluding parents.

Case conferences

The above uncertainty was also evident in the use of pre-birth case conferences. There were 14 pre-birth case conferences but, although pre-birth and initial conferences have the same status, there was a reluctance to make 'final' decisions before birth. In 8 of the 14 cases it was decided to reconvene when the baby was born. This is sanctioned by the local procedures (see p.74) and may have been entirely reasonable, given that it is useful to evaluate the actual care given to a baby, but it may also be a further indication of uncertainty. It was linked with another frequent decision: to recommend a 'longer post-natal stay' on the ward than is usual. In 11 of the 14 cases, the possibility of a residential mother and baby placement was raised and the conference used as a forum for exploring and ratifying this option with the wider network. In effect, the conclusion of most assessments

was that there needed to be further assessment in a 'safe' setting. In 2 cases, however, this further period of assessment was considered to be either unnecessary or too dangerous. Sufficient information was already available: the prospects of the parents being able to care for the baby were thought to be so bleak that there should be removal at birth. One homeless couple were displaying extreme violence and psychiatric disorder, and the father had expressed sexual feelings about the expected baby. Another learning-disabled mother, also homeless, had already had 3 children removed: the most recent being less than a year previously. A further 3 conferences also recommended that legal proceedings be taken at birth although not necessarily with a view to removal. These were all in situations where the mothers had a history of severe mental illness, previous children removed and were considered to be unpredictable.

The remaining 12 babies were not considered until an initial conference following the birth: 3 were not referred until they were born but the remaining 9 had been the subject of concern during the pregnancy. In 3 such cases it was known that the baby would need to remain in hospital with drug withdrawal, reducing the urgency, but in the other 6 it is unclear why a pre-birth conference was not convened. In some cases the initial conference did not take place until a crisis occurred, in spite of considerable knowledge about the risks. Seemingly identical situations prompted a different response: hospital A held pre-birth conferences to consider mothers with psychotic illness whilst hospital B did not.

Child Protection Register

Although *Working Together* sanctions the registration of unborn children, there seemed to be uncertainty in practice as to when it was appropriate. Again, apparently identical situations sometimes resulted in registration and sometimes did not. Only in 4 cases was a decision taken to register an unborn baby. Two were the cases described above where a decision had been taken to remove at birth (although it could be argued that the plan meant that these children should be the *least* 'at risk'). The remaining 2 were also cases where legal action was planned. The register seems to have been used to mark the seriousness of concerns about the parents rather than because of any benefit the protection plan would offer. The fact that the other 10 babies who were considered at a pre-birth conference were *not* registered cannot be taken as an indication of a lack of concern: none of the families were actually allowed to exit the system at that point. Instead, the plan was either to reconvene and/or to assess further or, at the very least, to monitor informally for a period of time. Thus

plans did not differ significantly whether the baby was registered or not.

Following the birth, a further 14 babies were registered at a reconvened or initial conference (18 registrations in total) and another 4 remained in the 'system' with ongoing assessment and monitoring. Only 4 study babies could be said to have exited the child protection system following the conference in a way that did not denote any risk.

Outcomes

What happened to the 26 study babies in the year following the initial conference? The term outcome is used to mean both the final result (output) and an evaluation of the factors contributing to that result: what it is an outcome *of*. Whilst it is relatively straightforward to describe where the babies were living at the point of follow-up, an evaluation of that outcome is more complex. To begin by presenting the 'facts', the whereabouts of the study babies are summarised in *Table 5j*.

Table 5j: Whereabouts of baby one year after pre-birth or initial conference

<i>Placement of baby</i>	<i>Instances</i>
Short term fostering	9
With mother/ both parents in community	6
With mother in residential unit	3
Adoptive parents	2
Lost to follow-up	2
With extended family	1
With father	1
Stillborn	1
Died	1
Total	26

Two babies were lost to follow-up because their families moved out of the borough during the study period and there is no record of subsequent events. Another baby was stillborn, having died in utero at 7 months gestation. The mother refused a post-mortem but the cause was not thought to be suspicious. A further baby died at the age of 3 months. There were therefore 22 live babies whose whereabouts one year after the conference were known and, of these, 13 were already with alternative carers. Only 9 babies were being cared for by their mothers either independently or in a residential setting and, in fact, 2 disrupted shortly afterwards and their fathers took over their care.

Case career

It is important not only to consider where the baby ‘ended up’ but the route they had taken. This is, in part, because the process needs to make sense to the families. The fact that considerable effort was made to keep a family together may have long-term benefits in terms of their ability to live with the outcome. In the words of one mother, at least she ‘had a go’. As stated above, 2 babies were lost to follow-up and 1 was still-born. The case career of the remaining 23 babies was as follows.

- Six babies were never cared for by their mothers. Plans had been made to remove 2 babies at birth, and these plans were effected: a further 2 babies were effectively abandoned by their parents whilst in hospital being treated for withdrawal syndrome and, in the remaining 2 cases, the mothers were considered too psychotic to care for them. All 6 were placed with short term foster carers straight from hospital, 2 of whom had then been moved to adoptive placements by the point of follow-up.
- A further 6 mothers only cared for their baby for a limited time within a supervised residential setting before the children were also placed with alternative carers (although 1 was subsequently rehabilitated).
- Another 3 mothers had continued to care for their babies throughout in a residential setting: it was considered unsafe for 1 mother to do so without supervision and 2 were awaiting re-housing.
- Only 8 mothers had looked after their babies at some point in the community and, of these, 1 baby died and 2 spent time in emergency foster placements following crises.

‘Significant harm’

An important factor when considering outcome, given that all the babies were considered within the child protection framework, is whether any of the babies were harmed during the period of study. Physical harm is more easily identified from the records than emotional harm. There was major concern amongst professionals about the baby who died suddenly, shortly after being discharged from a psychiatric mother and baby unit into the care of his schizophrenic mother. His older brother had died in similar circumstances but it is impossible to draw firm conclusions as no prosecution was brought. The failure of another baby’s drug using parents to recognise that he was dangerously ill is perhaps the other most serious harm, but this was an act of omission rather than commission. Although there were other incidents, e.g. the mother who was both an opiate user and had a schizophrenic illness

threw her baby to the floor, it does appear that the babies were largely protected from physical harm.

The emotional well-being of the children is much more difficult to ascertain. There are indications in some cases that the babies were beginning to show signs of insecurity or developmental delay. The fact that 16 babies experienced at least one change of primary carer during their first year must also have implications for their emotional well-being. Some of these moves were unavoidable but others were not.

'Good' and 'bad' outcomes

Given the complexity in defining these, it is suggested that a *good outcome*, for the purpose of this study, is one where the baby was both safe and settled with a primary carer who would remain consistent throughout childhood *or* where a clear plan to achieve this goal was being actively pursued. A *bad outcome* is, conversely, one where the baby was living in a situation of danger or uncertainty. Excluding the 2 babies lost to follow-up, 15 of the remaining 24 study babies could be said to have experienced a *good outcome*. Although the pathway for these children had not necessarily been straightforward, 7 were with their mother, 4 were with an alternative permanent carer who had been legally secured and a further 4 were in temporary foster homes but with plans underway to find permanent families as soon as possible. By definition the remaining 9 babies could therefore be said to have experienced a *bad outcome*. This includes the baby who was still-born and the baby who died. The other 7 were neither in a settled home nor was there any prospect of one a year after the initial case conference. The babies who were increasingly being cared for by their fathers but with no legal certainty as to their future have been included in this category. The others were all in short-term foster homes but with no clear plan. It could be argued that it was too soon to give up on the prospect of rehabilitation, but it could equally be argued that this constituted evidence of drift. The relationship between the way the case had been processed and the outcome are summarised in *Table 5k* as a first step in considering whether there are lessons to be learned.

Table 5k: The relationship between child protection process and outcome

Case no.	Pre-birth conference	Post-birth conference	Removed at birth	Residential assessment	Legal action	Harmed/disrupted care	Output	Good ¹ outcome
1	√	√ CPR		√			residential with mother	√√
2		√ CPR					home	√√
3		√ CPR		√	√	√	fostered – not secure	
4		√ CPR				√	shared care – not secure	
5	√						stillborn	
6		√		√			lost to follow-up	?
7	√	√ CPR		√			home	√√
8	√ CPR	√	√		√		fostered - secure	√√
9	√			√		√	died	
10		√ CPR		√	√	√	with family	√
11	√	√		√		√	shared care – not secure	
12	√	√ CPR		√	√	√	fostered – not secure	
13	√ CPR		√		√		adopters	√√
14		√ CPR		√	√	√	fostered – not secure	
15	√ CPR		√		√		fostered - secure	√√
16	√	√		√			residential with mother	√√
17	√ CPR		√		√		adopters	√√
18	√	√ CPR		√	√		fostered - secure	√√
19		√ CPR		√		√	fostered – not secure	
20		√	√		√		fostered - secure	√√
21	√	√ CPR		√		√	home	√
22		√					home	√√
23	√						home	√√
24		√ CPR		√	√	√	with father	√
25		√ CPR	√		√	√	fostered – not secure	
26		√ CPR					lost to follow up	?

¹ Two ticks indicates that the baby has been physically unharmed, has had minimal disruption of primary carer and is settled.

It can be seen that there may be some links between aspects of the child protection system and outcome, in that the babies where a pre-birth conference decided to place them on the child protection register and babies removed at birth achieved a *good outcome*. This question will be revisited when discussing the findings in Chapter 8. The link between

bureaucratic process and outcome cannot be understood simplistically, however. Social work involves human interaction in which both the families and practitioners play their parts in constructing the case. Before attempting to attribute meaning to the practice, it is necessary to look beyond the recorded events.

Conclusion

This chapter has concentrated on the surface aspects of the phenomenon of pre-birth intervention. The emerging picture is of a distinct population of families where concerns centre on *future-parenting* rather than specific incidents of abuse. These study families were living in extreme situations but met with a professional response characterised by uncertainty. In the following chapter, the dilemmas will be illustrated through 3 case studies.

CHAPTER 6: TELLING THE STORIES

The descriptive phase of the study began to highlight the complexity of assessing *future-parenting*, both in the difficulties experienced by the study families and the social work response. It was seen that the prospect of the mothers being able to sustain care of their babies was bleak, but that a good outcome could not be related simply to the application of child protection procedures. There is a need to look beneath the surface in order to understand. The premise within this thesis is that social work is more than a technocratic exercise but exists also in the invisible world of interaction between social worker and subject. This chapter will begin the process of exploration by a narrative analysis of 3 'real' cases behind the statistics, with a view to both illustrating the nature of the task and introducing an element of critical reflection. Before this, however, the ways in which other researchers have attempted to explore social work issues within a constructionist or postmodernist paradigm are described.

Making sense: a return to the literature

Trinder (2000) identifies two broad strands within postmodern (feminist) methodology: narrative analysis, with its emphasis on the individual account, and discourse analysis, which draws on a variety of texts constitutive of the actors' social world. Hall (1997) uses a narrative analysis to suggest that social workers' verbal or written accounts construct a story containing characters and a plot in order to justify their actions:

Characters in social work stories are portrayed as people with problems, attributes and histories, enabling events and behaviours to be rendered understandable. At the same time, strange or dangerous behaviour and extraordinary events form the basis for tales of alarm and action (p.233).

He describes the linguistic devices used by childcare social workers, firstly to demonstrate a moral rhetoric: 'the deserving client, the inadequate parent, the child abuser'. Secondly, readers are persuaded to accept the factual rhetoric of social work accounts and to recognise the authority of the storyteller. Techniques such as three line lists e.g. 'very unhappy, withdrawn, totally shut off emotionally' and the use of definitive terms such as 'in fact' or 'actually' indicate the authoritative status of the account. Through these devices, clients are constructed and categorised and cases divided into serious or not serious. The more

seriously the writer wants the account to be taken, the more detail about background and moral character are offered. Featherstone (2000) also drew on narrative theory in devising the methodology for a study of women's violence towards their children. She rejected the guided interview in favour of an invitation to participants to tell their own story and then attempted to track the whole narrative, 'exploring how the story unfolded and how continuities and discontinuities emerged and what these appeared to signify', rather than simply breaking the material into categories and thus losing the chronology. This approach highlights the need for reflexivity in order to ensure that the researcher's own theorising does not 'bend the data', both at the stage of data collection and analysis.

The nature of the power inherent in the social worker/ client relationship is widely acknowledged, although there are differences in perspective as to the way in which power is exercised. Within modernist conceptualisation, social workers can be said to 'possess' power with the opportunity to wield it oppressively: hence the move towards participative practice and empowerment (Featherstone and Fawcett 1991). Constructionists perceive power in social workers' opportunity to position their clients and thereby deny them status as subjects. Houston and Griffiths (2000) argue that social workers impose their taken-for-granted assumptions about parenting on the families they are called upon to assess. Families are thereby classified and processed rather than genuine attempts being made to understand the meaning of their experiences. But does this mean that the 'client' is power-less and never has a part to play in devising the story? Fawcett (2000) suggests an approach that moves away from merely seeing the subject as socially constructed and recognises that an element of agency can be retained. She describes the textual analysis of accounts given by people with disabilities living in a variety of settings characterised by different models of disability. By deconstructing the 'style or styles used, the emotional tones and intensities, the omissions, variations, contradictions, paradoxes and interpretative shifts found in the text' Fawcett contends that the subjects were not simply constructed by others but played a part in positioning themselves. Even if not invited to contribute, subjects may be able to control the information available to the assessor. For example, Buckley (2000) describes clients effectively controlling the intervention by refusing social work contact.

These studies raise questions not only for research but for practice, particularly with regard to the relationship between practitioners and their clients. Are they subjects, entitled to a degree of agency in telling their own stories, or merely administrative objects? Official

guidance directs that practitioners should work in ‘partnership’ but this is defined in procedural rather than human terms (surface rather than depth). McBeath and Webb (1991) criticised the *Orange Book* not only because of the flawed nature of its ‘moral truths’ but also because of its assumption that these moralities are universal, considerable emphasis being placed on establishing a shared understanding or ‘the veneer of co-operative contract’ between social workers and parents. This emphasis on co-operation is also highlighted by Holland’s (2000) study of the interactions between social workers and parents during comprehensive assessments. She found that it was parents’ ability to articulate their co-operation that most influenced social work judgements about risk to the child. Inarticulate parents were disadvantaged because they were less able to form a working relationship with the assessing social worker based on a perception of shared values. It could be argued that the aim of partnership is not, therefore, to share the task of constructing the ‘case’ but to enlist the participation of the family in the construction of the social worker’s version.

Case studies: the findings continued

When trying to make sense of the social work process, it is therefore essential to consider how the ‘client’ has been constructed, and whose story is being told. A thematic analysis of the factors used to construct ‘safe’ or ‘unsafe’ families within the study population as a whole is presented in the next chapter. However, as suggested in the account of the developing methodology, this is at the expense of the individual stories. In order to retain a sense of the way in which the narrative was developed over time, there is a need to give illustrations of the ‘whole’ story. They are thus exposed to critical scrutiny, and to consideration of whether the social worker’s version of events was a reasonable one.

The cases were selected to illustrate both the complexity of the families and the range of social work responses. In common with all the study population, the parents were facing mental health and/or substance misuse problems. The names of the family members and minor details have been altered to protect the confidentiality of those involved. The studies are presented as being the story of each child, indicating that it is s/he who is the proper subject of the assessment. However, perhaps it is more accurate to consider them as the story of the social worker who put forward the assessment for consideration by colleagues within the child protection system. The account is formally presented in the *Social Worker*

Report for Initial Child Protection Conference, where the social worker must offer an assessment of risk and make recommendations, but the steps along the way are evident in the case notes, the correspondence and the supervision notes. The *Minutes of the Case Conference* indicate whether other professionals within the child protection system accepted the social worker's account. Following the Initial Case Conference, the dénouement is evident in the continuing case notes and subsequent reports or *Review Case Conference Reports* and *Minutes*. The stories are presented chronologically starting from the beginning, when the family is referred and the social worker frames the problem to be assessed; then the middle, when the allocated social worker gathers the evidence deemed to be relevant for an assessment of risk; and the conclusion, where the social worker presents their recommendations and decisions are made about the action needed to ensure the baby's safety. Each account is followed by a postscript, which indicates the subsequent outcome for the baby. At each stage, the researcher offers a commentary about the social worker's version of events and suggests possible alternative readings of the 'evidence'.

Hassan's story

The beginning

Jean was a 36-year-old woman who had no previous children when she was referred to the social work department in hospital A. She was 22 weeks pregnant and referred by the midwife who had been asked to book her for antenatal care by staff on the psychiatric ward where Jean was an in-patient. It was clear that Jean had not requested or consented to social work involvement and the midwife recorded the reason for referral as follows:

Schizophrenic. Denies pregnancy. Does not allow blood tests, ultrasound or abdominal palpation.

The duty social worker made enquiries of the psychiatric team who confirmed that Jean had been diagnosed as having schizophrenia several years previously. They expressed a fear that Jean may abscond from the ward as she was an informal patient and would then not attend for antenatal care. They also offered the information that the father of the baby was Jean's ex-husband. Until her admission they had been living in the same household but it was said that he now did not want her to return home. The case was allocated to Ann, a recently qualified social worker. She contacted Jean's key nurse on the psychiatric ward who told her

that:

Jean will not talk to people if she feels that they want to discuss the 'phantom baby' not her.

On the basis of this information, Ann agreed with her team manager that she would seek more background information about Jean and her ex-husband (whose name had not yet been elicited). She contacted the referring midwife who said that when she tried to discuss the pregnancy, 'Jean either refuses to discuss the matter or insists that she's a boy'. Ann next contacted the GP who provided information about the extended family. Jean was one of nine children, and several were said to have mental health problems: 'the children received very poor parenting and shared 3 different fathers.' Jean had had two terminations of pregnancy, the first at the age of 12 and Ann queried if this was the result of abuse. Jean had worked as a nursery nurse and had her first breakdown 6 years previously. She had been stabilised on medication and she and her husband were referred for fertility treatment, although this was apparently abandoned. For the first time, Jean's ex-husband's identity appears in the record: his name is Mohammed and he originates from Algeria. The most recent breakdown had been particularly severe with Jean threatening to kill him and punching and hurting herself. The GP warned that any threats of self-harm made by Jean must be taken seriously.

Liaison with the psychiatric ward staff continued. When Jean was thought to be about 28 weeks pregnant, the question as to whether the baby had subject status was raised. Jean was vomiting and losing weight and staff on the psychiatric ward asked if any legal steps could be taken 'to conduct treatment/ tests on the baby' either through the *Mental Health Act 1983* or *Children Act 1989*. An enquiry was made of the council's legal department who advised that Jean could not be forced to have medical intervention against her will. The psychiatrist also raised the possibility of regulating Jean in the interests of the baby. His plan is recorded as:

... to offer the choice of agreeing to medication and antenatal care or place on Section 3 because of risks to self and child.

There was also mention of the need to 'confront' Jean about the pregnancy because of the lack of 'progress'. An interesting description of the issues is as follows:

Nurse also told me that part of the problem is that many of Jean's delusions have

a developed internal logic which is hard to contradict. These mainly concern a paranoid vision of the 'system' being out to get her and all women. Therefore when it is suggested that she is pregnant she reflects this back as a desire for her to be impregnated and subjugated.

The social worker consulted her team manager and it was decided that Ann would write and offer an appointment to Mohammed and that a pre-birth conference would be convened. This is the first clear indication in the records that the case is being dealt with under s.47 i.e. as a child protection investigation. In her letter offering an appointment, Ann explains her role as follows:

Part of my role involves making plans for children where there are concerns about how well one or other of the parents will be able to care for a new baby. I understand that your former wife is currently a patient on (*psychiatric ward*) and that she is expecting a baby early in the New Year. However, I also understand that she believes that she is not pregnant which is causing some concern. I should very much like to know your views and wishes about the baby.

Mohammed failed his appointment and Ann sent him another. Christmas then intervened and Ann returned to hear from the ward that nothing had changed:

Jean still denies she is pregnant and verbally abuses anyone who says she is ... Doctors are starting to get ready to confront Jean and are preparing to take out a Section 3 on her.

Comment

Jean is now possibly only 5 weeks off the expected date of delivery and Ann has not met either her or Mohammed. This does not reflect a lack of activity and contact has been made with 9 other professionals either within the health service or the local authority. There are by now 9 pages of case notes in which Jean is mentioned 57 times but Mohammed only 19 times. He is referred to as the ex-husband until page 6 when he is named by the GP. The baby is rarely mentioned – only 7 times in all.

The construction of Jean's character has already begun. She is portrayed as a 'mad' woman who will not accept the role of mother: she denies she is pregnant and will not allow the unborn baby's welfare to be monitored. Her utterances and behaviour are clearly attributed to her delusional mental state and not allowed to carry any other meaning (in spite of their resonance with some feminist writing on motherhood). There is confusing information about whether Jean wanted to become pregnant and take on the role of mother. Even more

confusing is Mohammed's perspective. It is acknowledged that he visits Jean on the ward and appears to be caring but little else is known.

Ann has been explicit in her letter to Mohammed that her role is to 'make plans for children' but her gaze is overwhelmingly on Jean. The baby has not yet acquired subject status. Enquiries were made about the possibility of taking legal action in respect of the baby but this was deemed not to be possible. S/he returned to the wings to await the cue to enter the stage. There appears to be a discontinuity between the stated aim of making plans for the baby and the emphasis within the records on persuading Jean to accept her role as mother.

The middle

Ann now seemed to enter a different phase of the work. There were daily entries on the record detailing the practical arrangements for the pre-birth case conference but also a long account of a supervision session in which the possible components of a protection plan for the baby were discussed:

1. For medical staff to confront Jean about her pregnancy.
2. Investigate possibility of assessment by a psychiatric mother and baby unit (although this may not be possible if Jean continues to deny the pregnancy).
3. I will make commitment to continue to try and engage Jean and to make plans.

Ann recorded the following but offered it as advice given by her manager rather than owning it as her own point of view.

If Jean continues to deny her pregnancy then baby's safety will need to be secured via EPO or Police Protection Order if there is a fear of her absconding with baby or via care order if Jean wants to work with social services but does not want to keep the baby (could even simply offer foster care without a care order).

Ann then meets Mohammed and explains her 'role and duties as a child care social worker'. There follows a long account of the interview under the headings of 'history' and 'current situation'. The history is, in fact, Jean's personal history as elicited from Mohammed, and the history of their relationship. Mohammed's own history prior to the marriage is not recorded. Ann records that Mohammed and Jean had been married for 6 years but that he

only became aware of her mental health problems about 4 years previously. The illness had placed a strain on their relationship:

... she was very difficult to live with when ill – i.e. she would become very aggressive, constantly ring the police and suffer extreme mood changes and threatened him on several occasions.

He became unable to cope and filed for divorce but they continued to have a relationship which was sometimes 'intimate', sometimes 'platonic'. Mohammed says that Jean had been fitted with a coil contraceptive but 'must have had this removed and did not tell him'. He speculated that 'she may have at least partly become pregnant on purpose to stop him from leaving'. He said that Jean had previously vacillated about whether she wanted a baby, sometimes saying that 'she hated children and might kill any baby she had'. Mohammed said that Jean had an almost non-existent relationship with her family apart from one brother and confirmed the GP's story of Jean's troubled childhood:

Jean's mother had been a very poor parent and had even thrown Jean and two of her siblings out of the home when Jean was only 12. Further Jean's mother, grandmother and 3 of her brothers have all suffered from mental illness.

Moving on to 'current situation', Ann's opening sentence is as follows:

I asked Mohammed about his thoughts and feelings regarding Jean's pregnancy. He immediately said that although he would not want to separate the baby from his/her mother he would wish to care for it should Jean be unable to.

He went on to describe how he would cope as a single parent, given that his family were in Algeria. He did have a supportive network of local friends but, if he couldn't manage, he would consider asking his parents to look after the baby. Ann's response was to raise the issue of Mohammed's legal status in respect of the baby: he might not have automatic parental responsibility because of the divorce.

I also advised him that he would need to seek Jean's permission to remove the child from the UK – and so it would be advisable to contact a solicitor so that he can clarify where he stands on these matters.

Ann describes how she ended the interview:

Before Mohammed left I said that I appreciated that this was a difficult and upsetting time for him and asked if he had been able to discuss it with anyone – he said he hadn't as he is a reserved/ introverted person. I then said that if he came to look after the child we would offer him help and support, and also explained that should Jean change her mind and accept the baby we would try to arrange for her to go into a psychiatric mother and baby unit after the birth – so that she could be offered support there whilst ensuring the baby's security.

Comment

The account of the interview with Mohammed serves to emphasise his position as a supporting player in the narrative. His personal history is not deemed to be relevant, other than as it relates to Jean and his wish to be a parent. When he volunteers the suggestion that he may become a primary carer for the expected baby and goes on to describe the possible ways he could manage this, he is politely reminded that his role is contested. He might not have parental responsibility and, even if he has, it is contingent on Jean's 'permission' and wishes. Whilst acknowledging that she is uncertain as to Mohammed's exact legal status as a parent, Ann nevertheless claims the authority of this position through the use of phrases such as 'I advised him that' and 'I explained that' when expounding his and Jean's respective autonomy to take decisions about the baby. Although Ann has asked Mohammed what he wants, the conclusion of the interview makes it clear that it is what Jean wants that really matters.

Meeting Jean

Three days later Ann received a message that Jean has been placed on a Section 3 of the *Mental Health Act 1983* and transferred to a secure psychiatric ward: 'very disturbed - says she is "going to cut this thing out of her".' A ward meeting was arranged for the following day, which Ann attended along with the community midwife. She records that Jean had become more disturbed over the past 2 weeks and had attacked another patient. Apart from the comments about cutting the baby out, she had referred to the maternity service as a 'butcher's shop and as cannibals'.

In the past she had also said that she feared she would give birth to an elephant, that others were trying to control / dominate her and that she feared she would be cut open by the obstetric staff.

In discussions with ward staff, the meaning of these statements was considered. It is recorded that Jean had been in a 'road traffic accident in which she bled quite heavily and

this could be relevant in her view of her baby'. This interpretation of Jean's point of view is interesting: there would seem to be more plausible readings relating to her past history of terminations and current experience of being pregnant and facing imminent childbirth.

Ann and the community midwife then met Jean on the ward and she is reported as being happy to see them, 'much to our surprise'. She allowed some antenatal checks to be carried out. Ann then introduced herself:

When I explained to Jean who I was and that I wanted to talk to her about the baby – she was not worried or aggressive at all but simply said that she felt drugged up and asked if I could come back in a few days.

There is a sense of relief in these extracts. It appears that Ann was expecting a hostile, possibly even violent, or defensive response. She visited Jean three days later, repeating that she had come to talk to her about her feelings and plans for the baby:

She said that she now felt very protective about the baby because of her own childhood (she didn't elaborate) but that when she first realised she was pregnant she had been very shocked but was now looking forward to the birth. I asked her when she had realised she was pregnant and she said when she was sectioned – I asked if she had any inkling before then, she said none. I then asked her about her thoughts about the child and she said she could see herself living in a council house with the child, and that when the child would go to school she could maybe do some part time work. I asked her if she had had a chance to make any plans. She said she hadn't really – I then explained about the psychiatric mother and baby units and Jean said she thought these would be a good idea ... I then said that I understood Mohammed was supportive and Jean took the cue to say that she wanted to share the care of the child with Mohammed, that she wanted the child to know his/her natural father.

Ann goes on to tell Jean about the planned pre-birth case conference (but does not invite her to attend) and records that she:

... asked Jean if she would like me to put to the meeting that she would be interested in going to a psychiatric mother and baby unit (I told Jean where 2 local ones are).

Comment

The recording of this interview is different in style from that with Mohammed. The 'I said ... she said' nature of the exchange is suggestive of a script unfolding whereby a set of lines

is being offered to Jean as to what she *should* be saying. Ann hints at this when she refers to Jean taking the 'cue'. The suggestion of a mother and baby unit is clearly made by Ann, but she offers to present this option *on Jean's behalf* to the conference. Ann therefore gives Jean considerable assistance in framing her position. The worrying aspects of Jean's situation - her mental illness, troubled childhood, violent behaviour, lack of support and negativity towards the baby - are glossed over. She is not challenged about the vague nature of her plans, leaping as she does to the time the child is of school age, and there is no discussion about possible risks to the baby. This is in contrast to the discussion with Mohammed, who was not helped to say the right thing and even received hints that his bid to be primary carer was somehow *not* right.

Pre-birth case conference

In her report to the pre-birth child protection case conference, Ann's task was to summarise the information felt to be relevant to the unborn baby's safety and make recommendations about a course of action that would protect her/him if necessary. The *Report* is structured into headings. Ann gives the *Reason for Investigation* as being Jean's diagnosis of schizophrenia and denial of the pregnancy. Ann describes her original role as being to liaise with other professionals to get Jean to book for antenatal care but 'it soon became apparent that Jean could not acknowledge the pregnancy'. The conference was therefore arranged to 'plan for Jean's and the baby's welfare'. Under the heading of *Background*, Ann refers to Jean's unhappy childhood, her termination of pregnancy at the age of 12 around the time she was 'thrown out of home by her mother', her subsequent employment as a nursery nurse and diagnosis of schizophrenia. She then describes the marriage, Mohammed's difficulty in coping with Jean's aggressive behaviour when unwell and the subsequent divorce. This section ends with an account of Jean's latest admission and the discovery of the pregnancy. Perhaps the most crucial extract from the report is the following, under the heading of *Social Work Assessment and Situation/Risk and Recommendations*:

Within the last week I have spoken to both Mohammed and Jean about their views. I spoke to Mohammed before the most recent Section, when Jean was still very disturbed. He said he would want to care for the baby if Jean was unable to, although concerned about how well he would cope. He does not have automatic parental responsibility.

Jean's mental health is now stable, and she wishes to parent the baby and if necessary go to a psychiatric mother and baby unit for assessment/support. She

also spoke of sharing care/responsibility with Mohammed.

My assessment is that Jean should not be discharged with her baby into the community, but should be given the opportunity to parent the child within a secure, supervised environment so as to safeguard the baby's welfare ... I will continue to work with all concerned to develop a more detailed child protection plan in time for the delivery and next case conference.

Comment

Prince (1996) suggests that the social work report is a powerful document in shaping child protection decision making. This is reflected in the *Minutes of the Conference*, which endorsed the plan. Some additional information is recorded, however. Jean's violence when ill is noted, as is the police report that they have been called to the home address 8 times within the past year because of violence involving Jean and Mohammed and two of her brothers. Psychiatric staff also report that the stability of Jean's mental state is linked with her compliance with medication.

The moral rhetoric (Hall *et al.* 1997) within Ann's report is interesting. It constructs Jean as a victim, both in terms of her childhood and subsequent mental illness. Her violence and aggressive ideation about the baby are played down and her agency denied. It is reported that she 'could not' acknowledge the pregnancy, and her ability to choose to feel negatively about the baby is hence rejected. In spite of the fact that her mental health appeared to have improved only hours before the report was written, she is described as having stabilised and wanting to be a parent. It is as if the weeks of fighting against the role of mother never took place. The question posed about risk to the baby is side-stepped: instead it is stated that Jean should be *given a chance* to parent, whatever ambivalence she has expressed. In contrast, Mohammed's role as parent is challenged. He may not be able to cope and has no 'automatic' claim.

The conclusion

Following the conference, the unborn baby again entered the arena because an ultrasound scan suggested that s/he might have some growth abnormalities. Jean was transferred to the maternity unit where Ann was based. She mentioned the concerns about the baby to Jean:

... but whilst expressing some concern Jean did not want to talk about this. She talked instead about how she felt that Mohammed was not really prepared yet for being a father and also about her mum's life caring for 8 children.

From that point until the birth Ann met Jean at least once a week and records this phase as being the 'assessment process'. She asked Jean about her perceptions of her mental health problems and the impact these may have on the baby. From the records, it appears that she was keen to accept what Jean was saying without challenge. For example, Jean describes herself as becoming angry and unable to cope when ill:

I asked how she felt she would cope if she felt that her mental health was deteriorating – she said that if she felt she was getting more anxious she would go for long walks, swim etc. which she often found had helped ... She would also arrange for someone to look after the baby for a short time to give herself the break ... I then moved to asking her questions about the baby – she smiled when I asked her if she thought she would find it easy to cope with domestic aspects of baby care – feeding, changing etc. Negative aspects? She couldn't think of any – not even crying, sleeplessness, she felt she would be able to cope. I asked her about her feelings and she said she felt very positive apart from worries about her baby's health and the possibility of a caesarean.

At another point in the same interview Ann records:

... Jean said that she wanted to have a fair try at parenting – (and felt that if she could cope until the child would be school age then she would cope from then on). But that if she felt she was going to continue to have breakdowns rather than have the child shunting between foster homes and her she would arrange long term fostering for the child's welfare. However she saw the child as a fresh start and felt that with help this child would help her to avoid further breakdowns.

It is difficult to link these statements into a coherent story, even within this single interview, and they also appear to conflict with previous information. Similar discontinuities are evident when Ann focuses in the next interview on Jean's personal history:

When asked about her family, Jean said that she had a normal, stable, reasonably happy upbringing, and could only think of one traumatic incident; that of being told at age of 15/16 yrs that her mum was a paranoid schizophrenic and that the condition could be inherited.

Later in the same session, it is recorded:

At 14 years of age Jean left home to live in a children's home – primarily she says because of the overcrowding at home.

In relation to Mohammed:

Jean said that she thought the main reason for his divorcing her was on account of her smoking ...

Ann also met separately with Mohammed and asked him similar questions, i.e. how Jean's psychiatric illness manifested itself and how this may impact on the baby. She records that she based this questioning on different scenarios 'mainly if Jean is in either a psychiatric mother and baby unit or in the community'. Mohammed's responses were specific. He expressed a clear opinion that Jean displays the following symptoms if she does not take her medication:

- (i) Takes less care of herself
- (ii) Sleeps more – in daytime – awake at night
- (iii) Paranoid delusions

In relation to the parenting role, she might:

- (iv) Neglect herself and baby
 - (v) Forget to feed baby and may go out and leave baby behind.
- He did not know if Jean would physically harm baby although she has been aggressive towards him.

Hassan's birth

Baby Hassan was born following an induced labour and belied the fears about his health, although he was small. Jean and Hassan remained on the maternity ward whilst a case conference was arranged and attempts made to find a place in a psychiatric mother and baby unit. Jean was said to be 'delighted' with her son and 'attentive' to his needs but she also told Ann that she felt 'overawed by experience of labour and caring for her baby'. The midwife who was looking after her described Jean's demeanour as 'spaced out' and said she needed reminding about aspects of baby care but thought this was partly due to a change in medication. Interestingly, Ann seemed to feel able to take a more direct stance with Jean in relation to the fact that neither of her parents had visited in spite of the previously 'very friendly picture' she had painted of her family. She also asked for details of Jean's

medication history: 'I asked if she had forgotten or chose not to take it'.

The reconvened case conference

Ann reflects some of these themes in the *Social Work Report to the Case Conference*, but offers accompanying explanations or solutions to defuse their impact. For example, Jean is described as 'not yet fully confident' in her care of Hassan, and is reported to have said that 'she would take her medication and suggested she could be given 'depo' injections on a regular basis'. There is no mention of the earlier denial of the pregnancy or the diagnosis of schizophrenia, rather:

Jean said that she thought she became ill because she is a shy/anxious person who can find stressful events overwhelming.

In contrast, Mohammed's specific concerns about the care of the baby are not mentioned and he is marginalised by the following authoritative statement:

It is important to note that as far as I am aware Mohammed has still not sought parental responsibility.

Ann concludes:

My main concern would be if Jean goes back to the community without (this) professional network in place, and then suffers a breakdown. In such a situation based on the fact that Jean's mental health can decline very rapidly based on past episodes – there would be a real danger of neglect and harm.

The *Conference Minutes* describe some concerns in relation to Jean's history of mental illness and reluctance to take medication, domestic violence and the lack of a support network but are predominantly positive about her ability to care for Hassan. Mohammed's position is recorded as having: 'expressed a desire to help support Jean'. The *Minutes* conclude:

General consensus was that should Jean continue taking her medication on regular basis and with support she will parent effectively but it was felt that a longer period of assessment at mother and baby unit is needed before definite decisions can be made.

Hassan's name was not placed on the child protection register and the plan was endorsed to

transfer Jean and Hassan to a mother and baby unit within a psychiatric hospital for a period of assessment.

Comment

Ann saw this phase of the work as being the ‘assessment’ and made detailed notes regarding the areas she intended to cover. These notes consist of 1 side of A4 in relation to Mohammed focussing on his proposed involvement with Jean and the baby: he is offered possible scenarios regarding the care of Hassan on which to comment but these are all based on the assumption that he will be in Jean’s care. In contrast there are 6 sides of notes in relation to the planned assessment of Jean on topics ranging from her mental illness, her views about the baby, detailed personal history and support networks. Ann did not see the couple together or attempt to meet extended family. Following the birth, she refers to Hassan only in relation to the care given to him by Jean and does not note his responses. There are many discontinuities in the evidence provided by others about Jean’s problems and those she describes herself. Ann seems to perceive herself primarily as a channel for Jean’s version of events, and either suppresses these discontinuities or mediates them with suggested explanations in order to arrive at a version which is likely to be acceptable to the child protection network. She does not take the same approach with Mohammed and discredits his claim to be a co-parent to Hassan. There is no mention of Mohammed’s care of Hassan or his attitude towards him. There are clearly alternative readings of the information within the case record. For example:

Ann's story	Alternative story
Jean wants to have a baby but did not realise it because she was mad	Jean is deeply ambivalent about having a baby
Jean is shy/anxious	Jean is schizophrenic
Jean is able to care for Hassan but lacks confidence	There are early indications of difficulty in Jean's care of Hassan
Jean will continue to take medication	Jean is unlikely to take medication on a long-term basis
Mohammed's role is to support Jean in caring for Hassan	Mohammed could be central to the care of Hassan
Jean wants to go to a mother and baby unit	Jean has been given little choice but to go to a mother and baby unit
Jean is a victim of circumstances	Jean can exercise agency, including violence to others
Jean would be able to cope if she had enough support	Jean may be too disturbed to benefit from supportive services
Issues of racial and cultural identity are not relevant in this case	Hassan is a child of mixed heritage and this identity must be taken into account when assessing his needs

Postscript

If the intention is to tell a story, then it makes sense to tell the reader what happened next. Before the transfer to the mother and baby unit, Jean told Ann the following:

... she wanted what was best for Hassan, but felt that she couldn't manage, that he wasn't gaining weight and in particular she found it very difficult to feed him. In addition Mohammed has said that if she feels she cannot cope he will give up work to look after Hassan.

Ann replied:

I said to Jean that most new mothers have a crisis of confidence in the early days and that as Hassan was still only a few days old she should give herself more time before making any decisions.

Over the following weekend Jean:

... became more depressed, presented herself at (*psychiatric ward*) with suicidal feelings and feelings of wanting to smother the baby. Jean was readmitted to (*psychiatric ward*) over the weekend and has visited baby briefly on both days. Initially couldn't touch Hassan but yesterday she was able to hold him ... Mohammed very concerned and wanting to seek custody following above.

The admission to the mother and baby unit went ahead, without any discussion with either Jean or Mohammed, and the case was transferred to a new social worker. Jean rang her the next day:

Says she cannot and does not want to look after Hassan. Has decided that she wants him to be looked after by a foster carer or his dad.

This was attributed to anxiety and the placement continued. When the social worker visited she noted the following behaviour from Jean towards Hassan:

Seemed content to let staff feed and cuddle him – made no attempt to care or cuddle him herself until I suggested he might want her to hold him.

Six weeks later, it was decided to transfer Jean and Hassan to another mother and baby unit in the voluntary sector for another period of assessment, specifically of Jean's parenting skills. The new unit reported to the social worker that Jean:

Does not have maternal instinct to feed or reassure.

Later entries in the case file record Hassan as being; 'quiet', 'pale and depressed', 'dirty', 'emotionally neglected. Not stimulated in any way', 'miserable and irritable, skin very dry, very skinny'.

When Hassan was 4 months old, a meeting was held in which it was decided to continue the placement for another year, to provide counselling for Jean and to offer her child-minding support. When he was 9 months old, Jean was re-admitted to a psychiatric unit and Hassan was cared for by Mohammed. A meeting decided that a parenting assessment was needed and that Hassan should be referred for investigation of possible developmental delay. For the next few weeks he moved between both parents and relatives, and also received some direct care from residential unit staff. At the age of 1 year, Jean resumed full-time care but was reported not to be looking after or feeding him and it was agreed that, unless



Mohammed took Hassan to live with him, an application would be lodged for a care order. Mohammed obtained a residence order when Hassan was 16 months old.

Comment

It is difficult to know why the professionals in this case chose to tell the story as they did. Practitioners are influenced by a mixture of organisational, theoretical and personal factors which are difficult to unravel. It is legitimate to challenge the validity of this evidence base, particularly as there are alternative readings of the information which, admittedly with the benefit of hindsight, seem to be more plausible. However, Ann's original version had assumed authoritative status and subsequent workers appeared unable to challenge it. If the text is analysed, it could be argued that Ann exercises considerable power, albeit not in the expected sense of oppressing parents by classifying them as dangerous. Rather, she appears to 'bend over backwards' to take a non-judgemental and benign position. Philp's (1979) concept of the social worker mediating the subject status of their clients, or Lee's (1994) description of the social worker 'speaking for' clients, could be said to be in operation. However, closer analysis suggests that there are difficulties with this perspective. Ann does appear to speak for Jean and Mohammed, but in a way that determines the story they tell. The script she offers to them appears to originate from a belief in the 'natural mother' and the 'rule of optimism': that all women want to be mothers, love their children and can do a good job. Jean's ambivalence is suppressed and denied meaning. In contrast, fathers are assumed to be the secondary and contested parent, and Mohammed's claim to be central is similarly suppressed. There is no attempt to take into account the issues of race or culture in spite of Mohammed being from North Africa and a Muslim, or Hassan's identity as a child of mixed heritage. No-one appears to be speaking for (or even about) Hassan until his mother's care of him is floridly inadequate. Although this has ostensibly been Hassan's story, his voice remained silent. It is not evident from the record whether he was able to establish a secure attachment to either of his parents and questions are inevitably raised about whether he would have been better served if his story had been told differently.

Jake's story

The beginning

Sharon, aged 27, was referred by a midwife to the social work team in hospital A when she was 3 months pregnant. She was described as a 'previous heroin abuser - now on methadone' and it was said that she had a 6-year-old child who was a ward of court, living with her ex-partner's mother. The duty social worker established that, perhaps surprisingly, Sharon had no previous contact with social services although her sister had been looked after during her teens. She was, however, known to the local drug clinic. They provided a report, confirming that Sharon had been receiving methadone treatment for several months but continued to use street drugs in addition. They were considering increasing her methadone to help her gain control. Her partner, Mike, had also been in treatment but discharged for non-compliance.

The case was allocated to a social worker, Marie, for a pre-birth assessment when Sharon was 5 months pregnant. Marie wrote to Sharon:

I hope you are feeling well. I'd like to offer you an appointment to come and see me to discuss plans for your baby's birth.

In fact, 6 weeks went by before Marie was able to persuade Sharon to see her, in spite of arranging several appointments and asking antenatal and drug clinic staff to actively encourage Sharon to attend. The drug clinic reported that, although Sharon's methadone prescription had been increased, she continued to use other opiates, cocaine, codeine and benzodiazepines in addition. They had taken Mike back into treatment to try and help her to stabilise. On one occasion Marie spoke to Sharon on the phone whilst she was picking up her methadone prescription and recorded:

She sounded very badly – very runny nose; lethargic; very passive – perhaps withdrawing. Explained time was drawing near and we needed to meet to discuss the baby's birth.

An appointment was arranged for the following day which Sharon attended, accompanied by Mike. The purpose of the social work assessment was clearly a major issue:

Sharon is very anxious that we are going to take her baby away. I explained at this point no decision has been made. I explained procedures and expectations of the department.

Sharon and Mike agreed to return 'to begin social history taking' and, although a further two appointments were failed, Sharon turned up for the third. She was then over 6 months pregnant. Marie spent the session talking to Sharon about her family background and they worked together on a genogram. Marie records that Sharon was one of 6 children, 2 of whom had died. Sharon described a childhood where she had been physically, sexually and emotionally abused by her alcoholic father. This meeting appears to have marked a turning point in their contact and Sharon began to attend appointments, albeit erratically. After her next antenatal check-up, Sharon and Mike came to see Marie, who recorded Sharon's feelings of being under pressure because of the number of appointments she now had to keep and the need to sort out her accommodation and finances to prepare for the baby. Sharon also repeated her anxiety about the baby being taken away and was again reassured by Marie that no decision had been taken. Marie records her own opinion that:

It is this anxiety rather than fatigue or chaos that is stopping her from attending meetings regularly or on time.

Marie concluded:

Sharon's baby is likely to be in hospital for sometime following the birth and in a sense, it will be post-delivery behaviour that will determine future plans. At the moment, I feel that within Sharon's terms of reference, she is doing as best she can to be co-operative and reliable in what is an enormously threatening and difficult process for her.

Marie attempted to find out more about Sharon's previous child. Sharon had told her that this child was a ward of court, living with paternal grandparents, and had provided details, but the local social services office had no knowledge of the family. Marie spoke to the community midwife, who told her that both Sharon and Mike were making real efforts to ensure her flat was suitable for a baby. They agreed that Sharon should be 'given every opportunity to make it work'. One area of concern was the fact that Sharon had unresolved issues about childhood abuse which were best addressed by female workers. She had asked to transfer from her male key worker at the drug clinic and Marie agreed to advocate for this on her behalf.

An 'early planning meeting' was held at that point, which was the usual practice at hospital A. It was attended by paediatric and obstetric staff, the drugs worker and the social work team manager at hospital A as well as Marie. Sharon and Mike were not invited. The minutes record that information was shared about Sharon's childhood, the loss of custody of her previous child and her drug history. She had by now been in treatment for more than a year and had originally been motivated by a wish to 'get herself together' in order to regain custody of her daughter. The focus had then shifted to the effects of her drug use on the unborn baby, referred to as the foetus. She continued to use a variety of drugs in addition to those prescribed and would have been discharged from treatment for non-compliance had it not been for the pregnancy, as would Mike. The meeting acknowledged that both parents had repeatedly expressed a desire to look after the baby and be given a 'second chance'. The decisions were:

- in view of Sharon's drug intake, the baby would need to be transferred to the neo-natal unit for treatment for at least a month;
- both parents would be offered a meeting with the paediatrician to discuss the care the baby would need and to show them round the neo-natal unit;
- Marie would continue to seek information about Sharon's previous child, talk to Sharon about 'issues of good parenting' and the option of counselling in relation to her past abuse;
- the community midwife would continue to visit at home and refer on to the health visitor;
- the drug clinic would continue to prescribe methadone;
- Sharon to be offered in-patient treatment to stabilise her drug use before the birth;
- a case conference to be convened 3-4 weeks after the birth.

After further investigation, Marie discovered from the previous health visitor that Sharon's first child had been removed from her care through a civil case which had granted custody to her paternal grandmother. The health visitor knew the family well – she was currently working with Sharon's sister who was also a drug user, as were other family members. The family were closely involved, rallying around to keep social services at bay in times of crisis.

Sharon and Mike came to see Marie a couple of weeks later, having again missed some appointments. They were both reported to be pale and drawn and Mike had lost weight.

Sharon reportedly not sleeping and constantly worried about possibility of losing the baby. Feeling as if she has to use cannabis to calm down and has drunk on at least one occasion. Does not want to consider residential treatment at this point, although encouraged to. Sharon missed above appointments because Mike was arrested (from her home) on robbery (armed?) – flat searched – nothing found – Mike to appear in identity parade. Car was impounded by police with diary of appointments inside.

Marie took Sharon to the antenatal clinic for a check up and she returned later, saying that it had been suggested she come into hospital to stabilise her drug use:

Sharon would not stay. I repeated concerns for her and asked her to consider it and call back anytime before her due date.

She saw the couple 10 days before the expected date of delivery and, for the first time, the baby was discussed. The obstetrician had said that s/he ‘was about 6 lbs. – slightly low on amnio fluid but nothing to be alarmed about’.

Comment

Marie’s energies during this phase of the work are directed towards trying to engage Sharon in the assessment process, working with other professionals to encourage attendance. Although she tells Sharon, somewhat euphemistically, that the purpose of social work involvement is to plan the baby’s birth and does not make it explicit that the assessment takes place within a child protection framework, it is clear that Sharon and Mike have no doubt that their ability to care for the baby is in question. Marie responds to this anxiety honestly by acknowledging that this is true but reassuring them that no decision has yet been made. Once this is clarified, there is evidence that she is able to develop a degree of trust with the couple. They are able to describe the stress they are under and to admit to Mike’s encounter with the police and Sharon’s chaotic drug use. She also provides information about her previous child to enable Marie to gather information. Interestingly, there is little detail in the case notes about Sharon’s drug use (other clients’ records provide detail of drug screens/ methadone dosages etc). Instead, the first session with Sharon is devoted to the shared task of constructing a genogram and Marie repeatedly expresses concern for Sharon’s physical and emotional well-being, rather than that of the baby.

The reasons for this approach are not made explicit. It could be understood as evidence of the traditional social work values of empathy and a non-judgemental attitude, or perhaps an

attempt to allow Sharon to have subject status. Sharon is seen first as an individual, whose personal history is meaningful, rather than allowing her to be defined solely by her status either as a drug user or ‘human incubator’ (Varley 1996). Alternatively, it could be that Sharon is being constructed in different terms: not as a ‘drug user’ but as a ‘victim’ who has been driven to drug use by her abusive past. It could be argued that this approach is at the expense of the baby, who is rarely mentioned and has no status as a subject until just before the birth. The effect on the baby of exposure to a cocktail of drugs is not explored. There is, however, evidence of planning to meet the baby’s needs. The drug clinic is prepared to bend its usual rules to try to promote the baby’s health, and the need for treatment and protection following the birth are considered at a multi-disciplinary meeting. In a sense the baby’s status could be more accurately described as *future-subject*. Marie’s aim appears to be to engage the parents as *individuals* with a view to assessing them as *parents* only following the birth, in the knowledge that the baby will be in the safety of a hospital setting. Marie’s efforts were primarily directed at Sharon. She did see Mike if he accompanied Sharon to appointments, and talked to him about the progress of his criminal case. However, she did not offer him any separate appointments during the pregnancy, nor did she gather information about his history. Discussions about a possible residential placement are directed at Sharon alone. The model appeared to be one of Sharon as primary carer, with Mike as supporting partner.

The middle

Jake’s birth

Jake was born at full term. Marie was told that he had initially been unwell, needing to be ventilated, and that he was on the neonatal unit being treated for drug withdrawal. She went to see Sharon, who was tired and disappointed that Mike had not been with her during the birth. Marie was then off work for a few days and returned to the news that, following some fits, tests had revealed Jake to be brain damaged. It was unclear whether this had been sustained before or at the time of birth. Both parents came to see Marie to tell her of their shock and distress at this news and there followed a period of frequent contact, often initiated by the couple themselves. Marie also maintained regular contact with hospital staff who told her that both parents were visiting Jake regularly and providing good care. They were thought to be ‘coping by being hopeful’ and said that they were now only using cannabis in addition to their prescribed drugs. With Mike’s permission, Marie tried to

intervene to sort out his legal problems. She also participated in a meeting between a paediatrician and both parents when they were told that Jake's brain damage was severe and irreparable. On the same day, hospital staff requested Marie's involvement in dealing with suspicions that Sharon and Mike were stealing from the neonatal unit. She told both parents about these allegations and advised all parties that security staff would need to be notified.

Mike initiated contact with Marie – the first time that she had seen him alone – and she records his account of their reaction to Jake's diagnosis. Sharon was said to feel as if 'her heart has been bitten out'. Mike expressed their wishes in relation to Jake:

Mike and Sharon have discussed the situation and understand that Jake may be handicapped but they feel his best chances for development are with them who can provide the constant love, cuddling and attention unable to be provided in hospital.

He denied the allegations of stealing and insisted that neither he nor Sharon had used any illicit drugs since the birth and 'that they were both totally committed to caring for Jake', wanting to take him home as soon as possible. Marie reminded Mike of the plan to hold a case conference and that there were still 'social concerns' which precluded immediate discharge.

A case conference was arranged and Marie continued to liaise with other professionals about the standard of care both parents were providing for Jake. They were allowed to stay on the neo-natal unit until the case conference and Marie records that they were enjoying this, partly because Jake was responding to their care but also because:

... it helps them to be with him and away from local friends/acquaintances who use drugs. Discussed the fact that this will no longer be the case when they return home with Jake.

Allegations about theft continued, including one incident where Mike was seen to be tampering with a locked cupboard.

Comment

This phase of the work constructs Sharon and Mike as parents and the previous focus on Sharon as an individual fades away. Marie tends to describe them as a composite, recording

how ‘they’ care for Jake rather than disaggregating their behaviour. The issue of Jake’s considerable disability prompts a supportive reaction, with all professionals clearly feeling sorry for Sharon and Mike and wanting to help them. In turn, Sharon and Mike are providing evidence of their fitness to parent. They spend time with Jake, are distressed about his diagnosis and not only express their wish to care for him but indicate that they appreciate his special needs. They also demonstrate that they can modify their previously out of control drug use in response to Jake’s arrival. Sharon’s status as victim is confirmed by Jake’s disability: she is a woman doing her best in the face of adversity. The aetiology of Jake’s disability is not explored, other than to state that it could have been caused before or at birth, and the question as to whether Sharon’s chaotic drug use was a contributory factor remains unasked.

The conclusion

Marie prepared the *Social Work Report to the Case Conference* in which she described Sharon’s background of deprivation and abuse. In relation to her previous child, Marie reported that the child’s father had been using and dealing drugs throughout the pregnancy and that Sharon started to use opiates shortly after the birth:

Unable to document quality of past parenting. However, Sharon describes herself as being unable to meet (child’s) emotional needs as her main pre-occupation at that time was securing a steady availability of drugs.

Marie reports that the child’s paternal grandmother offered to look after her when she was a toddler, whilst Sharon:

... attempted to gain some control over her drug addiction. When Sharon approached her to regain custody, the family refused to hand her over to the care of her mother.

Since then, Sharon saw her daughter playing on the estate but had no other contact. This was described as the worst time of her life:

According to Sharon, she felt that life was not worth living and she cannot bear to think of the level of despair she felt she had reached.

Marie goes on to describe Mike. This is brief and bland in comparison. There are 53 lines of text in relation to Sharon and 13 about Mike. All Sharon's family are named and their stories told, whereas Mike is said to be 1 of 2 children of divorced parents but little else, in spite of the fact that both his parents and sister had been frequent visitors to the hospital.

Mike had a fairly settled childhood. He had been a very promising student and involved with school sports until he became involved with drugs at approximately the age of 16. Since this time he has lived a more chaotic life, occasionally employed as a bricklayer. Mike currently awaiting committal to court on robbery charge.

The section for *Quality of the Relationship with Worker* was still part of the report format at the time. Marie describes both parents as:

... very open and co-operative in our contact. They have both been prepared to address concerns regarding their ability to care for Jake and have been fully engaged in plans for Jake's safe discharge from hospital.

Marie summarises the initial concerns:

Throughout the pregnancy there was great deal of concern about Sharon's ability to control her use of drugs and therefore look after her baby adequately.

She goes on to describe events since Jake's birth, with Sharon's urine tests revealing no evidence of street drugs. She also describes Jake's medical difficulties, suffering from drug withdrawal and severe brain damage, and the uncertainty about his future mental and physical development. Marie comments on both parents' distress at Jake's condition, and their commitment to caring for him at home, evidenced by their constant presence at the hospital. Marie concludes:

Sharon and Mike's long-term plans are to marry and eventually be drug free. Despite the intense pressure and stress brought on by the diagnosis of brain damage, both Sharon and Mike have managed to continue to control their use of drugs whilst bonding with and providing a high level of care for their son albeit in an institutionalised environment. I feel Sharon and Mike are aware of the expectations placed on them to adequately care for Jake and have met those expectations. I feel, together, with support they could care for Jake in the community as long as they can maintain a level of controlled drug use. If either of their use of drugs should become out of control, I feel Jake would be at risk.

Marie then goes on to describe other issues which may affect parenting ability:

- Sharon's past abuse and the need for counselling. ('She sees a link between her low sense of self, drug use and the abuse she has suffered as a child').
- The possibility of Mike receiving a custodial sentence, in which case Sharon would have difficulty coping on her own, even with the help offered by his father in this eventuality.
- Finally, the fact that Jake has special needs may also affect Sharon and Mike's ability to cope in the long term.

In view of these factors, Marie recommends 'close supervision over time'.

The case conference

The case conference was held when Jake was 6 weeks old and nearly ready for discharge from hospital, although requiring ongoing medication for drug withdrawal. The *Case Conference Minutes* repeat the information contained in Marie's report about each parent's history, their pattern of chaotic drug use during the pregnancy but compliance with treatment since the birth. Details of their current prescribed drugs were given, and their care of Jake described. They had demonstrated that they could provide care day and night and the quality of care was assessed as being 'very good'. It was mentioned that Mike had a conviction for assault but no details were provided.

The conference decided to place Jake's name on the child protection register under the category of 'concern of neglect' but to discharge him home to his parents. A detailed plan was drawn up regarding weekly monitoring of Jake at either the outpatient or health visitor's clinic. Support was to be provided by a local centre for disabled children and a parenting project, and Sharon was to be referred for individual counselling. Both parents were expected to continue their drug treatment and not to take street drugs. The case was to be transferred to a social worker in the local centre and reviewed in 3 months time.

Neither Sharon nor Mike were invited to the case conference, and no reason is recorded. It is recorded that Mike's father was invited but his name is not on the list of those present. Marie appears to have met the three of them together after the conference to tell them the decisions and writes that they were pleased with the outcome. She also records that she stressed the difficulties they would face and urged them to use the support available.

The day after the conference, Sharon and Mike left the hospital and were not seen for 2 days

before returning to resume Jake's care without explanation. Marie asked to see them and Mike came to the office to say that they had been at DSS all day and then fell asleep until the following afternoon. Marie also records another version from a nurse that Sharon had said they were 'on a drinking binge celebrating the outcome of case conference'. This information was communicated to the new (female) key worker at the drug clinic but did not lead to a review of the plans. It was decided to give them 6 weeks 'breathing space' before considering reducing their methadone prescriptions.

An intense period of activity then followed to make the practical arrangements for Jake's discharge, setting up supports and sorting out benefits. All agencies were advised of whom to contact if appointments were failed or they had other concerns. Jake was finally discharged home at the age of 8 weeks. Both parents and Jake came to the social work department to say good bye to Marie, who was transferring the case to the new social worker.

Comment

As with Hassan, it is clear that the construction of Sharon and Mike as parents, and the consequent recommendations of the assessing social worker were accepted without challenge. However, there is also a sense in which Sharon and Mike were allowed to construct themselves, albeit with the requirement that they provide evidence, rather than solely being constructed by Marie. It is difficult to conclude whether this is due to differences in the style of the workers involved or the fact that Sharon and Mike were conforming to a more acceptable parenting script. As Dingwall *et al.* (1983) suggest, there is an assumption that parents love their children and want to care for them. Sharon and Mike repeatedly expressed their love for Jake to professionals, contributing to the operation of the 'rule of optimism'. They were also seen as 'co-operative'. Although there was evidence of their 'in corrigibility' (see Dingwall *et al.*) in terms of illicit drug use and criminality, this was not portrayed as being directly relevant to parenting ability. However, again, a different story could have been told:

Marie's story	Alternative story
Sharon's experience of abuse has resulted in her resorting to drug use	Sharon is an adult who has chosen to use drugs
Sharon and Mike have shown that they can control their drug use. There is therefore reason for optimism.	The longstanding and chaotic nature of Sharon and Mike's drug problems indicate a poor prognosis.
Although there were parenting problems, Sharon was manipulated into losing custody of her previous child.	Sharon's inability to sustain the care of her previous child is a poor indicator
Jake's disability is a tragic accident	Sharon's drug use during pregnancy could have contributed towards Jake's disability.
The concerns about theft from the hospital are not relevant to the case conference.	The concerns about theft from the hospital may be an indicator of parents' ongoing problems.
Intensive support will enable Sharon and Mike to meet Jake's needs	A high level of professional input will place Sharon and Mike under pressure
Sharon's childhood experiences of abuse can be addressed by counselling.	Sharon may have been irrevocably damaged by her experiences.

Postscript

Marie attended the review case conference two months later. The *Minutes* indicate that the care of Jake continued to be good, and he was gaining weight. However, Sharon complained about feeling 'hounded' by the number of professionals involved and the appointments they had to keep. The drugs worker reported that she had not attended for 3 weeks, although Mike continued to go. The health professionals reported that Jake was a difficult baby to care for, crying a lot and not wanting to be put down. Both parents were present and denied any problems, including the fact that Jake was difficult or any anxiety about the outcome of Mike's forthcoming court case. The plan remained largely unchanged.

Sharon dropped out of treatment at the drug clinic a fortnight later. Mike did not receive a custodial sentence. The new social worker records frequent contact, seeing parents together and separately. She became concerned about Sharon, describing her as 'very agitated' or 'anxious and upset' but recorded that she still seemed to be responding appropriately to Jake. The situation was thought to be deteriorating and the social worker attempted to engage both

parents in adhering to the protection plan, including the use of a written agreement. It is recorded that Jake was briefly admitted to hospital because he was unwell at the age of 6 months and, shortly afterwards, Mike violently assaulted Sharon. Neighbours alleged that Mike was always shouting at the baby and on one occasion Sharon had been heard to say 'don't smother him...you're suffocating the baby'. When Jake was 8 months old, his parents took him to the A&E department of a hospital in an adjoining borough with dehydration, severe enough to be life-threatening. There was no obvious explanation as his parents did not describe any history of vomiting or diarrhoea. He was also dirty and the doctors concluded that his condition was due to negligence: either he had been unwell and parents had failed to notice or he had not been given enough to drink. Parents were said to be obstructive when medical staff tried to give intravenous fluids. A strategy meeting was held and it was decided that they could no longer live alone with Jake in the community until they had completed a drug rehabilitation programme. Whilst waiting for this to be arranged, it was negotiated that the family would live with Mike's sister. The monitoring of Jake was tightened up, with weekly weighing and a day care placement being provided. If Sharon and Mike did not comply with this plan, an Emergency Protection Order would be sought to remove Jake from their care. The plan was endorsed by a further case conference.

Both parents did agree and the family entered a residential drug rehabilitation unit when Jake was 9 months old. The placement lasted just over 3 weeks, when Sharon said that she could no longer cope. She asked for Jake to be accommodated because she was afraid she would slap him. Both parents returned home and Jake was placed with foster parents. Earlier that day, he was noted to have a lesion under his tongue and 'red cheeks'. Sharon alleged that a staff member had injured him. Medical opinion was that a bottle had been forced into his mouth but that the redness of his cheeks was due to chapping. A strategy meeting was held and the matter investigated but no conclusion reached. At the age of 1 year, Jake remained with foster carers but plans were being made to return him to his parents, provided they could demonstrate that they were now drug free and agreed to close monitoring of Jake. The foster mother confirmed that he was a difficult baby to care for.

Jake did eventually return to the care of his parents, with extensive support including respite breaks with the foster carer, but there were ongoing concerns about neglect and he was finally removed on a care order when he was 2 years old and again placed in foster care. By this time, the case had transferred to yet another social worker. Sharon's drug use spiralled

out of control and she and Mike split up. She went on to have another baby, Kylie, with Mike claiming paternity. Kylie had severe drug withdrawal but this time Sharon rarely visited and refused to engage in discussions with hospital staff or the social worker allocated to herself and Jake. (Marie was no longer working at the hospital). Mike had a new partner, also a drug user, who was expecting his child. They visited Kylie regularly and wished to care for her but the decision of social services was that neither parent could meet Kylie's needs and they successfully applied for a care order. She went straight from hospital to foster carers, and is now cared for by a relative. Mike's new partner died from an overdose shortly after the birth of their baby and that child was also the subject of care proceedings and subsequently adopted. Jake is now 7 years old and severely disabled. He is in a settled placement with foster carers who plan to adopt him.

Comment

Sharon and Mike asked for a chance to care for Jake and they were given it. There was worrying information about their chaotic drug use and Sharon's personal and parenting history which could have been used to construct them as unsafe parents, particularly in view of Jake's special needs. Instead, there is evidence that they participated with Marie in the construction of themselves as parents who deserved a chance. With the benefit of hindsight, it could be argued that this was incorrect because they were unable to meet his needs in the longer term. Indeed, he suffered significant harm. Is this evidence that Marie was 'wrong', seduced by the 'rule of optimism'? Or was it right to take a risk, but wrong not to intervene earlier when deterioration was evident? These are moral questions to which there is no obvious answer. It is clear that Marie's style was successful in engaging the couple in an assessment. Despite their initial suspicion, her concern for them as individuals, particularly Sharon, enabled them to work in partnership in a way that they were unable to achieve before or afterwards. Their wishes and feelings were not only heard, but respected. Perhaps this was a valuable outcome in itself, allowing them to be reconciled to the loss of Jake. A fundamental issue arising from Jake's story is the balance that social workers have to strike between parents' and children's subject status.

Leanne's story

The beginning

Leanne's story is a difficult one to unravel. Her mother, Tania M, was already a social services client when she became pregnant, albeit banned from the local office '...due to excessive and on occasions unprovoked violence both to the building and to staff'. At that time Tania was 16 years old and her family well known to the study department. Tania and her siblings had been on and off the child protection register because of the volatile and abusive relationship between their parents and the possibility that they had experienced or witnessed sexual abuse. The family had received input from child psychiatric services in addition to years of social work involvement. Tania had displayed troubled behaviour since infant school and had not been in main stream education since the age of 7. A variety of provision had been tried, including boarding school, but the bulk of her education had been provided by home tutors. Mr and Mrs M separated, although continuing their conflictual relationship, and Tania initially lived with her mother. However, from the age of 14 Tania had been in and out of care following a breakdown in her relationship with Mrs M. She had lived in a range of fostering and residential placements, including some time in a secure unit, but all had broken down. A semi-independent arrangement was established but was 'fraught with problems' and for the previous 6 months she had either moved between her parents or, in crisis, been placed in bed and breakfast accommodation by social services where her volatile behaviour often led to her eviction. There is a suggestion in the records of Tania using drugs but this is not clarified.

Tania's pregnancy came to the attention of the worker in the intermediate treatment team who was preparing a pre-sentence report following her conviction for 'threatening kids in the street'. Tania told her that she was 6 weeks pregnant and requested accommodation – her relationship with both parents having broken down yet again. She was placed in a bed and breakfast hotel on a temporary basis but with a view to holding a family meeting to plan what would happen next. Mrs M approached the principal officer:

Wants housing for Tania. She doesn't want her, nor does she think she should be at her father's. She has to be near here for Tania to be visited. Tania is staying with various people, very sick in her pregnancy. Wants the baby 'for herself', she doesn't want to share it. Boyfriend in (*young offenders unit*).

On the day of the planned meeting, Mrs M phoned the office and spoke to one of the team managers. The purpose of the meeting was described to her as being to sort out the 'responsibility of everyone concerned'. It is recorded that Mrs M lost her temper at this:

She launched into a long tirade about how Tania has changed – no longer into drugs. Desperately wants baby. Wants 'something for herself to love'. This will make her change.

On this basis, Mrs M wanted social services to provide Tania with independent accommodation locally. When the manager said that Tania had been banned from most local hotels, Mrs M is reported as saying that she could not cope with 'all this worry' and had tried to kill herself, then:

'... are we waiting for her to do this again' or 'for Tania to hurt her or baby before we do anything'. I pointed out that Tania's problems were not just to do with housing or drugs, situation went back 10 years.

In spite of this acrimonious exchange, Mrs M maintained contact, updating staff about Tania's attempt to claim benefit and the fact that she had booked at hospital A for antenatal care.

Mr and Mrs M came to meet the principal officer and team manager a couple of days later. The issue was whether social services would yet again take responsibility for Tania and provide her with accommodation in spite of the 'previous roundabout which resulted in violence from Tania'. Mr M walked out but:

Mother stayed – in very distressed state. Said she not only feared violence but feared her own violence and hate to Tania.

It was finally agreed that social services would find a placement for Tania but on the basis of a contract with Mrs M regarding her involvement. An appointment was made for Tania with the homeless persons unit but they reported that she was 'shouting etc in the interview' and they could not find a hostel prepared to take her. A few days later, a worker from the intermediate treatment team reported a violent incident where Tania had attacked and threatened to murder her mother. Police had been involved and it was said that both were bruised and a window broken. Tania had also 'blown up' when shown the pre-sentence

report and 'threw the furniture'. The principal officer contacted the legal division for advice as to whether there were grounds for a secure order and tried to get a psychiatric opinion but neither of these options appears to have been pursued.

There was then an official request to the Placements Panel (responsible for approving the plans for looked after children) and documented in a report by the principal officer, for 'short term bed and breakfast/ hostel placement now' and 'a possibility of specialised mother and baby unit for Tania from third trimester of pregnancy'. In arguing for these resources, Tania's troubled family history is described:

Mother has unbearably negative feelings towards Tania, and remains intensely ambivalent about her.

In terms of Tania's current difficulties:

Tania has a pattern of reactive violence. She appears not very bright and at times is extremely babyish. She curls into the foetal position in public, and mother says she wants to sit on her knee ... father sees her as about a 7 year old in her development.

The report states that Tania sabotages all attempts to help her, including psychiatric input. In addition to her family and personal difficulties:

A further problem is that she is now pregnant and in major need. She refuses counselling with a view to termination although this is being explored with her by intermediate treatment and, I think, by her mother, although her mother feels quite guilty about it. Mother sees the pregnancy in some ways as the one positive possibility in Tania's situation. At first sight this seems very unrealistic, but after further discussion with the family I do appreciate mother's feeling in this regard as there is so little positive for this girl.

The principal officer records as progress the fact that Tania says she will work with social services but goes on to suggest that there will need to be an element of financial reward because she cannot:

... understand anything at an emotional level. In fact I think too great a closeness by a worker would actually increase the risk of violence.

The long-term plan is presented as follows:

Although her plan to have and keep her baby are very bleak, we have to provide a long term placement as an offer to Tania – hopefully that which provides psychiatric help and closely monitored assistance. She and her mother believe this baby is Tania's only hope and although this seems very unrealistic we have little else to work on at the present moment. We also need to do a full search of previous information on Tania to draw the picture together again. Further consideration of legal intervention and of course a possible need to change plan rather rapidly when the baby is born.

Separate contracts were then drawn up with Mrs M and Tania. The purpose of the contract with Mrs M was to ensure that she maintained parental responsibility for Tania, undertaking to visit her in placement, accompany her to appointments and encourage her to accept counselling. The contract with Tania confirms that social services will pay for her accommodation and provide a weekly travel warrant 'while she is behaving well'. In turn, Tania should keep appointments with health services and other agencies, sort out her benefits and YT scheme. It also requires her:

- To consider a placement at mother and baby home or at least look at the possibility.
- Tania not to be violent with social workers or any workers but to tell them to go away or go away herself when she feels she is at risk of behaving aggressively.

In terms of Tania's own future interests and that of the baby, if she wants to look after the baby Tania does need to accept a lot of help and it is important that she looks to this as early as possible.

Comment

The initial phase of the work centres on Tania as the subject of the story, and the issue which preoccupies the social work managers is whether to take responsibility for receiving her back into the 'care' system or whether to leave the family to their own devices. Tania is presented as the child in the case, and her own child has no subject status at this stage. It was seen in the previous stories that this seems to be the norm during pregnancy, but there was a sense of both Hassan and Jake having the status of *future-subject* during the pregnancy. Tania's unborn baby does not appear to be accorded even this. S/he is presented as a 'problem' which may yet be resolved via termination; as a possession – 'something to love'; as a 'positive possibility' or 'only hope' for Tania. Any significance the baby has lies in the impact s/he will have on Tania's life. There is little recognition of the baby as a being with pressing needs of her/his own, either now or in the future. No attempt is made to speak to the hospital staff responsible for monitoring the health of the unborn baby. The principal

officer does seem to be suggesting that the baby will be a consideration at some point when she refers to the need for 'a full search of previous information on Tania to draw the picture together again'. She also acknowledges that the prospect of Tania being able to care for the baby is bleak and mentions the possibility of legal intervention. There is no clear statement, however, that a pre-birth assessment should take place or any discussion of the process whereby plans could be made for the baby. What does emerge from this part of the story is the extent of the disturbance within Tania's family characterised by violence, hatred, rejection and abusive relationships. It is not surprising that Tania faces overwhelming emotional difficulties. Again, in spite of this, it is presented that she will be the one responsible for parenting the baby. The baby's father is not named and there is no attempt to gather any information about him, or the role he wishes to play in his child's life, in spite of the fact that his status as a convicted prisoner would make his story easily accessible.

The middle

The plan was accepted and Tania's placement in a hotel was formalised. The case was allocated to a social worker, Jo, and she records her first meeting with Tania when she was 3 months pregnant. Tania admitted to the recent violent incident with her mother, which she regretted, and said it was caused because her mother refused to buy her a leather coat. She talked about the problems with both parents:

... she said that her father does not hit her now that she does not ask him for things. In a sense she completely identified with her mother's attitude towards her father. While saying that, her mother went for her with a knife last week.

In view of these difficulties and her 'reputation locally', Jo urged her to consider a long-term placement outside the borough. There is then a gap of a month in the records before Jo describes a meeting where Tania tells her she has left the hotel and is staying with various friends and her sister. They made an appointment where Jo planned to 'formulate a care plan'. Tania rang to say she would only attend if social services paid for a taxi but then did not arrive. Jo contacted Mrs M who said that Tania was very depressed and 'unsure if she wanted to keep the baby after all.' Part of the problem was apparently the fact that she could not afford to buy maternity clothes.

Tania did keep a subsequent appointment and voiced her frustration at not being able to wear

‘flattering’ clothes. She asked if she could be placed in foster care as she would then have access to more money and would not have to buy second hand items for her baby. Jo questioned the suitability of foster care, given her age and ‘violent history’ but did subsequently contact the fostering team. One of Tania’s previous carers, Liz, said that she would consider a placement if Tania’s ‘violent and aggressive behaviour was under control’. It was envisaged that this would be until a mother and baby placement was found.

A couple of days later, the intermediate treatment worker reported that Tania had hit her but Tania denied this in a subsequent conversation with Jo, admitting only to ‘freaking out’ because she thought the worker was ‘laughing at her and winding her up’. In spite of this, Jo raised the possibility of returning to Liz to which Tania agreed. She had found the placement positive although admitted to having been abusive to Liz. She also told Jo that she was arguing with her family and:

... getting very anxious about her pregnancy and her relationship with her boyfriend. She continues to visit him in (*prison*) almost every week.

Jo did not appear to pursue either of these topics. When Tania was 6 months pregnant, she moved to the foster placement. The meeting to draw up the placement agreement did not take place for a further 6 weeks and there are no records to indicate that Tania saw Jo during that time. There is a copy of the placement agreement on file describing the reason for Tania being looked after:

Tania needs a suitable base in order to prepare for the birth of her child and a suitable environment to care for the baby. If Tania continues her current lifestyle prior to the birth and after the birth then I would have grave concerns about the child’s welfare. Tania is a very volatile young person. She is in a lot of emotional turmoil which she has expressed by behaving uncontrollably – verbally and physically abusing anyone who she says ‘winds her up’.

Jo, however, goes on to say that Tania is becoming much calmer and ‘appears to be more reflective’. She also indicates that Tania wants to work on her problems and have some therapeutic input so that she does not make the same mistakes as her mother. Tania is said to be worried about her ‘feelings and anxieties’ about the baby, particularly her response if the baby were to cry constantly. The plan is described as being for Tania to live either in a foster placement or mother and baby unit until the baby is at least 6 months old or until she

is ready to live independently. Even then, there would be an indefinite need for support and regular monitoring of the baby.

Jo saw Tania a few days later and gave her money to attend the antenatal clinic and was told that her boyfriend, Ronnie, was now out of prison. This is the first time his name appears on the file but his second name is omitted and his circumstances not explored. Instead Jo arranged to visit the following week to discuss buying baby items. When she arrived for this visit, Tania was going out and swore at Jo. Tania was by then in the last month of her pregnancy and there was no further mention of the plan to seek a mother and baby unit or therapeutic input. From the records, there is no evidence that Jo saw Tania again during the pregnancy.

Comment

This part of the story is striking in relation to what is omitted rather than what is said. It may be the case that Jo undertook work which she did not record but, if it can be assumed that she recorded what was considered to be important, the file can still be read as a construction of Tania's 'case'. It could have been expected that, having agreed to take responsibility for looking after Tania, an assessment would then have taken place of her needs and ability to look after her expected baby. Instead, the focus of Jo's involvement appears to have been to secure somewhere for Tania to live. The possibility of Tania returning to her previous foster carer appears to have been seen as a solution to all the problems and information which could have been interpreted as a contra-indication to the placement not acted upon.

Although Liz is clear that she can only take Tania if her violence is under control, Jo proceeds to plan the placement on the very day that Tania is alleged to have hit her intermediate treatment worker. It is unclear whether Liz was told of this incident. The remit of the placement is also unclear. When Jo approached the fostering team, she requested a foster placement for Tania 'until she goes into a mother and baby unit' but, without it being made explicit, the expectation became that Liz would keep Tania after she had the baby. The need for 'therapeutic input' appears to have been replaced by a plan to 'help Tania develop parenting skills'. The file indicates that, once the plan had been made for Tania to live with Liz, Jo did not see her for at least 6 weeks and subsequent discussions seem to have centred on Tania's requests for money and baby equipment. The review of Tania's history, envisaged by the principal officer, did not take place. Neither did Jo pick up on the anxieties expressed by Tania about her ability to cope with a crying baby, despite describing her as

someone who was verbally and physically abusive to anyone who wound her up and as having difficulties with close relationships. The implications of these traits in someone caring for a young baby are not explored. Instead, Jo reports that Tania is becoming calmer and more reflective, although it is difficult to detect the evidence for this.

There is also a failure to engage or gather information about Tania's boyfriend. At the time of the placement, there is a vague statement that Jo would explore Tania's relationship with her partner but she doesn't appear to have pursued this. He is now out of prison and in frequent contact with Tania, and therefore likely to have contact with the baby, but does not seem to have been considered as a key player either in terms of the contribution he may make or the risks he may pose. Finally, there is a failure to liaise with the hospital where Tania is booked to have her baby. Although Tania frequently asks for money to attend antenatal appointments, Jo does not speak to either hospital staff or the social work team in hospital A to gather information or to inform them of the plans. The possibility of convening a pre-birth meeting or case conference does not seem to have been considered.

The conclusion

Leanne's birth

The next entry on the file is a phone call to the duty manager from a social worker at hospital A to say that Tania had given birth to her baby, and requesting information. The hospital social work team had not previously been aware of Tania but had received a referral from midwives because they were so concerned about her behaviour on the ward:

She is apparently not taking any part in the care of the baby but is very anxious about it (forgot to ask gender) and is worried it will be snatched. For instance she is taking it into the toilet with her.

The social worker was advised of the plan for Tania and the baby to return to the foster home. Later, Jo rang and the social worker told her that midwifery staff said of Tania:

She was one of the most abusive and disturbed young mothers they have delivered at the hospital. They were concerned that she rejected the baby at birth and is refusing to care for her. Her sister apparently cared for the child overnight.

Jo contacted Liz and was told that they had arranged for Tania and the baby to be discharged later that day. Jo said that she would be on leave for a week but asked Liz to then let her have feedback on Tania's interaction with the baby and to contact the duty social worker in the meanwhile if there were any problems. It is not recorded whether she told Liz of the midwives' observations or concerns.

Jo contacted Liz a week later and was told that the baby was developing well but that:

Tania, apparently, appears to be depressed. Her boyfriend has apparently given himself up as he was allegedly on the run. Tania is very upset as she misses him.

The baby was not referred to by name and the gender is only evident by a reference to 'she'. Jo visited the next day. Tania complained of feeling tired and finding the need to attend to the baby during the night and early morning stressful. There is one reference to the baby as Leanne but otherwise she is referred to as 'the baby'.

She has refused to breastfeed the baby – but hasn't expressed why.

Tania admitted to feeling depressed and said she was finding it difficult to ask Liz for support and Jo talked to her about how she could build up her confidence.

Within 24 hours, when Leanne was 13 days old, Liz expressed concern:

Tania was refusing to care for the baby because she was crying non-stop ... she ran out of the house leaving the baby:

This pattern continued, with Tania taking Leanne out late at night or leaving her to be cared for by Liz. Although it is recorded that Tania was able to undertake the practical aspects of caring for a baby, she was clearly struggling emotionally. A planning meeting was held when Leanne was 1 month old and one of the decisions was that Tania 'must learn to cope with her own emotions with regard to Leanne's crying'. It also decided that 'time out' must be negotiated with Liz rather than Leanne being left in her care without prior discussion, and that Tania should discuss her difficulties in parenting with Liz. However, Tania refused to attend the meeting. When Leanne was 2 months old, Tania asked for her to be accommodated and social services agreed. After one night with a foster carer, she was

placed with Tania's sister with a view to Tania visiting daily and resuming her care when she felt ready. Meanwhile, the Review of Tania as a looked-after child took place. It records:

Since the birth of Leanne, Tania has found it increasingly difficult to cope with the demands of parenting. Although she cares for Leanne well, her mental state (possible postnatal depression) does not allow her to cope with pressure and demands.

Ronnie was invited but did not attend. It is said of him that he:

Is now back on the scene and is offering Tania a lot of support and help with the care of Leanne.

It was decided that, if Tania wanted to continue in the placement and to have Leanne returned to her there, she must agree to a contract regarding her behaviour and also make a commitment to work with social services and keep appointments. The ongoing aim appears to have been to offer help and support with 'parenting skills' and to persuade Tania to engage in counselling to 'deal with past issues'. After 6 weeks in the care of her aunt, Leanne returned to live with Tania at Liz's. Although Tania agreed to the contract, she broke it almost immediately and there were incidents of 'verbal abuse and physical aggression'. There was also concern about an incident where she had been racially abusive towards Jo and the case was transferred to another worker, Peter, as a result. Only a week after she had been returned to her mother's care, with Leanne now 3 ½ months old, the placement was terminated and a hostel found for Tania and Leanne. Tania was angry as she had requested a hotel but this was rejected as offering inadequate supervision. She refused to take Leanne there and she was placed with Mrs M. It was decided to convene a child protection conference because of the accumulation of concerns and the breakdown of the placement with Liz.

The case conference

The initial case conference was held when Leanne was 4 months old. Tania and Ronnie both attended. The conference report is not available but the *Minutes* of the conference present a mixed picture. On the one hand, Leanne was reported to be developing normally and to be physically well-cared for by Tania. She was said to be a difficult baby, suffering from colic, eczema and chestiness, which made her cry a lot. In addition, Tania had suffered from post-natal depression and was having difficulties in her relationship with Ronnie. Concerns

appeared to centre on the fact that Tania repeatedly left Leanne to cry because:

Tania has expressed fears of hurting baby so feels it is safer to leave her.

Tania did not dispute this but became upset when it was alleged that she had been seen to 'put her fist up to the baby's face'.

At this point Tania threw a cup of coffee at the wall and left the room.

It is not recorded that Ronnie said anything at all, although other people commented on him. Liz described him as being 'very supportive' and his probation officer for the past year said that he '... had taken on a good parenting role and offers emotional stability to Tania'. Interestingly, he had also been Tania's probation officer for the last month but had never met her, instead receiving regular reports about her from Mrs M. The reasons for the couple being on probation are not recorded in the *Minutes*.

Tania is reported as saying that she was 'confused - wants to be alone but wants support'. The conference decided to place Leanne's name on the child protection register under the category of emotional abuse. It was recommended that a plan be worked out to ensure close monitoring of Leanne, either through a day care placement or supervised accommodation, and that social services would consider court action if this could not be agreed. A few days later, Leanne was returned to the care of Tania and Ronnie in temporary accommodation and they did agree to a day care placement.

Comment

The birth of Leanne does mark a shift, in that she is seen by hospital staff as having needs of her own. They view Tania as a parent, and have clear and immediate concerns about her ability to look after Leanne even without any information about her history. The plan made by Jo, however, is based on Tania as a looked-after child rather than a parent and she does not appear to reflect on whether the plan is safe for Leanne. The foster mother is left with responsibility for arranging Tania's discharge from hospital and for monitoring her interaction with Leanne for the crucial early days. Jo and her colleagues are slow to recognise Leanne as a subject, omitting to establish her gender or name for some time. No details of her birth weight are recorded and there is no mention of her health or development

until the first case conference when she is 4 months old. The problems which Tania herself had predicted in coping with her baby's crying were manifest from the start and there does not seem to be any attempt to help with this, other than encouraging her to talk to Liz. Tania is criticised for leaving Leanne to cry in spite of her explanation that this is a coping strategy and an alternative to possible violence. Although there had been previous mention of the need for therapeutic input, there is no evidence of any attempt to provide it.

It is not until the decision to convene a case conference that there is a sense of Leanne becoming the subject of the story and, interestingly, the *Minutes* make a point of noting that 'baby must come first'. Tania's own parents seem to have finally taken a back seat as she has increasingly been expected to behave as a mother. Perhaps the introduction of a new social worker at this point helped to mark this transition.

The role of Ronnie is interesting. There is no evidence of any enquiries having been made about him. He is mentioned in passing as being 'around' and 'supportive' but the first formal attempt to involve him was when it was decided that he should be invited to Tania's review as a child looked-after. Neither is there evidence that Jo tried to engage him although he turned up at the office with Tania. Even at the case conference, there is no record of his relationship with Leanne. He is clearly not seen as a parent but rather as Tania's partner and there appears to be no intention to assess his parenting ability.

An alternative story could have been told:

Jo's story	Alternative story
Tania is the subject	Leanne is the subject
Tania wants to be a parent and must be given every support	Tania is frightened and ambivalent about having a baby and the plan needs to recognise this
Tania has severe and longstanding emotional and behavioural problems, including violence, but this will not necessarily affect her ability to look after a baby	Tania's violence is associated with poor impulse control within close relationships. This will inevitably pose a risk to her baby.
There is evidence that Tania is changing and maturing. She just needs help with parenting skills	There is ongoing evidence of the severity of Tania's disturbance. She needs psychiatric treatment
We'll wait and see how Tania copes with the baby over time	There is a need for a clear plan to be made before the baby is born
A foster home is a suitable resource to meet both Tania's and Leanne's needs	The level of disturbance within this family poses an unrealistic burden on a foster placement
We will only consider alternative plans for Leanne when all attempts at rehabilitation have been exhausted	Given the poor prognosis, consideration will be given to alternative carers for the baby at an early stage
There is no need to assess Ronnie because his only role is to support Tania	Ronnie is a significant figure and needs to be assessed

Postscript

A month after her return home, at the age of 5 months, Tania again asked for Leanne to be accommodated and she was placed in an emergency foster placement and moved to another the next day. The review case conference was brought forward because of concerns about the increasingly erratic care of Leanne. Although she was said to 'look well', she was chesty with dry skin, overdue an immunisation and not attending clinic regularly. There were various reports that Tania was behaving erratically and threatening violence towards Leanne. The GP also said that Tania 'had ambivalent and negative feelings towards Leanne: there should be better bonding between them.' One source of information was Mrs M, and Ronnie said that she was exaggerating. Appointments had been made for Tania at a local project

providing counselling for adolescents but she had not attended. There seems to have been a consensus at the conference, apart from Tania herself, that she needed to be placed with Leanne in a mother and baby unit where she would be 'supervised and helped'. Ronnie shared this point of view but:

Tania said she wants her own flat, her baby back and to be left alone with no interference from anyone.

She refused to stay in the conference, despite attempts to persuade her to return by Ronnie and Peter. Nevertheless, the conference decided to seek a mother and baby placement and to ensure that Leanne had a health check and immunisation. She was to remain on the child protection register.

After some weeks, both parents moved to a residential placement but, before Leanne could join them, it broke down because of violence between them. It was decided to seek alternative means of assessing whether they could ever care for Leanne. Meanwhile Leanne had a further move of foster placement at 11 months of age.

When Leanne was 15 months old, it is recorded that there was a tussle over her buggy between Tania and Ronnie in the social services office during a contact visit. There were fears that the situation was so volatile that Leanne might be removed from her placement. She was taken into police protection and social services successfully applied for an emergency protection order and then an interim care order. Leanne was moved to yet another placement. The plan was still to consider rehabilitation and leave was given to seek an assessment at a specialist unit. This was arranged but, having met Tania, the psychiatrist felt her mental state was too uncertain and that she would need psychiatric treatment before there was any possibility of her caring for Leanne. She had been admitted to a psychiatric ward earlier in the year following an incident where she had been sitting in the road and was thought to be using a lot of 'dope'. Finally, at the age of 21 months, Leanne was permanently placed with a member of her extended family under a residence order.

Comment

Leanne ceased to be cared for by Tania at the age of 5 months but was not settled with a permanent alternative carer until the age of 21 months, by which time she had experienced 9

changes of placement and primary carer. Difficulties had been evident from before Leanne was born: not in relation to Tania's practical skills but in terms of her emotional state. Given the extent of Tania's own difficulties, which were well known to social services, it is tempting to question why more decisive action was not taken. Tania came from a family where there had been a multigenerational pattern of violence and abuse. It was clear that Tania had been damaged by her experiences and that this manifested in aggressive outbursts, particularly within close relationships. Tania's propensity for violence was well known to social services, who had been on the receiving end: there are 16 references to her violence in the file between her pregnancy being recognised and the birth. Even Tania herself was able to see that this may be problematic if caring for a crying baby. Although there are hints in the file that Tania's ability to look after her baby would need to be considered and that the prospect was 'bleak', there was no clear direction to the allocated worker, Jo, that she should be undertaking a pre-birth assessment or using the child protection system to make plans. Instead, Tania was constructed as a child in need of support rather than as a prospective parent. No real assessment took place and the evidence of Tania's ongoing volatility during the pregnancy was played down. Indeed, Jo portrayed her as becoming reflective and less impulsive. Once the option of a foster placement was presented, it appears to have been seized upon and alternatives not explored. There seems to have been an assumption that this placement would safeguard the baby, although this is not made explicit in the records, and the respective roles of the professionals not clarified. Although the principal officer had suggested that a rapid change of plan may be needed following the birth, the alarmingly negative observations of the midwifery staff did not prompt any such review. The only record of Jo having discussed the case with her manager was when Tania racially abused her.

Leanne only appeared to be seen as the case subject following a crisis when the foster placement broke down and social services were forced to consider the prospect of Tania living independently. This coincided with a new social worker being allocated who had not had the historical responsibility for Tania as a child looked after and perhaps had a different perspective of the 'subject' of the case. However, there still appears to have been a residual commitment to giving Tania a chance to resume parenting in the face of overwhelming evidence. Further assessments were planned in spite of Tania's clear lack of co-operation. The early view that having a baby was Tania's 'only chance' seems to have prevailed, and other evidence of her ambivalence about being a parent not acted upon.

Ronnie, in contrast, was never seen as a key player in Leanne's life. No attempt was made by social services to discover anything about his background and information about him only appears on the file when the Guardian ad Litem became involved. He established a great deal of information about Ronnie that had not previously been known: a long history of offending; a number of prison sentences for possession of drugs and violence, including ABH of Tania; a history of heroin dependence; extensive involvement with another social services department during his own childhood and, finally, he had a wife and child unknown to Tania.

Conclusion

These stories confirm that there is more to childcare practice than the application of procedures. Instead, judgements about safe babies and dangerous parents are constructed by the social workers through their selection and presentation of the relevant 'evidence'. An additional complexity is that the evidence does not exist *a priori*, waiting to be uncovered by the social worker, but is extracted through a process of interaction between the assessor and the assessed. It is then attributed with meaning by the social worker in the light of implicit values and beliefs, including the way in which they perceive their role: as advocate, judge, befriender or supporter. Even then, the construction is not final but must be constantly re-framed in the light of unfolding events. The elements of the construction are not made explicit and may be difficult to understand, even to the entitled reader.

All child protection work is contested, with practitioners caught between the paradigms of risk and uncertainty, but the case studies illustrate that the challenge is increased when subject status is also contested. The social workers seemed uncertain whether the unborn child should take her/his place as a full character in the story, and then had difficulty in modifying this perspective following the birth. The standard child protection plot is unavailable yet families prompting concern about *future-parenting* are characterised by complex and major problems. The babies are particularly vulnerable and the stakes high. It is essential to understand the way in which practitioners make sense of the messy and distressing reality facing such families, and to expose the practice to critical scrutiny if it is to be improved. This process of looking beneath the surface has begun with the case studies, where it can be seen that social workers appeared to be drawing on a range of organisational imperatives and implicit assumptions to make their case. Although the practitioners adopted

different styles, they appeared to be drawing on common themes in the way they constructed their cases. The final level of analysis involves the identification and elaboration of these emerging themes and is presented within the next chapter.

CHAPTER 7: CONSTRUCTING THE SAFE BABY

The impossibility of arriving at a single truth, and thus the challenge that assessment is a myth, was discussed earlier. It could be argued that the case studies endorse this perspective but this does not assist practitioners, who must strive to protect children even where there cannot be certainty.

Sociologists ask questions; social workers must act as though they have answers (Davies 1991, p.7).

Moreover, the reader will no doubt have formed their own opinion of the validity or otherwise of the stories told, indicating that some constructions are more plausible than others. Social workers must have some basis for their actions, whether theory, guidelines, assumptions, practice wisdom or an eclectic combination of influences. These are rarely made explicit, however, and closer examination is needed if we are to understand and challenge the ways in which the study social workers arrived at their judgements and plans.

The final section of the findings thus presents a textual analysis of themes within the social work records. This analysis is applied to an area of practice that is both little researched and raises unique dilemmas. Not only is it difficult to be clear about who is the subject/object of the story but the evidence is particularly contentious. Although all assessments are inevitably subjective, those of unborn children are perhaps more subjective than most because there are crucial elements of the usual story missing: there is no abused child to observe, examine or interview, and the relationship between parent and child is invisible. The social worker must therefore rely heavily on information about, and impressions of, the prospective parents and speculate about the likely impact on the care of the expected baby. Inter-related elements of this process of construction are considered: firstly, the extent to which parents were involved; secondly, the nature of the evidence presented to persuade the reader that a baby was safe and, finally, the relationship between the evidence and the decision-making process.

Establishing partnership

The nature of the relationship between the social worker and the family appeared to be a

crucial element throughout the construction of the case, shaping both the assessment and subsequent work. Guidance directs that practitioners should work in partnership with families, but this can be interpreted on a number of levels: as a procedural requirement, a component of good practice or an essential prerequisite to understanding. The achievement of partnership is not easily pinned down from a study of case files. Whilst there are some relatively concrete measures in the form of letters, case conference minutes and written agreements, other aspects of the work, for example conversations between social worker and parents, are less tangible. Different levels of partnership with the study families were apparent, ranging from information-giving, through participation, to 'true' partnership. This reflected differences in the extent to which parents contributed to the construction of their case, i.e. whether their own attributions of meaning were taken seriously (Featherstone 1999).

Information giving

Whatever the level of involvement, a minimum expectation within child protection work is that the family should be given information about the process. There was only one case where it was decided that any attempt at parental involvement would be so dangerous that the parents could not be told of either the case conference or the decision to remove their child at birth. This was based on the fear that they would not present at hospital for the delivery and the baby's life could be in danger. Otherwise all parents were given some information. Within the study department, explanatory leaflets about case conferences and the child protection register had been produced and it was the social worker's responsibility to give them to the family. However, it was rarely recorded whether this had been done. Indeed, it was not always clear from the records that the study families were made aware that their baby was the subject of a child protection investigation. The suitability of the child protection system to assessments of *future-parenting* is questionable, focusing as it does on suspected abuse. This perhaps accounts for the tentative nature of the attempts to engage parents in the process, for example:

I would like to have the opportunity to meet with you soon in order to talk over any problems you may be facing and to see if there is anything I can do to help.

This mother is unlikely to have realised that the worker was concerned that her alcoholism would impair her ability to care for the expected baby and may well have assumed that the

role was purely a supportive one.

Participation

The extent to which parents participated in the child protection process varied, with some workers striving to find ways of involving them and others appearing to make little effort. It is usually possible to determine from the records whether parents were *invited to attend meetings* about their baby. The majority of mothers (19) were invited to the case conference but the general exclusion of fathers extended to the conference, with only 4 appearing to have been invited. Women with psychotic illness were the least likely to attend (3 out of 11), without the reasons being fully recorded or alternative means of representation explored. However, it is impossible to read from the records whether parents who *did* attend felt able to actively participate, although other research has addressed this issue (Brazil and Steward 1992; Bell 1996). The social workers did not record parents' feedback and their voice was often not decipherable from the conference minutes unless particularly vociferous, as in Tania's throwing of her coffee at the wall.

A range of other meetings took place during the course of the assessment, many of which excluded parents. Some seemed to be akin to strategy meetings, being convened to plan the assessment, and may have had a useful function that could have been impeded by parental presence. Others, however, would more legitimately have been convened as case conferences because they clearly considered the risk to the baby and formed a quasi-protection plan. A planning meeting was held to consider one couple, both of whom had a history of psychiatric illness and the removal of previous children. They were not invited, despite indicating their willingness to co-operate, and were effectively denied any opportunity to express a view. It was decided that the mother must go to a mother and baby unit and:

If she does not comply then the following options to be considered, a) Either she is sectioned or b) Her baby removed under Emergency Protection Order.

Another means of facilitating participation is the *use of written agreements* with families. The Child Protection Procedures did include a pro forma for explaining child protection plans following registration, but nothing for use during the assessment stage. Nevertheless, some workers attempted to prepare 'contracts', making explicit the behaviour expected of

the parent/s and, to a lesser extent, the role that the professionals were committed to play. They may or may not have been signed but, in any event, were clearly formulated according to the professionals' agenda rather than that of the parents and it is impossible to establish the extent of any negotiation. Nevertheless, they did serve to inform parents of the criteria against which they were being judged. This afforded them the opportunity to exercise agency, albeit through compliance with an externally imposed standard of 'good enough parenting'. For example, Tania was given a very explicit list of expectations about her behaviour, described on p.129.

At times, letters appeared to serve the same purpose as a written agreement but with no aspirations to being anything other than one-sided. There was a sense in which this was not only to give parents a chance to comply, but also to warn them of possible consequences and, perhaps, to provide evidence for any subsequent legal proceedings. For example, following the case conference in respect of a baby who was still in hospital being treated for drug withdrawal, the social worker wrote to the parents outlining the expected pattern of visiting and then went on:

I wish to put it in writing that we are gravely concerned about whether we are going to be able to help you sufficiently to give Stewart the care that he needs when he is ready to leave hospital.

'True' partnership

Although the above measures do serve to involve parents, their role remains essentially passive whereas the term *partnership* implies an interaction where the views of both parties are respected. There were some attempts to establish a more genuine partnership with parents. Perhaps the clearest manifestation of this was the extent to which parents made a difference to the outcome by participating in the construction of the case and/or influencing decisions. Social workers certainly overwhelmingly indicated in the records that they were listening to parents, with most files including accounts of their *wishes and feelings*, albeit mediated through the words of the social worker:

Now desperately wants to keep the baby and feels she will love and protect it in a way that never happened to her.

Another means of conferring agency was somehow to convey that the *assessment was a*

shared task, rather than something which the social worker did to the family: for example by working with Sharon to prepare a genogram and thus identifying *together* the links between an abusive childhood, drug use and the neglect of a previous child. Another social worker recorded:

Told Pauline what I knew of her background and asked her to fill in the gaps.

Pauline responded to this invitation with enthusiasm, suggesting professionals who could provide information, even though their involvement was likely to add to the level of concern.

In these instances, it could be said that the mothers helped to construct, and therefore shape, the version of their story. However, the extent to which they shared in the decision-making is a different matter and Department of Health guidance (1995b) makes it clear that this cannot always be achieved. Where a parent's wish to care for their child is deemed too 'risky', as in the decision to remove 2 study babies at birth and to discharge a further 17 only into a supervised setting, it could be assumed that partnership is precluded. However the practice revealed a more complex picture. Some workers did not accept this assumption and were keen to allow parents a sense of agency, however limited. For example, the following mother was given a choice of options on the issue of placement:

She agreed she would go to mother and baby unit but does not want to go to (*hospital*) which she says is a nut-house.

It was negotiated that she could either accept an immediate placement in the above psychiatric unit or wait for a mother and baby placement more acceptable to her. If she chose the latter, her baby would have to be placed with foster carers until the placement was available. Although this was a painful choice, it did invest her with some control.

Partner or subject?

The argument that the forensic nature of child protection assessment has resulted in the interpersonal nature of the task being devalued was discussed in Chapter 3 (see Howe 1992, 1994, 1996; Blaug 1995). Yet, if partnership can be characterised as the exercise of agency, there was evidence of another strand in the practitioner's interaction with the family: the extent to which they could be said to have a *relationship*. The strands are interwoven in that the involvement of parents in the decision-making process seemed most likely to occur in the

context of a positive relationship with the social worker. The nature of such a relationship is intangible but there are clues in the language within the records as to whether one could be said to exist. Interestingly, this seemed to depend on the stance of the worker rather than the circumstances of the case. Even where the opportunity to exercise agency may have been limited or non-existent, there is a sense in which some parents were still accorded subject status. The following exchange was recorded with a woman who was acutely psychotic:

She asked if the salary was good; I replied it was okay. She said then that she would expect me to be a good personal social worker. I said I would try and be fair and honest. She said she would too.

The commitment to be *honest* with parents seemed to be important so that they at least knew what had been decided and on what basis. One mother was told of the decision to seek a care order at birth:

I made it clear that our plan regarding her expected baby was not negotiable but that she could have contact with the baby while still in hospital.

Expressions of warmth were evident in a few cases. When one worker transferred a case to another team following the birth, and removal of, the baby, she wrote to the mother:

I did not want to go away without saying goodbye to you and to wish you and (baby) all the very best. I know that this has been a very difficult time for you and I think you've been very strong to cope with all the strain. It has been a pleasure meeting you, even if our discussions have at times been difficult and painful.

The concept of *positive regard* is rarely mentioned in current literature. *The Challenge of Partnership* (Department of Health 1995b), guidance issued to assist social workers in establishing partnership, certainly does not mention it, yet it seemed to be an interesting factor in social workers' approach to the work. The above example could be said to demonstrate it but instances were relatively isolated. It may be that other workers adopted a similar stance but did not record it. There was also evidence, however, of attitudes that could be described as 'negative regard':

Charlene became very loud and angry stating that everybody was an idiot and messing her about deliberately - she then stormed out of the office ... Up to Charlene's room which was opened by a member of staff with a master key ... I was informed by hostel workers that Charlene's body odour and unwashed clothes was causing problems at the hostel and other residents would leave the

communal rooms if Charlene entered them as they found the smell offensive and overpowering.

This account referred to a mother with significant learning difficulties who had been told of the plan to remove her child at birth. Although ostensibly factual, there is no evidence that the worker empathised with her position, which would seem to preclude the possibility of partnership.

There were other instances where the social worker appeared to make no attempt to establish any *rappport* with the parents, or to understand the cultural context of their lives. The most striking example was that of Rawda, a woman of black African origin, whose schizophrenic illness was deemed to render her unable to parent. Her baby, Theo, was removed from her care after a perfunctory assessment in a residential unit. The social worker made no attempt to undertake a pre-birth assessment and the residential placement was therefore arranged without a clear purpose. Having decided almost immediately that Theo's mother was too disturbed to care for him, the social worker began negotiation with the extended family to assume his care. This took many months, however, and foster-carers looked after Theo in the meanwhile. All the discussions took place with her family and Rawda was not invited to participate at any level. Instead, attempts to negotiate with her were left to the family and the social worker wrote to the maternal aunt:

Please discuss the future with her. She needs to be made aware that she will not be able to care for her child unsupported. I understand the situation is distressing for Rawda and also for you, but the family need to be taking responsibility in helping Rawda in coping with this emotional period as gently but firmly as possible.

This worker clearly saw no need to establish even a minimal relationship with Rawda or to accord her any status. The records do not include any consideration of the ethnic or cultural needs of the family and, although it is not made explicit, there may have been an element of cultural relativism in the social worker's approach: an assumption that black families can take care of their own without support from the state. This issue will be revisited in Chapter 8 when discussing the findings.

It could be argued that the value of relating to parents on a human level, rather than seeing them as objects of administration, is essentially moral but there are also some indications

that it may contribute towards a successful outcome. The following mother certainly thought so: she had retained the care of her baby despite having had 2 previous children removed and, several months later, she wrote to the social worker:

I always think of you and will never forget your kindness to me ... anyone who has you for a social worker is a lucky person plus you're very good at your job too. I only regret that I never had you when all that happened with the boys as I know you would have helped me to get through it.

Presenting the evidence

Whether parents are involved or not in the construction of their case, the social work task is to arrive at an authoritative version which will inform decisions about the baby. The elements of the stories told by the social workers to demonstrate that a baby was safe (or not) are now analysed. The evidence is presented in the order of importance as perceived by the authors of the records: firstly mothers, reflecting their status as the key player in the assessments, followed by fathers, in view their secondary role, then the babies themselves and, finally, family and social relationships. Where the evidence differs from that presented within standard child protection investigations, as illustrated by the cases referred following an incident or injury, this will be highlighted.

Mothers

Both the descriptive analysis and the case studies demonstrated that the social workers' gaze was directed primarily at mothers. It was the mothers' characteristics which prompted the referrals, they were seen as the prime source of information, and the focus of the work throughout. Their role as the key player continues when considering the evidence for judgements about the 'safe' baby. The following were recurrent themes within the social work accounts: interaction with the social worker; attitude to the baby; relationship with partner and history.

Interaction with the social worker

Interestingly, much of the evidence arose from the observations of the worker about their interaction with the mother rather than an account of the 'facts' of her situation. There were universal descriptions of the mothers' *demeanour*, many of them implying an inability to be

fully adult or responsible: fragile, childlike, babyish, not very bright, odd, vulnerable. Even the more positive words carried an infantilising connotation: sensible, cheerful. The social worker appeared to be looking for evidence of *reasonableness* and aspects of the mothers' behaviour were described, particularly if unusual or problematic, in order to claim authority for their opinion. A long account of the *bizarre* behaviour of one mother is given:

... was kissing me inappropriately; swinging off the door frame singing in a childish voice and then crawled across the floor on hands and knees.

When these accounts are compared with those of the mothers undergoing a standard child protection investigation, the latter seemed to be accorded more adult status, although this may be a reflection of the fact that they were a less troubled population.

Another important aspect of the mother's presentation appeared to be her *response to the situation* she found herself in. There was an implicit suggestion that social work involvement is a serious matter and the practitioners were looking for indications that the mother shared this view, with many references to mothers being worried or anxious about losing their child. Where this anxiety was lacking, it was seen as a cause for concern:

I feel uncertain about Liz who seemed dismissive of any problem about her caring for the baby and almost over-accepting of my involvement.

Where a mother was mentally ill, her response was often described in terms of *insight*:

I found Lyn lacking in insight and/or appropriate affect in regard to the loss of her children. At one point she asked me, giggling, whether I was jealous of all the adventures she had had in her life.

Linked with an ability to take the assessment seriously was the degree of *compliance* demonstrated by the mother. This was seen as being of central significance and almost universally commented upon by the use of the word co-operation. The measure of compliance was usually whether the mother kept appointments, agreed to the social work plan and accepted advice in her care of the baby:

Cathy now leaving the baby to lie down more in her carrycot on Pam's (*foster mother*) advice as Cathy tending to give a little too much cuddles.

Attitude to baby

Social workers appeared to feel able to ask the *future-mothers* if they *wanted the baby*:

She is greatly looking forward to the baby. She says if she had known earlier in the pregnancy she would have asked for a termination but is very pleased now.

Once a baby had been born, these discussions declined and there seemed to be an assumption that the baby *was* wanted. This is confirmed by practice with the *incident-families*, where it appeared to be taken for granted that the mother was attached to her baby and it was never explored.

Confusion and ambivalence were noted in some cases, particularly where previous children had been removed:

She did not know how she felt about this baby. She had felt so devastated about losing the others that she was numb. Asked what she wanted in the future she replied to 'love the baby'.

There were also indications of *rejection or negative feelings* towards the baby:

... she did not feel any love for him and did not like the way he looked at the moment - she thought he was ugly.

Some of the women with psychotic illness were noted to have alarming *delusions* about their unborn babies. For example, a mother was convinced that it had been a twin pregnancy but that one baby had devoured the other, whilst another had heard voices telling her to hurt the baby.

The mother's *prioritisation of* her baby was recorded and attempts made to test its extent:

When pressed about a possible situation where she'd have to choose between her partner and her child, said she would choose child who was the 'top priority in her life'.

This was clearly the 'right' answer. Not only must the baby take priority over other relationships but also the mother herself, with several allusions to the expectation that a mother would *put the needs of her baby first*:

I feel that Ms Norton has demonstrated that despite being fond of her son, her own needs and interests are being given paramount consideration.

Other evidence was cited of *positive feelings* using words such as: delighted, loving, protective, besotted, bonded well. The concept of *bonding* is interesting in that it was usually offered as a statement of fact without substantiating information to convince the reader, or even accompanied by conflicting information:

She has bonded with the baby. However the baby was moved to the Nursery because Jan was not responding to the baby crying.

Celine said to be bonding well with baby but not safe in her care of him and not able to carry out simple instructions re hygiene.

The mother's direct *care of her baby* was usually described, often in a fairly bland way when the description was positive e.g. care of her baby is very good. Where there were problems in the handling of the baby the descriptions were more graphic:

'Why can't someone else feed her - I'm sick of feeding her - why me?'

One of other residents reported to have witnessed Tania put her fist up to baby's face.

The mother's level of *competence* was frequently described, sometimes in terms of childcare but also more generally:

The accommodation is squalid and concerns were raised about her hygiene and her ability to look after the needs of the baby.

She had left a cigarette burning last night that burnt a hole in the mattress.

Relationship with partner

Most of the women had *difficult and violent relationships* with their partners. This was seen as problematic and, as described earlier, there was often an agenda introduced by the social worker about separation:

Maureen was felt to be highly vulnerable within the relationship and likely to need help and support in separating from her partner.

The relationship was considered to be of less importance than that with the baby and appeared to be seen as dispensable.

History

Many of the women had *previous children* who were no longer in their care. This was considered to be highly relevant and the social workers gathered extensive material in order to understand the circumstances:

Tried to talk to Lyn about her understanding of how she came to lose custody of previous children; not able to share any memories / insight into past experiences of parenting.

The extent to which social workers recorded the mother's *personal history* varied considerably, with no apparent consensus about what was relevant unless it related to a history of *substance use or psychiatric illness*. Information about this was usually recorded in considerable detail including diagnosis, hospital admissions and treatment regimes:

Sara is said to have been using heroin since 1990 and was in treatment in Glasgow ... was using IV heroin and methadone linctus. Sara has been on a weekly script since entering treatment but the majority of her urines sent for addictive drug screening have shown that she has continued to use on top of her script (opiates and benzodiazapines).

Whatever the issues, there appeared to be an implicit expectation that the mother should seek to resolve them in some way, leaving her free to concentrate on her task as a mother. Seven of the mothers had reported *childhood abuse* and this was usually recorded as being of importance for their own mothering ability:

... Pauline's unresolved difficulties around her family relationships and past sexual abuse. These difficulties will be highlighted and possibly exacerbated by motherhood.

Several of the women had a history of *violence or criminality*, which was explored to varying degrees:

Has assaulted people in the past, but said this followed incidents of sexual abuse or harassment.

Fathers

The ways in which the study fathers were excluded as a source of information were described in Chapter 5, the impression being that social workers assumed them to have nothing positive to offer hence obviating the need to hear their voice in the assessment. This theme is continued in the construction of the fathers' role as parent within the social work records, beginning with a challenge to their status as '*real*' fathers where a distinction appeared to be drawn between the fact of fathering a child and the role of 'father':

Alan told Probation Officer that he was the father of James ... I explained that this was not Lyn's version of events and that we were proceeding as if Lyn was the only one with parental responsibility.

Even where paternity was not contested, there appeared to be no assumption that a biological father would be an active and loving participant in his child's life. Again, the four themes of interaction with the social worker; attitude to the baby; relationship with partner and history emerge from the social work accounts, but with different emphases.

Interaction with the social worker

Where it was acknowledged that the father had a role and must therefore be assessed, it could be assumed that he would be measured against the same criteria as the mother. In fact the rich descriptions of the mothers and the way they were perceived by the social worker were largely absent in relation to the fathers. It is difficult to get any sense of what they were 'like' and descriptions, where available, were usually mediated through the voice of the mother rather than being the product of direct observation:

Sally described him as not very supportive and that he did not care about her or the baby ... Sally describes Paul as a drunk and that he gambles.

One important aspect of the father's presentation, which was noted, was *his level of aggression*:

'If you think you're taking away our baby, I'll wait in an alley and slit your throat'.

Violence posing a *current threat to staff* was deemed to be significant in deciding on the level of risk whereas past episodes were more open to interpretation and perhaps a certain

naïveté. One father had many convictions, including abduction, rape and assault, but the social worker recorded:

Mr Harding presents as both insightful and supportive and appears to have a genuine desire to put the past behind him.

The father of another baby was, however, abusive to hospital staff and this seemed to have had direct consequences:

Decided to go for EPO in view of partner's aggressive behaviour on ward.

A general perception of dangerousness seems to have been more significant than specific harm to the baby at that time.

Compliance, seen as an important component in assessing mothers, was present in the records about fathers but less universally and without the same sense of imperative. After her first meeting with one father the social worker wrote:

Geoff stating that he 'hates' social workers and resents their involvement in his family.

Nevertheless, she assessed the case as being of low risk. Had it been the mother who expressed this opinion it is questionable whether the risk would have been considered to be greater. It seems that a lack of active co-operation could be overlooked as long as the father was not positively aggressive.

Attitude to baby

Again, this had been a major component in the evidence about mothering and was noted in some cases, but usually based on the reports of the mother rather than direct discussions with the father. Unlike the mothers, there was certainly no presumption that the father *wanted to be a parent* and care for his child:

Said pregnancy wasn't planned but he 'doesn't mind'- not sure whether they have a future together but is happy to be around now and be involved.

Another father did want his baby but talked in a way that raised instant alarm:

Has disclosed to his probation officer and myself concerns regarding his ability

to parent his child. Has explained sexual impulses will be controlled by avoiding changing nappies. Physical impulses by getting 'Kim (*partner*) to hit the baby'.

Following the birth, fathers' *direct care of the baby* was mentioned but with markedly less frequency than that of the mothers and, again, was not necessarily the result of direct observation by the social worker.

Attitude to partner

In contrast to the paucity of information regarding a father's attitude to his baby was the emphasis on his relationship with the mother. Whilst the mothers were expected to prioritise their relationship with the baby over that with a partner, this was not the case with the men: they seemed to demonstrate their suitability as fathers through concern and commitment to the mother. This criteria of *supportiveness* emerges as a significant factor in the assessment, as was apparent in Hassan's story with the concentration on Mohammed's ability to offer 'practical help/ emotional support' to Jean and the issue of how he would 'protect' the baby from the consequences of her psychiatric illness. His suggestion that he might wish to be the main carer was not acted upon for many months until Jean effectively handed over the parenting role.

This is perhaps the key to the assessment of fathers: they were judged according to their ability to act as '*back-up*' carers to the mother and to alert professionals to the mother's difficulties. The discharge plan for a baby whose mother was displaying disturbed behaviour included the following role for the father:

That Gerry protect Tina (*baby*) and inform GP, HV, SS or police if there are causes for concern.

Where a father did put himself forward as the primary carer he was usually directed to see a solicitor and not actively encouraged. The decision in many cases to seek a residential placement for the mother and child alone must have reinforced this clear message to fathers that their perceived status was as the secondary parent.

History

Overall, information on the fathers' personal history was sparse compared to the mothers'. With a couple of exceptions, details of the father's *own childhood* were not recorded or

noted in purely factual terms. Experiences which were deemed a significant influence on 'mothering' ability, such as the experience of having been abused as a child or brought up in the care system, were rarely elicited in respect of fathers. Beyond childhood, a history of *criminality, violence or substance use* was often described but the implications for parenting not analysed. The overall impression was that less was expected of fathers than of mothers leading to a more tolerant view of such a history. An interesting difference is also seen in the way that *parenting history* was perceived. Many of the men had previous children but the same rigour was not applied to exploring this as was the case with mothers. There was usually no attempt to seek independent information about these children and the father's version of events was accepted. For example, one father:

... seems to have four, possibly five children - aged around eight to twelve years.

Babies

It is understandable that evidence was not presented about the babies when they were unborn but this continued after birth. Given their age, the social workers could not establish the children's wishes and feelings verbally but there is little evidence that they give them a voice in other ways. Many of the descriptions of the babies were as physical objects to be looked after e.g. beautifully dressed and well fed; clean; dirty. Seven babies were perceived as particularly vulnerable because of *special health needs*: 4 babies had opiate withdrawal, (one of whom, Jake, was also severely brain damaged), 2 were premature ('was born prematurely and is a fragile tiny baby') and another had a diseased kidney.

There was little evidence of a systemic approach being applied by the social workers with the *position* of the baby in the family rarely considered. In one case, it was planned that the mother should first demonstrate that she could care for the new baby and that her (disturbed) toddler could then be reunited with her. The social worker for another family was asked to extend her assessment to explore the feasibility of returning 2 older children to her care despite years of separation. The emotional and practical significance of trying to cope with a new baby when previous children had been removed did not appear to have been calculated.

The *meaning* that the baby held for the parents was sometimes explored. This provided some interesting clues as to the expectations which the child might be expected to fulfil. The

baby as *cure* was described:

... this child would help her to avoid further breakdowns.

... will give their lives more purpose and assist them in controlling their drug use.

Other expectations placed on the babies were as hope for the future, a fresh start, a reminder/ replacement of previous children, or a means of exorcising childhood experiences:

... very protective about the baby because of own childhood.

Further meanings ascribed were as a reminder of the father, a 'means of subjugation' or, as was mentioned above, babies sometimes became involved in mothers' psychotic delusions:

'He's the boss and really nasty sometimes'.

The baby was usually seen as a passive recipient of the care given, with little mention of any *interaction* between mother and child except as a reaction to adverse care, particularly where the mother and child were separated and contact supervised:

Already we have seen Sian showing signs of distress and confusion at her mother's changeable moods and apparently rejecting behaviour.

Family and social relationships

So far the evidence has focused on each family member as an individual and, indeed, this material *was* the main component. However, there was some exploration of the wider familial context. As has been described in the preceding sections, the impression from the records is that a good mother cares above all for her child and her partner's task is to support her. Where the reality of the *parental relationship* was explored during the assessment the social workers presented a bleak picture:

Janice disclosed that she was frightened of Marco and that he had assaulted her using a crowbar and that he had hit her in the stomach when she was pregnant.

In over half the cases, the impact of domestic violence was seen as contributing to a 'risky' environment, for example it was feared that one baby 'might get caught in the crossfire'.

Instances of positives in the parental relationship were hard to find and described in restrained terms: 'managing to co-exist as a family group'. Of the 26 study families, only 5 sets of parents appeared to be, even partially, sharing the care of the baby at the point of follow-up. It is perhaps unsurprising that the social workers presented little evidence of satisfaction with the relationship.

The *extended family* were seen as having a potential role in safeguarding the babies but the image of a loving family being available to offer help was not presented as a reality for most of the study parents. Several had lost contact or lived too far away and others appeared to have problems of their own. One mother described her own mother as 'a stranger to her'; the maternal grandmother of another baby was discovered to have a significant drug problem and Jean's brothers were frequently involved in violent incidents at her home. A condition within one protection plan was that the mother exclude her own parents from the home because of the 'apparent abusive nature of family relationships'. The social worker's account of Tania's parents suggested that their involvement was more part of the problem than the solution. The picture was not unrelievedly bleak and a few family members were considered to be *supportive*. As with fathers, this word is used repeatedly in respect of the extended family:

A home visit was made to Mel's sisters ... This visit established that they were willing and able to offer a great deal of help and support to Mel in caring for her baby. In the event of Mel being unable to care for her baby, or being deemed unable to do so, Selina expressed keenness to be considered as substitute carer.

This offer to act as a 'back up' mirrors the role of some of the fathers. In fact the supportive nature of the extended family was somewhat ambiguous in that they were asked to adopt a quasi-professional role in supporting the social work plan rather than the parents *per se*.

The perceived need for 'support' was not restricted to the extended family but was also looked for within their *network* or, as was more commonly the case, the lack of one. It was described as a cause for concern that so many of the families were isolated.

She is however very isolated - no family or friends to speak of.

It was assumed that parents need social contacts, but these must be of the 'right' kind:

They wished to build up contact with non drug-users but were hesitant to do this because of their fear of what people would think of them.

This was equated with *vulnerability*. Where it was perceived that families had no adequate network, attempts were often made to create one for them via local voluntary organisations: the social worker in one instance intended to 'encourage her to make contacts - possibly a mother's group of some kind'. These seem to have had the dual purpose of providing the support, deemed to be essential, but also to act as part of the protection plan in 'keeping an eye' on the baby.

Many of the families faced *practical difficulties*, such as poor housing or poverty, and the social workers became involved in trying to resolve these. They were not usually seen as particular risk factors in themselves although it was acknowledged that they were an added stress for parents. Where these issues did seem to become relevant was when parents were deemed to be *responsible* for them through a lack of competence, for example:

Poor state of family home: quantities of rubbish in all parts of the flat, dirt, grossly unhygienic. This has been the case over a number of years despite frequent offers of assistance to bring about change.

Problems with homelessness came into this category: 'two previous tenancies have been rendered uninhabitable through fires'. Particular concern was expressed about an itinerant lifestyle as it meant the social workers were worried about losing track of the baby. Other external pressures thought to be relevant were the threat of imprisonment or eviction, possible redundancy and uncertain immigration status. Again, it was not so much the existence of these problems but the family's ability to deal with them that was important.

The department had a policy of ethnic monitoring requiring the *ethnicity* of service users to be recorded. This was not always adhered to although it was usually possible to deduce an individual's ethnicity from the records. Furthermore, the Child Protection Procedures stated that:

Race, culture, religion, gender, age, language and particular needs as well as general background are all factors which must be taken into account.

In fact, these issues were only mentioned in passing in the records rather than explored, giving the impression that the social workers lacked confidence as to *how* they should take

them into account. The social worker in one case recognised this and involved a worker from a voluntary agency who shared the same background as the parents but, otherwise, there was little evidence that the impact of *race or culture* were considered. With the exception of Rawda's case, this would seem to originate mainly from the 'colour blind' stance identified within the literature rather than cultural relativism because the notion of diversity was rarely acknowledged. Interestingly, there was consideration given in one case to the difference in social class between the parents:

Louise comes from a middle class family - has read all the baby books and views birth as an empowering and mystical experience whereas Malcolm comes from a working class background where birth and many children are the norm and little fuss is made of the whole event.

From evidence to action

Analysing the evidence

The final stage in the construction of the case is to make sense of the evidence in order to arrive at a judgement as to whether this particular child is 'at risk' and, if so, the level of intervention needed to safeguard them. Given the importance of this judgement, it was surprisingly difficult to locate a concluded assessment and plan in the case records. There are a number of possible explanations for this: it may have been due to the ongoing nature of the assessment, or, more worryingly, because the activity was reactive rather than based on analysis. Social workers were skilled at eliciting 'facts' but there was a tendency to present these as if they spoke for themselves rather than requiring analysis:

I feel that given Sabine's mental health problems that she would be unable to safely parent a child alone.

There *were* instances where the social worker had attempted to translate the evidence into the context of childcare:

... when crossed or thwarted she can become very forceful and at times violent in attempts to secure her own way. Pauline must consistently demonstrate that she is able to tolerate frustration in her relationship with her child.

These were in the minority, however, as Leanne's case perhaps illustrated. Not only was it

often unclear how judgements were reached but the relationship between this judgement and the subsequent plan was equally difficult to understand. Despite the disturbed nature of the families, social workers were *not* desperate to remove their children, contrary to the fears of parents, even when the outlook was acknowledged to be bleak. For example, Lyn would seem to have a poor prognosis for parenting. She had a serious and long-standing schizophrenic illness which she did not acknowledge or accept treatment for, had been unable to care for 5 previous children, could not maintain her home environment, had no family support and a history of violent relationships. It was decided not to remove her baby but to provide a time limited assessment in a residential unit. The information provided by the assessment was worrying yet, instead of acting to remove the baby at that point, another placement was sought. A similar pattern was evident with both Hassan and Leanne. This seems to be at odds with the evidence base described earlier, which reflected a normative perspective of parenting. There seem to have been a number of other factors that influenced the plan, both ideological and pragmatic.

A rationale for inaction

These factors seemed to operate to justify inaction. Whilst uncertainty is an inevitable component when assessing future parenting, this is not the same as concluding that nothing can be done. The lack of a clear framework seems to have led practitioners to a position where they were reluctant to act decisively, and their reasons can be summarised as follows.

We'll have to wait until the baby is born...

The purpose of intervention was ostensibly to safeguard the baby and this is supported by the decision that 19 babies should not be discharged into their mother's unsupervised care in the community. The focus on the baby was not always evident from the records, however, and it appeared to be particularly difficult to keep the needs of an unborn or new-born baby in mind. This was most marked where the family was already allocated to a social worker because of concerns about an older child. It seems that involvement with previous children was a distraction rather than an enabling factor in considering the needs of the baby. The potential advantage of having extensive knowledge of a family appeared to be outweighed by an inability to focus on the baby in the face of the other demands presented by the case. Minutes of one pre-birth conference barely mentioned the baby but discussed the plan for the previous child who had recently been removed. In another similar case, the worker learned

of the mother's pregnancy but took no action until:

Mother gave birth in the toilet of (*hospital A*) casualty. No antenatal care.

There isn't any proof yet...

In spite of the recognition of vulnerability, there appeared to be a sense of powerlessness in respect of the legal process and new-born children: an idea that no action can be taken however great the concerns because the baby had not yet been harmed. One mother was referred by the maternity ward:

It was obvious during the first few days that Celine had no practical parenting knowledge ... seemed very unclear re necessity of bottles despite the fact that she is bottle feeding ... when both (parents) are on SCBU together they either argue or become agitated ... very bizarre and strange view of pregnancy.

Yet it was decided that nothing could be done other than to monitor the situation and the baby was discharged home. The situation broke down almost immediately and the baby was made the subject of an emergency protection order following a series of incidents, culminating in Celine throwing the pram out of the window. This is in spite of the fact that the *Children Act 1989* does allow applications to be made on the basis of *likely* significant harm.

Mothers must be given a chance...

The belief that it is inherently wrong to separate a mother from her new-born baby was very apparent. The frequent mention of 'bonding' in the case records even in the absence of supporting evidence would support this premise. The studies (Tredinnick and Fairburn 1980a, 1980b; Corner 1997) highlighting social workers' feelings that it was cruel or unnatural to remove babies at birth were echoed here. Instead there was an implication that mothers must be given a chance. This was particularly complex where mothers expressed ambivalence or rejection of the baby: although it was noted, social workers appeared to have difficulty in truly hearing it. The assumption that mothers must *really* want their baby led them to seize on positive statements and base their plans on these, ignoring the more negative indicators, as in the story of Hassan. There were other situations where a mother did not openly express ambivalence, stating that she wanted to care for the baby, but where her behaviour suggested otherwise. In all such cases, the plan for the baby to be cared for by the mother was unsuccessfully pursued.

Implementing plans

Whatever the original plan, the ability of the social worker to adapt to changing circumstances varied. For example, a mother had expressed a wish to resume care of her children in spite of her substantial use of drugs and alcohol. She failed to adhere to her part of the agreement, i.e. maintaining regular contact with the children, attending appointments with the social worker and seeking treatment for her substance use. Nevertheless the social worker pursued the plan to place the family in a residential unit, which then broke down within hours because the mother had to leave to procure drugs to prevent withdrawal symptoms. A more responsive approach was adopted in another situation which allowed for a change of plan. The original decision had been to remove Cathy's baby at birth but she was able to satisfy her social worker that the risks had diminished:

Cathy now seems aware of the seriousness of Social Services concerns ... is able to discuss child care concerns with some insight ... has proved that she can make a comfortable home ... is able to discuss some of her own experiences as a child and relate it to that of her own child ... has 'unprompted' told me that she is considering sterilisation.

A striking feature of the planning was the fact that it was almost universally linear in style. Even where the prognosis was acknowledged to be bleak, social workers waited for the breakdown to happen before actively pursuing an alternative plan for the baby. It was as if they felt it insensitive to make the prospect of failure explicit. One mother was to live in a mother and baby unit and:

... to remain there until both Sally and professionals feel that she has developed the skills to parent the baby.

This raises a question as to what the contingency plan would be if Sally did *not* develop these skills: she had been unable to look after her previous child and was suffering from a significant personality disorder.

The fact that some plans were designed to be time limited is perhaps evidence that the social workers recognised the need to prevent delay for the children. Two mothers were each expecting a sixth baby, having failed to care for any of the previous children, and in both cases it was decided that a residential assessment would be limited to 3 months with a view to then making firm decisions. In fact these time scales were not adhered to. Even where

planning was proactive, this linear approach meant that consideration was only given to finding permanent carers when all attempts at rehabilitation had been abandoned. Given the delays in the legal process and the shortage of suitable permanent placements, children faced months if not years of uncertainty in short-term placements before they would be settled.

Conclusion

This identification and preliminary analysis of the themes within the social work texts has provided another dimension contributing to an overall picture of this area of practice. The constructed nature of the social work judgements has been confirmed, as has the normative perception of family life. The practice of assessing and managing concerns about *future-parenting* has now been explored at a number of different levels, from a description of the activity to an exploration of the meanings underlying the activity. This brings us back to the question of a 'good' outcome, with the approach of the social worker taking its place as a significant factor. We will now turn to a further analysis and discussion of the findings, addressing these different levels and preparing the ground for a consideration of good practice.

CHAPTER 8: A DISCUSSION OF THE FINDINGS

In discussing the findings, the original research questions will be revisited in order to explore the surface and depth of the topic. The study aims to contribute to an understanding of social work with *future-parents* at a number of levels: what social workers are *expected* to do, what they *actually* do and the more intangible nature of individualised practice that lies behind the activity. Each aspect will be considered in turn whilst acknowledging that the levels are inextricably linked. In particular, the case studies illustrated the struggle of individual practitioners to reconcile personal judgement with the requirements of the child protection system. It is contended within this thesis that, to do a 'good' job, social workers need both a procedural *and* theoretical framework to enable them to make sense of the task. The extent to which these were available to the study social workers is now considered and the final chapter will then attempt to synthesise these aspects in an exploration of the meaning of good practice at this point in the life of a child.

Performance in context

Setting the agenda

To understand any aspect of social work practice, it is necessary to first consider the context within which it is situated. This context consists of societal expectations distilled and reflected in a legislative and policy framework. Practitioners must then interpret this agenda on a case by case basis to arrive at judgements and plans. From an examination of the contextual documents, it is clear that the formal agenda for working with *future-parents* is problematic. *Working Together under the Children Act 1989* (Home Office *et al.* 1991) established the expectation that social workers should assess the potential for harm to unborn children, and that such assessments were located within the child protection system. This guidance included the facility to place unborn children on the child protection register but did not clarify how to implement this, given that the subject is nameless, genderless and legally a non-person. The result is a practice characterised by inconsistency at all levels, apparent throughout the findings.

A particularly tangible indication of inconsistency lies in the variable rates of registration of unborn children from one local authority to another. An early finding was the effect of the

questionable guidance within the study authority where, although the decision was taken to place 4 unborn babies on the child protection register, local practice determined that this would not be put into effect until the birth. The decisions did not therefore get formally reported in the annual statistical returns to the Department of Health (1994b) but were subsumed into the 'under 1' category when the child was born. It is not known whether other authorities also follow this practice, but it is sufficient to cast doubt on the reliability of the statistics and to suggest possible under-reporting. Moreover, unlike other age groups, the Department of Health offers no analysis of the statistics on registration prior to birth. Neither does it collect information regarding the overall incidence of pre-birth case conferences. The result is a situation where very little is known about the way in which the guidance is being implemented nationally.

A further weakness within the formal agenda is the poor definition of the task. It is left to practitioners to make sense of the requirement to protect, from the decision that an assessment is required, the form that assessment should take and the possible courses of action if it is decided that an unborn baby does need to be protected. Conferences convened before the child's birth are said to be essentially the *same* as any other conference, denying the obvious ethical, practical and legal difficulties. Within this uncertain context, the child protection procedures issued by the study authority in 1993 did offer more guidance to practitioners about aspects of the *system* when considering unborn children. They did not, however, elaborate upon the *content* of the work. Practitioners were left to interpret procedures designed primarily to steer the process of a child protection investigation following an incident, injury or other specific concern about an actual child. As a result of the uncertain agenda, not only was there inconsistency between authorities but variable practice within the study authority. This practice is now considered in more detail, linking the guidance and the activity of the study practitioners at each stage of the process.

Becoming a case

The first question is a fundamental one: which families cause sufficient concern to trigger the child protection system even before they have embarked on the task of caring for their baby? The premise within a liberal society is that the bearing and rearing of children is a private matter, warranting state intervention only where there are specific risks to a child. This is enshrined in the *Children Act 1989* and the *Human Rights Act 1998*. The latter

establishes the rights to ‘marry and found a family’ (Article 12) and ‘respect for private and family life’ (Article 8). Even the *UN Convention on the Rights of the Child* is based on the notion of the child as part of a family rather than solely an individual with uncontested subject status. State intervention is particularly controversial where the child is as yet unborn. The *UN Convention* is ambiguously worded on the subject of when childhood begins (and ends) but, in the UK, unborn children have no status in law and are therefore not viewed as subjects. Furthermore, interference by the state at this time raises the uncomfortable issue of ‘fitness to parent’, challenging the notion of individual freedom. There is inevitably a tension between this liberal value base and the duty placed on social workers to protect unborn children. Interestingly, Tredinnick & Fairburn (1980b) refer to professional intervention to remove a new-born baby as ‘disqualification’ from parenthood: a daunting responsibility even were the mandate clearer.

Although *Working Together* is silent on the topic, it was seen earlier that the study authority *did* define the criteria for pre-birth assessment, reflecting the ‘kinds-of-people’ approach described in Chapter 3. These were parents where there had been previous ‘child protection issues’, or where parental problems prompted serious concerns during the pregnancy that the baby might be at risk in the first few days of life. When the reasons for the referral of the study families were examined, this guidance appears to have been adhered to. However, rather than assessments being triggered by the characteristics of *parents* as prescribed in the guidance, all 26 study babies were referred because of *maternal* problems. These were mental illness (15), learning difficulties (4) or substance misuse (7), often accompanied by a history of ‘failed’ parenting. All 13 of the mothers who had previous children had experienced difficulty in sustaining their care, with only 2 out of the total 33 children still living at home. Both of these children had been on the child protection register. Although most of the fathers also had troubled histories, these often became evident during the course of the assessment rather than being a reason for referral. Fathers with a history of endangering previous children, or with mental health, substance misuse or learning difficulties, did not prompt a referral in their own right. This may be connected to the fact that 20 of the referrals were made by professionals within the maternity service. Fathers seemed marginal to the business of pregnancy and childbirth and their difficulties, therefore, more likely to be invisible to referring professionals. In fact, different responses on the basis of gender are a recurring theme throughout the work and will be revisited. This phenomenon is not restricted to childcare practice and feminist writing has drawn attention to the

gendered nature of social work practice in general (Dominelli and McCleod 1989; Langan and Day 1992).

It could be argued that the study authority's criteria for referral reflect stereotypical concepts about 'incurable' parents (Dingwall *et al.* 1983): those who have somehow prompted practitioners to question their usual assumptions about the natural love of a parent for their child. It is difficult, however, to conceive of an alternative. Given the absence of a child, with an unborn baby having only the contested status of a *future-subject*, what basis could a practitioner have for feeling concern if not related to parental characteristics? The question as to whether other, unidentified, families also presented a risk to their unborn children cannot be answered by this study. However, the fact that, of the 31 babies in the study authority who were the subject of a case conference before the age of a year, 26 were referred during pregnancy or within a week of birth would indicate that professionals are identifying a particularly vulnerable population of *future-parents*. This is confirmed by the spontaneous re-referral by health professionals of the 4 cases already 'open' before the pregnancy was identified, indicating a degree of consistency in the factors which trigger concern. It is impossible to state categorically whether this level of concern was related to the local criteria or had its origins in the respective practice wisdom, or even the elusive concept of common sense, of the referrers. Are women with mental health problems referred because the criteria dictate it or because professional judgement suggests that their symptomology may interfere with the ability to care for a small baby? The most likely explanation would seem to be that there is a congruence between the kinds-of-people identified by the local procedures and those who were seen as 'risky' in practice.

To return to an earlier debate within Chapter 3, the study population did not straightforwardly reflect the profile identified in the most commonly cited checklists of risky parents, although there is overlap. Greenland (1987) and Browne and Saqi (1988) both identify young, separated, disadvantaged parents as being particularly likely to be abusive, whereas the population of *future-mothers* giving rise to concern in this study had an average age of 28 and were notable for their level of disturbance rather than disadvantage. Although both checklists identify substance abuse and violence as risk factors, only Browne and Saqi mention mental illness. They also refer to a range of other factors such as childhood experience of abuse or deprivation, inadequate education or a history of criminality. These factors would not necessarily be known to the professionals likely to refer expectant parents,

i.e. health practitioners. The checklist approach may thus be flawed not only because of the statistical fallacy described in Chapter 3 (Dingwall 1989) but because it can only be operated where the factors are known to potential referrers.

It is interesting to note that the findings do indicate differences between the *future-mothers* and those referred at a later point in the baby's infancy. The latter were younger, with an average age of 22, and 4 (of the 5) were referred because of specific incidents but in the context of an otherwise satisfactory standard of childcare. In these instances, the mothers were less troubled than the *future-mothers*, with no evidence of either significant mental health or substance misuse problems and no major concerns about past parenting behaviour. This is not to say that they were without difficulties: they shared the common characteristic of domestic violence and problematic partners. However, the remaining mother did appear to fit the profile of those who 'should' have prompted concern before leaving hospital with her baby: she was said to be depressed and, it emerged, had a significant drug problem not detected by professionals at the time of the birth.

An additional consideration in the decision to refer to social services for an assessment of *future-parenting* is that of kinds-of-practitioner and the setting in which they work. The majority of referrals were made by midwives or other health professionals to hospital based social workers, although there were differences between the hospitals. The social work team based in hospital A had developed a protocol for multi-disciplinary work with pregnant drug users, and had issued guidelines to obstetric staff regarding the kinds-of-people who should be referred and the process for referral. In the absence of such guidance, referrals in other settings did seem more hit and miss, with area-based teams appearing unclear about their remit in relation to pre-birth assessment and perhaps communicating this uncertainty to others. Area teams only became involved in pre-birth assessment when they were already working with the family because of concerns about existing children or, in Tania's case, because she was herself a child in need.

By definition, all the study families were considered at some stage to merit the apparatus of the child protection system: they were selected on the basis that their baby had been the subject of a case conference. The study does not tell us anything about families who were not referred, or referred but filtered out. Deciding that a case requires a child protection investigation is always complex, with no universally agreed definition and only a small

minority of referrals providing any degree of certainty. In other cases the facts may be in question or, alternatively, the facts may not be in dispute but there is no agreement about whether they require a child protection response or not. In spite of the increasing bureaucratisation described by several writers (Howe 1992; Otway 1996), this continues to be the case. A recent study by Spratt (2000) indicated that this lack of consensus existed not only amongst senior social workers in the same department but also, surprisingly, amongst the Department of Health inspectors responsible for ensuring standardisation. When these groups were presented with real case scenarios and asked to decide on the most appropriate course of action, there was widespread disagreement. If there is such difficulty in categorising referrals of children, how much more complex is the task of deciding that an unborn child needs to be protected. This raises another important issue: whether the cause for concern in the study population was that parents would be abusive, or whether it could more accurately be portrayed as a concern that they would not be able to parent at all. What were the babies to be protected *from*?

Responding to the challenge

Whatever the complexities of the decision to make (or accept) a referral, it did provide an opportunity to respond proactively in order to safeguard a particularly vulnerable group of babies. How did the child protection system and its practitioners within the study authority respond to this challenge? In spite of the fact that the system does not formally recognise differences between pre-birth and other types of child protection activity, the findings indicate that assessments of *future-parenting* did not conform to the standard investigatory pattern. Within this overall picture, however, there was considerable variation from case to case. Some assessments were structured and proactive, with a clear statement to parents that judgements were being made about their ability to care for the expected baby, and that the outcome would be considered at a child protection case conference. Others were unstructured and reactive, with the decision to convene a case conference only being taken following the birth or at a point of crisis. This variation in process was not reflected where there had been an incident or injury in relation to an older baby living in the community. These referrals received a more consistent approach, compatible with the child protection guidance both in the study authority and *Working Together*. The stages of the activity are now considered in more detail.

Getting started

Having decided that an assessment was needed, the overall approach to the task was tentative. Firstly, there was often considerable delay from the point of receiving the referral to seeing the family, either because the social worker was slow to make contact or did not press the matter when parents were evasive. Secondly, when parents were approached, there was often a lack of clarity about the reason for the assessment, with vague statements about seeing how social services could help rather than making it clear that judgements would be made about parenting ability. There are a number of possible reasons for this. Barker (1997) raises the concern that pre-birth assessments undertaken in early pregnancy may pressurise the mother into seeking a termination. Alternatively, beliefs about the sanctity of motherhood may have led the social workers to feel squeamish about the intrusive nature of their intervention. Even Baroness Warnock, who was engaged in complex ethical debates about access to fertility treatment, described the prospect of social workers deciding to remove a baby at birth as ‘intolerable’ (see p.48). Where these ethical qualms were overcome, the lack of clarity about what could meaningfully be assessed in the absence of the baby may also have contributed towards a reluctance to act, as may the practical/legal impossibility of protecting an unborn baby.

This lack of confidence, however, must impact on the intelligibility of the intervention to the families concerned. Guidance directs that information about the child protection process should be communicated to families through standardised leaflets. Whilst a mother whose child has been injured and is the subject of a s.47 investigation is likely to find such information relevant and useful, that is unlikely to be the case for *future-parents*. An unsolicited contact from a social worker during pregnancy is guaranteed to raise anxiety about the possibility of having the baby removed, particularly since many of the mothers had indeed lost the care of previous children. Alternatively, they may fear being labelled as ‘mad’ or ‘bad’ because of their problems and are therefore concerned that social services will pre-judge them. Inevitably, social workers will be affected by this negativity but the study showed that families appreciated honesty. Jake’s parents *knew* that their ability to care for him would be assessed and found it easier to engage when this was openly expressed and the process could be explained.

Doing the assessment

Having overcome this reluctance and embarked on the assessments, the focus was

overwhelmingly on mothers and a variety of tactics used to marginalise or exclude fathers. These varied from explicitly denying their subject status as *father*, to justifications for not including them on the basis of their behaviour or hints that they were unimportant in the business of infancy. This phenomenon is interesting, not only because any assessment which excludes such a key player is likely to be flawed, but also because of the insight it gives into the differing expectations of men and women. Many of the men were known to be violent, and it was clear that they would be having considerable contact with the baby even if not living in the household. Others, conversely, were trying to indicate their interest and concern but had difficulty being heard. This finding was a further indication of the gendered concepts concealed within the term *parenting*, and has implications for anti-discriminatory practice.

The tentative nature of many of the assessments may be linked with the finding that social workers recommended a residential placement in 20 cases. Although the decision to pursue such a placement was sometimes purposeful, for example with the clear aim of finding out whether a mother could sustain the care of her baby over time, in other cases they seemed to be proposed as a safe setting for parenting to fail. It is as if the social workers either did not trust their own ability to form a judgement about whether a baby would be safe with parents (in fact, overwhelmingly this was mothers) or they had no doubt about the bleak prognosis but felt unable or unwilling to act decisively. Again, it can be argued that a more confident approach would be preferable, in that it would not raise a family's hopes unrealistically and may lead to a more speedy resolution for the baby. However, such judgements are fraught with uncertainty and pain and it is right that they should feel uncomfortable. Perhaps it is a positive sign when practitioners arrive at a human rather than a bureaucratic response and want to give families an opportunity to succeed, however unlikely. A more cynical view might be that there is also a need to gather evidence in order to convince a court of significant harm, and that a residential placement provides a rich source of such evidence. A final reason for the recommendation may be the lonely nature of the assessment task for social workers. Other professionals were able and, usually, willing to contribute information about specific issues such as parental drug use or level of antenatal attendance, but the judgement as to whether they would be able to care for a baby was a different matter. We have seen that this is a momentous decision, arousing strong emotions. It is no wonder that social workers seek mechanisms for sharing such decisions, and a residential assessment may fulfil this function.

Using the system

Perhaps there would be less demand for residential assessments if there were other means of sharing responsibility. The usual child protection process does allow for shared decision-making, with its range of formal meetings, but these were not fully utilised here. Strategy meetings did not take place and the use of child protection conferences was variable, with evidence of inconsistency both in decisions to convene conferences before birth and in the firmness of the plans that were made. Confidence increased following the birth, with social workers feeling more able to draw on their usual protective procedures. Although the decision was taken to register only 4 of the study babies before birth, a further 14 were registered at a subsequent conference. This does cast doubt on the usefulness of the pre-birth conference if it failed in its task to make a protection plan. In fact the purpose of a child protection case conference is not necessarily as straightforward as the guidance would suggest. Although the only formal decision open to conference members was whether to place the baby on the child protection register, a number of recommendations were made which acquired the status of informal decisions.

It is unlikely that the distinction between recommendation and decision was always clear to parents, particularly in view of the definite nature of some recommendations made by the study conferences. These ranged from plans to transfer babies to the special care baby unit at birth, to seek a residential placement or arrange a psychiatric opinion. At times such recommendations were given added authority by the ‘threat’ of legal action if they were not complied with. It could be argued that parents were oppressed by these plans, of uncertain status. Alternatively, they may have served to clarify the concerns and expectations of the professionals, allowing parents to learn where they stood and to prepare their response. The value placed by social workers on parental co-operation was described in Chapter 3 and endorsed by the findings. Although it can be questioned whether the conflation of compliance with parenting ability is valid, in order to have a choice as to their level of co-operation, parents must first know what the rules are: what it is they are being asked to co-operate *with*. A pre-birth conference in which parents are given an opportunity to participate does at least afford this opportunity whilst they still have everything to play for and is certainly preferable to a situation where decisions are taken in private, denying parents an opportunity to challenge or to negotiate their position.

Variations in process are understandable given the combined factors of unclear guidance and

ethical complexity, yet the outcomes (or more accurately outputs) for the babies and their families would suggest that social workers need to find a way through the morass. The case studies illustrate that most of the families would not have thrived if left in peace but were facing such difficulties that *not* to intervene would have been unethical. This vulnerability is confirmed by the finding that, of the babies available for follow-up, only ¼ were living with their mother in the community a year after the initial case conference and one baby had died in suspicious circumstances. Although none of the others had suffered serious physical abuse, this may have been due in part to the operation of the child protection system: several parents had not actually cared for the babies at all, or had only done so for a limited period/under close supervision. The babies may also have sustained other, less tangible, harms as a result of negligence, instability of caregiver or inadequate affection and stimulation. There is an increasing body of evidence (see Rickford 2000) about the effects of early trauma on subsequent development which may be relevant for this population, given the level of disturbance and domestic violence within the families. The issue of outcome will be returned to at a later point in the chapter, but the next task is to start the process of looking beneath the surface performance to more invisible aspects of the practice; firstly, the way in which the social workers worked with the families.

Partnership: subject or object of concern?

The way in which social workers involve family members in their work can be seen both as a feature of the formal system and of individualised practice. It was a stated principle within the *Children Act 1989* that practitioners should work in ‘partnership’ with families but the findings indicate varying approaches to the task. Of particular interest is the extent to which practitioners involved parents in the assessment, either seeing them as an essential participant in the shared task of telling the story or as a marginal and unreliable source of information.

A procedural approach

Guidance as to how partnership should be implemented took some time to appear. The study authority revised its child protection procedures in 1993 but the Appendix headed *Partnership with Parents* simply says: ‘To be produced at a later date’. However, the

procedures did contain instructions about the involvement of parents in the mechanics of the child protection system, including the expectation that they be invited to attend case conferences and fully informed of concerns and decisions at each stage. Leaflets were produced for parents explaining the process, from investigation through to conference and registration. These measures could more accurately be described as allowing participation rather than encouraging partnership. Official practice guidance, *The Challenge of Partnership in Child Protection* (Department of Health 1995b), was not available until later but would not have offered any new insights. It too focuses primarily on the procedural aspects of parental involvement. There are clearly sound ethical reasons for telling parents what is happening and inviting them to participate in meetings where important decisions will be made about their children. This could be seen as ensuring 'fair play' but is qualitatively different from involving them in a shared task. The guidance recognises this to some extent, but suggests that it is the characteristics of parents that either allow for or preclude partnership:

Possibilities for partnership vary from family to family. Some adults are relieved to know that the ultimate power to protect the child rests with the professionals and others chafe against this use of authority (para 2.14).

This is to deny the more invisible aspects of practice indicated by the findings whereby the possibility for partnership seemed also to vary from practitioner to practitioner.

Beyond the procedural

In both the case studies and thematic analysis, it was apparent that some social workers were attempting to establish a relationship with families rather than merely complying with the bureaucratic aspects of partnership. Such relationships are difficult to pin down but traces of their existence were evident within the text: in the language used by the social worker to describe the parents, expressions of concern for their well-being or acts of kindness. The opportunity for this manifestation of partnership was *not* dictated by the family characteristics, as suggested above, but seemed to stem from the value base of the social worker, respectful of the subject status of their clients however challenging their behaviour. Maybe this stemmed from an older tradition within social work: that of empathy, positive regard and a non-judgemental approach. Other social workers clearly did not share this perspective, and looked no further than the behaviour. Interestingly, both styles were

achievable whilst conforming to the bureaucratic requirements but it could be argued that the latter approach accords more closely with a child protection discourse: a significant degree of agency cannot be accorded to such a disturbed and possibly dangerous group of parents. Practitioners operating within the current climate are likely to be held accountable for any harm suffered by children and their priority becomes to 'cover their backs' through adopting a cautious and protective stance. *The Challenge of Partnership* would seem to encourage this approach in urging social workers not to go too far:

Well-informed decisions, based on careful discussion, observation and evaluation of each situation, have to be made about when partnership may be detrimental to the child (para 2.24).

The difficulty with this position is that it provides a get-out clause, allowing practitioners to argue that partnership working is not appropriate to their particular cases, and does not encourage critical reflection. It has been seen that the study mothers with psychiatric illness were particularly likely to be excluded without creative means being developed to allow their voice to be heard. Yet the story of Jake would seem to demonstrate that a degree of partnership can be achieved in unlikely circumstances, given the commitment.

Joint constructions

A final element in partnership working is the extent to which parents are able to exercise agency in jointly constructing their case alongside practitioners (see Healy 1998; Fook 2000). *The Challenge of Partnership* proposes the family as a valuable source of information:

They have unique knowledge and understanding to contribute to discussions about what has and has not happened to the child and the best way to provide protection (para 2.4).

However, if it is to be useful, this knowledge and understanding must be properly heard and respected, even where family members are saying things that do not accord with the practitioner's assumptions. Here, the guidance again suggests caution: although social workers are directed to elicit the wishes and feelings of parents, they are not advised how far these should 'influence events'. Instead the guiding principle is to:

Listen to the concerns of the children and their families, and take care to learn about their understanding, fears and wishes before *arriving at your own explanations and plans* (para 2.20: emphasis added).

It would be possible to comply with this principle without actively taking those understandings, fears and wishes into account at all. There is an implication that the practitioner is the *expert*, having a better understanding of the family than they can have themselves. Yet, on the basis of the findings, it is suggested here that the importance of partnership lies not only in an ethical position, but also in the fact that it may provide ‘better’ evidence. Hassan’s story illustrates the fact that a benign social worker, whilst clearly keen to do a good job, was unable to ‘hear’ what his mother was saying: that she was deeply ambivalent about the mothering role and doubted her capacity to care safely for the baby. She was similarly unable to hear the perspective of Hassan’s father, who wished to step out of role to be the primary rather than supporting parent. True partnership would suggest that the players are allowed to demonstrate agency: to position themselves rather than merely being constructed by others (Fawcett 2000) or, as Featherstone (1999) phrases it, to be ‘taken seriously’. The construction of evidence thereby becomes a shared task, achievable within the context of a relationship between assessor and assessed. These notions of constructed knowledge and expertise in relation to the meaning of *good practice* will be further explored in the final chapter.

Practice and meaning

This chapter began with a consideration of the ways in which social workers act when confronted by *future-parents*, trying to work out what to *do* within an uncertain context. When describing the attempts to work in partnership with parents, however, the nature of the discussion contained elements of both performance and meaning. Whilst operating within the same procedural framework, it can be seen that social workers interpret their remit in different ways. This shift towards the more invisible aspect of the practice is continued through a discussion of the way the study social workers conceptualised the problem, the stories that were told, and the plans that resulted.

Deconstructing the evidence

The findings confirm the constructive nature of assessment. Rather than a simple presentation of the facts, leading to inevitable and uncontested conclusions, the study practitioners selected and framed information at each stage of the process to ‘make their case’ (Wattam 1992). There was a sense of roles being ascribed to key players in a drama, encouraging them to act out a pre-determined script rather than allowing them full agency. The origin of these roles is difficult to unravel: whether from the formal knowledge base that directs social workers to understand human behaviour in a particular way or, alternatively, ‘everyday social’ (Secker 1993) views about the proper conduct of parents and children, absorbed and unquestioned by social workers as members of that society. Whatever its origin, the resulting story provides a basis for judgements and plans whether it is a version of events understood and agreed by the families or not. It is thus important to submit these stories to critical scrutiny, otherwise we are lost in the ‘vertigo of relativity’ (Parton 1996a) where every story is equally valid. This is unacceptable in a moral universe. Given that social workers must act, they should have evidence for their actions. The key question is what information can be claimed as valid evidence.

Hall (1997) used narrative theory to demonstrate the mechanisms by which social workers portrayed their clients as victims or villains. These constructions are insufficient to describe the *future-families* within this study: instead the findings tell a story of the natural mother, the peripheral (more-or-less supportive) father and the passive baby. The way in which the evidence was constructed demonstrates that the social workers’ gaze was directed predominantly at maternal history and behaviour. Particular characteristics constituting a ‘safe’ mother began to emerge in the case studies and were further developed through the textual analysis of the records as a whole. To summarise, the findings revealed a *safe mother* to be one who:

- Presents herself as reasonable, and does not behave in a way which is perceived as ‘bad’ or ‘mad’;
- Takes social work intervention seriously and is worried that she may lose her child;
- Complies with the social worker’s plan as to how she should conduct her life;
- Wants to be a mother and to care for her child herself;
- Is willing to sacrifice her own needs in order to ‘put her child first’;

- Bonds with her baby and expresses loving sentiments;
- Does not cause concern to others in the way she handles her baby;
- Can look after herself and her environment in a competent manner;
- Can acknowledge any personal difficulties and find solutions;
- Is willing to regulate her relationships in ways suggested by professionals.

Social workers did not present mothers and fathers as equal partners in the task of parenting and the role of fathers was consistently minimised. The *safe father* was not a mirror image of the *safe mother* but someone who would take a complementary and secondary place. He demonstrates the following qualities:

- He will be the uncontested biological father of the child and make his identity known;
- If he wishes to be involved he will accept that his role is secondary;
- He will understand and accept the involvement of professionals in the life of his child and will not be aggressive towards them;
- He will make a commitment to the child's mother and support her in caring for the baby;
- Although his past is of some importance it is less significant than that of the mother;
- If he is unable to comply with the above requirements he can opt to remain absent and silent.

The babies played a shadowy part in the assessments and had little voice. Whilst a father might be cast as a supporting actor, the baby was never more than an extra. Their vulnerability was emphasised, particularly if they had health problems, and they were generally described as passive recipients of the care and expectations of their parents rather than 'small people' in their own right.

Did this construction of the *safe family* provide a solid foundation for deciding that a particular baby was 'at risk'? It certainly had its limitations. Much of the evidence related not to the care of the child but to parents' response to the child protection system or the individual social worker. It is also clear that the social workers focused their attention on the individuals within the family constellation rather than taking a systemic or ecological approach. Those individuals then tended to be categorised, with substance misuse or psychiatric illness casting doubt on their fitness to parent, and an unco-operative stance confirming these doubts.

The origin of this discourse of a *safe family* is not made explicit. Returning to the models discussed within Chapter 2, it appears to be based on developmental psychology rather than sociology, with childhood seen as a series of universal stages through which the child is guided on the journey to becoming a person (Woodhead *et al.* 1991; Hill and Tisdall 1997). Childhood is essentially passive and powerless, although with increasing autonomy being allowed as each stage is reached. Babyhood within this model is therefore the point furthest away from being a person, and a baby has little status as a subject. In turn, this would seem to confirm the position of the unborn child as a non-person/subject but acquiring more status as gestational age increases (see p.10). (Thus the focus began to shift towards planning for Hassan and Jake as the birth approached). This paradigm of the Welfare child (Hendrick 1990), in need of care and protection, is clearly endorsed by Government guidance to social workers. It was implicit in the detailed list of developmental stages within the *Orange book* (Department of Health 1988), in force at the time the study social workers were undertaking their assessments, and is now explicitly espoused by the updated guidance (Department of Health *et al.* 2000). In spite of attempts to persuade society as a whole of its shared responsibility (National Commission of Enquiry into the Prevention of Child Abuse 1996), the care of children is still left to parents, however disadvantaged. A normative model of family life prevails whereby the baby is a ‘bundle of needs’ and the proper role of a parent is to meet those needs.

The implications of this official model will be considered in more detail in Chapter 9 but, whatever its deficiencies, it does offer the practitioner some overall direction. What it does not do is address the problem of gender, which is effectively ignored within both national and local guidance. This failure to recognise that the practical and emotional tasks of childcare are primarily the responsibility of women poses a dilemma for practitioners. In the absence of an adequate model of parenting, they are left to fall back on personal beliefs, assumptions and experiences: for example, that fathers are often conspicuous by their absence or the problems they cause when present. This study indicates that the result is a somewhat traditional representation of gender roles. However, studies have shown that fathers play at least an equal role in causing harm to children (Corby 1993; Hagell and The Bridge Child Care Development Service 1998) and those taking decisions about a child’s safety cannot afford to ignore them.

The issues of race and culture are similarly ignored within the portrayal of the universal

parent and, again, this is reflected in the findings. The social workers for Hassan (p.112) and Theo (p.149) did not seem to take their ethnic, cultural or religious heritage into account either in the assessment or subsequent intervention, and there is evidence that the voice of their black parents was suppressed.

Making judgements

The problematic nature of the evidence base brings us to the next stage in the process: drawing conclusions from the evidence. The dominant paradigm at the time the assessments took place was one of determining and managing risk through standardised procedures. However, advocates of this 'rational-technical' perspective (Parton and O'Byrne 2000) would probably still agree that the element of judgement cannot be eliminated: evidence must be interpreted.

For social workers, the link between data (observation and dialogue) and subsequent 'problem' construction cannot be side-stepped, since the ideas so generated have powerful material consequences for service users. Therefore, we must have some mechanisms for evaluating the ways in which workers seek to make sense of the lives of others (White 1997, p.742).

If practice is to be accountable, it is important to attempt to deconstruct this process of making sense. Spratt and Houston (1999) identify a number of ideological models used by childcare practitioners. For example, the same act by a parent towards their child can be interpreted as deliberate abuse, a symptom of individual pathology or of family dysfunction. The social worker evaluates the situation through these ideological filters, originating from their personal values and those of the employing agency. Spratt and Houston argue that these ideologies should be made explicit and debated by practitioners, requiring a reflexive position. Similarly, White (1997) and Sheppard (1995,1998) draw parallels between qualitative research and social work, both requiring the development and testing of hypotheses through reflexivity to make sense of the data/ information.

The social workers in this study may have been tacitly engaged in this process, and their judgements may have been sound, but unless it is clear how they were reached their validity must be in doubt. However, as is apparent to an entitled reader of the case studies, the plans made by the study social workers did not always seem to 'make sense' in the light of the

bleak stories which were told. The findings are more compatible with a view that, at times, workers were operating on the basis of fixed ideas, or ideologies, rather than a reflexive analysis. It is clear that the social workers thought the study babies were at risk: 18 were placed on the child protection register. Thus the discourse of risk management was clearly a feature of the planning process, but appears to have been both interwoven, and in conflict with, alternative discourses operating as a rationale for inaction: i.e. that decisions cannot be made until a baby is born, that mothers must be 'given a chance' and that proof of harm is needed before any action can be taken. This reluctance to act was not necessarily a result of parental pressure, although there were instances where they were given a voice in the decision-making, but seemed to originate in the social worker's view of the world. Once decisions had been made, whatever their discursive underpinning, it sometimes seemed difficult to modify them in the face of subsequent events. It was as if, having decided to give a particular mother a chance, this had to be pursued to the bitter end, as illustrated by Leanne's story (pp.138-141).

Effective interventions?

Whilst recognising that such theorising is an interpretative activity through which the researcher's voice is added to those of the other actors, some implications for practice are raised through this analysis. Although not an evaluation study in the sense of looking at whether pre-birth assessment 'works', the inevitable question arises as to whether the babies were well-served by the practice. It was suggested in Chapter 3 that outcomes in childcare work are extremely difficult to evaluate because of the competing perspectives of the various stakeholders. The principle on which the system is based is that the interests of the child are paramount, but what does this mean? It is impossible to go through childhood without suffering some harm, and the threshold as to when that harm becomes significant, prompting protective action, is highly contentious. Moreover, a child may be protected from one harm e.g. sexual abuse, but suffer other harms as a result, such as the loss of family life and identity. Finally, it cannot be asserted that harm has been avoided because an event that has not occurred cannot be measured. Daisy illustrates these dilemmas. A year after the initial case conference, she could be said to have achieved a good outcome: cared for by a loving mother and apparently thriving. In giving her mother a chance, however, she had also been exposed to the following bad experiences: opiate withdrawal at birth, being thrown to the floor whilst her mother was psychotically disturbed and abrupt, albeit temporary, changes of

primary carer in times of crisis. The question of whether her best interests have been served will depend, in part, on what happens during the rest of her childhood but can never be answered conclusively because it cannot be known how she would have fared if different decisions had been made.

Whilst recognising the complexities in defining a good, or 'least bad' (Gibbons 1997) outcome, it was defined within this study as one where the baby was both safe and settled with a primary care giver who would remain consistent throughout childhood *or* where a clear plan to achieve this goal was being actively pursued. A bad outcome was, conversely, one where the baby was living in a situation of danger or uncertainty. Only a limited consideration of outcome can take place after a year because the story is far from finished, but it was seen that 15 of the 24 study babies on whom there was information at follow-up could be said to have experienced a *good outcome* if these criteria are applied. By definition, the remaining 9 babies had experienced a *bad outcome*. In order to improve practice, we must first understand the elements of the case that contributed to the outcome. Within a constructionist paradigm, it is inadequate to concentrate on the characteristics that the families themselves bring to the situation: the nature of the intervention is also an essential component in understanding. Individual outcomes can thus be said to depend on the interplay between:

- the parents' problems and capacities
- the child protection process to which they are subjected
- the nature of individual social work practice.

Parental problems

Although it was clear that the nature of the parents' problems did contribute to their difficulty in sustaining the care of their children, the question of who 'succeeded' and who 'failed' could not be understood simplistically: there were some surprises. The findings do support the premise that mothers facing problems of mental health or substance use and the loss of previous children are likely to have difficulty in caring for a baby. *Psychotic illness* appeared to be particularly problematic with only 3 of the 12 mothers caring for the baby at follow-up. Similarly, when *parenting history* is considered, of the 12 mothers who had previous children no longer in their care, only 3 retained the care of the baby. Again a simplistic view cannot be taken: in spite of their history and multiple problems these 3 mothers appeared to be providing a reasonable standard of care. The risks taken by the

social workers in ‘giving them another chance’ seemed to be paying off. *Fathers’ characteristics* were more elusive. Where a father was present in his baby’s life and did not have significant mental health or substance use problems, he seemed to contribute to a positive outcome, even though he may have to struggle to assert this role. Conversely, some fathers’ involvement appeared to have a negative impact, particularly in view of the almost universal prevalence of violence.

Thus a level of assessment is always required, however ‘high risk’ a family appears to be: one family facing overwhelming odds may succeed in meeting the needs of their children whereas another with fewer obvious difficulties may not. Once a family becomes the subject of professional intervention, that will also inevitably contribute to the outcome for the child, both through the child protection system and its practical application by individual social workers.

Child protection process

The child protection system provided the context for both assessment and intervention, and the way in which the babies were processed is described on p.92. Again, the impossibility of demonstrating that harm has been prevented must be acknowledged but what does not seem in doubt is the decision to become involved with the families, given their level of disturbance and bleak parenting history. If several of the babies had not been the subject of a protection plan, effected at birth, they could have been at risk of significant harm, particularly those experiencing opiate withdrawal or with very disturbed mothers. Even though some of these babies experienced ‘bad’ outcomes in that they were not settled by the end of the study, they may have faced a much worse fate had there been no plan at all. The baby whose opiate-using mother ‘slipped through the net’ and was not identified until the age of 6 weeks had a particularly poor experience. The department seemed unable to regain the initiative and she had 9 placement moves within her first year. When we consider particular aspects of the system, 10 of the 14 babies who had been the subject of a pre-birth case conference achieved a good outcome, compared with 5 of the 12 who were not conferenced until later.

Interestingly, the placing of a baby on the child protection register did not generally seem to be associated with a particular outcome except where the decision was taken before birth. Of the 4 babies in this category, 2 had been placed with prospective adopters and permanency plans were well advanced for the remaining 2. Similarly, removal at birth (but not other types of legal intervention) was associated with a good outcome whereas

residential assessment did not seem to make a positive difference. These findings suggest that the significant factor may be proactive planning rather than the child protection system *per se*, in which case a similarly confident approach taken whatever the procedural context may be equally effective.

However, the existence of a plan cannot be separated from the quality of the plan and the way in which it was implemented. The opportunity for drift was considerable, partly as a result of the rationale for inaction (pp.163-164), but partly because of structural problems such as delays in the legal process or the shortage of suitable carers.

Social work style

An additional factor was the way in which the individual practitioner approached their task. Although this inevitably overlaps with process in that a confident practitioner is likely to make better use of the system, a particular style was evident amongst some practitioners which seemed to contribute towards good outcomes. It echoes the reflexive approach described earlier and was characterised by an ability to reflect both morally and theoretically about the nature of the problem, to modify opinions and plans in the light of new information and to negotiate meanings with the case subjects. Interestingly, the connection between social work style and the management culture was not clear-cut. Critics have argued that a managerial, or procedural, approach conflicts with a practice based on a relationship between practitioner and client (Howe 1996). The findings of this study do not support this: hospital B had the least managed practitioners but had created a culture of excluding parents from decision-making whereas other workers managed to combine a procedural *and* reflexive style. Perhaps managerialism ensures a degree of accountability, whatever its other disadvantages. This theme will be revisited in Chapter 9.

Ethical practice: a tentative conclusion

The crucial issue of social work style is significant not only because of the impact on outcome, but because of the more intangible aspects of evaluation: that of good or ethical practice as a goal in itself (Everitt and Hardiker 1996). An ethical approach to practice must be anti-discriminatory and recognise the inextricable connection between process and outcome. It is possible to conceive of a situation where a baby did achieve a good outcome, but there was nevertheless reason to criticise the actions of the social worker. One such case

is that of Theo and Rawda, described earlier (p.149). It could be argued that the denial of Rawda's subject status did not detract from the fact that the ultimate plan was probably the most likely to meet Theo's needs. However, the children and families whose lives are shaped by our intervention will have to live with the consequences forever. Will Theo grow up feeling that his mother did not want him or was not given a fair chance to look after him? Does Rawda fully understand why the decision was taken that she was not 'fit' to look after her son and feel reassured that she is not to blame? Are the family members who finally assumed Theo's care able to make up for the time they lost with him in early infancy? Do they also feel that the process was fair or are they carrying some guilt that they may have infringed the rights of the 'natural' mother? Alternatively, although the outcome for Jake was ambiguous (pp.123-125), there is evidence that his social worker adopted aspects of a reflexive style in trying to engage and negotiate with the family.

These are fundamental questions if we are to reflect critically on the nature of practice, yet are not necessarily reflected in the procedural requirements. The rational-technical paradigm cannot provide answers to practical-moral questions (see Parton and O'Byrne 2000) and practitioners need to look elsewhere if they are to fulfil the role of mediating on behalf of the 'the mad, bad and the stigmatised' (Philp 1979). We have seen within this study that there are particular deficiencies in both the pragmatic and theoretical support available to practitioners working with future parents, and little solid ground on which to base their work. Nevertheless, there is reason for optimism in the way in which practitioners tried to reach out to these troubled families. Although not necessarily recognised within a managerial culture, there are indications that these efforts were valued by the families themselves. There would still seem to be scope for expertise (Fook 2000) or, as one of the study mothers phrased it, being a 'good' social worker. These matters are now explored in more detail.

CHAPTER 9: CONCLUDING DISCUSSION

The study demonstrates that pre-birth assessment would be a daunting task for practitioners in any circumstances, but the challenge is compounded by the lack of a clear mandate. This stems, in part, from the fact that uncomfortable ethical issues are raised about the fundamental ‘right’ to be a parent and a related reverence for the institution of motherhood. Although there may well be unofficial mutterings amongst the public, and indeed professionals, about those who ‘shouldn’t be allowed’ to have children, interference with adults’ ability to procreate is rarely sanctioned in a liberal society. Advocates of licensed parenthood challenge this perspective and argue that certain criteria should debar people from having children. In the UK this appears to be applied only to women with serious learning difficulties, interestingly without major outcry, or where medical or legal intervention is needed in order to become a parent, when the state feels more justified in assessing suitability. Perhaps this arises from the pragmatic position that it is *possible* to intervene in such situations. Otherwise the right seems inviolable: people cannot be *stopped* from having children.

Having had them, however, ‘fitness to parent’ may be questioned on the grounds of inability to provide adequate care. Such concerns are not usually raised until parents or carers are thought to be causing harm to a child and are therefore applied on the basis of here-and-now evidence rather than prospectively. The rare situations where there is concern about *future-parenting* have received little attention from policy makers or researchers and are therefore poorly understood. There has also been a dearth of public debate: beliefs about what constitutes a fit parent rarely being made explicit. It would be possible, on the basis of this study, to suggest that the likelihood of a woman with severe mental illness and a history of failure in parenting previous children being able to care for any future baby is sufficiently remote to warrant her ‘disqualification’ from parenthood. This is not the case in practice: decision-making is not based on universally applied criteria but on individual assessments undertaken when the prospect of parenthood becomes real rather than notional. Social workers are left to hold the tension between parental autonomy and the duty to protect the child from harm on a case by case basis.

The definition of significant harm is contested even where it applies to existing children who

can be examined, observed and interviewed. It is even more contested in respect of unborn children, where any such harm is inevitably speculative and set in an uncertain future. The result is a practice characterised by inconsistency and tentativeness, both in organisational and professional terms. Given this confusion, it is tempting to suggest that practitioners should abandon such assessments: they are not only ethically dubious but also impracticable. Yet there is a moral argument that a way must be found of *making* them practicable: there exists a small but troubled population of families with problems so overwhelming that they may be incompatible with caring for a baby. The identification of this population does not seem to be problematic. Professionals working with pregnant women regularly refer such women to social services (although there remains a concern about whether professionals working with men are able to exercise the same level of judgement about their capacity as potential fathers). The problem lies in how to respond, particularly in view of the complex subject status of the respective players. As a result of this lack of a clear practice framework, some babies and their parents appear to be well served by the process whilst others do not. Social workers need to be enabled to embark on this challenging but important activity in a way that ensures both overall consistency and individual equity.

This study has attempted to develop a knowledge and understanding of the way in which social workers respond to the challenge through an exploration of casework, looking both at ‘whole’ stories and underlying themes. Before discussing the implications of this increased knowledge and understanding, it is necessary to return to a theme raised earlier when describing the methodology: that of the dilemmas raised by the position of the researcher as a practitioner-manager within the study authority.

Practitioner-research: challenge or opportunity?

The perspective throughout this study has been that there can be multiple readings of a text, and the versions of reality presented by the study social workers have thus been subjected to continual deconstruction. This raises a question as to the origin and validity of the alternative readings presented by the researcher. Is it claimed that they are ‘better’, or just different, versions of reality? These dilemmas are widely debated by those who write about qualitative research methodology and positions are taken about the feasibility of eliminating bias when collecting and interpreting qualitative data (Hammersley 1989; Mason 1996; Shaw and Gould 2001). It was suggested, however, when describing the developing

methodology (pp.71-72) that there are additional challenges facing the practitioner-researcher. This complexity is further compounded where the researcher has some responsibility for the practice being studied and, hence, commenting not only on an area of work which is professionally familiar but where there is a degree of direct involvement. If it is an expectation of valid research that it contain an element of neutrality, then a personal stake could be said to invalidate the findings. These dilemmas, and the resulting challenges posed to the credibility of the study, are now explored with a view to the reader making their own judgement.

Claims to knowledge within social work theory and practice have been the subject of considerable recent attention (ESRC 1999-2000; Gibbs 2001). The notion that social work researchers possess privileged knowledge is challenged by suggestions that 'practice wisdom' (Sheppard 1995, 1998) or 'informal theory' (Powell 2002) held by practitioners are also valid ways of knowing. Powell advocates a dialogue whereby knowledge is negotiated rather than claimed and where the participation of the practitioner is an essential element. Fook (2001) describes the development of her ideas about knowledge when undertaking a study of social work expertise and summarises the researchers' dilemma in considering: '...what right we had to make particular judgements and interpretations of interviewees' transcripts (p.120).' Fook consequently questioned the privileged role of the researcher over that of the study practitioners themselves but also described the difficulty of trying to empower them to develop their own meanings given their lack of access to an overview. She concluded that there is a place for both researcher and practitioner knowledge.

One response to these contested ways of knowing has been to advocate a reflective style, whereby the researcher attempts to identify and describe both their pre-conceptions and the influence they may have had on the research. Both Gould (2000) and White (2001) identify dangers with this 'confessional' approach. By potential sources of bias being made explicit, the reader is disarmed from criticism and persuaded of the authenticity of the account. This is just another form of realism, whereby the researcher claims better knowledge. White suggests that a more useful approach, described as reflexive rather than merely reflective, is to problematise taken-for-granted knowledge, requiring the researcher to look not just at their inner processes but to the outside world. She describes the research project she began when working as a social work manager and characterises her stance as being on the *inside* 'out'. White challenges the suggestion that a practitioner-researcher cannot achieve

sufficient distance from the material and thereby can only reproduce dominant forms of thought. Instead, she describes a process of defamiliarisation with everyday practice through adopting a different personal or theoretical gaze. When conducting her study of child protection practice, White's early examination of the case files which formed the data suggested nothing remarkable because of their familiarity. However, through reading and re-reading them it became possible to see patterns, such as a subtle blaming of families, which had not previously been apparent. Once aware of this, the components of the social worker's 'sense-making' were exposed to critical scrutiny. A result of this process, described as one of destabilisation, is that 'it becomes extraordinarily difficult to continue to think as usual' in the practitioner role. The identities of researcher and practitioner become separated and engage in an unsettling dialogue.

The experience of combining the role of manager and researcher, and of conducting a study which touches personal practice, is closely mirrored here. The process of defamiliarisation described by White has considerable resonance, and is perhaps similar to the 'thinking against' process described by Featherstone (2000). A conscious effort was made to think differently whilst reading the data. The fact that new and unexpected meanings presented themselves is perhaps an indication that this was, to some extent, successful. White suggests that the social work judgements she illuminated in her practitioner-research were not necessarily wrong but would benefit from being made explicit and thus exposed to challenge. She also acknowledges that her own readings were not infallible but were presented so that they, in turn, could be argued with. The same position is taken here. However, it would be misleading to pretend not to have a personal standpoint. When reading the case files, it was impossible not to occasionally think as a manager: to feel that particular instances of practice were 'bad' or to seek reassurance about the superior standard of the researcher's own practice (*...had that been my case, I wouldn't have done it like that...*). Interestingly, however, personal practice was not immune from this phenomenon of defamiliarisation. There were instances where there had been direct involvement with a case but the research process opened up alternative viewpoints (*...if I were working with that case now, I would do it differently...*). Phrases which had been used without question as a practitioner, such as the need for mothers to 'put the baby first', began to provoke discomfort. This was a disturbing experience because it led to both a recognition and questioning of the assumptive basis of decisions that had been made as a manager. It also raised interesting questions about the value base underpinning practice. Long forgotten

principles of empathy, positive regard and a non-judgemental attitude were remembered and re-evaluated, as was an awareness of power and gender issues. Inevitably, this process of destabilisation began to change the approach to practice and there was a need to develop a personal strategy for dealing with both the *surface* and *depth* issues presented by current cases. The social work practice and the research process became inextricably linked, both requiring a reflexive stance.

A constant temptation was to present alternative (better) practice responses: (...*this is what should have been done*...). Whilst this may be at odds with the notion of research as the pure generation of knowledge, it is perhaps understandable when researching an applied discipline. The problem is particularly acute within practitioner-research where the dilemma becomes whether to try to suppress these impulses in order to be a ‘proper’ researcher, or to somehow ‘use’ the insights gained from seeing the practice in a different light. This struggle relates to the notion of identity, and whether the elements of practitioner and researcher can be said to engage in a dialogue or are inevitably in conflict. Within this study, the sections of the text where the dilemma may be particularly evident to the reader are in the alternatives to the stories offered by the social workers of Hassan, Jake and Leanne within Chapter 6 (pp.110;123;138). It would be legitimate to question where these stories came from: were they *really* present in the text and, if so, which identity within that of the practitioner-manager-researcher was taking the lead in their telling? When ‘better’ ways of practising suggested themselves, did this mean that the researcher role had temporarily been suspended or were multiple ways of knowing being called into play? These are impossible questions to answer in that the identities were simultaneous and overlapping, albeit with occasional skirmishes for supremacy. As Fook (2001) describes it, we can never escape from our own lens. The alternative readings of the evidence offered were intended to challenge the taken-for-granted, and it is hoped not only that readers will find them plausible but that they will stimulate debate about ethical practice. However, they are offered without apology. Even were it possible to suppress the practitioner and manager aspects of the identity, this would seem to be a denial of an important voice. As Powell suggests (2002), there is no reason why the knowledge-claims of researchers and theorists should be privileged over those originating in practice.

Similarly, it could be argued that the researcher’s identification and commendation of reflexive practice (p.205) indicates an inability to escape from the identity of manager.

Again, this is accepted but without apology. The wish to 'judge merit' within social work, and to identify the components of good practice, are inherent in an ethical approach to social work theorising. An analysis of how social work operates without some attempt to apply the insights gained would seem to be a sterile exercise. The origin of the model which is offered can certainly be challenged, in that nuances of practice are inevitably subjective. It is possible that another researcher might read the texts and have a different interpretation, perhaps feeling that the failure to engage in a relationship with families reflects a more business-like approach, or that the recorded reflections of some social workers about their practice were a self-indulgent waste of time. These are essentially value judgements, and perhaps the best we can aspire to is to know where we stand. However, personal experience suggests that research activity influences this standpoint: instead of declaring a (fixed) position and thus setting it aside, new positions evolve. Fook (2001) acknowledges this and suggests that the perspective of the practitioner-researcher may be an integral part of the experience being studied, opening up different ways of understanding practice. The practitioner is perhaps uniquely placed to develop new meanings because of their first-hand knowledge of those that already exist. Thus the nature and purpose of social work research are inextricably linked to practice. In his attempt to propose a code of ethics for social work research, Butler (2002) suggests that it must derive from the ethics of social work itself. Rather than being rigidly fixed in time and space, he proposes a framework based on the four principles of respect for autonomy, beneficence, non-maleficence and justice, 'plus scope'. This notion of scope obliges the 'morally active practitioner' to determine how the principles are applied in their day-to-day social work practice/research. The requirement to ask moral question is inherent in all aspects of the work, whether as a practitioner making judgements about families or a researcher generating and analysing data about that practice. The presentation of the resulting interpretations to an audience, whether as social work reports or research findings, must be particularly scrupulous because this is where claims to truth can be found.

This debate relates back to the fundamental nature and purpose of the study as discussed in Chapter 1. Having identified a topic that seemed to justify closer examination because of its practice relevance, the first question was *how* it could be studied by an involved practitioner with limited knowledge of research methodology. In the early stages, anxieties were raised about the notion that the proper purpose of research was to test a predetermined hypothesis, and the perceived need to eliminate bias. However as the study unfolded, the process of

being *inside* 'out' began to offer new ways of seeing the practice, both positive and negative. The challenge became, not to strive to be an objective researcher, but to integrate and build on the knowledge gained as a practitioner with the emerging insights from the study. It would be unrealistic to claim that the perspectives of the practitioner could be distinguished from that of the researcher, and any vested interests set aside. Robson (2002) describes the advantage of 'practitioner-researcher synergy' whereby practitioner insights are of assistance at all stages of the research process. Within this study, practice experience provided not only an understanding the organisational context but facilitated a process of 'making sense' of data that may have seemed impenetrable to others. For example, child protection workers are under immense pressure both to *get it right* and to *give parents a chance*. Personal experience of these pressures was of benefit when trying to understand the stories they told. Not only did the voice of the practitioner creep into the research, however, but the researcher demanded a re-evaluation of the practice. Rather than the goal being to achieve the separate identities advocated by Fuller and Petch (1995), it seemed beneficial to allow them to co-exist and communicate if useful knowledge was going to be generated. The aims of the project had thus changed from an attempt to 'prove' the effectiveness of pre-birth assessment to an opportunity to critically reflect on what the practice meant, allowing the researcher to rediscover and develop personal values and understandings. The goal of social work research is thus proposed as the negotiation of knowledge which rings true rather than that which lays claim to methodological purity. Indeed, the same goal could be applied to social work itself, whereby knowledge should be negotiated between practitioner and client rather than being claimed as the product of expertise.

To return to the topic of the study, it is hoped that the process of pre-birth assessment will have been illuminated and the reader is now invited to consider the wider implications. Reflecting the themes of surface and depth which underpin the thesis, these will be considered, firstly, in terms of the policy and procedural framework and, secondly, the meaning of good practice.

The procedural context: guidance or bureaucracy?

All practice is located within a policy and procedural framework. Although this thesis rests on the premise that pre-birth assessment cannot be understood merely as a technocratic activity, an argument can certainly be made for clarifying the bureaucratic framework within

which the work takes place. It is important that practitioners can work to an agenda which makes sense both to them and to the families on the receiving end, and that all the players know what the rules are. The evidence of this study would suggest this not to be the case. Although government policy places the practice of pre-birth assessment firmly within the child protection system, the findings reveal that social workers struggle to make the system fit these complex and highly charged situations. *Working Together* (Home Office *et al.* 1991; Department of Health *et al.* 1999) implies that there is no distinction between an unborn child and one who has achieved the independent identity conferred by birth. This glosses not only over the philosophical conundrum of the concept of personhood but also the practical and legal impossibility of protecting a child who is inextricably linked with her/his mother.

Practitioners are given no guidance as to how to make sense of the decision to place an unborn child on the child protection register or how the standard process of undertaking s.47 enquiries can be adapted to meet the unique circumstances of unborn children. Perhaps the answer lies in yet more procedures clarifying the bureaucratic process: the historic response to perceived shortcomings within the child protection system. Certainly some anomalies could usefully be addressed, but a more fundamental challenge is whether the system actually provides the most appropriate framework for undertaking such assessments.

The overwhelming nature of the concerns places such families in a category described by one conference chair as being 'beyond child protection'. Moreover, apart from any logistical problems, the child protection framework compounds the moral unease of intruding into the sanctity of private procreative activity. It could also be seen as unnecessarily persecutory of parents facing problems of their own to talk in terms of abuse when the real issue is one of capacity. But is there an alternative way of conceptualising the problem whilst still responding effectively? If a 'softer' option were allowed, this could provide an opportunity for social workers to take an even more tentative approach and for families to successfully avoid attempts to engage them in an assessment. This would be at the expense of an extremely vulnerable population of babies where, if anything, concerns are greater than for many of those subject to a standard child protection investigation.

The need is for a process that can respond to the potential harm facing the unborn baby but without necessarily locating the activity within the child protection discourse. The new

Framework for the Assessment of Children in Need and their Families (Department of Health *et al.* 2000) theoretically provides this opportunity in that it is based on a single model for assessing *all* children, whether prompted by the need to safeguard or to promote their welfare. It prescribes an ecological approach which recognises that the well-being of a child is dependent on the interplay between their individual needs, the parents' capacity and the wider social and environmental network. The language of 'risk' has been abandoned in favour of the language of 'need'. This could be seen as a useful shift away from the stark and accusatory nature of the forensic child protection discourse towards a more collaborative approach. However, themes regarding parental dangerousness can still be detected in suggestions that the factors having an adverse effect on parenting behaviour are primarily substance use, mental illness and domestic violence: echoing Dingwall *et al.*'s (1983) 'incurable' parents. Moreover, the procedural nature of child protection work remains largely unchanged, with separate guidance being provided in an updated version of *Working Together* (Department of Health *et al.* 1999). If the system were genuinely integrated, the need for separate bureaucratic responses should disappear. It remains to be seen whether families will notice and make sense of the changes.

The *Framework* reflects the child development model of childhood, with social workers being prompted to base their judgements on the child's needs according to their age and stage of development. It contends that normative judgements can be made both about those needs and the parenting tasks required to meet them. There is no attempt to disaggregate the respective roles of mothers and fathers in spite of the growing body of evidence about the gendered nature of both parenting and childcare practice (see Chapters 2 and 3). Of interest here is whether the *Framework* is likely to provide a more coherent system for assessing unborn children. The literature review underpinning the *Framework* (Cleaver *et al.* 2000) did grapple with the needs of the unborn child and the nature of good parenting at this stage but the guidance itself has omitted the topic altogether. Although the dimensions of children's needs, parenting capacity and the wider social and environmental context could conceivably be adapted to a consideration of *future-parenting*, this task is left to the practitioner. If we consider the study population, the *Framework* would perhaps have allowed a more systematic exploration of matters such as parents' ability to ensure safety or the likelihood of the baby's health needs being met. As with the previous guidance, however, there is a sense in which unborn children are not consistently held in mind. This is confirmed by the accompanying practice tools, the first of which is designed for use when

assessing 0-2 year olds. Childhood is thus established as beginning at birth.

It is too early to say how far the new policy agenda will impact on social work practice, and pre-birth assessment in particular. On the one hand, it does require practitioners to be more transparent and systematic about the evidence for their opinions: on the other, it takes an unquestioning stance towards the nature of that evidence with no apparent recognition of the social constructionist perspective ostensibly acknowledged in *Messages from Research* (Department of Health 1995a). Interestingly, the *Framework* itself urges social workers to exercise professional judgement, and to acknowledge the importance of meaning when undertaking assessments. The accompanying forms, however, are highly prescriptive and could be criticised for implying that asking the right questions (in fact ticking the right boxes) will provide the right answers. Social workers risk becoming bogged down in gathering standardised information of little meaning to the families, or indeed to the workers themselves. The rigid timescales may also not reflect the evolving, negotiated nature of pre-birth assessment, with the unborn child gradually acquiring subject status as the pregnancy advances. There appears to be no good reason for completing an assessment within the mandatory 35 days, rather than at a pace which is acceptable to the family and allows for consideration of the new information that will emerge following the birth.

Moreover, there is a tension between an essentially normative, passive view of childhood and the directive to consider the wishes and feelings of children. If children, and particularly babies, are considered to be essentially an immature 'bundle of needs', how can they also be taken seriously as subjects? Perhaps this has contributed to many aspects of the *UN Convention on the Rights of the Child* remaining a statement of intent rather than a reality. The alternative paradigm proposed by sociologists of childhood portrays children as competent social beings who should be valued in their own right, and as active participants in their own socialisation (James and Prout 1990; Mayall 1994). The challenge then becomes one of finding ways in which they can be given an effective voice.

Whatever the proper bureaucratic framework for conducting pre-birth assessment, the findings indicate that a *lack* of guidance is also problematic. Social workers need to have some basis for their actions and, in the absence of guidance, are forced to rely on implicit values and assumptions. A framework is needed which can encompass valid areas of concern but still allow for an acceptance of uncertainty within which meaning can be

negotiated. Reliable prediction may be an unrealistic aspiration, but the exercise of sound judgement is not. The findings suggest the essential procedural requirements to be: that the family know they are going to be assessed; the form that assessment will take; the process for making decisions, and that they have a voice in the process. Whether this assessment takes place within the child protection system or not seems to be of less importance than the necessity to undertake it in a spirit of openness and engagement with both parents and the baby.

Having undertaken the assessment, it is essential to maintain this stance to ensure a good outcome for the baby. Again, policy and procedures need to respond effectively where children cannot be cared for by their parents. This study demonstrated that the current planning system for children is essentially rigid and linear, with attempts to provide alternative permanent carers commonly only being initiated when all attempts at rehabilitation have failed. It is usually the case that babies who are removed from their parents are initially placed, sometimes for months or even years, with short-term carers because to do otherwise is seen to pre-empt the decision-making powers of the courts. There may also be repeated attempts to give parents another chance even where there are no reasonable grounds for optimism, or, as occurred with some of the study families, purposeless residential placements. Although a position where parents are *not* given a chance would be morally indefensible, a crucial judgement must be made as to when to draw the line given the critical age of the children. These matters are complex and indefinable in bureaucratic terms.

However, the bureaucracy could respond more effectively in recognising that the prospect of some parents being able to provide care for their baby is unlikely but not hopeless. The reader may feel that this scenario was illustrated by the case studies. The development of concurrent planning schemes (Katz 1996) is an attempt to balance the needs of parents and babies by recruiting carers specifically to look after children in these situations. Carers are enlisted who are prepared to support parents in their efforts to resume care of their children *but* will look after them on a permanent basis if this becomes unfeasible. Again, this accords with a flexible and collaborative approach.

The study highlights the need for debate about the fact that some babies' interests are likely to be served by providing them with alternative carers at an early stage. Whilst this falls

within the broader childcare agenda, there are unique dilemmas requiring recognition if practitioners are to be properly supported. Guidance needs to go beyond a narrow assessment of risk to respond to the emotional impact of making such momentous and far-reaching decisions, on what may appear to be an uncertain evidence base. The current policy context fails to acknowledge these issues, leaving social workers to manage and make sense of the dilemmas on behalf of a liberal society where such matters provoke discomfort.

The nature of good practice: competence or expertise?

The policy framework within which pre-birth assessment takes place is important because it defines the purpose and shape of the activity. However, we have seen that individual practitioners chose to fulfil their mandate very differently. The surface world of procedures is fixed but the in-depth world where practitioners interpret those procedures allows some room for manoeuvre. Turning now to the professional implications of the study, the question arises as to the meaning of good practice in this area of work. It is not the aim of this thesis to suggest a checklist of factors that should be included in every pre-birth assessment - this would not accord with the perspective of the researcher - but it is contended that there are lessons to be learned.

The essence of social work theory is elusive:

Social work rests on a set of contradictory assumptions, a pot pourri of paradigms – a generous helping of psychodynamics, social science theories, systems theory and a sprinkling of behaviourism. It is small wonder that social work is characterised by confusion, burn-out, endemic vagueness and a lack of professional confidence (Thompson 1992, p.71).

How then can the meaning of good practice be understood? A traditional version of expertise is the skilled application of specialist knowledge, generated by research. Before the demise of welfarism in the 1980s (Otway 1996; Parton 1996c), social workers were considered to be specialists in the new human sciences, the ‘psy’ complex, whereby they were able to diagnose and treat the pathology underlying abusive parenting. Now the very existence of social work expertise is contested. Cohen (1996), writing about the credibility of expert witnesses, reports the appeal court’s view that social work experience is insufficient as a basis for reliable opinion evidence and that only those with a psychology or psychiatric background can claim expertise. This reflects the assertion of White (1998) that

the psy complex is alive and well but has been incorporated into the legal process rather than being the province of social workers.

If social workers are no longer considered to have privileged knowledge about the inner world of their clients, how else can expertise be claimed? The current emphasis is on competence, displayed through standardised and measurable performance, rather than the exercise of judgement (Jones 1996; Webb 1996; Aymer and Okitikpi 2000). Yet this question of judgement cannot be avoided, even though it is largely invisible and does not lend itself to quantitative measurement. This is echoed within the study, where there appeared to be different approaches to practice whilst ostensibly operating within the same 'rules'. Thus it appears possible for a social worker to perform well whilst not necessarily doing a good job: the invisible aspects of practice must also be considered before it can be evaluated.

The difficulty lies in determining the nature of sound judgement. Within this study, judgements appeared to be based on an unquestioned discourse about the natural mother, the peripheral father and the passive baby. Whilst the validity of these notions in telling a reliable story about family life is challenged, it is not asserted that there is a ready-made body of knowledge that *should* have been applied in their place. Instead, it is proposed that alternative, more productive, ways of thinking about the assessment task are needed. Smale *et al.* (1993) describe three models of assessment: questioning, procedural and exchange. The implicit assumption of both the questioning and procedural models is that, if the right information about the family is collected, judgements will be unproblematic but, as Munro (1998a) points out, 'Facts on their own are silent'. This hints at a conspicuous weakness in the guidance to social workers: how to *make sense* of information in order to reach a judgement. Returning to Sheppard's assertion (1995,1998), observing and attempting to make sense of the behaviour of others can be described as a process of analytic induction whereby hypotheses are developed in the light of evidence. The accumulated knowledge gained by practitioners through this process is defined as practice wisdom. To operate effectively, practitioners need to develop reflexivity: to be 'active thinkers', continually refining their hypotheses about the client's situation whilst retaining an awareness of the way in which their own participation affects the process. White (1997) agrees with Sheppard's premise, but feels it does not go far enough because it operates within a realist paradigm, implying that the social worker can uncover the truth rather than accepting that there are

multiple truths to be told.

This brings us back to an earlier debate about the ‘myth’ of assessment. The contention that multiple constructions of the evidence are always possible could be seen as undermining claims about the validity of social work judgements. However an alternative position could be argued: that subjectivism is an essential element of practice and not an indication of failure. This does not mean that all judgements are equally valid. Some would appear to stand up to scrutiny whereas others would not. Krane and Davies (2000) contest that it is proper for social workers to make judgements and to exercise authority:

The problem is not in judgement itself, but in the lack of reflexivity in the way that judgements have been developed and applied. Professional judgements should be transparent and open to critical reflection and challenge (p.43).

These themes are explored by a number of writers and can be seen as a plea for a new paradigm for practice based on a rejection of the technocratic nature of the present system and a commitment to critical reflection. One element of this paradigm may be characterised as the recognition of uncertainty (Thompson 1992; Pozatek 1994). As Parton (1994, 1998) suggests, the goal of certainty was, anyway, unrealisable. This stance requires an acceptance that the risk of harm can never be completely eliminated from social work practice (Hollis and Howe 1987). Another element is self-awareness, whereby social workers unpack the ‘dominant professional constructions influencing their practice’ (White 1997). She characterises those currently operating within childcare as being ‘notions of parental dangerousness and fragile childhoods’, echoing the findings of this study. This awareness is with a view, not necessarily to rejecting the constructions, but subjecting them to critical scrutiny. Munro (1998b) also urges social workers to put their reasoning into words, thus exposing it to scrutiny and evaluation. This will not only make practice more accountable but contribute to its effectiveness:

The evidence from research suggests that much practice rests on incomplete assessments and hazy plans. For some social workers therefore being more explicit will not just involve making their reasoning public but adopting a more reflective, purposeful style of working (pp.195-196).

The process whereby judgements are reached is therefore exposed to challenge. An important element within this process is the extent to which the client has been involved.

Horne (1990) writes about a return to the basic value of respect for persons, relating to individuals and mediating on their behalf. This is not a plea to return to welfarist notions. Both the psy (casework) *and* the competency approach require a level of involvement with clients but fail to relinquish the practitioners' monopoly of valid knowledge. Alternatively, rather than the assessor examining the evidence and drawing their own conclusions, an *interactive* approach would allow for all versions to contribute to the social worker's understanding. This accords with Smale *et al.*'s (1993) exchange model, whereby the assessor and the assessed enter into both dialogue and negotiation. For example, Ryburn (1991) concludes that prospective adopters should be given the opportunity to undertake a self-assessment: to tell their *own* story with social workers acting as facilitators. Boushel and Lebacqz (1992) present examples of 'empowerment' in child protection work where individuals were allowed to determine their own roles rather than having them imposed by professionals. Mass (1994) proposes the development of a new paradigm for assessments of parenting, based on the relationship between parental beliefs and actions. Again, it is the subjective meaning of parenting rather than generalised assumptions about parental love that is considered to be crucial. The infant is accorded subject status within this model, actively shaping the relationship with the parents. Spratt and Houston (1999) argue that the worker/client relationship is central to the social work process. Rather than an insistence on expertise, social workers need to adopt a reflexive style. Similarly:

In objectivist approaches, there is no need for reflexivity because the professional is perceived as the expert; however, in constructivist social work (i.e. social work founded on subjective assumptions) there is an emphasis on mutuality: on a two-way exchange of perceptions between the worker and client (Houston and Griffiths 2000, p.7).

However, it may not be necessary to reject the notion of expertise but to develop an alternative understanding of its meaning. Fook (2000) describes perceptions of expertise amongst experienced social workers and contrasts these with modernist conceptions. She found that the attributes of a 'good' worker seemed to be rooted in practice rather than an ability to apply theoretical knowledge. Social workers in her study recognised the need to engage rather than attempting to maintain detachment, and saw this involvement as crucial to the outcome. Fook asserts that expertise is demonstrated by the mutual generation of knowledge with clients and an ability to live with uncertainty, rather than the imposition of preconceived ideas. The notion of knowledge as negotiated reflects the earlier theme of 'true' partnership with parents whereby their status as subjects is restored.

A theory for practice?

Whilst the alternative paradigm/s described above are relevant to the themes of the study, the question remains as to whether they could feasibly be implemented in this area of practice. Is it possible to embrace the notion of uncertainty and subjectivity whilst working within a system that expects practitioners to 'get it right' by following procedures? In spite of the official rhetoric, practitioners are left in no doubt that they will be judged on their ability to identify abuse. Press coverage and Government statements following the death of Victoria Climbié (*Community Care*, 11 and 18 January 2001) make it clear that the social worker was considered to have 'failed' in her duty to assess and manage a child at risk. The responsible minister has promised yet another overhaul of the child protection system. A paradigm for practice that does not acknowledge this political context is inevitably flawed and indicates to practitioners yet more ways in which they are failing, without offering any thoughts as to how ethical practice can realistically be achieved.

Consequently, the suggestion that social workers should be able to *openly* engage in critical reflection with colleagues and clients may be difficult to achieve in the current climate. The 'discourse of ethics' described by Habermas (1993) is rarely evident to those of us in practice, where there are endless debates about systems, targets and budgets but sparse discussion of fundamental values. Without this discussion, individual workers may feel too vulnerable to expose their practice to the critical examination of others. This was confirmed by a study undertaken by Rossiter *et al.* (2000), who found that ethical practice is negotiated through open dialogue rather than existing within individual cognition or the application of fixed codes of practice. Where there was a culture of distrust or problematic office 'politics', this process was impeded. There may be a sense in which alternative paradigms are subversive and cannot be openly expressed, only therefore being sustained, as Fook (2000) suggests, by a strong personal value base.

The conditions within which a reflective approach can thrive are not straightforward, however, and cannot be simplistically linked to the oppressive effect of proceduralisation. Some of the least reflexive practice within the study took place in the least managed settings and vice versa. It is important to draw a distinction between management, where practitioners are required to be accountable for their practice, and managerialism, with its focus only on technical performance. There is nothing intrinsically wrong with procedures:

the danger lies in an inability to see beyond them. The approach of practitioners appeared to be determined by a combination of individual perspective and informal office culture. As Pithouse (1987) says, perhaps practice can only be understood in its situated context, with workers taking on the ethos of their team to demonstrate that they are doing a good job. It is also important to acknowledge that workers practising in contemporary society have no choice but to follow procedures. However, this still allows some scope in the way in which the 'invisible' aspects of the role are conducted. The restoration of the subject is one element but, again, there is a particular difficulty for childcare practitioners in the notion of subjectivity. Although it may be possible to accord a degree of agency to parents, the 'real' client is the child. The subject status of children is problematic, with few opportunities for them to make their voices heard or to exercise agency. What hope, then, is there of 'listening to' babies - particularly the unborn?

In spite of these difficulties, the study provides clues that it is still possible to incorporate reflexivity and respect for persons into practice. Aspects of a particular style were evident which, interestingly, seemed to be associated with a good outcome for the baby in addition to any gains for the other players. It was characterised by the following:

- *Proactive engagement*: rather than waiting for events to unfold, the social worker actively engaged the family in the assessment process and formulated a clear plan.
- *Adaptability*: whatever the initial plan, the social worker was prepared to adapt it to meet changing circumstances.
- *Child focused approach*: the social worker was able to perceive the baby as a subject, and to ensure they remained at the centre of the process.
- *Partnership*: while recognising the previous point, some social workers were able to establish a relationship with parents which enhanced the quality of both assessment and planning.
- *Non-stereotypical*: social workers were able to work with subjective and individually negotiated meanings rather than basing their judgements solely on assumptions about, for example, gender or race.

Social workers adopting this style were able to negotiate a position whereby they adhered to the bureaucratic framework whilst also allowing parents a degree of agency in telling the story and shaping their destiny. Rather than providing a family with the script of self-

sacrificing mother and indifferent father, they allowed them to improvise aspects of their role and reported conversations in which they shared perspectives and acknowledged difference. This approach was markedly lacking in other instances, where the emphasis was purely on categorising families with minimum interaction.

There is no way of knowing from an examination of the case files whether these respective practice styles were valued and associated with expertise, viewed with suspicion, or went unnoticed. The only clues are available through the rarely expressed comments of the families or, implicitly, through their recorded behaviour. A failure to engage may not, as *The Challenge of Partnership* (Department of Health 1995b) suggests, be the responsibility of parents but rather a consequence of the practitioner's attitude. Social work records do not require their authors to explain their approach and it may be that practitioners were operating intuitively rather than critically. Alternatively, they may have been driven by the need to construct a 'safe practitioner' alongside the 'safe' family: one who dare not expose their reasoning to challenge.

What are the implications for those who want to develop their practice beyond the more narrowly conceived goal of competence? A central element of these emerging notions is the importance of genuine communication between worker and client, rather than a mechanistic response. This may be a more achievable goal within the current climate than the overt critical reflection proposed earlier. Blaug (1995) describes social work as having been colonised by instrumental methods, designed to get the task done at the expense of communication. This is 'a distortion of the face-to-face interaction which lies at the heart of human caring'. He draws on the work of Habermas in calling for practitioners to adopt instead a model of communicative fairness whereby 'all those affected must be allowed to speak, all must be listened to, and all must be allowed to question others'. Practice can be judged against this standard.

Our best hope is to remain focused on the basic insight: that care involves people and is thus most properly conceived as communicative practice oriented to mutual understanding. For this reason, fair discussions about aims, means, fears and ideas are not to be described as merely wasteful adjuncts to efficient care (Blaug 1995, p.437).

Parton and O'Byrne (2000) cite the numerous studies in which clients have asserted the value of being listened to and understood. They emphasise the need to have conversations

with clients about their perception of their difficulties not, as Sheppard (1995) suggests, in order to develop and test a hypothesis, but in order to allow the client's own agency in finding a solution. They describe their attempt to develop a 'theory *for* rather than *of* practice' and propose a model of 'constructive social work' which recognises the importance of talk and language, both in making sense of situations and achieving change. If the client is allowed to tell their own story (Featherstone 2000; Houston and Griffiths 2000) then a genuine dialogue can take place. The practitioner thus has to constantly evaluate their own responses, challenge their assumptions and resist the urge to impose their own story.

Final thoughts

Social workers need an approach to assessment which avoids the pitfalls of naïve objectivism and the nihilism of anarchic relativism, whilst retaining *creativity*, *imagination* and *hope* (White 1997, p.751).

The thesis began with an account of the uncertainty experienced by the writer at the start of a career in social work. This was resurrected by taking on the new role of practitioner-researcher but, instead of resolving the problem by uncovering the 'truth', the research suggested yet more ways of understanding social work practice. Uncertainty is now valued, however, as a reminder of the extraordinary power we have to influence the most fundamental aspects of other peoples' lives. When working with *future-families*, social workers make recommendations about who should take their baby home from hospital and who should be 'disqualified' from parenthood. Such decisions must be amongst the most challenging within the profession, arousing strong emotions about state intrusion but with serious consequences if they are 'wrong'. The vulnerability of both the babies and their parents was demonstrated by this study, including the fact that their very survival as a family unit was unlikely. Sadly, Tyra Henry, Doreen Aston and Mia Gibelli demonstrated that survival itself may be at stake if the risks are not addressed. All died at the hands of their parents despite serious concerns about their safety having been expressed before they were born. Yet practitioners are offered little support in doing, or even thinking about, the task. The procedural framework states only that the work must be done, whilst failing to address the complexity, and there is no adequate conceptual framework for making judgements when faced with such concerns.

This inadequate basis for practice has much in common with other aspects of child

protection work, and indeed social work in general, within contemporary society. The focus on a rational-technical model has led to a belief that assessment is a straightforward task if only the right information is gathered in a competent manner. Whilst this may generate some nostalgia towards an earlier tradition within social work, based on principles such as empathy and positive regard, this too had its problems. Both models are based on the claim that social workers know best. Instead a new movement is emerging which proposes the restoration of the client as subject, whereby meanings are negotiated rather than imposed and human interaction is at the heart of the enterprise.

It could be argued that this model for practice is particularly relevant to work with *future-families*. All the subjects are uncertain and, therefore, there are *only* meanings on which to base a judgement, but it must be acknowledged that these meanings will be uniquely complex. The challenge is to conceptualise and value the unborn child whilst avoiding the trap of treating the mother as a human incubator. It would be naïve to suggest that there will never be conflict over whose needs should be privileged, and this thesis is not advocating that the bureaucracy be dismantled in order to return to a purely welfarist model where everyone can be ‘helped’. Instead, the task for the future is to initiate a wider debate about the concept of *future-parenting*. Social workers may be responsible for mediating between individuals and society but they are also the bearers of that society’s cultural norms and values. Unless these values are made explicit, social workers carry the burden alone.

The focus of this study has been an invisible aspect of social work practice. The problematic nature of the task has inevitably resulted in a problematic response and the study has revealed something of the diversity of this response, much of which gives cause for concern. Nevertheless, in spite of the difficulties, there were instances of practice which suggested that the creativity, imagination and hope described by White may still be possible, and that good practice can be achieved even within the current climate of quantitative measures and scarce resources. This is because the intangible element which seems to make a difference is whether the practitioner places value on the formation of a human relationship with family members rather than relating to them only as objects of concern. The result may be a more dynamic and negotiated version of the family. Whatever the prevailing system, social workers can always *listen* to their clients and enable them to tell their story. In a sense the thesis ends where it began: with the struggle to communicate and understand restored to a central position within social work practice.

PRE-BIRTH ASSESSMENT:

Case no.....

CENTRE / HOSPITAL: 1..... 2..... 3.....**FAMILY COMPOSITION:**

	<i>DOB</i>	<i>GENDER</i>	<i>ETHNICITY</i>	<i>IN HOUSEHOLD</i>	<i>AGE AT BIRTH OF CHILD</i>	<i>AGE AT CONFERENCE</i>	<i>REGISTER</i>	<i>CATEGORY</i>
SUBJECT								
MOTHER								
FATHER								
SIBLINGS								
OTHER								

1. BACKGROUND.

Previous involvement with Social Services / other agencies.

2. REFERRAL RELATING TO SUBJECT

a. Who made the referral?

b. Gestation / age of subject

c. Identified concerns

d. Response to referral. Was an assessment/ investigation undertaken? When?

3. NATURE OF ASSESSMENT

a. Network checks?

b. Contact with mother. When? How often? Where? By appointment?

c. Contact with father.

d. Contact with extended family.

4. CONTENT OF ASSESSMENT

a. Mother. Language used. Opinion re parenting ability. Evidence cited. Meaning of pregnancy/ child explored.

b. Father. As above.

c. Other factors considered to be relevant. Social circumstances. Support networks. Race and culture etc.

5. PARTNERSHIP WITH PARENTS

a. Mother. Involvement in assessment. Invited to meetings. Written agreements. Wishes / feelings taken into account. Views recorded and acknowledged in plan/ correspondence/ case notes.

b. Father. As above.

6. PROFILE OF PARENTS

a. Mother. Substance use. Mental health. Violence . Self harm. Housing. Employment. Age. Childhood experiences. Stability of partnership.

b. Father. As above.

7. INVOLVEMENT OF OTHER PROFESSIONALS.

Who did social worker consult? What about? Are their views recorded?

8. MEETINGS HELD.

a. When.	b. Status.	c. Decisions taken.
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9. CONFERENCES HELD.

a. When.	b. Decision re register.	c. Category
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10. PROTECTION PLAN.**11. IF NOT REGISTERED, SERVICES OFFERED / PLAN.****12. WERE PLANS IMPLEMENTED.****13. CAREER OF CASE**

a. Was child harmed.

b. Did registration status change. When.

c. Did child remain with parent/s. If not, who cared for child.

d. Legal intervention.

14. COMMENTS.

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